

# This Provider Kit Includes ...

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# Welcome to the Passport Health Plan Provider Network

As Vice President of Clinical Operations of Passport Health Plan, I want to take this opportunity to welcome you to our team.

We have created this Provider Kit to help familiarize you with Passport Health Plan. In this Kit, you will find information about many Passport Health Plan programs, including Mommy & Me, Early Periodic Screening Diagnosis and Treatment (EPSDT), Case Management, Health Management, and Disease Management, along with other information to assist you in caring for Passport Health Plan members.

Communication is key to good provider relations, and we strive to keep our providers up-to-date with changes that may affect you. Many of these changes are communicated to you through our provider communications, such as Pharmacy News, Provider Alerts, letters, Medical Office Notes, and our free e-mail service, the Passport Online Information Service (POIS).

I also encourage you to access the Provider Center of our web site, **[www.passporthealthplan.com](http://www.passporthealthplan.com)**, where you may subscribe to POIS, access recent and archived provider communications, obtain details of our programs and services, and find links to important resources and forms.

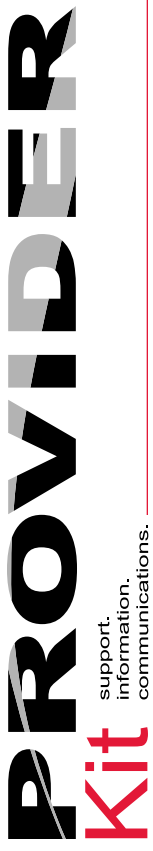
We welcome your insight and input to our quality improvement programs and invite you to join one of our medical committees. All practitioners are welcome to participate in the Quality Medical Management, Medical Criteria/Policy Review, Pharmacy & Therapeutics, Women's Health, Credentialing, and Child & Adolescent Health committees (more information regarding involvement in these committees is enclosed). If you would like to learn more about these committees, or would like to join one, please contact me at (502) 585-8221, and I will be happy to discuss our committee process with you.

If you have any other questions about Passport Health Plan, please do not hesitate to contact your Provider Relations representative or the Provider Relations department at (502) 585-7943. We hope your partnership with Passport Health Plan will be a long and pleasant one. We look forward to working with you to improve the health and quality of life of our members.

Sincerely,



Denise Kirkham  
Vice President of Clinical Operations



Welcome Letter

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# All About Benefits

## SUMMARY OF BENEFITS FOR PHP MEMBERS

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.
- 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, physician assistants and Federally Qualified Health Centers, 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.

Please remember some services/benefits require a prior authorization.

## UTILIZATION MANAGEMENT

The Utilization Management (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 Plan participating providers are required to obtain prior authorization from the Plan's UM department for inpatient services and specified outpatient services.

To determine which services require prior authorization, please see the following page or refer to the UM section of our *Provider Manual*, available on our web site at [www.passporthealthplan.com/providercenter](http://www.passporthealthplan.com/providercenter). More information regarding iEXCHANGE®, the Plan's web-based authorization system, may be found under "Electronic Services" in this kit.

To determine if a service or supply is considered a benefit exclusion, please contact the UM department.

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

Passport Health Plan invites you, 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.

## MEDICAL SERVICES AND PRIOR AUTHORIZATION

The following is a list of procedures and/or services requiring prior authorization from PHP's UM department. For the most current list of procedures/services requiring prior authorization, refer to the UM section of our Provider Manual, available on our web site at [www.passporthealthplan.com/providercenter](http://www.passporthealthplan.com/providercenter).

|   |  |
|---|--|
| Specified Outpatient Surgery Procedures     | 23 Hour Observation****<br>(Excludes OB Labor Check Observation) |
| Adenoidectomy                               | MRI (Knee, Cervical, Lumbar)                                     |
| Cardiac Catheterization                     | Nonparticipating Provider Services                               |
| Colonoscopy                                 | OB Care (After 1st Prenatal Visit)                               |
| EGD   | Ocular Photodynamic Therapy<br>with Verteporfin (Visudyne)       |
| Laparoscopic Cholecystectomy                | Pain Management Services   |
| Myringotomy                                 | Epidural Blocks  |
| Tonsillectomy                               | Trigger Point Injections   |
| Cardiac Rehab                               | PET Scans  |
| Chiropractic Services*                      | Prosthetics/Orthotics  |
| Cosmetic Procedures**                       | Pulmonary Rehab  |
| Diabetic Education                          | Stem Cell/Progenitor Cell Retrieval                              |
| DME >\$500                                  | Therapy Services including:                                      |
| Home Health Care                            | Physical Therapy   |
| Home Infusion Services                      | Occupational Therapy   |
| High Cost Medications<br>(>\$400 a dose)*** | Speech Therapy   |
| Hospice                                     | Transplants  |
| Inpatient Hospitalization                   | Neuropsychological Testing                                       |
| Investigational/Experimental Procedures     |  |

**Most services require a referral from the PCP to the specialist if the specialist is ordering or performing the procedure.**

\*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 deemed a medical necessity 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.

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

## PASSPORT HEALTH PLAN COPAYS

Some Passport Health Plan (PHP) members have a copay for dental and pharmacy services, as determined by the Department for Medicaid Services (DMS).

