PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Passport Health Plan by Molina Healthcare

(Passport Health Plan or Passport)

Medicaid 2021

Last Updated: January 2021

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at **www.passporthealthplan.com**.

Passport Health Plan by Molina Healthcare Medicaid Provider Manual
Any reference to Passport Members means Passport Medicaid Members.

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1. Addresses and Phone Numbers

Passport Health Plan by Molina Healthcare
5100 Commerce Crossings Drive
Louisville, KY 40229

Network and Provider Services Departments

The Network and Provider Services departments handle telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. The Provider Services department has Provider Services representatives who serve all of Passport's Provider network. Eligibility verifications and claims status can be conducted at your convenience via the Provider Portal. There are also telephone representatives available to answer general inquires 8:00 a.m. to 6:00 p.m. Monday through Friday.

Phone: (800) 578-0775
Fax : (502) 585-6060

Member Services Department

The Member Services department handles all telephone and written inquiries from Passport Members regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services representatives are available 7:00 a.m. to 7:00 p.m. Monday through Friday. Eligibility verifications can be conducted at your convenience via Provider Portal.

Phone : (800) 578-0603
TTY/TDD : 711

Claims Department

Passport strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or Provider Portal) whenever possible.

- Access the Provider Portal (**www.Availity.com**)
- EDI Payer ID 61325.

To verify the status of your Claims, please use the Provider Portal. For other Claims questions contact Provider Services.

Claims Recovery Department

The Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims.

Passport Health Plan by Molina Healthcare
5100 Commerce Crossings Drive
Louisville, KY 40229

Phone: (866) 642-8999

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, you must report it to Passport. You may do so by contacting our AlertLine or submit an electronic complaint using the website listed below. For more information about fraud, waste and abuse, please see the Compliance section of this Provider Manual.

Confidential
Compliance Official
Passport Health Plan by Molina Healthcare
5100 Commerce Crossings Drive
Louisville, KY 40229

Phone : (866) 606-3889
Website : https://MolinaHealthcare.alertline.com

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every 3 years, or sooner, depending on Passport's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Passport network.

Molina Healthcare, Inc.
Attn: Credentialing Dept.
PO Box 2470
Spokane, WA 99210

Phone: (800) 578-0775

24-Hour Nurse Advice Line

This telephone-based nurse advice line is available to all Passport Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week to assess symptoms and help make good health care decisions.

English & Spanish: (800) 606-9880
TTY/TDD: 711 Relay

Healthcare Services Department

The Healthcare Services department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Healthcare Services (HCS) department also performs Care Management (CM) for Members who will benefit from Care Management services. Participating Providers are required to interact with Passport's HCS Department electronically whenever possible. Prior Authorizations(PA)/Service Requests and status checks can be easily managed electronically.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access 24/7 online submission and status checks.
- Ensures HIPAA compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces cost associated with fax and telephonic interactions.

Passport offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Passport via the Provider Portal. Contact your Provider Services representative for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of the Passport website for guidance.

Provider Portal	:	www.Availity.com
Phone	:	(800) 578-0775
Medical PA Fax	:	(833) 454-0641
CM Fax	:	(800) 983-9160

Health Management

Passport's Health Management programs will be incorporated into the Member's care plan to address the Member's identified health care needs.

Phone: (866) 472-9483

Behavioral Health

Passport manages all components of Covered Services for behavioral health. Members in need of Behavioral Health Services can be referred to a Provider by their PCP for services or Members can seek services on their own. If the Member needs help finding a Provider, they can call Member Services at (800) 578-0603. Additional detail regarding Covered Services and any limitations can be obtain in the Benefits and Covered Services chapter of this Manual, or by contacting Passport. Passport's Behavioral Health Crisis Line is available twenty-four (24) hours a day, seven (7) days a week for mental health or substance abuse needs by calling (844) 800-5154. The services Members receive will be confidential.

Pharmacy Department

Prescription drugs are covered through CVS Caremark. A list of in-network pharmacies are available on the www.passporthealthplan.com website or by contacting Passport. For drug prior authorization requests Providers should fax their requests to the fax number below. Pharmacy related inquires can be directed to Passport at the number below:

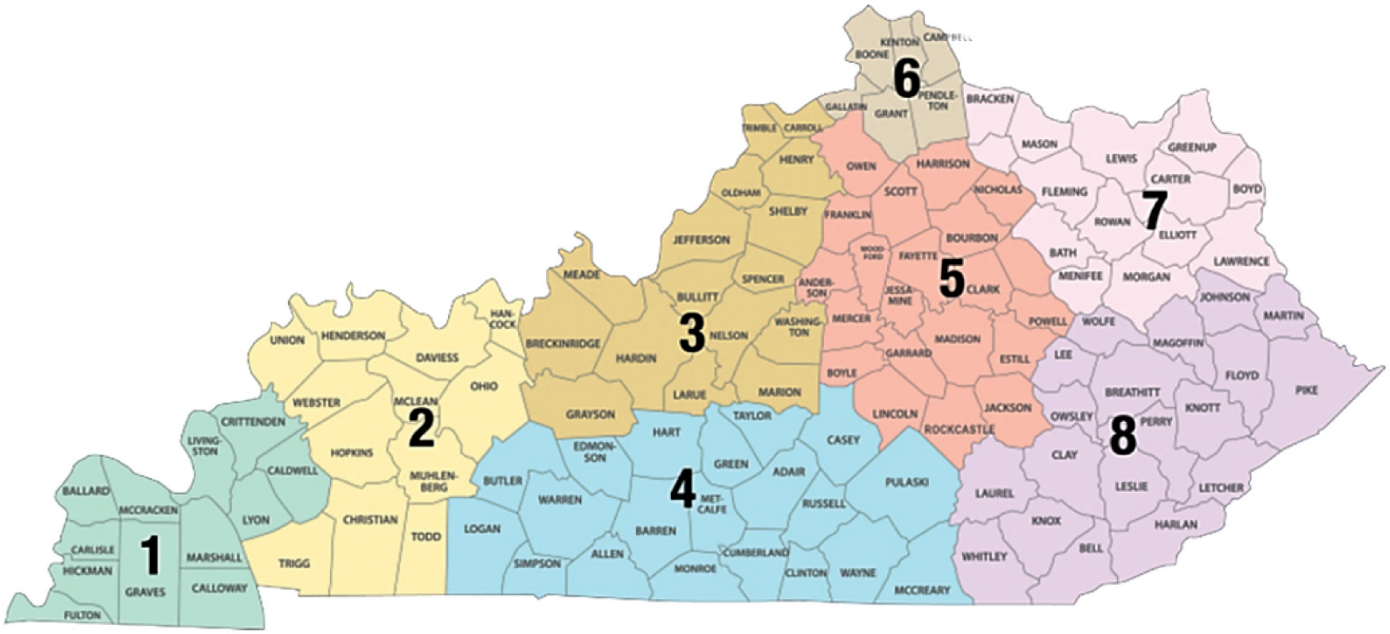
Phone	:	(800) 578-0775
Drug PA Fax	:	(844) 802-1406

Quality Improvement

Passport maintains a Quality Improvement (QI) department to work with Members and Providers in administering the Passport Quality Program.

Phone : (800) 578-0775
Fax : (502) 585-7915

Passport Health Plan by Molina Service Area



2. Provider Rights and Responsibilities

Non-discrimination of Healthcare Service Delivery

Passport complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act (ACA), which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve Passport Members, and all Passport Medicaid website home pages. All Providers who join the Passport Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Passport requires Providers to deliver services to Passport Members without regard to race, color, national origin, age, disability, religion, or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top 15 languages spoken in the State/Commonwealth to ensure Passport Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance from a State Medicaid Program.

Section 1557 Investigations

All Passport Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to Passport Health Plan's Civil Rights Coordinator.

Passport Health Plan by Molina Healthcare
Civil Rights Coordinator
5100 Commerce Crossings Drive
Louisville, KY 40229

Toll Free	:	(866) 606-3889
TTY/TDD	:	711
On Line	:	**https://MolinaHealthcare.AlertLine.com**
Email	:	**civil.rights@passporthealth.com**

Providers Not Participating in Medicaid Fee-for-Service:

All Passport Providers participating in the Passport network must be enrolled in the Kentucky Medicaid program. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the Department for Medicaid Services (DMS) and meet the Medicaid Provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service Providers of the appropriate provider type. To submit a Kentucky Medicaid enrollment application with DMS, go to the Medicaid Partner Portal Application (MPPA) at **https://medicaidsystems.ky.gov/Partnerportal/home.aspx**.

Role and Responsibilities of Primary Care Provider (PCP)

The PCP is the manager of the patients' total health care needs. PCPs prescribe and provide routine and preventive medical services and coordinate all care that is given by Passport's participating specialists and facilities or any other medical facility where patients might seek care (e.g., Emergency Services). The coordination provided by PCPs may include direct provision of primary care; referrals for specialty care, including behavioral health and to programs including disease management, educational programs, public health agencies, and community resources. In addition to fulfilling these roles, the PCP has a responsibility to:

- Have screening and evaluation procedure for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders;
- Provide all needed initial, periodic and inter-periodic health assessments for a Member under the age of 21 years, and shall be responsible for providing or arranging for complete assessments at the intervals specified in the Kentucky approved periodicity schedule and at other times when Medically Necessary;
- Discuss Advance Medical Directives with all Passport Members as appropriate;
- Submit an encounter for each visit where the Provider sees the Member, or the Member receives a HEDIS® services;
- Maintaining continuity of the Member's health care;
- Maintaining a current medical record for the Member, including documentation of all PCP and Specialty Care services;
- Provide primary and preventive care, recommend or arrange for all necessary preventive health care, including EPSDT for Members under the age of 21 years;
- Arrange and refer Members when clinically appropriate, to behavioral health Providers;
- Make referrals for Specialty Care and other Medically Necessary services, both in and out of network, if such services are not available with Passport's network; and
- Ensure Members use Network Providers. If assistance is needed in locating a participating Passport Provider, please contact Passport Health Plan at (800) 578-0775.
- Maintain formalized relationships with other PCPs to refer their Enrollees for after-hours care, during certain days, for certain services, or other reasons to extend the hours of service of their practice.
- The PCP remains solely responsible for the PCP functions listed above.

Facilities, Equipment and Personnel

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

It is important for Providers to ensure Passport has accurate practice and business information. Accurate information allows Passport to better support and serve the Provider Network and Members.

Maintaining an accurate and current Provider Directory is a Commonwealth and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Passport in writing (some changes can be made online) at least 30 calendar days in advance of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition or termination of a Provider (within an existing clinic/practice).
- Change in practice name, Tax ID and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Any other information that may impact Member access to care.

Please visit the Passport Provider Online Directory (POD) to validate and correct most of your information. To access the POD, please visit **www.PassportHealthPlan.com** and select "Find a Doctor or Pharmacy." Incorrect information can be reported by selecting the link located on the POD and on the **Provider Portal**. You can also notify your Provider Services representative at (800) 578-0775 or submit the Provider Update Information Form located on the **www.PassportHealthPlan.com** website if your information needs to be updated or corrected.

Note: Some changes may impact credentialing. Providers are required to notify Passport of changes to credentialing information in accordance with the requirements outlined in the Credentialing section of this Provider Manual.

Passport is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Passport also may use a vendor to conduct routine outreach to validate data that impacts its Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

National Plan and Provider Enumeration System (NPPES) Data Verification

CMS recommends that Providers routinely verify and attest to the accuracy of their NPPES data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Passport supports the CMS recommendations around NPPES data verification, and encourages our Provider network to verify provider data via **https://nppes.cms.hhs.gov**. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQs) document published at the following link: **https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index**.

Passport Electronic Solutions Requirements

Passport requires Providers to utilize electronic solutions and tools whenever possible.

Passport requires all contracted Providers to participate in and comply with Passport's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of the Provider Portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Provider Portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Passport's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Provider Portal within 30 days of entering the Passport network.

Passport is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Passport. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Passport. Providers may obtain additional information by visiting Passport's HIPAA Resource Center located on Passport's website at **www.passporthealthplan.com**.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Passport Providers include:

- Electronic Claims Submission Options
- Electronic Payment: Electronic Funds Transfer (EFT) with Electronic Remittance Advice (ERA)
- Provider Portal

Electronic Claims Submission Requirement

Passport strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider including:

- Promotes HIPAA compliance.
- Helps to reduce operational costs associated with paper Claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminates mailing time and enabling Claims to reach Passport faster.

Passport offers the following electronic Claims submission options:

- Submit Claims directly to Passport via the Provider Portal. **www.Availity.com**.
- Submit Claims to Passport through your EDI clearinghouse using Payer ID 61325, refer to Passport's website **www.passporthealthplan.com** for additional information.

While both options are embraced by Passport, submitting Claims via Provider Portal (available to all Providers at no cost) offers several additional Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Provider Portal Claims submission benefits:

- Add attachments to Claims
- Submit corrected Claims
- Easily and quickly void Claims
- Check Claims status
- Receive timely notification of a change in status for a particular Claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

For more information on EDI Claims submission, see the Claims and Compensation section of this Provider Manual.

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Passport uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Below is the link to register with Change Healthcare ProviderNet to receive EFTs/ERAs. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Passport's website: **www.passporthealthplan.com**.

Any questions during this process should be directed to Change Healthcare Provider Services at **wco.provider.registration@changehealthcare.com** or (877) 389-1160.

Provider Portal

Providers and third-party billers can use the no cost Provider Portal to perform many functions online without the need to call or fax Passport. Registration can be performed online and once completed the easy to use tool offers the following features:

- Verify Member eligibility, covered services and view HEDIS needed services (gaps).
- Claims
    - Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files.
    - Correct/Void Claims.
    - Add attachments to previously submitted Claims.
    - Check Claims status.
    - Create and manage Claim Templates.
    - Create and submit a Claim Appeal with attached files.
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization/Service Requests.
    - Check status of Authorization/Service Requests.
- View HEDIS® Scores and compare to national benchmarks.
- View a roster of assigned Passport Members for PCP(s).
- Download forms and documents.
- Send/receive secure messages to/from Passport.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Passport to the Provider. Balance billing a Passport Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Passport's Member materials (such as Member Handbooks).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Passport Members must be developed and distributed in a manner compliant with all Commonwealth and Federal Laws and regulations and approved by Passport prior to use.

Please contact your Provider Services representative for information and review of proposed materials.

Member Eligibility Verification

Possession of a Passport ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Passport Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Passport places the responsibility for eligibility verification on the Provider of services.

For additional information please refer to the Eligibility, Enrollment, and Disenrollment section of this Provider Manual.

Member Cost Share

Cost Sharing is the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services provided under their Passport plan. The Cost Sharing amount Members will be required to pay for each type of Covered Service is summarized on the Member's ID card. There are no copayments for Passport Health Plan by Molina Healthcare Members.

Healthcare Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Passport's Utilization Management and Care Management programs, including all policies and procedures regarding Passport's facility admission, prior authorization, and Medical Necessity review determination procedures. Providers will also cooperate with Passport in audits to identify, confirm, and/or assess utilization levels of covered services.

For additional information please refer to the Healthcare Services section of this Provider Manual.

In Office Laboratory Tests

Passport's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Passport website at **www.passporthealthplan.com**.

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at **https://appointment.questdiagnostics.com/patient/confirmation** and **https://www.labcorp.com/labs-and-appointments**.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your agreement with Passport and applicable Commonwealth and Federal billing and payment rules and regulations.

Claims for tests performed in the Provider's office, but not on Passport's list of allowed in-office laboratory tests will be denied.

Referrals

The Member's PCP is the primary leader involved with the direction of services for the Member. The Member's PCP will refer the Member when Medically Necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals. PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a prior authorization. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. While referrals are not required in order for the specialist's claims to be paid, Providers need to document referrals that are made in the patient's medical record and on the claim submission in Box 17. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Passport Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted with Passport. In the case of Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and Emergency Services.

There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Passport except in the case of Emergency Services. The prior authorization requests will be available on the Provider Portal for out-of-network Providers. Referral details will also be available for Passport Members in the Member Handbook.

Direct Access Services: Members have direct access, and do not require a referral for the following types of service:

- Primary care vision services,
- Primary care dental and oral surgery services and evaluation by orthodontists and prosthodontist
- Voluntary family planning (in accordance with commonwealth laws and judicial opinion)
- Maternity care for Members under 18 years of age
- Immunizations to Members under 21 years of age
- Sexually transmitted disease screening, evaluation and treatment
- Tuberculosis screening, evaluation and treatment
- Testing for HIV, HIV-related conditions and other communicable diseases as defined by 902 KAR 2:020
- Chiropractic services
- For Members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, Members may directly access a specialist as appropriate for the Member's condition and identified needs; and
- Women's health specialists

Treatment Alternatives and Communication with Members

Passport endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Passport promotes open discussion between Provider and

Members, following HIPAA compliant communication practices, regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Pharmacy Program

Providers are required to adhere the Kentucky Preferred Drug List and prescription policies, including the Pharmacy Lock-In program policies. For additional information please refer to the Pharmacy section of this Provider Manual.

