

Provider Manual

Section 8.0

Benefit Summary and Exclusions

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8.0 Benefit Summary and Exclusions

8.1 Benefit Summary

Basic services covered under Passport Health Plan include, but are not limited to:

- Alternative birthing center services.
- Ambulatory surgical center services.
- Behavioral health visits (provided by the assigned primary care provider).
- Chiropractic services.
- Dental services, including oral surgery, orthodontics, and prosthodontics.
- Durable medical equipment (DME), including prosthetic and orthotic devices and disposal medical supplies.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and special services.
- End stage renal dialysis services.
- Family planning clinic services in accordance with federal and state law and judicial opinion.
- Hearing services, including hearing aids for members younger than age 21.
- Home health services.
- Hospice services.
- Independent laboratory services.
- Inpatient hospital services.
- Meals and lodging for appropriate escort of members.
- Medical detoxification as defined in 907 KAR 1:705.
- Medical services, including those provided by physicians, advanced practice registered nurses, physicians assistants and FQHCs, primary care centers and rural health clinics.
- Organ transplant services not considered investigational by FDA.
- Other laboratory and x-ray services.
- Outpatient hospital services.
- Pharmacy and limited over-the-counter drugs.
- Podiatry services.
- Preventive health services, including those currently provided in public health departments, FQHCs/primary care centers, and rural health clinics.
- Therapeutic evaluation and treatment, including physical therapy, speech therapy, occupational therapy.
- Transportation to covered services, including emergency and nonemergency ambulance and other stretcher services.
- Urgent and emergency care services.
- Vision care, including vision examinations, services of opticians, optometrists and ophthalmologists, including eyeglasses for members younger than age 21.

NOTE: Please remember some services/benefits require a prior authorization. Please see Section 6.0 for more information.

Meals, lodgings and transportation necessary to maintain a member and one designated attendant are covered, if necessary, when the member is accessing approved and necessary medical care at a site, in or outside Kentucky, that is at a sufficient distance to preclude daily travel to and from the recipient's home. This service requires prior approval with specific maximum rates applicable to standard and high rate areas.

8.1.1 Allergy Testing and Treatment

Consultation and testing by an allergist is covered for any member with a referral from the member's PCP. Allergy injections are only covered for children younger than age 21. Allergy injections may be administered by either an allergist or by the member's PCP.

8.1.2 Dental Care

Passport Health Plan has contracted with a dental benefits manager to administer and provide all primary care dental services for all members. A PCP referral is not required for routine dental services. Members may obtain assistance with locating a dental practitioner by calling Member Services at (800) 578-0603. Members may also visit the Plan's web site at www.passporthealthplan.com.

Specialty dental services do not require a referral, for example, orthodontic evaluation (see Section 7.1, "Member Self-Referral (Direct Access)") and are only covered for children younger than age 21.

For more information, please see to Section 1, "Important Telephone Numbers," for our dental benefits manager's contact information.

8.1.3 Durable Medical Equipment (DME)

Passport Health Plan covers medically-necessary durable medical equipment (DME) and supplies that are covered under the fee-for-service Medicaid program. Members are required to have an order to receive the covered DME or supplies (see Section 6.4.3).

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.

8.1.4 Family Planning Services (also see Section 17)

Family planning services are meant to prevent or delay pregnancy for individuals of childbearing age. These services include:

- Health education and counseling.

- Limited history and physical exam.
- Laboratory tests as medically necessary.
- Diagnosis and treatment of STDs.
- Screening, testing, and counseling of at-risk individuals for HIV and referral for treatment.
- Follow-up care for complications associated with contraceptive methods issued by family planning provider.
- Contraceptive prescriptions, devices, supplies.
- Tubal ligation with required consent form completed.
- Vasectomies with required consent form completed.
- Pregnancy testing and counseling.

Passport Health Plan members may obtain family planning services from any state-approved Medicaid provider. No referral from the PCP is required for routine family planning services.

For some services, authorization is required. For more information on benefits and/or a list of providers, refer to Section 17, “Family Planning” in this *Provider Manual* or call AmeriHealth HMO, Inc., Passport Health Plan’s family planning administrator at (800) 541-4560. All claims for family planning should be sent to AmeriHealth HMO, Inc. (see Section 20.2, “Other Important Contact Information”).

Please direct members to call our Member Services department at (800) 578-0603.

8.1.5 Home Health Care

When medically appropriate, home health care may be a good alternative to hospitalization. Home health care, including skilled and unskilled nursing, may be medically appropriate at other times as well. Passport Health Plan’s Utilization Management department must prior authorize all home health services (see Section 6.4.2).

8.1.6 Hospice Care

If a member needs hospice care, the hospice provider must contact Passport Health Plan’s Utilization Management department for prior authorization.

8.1.7 Laboratory Services

All laboratory work should be sent to participating laboratories. For assistance locating a participating laboratory, contact Provider Services at (800) 578-0775.

Both PCP and specialists may order lab services. Participating practitioners who cannot perform venipuncture in their office should send members to the nearest participating laboratory.