### **These copays include:**

- \$0 – \$1 for each prescription\*, including over-the-counter medications.
- \$0 – \$2 for each dental visit.

### **The following members do not have copays:**

- Members under the age of 18 years.
- Pregnant members.
- Members getting services within the first 60 days after delivery of a baby.
- Members in a nursing facility.
- Members in a family care home or 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 Kentucky Children’s Health Insurance Program (KCHIP).
- Members in hospice care.

If you have any questions regarding member copays, please call your Provider Relations representative or the Provider Relations department at (502) 585-7943.

### **\*Prescriptions**

Prescriptions are administered for PHP members through our pharmacy benefits manager (PBM), PerformRx.

# PRESCRIPTION MEDICATIONS AND PRIOR AUTHORIZATION

## When is a Prior Authorization (PA) Required?

PA is necessary for some medications to establish medical necessity and to ensure eligibility for coverage per State and/or Federal regulations. This may be due to specific Food and Drug Administration (FDA) indications, the potential for misuse or overuse, safety limitations, or cost-benefit justifications.

PA is required for medications that are:

- outside the recommended age, dose or gender limits;
- non-preferred (potential for “step therapy<sup>2</sup>” before approval);
- non-formulary;
- duplication in therapy (i.e. another drug currently used within the same class);
- new to the market and not yet reviewed by the Plan’s Pharmacy & Therapeutics (P&T) Committee;
- prescribed for off-label use or outside of certain diseases or specialties; or
- an incorrect ICD-9 code for atypical antipsychotics.

## How to Submit and Receive Notification on a PA

### STEP 1: Determine if the drug requires PA.

For the PA status of specific covered medications, please refer to our online searchable formulary by visiting [www.passporthealthplan.com/pharmacy](http://www.passporthealthplan.com/pharmacy).

You may also request a copy of our No-Prior Authorization Booklet by calling your Provider Relations representative or the Provider Relations department at (502) 585-7943.

### STEP 2: Complete the PA form in its entirety.

The PHP Prior Authorization Form is available on [www.passporthealthplan.com/pharmacy](http://www.passporthealthplan.com/pharmacy). A physician, nurse practitioner, or pharmacist may complete this form.

### STEP 3: Determine if the request is urgent or standard.

Urgent requests must be reserved for those situations in which applying standard processing may seriously jeopardize the member’s life, health, or ability to regain maximum function. The use of urgent fax lines for non-urgent requests is not appropriate.

### STEP 4: Fax the completed form for review.

- PHP standard requests: (877) 693-8280
- PHP urgent requests: (877) 693-8476

<sup>1</sup> Step therapy is defined as a trial of the safest and most cost effective therapy prior to progressing to other, more costly or recently-approved therapies (i.e. “step protocol”).

## What Happens During the PA Review Process:

**1st review:** A pharmacy technician compares all information on the request to the Plan's clinical authorization criteria. The Plan utilizes medical criteria developed in collaboration with our Pharmacy Benefits Manager (PBM) PerformRx, and the P&T Committee. Criteria are derived from one or more of the following:

- Published American Federal Food and Drug approval indications for therapy,
- Federal and/or State regulatory requirements,
- Drug compendia such as American Hospital Formulary systems (AHFS) and the United States Pharmacopeia drug compendia (USPDI), Drugdex or "Facts and Comparison,"
- Evidence-based guidelines provided by non-biased resources from government agencies, such as Agency for Healthcare Review and Quality (AHRQ), American Society of Clinical Oncologists (ASCO), or the American Academy of Pediatrics (AAP), and/or
- Current medical literature and peer-reviewed, non-biased publications, based on appropriate scientifically-designed study protocol with validated outcome endpoints.

**2nd review:** If the request does not meet the Plan's clinical authorization criteria, it is forwarded to a registered pharmacist. Additional information may be requested via fax or telephone from the prescribing provider.

**3rd review:** If the pharmacist cannot approve the request, the request is forwarded electronically to a Plan Medical Director for a decision.

### STEP 5: Receive the response.

You may expect a response within the following timeframes\*:

- PHP urgent request: no later than **24 hours** after submission
- PHP standard request: no later than **48 hours** after submission

Your office must have the area code programmed into your fax machine with a Called Subscriber Identification (CSID) number in order to receive fax confirmation of PA receipt.

*\*Timeframes are developed in accordance with requirements established by the Kentucky Department for Medicaid Services (DMS) and are subject to change. Incomplete or unclear information on the form may delay processing of a PA.*

### How Providers Are Notified of PA Decisions

A fax will be sent to the requesting provider's submitted fax number with one of the following PA decisions.

(Note: PA decisions are not faxed to the pharmacy.)

**Approved** The PA request has been approved for pharmacy reimbursement. Based on the medication and if requested by the prescriber, approvals may be granted for up to twelve (12) months.

|                       |  |
|-----------------------|--|
| <b>Partial Denial</b> | Reimbursement has been approved for a therapeutic alternative or for a different dose than requested.  |
| <b>Deferral</b>       | The final PA action was not decided due to the need for additional information. Providers must fax the requested information back to the PBM in order to obtain a final PA decision. |
| <b>Denial</b>         | The PA request was denied. <b>All PA denials are issued by a licensed physician.</b> These decisions may be appealed.  |

**Denial rationale** is included on every PA denial fax, and whenever possible, with a recommendation for an alternate preferred medication. However, denials for medications not indicated for clinical use may not include medication alternatives.