Participation in Quality Programs

Providers are expected to participate in Passport's Quality Programs and collaborate with Passport in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews as applicable
- Delivery of Patient Care Information

For additional information please refer to the Quality section of this Provider Manual.

Compliance

Providers must comply with all Commonwealth and Federal Laws and regulations related to the care and management of Passport Members.

Confidentiality of Member Health Information and HIPAA Transactions

Passport requires that Providers respect the privacy of Passport Members (including Passport Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI, including maintaining confidentiality for Family Planning Services in accordance with applicable Federal and Commonwealth laws and judicial opinions for Passport Members less than 18 years of age pursuant to federal and commonwealth regulations. For additional information please refer to the Compliance section of this Provider Manual.

Participation in Grievance and Appeals Programs

Providers are required to participate in Passport's Grievance Program and cooperate with Passport in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information please refer to the Complaints, Grievance and Appeals Process section of this Provider Manual.

Participation in Credentialing

Providers are required to participate in Passport's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Passport and applicable accreditation, Commonwealth and Federal requirements. This includes providing prompt responses to Passport's requests for information related to the credentialing or re-credentialing process.

Providers must notify Passport no less than thirty (30) days in advance when they relocate or open an additional office.

More information about Passport's Credentialing program, including Policies and Procedures is available in the Credentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Passport's Delegation Policies and Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Passport's delegation requirements and delegation oversight.

Provider Rights

Passport values the partnership with our network of Providers. Providers have the following rights:

- Providers have the right to expect 90% of Clean Claims to be paid within 30 days of receipt by Passport.
- Providers have the right to file a claims appeal regarding payment or contractual issues and expect timely processing and decision of that appeal by Passport.
- In the event of coordination of benefits, Providers have the right to compensation from Passport up to the allowable rate for covered services, minus any payments received from primary payer. (If the Member's primary insurance pays less than Passport's allowable rate, Passport will reimburse the additional amount up to our allowable rate.)
- Providers have the right to expect a Passport to ensure that a Nurse Advise line is available to Members 24 hours per day, 7 days per week.
- Providers have the right to expect Passport to ensure that a Behavioral Health/Mental Health Crisis line available to Members 24 hours per day, 7 days per week.
- Providers have the right to expect prompt and accurate Member eligibility information from Passport via the Provider Portal and by phone.
- Providers have the right to receive a timely response to Prior Authorization requests; within 2 business days from receiving all required information for standard requests; and within 24 hours from receiving all needed information for expedited/urgent requests.

3. Cultural Competency and Linguistic Services

Background

Passport works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Passport complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages and religions as well as those with disabilities in a manner that recognizes, values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at **www.passporthealthplan.com**, from your local Provider Services representative and by calling Passport Provider Services at (800) 578-0775.

Nondiscrimination of Health Care Service Delivery

Passport complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve Passport Members, and all Passport website homepages. All Providers who join the Passport Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Passport requires Providers to deliver services to Passport Members without regard to race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Providers must post a non-discrimination notification in a conspicuous location in their office along with translated non-English taglines in the top 15 languages spoken in the Commonwealth to ensure Passport Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, participating Providers or contracted medical groups/Independent Physician Associations (IPAs) may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

Providers can refer Passport Members who are complaining of discrimination to the Passport Health Plan Civil Rights Coordinator at: (866) 606-3889, or TTY, 711.

Members can also email the complaint to **civil.rights@passporthealth.com**.

Members can mail their complaint to Passport Health Plan at:

Passport Health Plan by Molina Healthcare
5100 Commerce Crossings Drive
Louisville, KY 40229

Members can also file a civil rights complaint with the
U.S. Department of Health and Human Services, OCR. Complaint forms are available at **https://www.hhs.gov/ocr/complaints/index.html**. The form can be mailed to:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Members can also send it to a website through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

If you or a Passport Member needs help, call (800) 368-1019; TTY (800) 537-7697

Should you or a Passport Member need more information you can refer to the Health and Human Services website for more information: **https://www.federalregister.gov/d/2016-11458**.

Cultural Competency

Passport is committed to reducing health care disparities. Training employees, Providers and their staff, and quality monitoring are the cornerstones of successful culturally competent service delivery. Passport integrates cultural competency training into the overall Provider training and quality monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Passport offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Passport conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services and/or online/ web-based training modules.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials;
2. On-site cultural competency training;
3. Online cultural competency Provider training modules; and,
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement – Ensuring Access

Passport ensures Member access to language services such as oral interpretation, American Sign Language (ASL) and written translation. Passport must also ensure access to programs, aids, and services that are congruent with cultural norms. Passport supports Members with disabilities and assists Members with LEP.

Passport develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e., braille, audio, large print), leading to better communication, understanding and Member satisfaction. Online materials found on **www.passporthealthplan.com** and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key Member information, including Appeal and Grievance forms, are also available in threshold languages on the Passport Member website.

Program and Policy Review Guidelines

Passport conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity and language data from:
    - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership, and,
    - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Passport's Contact Center toll free at (800) 578-0775. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service Provider.

Passport Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Passport Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

Documentation

As a contracted Passport Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Passport.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Passport's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his or her right to have a qualified interpreter at no cost.

Members Who Are Deaf or Hard of Hearing

Passport provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center, Quality, Healthcare Services and all other health plan functions.

Passport strongly recommends that Provider offices make assistive listening devices available for Members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

Passport will provide face-to-face service delivery for ASL to support Members who are deaf or hard of hearing. Requests should be made 3 business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Passport Member Services.

Nurse Advice Line

Passport provides 24 hours/7 days a week Nurse Advice Services for Members. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Passport's Nurse Advice Line directly, (800) 606-9880 (English and Spanish) or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

4. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Passport Members as outlined in the Passport Member Handbook and on the Passport website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the Member pages on www.passporthealthplan.com.

Member Handbooks are available on Passport's Member Website. Member Rights and Responsibilities are outlined under the heading "Your Rights and Responsibilities" within the Member Handbook document and copied below for easy reference.

Kentucky and Federal Law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact Passport Provider Services at (800) 578-0775, 8:00 a.m. - 6:00 p.m. Monday through Friday. TTY users, please call 711.

Member Rights and Responsibilities:

Passport Health Plan Members have the right to:

- Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination
- Get information on the structure and operation of the health plan, its services, its practitioners and providers and member rights and responsibilities
- To receive notice of any significant changes in the Benefits Package at least thirty (30) days before the intended effective date of the change
- Prepare Advance Medical Directives
- Timely referral and access to medically indicated specialty care
- Be furnished health care services in accordance with federal and state regulations
- Choose your Primary Care Provider and to change your PCP in a reasonable manner
- Consent for or refusal of treatment and active participation in decision choices
- Voice Grievances and receive access to the Grievance process, receive assistance in filing an appeal, and request a State Fair Hearing from the Contractor and/or the Department
- Know if a co-payment or contribution is required. Know the names, education, and experience of your health care providers
- Be treated with respect with recognition of your dignity and your right to privacy
- Timely access to care that does not have any communication or physical access barriers
- Timely referral and access to medically indicated specialty care

- Receive Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services
- Take part in decision making with your doctor about your health care, including the right to refuse treatment and openly discuss appropriate or medically necessary treatment choices of your health problems, regardless of cost or coverage. Get a fair and timely reply to requests for service. Voice complaints or appeals about the organization and the care it provides
- Know that your member information will be kept private. It is only used in reports to the state to show that the Plan is following state rules and laws
- Ask how your doctor is paid
- To be able to file an appeal, a grievance (complaint) or request a State Fair Hearing (after Passport has made a decision and you aren't happy with that decision)
- To get help with filing an appeal, grievance (complaint) or request a State Fair Hearing (after Passport has made a decision and you aren't happy with that decision)
- To receive information and timeframes for filing an appeal, a grievance or a State Fair Hearing
- To make recommendations regarding the Plan's member rights and responsibility policy
- To use any hospital or other setting for emergency care
- To receive detailed information on emergency and after-hours coverage
- To receive all information, including but not limited to, enrollment notices, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood
- Be free from any form of restraint or seclusion used as means of pressure, discipline, convenience or retaliation
- Include assistance with requesting and receiving a copy of your medical records at no cost to you, and request that they be corrected
- Be provided culturally and linguistically appropriate healthcare services (CLAS) Be provided covered healthcare services
- Be free to exercise your rights without negatively affecting the way Passport, our providers or the State treat you.
- Be free from other discrimination prohibited by State and Federal regulations
- Request clinical practice guidelines upon request
- Get a second medical opinion
- Get help with any special language needs
- To receive interpretation by phone services free of charge for all non-English languages, not just those identified as prevalent
- Prepare Advance Medical Directives
- Be furnished health care services in accordance with federal and state regulations

Passport Members have the responsibility to:

- Work with their PCP to protect and improve your health. You can report other insurance benefits, when you are eligible, to your Department for Medicaid Services Specialist by calling Beneficiary Help Line at (800) 642-3195, TTY (866) 501-5656
- Show your Passport Health Plan ID card, Medicaid card and valid ID to all providers before receiving services
- Never let anyone use your Passport Health Plan ID card or Medicaid card
- Make appointments for routine checkups and immunizations (shots)
- Keep your scheduled appointments and be on time calling as soon as you can if you must cancel
- Provide complete information about your past medical history
- Provide complete information about current medical problems
- Listen to your PCP's advice and ask questions about your care when you are in doubt
- Call or go back to your PCP if you do not get better or ask to see another provider
- Follow your provider's medical advice
- Respect the rights of other patients and healthcare workers
- Use emergency room services only when you believe an injury or illness could result in death or lasting injury
- Notify your PCP if emergency treatment was necessary and follow-up care is needed
- Report changes that may affect your coverage to your Department for Medicaid Services specialist. This could be an address change, birth of a child, death, marriage or divorce, or change in income
- Promptly apply for Medicare or other insurance when you are eligible
- Find out how your health coverage works
- Call your PCP when you need medical care, even if it is after-hours
- Tell us if you have problems with any health care staff by calling Member Services at (800) 578-0603, 7 a.m.- 7 p.m., Monday through Friday

Second Opinions

If Members do not agree with their Provider's plan of care, they have the right to a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

5. Eligibility, Enrollment, Disenrollment

Enrollment

Enrollment in Medicaid Programs

The Kentucky Department for Medicaid Services has the exclusive right to determine an individual's eligibility for the Medicaid Program and eligibility to become a Passport Member.

No eligible Member shall be refused enrollment or re-enrollment, have their enrollment terminated, or be discriminated against in any way because of their health status, need for health services race, ethnicity, national origin, religion, gender, age, mental or physical disability, or sexual orientation.

Effective Date of Enrollment

Eligibility begins on the first day of the month for Members joining Passport with the following exceptions:

- Newborns, born to an eligible mother, are eligible at birth;
- Members who meet the requirements for presumptive eligibility, in accordance with commonwealth and federal guidelines, are effective on the of eligibility determination;
- Unemployed parent program Members are enrolled beginning the date that the definition of unemployment or underemployment, in accordance with 45 D.F.R. 233.100, is met.

Newborn Enrollment

Passport begins coverage of newborns on the date of birth when the newborn's mother is a Passport Member. The delivery hospital is required to enter the birth record into the birth record system, KY CHILD (Kentucky's Certificate of Live Birth, Hearing, Immunization, and Lab Data). That information is used to auto enroll the deemed eligible newborn within 24 hours of birth.

Providers can verify Newborn eligibility in the Provider Portal at **www.Availity.com**.

Eligibility Verification

Medicaid Programs

The Commonwealth of Kentucky, through the Department for Medicaid Services determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The Contractual Agreement between Providers and Passport places the responsibility for eligibility verification on the Provider of services. Additionally, a Provider is required to verify if a Member has been enrolled in a Lock-In Program which directs Members to certain Providers. Failure to verify a Member's enrollment in the Lock-in Program will result in Claims denials for Providers who are not on the Member's restricted Provider list.

Eligibility Listing for Medicaid Programs

Providers who contract with Passport may verify a Member's eligibility and/or confirm PCP assignment by checking the following:

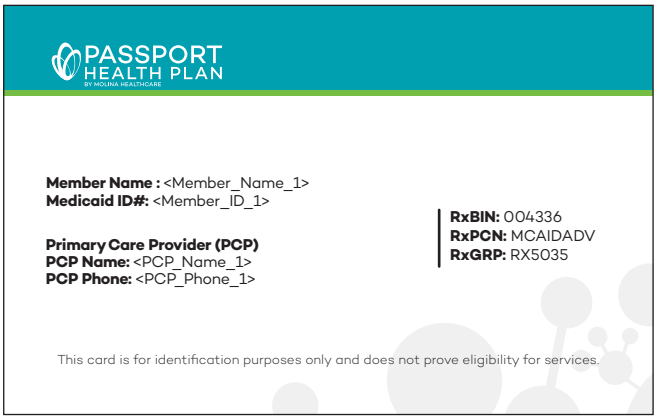
- Passport Provider Services at (800) 578-0775
- Eligibility can also be verified through the KyHealth Net System. **https://chfs.ky.gov/agencies/dms/Pages/kyhealthnet.aspx**
- Provider Portal **www.Availity.com**

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

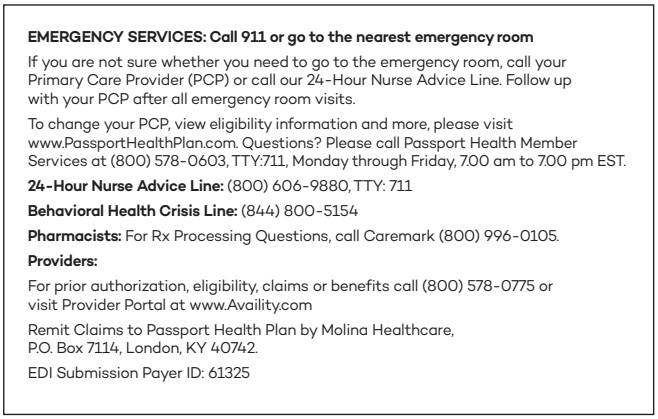
Identification Cards

Passport Sample Member ID Card

Card Front



Card Back



Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Passport Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an Emergency Medical Condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Passport Members may change to another health plan during their first 90 days after initial enrollment, and annually thereafter.

Voluntary disenrollment does not preclude Members from filing a grievance with Passport for incidents occurring during the time they were covered.

Involuntary Disenrollment

The Department for Medicaid Services has the sole authority to disenroll Members. Disenrollment may be initiated for the following reasons:

- Member commits fraud related to the Medicaid program
- Member is abusive or threatening to Passport, Passport's agents, or Providers
- Member is admitted to a nursing facility for more than 31 days
- Member is incarcerated in a correctional facility
- Member no longer qualifies for Medicaid Assistance
- Member cannot be located

PCP Dismissal

A PCP may dismiss a Member from his/her practice under following circumstances:

- Incompatibility of the PCP/patient relationship;
- Member has not utilized a service within one (1) year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year;
- Inability to meet the medical needs of the Member.

A PCP may not dismiss a Member from his/her practice under following circumstances:

- Change in Member's health status or need for treatment;
- Member's utilization of medical services;
- Member's diminished mental capacity;

- Disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others;
- Transfer requests shall not be based on race, color, national origin, handicap, age or gender.

All transfer requests must be sent in writing with reason for dismissal and approved by Passport Health Plan. The PCP must continue providing services to the Member until the new PCP begins providing services to the Member, barring ethical or legal issues. Passport Members have the right to file a grievance regarding such a transfer.

Missed Appointments

Participating Providers are responsible for establishing a process for documenting missed appointments. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record.

PCP Assignment

Passport Members are encouraged to choose their own PCPs upon enrollment. If the Member or his/her designated representative does not choose a PCP, one will be assigned to the Member. Passport will take into consideration known factors such as:

- Previous member PCP information
- PCP information of family members (e.g. siblings)
- Member's geographic location (within 30 miles or 30 minutes)
- Provider relationships
- Age and Gender of the member
- Primary Language (to extent known)

PCP Changes

If for any reason a Member wants to change PCPs, he or she may conveniently do so by logging on to **http://www.mypassporthealthplan.com** or by calling Member Services and asking for the change. If Passport Health Plan assigned the Member to the PCP and the Member calls within the first month of membership with Passport, the change will be backdated to the first (1st) day of the current month. All other PCP changes are effective immediately upon request. A new ID card is sent to the Member when a PCP change is made with new PCP information.

6. Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Passport Health Plan Medicaid Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization please contact Passport at (800) 578-0775 Monday through Friday, 8:00 a.m. to 6:00 p.m.

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services provided under their Passport plan. There are no copayments for Passport Health Plan Members.

Services Covered by Passport Health Plan

Passport covers the services described below. If there are questions as to whether a service is covered or requires prior authorization, please contact Passport at (800) 578-0775; Monday through Friday, 8:00 a.m. to 6:00 p.m.

