

Provider Manual

Section 3.0

Provider Roles and Responsibilities

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3.0 Provider Roles and Responsibilities

3.1 Confidentiality

In accordance with federal and state laws, Passport Health Plan has established confidentiality policies and practices for its own operation and to outline expectations to its provider network. To obtain a copy of Passport Health Plan's Notice of Privacy Practices (NPP), please visit www.passporthealthplan.com/membercenter.

All providers are to understand and comply with Passport Health Plan's policies on the confidential treatment of member information in all settings.

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

Providers/practitioners are authorized to share members' protected health information with Passport Health Plan for the purposes of treatment, payment, and health care operations according to the member signature on the Medicaid application.

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

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

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

Passport Health Plan will use member information for quality studies, health outcomes measurements, and other aspects of health plan operations and will de-identify the information as dictated by federal privacy legislation.

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

Passport Health Plan members are permitted to access, copy, and inspect their medical records upon request. One copy of a member's complete medical record must be made available from the provider upon request at no charge and in accordance with state administrative regulations.

To obtain a copy of Passport Health Plan's Notice of Privacy Practices (NPP), please visit www.passporthealthplan.com/membercenter.

3.2 The Role of the Primary Care Provider (PCP)

Primary care provider (PCP) means a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced registered nurse practitioner, including a nurse practitioner, nurse midwife and clinical specialist, physician assistant, or clinic, including a primary care center and rural health clinic, that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide 24 hours a day, seven days a week primary health care services to individuals, and for a member who has a gynecological or obstetrical health care need, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

The PCP serves as the member's initial and most important contact for receiving medically-necessary covered services. The PCP has the responsibility to provide or refer each member of his or her panel for the services needed to help ensure positive health outcomes.

This includes:

- Maintaining continuity of care for all members by serving as PCP.
- Exercising primary responsibility for arranging and coordinating the delivery of medically-necessary health care services to members.
- Maintaining a current medical record for each member, including documentation of all medical services (PCP and specialty) provided to the member.
- Providers/practitioners are to have a PCP designation in each member's medical record as appropriate.
- Providing periodic physical examinations as outlined in the Preventive Health Guidelines.
- Providing routine injections and immunizations.
- Providing or arranging 24-hours a day, seven days a week access to medical care.
- Making referrals to specialty care and other medically-necessary services.
- Arranging and/or providing necessary inpatient medical care at participating hospitals.
- Providing health education and information.
- Discussing advance medical directives with all members as appropriate.

- Providing or arranging all necessary preventive health care, including EPSDT for persons younger than 21 years of age.
- Adhering to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule and the Vaccines For Children (VFC) immunization schedule for each Passport Health Plan member younger than 21 years of age.
- Maintaining records of periodic preventive and well-care services, and providing appropriate and timely reminders to members when services are due.
- PHP members have the right to a second opinion. If the member requests a second opinion, the PCP should complete a referral to a participating specialist. If there is not a specialist within the network, the PCP can request an authorization to a non-participating specialist by calling PHP's Utilization Management department at (502) 578-0636.

All of the instructional materials provided to members encourage members to seek their PCP's advice before accessing medical care from any other source except for direct access services and emergency services. It is imperative the PCP's staff fosters this idea and develops a relationship with the member that will be conducive to continuity of care.

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

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

All members in categories of aid that require a PCP selection must choose a PCP within 30 days or a PCP will be assigned to them. (Please note this excludes SSI members without Medicare. These members have 90 days to select a PCP.)

The name and telephone number of the PCP or group selected appears on the member's Passport Health Plan Identification Card. Please see Section 2.4.1 for more information about member eligibility and identification.

Each PCP receives a monthly member panel list of those members who have selected or been assigned to him or her.

3.3 The Role of Specialists and Consulting Practitioners

Specialty care practitioners provide nonprimary care services to members referred by their PCP. The specialty care practitioner must coordinate care through the PCP and must obtain necessary prior authorization for hospital admissions or specified diagnostic testing procedures. Refer to Section 6.3,

“Prior-Authorization Requirements,” for a complete listing of procedures requiring prior authorization from Passport Health Plan’s Utilization Management department.

Except for Direct Access Services and a few other services (see Section 7.1, “Member Self-Referral (Direct Access),” all members must obtain a valid referral from the PCP prior to receiving services from most specialty care providers/practitioners.

Specialty practitioners must review the referral section of the PCP referral form to determine which services have been referred. The specialist must contact the PCP if he or she intends to provide services in excess of those initially requested. In these cases, the PCP must generate a second referral form and distribute copies of the new referral to all parties: the Plan, the member, and the specialist.

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

For electronic referral submission guidelines, please refer to Section 7.3.

