Provider Manual
Section 6.0
Utilization Management

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6.0 Utilization Management

6.1 Utilization Management

Utilization Management (UM) is the process of influencing the continuum of care by evaluating the necessity and efficiency of health care services and affecting patient care decisions through assessments of the appropriateness of care. The UM department helps to assure prompt delivery of medically-appropriate health care services to Passport Health Plan members and subsequently monitors the quality of care.

All Passport Health Plan participating providers are required to obtain prior authorization from the Plan's UM department for inpatient services and specified outpatient services listed in Section 6.3, "Prior-Authorization Requirements."

The UM department is available Monday through Friday from 8:00 a.m. to 5:30 p.m., except holidays. All requests for authorization of services may be received during these hours of operation by calling:

General: (800) 578-0636
Home Health: (800) 578-0636, ext. 77320
DME: (800) 578-0636, ext. 77310

Requests may be faxed to:

General fax: (502) 585-7989
Home Health: (502) 585-8204
DME: (502) 585-7990
Retro fax: (502) 585-8207
Therapy fax: (502) 585-8205

After business hours or on holidays, a provider can leave a message, and a representative will return the call the next business day.

Passport Health Plan provides the opportunity for the provider to discuss a decision with the Medical Director, to ask questions about a utilization management issue, or to seek information from the nurse reviewer about the Utilization Management process and the authorization of care by calling Utilization Management at (800) 578-0636.

6.2 Review Criteria/Standards for Review

Passport Health Plan's Utilization Management (UM) department is charged with ensuring that the Plan's members use their benefits appropriately. Passport Health Plan utilizes medical review criteria approved through the Partnership Council and/or Medicaid/Medicare.

The criteria approved by the Partnership Council includes guidelines developed by Milliman Care Guidelines®, InterQual® Rehabilitation Criteria, and criteria reviewed and approved by actively-practicing practitioners in the community.

These guidelines are only made available to participating and non-participating providers as allowed under licensing restrictions, copyright limitations, trademark considerations, or materials labeled as "For Internal Use Only."

At the request of the practitioner, either the Passport Health Plan UM Department or the Chief Medical Officer will provide a copy of up to three (3) Milliman Care Guidelines® or three (3) Interqual® Rehabilitation Criteria. If the guidelines are not available for distribution or the number of guidelines exceeds the copyright limit, the practitioner has the option to request the guideline be read over the telephone, or review the guideline at Passport Health Plan.

Medical policies, including guidelines, are communicated to providers via the Provider Newsletter or the Passport Health Plan web site, www.passporthealthplan.com. Providers may request a copy of a policy at any time from the UM Department or the Chief Medical Officer.

The Medicaid and Medicare guidelines are established by the Kentucky Department for Medicaid Services and the Centers for Medicare & Medicaid Services. As a general rule, inpatient admissions, concurrent review, and outpatient services are reviewed utilizing the Milliman Care Guidelines®, InterQual® Rehabilitation Criteria, and local guidelines.

Durable medical equipment is reviewed utilizing Medicaid and Medicare guidelines as well as any applicable Passport Health Plan medical policies. Medicare and Medicaid criteria/guidelines are shared with providers upon request. These requests may be made by contacting the UM department or the Chief Medical Officer. Criteria are distributed to providers who have Medicare/Medicaid practitioner numbers issued by state and federal entities.

Passport Health Plan is equally concerned with and monitors for over- and under- utilization of health care services. Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. Passport Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or services. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

6.3 Prior Authorization Requirements

The UM department hours of operation are 8 a.m. to 5:30 p.m., Monday through Friday. The UM department can be reached at (800) 578-0636. The following is a list of procedures and/or services requiring prior authorization from Passport Health Plan's Utilization Management (UM) department.