Passport, through its contracted Providers, is required to arrange for the following Medically Necessary services for each patient:

- Alternative birthing center services
- Ambulatory surgical center services
- Behavioral health services – mental health and substance abuse disorders
- Chiropractic services
- Community mental health center services
- Dental services, including oral surgery, orthodontics and prosthodontics
- Durable medical equipment, including prosthetic, orthotic devices and disposable medical supplies
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and special services
- End-stage renal dialysis services
- Family planning services in accordance with federal and state law and judicial opinion
- Hearing services, including hearing aids for Members younger than 21
- Home health services
- Hospice services (non-institutional only)
- Independent laboratory services
- Inpatient hospital services
- Inpatient mental health services
- Meals and lodging for appropriate escort of Members

- Medical detoxification, i.e., management of symptoms during the acute withdrawal phrase from a substance to which the Member is addicted
- Medical services, including but not limited to, those provided by physicians, advanced practice registered nurses, physicians assistants and federally qualified health centers (FQHCs), primary care centers and rural health clinics (RHCs)
- Organ transplant services not considered investigational by Federal Drug Administration (FDA)
- Other laboratory and X-ray services
- Outpatient hospital services
- Outpatient mental health services
- Pharmacy and limited over-the-counter drugs, including mental/behavioral health drugs
- Podiatry services
- Preventive health services, including those currently provided in public health departments,
- FQHCs/primary care centers, and RHCs
- Psychiatric residential treatment facilities (Level I and Level II)
- Care management services for Members with complex chronic illnesses (includes adult and child targeted care management)
- Specialized children's services clinics
- Targeted case management
- Therapeutic evaluation and treatment, including physical therapy, speech therapy and occupational therapy
- Transportation to covered services, including emergency and ambulance stretcher services
- Urgent and emergency care services
- Vision care, including vision examinations, services of opticians, optometrists and ophthalmologists, including eyeglasses for Members younger than 21

Extra Benefits and Rewards

Passport Health Plan offers additional benefits to our Members beyond the benefits outlined above. Information regarding the most current extra benefits and rewards available to Passport Members is available at the following link:
https://www.molinahealthcare.com/members/ky/en-us/mem/medicaid/overvw/coverd/benefits.aspx

Obtaining Access to Certain Covered Services

Non-Preferred Drug Exception Request Process

The Provider may request a prior authorization for clinically appropriate drugs that are not covered under the Member's Medicaid Plan. Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring prior authorization.

Providers may use the Kentucky Medicaid pharmacy universal Prior Authorization form, which is found on Passport's website. The most current Prior Authorization guide is also available on the https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ky/medicaid/Pre_Service_Review_Guide_Request_Form.pdf website. Pharmacy Prior authorization forms can be faxed to Passport at (844) 802-1406. More details about the Pharmacy prior authorization process are found in the Pharmacy chapter of this Manual.

Specialty Drug Services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they will be made available through a vendor, designated by Passport. More information about the prior authorization process, including a link to the Prior Authorization Request Form, is available in the Healthcare Services section of this Manual. Physician administered drugs require the appropriate 11-digit NDC with the exception of vaccinations or other drugs as specified by CMS.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered at no cost.

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor, designated by Passport. More information about the Prior Authorization process, is available in the Healthcare Services and Pharmacy Chapters of this Provider Manual.

Access to Behavioral Health Services

Members in need of Behavioral Health Services can be referred to a Provider by their PCP for services or Members can seek services on their own. If the Member needs help finding a Provider, they can call Member Services at (800) 578-0603. Additional detail regarding Covered Services and any limitations can be obtained in the Benefits list above, or by contacting Passport.

Emergency Mental Health or Substance Abuse Services and Behavioral Health Crisis Line

Passport's Behavioral Health Crisis Line, staffed by trained personnel is available 24 hours a day, 7 days a week 365 days per year assist with Member emergency and crisis behavioral health needs at (844) 800-5154.

Members are directed to call "911" or go to the nearest emergency room if they need Emergency Services mental health or substance abuse. Examples of emergency mental health or substance abuse problems are:

- Danger to self or others.
- Not being able to carry out daily activities.
- Things that will likely cause death or serious bodily harm.

Out of Area Emergencies

Members having a behavioral health emergency who cannot get to a Passport approved Providers are directed to do the following:

- Go to the nearest emergency room
- Call the number on ID card
- Call Member's PCP and follow-up within 24 to 48 hours

For out-of-area Emergency Services, plans will be made to transfer Members to an in-network facility when Member is stable.

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or ground transports.

Non-Emergency Medical Transportation

The Kentucky Department for Medicaid Services contracts with the Kentucky Transportation Cabinet, Office of Transportation Delivery's HSTD program to provide non-emergency medical transportation (NEMT). Through the HSTD program, certain eligible Members receive safe and reliable transportation to Medicaid Covered Services. More information about the HSTD program is available at: **https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/transportation.aspx**.

Passport covers non-emergency transport by stretcher and by ambulance for Members. Only non-emergency Air Ambulance requires prior authorization. Additional information regarding the availability of this benefit is available by contacting Provider Services at (800) 578-0775.

Telehealth and Telemedicine Services

Passport Members may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services do not include texting, facsimile or email only.
- Services include preventive and/or other routine or consultative visits during a pandemic.
- Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment.

Upon at least ten (10) days prior notice to Provider, Passport shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Passport. Provider shall make its personnel reasonably available to answer questions from Passport regarding telehealth operations.

Preventive Care

Preventive Care and Clinical Practice Guidelines are located under the "health resources" tab on the Provider pages of the **www.passporthealthplan.com** website.

We need your help conducting these regular exams in order to meet the targeted Commonwealth and Federal standards. Passport provides and coordinates Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), and EPSDT Special Services, through the PCP, for any Member under the age of 21 years. If you have questions or suggestions related to well child care, please call Passport's Healthcare Services Department at (800) 578-0775.

Immunizations

Adult Members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the Member's PCP. Child Members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics (AAP) and prescribed by the child's PCP.

Immunization schedule recommendations from the American Academy of Pediatrics and/or the CDC are available at the following website: **https://www.cdc.gov/vaccines/schedules/hcp/index.html**.

Passport covers immunizations not covered through Vaccines for Children (VFC).

EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program that covers individuals from birth until 21 years of age requiring the provision of early and periodic screening services and well care examinations, including lead exposure screening and assessment, with diagnosis and treatment of any health or mental health problems identified during these exams. In Kentucky, this program is divided into two components: EPDST Screenings and EPSDT Special Services.

Passport provides and coordinates EPSDT and EPSDT Special Services, through the PCP, for any Member under the age of twenty-one (21) years. EPSDT Special Services, indicated as the result of an EPSDT health assessment or any other encounter with a licensed or certified health care professional, even if the service is not otherwise covered by the Medicaid Program, are covered by Passport and include any Medically Necessary health care, diagnostic, preventive, rehabilitative or therapeutic service that is Medically Necessary for a Member under the age of twenty-one (21) years to correct or ameliorate defects, physical and mental illness, or other conditions whether the needed service is covered by the Medicaid State Plan in accordance with Section 1905 (a) of the Social Security Act. These services which are not otherwise covered by the Medicaid Program are called EPSDT Special Services.

EPSDT Provider Training and Education

Passport trains Providers offering EPDT services concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Members. In addition, training is provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services and who are supported by adequately equipped offices to perform EPSDT services.

Well Child Visits and EPSDT Screening Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until 21 years of age, with diagnosis and treatment of any health or mental health problems identified during these exams. The standards and periodicity schedule generally follow the recommendations from the AAP and Bright Futures. To view the most current schedule, please visit **https://www.aap.org/en-us/professional-resources/practice-Transformation/managing-patients/Pages/Periodicity-Schedule.aspx**.

The screening services include but are not limited to:

- Comprehensive health and developmental history (including assessment of both physical and mental health development).
- Immunizations in accordance with the most current Kentucky Recommended (or American Academy of Pediatrics, Centers for Disease Control and Prevention Advisory Committee on Immunization Practices) Childhood Immunization Schedule, as appropriate.
- Comprehensive unclothed physical exam.
- Laboratory tests as specified by the AAP, including screening for lead poisoning.
- Health education.
- Vision services.
- Hearing services.
- Dental services.

When a screening examination indicates the need for further evaluation, Providers must provide diagnostic services or refer Members when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

We need your help conducting these regular exams in order to meet the Kentucky Department for Medicaid Services standards. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well child care, please call Molina Healthcare Inc.'s Health Education line at (866) 472-9483.

EPSDT Special Services

EPSDT provides any Medically Necessary diagnosis and treatment for Members under the age of 21 indicate as the result of an EPSDT health assessment or any other encounter with a licensed or certified health care professional, even if the service is not otherwise covered by the Medicaid Program. These services which are not otherwise covered by the Medicaid Program are call EPSDT Special Services. EPSDT Special Services shall be available for eligible Member, including Provider who can deliver the Medically Necessary services described in federal Medicaid law.

Passport provides EPSDT Special Services as required by 42 USC Section 1396 and by 907 KAR 1:034, Section 7 and Section 8.

Passport provides the Medically Necessary health care, diagnostic services, rehabilitative services, treatment and other measures described in 42USC Section 1396d(a) to all Members under the age of 21. Medical Necessity is determined without regard to whether the screen and/or service was performed by a contracted or a non-contracted Provider if there are no participating Providers who can provide the service. Some EPSDT services require prior authorization.

EPSDT Primary Care Provider Responsibilities

Passport ensures compliance with Kentucky law and/or regulation (907 KAR 11:034) that delineates the requirements of all EPSDT Providers participating in the Medicaid program. The Members' Primary Care Provider (PCP) shall provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and Federal government and in conformance with the DMS approved periodicity schedule. The PCP shall provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034. The PCP assigned to each eligible Member shall be responsible for providing or arranging for complete assessments at the intervals specified by the commonwealth department's approved periodicity schedule and at other times when Medically Necessary. The PCP shall provide all needed diagnosis and referrals to treatment/treating Providers/specialists for eligible Members in accordance with Kentucky law and/or regulations. The PCP and other Providers in Passport's network shall provide diagnosis and treatment or provide a referral to out-of-network Providers who shall provide treatment if the service is not available within Passport's network. The PCP shall maintain a consolidated record for each eligible Member, including reports of informing the Member and/or their family about EPSDT, information received from other Providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and send Passport reports from referral physicians or Providers. PCPs providing EPSDT services shall submit an encounter record for each EPSDT service provided according to requirements provided by DMS, including use of specified EPSDT procedure codes, referral codes and the Member and/or their families acceptance or refusal for EPSDT services.

Emergency Services

Emergency Services or Emergency Care means: covered inpatient and outpatient services that are as follows:

- Furnished by a Provider that is qualified to furnish these services; and
- Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition or Emergency means:

- 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 the absence of immediate medical attention to result in:
    - 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,
    - Serious impairment of bodily functions, or
    - Serious dysfunction of any bodily organ or port; or
- With respect to a pregnant woman having contractions:
    - That there is an inadequate time to effect a safe transfer to another hospital before deliver, or
    - That transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergent and Urgent Care Services are covered by Passport without an authorization. This includes non-contracted Providers inside or outside of Passport's service area.

Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week, to assess symptoms and help make good health care decisions.

English/Spanish Phone: (800) 606-9880
TTY/TDD: 711 Relay

Passport is committed to helping our Members:

- Prudently use the services of your office.
- Understand how to handle routine health problems at home.
- Avoid making non-emergent visits to the emergency room (ER).

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the ER. By educating patients, it reduces costs and over utilization on the health care system.

Services Not Covered

Certain services, including but not limited to the following are services currently not covered by the Kentucky Medicaid Program:

- Any laboratory service performed by a Provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual Providers of any laboratory service;

- Cosmetic procedures or services performed solely to improve appearance;
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization, etc.);
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions;
- Paternity testing;
- Personal service or comfort items;
- Postmortem services;
- Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental in nature;
- Sex transformation services;
- Sterilization of a mentally incompetent or institutionalized Member;
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services;
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein; and
- Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.

Additional information is available by calling Passport at (800) 578-0775.

Health Management Programs

Health Management

The tools and services described here are educational support for Passport Members. We may change them at any time as necessary to meet the needs of Passport Members.

Health Education/Disease Management

Passport offers programs to help our Members and their families to manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or disenrolled in these programs. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Nutrition Consultation

- Weight Management
- Smoking Cessation Substance Use Disorder

For more information about our Health Management programs, please call Health Management at (866) 891-2320, Option 2, Monday-Friday 6 am - 6 pm PST (TTY:711).

7. Healthcare Services (HCS)

Introduction

Healthcare Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Passport provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Passport utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, Medical Necessity review, and restrictions on the use of out-of-network Providers.

Utilization Management (UM)

Passport ensures the service delivered is Medically Necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes in the Member's condition and is designed to influence Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care is provided.
- Evaluating the Medical Necessity and efficiency of health care services across the continuum of care.
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs.
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring that qualified health care professionals perform all components of the UM and CM processes.
- Ensuring that UM decision making tools are appropriately applied in determining Medical Necessity decision.

Key Functions of the UM Program

The table below outlines the key functions of the UM program. All prior authorizations are based on a specific standardized list of services.

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and referral management	Satisfaction evaluation of the UM program using Member and Provider input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Ensure authorized care correlates to Member's Medical Necessity need(s) & benefit plan	Post service/post Claim audits	Monitor for possible over- or under-utilization of clinical resources
Verifying current Physician/hospital contract status	Referrals for Discharge Planning and Care Transitions	Quality oversight
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA, Commonwealth and health plan UM standards

This Passport Provider Manual contains excerpts from Passport's Healthcare Services Program Description. For a complete copy of Passport Health Plan's Healthcare Services Program Description you can access the Passport website or contact the UM Department to receive a written copy. You can always find more information about Passport's UM program, including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Passport's website or by calling the UM Department.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to Passport's UM Policies. Their programs, policies and supporting documentation are reviewed by Passport at least annually.

UM Decisions

A decision is any determination (e.g., an approval or denial) made by Passport or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination).
- Determination to deny payment of request (adverse determination).
- Discontinuation of a payment for a service.
- Payment for temporarily out-of-the-area renal dialysis services.
- Payment for Emergency Services, post stabilization care or urgently needed services.

Passport follows a hierarchy of Medical Necessity decision making with Federal and State/ Commonwealth regulations taking precedence. Passport covers all services and items required by State and Federal regulations.

Board certified licensed Providers from appropriate specialty areas are utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal regulatory requirements and NCQA standards.

Requests for authorization not meeting criteria are reviewed by a designated Passport Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate may determine to delay, modify or deny services to a Member for reasons of Medical Necessity.

Providers can contact Passport's Healthcare Services department at (800) 578-0775 to obtain Passport's UM Criteria.

Medical Necessity

"Medically Necessary" or **"Medical Necessity"**: To be Medically Necessary or a Medical Necessity, a Covered Benefit shall be:

- Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;
- Appropriate in terms of the service, amount, scope, and duration based on generally accepted standards of good medial practice;
- Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care Provider, or for cosmetic reasons;
- Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposed, be safely and effectively provided;
- Needed, if used in reference to an Emergency Medical Service, to exist using the prudent layperson standard;
- Provided in accordance with EPSDT requirements established in 42 U.S.C. 1396d(r) and 42 C.F.R. Part 441 Subpart B for individuals under 21 year of age; and
- Provider in accordance with 45 C.F.R 440.230

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/benefit.

Medical Necessity Review

Passport only reimburses for services that are Medically Necessary. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine Medical Necessity, in conjunction with independent professional medical judgment, Passport uses nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, state/commonwealth guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Passport review process begins with administrative review followed by clinical review if appropriate.

The administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage:

- Verifying Member eligibility.
- Requested service is a covered benefit.
- Requested service is within the Provider's scope of practice.
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor.

The Clinical review includes Medical Necessity and level of care:

- Requested service is not experimental or investigation in nature.
- Servicing Provider can provide the service in a timely manner.
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition.
- Medical necessity criteria (according to accepted, nationally recognized resources) is met.
- The service is provided at the appropriate level of care in the appropriate facility; e.g., outpatient versus inpatient or at appropriate level of inpatient care.
- Continuity and coordination of care is maintained.
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

All UM requests that may lead to a denial are reviewed by a health care professional at Passport (medical director, pharmacy director, or appropriately licensed health professional).

Passport's Provider training includes information on the UM processes and Authorization requirements.

Clinical Information

Passport requires copies of clinical information be submitted for documentation in all Medical Necessity determination processes. Clinical information includes but is not limited to; physician

emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Passport does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allows such documentation to be acceptable.

Referrals

The Member's PCP is the primary leader involved with the direction of services for the Member. The Member's PCP will refer the Member when Medically Necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals. PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a prior authorization. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Passport Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted with Passport. In the case of Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Passport except in the case of Emergency Services.

The electronic forms will be available on the Provider Portal for Providers. Referral details will also be available for Passport Members in the Member Handbook.