## Additional Information

### How do I check the status of my request?

To check on the status of your request, please call PerformRx, 7 days a week, from 8:30 a.m. to 9:00 p.m. at: (800) 578-0898

### Can members receive an emergency supply without a PA?

The PA department is not available at all times. Pharmacists may process an emergency supply if, in their clinical judgment, it is in the best interest of the member.

For PHP, the maximum quantity to be dispensed is a **3-day supply**. This does not apply to narcotic agents or drugs excluded from coverage by state and federal regulations.

### How often does the Formulary change?

The PHP online searchable formulary and downloadable PDFs are typically updated each quarter. In addition, a "Formulary Changes" document is updated online on a monthly basis. The *No-Prior Authorization Booklet* is updated annually.

### How do I request additions/deletions to the Passport Health Plan Formulary?

To request additions or deletions to the PHP Preferred Drug List, visit [www.passporthealthplan.com/pharmacy](http://www.passporthealthplan.com/pharmacy) to download the "Request for Drug Review" form. Mail the form to our Pharmacy department to have an addition or deletion considered by our P&T Committee. Requests from pharmaceutical manufacturers will not be accepted.

## URGENT CARE SERVICES

Urgent care is covered in an urgent care center, PCP office, or other ambulatory setting. Urgent means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Members are advised to contact their PCP before seeking medical treatment elsewhere.

### PCP Responsibilities

If the member calls prior to going to the urgent care center and care can be administered in the PCP's office, it is the PCP's responsibility to see the member in accordance with Passport Health Plan access guidelines.

**A referral is required for all urgent care visits except if it is Saturday, Sunday, a national holiday, or a weekday before 8 a.m. or after 4 p.m.** Passport Health Plan members may go to the following urgent care centers\* without a referral as indicated above:

After Hour Care of Kentuckiana Inc.  
 215 Central Avenue  
 Louisville, KY 40208  
 (502) 852-5792

After Hour Care of Kentuckiana Inc.  
 10216 Taylorsville Road, Suite 500B  
 Louisville, KY 40299  
 (502) 297-8900

Baptist Urgent Care  
 12010 Shelbyville Road  
 Louisville, KY 40243  
 (502) 238-2800

Bardstown Immediate Care Center  
 9409 Cedar Look Drive  
 Louisville, KY 40291  
 (502) 239-8431

Camelot Immediate Care Center  
 1102 Lyndon Lane  
 Louisville, KY 40222  
 (502) 423-7911

Carefirst Urgent Care Center  
 1111 Ring Road  
 Elizabethtown, KY 42701  
 (270) 706-1111

Dorsey Immediate Care Center  
 10284 Shelbyville Road  
 Louisville, KY 40223  
 (502) 244-5827

Immediate Care Center Shepherdsville  
 115 Huston Drive, Suite A  
 Shepherdsville, KY 40165  
 (502) 957-6434

Norton Immediate Care Center  
 2450 Bardstown Road  
 Louisville, KY 40205  
 (502) 459-3991

Norton Immediate Care Center  
 4420 Dixie Highway, Suite 112  
 Louisville, KY 40216  
 (502) 449-6444

Norton Immediate Care Center  
 4950 Norton Healthcare Boulevard  
 Louisville, KY 40241  
 (502) 394-6333

Norton Immediate Care Center  
 12615 Taylorsville Road, Suite B  
 Louisville, KY 40299  
 (502) 261-1565

Pediatric Acute Care  
 3793 Poplar Level Road  
 Louisville, KY 40213  
 (502) 452-1916

Pediatric Prompt Care  
 219 E. Broadway  
 Louisville, KY 40202  
 (502) 587-0394

Preston Immediate Care Center  
7926 Preston Highway  
Louisville, KY 40219  
(502) 964-4357

Simplistic Urgent Care PLLC  
915 Baxter Avenue  
Louisville, KY 40204  
(502) 479-3245

Urgent Care Center  
1360 Rogersville Road  
Radcliff, KY 40160  
(270) 351-1150

\* This list is subject to change. Please refer to the PHP Provider Manual for the most current information.

## 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.

### To Qualify for PE a Woman Must:

- Go to a PHP certified provider for a pregnancy test;
- Qualify for financial assistance;
- Be a Kentucky resident;
- Have a monthly household income of less than 185% of poverty level; and,
- Not have a pending Medicaid application.

Please note, PE is only good for 90 days. This coverage is for prenatal care only; and does not cover inpatient care or deliveries. For this reason, it is important for certified PE providers to encourage PE recipients to apply for full Medicaid benefits as soon as possible.

### The Certified PE Provider:

- Supplies the applicant with a Patient Information Form and assists her in calculating her income to determine eligibility;
- Contacts the PE Help Desk Specialist at (866) 818-0073 to secure a PE Confirmation Number;
- Accesses [www.kymmis.com](http://www.kymmis.com) to complete the online patient form and to print the paper PE card; and,
- Completes the Passport Health Plan Global Authorization Request Form. The form must be returned to the Plan by:
  - Fax at (502) 585-7970, or
  - Online at [www.passporthealthplan.com](http://www.passporthealthplan.com).
- Encourages the PE recipient to visit the local Department for Community Based Services (DCBS) to apply for full Medicaid benefits.