8.1.8 Prenatal Care

No referral is necessary to an obstetrical provider, and a member may self-refer to any participating provider. The OB provider should confirm eligibility. No authorization is needed for the first obstetrical visit. After the first obstetrical visit, an authorization for continued services is required. Authorization may be obtained by using the online Global Authorization Request Form, iEXCHANGE[®], or by faxing the Global Authorization to Passport Health Plan's Mommy & Me Department (see details in Section 16).

8.1.9 Prescriptions

Prescriptions are administered for Passport Health Plan members through a pharmacy benefits manager (PBM). Members must have prescriptions filled at participating pharmacies. For assistance locating a participating pharmacy, members should call Member Services (800) 578-0603. Some Passport Health Plan members have a copayment for each pharmacy prescription.

Refer to Section 8.2 for a list of members who do not have to pay copayments.

For additional information on the outpatient pharmacy benefits, please refer to Section 14 of this *Provider Manual* or visit www.passporthealthplan.com.

8.1.10 Presumptive Eligibility

Presumptive Eligibility (PE) was implemented on November 1, 2001 by the Kentucky Department for Medicaid Services (DMS). PE enables qualified pregnant women to receive prenatal care (for up to 90 days) while their eligibility for full Medicaid benefits is determined.

For additional information regarding PE (including the complete list of covered services), please see Section 16.13.

8.1.11 Radiology

PCPs and specialists may order routine radiology services for members.

8.1.12 Skilled-Nursing Facility

Should a member need authorization to a skilled-nursing facility, the PCP should contact the Department for Medicaid Services (DMS). They will coordinate necessary arrangements between the PCP and the skilled-nursing facility in order to provide continuity of the member's care.

Passport Health Plan covers the costs of health care services that are not part of nursing facility costs for up to 31 days or until the member is disenrolled from Passport Health Plan by DMS. After the member has been in a skilled nursing facility for 31 days, the disenrollment process begins. After disenrollment, the member is re-enrolled with the fee-

for-service Medicaid program except when a member is under the care of Hospice and in a skilled-nursing facility. In this case, Passport Health Plan will continue to cover services under the hospice benefit even after 31 days.

8.1.13 Transportation

Emergency transportation is covered for Passport Health Plan members.

Members may be eligible for non-emergency transportation services to and from medical appointments.

Members should call the appropriate transportation broker at least three days ahead when scheduling transportation.

The telephone numbers for transportation brokers for each county can be found in Section 20.2, “Other Important Contact Information.” Members may also access this information by calling Passport Health Plan Member Services at (800) 578-0603.

8.1.14 Vision Care

Passport Health Plan has contracted with a vision benefits manager to administer and provide routine vision care benefits to members. A PCP referral is not required for vision services.

An annual routine eye refraction is covered for adult and child members. Eyeglasses are a benefit for children under age 21. Some exceptions apply to KCHIP members. Members may obtain a list of vision practitioners by calling Member Services at (800) 578-0603.

Members requiring vision care because of a medical condition must be referred by their PCP to a participating Passport Health Plan ophthalmologist. For more information, call Provider Services at (800) 578-0775 or refer to Section 1, “Important Telephone Numbers,” for our vision benefits manager’s contact information.

8.2 Copayments

Some Passport Health Plan members will have to pay a copayment for dental and pharmacy services (see Section 14.0 “Outpatient Pharmacy Services”).

The following members will **NOT** have to pay any copayments:

- Members younger than the age of 18 years.
- Pregnant members.
- Members receiving services within the first 60 days after delivery of a baby.
- Members in a nursing facility.
- Members in a personal care home.
- Members in an intermediate care facility for people with mental retardation (ICF/MR).

- A foster child in state custody.
- An American Indian or Alaskan native served through KCHIP.
- Members in hospice care.

Some specific benefits are described in more detail below.

8.3 Services Covered Outside Passport Health Plan

Members may continue to receive certain health services not covered by Passport Health Plan but covered by DMS. Members may obtain these services from any Medicaid provider by using their Medicaid ID. Members choosing to obtain these services are encouraged to notify their PCP to update their medical records. The following services are covered outside Passport Health Plan:

- Mental or emotional health services provided by behavioral health providers other than PCPs.
- Nursing facility services.
- Early-intervention services for children.
- School-based services for any child member younger than the age of 21 years with an individualized education plan.
- Waiver services.

Additional information about these services can be obtained from DMS.

8.4 Non-Covered Services

Services that are not covered by Passport Health Plan or the Kentucky Medicaid Program include:

- Non-medically-necessary services.
- Cosmetic services.
- Custodial, convalescent, or domiciliary care.
- Experimental procedures not approved by Kentucky's Medicaid Program.
- Hysterectomy procedures, if performed for hygienic reasons or sterilization only.
- Infertility treatment (medical or surgical).
- Paternity testing.
- Personal items or services, such as a television or telephone, while patient is in the hospital.
- Postmortem services.
- Reversal of sterilization services.
- Sex-change procedures.
- Sterilization of a mentally incompetent or institutionalized individual.

NOTE: Under EPSDT, some exceptions may be made if a service is medically-necessary.