Direct Access Services: Members have direct access, and do not require a referral for the following types of service:

- Primary care vision services,
- Primary care dental and oral surgery services and evaluation by orthodontists and prosthodontist
- Voluntary family planning (in accordance with state laws and judicial opinion)
- Maternity care for Members under 18 years of age
- Immunizations to Members under 21 years of age
- Sexually transmitted disease screening, evaluation and treatment
- Tuberculosis screening, evaluation and treatment
- Testing for HIV, HIV-related conditions and other communicable diseases as defined by 902 KAR 2:020
- Chiropractic services
- For Members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, Members may directly access a specialist as appropriate for the Member's condition and identified needs; and
- Women's health specialists

Prior Authorization

Passport requires prior authorization for specified services as long as the requirement complies with Federal or Commonwealth regulations and the Passport Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Passport prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Passport website at **www.passporthealthplan.com**.

Providers are encouraged to use the Passport prior authorization form or the Kentucky Universal prior authorization form, both of which are provided on the Passport web site. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Passport ID number).
- Provider demographic information (referring Provider and referred to Provider/facility).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the Medical Necessity of the requested service is required including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data).
    - Requested length of stay (for inpatient requests).
    - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and Commonwealth Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon Medical Necessity and Member eligibility at the time of service.

Passport makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the situation where the standard time frame or decision making process could seriously jeopardize the life or health of the enrollee, the health or safety of the Member or others, due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Enrollee's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request, or could jeopardize the Enrollee's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited request for authorization, a determination is made as promptly as the Member's health requires and no later than 24 hours after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. Requests for authorization or preauthorization for treatment of a Member with a diagnosis of a substance use disorder will be reviewed under the expedited timeframe. For a standard authorization request, Passport makes the determination and provides notification within 2 business days.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Passport has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (800) 578-0775.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Molina, Molina may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the **www.passporthealthplan.com** website:

- Prior Authorization Code Matrix
- Prior Authorization Guide

Provider Portal: Participating Providers are encouraged to use the Provider Portal for prior authorization submissions whenever possible. In the Provider Portal, select Payer Spaces > Passport Health Plan > Applications > Prior Auths. If you don't find the Prior Auths option in Payer Spaces, please request the Authorization and Referral Request and Authorization and Referral Inquiry role from your organizations Availity administrator. The benefits of submitting your prior authorization request through the Provider Portal are:

- Create and submit Prior Authorization Requests
- Check status of Authorization Requests
- Receive notification of change in status of Authorization Requests
- Attach medical documentation required for timely medical review and decision making

Fax: The Prior Authorization Request Form can be faxed to Passport at: (833) 454-0641.

Phone: Prior authorizations can be initiated by contacting Passport's Healthcare Services Department at (800) 578-0775. It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:

Passport Health Plan by Molina Healthcare
Attn: Healthcare Services Dept.
5100 Commerce Crossings Drive
Louisville, KY 40229

Emergency Services

Emergency Services or Emergency Care means: covered inpatient and outpatient services that are as follows:

- Furnished by a Provider that is qualified to furnish these services; and
- Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition or Emergency means:

- 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 the absence of immediate medical attention to result in:
    - 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,
    - Serious impairment of bodily functions, or
    - Serious dysfunction of any bodily organ or port; or
- With respect to a pregnant woman having contractions:
    - That there is an inadequate time to effect a safe transfer to another hospital before deliver, or
    - That transfer may pose a threat to the health or safety of the woman or the unborn child.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent Emergency Services rendered to the Member do not require prior authorization from Passport.

Emergency Services are covered on a 24-hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

Passport accomplishes this service by providing a 24-hour Nurse Advise line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Passport contracts with vendors that provide 24-hour Emergency Services for ambulance and hospitals. An out of network emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member will be responsible for payment.

Members over-utilizing the emergency department will be contacted by Passport Case Managers to provide assistance whenever possible and determine the reason for using Emergency Services.

Case Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Inpatient Management

Elective Inpatient Admissions

Passport requires prior authorization for all elective/scheduled inpatient admissions and procedures to any facility. Facilities are required to also notify Passport within 24 hours or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Passport requires notification of all emergent inpatient admissions within 24 hours of admission or by the Following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Passport requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting notification, Medical Necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient/Concurrent Review

Passport performs concurrent inpatient review to ensure Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Passport will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Passport requires that requested clinical information updates be received by Passport from the inpatient facility within 24 hours of the request. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Passport will authorize hospital care as an inpatient, when the clinical record supports the Medical Necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge the Provider must provide Passport with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Passport's UM staff follow CMS guidelines to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and Medical Necessity requirements (refer to the Medical Necessity section of this manual).

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review Medical Necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of Passport's Quality Improvement Program to ensure that Passport Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and Commonwealth regulations.

Passport will conduct readmission reviews for participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates. There are two situations for Readmissions: Readmissions occurring within 24 hours from discharge (same or similar diagnosis); and Readmissions occurring within 2-30 days of discharge (same or similar diagnosis PLUS preventable).

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:

- Premature or inadequate discharge from the same hospital.
- Issues with transition or coordination of care from the initial admission.
- For an acute medical complication plausibly related to care that occurred during the initial admission.

Readmissions that are excluded from consideration as preventable readmissions include:

- Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
- Neonatal and obstetrical Readmissions.
- Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.
- Behavioral Health readmissions.
- Transplant related readmissions.

Post Service Review

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Passport Member or there was a Passport error, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance and evidence-based criteria sets.

Specific Federal or Commonwealth requirements or Provider contracts that prohibit administrative denials supersede this policy.

Retrospective (Retro) Eligibility

Retrospective Eligibility is coverage of Medicaid benefits for an applicant that may be back-dated for a full three months prior to the month in which the application for Medicaid is filed.

UM requests for services which occurred during the retrospective eligible time period may be received in writing from the provider, either by fax, mail, secure email or the provider portal. Providers may submit a request utilizing the available forms including the Universal Fax Form for either pre or post-pay; medical records may be attached for UM to determine medical necessity. For Outpatient Services conducted during the Retro Eligible period, authorization is not required; providers should submit the claim. UM will only conduct review for Inpatient Services that occurred during the retro eligible period.

UM determination of a retrospective review request will be completed within 5 calendar days.

If a request for a retrospective review is received and the member was eligible at the time the service was rendered, the provider shall be instructed to submit a claim appeal. The Utilization Management Department does not conduct review requests where the provider failed to obtain authorization for an eligible member.

Affirmative Statement about Incentives

All medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns. Passport and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Passport requires that all utilization-related decisions regarding Member coverage and/or services are based solely on appropriateness of care and service and existence of coverage. Passport does not specifically reward practitioners or other individuals for issuing denials of coverage or care. And, Passport does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Open Communication about Treatment

Passport prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Passport requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of

securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Passport and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans or other coverage arrangements.

Delegated Utilization Management Functions

Passport may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. They must have the ability to meet, perform the delegated activities and maintain specific delegation criteria in compliance with all current Passport policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Communication and Availability to Members and Providers

Healthcare Services staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (800) 578-0775 during normal business hours, Monday through Friday. All staff Members identify themselves by providing their first name, job title, and organization.

Passport offers TTY/TDD services for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

After business hours, Providers can also utilize fax and the Provider Portal for UM access.

Passport's Nurse Advice Line is available to Members and Providers 24 hours a day, 7 days a week at (800) 606-9880. Passport's Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Peer to Peer

A Peer to Peer (P2P) is a conversation between the provider directing the care of the member and the UM Medical Director to re-evaluate an adverse benefit determination. The requesting provider may share additional information to support an approval of the requested services. This conversation can occur for inpatient or PA requests. The requesting provider must indicate that (s)he wishes to have a P2P conversation with the UM Medical Director who generated the adverse benefit determination within 2 business days of the decision to deny. A P2P will be scheduled ASAP but will not exceed 2 business from date of P2P request.

Out of Network Providers and Services

Passport maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to Passport Members. Passport requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services or EPSDT Special Services that cannot be provided by any participating Provider as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior

authorized by Passport. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or Commonwealth Laws or regulations.

Coordination of Care and Services

Passport HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Passport's Integrated Care Management (ICM) program via assessment or referral such as, self-referral, Provider referral, etc. In addition, the coordination of care process assists Passport Members, as necessary, in transitioning to other care when benefits end.

Passport staff provide an integrated approach to care needs by assisting Members with identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Passport staff is done in partnership with Providers, Members and/or their legally authorized representative(s) to ensure efforts are efficient aretrond non-duplicative.

Continuity of Care and Transition of Members

It is Passport's policy to provide Members with advance notice when a Provider they are seeing during the course of active treatment will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to ninety (90) days or longer if necessary, for a safe transfer to another Provider as determined by Passport or its delegated Medical Group/IPA.
- Passport will not disrupt or interrupt active care of new Members and will ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the plan even if the current treating Provider is not contracted with Passport.
- When a woman has entered prenatal care before enrolling with Passport, Passport will allow the Member to continue with the same prenatal care Provider throughout the entire pregnancy whether or not the Provider is contracted with Passport to perform such services. Passport shall ensure prompt initiation of prenatal care or continuation of care without interruption for women who are pregnant at the time they enroll.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Passport at (800) 578-0775.

Continuity and Coordination of Provider Communication

Passport stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers, and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or child care givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers

Suspected abuse and/or neglect should be reported as follows:

Child Abuse

Suspected child abuse should be reported to the Child Protection Branch of the Kentucky Cabinet for Health and Family Services (CHFS).

To report suspected child abuse and neglect call toll-free to:
877-KYSAFE1 (877-597-2331)
(800) 752-6200

Non-emergency reports can be made online:
https://prd.webapps.chfs.ky.gov/reportabuse/OutofHours.aspx

If the child's life is in danger, call 911.

Adult Abuse

Suspected abuse or neglect of an adult should be reported to the Adult Protection branch of CHFS.

For non-emergency reports should be made online using the Kentucky Child/Adult Protective Services Reporting System at: **https://prd.webapps.chfs.ky.gov/reportabuse/OutofHours.aspx**.

If the situation is a life-threatening emergency, call 911.

Passport's HCS teams will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities or other clinical personnel. Under Commonwealth and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Providers who report any form of abuse should notify Passport Care Coordination team of the nature of the report that was made. The Care Coordination team can be reached at (800) 578-0775. Passport will follow up with Members that are reported to have been abused, exploited or neglected to ensure appropriate measures were taken, and follow up on safety issues. Passport will track, analyze, and report aggregate information regarding abuse reporting to the Healthcare Services Committee and the proper Commonwealth agency.

PCP Responsibilities in Care Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with the Members' completed Health Risk Assessment (HRA) and or Enrollee Needs Assessment (ENA) as applicable, ICP, multidisciplinary care team (MCT) updates, and information regarding the Member's progress through the ICP. The PCP is responsible for the provision of preventive services, for the primary medical care of Members and referrals to appropriate treating Providers/specialists. The PCP is responsible for educating the Member about the benefits of care management and referring the Member to Passport's Care Management program if the Member's needs warrant additional care management support.

Case Manager Responsibilities

The case manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from Member's MCT, as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the case manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the case manager:

- Assesses the Member, at set intervals or after a significant change in condition, to determine if the Member's needs warrant care management and shares the completed assessments (HRA and/or ENA) with each Member and/or legally authorized representative.
- Monitors and communicates the progress of the implemented ICP to the Member's MCT, as Member needs warrant.
- Serves as a coordinator and resource to the Member, their representative and MCT participants throughout the implementation of the ICP and revises the plan as suggested and needed.

- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program.

Health Management

The tools and services described here are educational support for Passport Members and may be changed at any time as necessary to meet the needs of Passport Members.

Health Education/Disease Management

Passport offers programs to help our Members and their families manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Nutrition Consultation
- Weight Management
- Smoking Cessation
- Substance Use Disorder

For more information about our Health Management programs, please call Health Management at (866) 891-2320, Option 2, Monday-Friday 6 am - 6 pm PST (TTY:711).

Pregnancy Notification Process

The PCP shall submit to Passport the Pregnancy Notification Report Form available at **www.passporthealthplan.com** within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Passport at (800) 983-9160.

Passport has case management available for Members with a high-risk pregnancy, including Members with a history of a previous preterm delivery. For more information about our maternity programs, please call Passport's Maternity Department at (866) 891-2320 Option 1.

Member Newsletters

Member Newsletters are posted on the **www.passporthealthplan.com** website at least once a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members can access our easy-to-read materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, Members are directed to ask their doctor or visit the Passport website.

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Passport Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational newsletters, telephonic outreach or other materials to access information on their condition. Members can contact Passport Member Services or assigned Health Manager at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy Claims data for all classifications of medications.
- Encounter Data or paid Claims with a relevant CMS accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member Assessment calls made by staff for the initial or annual Health Risk Assessments (HRA) for enrolled Members.
- External referrals from Provider(s), caregivers or community-based organizations.
- Internal referrals from Nurse Advice Line, Medication Management or Utilization Management.
- Member self-referral due to general plan promotion of program through Member newsletter or other Member communications.

Provider Participation

Contracted Providers are notified as appropriate, when the Member is enrolled in a health management program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools'
- Patient education resources;
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and,
- Preventive Health Guidelines.

Additional information on health management programs is available from your local Passport Healthcare Services Department toll free at (800) 578-0775.

Care Management (CM)

Passport provides a comprehensive ICM program to all Members who meet the criteria for services. The CM program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Passport adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Passport case managers may be licensed professionals and are educated, trained and experienced in Passport's ICM program. The ICM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Passport case manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services and identify and address any barriers the Member experiences to accessing appropriate care. The Passport case manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Members' ICP.

Referral to Care Management: Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM program. The case manager works collaboratively with the Member and all participants of the MCT when warranted, including the PCP and specialty Providers, such as, discharge planners, ancillary Providers, the local Health Department or other community-based resources when identified. The referral source should be prepared to provide the case manager with demographic, health care and social data about the Member being referred.

Members with the following conditions may qualify for Care Management and should be referred to the Passport ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery.
- Catastrophic or end-stage medical conditions (e.g. neoplasm, organ/tissue transplants, End Stage Renal Disease).
- Comorbid chronic illnesses (e.g. asthma, diabetes, COPD, CHF, etc.).
- Preterm births.
- High-technology home care requiring more than 2 weeks of treatment.
- Member accessing Emergency Department services inappropriately.
- Individuals with Special Health Care Needs, including but not limited to:
    - Blind/disabled children under age 19
    - Adults over the age of 65
    - Homeless Members
    - Individuals with chronic physical health illnesses
    - Individuals with chronic behavioral health illnesses, such as SMI

    - Children receiving services in a Pediatric Prescribed Extended Care facility or unit
    - Children receiving EPSDT Special Services
- Members under guardianship with Department for Aging and Independent Living (DAIL).
- Members over utilizing prescription drugs.

Referrals to the ICM program may be made by contacting Passport at:

Phone: (800) 578-0775
Fax: (800) 983-9160

Transitions of Care

Passport's Transitions of Care (ToC) Program is designed to improve the quality of care while ensuring appropriate utilization for Members admitted to the hospital. During an episode of illness, Members may receive care in multiple settings, which can result in fragmented and poorly executed transitions. ToC provides targeted interventions for Members most likely to be negatively impacted. The program closely follows the Members most at risk for hospital readmissions by identifying specific diagnoses and other case determinants most correlated with readmissions. ToC provides a high level of support and intervention for Members upon notification of admission up to 30 days following discharge from a ToC setting back to the community. Settings that are supported in the ToC program include: home, hospital/acute care, Skilled Nursing Facility, rehabilitation facility, inpatient psychiatric facility/center and licensed personal care home.

The Passport ToC program confirms and reestablishes the Member's connection to his/her medical home. It provides services to support continuity and coordination of care from one care setting to another, as the Member's health status changes. The purpose of the ToC program is to improve clinical outcomes, identify and address transition of care needs, and promote Member self-determination and satisfaction, while reducing hospital readmissions and emergency department visits by:

- Ensuring the Member is fully prepared to continue the plan of care throughout the entire transition.
- Engaging the Member directly so they have an active voice in the implementation of their individualized plan of care.
- Facilitating the fundamental elements of the program designed to produce positive outcomes: medication review, practitioner and/or specialist follow-up appointments, assessment of health status, dietary and nutritional needs, and home health and DME needs.
- Supporting the Member through the transition and coordinating needed services with appropriate Providers and other payor sources.
- Promoting Member self-management and encouraging empowerment.

ToC Coaches aid the Member through the transition process to ensure a safe and successful transition. Upon notification of a transition need, the assigned ToC Coach/CM reaches out to the Member/designee to engage them in transitions of care activities, interventions and addressing the program elements. The Passport ToC Coach/CM attempts to reach out to the Member while

still inpatient and continues to support the Member as they transition from an inpatient level of care back to the community for up to thirty (30) days after the transition. The first post discharge call is aimed no later than five (5) calendar days of discharge notification or transition to perform a comprehensive physical and behavioral health assessment designed to support the successful transition to community-based care and/or housing. To perform such assessment, Passport will review the Member's Person-Centered Recovery/Care Plan and level of care determination developed by the Provider / Provider agency, as applicable, in tandem with Passport's routine UM/ToC procedures. Interventions conducted by the ToC Coach include inpatient and facility contacts, at a minimum one post discharge assessment, administration of an HRA for any changes in health status, assurance all ToC elements are appropriately assessed and addressed, assurance the ICP is appropriately completed/updated/reviewed to reflect Member's identified transition and individualized needs and preferences and Provider coordination to address the Member's transitional needs at each milestone. Intervals in which the Member receives follow up contacts are based on the Member's identified needs and preferences.