3.4 Responsibilities of All Providers

3.4.1 Provider and Member Communications

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

3.4.2 Treatment Consent Forms

Treatment consent forms for specific procedures must be completed and signed by the member. A copy of the appropriate treatment consent form must be maintained in the member’s record. The following original treatment consent forms must be sent to the Plan along with a copy of the claim as required by state and federal laws. These treatment consent forms are available from the Department for Medicaid Services and in Section 19 of this *Provider Manual*:

MAP-250 Consent Form for Sterilization

MAP-251 Hysterectomy Consent Form

MAP-235 Certification Form for Induced Abortion or Induced Miscarriage

MAP-236 Certification Form for Induced Premature Birth

For additional information on completion of the above forms, please contact the family planning administrator at (800) 541-4560. Additional information on family planning services is located in Section 17.

3.4.3 Advance Directives

Living will, living will directive, advance directive, and directive are all terms used to describe a document that provides directions regarding health care to be provided to the person executing the document. In Kentucky, advance directives are governed by the Kentucky Living Will Directive Act codified in KRS 311.621 to 311.643, and as otherwise defined in 42CFR, 489.100.

A member who is 18 years of age or older and who is of sound mind may make a written living directive that does any or all of the following:

- Directs the withholding or withdrawal of life-prolonging treatment.
- Directs the withholding or withdrawal of artificially provided nutrition or hydration.
- Designates one or more adults as a surrogate or successor surrogate to make health care decisions on his or her behalf.
- Directs the giving of all or any part of his or her body upon death for any of the following reasons: medical or dental education, research, advancement of medical or dental science, therapy, or transplantation.

A form of a living will is included in KRS 311.625. The form can be reviewed at www.lrc.state.ky.us/KRS/311-00/625.PDF. Advance directives may be revoked in writing, by an oral statement, or by tearing up the written living will. The revocation is effective immediately.

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

Artificially Provided Nutrition and Hydration. The health care surrogate may authorize the withdrawal or withholding of artificially-provided nutrition and hydration only in the following circumstances:

- When inevitable death is imminent, i.e. reasonable medical judgment indicates that death will occur within a few days; or
- When a member is in a permanently unconscious state and the grantor has authorized an advance directive authorizing such withdrawal or withholding; or
- When the provision of artificial nutrition cannot be physically assimilated by the person; or
- When the burden of the provision of artificial nutrition and hydration itself shall outweigh its benefit.

Artificially-provided nutrition and hydration cannot be withheld or withdrawn if it is needed for comfort or the relief of pain.

Pregnant Women. Advance directives must not be followed for a pregnant woman except under very limited circumstances. Advance directives will be followed only when the pregnant woman's attending physician and one other physician who has examined the woman certify that any life-

sustaining treatment and/or artificially-provided treatment will not sustain the woman in a way to permit the continuing development and live birth of the unborn child, will be physically harmful to the woman or will prolong severe pain which cannot be alleviated by medication.

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

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

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

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

- On the first visit, as well as during routine office visits when appropriate, discuss the member's wishes regarding advance directives for care and treatment;
- Document in the member's medical record the discussion and whether the member has executed an advance directive;
- If asked, provide the member with information about advance directives;
- Upon receipt of an advance directive from the member, file the advance directive in the member's record;
- Not discriminate against a member because he or she has or has not executed an advance directive; and,
- Communicate to the member if the provider has any conscientious objections to the advance directive as indicated above.

3.4.4 Suspected Child or Adult Abuse or Neglect

Cases of suspected child or adult abuse or neglect might be uncovered during examinations.

Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is an act of commission.

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

of child abuse (KRS 620.030) is printed on the reverse of the Child Abuse Reporting Form (DSS-115). These forms may be obtained from the local Department for Social Services office.

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

3.4.5 Fraud and Abuse

The Federal False Claims Act and the Federal Administrative Remedies for False Claims and Statements Act are specifically incorporated into § 6032 of the Deficit Reduction Act. These Acts outline the civil penalties and damages against anyone who knowingly submits, causes the submission, or presents a false claim to any U.S. employee or agency for payment or approval. U. S. agency in this regard means any reimbursement made under Medicare or Medicaid and includes Passport Health Plan. The False Claims Acts prohibits anyone from knowingly making or using a false record or statement to obtain approval of a claim.

Knowingly is defined in the statute as meaning not only actual awareness that the claim is false or fraudulent, but situations in which the person acts with his eyes shut, in deliberate ignorance of the truth or falsity of the claim, or in reckless disregard of the truth or falsity.

The following are some examples of billing and coding issues that can constitute false claims and high-risk areas under this Act.

- Billing for services not rendered;
- Billing for services that are not medically necessary;
- Billing for services that are not documented;
- Upcoding; and,
- Participation in kickbacks.

Penalties (in addition to amount of damages) may range from \$5,000 to \$10,000 per false claim, plus three times the amount of money the government is defrauded. In addition to monetary penalties, the provider may be excluded from participation in the Medicaid or Medicare program.

Providers are also required to cooperate with the investigation of suspected Fraud and Abuse. If you suspect Fraud and Abuse by a Passport Health Plan member or provider, it is your responsibility to report this immediately by calling one of the telephone numbers listed below:

Fraud and Abuse Hotline:	(866) 833-9718
KyHealth Choices Medicaid Fraud Hotline:	(800) 372-2970
Passport Health Plan Compliance Department:	(502) 585-7954