- Specified Outpatient Surgery Procedures
  - Adenoidectomy
  - Cardiac Catheterization
  - Colonoscopy
  - EGD
  - Laproscopic Cholecystectomy
  - Myringotomy
  - Tonsillectomy
- Inpatient Hospitalization
- 23 Hour Observation****
  - (Excludes OB Labor Check Observation)
- MRI (Knee, Cervical, Lumbar)
- Nonparticipating Provider Services
- OB Care (After 1st Prenatal Visit)
- Ocular Photodynamic Therapy/with Verteporfin (Visudyne)

Cardiac Rehab
Chiropractic Services*
Cosmetic Procedures**
Diabetic Education
DME >$500
Home Health Care
Home Infusion Services
High Cost Medications (>$400 a dose)***
Hospice

Investigational/Experimental Procedures

Pain Management services e.g.
Epidural Blocks
Trigger Point Injections
PET Scans
Prosthetics/Orthotics
Pulmonary Rehab
Stem Cell/Progenitor Cell Retrieval
Therapy Services including:
Physical Therapy
Occupational Therapy
Speech Therapy
Transplants
Neuropsychological Testing

Most services require a referral from the PCP to the specialist if the specialist is ordering or performing the procedure. An exception occurs when a member is new to the Plan (in the first 30 days after enrollment) and has not yet selected or been assigned to a PCP. Under these circumstances, if a member requires specialist care, a participating specialist provider may contact the UM department to request authorization of a one-time visit without a referral. Passport Health Plan members who are covered by Medicare or TriCare as their primary insurance are not required to have referrals for specialist care and may go to any participating or nonparticipating practitioner, as set forth in this *Provider Manual.*

PLEASE NOTE: All services and supplies are subject to review for medical necessity with audits performed retrospectively. Benefit inclusions/exclusions must be considered in determining eligibility for coverage for individual cases. To determine if a service or supply, such as cosmetic procedures, is considered a benefit exclusion, please contact the Utilization Management (UM) department.

*No referral or authorization for the first 12 visits in a rolling year. Services beyond 12 visits require an authorization. Upon the completion of 12 chiropractic visits per member, within a 12-month rolling calendar period, providers must contact Passport Health Plan to request additional chiropractic services. Members are limited to a total of 26 chiropractic visits within a 12-month rolling calendar period.

**Coverage for cosmetic procedures is not normally a covered benefit. Coverage may be based on medical necessity. For example, a request for breast reduction must be reviewed and medical necessity met prior to being a covered benefit.

***This applies to high-cost medications billed to Passport Health Plan excluding chemotherapy medications. This does not apply to the pharmacy benefit. See Section 14 for prior authorizations related to pharmacy.

****When a 23-hour observation is converted to an inpatient admission, the 23-hour observation day is converted to an inpatient day.

Durable Medical Equipment (DME)
Authorization requirements for DME purchases are based on total monthly cost or monthly quantity of items purchased. The following is a listing of purchases with authorization requirements by quantity:

- Name brand diapers, regardless of quantity, require an authorization. Generic diapers, quantities in excess of 180 total per month, require an authorization.
- Underpads (Chux) > 180 per month.
- Ostomy supplies > 2 boxes per month.
- Bedside drainage bags > 4 per month.
- Syringes > 100 per month.
- G-Tube > 1 per month.
- Compression Stockings > 6 pairs per year.

If the purchase is not on the list above, the authorization requirement is determined by the billed charges. DME items with billed charges greater than $500 require an authorization.

Authorization requirements of rentals are determined by the purchase price of the item being rented. If the purchase price of the rental is $500 or less, no authorization is required. If the purchase price of the rental is greater than $500, an authorization is required.
All items requiring customization or accessories require prior authorization.

All mini-nebulizers will be a purchase only item and do not require prior authorization.

Enteral Products

- Enteral products with billed amounts greater than $500 for a month's supply require an authorization.
- These services should be billed according to the fee schedule in your Provider Contract.

Allergy Injections/Serum
Coverage is for members ages 21 and younger. A referral is required from the PCP to the specialist. No prior authorization is required.

6.4 Prior Authorization of Outpatient Services

For authorization of those outpatient services listed in Section 6.3, "Prior-Authorization Requirements," the PCP/specialist notifies Passport Health Plan through a telephonic-authorization process or via iEXCHANGE®, the web-based auto-review system for specific procedures.

The PCP/specialist office contacts Passport Health Plan's Utilization Management (UM) department by telephone to report the type of procedure(s) requested and the facility at which the patient will access the services. The PCP/specialist provides UM with the clinical information to support the medical-necessity criteria of the service. Requests for prior authorization of elective services must be received by UM 14 days prior to the date the requested service will be performed. Prior authorization of the service must be requested prior to the procedure being performed.