The ToC Coach/CM serves as the main point of contact during the transition period, but other Passport staff may be engaged in the process as needed, including but not limited to: the Member's PCP as well as participants of the Member's multidisciplinary care team. The Member's PCP is notified of the admission to ensure that the Member's main Provider is aware of the transition and can assist with coordinating timely follow up care and post discharge services. The Passport HCS team will work with the Member and/or designee to ensure PCP and/or other treating Providers are aware of health status changes, address risk(s) associated with transition needs, and assist with planning, preparation and follow up care post-transition and may recommend a formal MCT meeting with inpatient, acute care, skilled nursing facility or post-discharge care team (home health, PT/OT/ST, specialty) participation, as needed. Passport ensures HIPAA compliance when sharing of relevant information with Providers as Members move between settings.

ToC Coaches and CMs, focus on an empowerment model to teach Members and/or their designees to self-manage their conditions, communicate with their Providers, and identify changes in health status to report to their physician and address at the right level of care. Passport's ToC program allows for identifying the Member's ability to self-manage and develop a plan to address their transition needs that includes, but is not limited to: assessment, goal setting, problem solving, care planning, engaging caregiver/designees, communicating with Providers, and empowering Members throughout the entire care continuum and transition needs.

Lock-In Program – Non-Emergent Care Settings

Members may be locked into a certain set of Providers or emergent / urgent care settings based on the Members misuse or overuse of pharmacy or emergency department care. Members potentially eligible for lock-in have their utilization reviewed to determine clinical composition, risk and possible misuse or overuse of healthcare services. Members may be referred to care management prior to lock-in to educate and support behavioral changes and positive health outcomes. If Member's behaviors do not change, regardless of care management engagement, the Case Manager will initiate Member enrollment into the lock-in program. The Member's Case Manager will contact their assigned PCP to make the PCP aware of the Member's potential to be locked-in to certain Providers and settings of care as a part of the Lock-In program. Members

should be referred to CM for potential non-emergent care setting lock-in if the PCP is aware of the Member using 3 different emergent care settings 3 or more times in a 6-month period. See the Pharmacy section for pharmacy lock-in criteria.

The PCP must collaborate with the Member's Case Manager by assisting the Case Manager with obtaining a list of Providers suitable for inclusion on the Member's lock-in list, all additional Providers in practice with the PCP, any active Providers outside of the PCP practice which may include specialists (must be current active Providers) and Behavioral Health Providers that may prescribe carved out medications. The Case Manager will notify the Member of their Lock-In enrollment and their appeal rights. The Member will receive a list of locked in Providers/pharmacy and/or settings of care. All lock-in decisions are made by a team of professional clinical Passport staff and Members are reevaluated for lock-in based on Member performance 60 days prior to the end of the 24-month lock-in term. If Member misutilization is still present the lock-in may remain in place for an additional 24 months. If Member misutilization is no longer present, the Member may be disenrolled from the lock-in program. Overrides/Emergencies will be made at the discretion of Passport and may be made available to Members and locked-in Providers if:

- The Member is out of town,
- The Locked-In Pharmacy is out of the Member's medicine,
- The Member moved and has not changed their pharmacy,
- If a Member's medication is stolen, or
- The Locked-In urgent care center cannot provide the urgent/emergent services a Member needs.

In certain circumstances the Member may request a change in Provider during their Lock-In period. Passport may consider a change in locked-in Provider if the:

- Provider does not want to serve the Member,
- Provider has closed and moved to another site, not convenient to the Member,
- Provider has been suspended/excluded/terminated/disqualified from the Medicaid program, or
- Member has moved beyond 30 min/miles from the Provider.

Additionally, enrollment in the Lock-In Program should be verified by checking the Member eligibility status in the Provider Portal. Failure to verify a Member's enrollment in the Lock-In Program may result in Claims denials for Providers who are not on the Member's restricted Provider list.

8. Behavioral Health

Overview

Passport Health Plan provides a Behavioral Health benefit for Members. Passport takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Behavioral Health inpatient and residential services can be requested by submitting a Prior Authorization form or contacting Passport's Prior Authorization team at (800) 578-0775. Providers requesting after-hours authorization for these services should contact (800) 606-9880. Emergency psychiatric services do not require Prior Authorization. All requests for Behavioral Health services should include the most current version of DSM classification. Molina utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews. American Society of Addiction Medicine (ASAM) criteria is utilized to determine Medical Necessity for SUD services. Please see the Prior Authorization section in the Healthcare Services chapter of this Manual for additional information.

Referrals

Members may be referred to primary care and specialty Providers to manage their health care needs. Members may be referred to an in-network Behavioral Health Provider via referral from a PCP or by Member self-referral.

Behavioral Health Providers may identify other health concerns, including physical health concerns, that should be addressed by referring the Member to a PCP. Behavioral Health Providers should refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or Member's legal guardian's consent. Quarterly audits will be conducted of a sample of outpatient Behavioral Health providers to ensure that Members are being referred to the PCP for physical health concerns and to ensure Behavioral Health Providers are sending initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's Behavioral Health status to the PCP with the Member's or Member's legal guardian's consent.

Behavioral Health Providers may refer a Member to an in-network PCP, or a Member may self-refer. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice. Behavioral Health Providers will refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Passport emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Passport's ICM program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care Management

Passport's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and SUD needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a Behavioral Health Provider to the ICM program.

Referrals to the ICM program may be made by contacting Passport at:

Phone: (800) 578-0775

Fax: (800) 983-9160

Additional information on the ICM program can be found in the Care Management chapter of this manual.

Responsibilities of Behavioral Health Providers

Passport promotes collaboration with Providers and integration of both physical and behavioral health services in effort to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health and substance use disorder services to Passport Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

To support the overall well-being of the Members, behavioral health Providers will send initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent.

Providers shall follow Quality standards related to access. Passport provides oversight of Providers to ensure Members are able to obtain needed health services within the acceptable appointment timeframes. Please see the Quality chapter for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within 7 days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

If either the Contractor or a Provider (including Behavioral Health) requires a referral before making an appointment for specialty care, any such appointment shall be made within thirty (30) days for routine care or forty-eight (48) hours for Urgent Care.

Behavioral Health Providers must assist Members with accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

Behavioral Health Providers shall participate in quarterly Continuity of Care meetings hosted by the commonwealth-operated or commonwealth-contracted psychiatric hospital and assist Members for a successful transition to community supports.

Behavioral Health Crisis Lines

Passport Health Plan has a dedicated Behavioral Health Crisis Line that may be accessed by Members 24 hours a day, 7 days a week, 365 days a year. The Passport Behavioral Health Crisis line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling (844) 800-5154.

Behavioral Health Toolkit for Providers

Passport has developed a Behavioral Health Toolkit to provide support with screening, assessment and diagnosis or common behavioral health conditions, Behavioral Health HEDIS Tip Sheets, and other evidence-based guidance and recommendations for coordinating care amongst the behavioral health population. The material within this toolkit is applicable to Providers in both primary care and behavioral health settings. The Behavioral Health Toolkit for Providers can be accessed under "Health Resources" on the **www.passporthealthplan.com** website for Providers.

9. Quality

Maintaining Quality Improvement Processes and Programs

Passport works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Passport Quality department toll free at (800) 578-0775.

The address for mail requests is:
Passport Health Plan by Molina
Attn: Quality Department
5100 Commerce Crossings Drive
Louisville, KY 40229

This Provider Manual contains excerpts from the Passport Quality Improvement Program. For a complete copy of Passport's Quality Improvement Program, you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

Passport has established a Quality Improvement Program that complies with regulatory requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of our Members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure and responsibilities.

Passport does not delegate Quality Improvement activities to Medical Groups/IPAs. However, Passport requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care. Passport Medical Groups/IPAs must:

- Have a Quality Improvement Program in place.
- Comply with and participate in Passport's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Passport's quality improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Passport to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Passport Quality personnel for site and medical record review processes.

Patient Safety Program

Passport's Patient Safety Program identifies appropriate safety projects and error avoidance for Passport Members in collaboration with their PCPs. Passport continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and care management/disease management programs and education. Passport monitors nationally

recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Passport has established a systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting Member care. Passport will research, resolve, track and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

Passport is not required to pay for inpatient care related to "never events."

Medical Records

Passport requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following medical record components, that include but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records.
- Medical record content and documentation standards, including preventive health care.
- Storage maintenance and disposal processes.
- Process for archiving medical records and implementing improvement activities.
- Medical Records Need to add content to reflect Passport has a process to systematically review provider Medical Records to ensure compliance with the Medical Records standards.
- Passport shall institute improvement and actions when standards are not met.
- Passport will assess performance/compliance to for Medical Record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years.

Medical Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's Medical records:

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available at each visit and archived records are available within 24 hours.
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving medical records and implementing improvement activities.
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

Content

Providers must remain consistent in their practices with Passport's medical record documentation guidelines. Medical records are maintained for each Passport Member and should include the following information:

- Each page in the record contains the patient's name or ID number;
- Member name, date of birth, sex, marital status, address, employer name, school, home and work address and telephone numbers, emergency contact, consent forms, preferred language spoken and guardianship information;
- Legible signatures and credentials of Provider and other staff members within a paper chart;
- All Providers who participate in the Member's care;
- Information about services delivered by these Providers;
- A problem list that describes the Member's medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed;
- Allergies and adverse reactions (or notation that none are known);
- Documentation that Advance Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services, serious accidents, illnesses and risk factors (for children, past medical history includes prenatal care and birth information, operations, and childhood illnesses, such as chickenpox);

- Treatment plans that are consistent with diagnosis;
- A working diagnosis that is recorded with the clinical findings;
- Pertinent history for the presenting problem;
- Pertinent physical exam for the presenting problem;
- Lab and other diagnostic tests that are ordered as appropriate by the Provider;
- Clear and thorough progress notes that state the intent for all ordered services and treatments;
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate;
- Notes from consultants if applicable;
- Up-to-date immunization records and documentation of appropriate history (pursuant to 902 KAR 2:060);
- Identification and history of nicotine, alcohol use or substance abuse;
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;
- All staff and Provider notes are signed physically or electronically with either name or initials;
- All entries are dated;
- Dates of encounter(s)
- All abnormal lab/imaging results show explicit follow up plan(s);
- All ancillary services reports;
- Documentation of all emergency care provided in any setting;
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report;
- Follow-up visits provided secondary to reports of emergency room care;
- Labor and Delivery Record for any child seen since birth;
- All written Denials of service and the reason for the Denial;
- A signed document stating with whom protected health information may be shared; and
- Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.

A Member's Medical Record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;

- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits;
- Plan of treatment including:
    - Medication history, medications prescribed, including the strength, amount, directions for use and refills;
    - Therapies and other prescribed regimen; and
    - Follow-up plans including consultation, referrals and directions, including time to return.

A Member's Medical Record shall include at a minimum for hospitals and mental hospitals:

- Identification of the Member;
- Physician name;
- Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 C.F.R. 456.172 (mental hospitals) or 42 C.F.R. 456.70 (hospitals);
- Initial and subsequent continued stay review dates (described under 42 C.F.R. 456.233 and 42 C.F.R. 465.234 (for mental hospitals) and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 (for hospitals);
- Reasons and plan for continued stay if applicable;
- Other supporting material appropriate to include;
- For non-mental hospitals only:
    - Date of operating room reservation; and
    - Justification of emergency admission if applicable.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Passport to release medical information for facilitation of medical care.

Retrieval

- The medical record is available to Provider at each Encounter.
- The medical record is available to Passport for purposes of Quality Improvement.
- The medical record is available to applicable Commonwealth and/or Federal agency and the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request. (Member is entitled to at least one free copy of his/her medical record.)

- A storage system for inactive Member medical records which allows retrieval within 24 hours, is consistent with Commonwealth and Federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, 1 year past their 20th birthday but, never less than 10 years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

Passport Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable Federal and Commonwealth regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or Commonwealth Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and Commonwealth Laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Passport Quality department. See also the Compliance Section of this Provider Manual for additional information regarding HIPAA.

Access to Care

Passport maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (adult and pediatric) and participating specialists (to include OB/GYN, behavioral health Providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 90% availability for Emergency Services and 90% or greater for all other services. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Passport Members in the timeframes noted:

Medical Appointment

Appointment Types	Standard
Preventive Care, non-urgent	Within 30 calendar days
Family Planning (Counseling & Medical Services	**Age 18 years and up:** As Soon As Possible, and within 30 calendar days **Less than 18 years:** As immediately as possible and within 10 calendar days
PCP	**Urgent:** within 48 hours **Urgent:** within 30 calendar days
Specialists	**Urgent:** within 48 hours **Non-Urgent:** within 30 calendar days
Dental	**Urgent:** within 48 hours **Non-Urgent:** within 30 calendar days
Vision	**Urgent:** within 48 hours **Non-Urgent:** within 30 calendar days
Labs & Radiology	**Urgent:** within 48 hours **Non-Urgent:** within 30 calendar days
After Hours Care	24 hours per day/7 days per week and in accordance with Commonwealth standards

Behavioral Health Appointment

Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-life Threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
Routine Care	**Initial Visit:** Within 10 business days of request **Follow-up visit:** within 30 calendar days of request
Post-Discharge Outpatient Aftercare	Within 7 calendar days of discharge
Referrals	Within 30 calendar days

Note: Behavioral Health Providers must contact Members who have missed an appointment within 24 hours to re-schedule. Additional information on appointment access standards is available from your local Passport Quality department.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 30 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

PCPs must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Passport requires Providers to maintain a 24-hour telephone service, 7 days a week.

Acceptable arrangements include:

- Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;
- Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and
- Office phone is transferred after office hours to another location where someone shall answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.

Unacceptable:

- Office phone is only answered during office hours;
- Office phone is answered after hours by a recording that tells Enrollees to leave a message;
- Office phone is answered after hours by a recording that directs Enrollees to go to the emergency room for any services needed; and
- Returning after-hours calls outside of thirty (30) minutes.

Women's Health Access

Passport allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Passport as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to participating Providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available from your local Passport Quality department.

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis.

Provider network adherence to access standards is monitored via the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Quality of Provider Office Sites

Passport Providers are to maintain office-site and medical record keeping practices standards. Passport continually monitors Member appeals and complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Passport assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical Accessibility.
- Physical Appearance.
- Adequacy of Waiting and Examining Room Space.

Physical Accessibility

Passport evaluates office sites as applicable, to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of Waiting and Examining Room Space

During the site visit as required, Passport assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

Facilities contracted with Passport must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Advance Directives (Patient Self-Determination Act)

Passport complies with the advance directive requirements of Kentucky as well as any federal requirements. Passport requires PCPs to ensure Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. There are three (3) types of Advance Directives:

- **Durable Power of Attorney for Health Care:** allows an agent to be appointed to carry out health care decisions.
- **Living Will:** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.
- **Guardian Appointment:** allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.

When There Is No Advance Directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Passport Members, 18 years old and up, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, Evidence of Coverage (EOC) and other Member communications such as newsletters and the Passport website. If a Member is incapacitated at the time of enrollment, Passport will provide advance directive information to the Member's family or representative and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or are directed to the CaringInfo website at **http://www.caringinfo.org/stateaddownload** for forms available to download. Additionally, the Passport website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

Passport network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Passport will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive. CMS Law gives Members the right to file a complaint with Passport or the State survey and certification agency if the Member is dissatisfied with Passport's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

Passport will notify the Provider of an individual Member's Advance Directives identified through Care Management or Care Coordination. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are State specific to meet State regulations.

Passport will look for documented evidence of the discussion between the Provider and the Member during routine Medical Record reviews.

EPSDT Services to Enrollees Under 21 Years of Age

Passport maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services to Enrollees under 21 years of age are timely according to required preventive guidelines. All Enrollees under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Passport's Quality or the Provider Services department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits

Visits consist of age-appropriate components, that include but are not limited to:

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening.
- Vision and hearing tests.
- Dental assessment and services.
- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident and disease prevention.

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

Passport shall have no obligation to pay for services that are not Covered Services. For more information on the EPSDT covered benefits and services, see the Benefits and Covered Services chapter of this Manual.

Monitoring for Compliance with Standards

Passport monitors compliance with the established performance standards as outlined above at least annually. Within 30 calendar days of the review, a copy of the review report and a letter

will be sent to the medical group notifying them of their results. Performance below Passport's standards may result in a Corrective Action Plan (CAP) with a request the Provider submit a written corrective action plan to Passport within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Passport maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management

The Passport Health Management Program provides for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases. For additional information, please see the Health Management heading in the Healthcare Services section of this Provider Manual.