If you are a participating PHP Primary Care, OB/GYN, or Health Department provider and you would like to become certified as a PE provider, please call the Plan's Provider Relations department at (502) 585-7943 to schedule training and receive a PE Manual.

### Services Covered Under PE:

- Office visits for primary care services provided by the primary care physician, OB/GYN, ARNP, midwife, PA, rural health clinic, or federally qualified health center;
- Prescription drugs (including prenatal vitamins);
- Laboratory services;
- Diagnostic radiology services (including ultrasounds);
- Dental services (excluding orthodontia);
- Emergency room services;
- Transportation (both emergency and non-emergency); and,
- Select ambulatory prenatal services from approved health care providers.

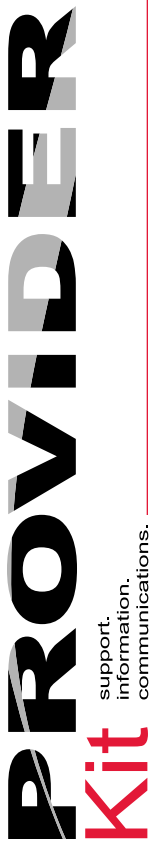
**Services NOT Covered Under PE:**

- Office visits or other procedures performed by a specialist, even if it is determined medically necessary;
- Inpatient hospital services, including labor, delivery, and newborn nursery services;
- Mental health/substance abuse services;
- Any other service not specifically listed as being covered under PE;
- Any service by a non-participating provider; and,
- Services provided by Urgent Care Centers.

If a PE recipient delivers her baby before qualifying for full Medicaid benefits, her baby is NOT automatically deemed eligible for Kentucky Medicaid.

For additional information please contact the KyHealth Choices PE Help Desk at (866) 818-0073 during the weekday hours of 8:00 a.m. to 5:30 p.m.

Please remind members that obtaining early prenatal care may promote healthier pregnancies and reduce the risk of adverse birth outcomes.



All About Benefits

# Rights & Responsibilities

## MEMBER RIGHTS & RESPONSIBILITIES

Members are informed of their rights and responsibilities through the Member Handbook. Passport Health Plan providers are also expected to respect and honor members' rights.

### **Passport Health Plan members have the following rights:**

- To receive information about Passport Health Plan, its benefits, services and providers, and their rights and responsibilities.
- To be treated with respect and have recognized their dignity and the right to privacy and nondiscrimination as required by law.
- To participate with their providers in making decisions regarding their health care.
- To discuss treatment options, regardless of cost or benefit coverage.
- To voice grievances or file appeals about Passport Health Plan decisions that affect their privacy, benefits, or the care provided.
- To expect their medical records and care to be kept confidential, as required by law.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To privacy of their health care needs and information, as required by law.
- To allow or refuse their personal information be sent to another party for uses such as data used in research studies, workers compensation claims, and outside marketing purposes, except when the release of information is required by law.
- To choose a primary care provider (PCP) and to change to another PCP.
- To receive timely access to care, including referrals to specialists when medically necessary, without barriers.
- To look at and get a copy of their medical records, as required by law.
- To file for a State Hearing with the Department for Medicaid Services at anytime.
- To receive materials in alternative formats and other languages if necessary.
- To make an advance directive, such as a living will.
- To choose a person to represent them for the use of their information by Passport Health Plan if they are unable to do so.
- To make suggestions about their rights and responsibilities.

### **Passport Health Plan members have the following responsibilities:**

- To take all their ID cards (Passport Health Plan ID card, Kentucky Medicaid ID card, and any other insurance card) to all medical appointments.
- To follow the policies and procedures of the Department for Medicaid Services and Passport Health Plan.
- To provide, to the best of their ability, information that Passport Health Plan and providers need in order to care for them.
- To follow the instructions and plans of care they have agreed to with their provider.
- To learn about their rights.
- To be honest with providers and treat them with respect and kindness.
- To get regular medical care from their PCP.

- To obtain a referral from their PCP before seeing a specialist.
- To ask their provider questions about the care they receive.
- To ask their provider questions about his or her instructions.
- To understand their health problems and work with their provider as much as possible to decide treatment goals that both agree on.
- To follow the steps of the appeal process.
- To make good decisions about their health and things that affect their health.
- To notify Passport Health Plan if they suspect fraud or misuse of Passport Health Plan ID cards or benefits by a member or provider.
- To notify the Department for Community Based Services (DCBS), Passport Health Plan, and their providers of any changes that may affect their membership, health care needs, or access to benefits. Some examples may include:
  - If they have a baby.
  - If their address changes.
  - If their telephone number changes.
  - If they or one of their children are covered by another health plan.
  - If they have a special medical concern.
  - If their family size changes.
- To keep appointments with providers and call to cancel appointments when they cannot be there.

# PROVIDER RESPONSIBILITIES

## Provider Access & Availability

PCPs are required to provide coverage for Passport Health Plan members 24 hours a day, seven days a week. When a PCP is unavailable to provide services, the PCP must ensure that he or she has coverage from another participating provider. Hospital emergency rooms or urgent care centers are not substitutes for coverage from another participating provider. Participating providers can consult their Passport Health Plan Provider Directory, or contact Provider Services at (800) 578-0775 with questions regarding which providers participate in the Passport Health Plan network.