Requests for authorization of urgent and emergent services must be submitted to UM within one business day of the procedure being performed. Failure to obtain prior authorization for an elective procedure or failure to request authorization of an urgent or emergent procedure within one business day of the procedure being performed will result in an administrative denial of the service (see Section 6.10.2).

The assigned prior-authorization number must be on the claim form. If practitioners wish to confirm authorization, they may verify online, via iEXCHANGE® as appropriate, or contact Provider Services at (800) 578-0775. The call will be expedited if the member's Passport Health Plan identification number and the prior-authorization number (if available) are provided at the time of the call.

Note: Abortion and sterilization services must be coordinated through AmeriHealth HMO, Inc. as described in "Family Planning," Section 17.

6.4.1 iEXCHANGE®

Passport Health Plan Utilization Management utilizes iEXCHANGE®, a web-based auto-review system, for providers to obtain authorization for services, including but not limited to:

- Inpatient OB Deliveries
- Obstetrical (OB) Globals
- Hospice
- EGD
- CPAP
- Colonoscopy
- Speech Therapy, Occupational Therapy, Physical Therapy
- Select MRI's
- Cholecystectomy
- Select ENT
- Synagis
- Cardiac Catherization
- Select Home Health Services

For questions regarding iEXCHANGE® , please call the Plan's Provider Training Specialist at (502) 585-8224.

6.4.2 Home Health Services

When medically appropriate, home health care may be a good alternative to hospitalization. Home health care, including both skilled and unskilled nursing, may be appropriate at other times as well. Prior authorization of all home health services is required.

Initial authorizations for home health services may be obtained from the Utilization Management (UM) department at (800) 578-0636 ext. 77320. If the member is an inpatient and the facility has a Passport Health Plan on-site nurse reviewer, the request may be given directly to the on-site review

nurse. Subsequent requests should be faxed to the Home Health department at (502) 585-8204. To check the status of a request that has been faxed, call (502) 585-7320 and leave a message. A home health specialist will return the call. A request for prior authorization must be received prior to the delivery of the service for a non-urgent request and within one business day of the service being performed for an urgent or emergent service. Failure to obtain prior authorization for a non-urgent service or failure to request prior authorization for an elective procedure or failure to request authorization of an urgent or emergent procedure within one business day of the procedure being performed will result in an administrative denial. Requests for continuation of a service that is ongoing should be sent to the Home Health department seven days prior to the end of the authorization period. Please fax request together with progress notes and current plan of care to (502) 585-8204.

6.4.3 Durable Medical Equipment (DME)

Passport Health Plan members are eligible to receive medically-necessary durable medical equipment and supplies. Passport Health Plan only covers those items covered under the traditional Medicaid program.

DME providers must fax the request to the Passport Health Plan DME specialist at (502) 585-7990 for authorization for rental or purchase of DME items with a purchase price greater than $500 per item (for a month's supply). To check the status of a request that has been faxed, call (502) 578-0636, ext. 77310 and leave a message. Requests for prior authorization must be received 14 days prior to the delivery of the service for a non-urgent request and within one business day of the service being performed for an urgent or emergent service. Failure to obtain prior authorization for a non-urgent service will result in an administrative denial. Failure to request authorization for an urgent or emergent service within one business day of the service being performed will result in an administrative denial.

Because of frequent changes in member eligibility for Medicaid coverage, providers should verify continued eligibility via the Plan's web site, www.passporthealthplan.com, or by calling the IVR or Provider Services at (800) 578-0775 if the need for an item or service extends beyond the calendar month in which the authorization was given. Maintenance, repair, or replacement in excess of $500 must have prior authorization from Passport Health Plan.

The Department for Medicaid Services (DMS) requires that an updated Certificate of Medical Necessity (CMN) be signed by the provider for all supplies and equipment and kept on file by the supplier for a period of five years. The only exception is oxygen for which Passport Health Plan follows the Medicare guidelines.

Note: All prosthetics/orthotics require prior authorization.

6.4.4 Letters of Medical Necessity/Medical Records

For some prior-authorization requests, the provider will be required to send a letter of medical necessity or a copy of medical records. These should be directed to the Utilization Management nurse who is coordinating the specific case.