Care Management

Passport's Care Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining best possible care outcomes to meet the Member's needs so they receive the right care, at the right time, and at the right setting. Passport Health Plan Care Management includes Health Management (HM) and Care Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services. For additional information please see the Care Management heading in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

Passport adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. CPGs are reviewed monthly and are updated as new recommendations are published.

Passport CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar Disorder

- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Detoxification and Substance Abuse Treatment
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Sickle Cell Disease

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services departments. The guidelines are disseminated through Provider newsletters, electronic Provider Bulletins and other media and are available on the Passport website. Individual Providers or Members may request copies from the Passport Quality department.

Preventive Health Guidelines

Passport provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Care for children up to 24 months old
- Care for children 2-19 years old
- Care for adults 20-64 years old
- Care for adults 65 years and older
- Immunization schedules for children and adolescents
- Immunization schedules for adults

All guidelines are updated monthly, as needed, and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at **www.passporthealthplan.com** and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Passport Provider Newsletter.

Cultural and Linguistic Services

Passport works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information

about Passport's program and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Measurement of Clinical and Service Quality

Passport monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Behavioral Health Survey
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

Passport evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and Facilities must allow Passport to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Passport's most recent results can be obtained from your local Passport Quality department or by visiting our website.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Passport utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are the measurement standard for many of Passport's clinical quality activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Passport to summarize Member satisfaction with the Providers, health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care, and Getting Needed Prescription Drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Passport's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Behavioral Health Survey

Passport obtains feedback from Members about their experience, needs, and perceptions of accessing behavioral health care. This feedback is collected at least annually to understand how our Members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, and perceived improvement in their conditions, among other areas.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Passport conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Passport, as this is one of the primary methods used to identify improvement areas pertaining to the Passport Provider Network. The survey results have helped establish improvement activities relating to Passport's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

Passport monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices". The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Passport also compiles complaint and appeals data as well as requests for out-of-network services to determine opportunities for service improvements

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;

- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed;
- Check that staff is properly coding all services provided; and
- Be sure patients understand what *they* need to do.

Passport has additional resources to assist Providers and their patients. For access to tools that can assist, please visit Provider Portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Passport Quality department.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

Value Based Payment Continuum (VBC)

Passport recognized the need to "meet providers where they are at." Our VBC payment methodologies support that objective with an accountable care continuum of value-based models, including pay-for-performance, quality payment bundles, gain share, partial shared-risk models, and full-risk capitation—all of which reward quality improvements, and some that also incentivize improved cost of care.

Passport partners with Providers in the following ways:

Pay for Performance:

- Initial engagement with fee-for-service providers
- Financial incentives are tied to key access, quality and outcomes indicators
- Identify Providers with at-risk patients and HEDIS score improvement opportunities

Pay for Quality:

- Enhanced reimbursement opportunities tied to HEDIS and STAR measures
- Focuses on providers investing in processes to drive better outcomes and lower costs
- Additional financial incentives for improved performance on utilization metrics with assigned members

Patent Centered Medical Homes

- Focuses on Providers engaging in team-based and integrated care coordination
- Rewards Providers who achieve NCQA Patient Centered Medical Home accreditation status
- Increases the level of care coordination and information sharing between different care settings

Shared Risk and Accountable Care:

- Offers Providers additional compensation from sharing in savings or risk resulting from improved care quality and outcomes with potential to move to accountable care contract including upside/downside risk based on benchmark data and quality measures

Full Risk Arrangements:

- Progresses into partial/full risk arrangements with more experienced Providers demonstrating a track record or positive administrative experience and capability in successfully managing government sponsored health care populations.

10. Compliance

Fraud, Waste, and Abuse

Introduction

Passport Health Plan by Molina Healthcare's Compliance program monitors compliance with federal and state/commonwealth laws, including health care fraud, waste and abuse statutes and regulations. Passport is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Passport's Compliance department maintains a comprehensive plan, which is designed to address how will uphold and follow state/commonwealth and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses education of appropriate employees, vendors, Providers and associates doing business with Passport Health Plan by Molina Healthcare.

A Special Investigations Unit (SIU) is a key element of the program. Molina Healthcare, Inc.'s Special Investigation Unit (SIU) supports Passport Health Plan by Molina Healthcare Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and report findings to the appropriate regulatory and/or law enforcement agencies.

Mission Statement

Passport Health Plan by Molina Healthcare regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Passport Health Plan has therefore implemented a plan to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Definitions

Fraud: Under applicable federal law or KRS 205.8451-KRS205.8483, "Fraud" means an intentional deception or misrepresentation made by a recipient or a Provider with the knowledge that the deception could result in some unauthorized benefit to the recipient or Provider or to some other person. It includes any act that constitutes fraud under applicable federal or state law

Waste: "Waste" means generally, but is not limited to, the overutilization or inappropriate utilization of services or misuse of resources, and typically is not a criminal or intentional act

Abuse: means, Provider Abuse and Recipient Abuse, as defined in KRS 205.8451: "Provider abuse" means, with reference to a health care Provider, practices that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary cost to the Medical Assistance Program established pursuant to this chapter, or that result in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes practices that result in unnecessary cost to the Medical Assistance Program. "Recipient abuse" means, with reference to a medical assistance recipient, practices that result in unnecessary cost to the Medical Assistance Program or the obtaining of goods, equipment, medicines, or services that are not Medically Necessary, or that are excessive, or constitute

flagrant overuse or misuse of Medical Assistance Program benefits for which the recipient is covered.

Clean Claim: A clean Claim is one that is accurate, complete (that is, includes all information necessary to determine Passport Health Plan by Molina Healthcare liability), not a claim on appeal, and not contested (that is, not reasonably believed to be fraudulent and not subject to a necessary release, consent or assignment), and supported with adequate and accurate medical records at the time service was rendered.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent Claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the Claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a Claim; or
- Acts in reckless disregard of the truth or falsity of the information in a Claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act ("DRA") aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with Passport Health Plan, Providers and their staff have the same obligation to report any actual or suspected violation of funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and State Laws pertaining to submitting false Claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as whistleblowers.

These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false Claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority.
- Two times the amount of back pay plus interest.
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the Law will be at risk of forfeiting all payments until compliance is met. Passport Health Plan will take steps to monitor Passport Health Plan contracted Providers to ensure compliance with the Law.

Anti-Kickback Statute – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other Federal health care programs.

Stark Statute – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to services provided only by Practitioners, rather than by all health care Providers.

Sarbanes-Oxley Act of 2002 – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Examples of Fraud, Waste and Abuse by a Provider

The types of questionable Provider schemes investigated by Passport Health Plan by Molina Healthcare include, but are not limited to the following:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Passport Health Plan Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Passport Health Plan identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.

- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

The types of questionable Member schemes investigated by Passport Health Plan include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud Medicaid.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from and the Member sells the medication to someone else.

Cooperating with Special Investigation Unit Activities

The Special Investigation Unit may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with Special Investigation Unit activities and will provide requested documentation to the unit following the timelines indicated in such requests. Failure to cooperate may result in further administrative action, up to and including termination of the Provider contract, and/or recovery of overpayment identified.

Review of Provider Claims and Claims System

Passport Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance department.

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices; ensure that Claims are processed accurately and ensure that payments reflect the service performed as authorized.

Passport performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Provider Profiling

Passport Health Plan by Molina Healthcare performs Claims audits to detect potential external health care fraud, waste, or abuse. These audits of Provider billings are based on objective and documented criteria. Passport uses a fraud, waste, and abuse detection software application designed to score and profile Provider and Member billing behavior and patterns. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a Provider or Member's prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid Claims data and ongoing daily Claims batches. If a score reaches a certain parameter or threshold, the Provider or Member is placed on a list for further review.

Passport will inform the Provider of the billing irregularities and request an explanation of the billing practices. The Compliance department, with the aid of the Special Investigation Unit, may conduct further investigation and take action as needed.

Prepayment Fraud, Waste, and Abuse Detection Activities

Through implementation of Claims edits, Passport's Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

Passport has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare and Medicaid Services (CMS), Federal CMS guidelines, AMA and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medical Medically Unlikely Edit table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/ National Coverage Determination (LCD/NCD) and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Passport may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the Claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Passport Health Plan by Molina Healthcare under the Provider Agreement or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Passport shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Passport, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Passport, in Passport's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Passport Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Passport and without charge to Passport. In the event Passport identifies fraud, waste or abuse, Provider agrees to repay funds or Passport may seek recoupment.

If a Passport auditor is denied access to Provider's records, all of the Claims for which Provider received payment from Passport is immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Passport may offset such amounts against any amounts owed by Passport to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Passport) and without charge to Passport. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Passport, Provider is required to allow Passport to conduct audits of its pertinent records to verify the services performed and the payment Claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Claim Auditing

Passport shall use established industry Claims adjudication and/or clinical practices, State/Commonwealth, and Federal guidelines, and/or Passport's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Passport's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina Healthcare Inc.'s Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Passport's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Passport may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Passport paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Passport asks that you provide Passport, or Passport's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If the Special Investigations Unit suspects that there is fraudulent or abusive activity, Passport may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Passport reserves the right to recover the full amount paid or due to you.

Provider/Practitioner Education

When Passport identifies through an audit or other means a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, Passport may determine that a Provider education visit is appropriate.

Passport will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP) to Passport addressing the issues identified and how it will cure these issues moving forward.

Medical Records

In accordance with your contract with Passport Health Plan by Molina Healthcare, which allows for the review of Claims, please submit **complete** medical records for all of the Members indicated for the dates of service provided. This includes, but is not limited to the following:

- Patient information sheets (completed by patient, parent, or guardian)
- Financial records including superbills, copayments, copies of identification cards, and patient intake forms

- Provider orders
- Diagnostic test results
- Referral/authorization requests and forms
- Physician progress notes
- Medication records
- Graphic reports
- Emergency room records
- History and physical notes
- Operative reports
- Lab requisitions and lab reports

Please photocopy each record. Make sure all copies are complete and legible and contain both sides of each page, including page edges. Complete copies should include specific records to support the services provided and be separated by patient in chronological order.

All records should be sent via a trackable manner (e.g., certified mail). Please return a copy of the records request letter with the medical records to the following address:

Molina Healthcare, Inc.
Attn: Special Investigation Unit
200 Oceangate, Suite 100
Long Beach, CA 90802

Molina Healthcare, Inc. must be in receipt of the requested document within 15 calendar days from the receipt of request. *Failure to submit requested documentation could result in the retrospective denial of Claims and other sanctions*

Provider Appeal Procedures

If a Provider disagrees with any of the results of any audit conducted by the Special Investigation Unit at Molina Healthcare Inc., the Provider has the right to file an appeal within 30 days from the data of the issued audit findings letter. In order for the appeal to be considered, the following must be enclosed:

- The written letter of appeal must be clearly labeled "Appeal Regarding SIU Audit Results;"
- A copy of the issued audit findings letter must be attached to the written letter of appeal;
- The written letter of appeal must contain all necessary information, such as the original Claim(s), medical record(s), prior authorization letter(s) or form(s), and any **new** information pertinent to the appeal, which **was not** originally submitted and/or reviewed by the SIU during the audit process.

Please send the written letter of appeal and supporting documentation to:

Molina Healthcare, Inc.
Attn: Special Investigation Unit
P.O. Box 22625
Long Beach, CA 90802

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare, Inc. AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare, Inc. Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina Healthcare, Inc.'s AlertLine can be reached toll free at (866) 606-3889 or you may use the service's website to make a report at any time at **https://molinahealthcare.alertline.com**

You may also report cases of fraud, waste or abuse to Passport Health Plan's Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Passport Health Plan by Molina HealthCare
Attn: Compliance
5100 Commerce Crossings Drive
Louisville, KY 40229

Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Member ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the Commonwealth at:

Office of Medicaid Fraud and Abuse Control
1024 Capital Center Drive, Suite 200
Frankfort, KY 40601

Toll Free Phone: 1-877-ABUSE TIP (1-877-228-7384)

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Passport's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Passport takes very seriously. Passport is committed to complying with all Federal and State Laws regarding the privacy and security of Members' protected health information (PHI).

Provider Responsibilities

Passport expects that its contracted Providers will respect the privacy of Passport Members (including Passport Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Passport provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Passport uses and discloses their PHI and includes a summary of how Passport safeguards their PHI.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:

- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act, ("HITECH Act")

Applicable Laws

Providers must understand all State and Federal health care privacy Laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of Laws that Providers must comply with. In general, most health care Providers are subject to various Laws and regulations pertaining to privacy of health information, including, without limitation, the following:

1. **Federal Laws and Regulations**
    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - 42 C.F.R. Part 2
    - Medicare and Medicaid Laws
    - The Affordable Care Act
2. **State Medical Privacy Laws and Regulations.**

    Providers should be aware that HIPAA provides a floor for patient privacy but that State Laws should be followed in certain situations, especially if the State Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of services[2].
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    - Quality improvement
    - Disease management
    - Care management and care coordination
    - Training Programs
    - Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Passport for our health care operations activities, such as HEDIS® and Quality Improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Passport may, on occasion, inadvertently misdirect or disclose PHI pertaining to Passport Member(s) who are not the patients of the Provider. In such cases, the Provider shall

[1]See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

[2]See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

return or securely destroy the PHI of the affected Passport Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Passport.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law.

Patient Rights

Patients are afforded various rights under HIPAA. Passport Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of Privacy Practices**

   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**

   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**

   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**

   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**

   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding 6 year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of Passport Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity theft – both financial and medical – is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity – such as health insurance information – without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Passport.

HIPAA Transactions and Code Sets

Passport strongly supports the use of electronic transactions to streamline health care administrative activities. Passport Providers are encouraged to submit Claims and other transactions to Passport using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Passport is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Passport's website at **www.passporthealthplan.com** for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For Claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Passport and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Passport within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Passport.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and Utilization Management activities are the "business associates" of Passport. Under HIPAA, Passport must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

Passport does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management.
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

11. Claims and Compensation

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Hypoglycemic Coma
    b) Diabetic Ketoacidosis
    c) Non-Ketotic Hyperosmolar Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow

11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Restrictive Surgery
    b) Laparoscopic Gastric Bypass
    c) Gastroenterostomy
12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13) Latrogenic Pneumothorax with Venous Catheterization
14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement

What this means to Providers

- Acute IPPS Hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and,
- No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: **http://www.cms.hhs.gov/HospitalAcqCond/**

Claim Submission

Participating Providers are required to submit Claims to Passport with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines, as well as any criteria explicitly required in the Provider Billing Manual as well as any criteria explicitly required in the **claim form instructions**. .Providers must utilize electronic billing though a clearinghouse or Provider Portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID 61325. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Passport ID card.

Providers must bill Passport for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

Required Elements

The following information must be included on every Claim:

- Member name, date of birth and Member ID number.
- Member's gender.

- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification number (TIN).
- 10-digit National Provider Identifier (NPI).
- Rendering Provider information.
- Billing/Pay-to Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location information.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the Claim. Please refer to any criteria explicitly required in the Provider Billing Manual as well as any criteria required in the **claim form instructions**.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Passport as soon as possible, not to exceed 30 calendar days from the change.

Electronic Claims Submission

Passport strongly encourages participating Providers to submit Claims electronically, including secondary Claims. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and Claims reach Passport faster.

Passport offers the following electronic Claims submission options:

- Submit Claims directly to Passport via the **Provider Portal**.
- Submit Claims to Passport via your regular EDI clearinghouse using Payer ID 61325.

Provider Portal

The Provider Portal is a no cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files.
- Correct/Void Claims.
- Add attachments to previously submitted Claims.
- Check Claims status.
- Create and manage Claim Templates.
- Create and submit a Claim Appeal with attached files.

Clearinghouse

Passport uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

Passport accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may call the Passport EDI Customer Service line at (866) 409-2935 or email us at **EDI.Claims@Passporthealthplan.com** for additional support.

Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Passport Health Plan by Molina Healthcare
PO Box 7114
London, KY 40742

Please keep the following in mind when submitting paper Claims:

- Paper Claims should be submitted on original red colored CMS 1500 Claims forms.
- Paper Claims must be printed, using black ink.

Coordination of Benefits (COB) and Third Party Liability (TPL)

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Passport or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Passport or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Passport of said entitlement Passport is considered the source of truth when verifying potential primary coverage for a member. In the event that coordination of benefits occurs, Provider shall be compensated based on the commonwealth regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including explanation of benefits (EOBs) and other required documents, by utilizing Provider Portal. Providers can also submit this information through EDI and paper submissions.