## Appointment Standards

Appointments with PCP and specialists must be scheduled within 30 days for routine care and preventive care visits.

Other appointment standards are as follows:

- Appointments for urgent care services must be scheduled within 48 hours.
- Appointments for emergency care must be immediately provided.
- Pregnant women in their first trimester are to be provided preventive care visits within 14 days of request.
- Pregnant women in their second trimester are to be provided preventive care visits within seven days of request.
- Pregnant women in their third trimester are to be provided preventive care visits within three days of request.
- Appointments for laboratory and radiology services must be scheduled within 30 days for routine care and 48 hours for urgent care.

Providers should provide care for conditions that are non-urgent but require attention within seven days.

## Office Standards

- Providers must not differentiate or discriminate in the treatment of any member because of the member's race, color, national origin, ancestry, religion, health status, sex, marital status, age, political beliefs, or source of payment.
- The office waiting times should not exceed 45 minutes.
- Members should be scheduled at the rate of six or less per hour.
- Health assessments/general physicals should be scheduled within 30 days.
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens for any new enrollee younger than 21 years should be scheduled within 30 days of enrollment, unless the child is already under the care of a PCP and the child is current with screens and immunizations.
- EPSDT screens for any new enrollee younger than two years should be scheduled within an appropriate time frame so that the child is not out of compliance with any required screenings.
- PCP should have a "no show" follow-up policy. For example, the PCP or specialist might send two notices of missed appointments to the member,

followed up by a telephone call to the member. Any actions for missed appointments should be documented in the member's medical record.

- Provider Relations must be notified of all PCP planned and unplanned absences of more than four days from the practice.
- Member medical records must be maintained in an area that is not accessible to persons not employed by the practice. When releasing a member's medical record to another practice or provider, providers are required to first obtain written consent from the member.
- Any provider's office administering care that may have an adverse effect must obtain the member's signature on a form that describes the treatment and includes the medical indication and the possible adverse effects.
- Providers must complete specific treatment consent forms, such as hospice, sterilization, hysterectomy, or abortion required by State and Federal regulations and laws.

## 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](http://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.

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.

## 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:

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



# Provider Support

## ELECTRONIC SERVICES

### Real-Time Eligibility and Claims Status Options

Providers may view claims status using any of the following methods:

1. **Online** – check eligibility and/or claims status by logging in under the “Secured Services” on the provider page of the Plan’s web site at [www.passporthealthplan.com/providercenter](http://www.passporthealthplan.com/providercenter).
2. **NaviNet** - a free, web-based solution for provider access to electronic transactions and information through a multi-payer portal. NaviNet offers PHP providers an additional option for accessing member, Plan, other administrative information, and services such as eligibility inquiries, information on patient third party liability (TPL), and claims status inquiry.
3. **Real-Time** – depending on your clearinghouse or practice management system, real-time eligibility and claims status information is available to participating providers. Contact your clearinghouse to access:
  - Emdeon Products for member eligibility and claims status transactions.
  - Zirmed Products for member eligibility transactions.
  - All other clearinghouses - ask your clearinghouse to access transactions through Emdeon.
4. **Telephone** – you may also check eligibility and/or claims status by calling our interactive voice response (IVR) system at (800) 578-0775, option 1.

### iEXCHANGE® for Online Authorizations

iEXCHANGE® is a web-based program that allows our health care providers to submit authorizations online. Currently, Passport Health Plan (PHP) utilizes iEXCHANGE® for online authorization of the following services:

- Inpatient OB Deliveries
- Obstetrical (OB) Globals
- Hospice
- EGD
- CPAP
- Colonoscopy
- Speech Therapy, Occupational Therapy, Physical Therapy
- Select MRI’s (knee, cervical and lumbar)
- Cholecystectomy
- Select ENT
- Synagis
- Cardiac Catherization
- Select Home Health Services - Medi-Planners and Home Health Aide
- Select DME Services - Breast Prosthesis, Knee/Ankle/Back Brace, and Hospital Bed

- Cardiac and Pulmonary Rehab
- More services to come ... see our web site for a current list.

iEXCHANGE® *Training Guides* are now available for specific services on our web site at [www.passporthealthplan.com/providercenter](http://www.passporthealthplan.com/providercenter) under "iEXCHANGE®." To request training or materials, please contact the Provider Training Specialist at (502) 585-8224.

### Electronic Referrals

Passport Health Plan currently offers two options for the initiation and submission of referrals. While paper referral forms remain an option at this time, providers are strongly encouraged to use the electronic submission process available at [www.passporthealthplan.com](http://www.passporthealthplan.com).

Referrals initiated via our web-based program are automatically transmitted to the Plan. PCPs should print three copies of the referral to be distributed as follows:

- Specialist copy (to be sent with member or mailed to a specialist).
- Member's copy.
- PCP's copy (to be placed in member's chart).

### ikaProHEDIS+ for Real-Time Clinical Care Data

ikaProHEDIS+ is an online application for real-time clinical care reporting and allows Passport Health Plan PCPs the ability to:

- Monitor your Provider Recognition Program (PRP) performance;
- Access real-time preventive care and use of services data;
- Identify members due for preventive health screenings; and,
- Generate reports by preventive health screening to guide your member outreach.