At a minimum, documentation must include:

- The member's name and Passport Health Plan ID number.
- The diagnosis for which the treatment or testing procedure is being sought.
- Other treatment or testing methods that have been tried, their duration, and any outcomes.
- Additional clinical information as applicable to the requested service.
- Applicable sections of the medical record.

6.5 Prior Authorization for Members with Original Medicare

Prior authorization is not required for services listed on the prior authorization list (see Section 6.3) when the member has Original Medicare as the primary payer and benefits under Medicare have not been exhausted. This applies to both inpatient and outpatient services. When benefits are exhausted or if the service is not a benefit covered under Original Medicare, and Passport Health Plan becomes the primary payer, prior authorization requirements apply for both outpatient and inpatient services.

For those members who have exhausted their Original Medicare Part A inpatient lifetime reserve days, prior authorization of inpatient services must be obtained. If a member's lifetime reserve days are exhausted during an inpatient hospitalization, notification to Passport Health Plan must be made within one business day of the notification to the facility of the exhaustion of benefits by Medicare.

Please see the Passport Advantage *Provider Manual* for prior authorization information for Passport Advantage members.

6.6 Inpatient Acute-Care Admissions/ Observations

6.6.1 Prior Authorization of Elective Inpatient Services

Providers are required to obtain prior authorization for all elective hospital admissions from Utilization Management.

Prior authorization is mandatory for elective inpatient cases to qualify for payment.

- Passport Health Plan will accept the hospital's or the attending physician's request for prior authorization of elective hospital admissions; however, neither party should assume that the other has obtained prior authorization.
- Failure to obtain prior authorization of an elective admission will result in an administrative denial of the admission (see Section 6.10.2).
- Denied prior-authorization requests may be appealed (see Section 6.11).

6.6.2 Emergency Admissions

For an urgent or emergent admission or observation at an acute-care facility, the facility must provide notice within one business day of the admission by calling the Plan's Utilization

Management (UM) department at (800) 578-0636. For weekend admissions to a hospital or for services delivered on the weekend or after normal business hours, authorization must be obtained within one business day of the service being provided. Clinical information must be provided at the time of the notification. Failure to provide timely notification or clinical data will result in an administrative denial of those days prior to the notification regardless of medical necessity (see Section 6.10.2).

To receive authorization for services, please call Passport Health Plan's Utilization Management department at (800) 578-0636 or fax request to (502) 585-7989, Monday through Friday between the hours of 8 a.m. and 5:30 p.m.

6.6.3 Observation to Inpatient Status

Some requests for inpatient evaluation of members who present with conditions that may warrant evaluation and monitoring, but do not meet the criteria for inpatient admission, are reviewed for an observation stay (hospital stay of 23 hours or less). Observation status is based on medical necessity determined by using Milliman Care Guidelines, medical policies, medical protocols, criteria, and/or accepted standards of care for, but not limited to, evaluation and monitoring. If the member's condition, results of evaluation, and testing meet inpatient criteria after the 23-hour observation period, the stay will be converted to inpatient beginning with the observation stay admission date. All claims for this type of stay should be submitted with the entire length of stay as an inpatient.

6.6.3.1 Inpatient Status

UM reviews all requests for inpatient admissions utilizing Milliman Care Guidelines® or InterQual® Rehabilitation Criteria. For those requests meeting the established medical necessity criteria, an inpatient stay will be authorized. If inpatient admission criteria are not met, but criteria for an observation is met, the UM nurse will offer approval of this alternative level of care to the requester for the service. If the requester is agreeable to this alternative level of care, an authorization will be issued for an observation stay. If the requester is not agreeable to the alternative level of care, the request for inpatient admission will be referred to the Passport Health Plan Medical Director for review and decision determination.

6.6.3.2 Inpatient Admissions to Non-Participating Facilities

Requests for admission to non-participating facilities should be submitted to the Passport Health Plan UM department for review.

6.6.4 Nonparticipating Hospital Transfer Policy

All members must receive inpatient services in a Passport Health Plan participating hospital. To assure payment for emergency services and hospitalization, the provider should use its best efforts to comply with this policy. However, Passport Health Plan recognizes that it may not be possible to comply with this requirement when a member presents himself or herself to the closest medical facility because of a medical emergency. When a Passport Health Plan member presents to the emergency room of a hospital not participating with Passport Health Plan, the Plan requires that the

member transfer to a Passport Health Plan participating hospital within 24 hours after the member's condition has stabilized.