TPL

Passport is the payer of last resort and will make every effort to determine the appropriate third party payer for services rendered. Passport may deny Claims when Third Party has been established and will process Claims for Covered Services when probable TPL has not been established or third party benefits are not available to pay a Claim. Passport will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Timely Claim Filing

Provider shall promptly submit to Passport Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Passport and shall include all medical records pertaining to the Claim if requested by Passport or otherwise required by Passport's policies and procedures. Claims must be submitted by Provider to Passport within 365 calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Passport is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Passport within 365 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Passport within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Passport requires coding of both diagnoses and procedures for all Claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and

3 (HCPCS codes) are required for professional and outpatient Claims. Inpatient hospital Claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Passport requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Passport utilizes a Claims adjudication system that encompasses edits and audits that follow State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
    - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Passport will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
    - In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
    - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
    - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific Claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Passport policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Passport.

Telehealth and Telemedicine Claims and Billing

Providers must follow CMS guidelines as well as State-level requirements.

All telehealth Claims for Passport Members must be submitted to Passport with correct codes for the plan type. Use the telehealth Place of Service (POS) Code 02, which certifies that the service meets the telehealth requirements. By coding and billing a place of service 02 with a covered telehealth procedure code, the Provider is certifying the Member was present at an eligible originating site when the telehealth services were performed. Modifier GQ is required when applicable. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Passport Health Plan uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

Correct coding is required to properly process Claims. Passport requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one physician.
- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS Codes

Passport utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny Claims that do not meet Passport's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

Place of Service Codes (POS) are two-digit codes placed on health care professional Claims (CMS 1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC's) Official UB-04 Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official UB-04 Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit Claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate Claim payment.

Passport processes DRG Claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Passport-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the Claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

Passport shall use established industry Claims adjudication and/or clinical practices, State/Commonwealth and Federal guidelines, and/or Passport's policies and data to determine the appropriateness of the billing, coding and payment.

Provider acknowledges Passport's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina Healthcare Inc.'s Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Passport's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Passport may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This sample gives an estimate of the proportion of Claims Passport paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Passport asks that you provide Passport, or Passport's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Passport's Special Investigations Unit suspects that there is fraudulent or abusive activity, Passport may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Passport reserves the right to recover the full amount paid or due to you.

Provider/Practitioner Education

When Passport identifies through an audit or other means a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, Passport may determine that a Provider education visit is appropriate.

Passport will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP) to Passport addressing the issues identified and how it will cure these issues moving forward.

Medical Records

In accordance with your contract with Passport Health Plan by Molina Healthcare, which allows for the review of Claims, please submit **complete** medical records for all of the Members indicated for the dates of service provided. This includes, but is not limited to the following:

- Patient information sheets (completed by patient, parent, or guardian)
- Financial records including superbills, copayments, copies of identification cards, and patient intake forms
- Provider orders
- Diagnostic test results
- Referral/authorization requests and forms
- Physician progress notes
- Medication records
- Graphic reports
- Emergency room records
- History and physical notes
- Operative reports
- Lab requisitions and lab reports

Please photocopy each record. Make sure all copies are complete and legible and contain both sides of each page, including page edges. Complete copies should include specific records to support the services provided and be separated by patient in chronological order.

All records should be sent via a trackable manner (e.g., certified mail). Please return a copy of the records request letter with the medical records to the following address:

Molina Healthcare, Inc.
Attn: Special Investigation Unit
200 Oceangate, Suite 100
Long Beach, CA 90802

Molina Healthcare, Inc. must be in receipt of the requested document within 15 calendar days from the receipt of request. *Failure to submit requested documentation could result in the retrospective denial of Claims and other sanctions*

Provider Appeal Procedures

If a Provider disagrees with any of the results of any audit conducted by the Special Investigation Unit at Molina Healthcare, Inc., the Provider has the right to file an appeal within 30 days from the data of the issued audit findings letter. In order for the appeal to be considered, the following must be enclosed:

- The written letter of appeal must be clearly labeled "Appeal Regarding SIU Audit Results;"
- A copy of the issued audit findings letter must be attached to the written letter of appeal;
- The written letter of appeal must contain all necessary information, such as the original Claim(s), medical record(s), prior authorization letter(s) or form(s), and any **new** information pertinent to the appeal, which **was not** originally submitted and/or reviewed by the SIU during the audit process.

Please send the written letter of appeal and supporting documentation to:

Molina Healthcare, Inc.
Attn: Special Investigation Unit
P.O. Box 22625
Long Beach, CA 90802

Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Provider Portal includes functionality to submit corrected Institutional and Professional Claims. Corrected Claims must include the correct coding to denote if the Claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original Claim number.

Claims submitted without the correct coding will be returned to the Provider for resubmission.

EDI (Clearinghouse) Submission

837P

- In the 2300 Loop, the CLM segment (Claim information) CLM05-3 (Claim frequency type code) must indicate one of the following qualifier codes:
    - "1"-ORIGINAL (initial Claim)
    - "7"–REPLACEMENT (replacement of prior Claim)
    - "8"-VOID (void/cancel of prior Claim)

- In the 2300 Loop, the REF *F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

- Bill type for UB Claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1" "7" or "8" goes in the third digit for "frequency".
- In the 2300 Loop, the REF *F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Passport or contracted medical group/IPA have agreed in writing to an alternate schedule, Passport will process the Claim for service within 30 days after receipt of Clean Claims.

The receipt date of a Claim is the date Passport receives notice of the Claim.

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Passport uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at **www.passporthealthplan.com** or by contacting our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Passport determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment.

A Provider shall pay a Claim for an Overpayment made by Passport which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider.

If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Passport may offset the Overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Passport, or the date that the Provider receives a payment from Passport that reduces or deducts the Overpayment.

Provider Claims Appeal

A Provider may request an Appeal regarding payment or contractual issues on his or her own behalf by mailing, by the secure Provider portal online, or faxing a letter of Appeal and/or an Appeal form with supporting documentation such as medical records to Passport Healthcare. Providers may file via:

- Provider Online Portal found on **www.Availity.com**
- Fax at (866) 315-2572
- E-mail: **MHK_Provider_GnA@passporthealthplan.com**
- Postal mail:

Passport Health Plan by Molina Healthcare
Attention: Provider Grievances and Appeals
P.O. Box 7114
London, KY 40742

Providers have sixty (60) calendar days from the date of our adverse determination to file an Appeal. Appeals submitted after that time will be denied for untimely filing. If the Provider feels they filed the Appeal within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is fax confirmation, a registered postal receipt signed by a representative of Passport Health Plan or similar receipt from other commercial delivery services.

Upon receipt of all required documentation, Passport has thirty (30) calendar days to review the Appeal for Medical Necessity and conformity to Passport Health Plan guidelines and to render a decision to reverse or affirm. If the Appeal is not resolved within thirty (30) days, Passport may request a fourteen (14) calendar day extension from the Provider. If the Provider requests the extension, the extension shall be approved by Passport.

It is the responsibility of the Provider to submit all the necessary documentation with their Appeal within sixty (60) calendar days of the denial to prevent a denial for lack of Information. Any information received after that time frame will not be reviewed.

Medical records and patient information shall be supplied at the request of Passport Health Plan or appropriate regulatory agencies when required for Appeals. The Provider is not allowed to charge Passport or the Member for copies of medical records provided for this purpose.

Reversal of Denial

If it is determined during the review that the Provider has complied with Passport Health Plan protocols and that the Appealed services were Medically Necessary, the denial will be reversed. The Provider will be notified of this decision in writing. If a Claim has been previously submitted and denied, it will be adjusted for payment after the decision to reverse the denial has been made. Passport Health Plan will ensure that Claims are processed and comply with federal and commonwealth requirements.

Affirmation of Denial

If it is determined during the review that the Provider did not comply with Passport protocols and/or Medical Necessity was not established, the denial will be upheld. The Provider will be notified of this decision in writing. For denials based on Medical Necessity, the criteria used to make the decision will be provided in the letter. The Provider may also request a copy of the benefit provision, guideline, protocol and other similar criteria used in making the Appeal decision by sending a written request to the Appeals addresses listed in the decision letter.

For information on Independent External Third-Party Review, see the Complaints, Grievance and Appeals Process chapter of this Manual.

Billing the Member

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Passport to the Provider. Balance billing a Passport Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

Fraud and Abuse

Failure to report instances of suspected Fraud and Abuse is a violation of the Law and subject to the penalties provided by Law. Please refer to the Compliance section of this Provider Manual for more information.

Encounter Data

Each Provider, capitated Provider or organization delegated for Claims processing is required to submit Encounter data to Passport for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least weekly, and within 30 days from the date of service in order to meet Commonwealth and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

Passport has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Passport. Encounters must be corrected and resubmitted within fifteen (15) days from the rejection/denial.

Passport has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two (2) types of responses:

- First, Passport will provide a 999 acknowledgement of the transmission.
- Second, Passport will provide a 277CA response file for each transaction.

12. Complaints, Grievance and Appeals Process

Definitions

Adverse Benefit Action- also known as, Adverse Benefit Determination. As defined in 42 C.F.R. 438.400(b), is:

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

Appeal - A request for review of an Adverse Benefit Action or a decision by or on behalf of Passport Health Plan related to the Covered Services provided, or the payment for the service.

Authorization - An approval of a Prior Authorization request for payment of services, and is provided only after Passport Health Plan agrees the treatment is necessary.

Department - Department for Medicaid Services (DMS).

Member Grievance - Any expression of dissatisfaction about us or the way we operate, as defined in C.F.R. 438.400

Member Grievance Process

A Member or Member's representative, including the legal guardian of a minor Member or incapacitated adult or a Provider acting on behalf of the Member, with written consent, may submit a Grievance orally or in writing at any time to any of the following:

- Hand delivered in the offices of Passport Health Plan by Molina Healthcare
- Toll-free contact center at (800) 578-0603
- Fax at (833) 415-0673
- Email: **MHK_Enrollee_GnA@Passporthealthplan.com**
- Postal mail:

Passport Health Plan by Molina Healthcare
Attention: Member Grievances and Appeals
5100 Commerce Crossings Drive
Louisville, KY 40229

Upon receipt of the Grievance, an acknowledgement letter will be mailed to the Member confirming receipt of the Grievance and an expected date of its resolution no later than five (5) days after receipt of their Grievance. A Grievance specialist will conduct the review and will mail a resolution letter to the Member within thirty (30) calendar days from the date the Grievance is received by Passport. The resolution letter may not take the place of the acknowledgement letter, unless a decision is reached before the acknowledgement letter is sent, then one letter shall be sent which includes the acknowledgement and the decision letter. The resolution letter will include:

- The results/findings of the Grievance;
- All information considered in the investigation of the Grievance; and
- The date of the Grievance resolution.

Please note: If the Member wishes to use a representative, she or he must complete an Appointment of Representative (AOR) statement. The Member and the person who will be representing the Member must sign the AOR statement. For authorized representative purposes, written consent unique to an Appeal or State Fair Hearing shall be required for the Appeal or State Fair Hearing. A single written consent shall not quality as written consent for more than one (1) of the following: Hospital Admission, Physician or other Provider visit, or Treatment plan.

Grievance Timelines

Member's or Member's representative, including the legal guardian of a minor Member or incapacitated adult or a Provider acting on behalf of the Member with written consent has the right to file a Grievance at any time after they experience any dissatisfaction, verbally or in writing to Passport. Within five (5) working days of receipt of a Grievance, Passport will send the Member an acknowledgement letter that will confirm receipt of the Grievance and the expected date of its resolution. The investigation and final resolution will be completed within thirty (30) calendar days of the date the Grievance was received.

Member Appeals Process

Members have the right to file an Appeal of an Adverse Benefit Action taken by Passport Healthcare of Kentucky. An Appeal may also be filed on the Member's behalf by an authorized representative or a Provider with the Member's written consent. Appeals received from Providers that are on the Member's behalf for denied services with requisite consent of the Member are deemed Member Appeals. To Appeal, the Member, or his or her representative, may file an Appeal request either verbally or in writing to one of the following:

- Hand delivered in the offices of Passport Health Plan by Molina Healthcare
- Toll-free contact center at (800) 578-0603
- Email: **MHK_Enrollee_GnA@passporthealthplan.com**
- Fax at (833) 415-0673
- Postal mail:

Passport Health Plan by Molina Healthcare
Attention: Member Grievances and Appeals
5100 Commerce Crossings Drive
Louisville, KY 40229

The Appeal must be received verbally or in writing within sixty (60) calendar days of the date of the Adverse Action. If an Appeal is filed verbally via Passport Health Plan's Contact Center, the request must be followed up with a written, signed Appeal to Passport Health Plan within ten (10) calendar days of the verbal filing. For verbal filings, the time frames for resolution begin on the date the verbal filing was received by Passport. Unless written confirmation of a standard verbal Appeal request is received, the case is closed as an invalid Appeal and a decision is not made on the Appeal. This requirement does not apply to Expedited Appeal requests.

An acknowledgement letter will be sent to the Member no later than five (5) days after the Appeal is received confirming receipt and will provide the expected date of resolution. An Appeal Specialist will ensure the appeal is reviewed as expeditiously as the Members health condition requires.

A resolution letter to the Member will be mailed no later than thirty (30) calendar days from the receipt of the Appeal, unless the Member requests a fourteen (14) calendar day extension. Passport may also request a fourteen (14) day extension when it can show that there is a need for additional information, and it will be in the Member's best interest. If Passport requests the extension, we will give the Member written notice of the extension and the reason for the extension within two (2) working days of the decision to extend.

If the Provider files an Appeal on the Member's behalf, Passport will respond to the Provider. The Provider shall give a copy of the notice to the Member or inform the Member of the provisions of the notice.

Passport will continue to provide benefits to a Member, if the Member requested a continuation of benefits, until one (1) of the following occurs:

- The Member withdraws the Appeal;
- Fourteen (14) calendar days have passed since the date of the resolution letter, if the resolution of the Appeal was against the Member and the Member has not requested a State Fair Hearing or taken any further action; or
- A State Fair Hearing decision adverse to the Member has been issued

Passport Health Plan will not take or threaten to take any punitive action against any Provider acting on behalf of or in support of a Member in requesting an Appeal or an Expedited Appeal.

Passport ensures that the decision makers assigned to Appeals were not involved in previous levels of review or decision making. When deciding an Appeal of a denial based on lack of Medical Necessity, a Grievance regarding denial of expedited resolution of an Appeal, or a Grievance or Appeal involving clinical issues, the Appeal reviewers will be healthcare professionals with clinical expertise in treating the Member's condition/disease or will have sought advice from Providers with expertise in the field of medicine related to the request.

Appeals Timelines

Member's or Member's representative, including the legal guardian of a minor Member or incapacitated adult or a Provider acting on behalf of the Member with written consent has the right to file an Appeal within sixty (60) calendar days of the date of the Adverse Action, verbally or in writing to Passport Health Plan. Within five (5) working days of receipt of an Appeal, Passport will send the Member an acknowledgement letter that will confirm receipt of the Appeal and the expected date of its resolution. The investigation and final resolution will be completed within thirty (30) calendar days of the date the Appeal was received.

Expedited Appeals Process and Timeline

An Appeal will be expedited in response to the clinical urgency of the situation; i.e., when a delay would jeopardize a Member's life or materially jeopardize a Member's health. A request to expedite may come from the Member, Member's representative, or a Provider with the Member's written consent. An expedited Appeal will be acted on quickly and a decision will be made within seventy-two (72) hours from the date the Appeal request is received either verbally or in writing. If we determine the request does not meet the Commonwealth's definition of an expedited Appeal we will immediately transfer the Appeal to the process and timeframes for a Standard Appeal resolution, in which a thirty (30) day period will begin on the date we receive the original Appeal request and we'll also notify the Member within two (2) calendar days.

State Fair Hearing for Members

A Member or his or her authorized representative may request a State Fair Hearing if he or she is dissatisfied with an action that has been taken by Passport Health Plan only after they have exhausted Passport's internal process. The request for a hearing must be in writing and specify the reason for the request, indicate the date of service or the type of service denied and be postmarked or filed within one hundred twenty (120) days from the date Passport Health Plan's adverse resolution letter issued at the conclusion of the MCO internal Appeal process. Passport will provide documentation supporting our adverse decision within five (5) days of receipt of the notice from the Department that a request for a State Fair Hearing has been filed by a Member. Documentation will also be made available to the Member or their legal counsel upon request. If Passport Health Plan does not comply with the above requirements or participate in and present evidence at the State Fair Hearing an automatic ruling will be made by the Department in favor of a Member.

Member Assistance Services

Members are provided reasonable assistance in completing forms and other procedural steps for an Appeal including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY capability.

Provider Grievance

Providers have the right to file a Grievance no later than thirty (30) calendar days from the date the Provider becomes aware of the issue generating the Grievance. Written resolution will be provided to the Provider within thirty (30) calendar days from the date the Grievance is received

by Passport. If additional time is needed, Passport shall orally request a fourteen (14) day extension from the Provider. If the Provider requests the extension, we will comply and approve the extension.

A Provider may not file a Grievance on behalf of the Member without written consent from the Member.