If you are a PHP PCP, you may access ikaProHEDIS+ on the Provider Center of our web site at [www.passporthealthplan.com](http://www.passporthealthplan.com) by logging onto the Secured Services portion and selecting the link to ikaProHEDIS+. A detailed instruction guide is also available online to help you navigate the ikaProHEDIS+ application.

If you have any questions regarding ikaProHEDIS+ please call the Provider Recognition Program representative at (502) 585-7946.

# ONLINE RESOURCES FOR PROVIDERS

## Enhanced Searchable Formularies

The PHP formulary is now available online in an enhanced, searchable format that:

- Allows searches via brand name, generic name, or therapeutic class;
- Denotes prior authorization requirements and offer access to authorization criteria (including but not limited to step therapy requirements);
- Displays the class, copayment tier, and quantity limits (if applicable) for each medication; and,
- Exhibits all medications within the same class.

We encourage providers and their staff to access this user-friendly searchable formulary by visiting [www.passporthealthplan.com/pharmacy](http://www.passporthealthplan.com/pharmacy).

## Passport Online Information Service (POIS)

The Passport Online Information Service (POIS) is the free e-mail service for Passport Health Plan providers. POIS allows you to:

- **Be the first to get important information.**
  - Receive information 5 to 10 days sooner than via standard mail!
- **Get only the most important news.**
  - Claims and Reimbursement
  - Policy Changes/Updates
  - State and Federal Laws Affecting Plan Providers
- **Find information easily.**
  - No more accidentally misplaced or discarded communications.
- **Keep information electronically for your records.**
  - No more paper files.

As a provider-sponsored plan, we value your time and are committed to sending you only important Plan information. You will never receive non-Plan related or spam e-mails from Passport Health Plan.

**Signing up is easy!** In just a few moments you can send us your information. Visit [www.passporthealthplan.com/providercenter](http://www.passporthealthplan.com/providercenter) and click "POIS."

## Provider Communications

PHP communications are available online! Provider communications include:

- **Provider Alerts** – relay urgent or essential Plan information for providers.
- **Provider Letters** – contain important, but non-urgent Plan information for providers.
- **Medical Office Notes** – provide detailed educational information regarding Plan policies and processes.

- **Provider Newsletters** – convey a variety of Plan updates, including clinical and billing guidelines, as well as a message from our Chief Medical Officer.
- **Pharmacy News** – offers dedicated pharmacy-related updates regarding our preferred drug list and prior authorization/billing requirements.

## Provider Directories, Manuals and Training Materials

### Provider Directories

Providers and office staff may access our PHP Provider Directories online at [www.passporthealthplan.com](http://www.passporthealthplan.com). These real-time provider directories allow providers and members easy access to practitioner and facility information using several search functions.

### Provider Manuals

The PHP *Provider Manual* contains valuable Plan information including up-to-date:

- Contact information;
- Office standards;
- Provider reimbursement, member benefits and pharmacy services information;
- Utilization Management and prior authorization requirements;
- Billing instructions and claim submission procedures; and,
- Clinical practice guidelines.

The PHP *Provider Manual* is available in a convenient electronic format on our web site, [www.passporthealthplan.com/providercenter](http://www.passporthealthplan.com/providercenter), under “Resources.” Providers may choose to view each section individually, or they may perform a search of the manual in its entirety.

### PHP Provider Online Training Materials Include:

- Claims Forms & Instructions;
- Practitioner and Facility Manuals for Submitting Secondary Claims Electronically;
- EPSDT Form & Instructions;
- Member ID Card Comparison Charts;
- iEXCHANGE® Training Guides;
- Member Satisfaction Tips and Suggestions;
- Provider Recognition Program (PRP) Resources;
- Electronic Referrals Quick Reference Guide;
- Helpful Hints for the Referral and Prior Authorization Forms; and,
- Much more ...

# CULTURAL AND LINGUISTICS PROGRAM

## Title VI Compliance is Federal Law

Title VI of the Civil Rights Act of 1964 is Federal legislation that requires any organization receiving direct or indirect Federal financial assistance to provide services to all beneficiaries without exclusion based on race, color, or national origin.

### What is required by Federal law?

All Passport Health Plan (PHP) and Passport Advantage (PAD) providers indirectly benefit from Federal financial assistance (via Medicaid and Medicare). Therefore, under Title VI of the Civil Rights Act of 1964 and the Culturally and Linguistically Appropriate Services (CLAS) Standards 4 - 7, as outlined by the Office of Minority Health, U.S. Department of Health and Human Services (DHHS), all providers are required by law to:

- Provide written and oral language assistance at no cost to Patients with limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. **This includes the provision of competent language interpreters, upon request.**

**Note:** The assistance of friends or family is not considered competent, quality interpretation; friends or family should not be used for interpretation services except where a patient has been made aware of his/her right to receive free interpretation and continues to insist on using a friend or family member for assistance. For more information, please see the section below, "Why not allow friends and family to interpret?"

- Provide patients verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.
- Post and offer easy-to-read patient signage and materials in the languages of the common cultural groups in your service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.