To determine transferability, the Passport Health Plan Utilization Management concurrent review nurse will monitor the condition of the member and communicate with the utilization review staff, the attending physician, and the PCP. Passport Health Plan will help to coordinate all necessary transportation for the timely transfer of the member.

If a member is discharged from an inpatient level of care and subsequently re-admitted to the same hospital within 24 hours, the UM Department continues the member's inpatient stay under the same case reference number.

6.6.5 Elective Participating-Hospital Transfer Policy

Elective inter-facility transfers must be prior authorized by Passport Health Plan. Patient clinical information will be required to complete the authorization process, approve the transfer, and determine prospective length of stay. Either the transferring or receiving facility may initiate the prior authorization; however, the transferring facility will be able to provide the most accurate required clinical information. If a hospital transfer request is made by another Passport Health Plan facility, the receiving facility may request that the transferring facility obtain the authorization before the case will be accepted at the receiving facility. The receiving facility should contact Passport Health Plan to confirm the authorization. In cases deemed emergent, notification of the admission is required within one business day after the transfer.

6.7 Inpatient Rehabilitation Admissions

If a member requires an inpatient rehabilitation admission, the rehabilitation hospital will contact the on-site review nurse at the acute-care facility where the member is currently inpatient. If there is no on-site review nurse at the acute-care facility, contact Passport Health Plan Utilization Management (800) 578-0636. If the member is to be directly admitted from home or other subacute facility, contact Passport Health Plan's Case Management department at (800) 578-0636 ext. 77915.

6.8 Inpatient Skilled-Nursing Facility

Passport Health Plan is not responsible for, nor does it reimburse nursing facility costs for members at skilled-nursing facilities. Those services are covered by the Kentucky Medicaid Program. Passport Health Plan is responsible for costs of professional services, such as physician or therapist services that are not part of the routine facility service. After a member is in a nursing facility for 31 days, the disenrollment process begins for that member. Passport Health Plan's responsibility for those non-facility services continues for any of its members while they are still enrolled with the Plan. After the Kentucky Medicaid Program completes the managed care disenrollment process and reinstates the member in the fee-for-service Medicaid program, the Plan no longer has financial responsibility for any services for that Medicaid recipient. To obtain skilled-nursing facility authorization, please call the DMS-contracted review entity, SHPS, at (502) 426-4888.

6.9 Authorization for Members with Eligibility Determined Retrospectively

Retrospective review of inpatient services is performed only when the patient was not a member of Passport Health Plan prior to or at the time of the service. Outpatient services do not require retrospective review by Utilization Management for members whose eligibility is determined retrospectively. Requests for retrospective review of inpatient services must be submitted in writing or by fax to (502) 585-8207. Providers have 60 days from the notification of eligibility on retrospectively enrolled members to submit medical records for review and utilization management authorization request. If the practitioner does not provide documentation, the card issue date, segment date, and claims history are used. A decision and written notification is provided within ten (10) business days of receipt of the medical information for the retrospective review request. An administrative denial is issued for retrospective requests when the provider fails to request a utilization management review of the medical record within the timeframe specified.

The provider is notified of all decisions regarding retrospective review. In cases of denial, a written notification is provided. Requests received beyond 60 days from the card issue date or from the provider's documentation of the date when they were aware of the member's eligibility will be administratively denied.

Send requests for retrospective review to:

Utilization Management
Retrospective Review
Passport Health Plan
305 W. Broadway, 3rd Floor
Louisville, KY 40202

6.10 Denials

An authorization request for a service may be denied for failure to meet guidelines, protocols, medical policies, or failure to follow administrative procedures outlined in the Provider Contract or this *Provider Manual*. Members may not be billed by participating providers for deductibles, copays, and coinsurance except those allowed by DMS. If pre-authorization criteria are not met resulting in a denied claim, members must be held harmless for denied services.

6.10.1 Medical-Necessity Denials

Utilization Management utilizes medical policies, protocols, and industry standard guidelines to render review decisions. Requests not meeting the guidelines, protocols, or policies are referred to a Medical Director for clinical review. A Passport Health Plan Medical Director renders all denial decisions. Whenever a denial is issued, Utilization Management provides the name, telephone number, title, and office hours of the Medical Director who rendered the decision. The Passport Health Plan Medical Director is available to discuss any decision rendered with the attending practitioner. To speak with the Medical Director or to the nurse reviewer, please contact Utilization Management at (800) 578-0636.