Provider Claims Appeal

A Provider may request an Appeal regarding payment or contractual issues on his or her own behalf by mailing, by the secure Provider Portal online, or faxing a letter of Appeal and/or an Appeal form with supporting documentation such as medical records to Passport Health Plan. Providers may file via:

- Provider Online Portal found on **www.Availity.com**
- Fax: (866) 315-2572
- E-mail: **MHK_Provider_GnA@passporthealthplan.com**
- Postal mail:

Passport Health Plan by Molina Healthcare
Attention: Provider Grievances and Appeals
P.O. Box 7114
London, KY 40742

Providers have sixty (60) calendar days from the date of our adverse determination to file an Appeal. Appeals submitted after that time will be denied for untimely filing. If the Provider feels they filed the Appeal within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is fax confirmation, a registered postal receipt signed by a representative of Passport or similar receipt from other commercial delivery services.

Upon receipt of all required documentation, Passport Health Plan has thirty (30) calendar days to review the Appeal for Medical Necessity and conformity to Passport Health Plan guidelines and to render a decision to reverse or affirm. If the Appeal is not resolved within thirty (30) days, Passport may request a fourteen (14) calendar day extension from the Provider. If the Provider requests the extension, the extension shall be approved by Passport.

It is the responsibility of the Provider to submit all the necessary documentation with their Appeal within sixty (60) calendar days of the denial to prevent a denial for lack of Information. Any information received after that time frame will not be reviewed.

Medical records and patient information shall be supplied at the request of Passport or appropriate regulatory agencies when required for Appeals. The Provider is not allowed to charge Passport or the Member for copies of medical records provided for this purpose.

Reversal of Denial

If it is determined during the review that the Provider has complied with Passport Health Plan protocols and that the Appealed services were Medically Necessary, the denial will be reversed.

The Provider will be notified of this decision in writing. If a Claim has been previously submitted and denied, it will be adjusted for payment after the decision to reverse the denial has been made. Passport will ensure that Claims are processed and comply with federal and state requirements.

Affirmation of Denial

If it is determined during the review that the Provider did not comply with Passport protocols and/or Medical Necessity was not established, the denial will be upheld. The Provider will be notified of this decision in writing. For denials based on Medical Necessity, the criteria used to make the decision will be provided in the letter. The Provider may also request a copy of the benefit provision, guideline, protocol and other similar criteria used in making the Appeal decision by sending a written request to the Appeals addresses listed in the decision letter.

Independent External Third-Party Review

In accordance with 907 KAR 17:035, if a Provider receives an adverse final decision of a denial, in whole or in part, of a health service [including a denial, in whole or in part, involving Emergency Services] or Claim for reimbursement related to this service, the Provider may request an external independent third-party review. A Provider may only do so after first completing an internal Appeal process with Passport Healthcare. A request for independent external third-party review must be submitted to Passport Health Plan within sixty (60) days of receiving the final decision letter from us.

Requests for independent external third-party reviews may be submitted to Passport Health Plan via one of the following methods:

- E-mail: **ReviewRequests@passporthealthplan.com**
- Fax: (502) 585-8334
- Mail:

Passport Health Plan by Molina Healthcare
Attention: Provider Review Requests
5100 Commerce Crossings Drive
Louisville, KY 40229

Passport Health Plan will confirm receipt of your request for external third-party review within five (5) business days of receiving your request.

As required by 907 KAR 17:035, if you request an external third-party review, we will forward to the Department for Medicaid Services all documentation submitted by you during the Appeal process within fifteen (15) business days of receiving your request. No additional documentation will be allowed for consideration by the external independent third-party review.

Additionally, if Passport's decision is upheld by the external independent third-party review, Providers have the right to request an administrative hearing in accordance with 907 KAR 17:040 within thirty (30) calendar days of the Department's written notice. You must submit your request for administrative hearing to:

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Program Quality and Outcomes
275 East Main Street, 6C-C
Frankfort, KY 40621

If the administrative hearing officer upholds Passport's decision, the Provider must reimburse the Department for Medicaid Services in the amount of $600.00 (per hearing) within thirty (30) days of the issuance of the final order.

Reporting

All Grievance/Appeal data, including Provider specific data, is reported quarterly to Member/Provider Satisfaction Committee by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the Member/Provider Satisfaction Committee (MPSC) and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Appeals and Grievances will be reported to the Commonwealth monthly. Grievance and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues.

Record Retention

Passport will maintain all Grievance and Appeal documentation that is hand-delivered or sent by mail, email, fax, and Passport Provider Portal electronically in a secure area and be accessible for a minimum of ten (10) years after the final decision. All records shall be maintained and available for review by authorized federal and state personnel during the entire term of this Contract and for a period of ten (10) years after termination of this Contract, except that when an audit has been conducted, or audit findings are unresolved. In such case records shall be kept for a period of ten (10) years in accordance with 42 C.F.R. 438.2 and 907 KAR 1:672, or as amended or until all issues are finally resolved, whichever is later.

13. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure the Molina Healthcare, Inc. and its subsidiaries (Passport Health Plan by Molina Healthcare) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Passport to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Passport Provider Services representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-Discriminatory Credentialing and Recredentialing

Passport does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the practitioner specializes. This does not preclude Passport from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Types of Practitioners Credentialed & Recredentialed

Practitioners and groups of Practitioners with whom Passport contracts must be credentialed prior to the contract being implemented. Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners

- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Passport Network

Passport has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Passport network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Passport network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Passport.

Passport reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. Passport may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Passport and the community it serves. The refusal of Passport to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Passport network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Passport network. If the Practitioner fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or administrative termination from the Passport network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application –** Provider must submit to Passport a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within one-hundred-twenty (120) days. Application must include all required attachments.
- **License, Certification or Registration –** Provider must hold a current and valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Passport Members. Telemedicine Practitioners are required to be licensed in the State where they are located, and the State the Member is located.
- **DEA or CDS Certificate –** Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Passport Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number. If a Practitioner does not have a DEA or CDS because it has been revoked, restricted or relinquished due to disciplinary reasons, the Practitioner is not eligible to participate in the Passport network.
- **Specialty –** Provider must only be credentialed in the specialty in which they have adequate education and training. Provider must confine their practice to their credentialed area of practice when providing services to Passport Members.
- **Education –** Providers must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training –** Provider must have satisfactorily completed residency programs from accredited training programs in the specialties in which they are practicing. Passport only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, Podiatric residencies are required to be 3 years in length. If the podiatrist has not completed a 3-year residency or is not board certified, the podiatrist must have 5 years of work history practicing podiatry.
- **Fellowship Training –** If the Provider is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification –** Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program

from an accredited training program in the specialty in which they are practicing. Passport recognizes board certification only from the following Boards:

- American Board of Medical Specialties (ABMS)
- American Osteopathic Association (AOA)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Podiatric Medicine (ABPM)
- American Board of Oral and Maxillofacial Surgery
- American Board of Addiction Medicine (ABAM)
- College of Family Physicians of Canada (CFPC)
- Royal College of Physicians and Surgeons of Canada (RCPSC)
- Behavioral Analyst Certification Board (BACB)
- National Commission on Certification of Physician Assistants (NCCPA)

- **General Practitioners –** Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Passport network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent 5 years without any gaps in work history. Passport will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), Urgent Care or Wound Care. General Practitioners providing only wound care services do not require 5 years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants –** In certain circumstances, Passport may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Passport.
- **Work History –** Provider must supply most recent 5-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds 6 months, the Practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds 1 year, the Practitioner must clarify the gap in writing.
- **Professional Liability Insurance and Malpractice History –** Provider must supply a history of malpractice and professional liability Claims and settlement history in accordance with the application. Documentation of malpractice and professional liability Claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice –** Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions,

limitations, sanctions, probations and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Passport will also verify all licenses, certifications and registrations in every State where the Practitioner has practiced. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions –** Practitioner must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out –** Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Passport network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File –** Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List –** Practitioners currently listed on the Preclusion List may not participate in the Passport network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance –** Practitioner must have and maintain professional malpractice liability insurance with limits that meet Passport criteria. This coverage shall extend to Passport Members and the Practitioners activities on Passport's behalf. Practitioners maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.

[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

- **Inability to Perform –** Practitioner must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use –** Practitioner must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions –** Practitioners must disclose if they have ever had any criminal convictions. Practitioners must not have been convicted of a felony or pled guilty to a felony for a health care related crime including but not limited to health care fraud, patient abuse and the unlawful manufacturing, distribution or dispensing of a controlled substance.
- **Loss or Limitations of Clinical Privileges –** At initial credentialing, Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges –** Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI –** Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Passport Health Plan by Molina Healthcare will notify the Practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Practitioner. Examples include but are not limited to actions on a license, malpractice Claims history, board certification, sanctions or exclusions. Passport is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Passport website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from Passport Health Plan by Molina Healthcare.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.

- The Practitioner's response must be sent to Molina Healthcare, Inc. Attention: Credentialing Director at PO Box 2470, Spokane, WA 99210

Upon receipt of notification from the Practitioner, Passport Health Plan by Molina Healthcare will document receipt of the information in the Practitioner's credentials file. Passport Health Plan will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within 10 calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Passport website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointed time to review their file and allow up to 7 calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

The only items in the file that may be copied by the Practitioner are documents, which the Practitioner sent to Passport Health Plan by Molina Healthcare (e.g., the application and any other attachments submitted with the application from the Practitioner. Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the Passport website and are included in this Provider Manual. Passport will respond to the request within two (2) working days. Passport will share with the Practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Passport Medical Director within 2 weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals are not required.

Recredentialing

Passport recredentials every Practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Passport and its Subcontractors may not subcontract with an Excluded Provider/person. Passport and its Subcontractors shall terminate subcontracts immediately when Passport and its Subcontractors become aware of such excluded Provider/person or when Passport and its Subcontractors receive notice. Passport and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Passport and its Subcontractors are unable to certify any of the statements in this certification, Passport and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

Passport monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality are identified. If a Passport Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- State Medicaid Exclusions – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- Medicare Exclusion Database (MED) – Passport monitors for Medicare exclusions through the Centers for Medicare and Medicaid Services (CMS) MED online application site.
- Medicare Preclusion List – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- National Practitioner Database – Passport enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- System for Award Management (SAM) – Monitor for Providers sanctioned with SAM.

Passport also monitors the following for all Provider types between the recredentialing cycles:

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Provider's contract based on quality of care or professional conduct, a certified letter is sent to the Provider describing the adverse action taken and the reason for the action, including notification to the Provider of the right to a fair hearing when required pursuant to Laws or regulations.

14. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Passport. Passport may delegate:

- Medical Management
- Credentialing
- Sanction Monitoring for employees and contracted staff at all levels
- Claims
- Complex Care Management
- Other clinical and administrative functions

When Passport delegates any clinical or administrative functions, Passport remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Passport's established delegation criteria and standards. Passport's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Passport's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Passport must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated to the identified Passport Delegation Oversight Staff within the timeline indicated by the Health Plan.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Passport's guidelines or regulatory requirements, Passport may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Passport may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Passport determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your Passport Contract Manager.

15. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Passport's goal is to provide our Members with high quality, cost effective drug therapy. Passport works with the Kentucky Department for Medicaid Services (DMS) and our Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. Passport covers prescription and certain over-the-counter drugs through the Kentucky Preferred Drug List (PDL).

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist Passport with managing pharmacy resources and to improve the overall satisfaction of Passport Members and Providers. It seeks to ensure Passport Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Drug Utilization Review Board

The Molina Healthcare, Inc. Drug Utilization Review (DUR) Board acts as an advisory board to the Molina Healthcare, Inc. National Pharmacy & Therapeutics (P&T) Committee for all drug utilization program activities. Drug utilization review program activities help to ensure that prescriptions for outpatient drugs are appropriate, Medically Necessary, and not likely to result in adverse medical consequences. The Molina Healthcare, Inc. DUR Board leverages professional medical protocols and data analytics to assist in reviewing trends of prescribing and dispensing of prescriptions over time. The Board meets quarterly to review and make recommendations to the National Pharmacy and Therapeutics Committee on prospective and retrospective drug utilization review criteria to identify and develop educational initiatives to improve prescribing or dispensing practices and periodically, evaluates established criteria and their usage as well as the educational initiatives.

Pharmacy Lock-In Program

The Pharmacy Lock-In Program is designed to address the unique needs of those Members who have demonstrated:

- Fraudulent or abusive patterns of service utilization; or
- Behavior that may indicate a chemical dependency issue; or
- Receiving services that are not Medically Necessary; or
- Prescription and/or service over-utilization that may represent a danger to the Member.

A multidisciplinary care team including physicians, pharmacists, registered nurses, licensed social workers and other allied health professionals comprise the team and have primary responsibility for the administration and oversight of the program.

Members exhibiting potential/suspected over-utilization of narcotic analgesics and/or other controlled substance medication(s) are identified by Passport Health Plan staff, by claims data

quarterly (at a minimum) and/or by a referral from the member's primary care provider. Once identified, final member enrollment into the Lock-In Program will be determined by Medical Director, Pharmacist, and/or Care Coordinator review.

1) Determination criteria for Inclusion into Pharmacy Coordination Program includes:
    a. Reviewing member prescription profile. Members who utilize more than 3 pharmacies and/or prescribers in one quarter or demonstrate aberrant utilization patterns.
    b. Reviewing utilization history and diagnosis.
    c. Initiating Care Management (CM) enrollment efforts by contacting Member and completing case management assessment(s)
    d. Contacting Member's physician(s) to discuss Member's medical care, if necessary
2) Members suitable for Lock In will receive the following:
    a. A case manager will initiate Care Management efforts
    b. Program enrollment notification, including a program brochure and provider/pharmacy selection form.

Members will remain in the program for a duration of two years. Re-evaluation will be done every two years by a Medical Director, Pharmacist and Care Coordinator. The Member will be notified of the outcome.

Pharmacy Network

Members must use their Passport ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting **www.passporthealthplan.com** or calling Passport at (800) 578-0775.

Drug Formulary

The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit **www.passporthealthplan.com**.

Information on procedures to obtain these medications is described within this document and also available on the Passport website.

Formulary Medications

Formulary medications with PA may require the use of first-line medications before they are approved.

Quantity Limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on limits are included and can be found in the formulary document.

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form. Clinical evidence must be provided and is taken into account when evaluating the request to determine Medical Necessity.

Generic Substitution

Generic drugs should be dispensed when available. If the use of a particular brand name becomes Medically Necessary as determined by the Provider, PA must be obtained through the standard PA process.

New to Market Drugs

Newly approved drug products may not be placed on the formulary during their first 6 months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

Medications not covered by Kentucky Medicaid are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit.

Submitting a Prior Authorization Request

Passport will only process completed PA request forms; the following information MUST be included for the request form to be considered complete:

- Member first name, last name, date of birth and identification number.
- Prescriber first name, last name, NPI, phone number and fax number.
- Drug name, strength, quantity and directions of use.
- Diagnosis.

Passport's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing Passport will either fax or call your office to request clinical information be sent in to complete review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Pharmacy PA Request Form to Passport at (844) 802-1406. A blank Pharmacy PA Request Form, may be obtained by accessing **www.passporthealthplan.com** or by calling (800) 578-0775.

Member and Provider "Patient Safety Notifications"

Passport has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Passport through the pharmacy benefit using national drug codes (NDCs) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications maybe covered through the medical benefit using Healthcare Common Procedure Coding System (HCPC) J-codes via paper or electronic medical Claim submission.

Passport, during the utilization management review process, will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any Federal or State/ Commonwealth regulatory requirements, and the Member specific benefit plan coverage prior to determination of benefit processing.

If it is determined to be a Pharmacy benefit, Passport's pharmacy vendor may coordinate with Passport and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations representative with any further questions about the program.

Newly FDA approved medications may be considered non-formulary or non-preferred and subject to non-formulary or non-preferred policies and other utilization criteria until a coverage decision is rendered by the Kentucky Medicaid Pharmacy and Therapeutics Committee. "Buy-and-bill" drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a Claim to Passport for reimbursement.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Passport requires Providers to adhere to Passport's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Passport is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Passport Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at **www.passporthealthplan.com** under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Passport's Pain Safety Initiatives.

16. Risk Adjustment Management Program

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Passport Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Why is Risk Adjustment Important?

Passport relies on our Provider Network to take care of our members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency.
- Recognize and address current and potential health conditions early.
- Identifies Members for Care Management referral.
- Ensures adequate resources for the acuity levels of Passport Members.
- Have the resources to deliver the highest quality of care to Passport Members.

Your Role as a Provider

As a Provider, your complete and accurate documentation in a Member's medical record and submitted Claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity as this will ensure Passport receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g. diabetic patient needs an eye exam or multiple comorbid conditions) provided by Passport and reviewed with the Member.
- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a face to face visit with the Member.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

RADV Audits

As part of the regulatory process, Commonwealth and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Passport is appropriate and accurate. All Claims/Encounters submitted to Passport are subject to Commonwealth and/or Federal and internal health plan auditing. If Passport is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information

For questions about Passport Health Plan's Risk Adjustment programs, please contact our Risk Adjustment team at: **RiskAdjustment.Programs@passporthealthplan.com**.

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