### What is encouraged by Federal guidelines?

Additionally, under the CLAS Standards, providers are strongly encouraged to:

- Provide effective, understandable, and respectful care to all patients in a manner compatible with the patient's cultural health beliefs and practices of preferred language/format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
- Establish written policies to provide interpretive services for patients upon request.
- Routinely document preferred language or format, such as Braille, audio, or large type, in all patient medical records.

### **Why not allow friends and family to interpret?**

The use of friends and family members to assist with interpretation may have a negative impact on care. Consider the following potential results and how they may impact your practice and the care you provide:

- Breach of confidentiality.
- Reluctance of the patient to reveal personal information, even information critical to his/her health.
- Incompetent interpretation due to lack of familiarity with medical terminology.
- Miscommunication during medical decision-making or follow-up instructions.

Patients may decline the use of a qualified interpreter, but they must sign a waiver in their preferred language or use a tele-interpreter to record their agreement.

### **Bilingual Staff**

The use of bilingual staff can help carry out important Title VI functions (such as staffing an information desk) – but using unqualified employees who are not trained as interpreters could be illegal under Title VI.

Qualified interpreters are people who have been tested to determine their level of proficiency in English, their native languages, and their ability to explain pertinent benefits and services. They have also been trained on confidentiality including HIPAA and how to convey messages without adding or removing words or phrases. To determine if your staff is qualified to provide medical interpretation, please see the Office of Minority Health's web site at <http://minorityhealth.hhs.gov>.

### **Are there legal consequences for non-compliance?**

Yes. The Office for Civil Rights (OCR) enforces anti-discrimination laws. All patients have the right to file complaints if they believe they have been discriminated against.

Patient complaints are evaluated individually by the OCR and may receive further investigation where certain criteria are met (i.e. sufficient information, appropriate jurisdiction, etc.). Patients also have the right to file suit in Federal court, regardless of the OCR's findings.

### **Penalties of non-compliance with Title VI may include:**

- Loss of federal and state funding, including future funding (i.e. you may be prohibited from participating in Medicaid, Medicare, and/or incentive programs such as the Electronic Health Records incentive).
- Legal action against you from the DHHS, legal service organizations, and private individuals.
- "Informed consent" issues which may also lead to medical malpractice charges.

### **Does the Plan offer training or resources?**

Yes, we offer both! To schedule an onsite training, contact the Plan's Cultural and Linguistics Services Program (CLSP) Coordinator at (502) 585-7303, e-mail [cals@amerihealthmercy.org](mailto:cals@amerihealthmercy.org). More information and resources are available online at [www.passporthealthplan.com/provider/services/cals](http://www.passporthealthplan.com/provider/services/cals).

- **Onsite Trainings/Resources**  
Our CLSP staff is a resource for Title VI/CLAS Standards and assists providers in reaching and maintaining compliance. We offer free trainings for your office staff, an informative Provider Toolkit, and also an annual Achieving Cultural and Linguistic Competency in HealthCare Conference for healthcare providers.
- **Provider Office Materials**  
In addition to our Provider Toolkit and other educational resources, we also offer provider office signage to assist your office staff in complying with Title VI. These materials are available online or by calling the CLSP coordinator.
- **Translated Member Materials and TDD/TYY Lines**  
Many member materials, including the Passport Health Plan Member Handbook, are available in other languages and alternative formats such as Braille, audio, and large type. Members may download these on our web site or call Member Services for copies.

Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf (TDD), the Plan's TDD/TYY numbers for Member Services are:

|                      |                |
|----------------------|----------------|
| Passport Health Plan | (800) 691-5566 |
| Passport Advantage   | (800) 648-6056 |

- **Discounts for Telephonic and Video Interpretation**  
The Plan also contracts with a telephonic and video interpretation vendor, InterpreTalk by Language Services Associates (LSA), to offer our providers a discounted rate. To set up an account and receive InterpreTalk services, please call (800) 305-9673 and select the option 7 for Client Services. It may take 24 to 48 hours to set up your InterpreTalk account so you may begin receiving interpretive services.

### Questions?

For questions about the Plan's Cultural and Linguistics Services Program (CLSP), please contact the CLSP Coordinator at (502) 585-7303 or e-mail [cals@amerihealth-mercy.org](mailto:cals@amerihealth-mercy.org).

For questions about this communication, please contact your Provider Relations representative or the Provider Relations department at (502) 585-7943.



# Billing and Reimbursement

## PAPER AND ELECTRONIC CLAIM SUBMISSION

### Submitting Paper Claims

Paper claims may be submitted on the CMS-1500 or UB-04 forms to:

Passport Health Plan  
P.O. Box 7114  
London, KY 40742

The Plan encourages all providers to submit claims electronically.

### Submitting Electronic Claims

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for PHP providers. EDI, performed in accordance with nationally recognized standards, supports industry effort's to reduce administrative costs.

Benefits of electronic billing include:

- **Reduction of overhead and administrative costs.** EDI eliminates the need for paper claim submission. It has also been proven to reduce claim rework (adjustments).
- **Receipt of reports as proof-of-claim receipt.** This makes it easier to track the status of claims.
- **Shorter transaction time.** An EDI claim averages 24 to 48 from the time it is sent to the time it is received.
- **Validation of elements on the claim form.** At the point the claim is transmitted electronically the information needed for processing is present.
- **Faster adjudication.** Claims not requiring additional investigation are processed more quickly. Reports have shown a high percentage of EDI claims are processed within 10 to 15 days of receipt.