6.10.2 Administrative Denials

An administrative denial is issued for those services for which the provider has not followed the requirements set forth in the Provider Contract or this *Provider Manual*. For example, an administrative denial may be issued for failure to prior authorize an elective service, procedure, or admission. It may also be issued for failure to notify Utilization Management within one business day of an emergency service, procedure, or admission. Administrative denials will only apply to those days between the admission/service date and the date the health plan was notified of the admission/service.

6.11 Appeals

An appeal is a request for review of a Passport Health Plan action related to covered services or services provided. An action is defined as the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; failure to act within specified timeframes; denial of a request to obtain services outside the network for specific reasons. All appeals must be received in writing. There are three types of appeals that may be directed to the Passport Health Plan appeals coordinator:

1. A pre-service medical-necessity denial appeal;
2. A post-service medical-necessity denial appeal; and,
3. An administrative denial appeal.

Please address all medical-necessity and administrative appeals to:

Passport Health Plan
Attn: Appeals Coordinator
305 W Broadway, 3rd Floor
Louisville, KY 40202

6.11.1 Pre-service Medical-Necessity Appeals

A pre-service appeal is a request for review of an action by Passport Health Plan related to covered services not yet received by the member. The member, an authorized representative of the member, or a provider acting on behalf of the member may file pre-service appeals. Appeals filed by the provider on the member's behalf require the member's written consent. If the member's written consent is not received within 30 days of the action, then no appeal will be initiated. The appeal must be filed in writing, and the Plan must receive it within 30 calendar days from the date of a notice of an action by the Plan. When an appeal request is submitted, it must be accompanied by all supporting documentation. Within three business days of receipt of the written appeal, the Plan will send the member a letter acknowledging receipt of the appeal and advising of the date the appeal will be heard. A board-certified physician with clinical expertise in treating the member's condition or disease, and who was not involved in the initial denial, reviews all member pre-service medical appeals. The Plan will communicate to the member and to the provider an appeal decision within 30 calendar days from the Plan's receipt of the appeal.

6.11.1.1 Expedited Appeals

An expedited review process is available when the Plan determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

Expedited appeals are available for prospective and concurrent services. An expedited appeal is not available for those requests which are made retrospectively. For all expedited appeals, a physician other than the physician rendering the original denial decision will review the appeal request. A decision will be communicated to the appeal requestor within 72 hours from the Plan's receipt of the appeal.

6.11.2 Provider Post-Service Medical-Necessity Appeals

A post-service appeal is a request for review of an action by Passport Health Plan related to covered services received by the member but for which the provider has not been paid because of a Utilization Management medical-necessity denial. Post-service appeals must be received within 60 calendar days from the date of the Plan's notice of an action or 60 calendar days from the date of discharge from an inpatient setting. The appeal must be filed in writing and must be accompanied by all supporting documentation. Within three business days of receipt of the written appeal, the Plan will send to the provider a letter acknowledging receipt of the appeal. A board-certified physician, who was not involved in the initial denial, reviews all post-service provider appeals. The provider may also request that the reviewing physician be of like or similar specialty. The provider will be notified in writing of the appeal decision within 30 calendar days from the Plan's receipt of the appeal. The appeal decision is final, and at this point, the provider has exhausted all appeal options with Passport Health Plan.

6.11.3 Provider Administrative Appeals

An administrative appeal is a request for review of an action by the Plan to administratively deny a service based upon the provider's contract and this *Provider Manual*. The provider is notified by a formal denial letter that specifies the reason for the administrative denial. The Plan must receive an appeal of a Utilization Management administrative denial within 60 calendar days from the date of the Plan's denial letter. The appeal must be filed in writing and must be accompanied by all supporting documentation. Within three business days of receipt of the written appeal, the Plan will send the provider a letter acknowledging receipt of the appeal. Passport Health Plan's Administrative Appeals Committee reviews all Utilization Management administrative denial appeals. The Plan will notify the provider in writing of the appeal decision within 30 calendar days from the Plan's receipt of the appeal. The appeal decision is final, and at this point, the provider has exhausted all appeal options with Passport Health Plan.