Many different products may be used to submit claims electronically – you must simply have the capability to send EDI claims to Emdeon\*, either through direct submission or through another clearinghouse/vendor.

If you are interested in submitting claims electronically and do not already have an EDI software vendor, you may choose to:

- Contact Emdeon Business Services at (877) 469-3263, option 7.
- OR**
- Contract with another EDI clearinghouse or vendor.

If you have questions regarding the EDI process, please contact the EDI Technical Support Hotline at (877) 234-2475 or [ediphp@kmhp.com](mailto:ediphp@kmhp.com).

## Electronic Remittance Advice (ERA/835)

PHP offers providers an Electronic Remittance Advice (ERA) option. If you are interested in receiving an 835 transaction from PHP or PAD, you must register with Emdeon Business Services by calling the Client Solutions Support Line at (800) 845-6592 or visiting [www.emdeon.com](http://www.emdeon.com).

## Submitting Third Party Liability Information Electronically

PHP electronic claim submission (837I and 837P) now includes the capability to accept and process secondary claims electronically.

To submit provider-to-payer coordination of benefits (COB) claims via EDI, you must have a system, data entry process, or clearinghouse able to:

- **Create or forward claims directly to EDI in:**
  - The HIPAA 837 format; or,
  - A format containing equivalent information.
- AND-**
- **Process payment information by:**
  - Receiving a HIPAA-standard electronic remittance advice (ERA) format from the previous payer; or,
  - Coding a paper remittance into the electronic claim.

To view technical specification and guidance for submitting secondary claims via EDI, please visit the “Billing Information” section of our web site, [www.passporthealthplan.com/providercenter](http://www.passporthealthplan.com/providercenter).

If your office does not have web access, please contact your Provider Relations representative or the Provider Relations department at (502) 585-7943 to request a hard copy of this information.

## ELECTRONIC FUNDS TRANSFER (EFT)

Passport Health Plan (PHP) offers direct deposit to our network providers for fee-for-service and capitation payments. PHP partners with Emdeon Business Services to bring you EFT. Emdeon's ePayment services will streamline the payment process by allowing you to:

- Secure payments quickly and easily;
- Reduce paper processing;
- Maintain your preferred banking partner;
- Simplify your bank connectivity when multiple banks are involved;
- Manage provider enrollment and authentication;
- Eliminate the possibility of checks getting lost or delayed in the mail; and
- View multiple payers in one easy-to-use application.

Providers wishing to enroll in EFT must agree to receive all Emdeon payers' payments electronically.

- **Practices with less than 15 practitioners may enroll online.** Begin the EFT enrollment process by clicking the "EFT" link on the Provider Center of our web site, [www.passporthealthplan.com/providercenter](http://www.passporthealthplan.com/providercenter). This link will connect you to the Emdeon web site, where you will be guided through the quick and easy steps to enroll.
- **Practices with more than 15 practitioners may enroll by calling Emdeon at (877) 363-3666.**

Once you are enrolled and have received a confirmation e-mail that your EFT account has been activated, you can expect to receive funds electronically within two weeks.

**If you choose to enroll in EFT, your paper remittance advice will be automatically discontinued after 90 days.** However, you will be able to view and print your remittance advice for free through Emdeon's basic Payment Manager, found at [www.emdeonepayment.com](http://www.emdeonepayment.com).

You may also want to consider enrolling in Emdeon's ERA online service, which allows providers to post payments automatically. The online PHP Provider Center includes frequently asked questions (FAQs) regarding Emdeon, EFT, and ERA. For more information about these services or to enroll in EFT and/or ERA, you may also contact Emdeon directly at [www.emdeonepayment.com](http://www.emdeonepayment.com) or by calling (877) 363-3666.

## FAMILY PLANNING CLAIMS

Paper claims for family planning services may be submitted to:

**AmeriHealth HMO, Inc. Family Planning**  
 ATTN: Claims  
 P.O. Box 42476  
 1901 Market Street, 29th Floor  
 Philadelphia, PA 19101-2476

If you are not yet submitting family planning claims electronically, please contact the AmeriHealth HMO, Inc. Family Planning Unit at (800) 541-4560 for assistance in setting up electronic claims submission.

All family planning claims must be submitted to the Plan's subcontracted vendor, **AmeriHealth HMO, Inc.** Any family planning claims submitted to PHP will result in a denial stating "Z06 or Z14: carrier of service – AmeriHealth HMO, Inc."

### Claims Containing Both Family Planning and Medical Services

When both family planning and non-family planning services are provided in the same visit/encounter, the family planning services must be billed separately to AmeriHealth HMO, Inc. as outlined above. All other services (medical) must be billed as normal to PHP. Please note, combined ancillary charges (e.g. supplies, room use, lab/x-ray) do not need to be separated and may be included on the medical claim billed to PHP.

Only family planning services should be billed to AmeriHealth HMO, Inc.

### Include Federal Treatment Consent Forms for Sterilization and Termination Procedures

All claims for sterilization and termination procedures must be submitted with the appropriate Sterilization (MAP 250) and Termination (MAP 235) treatment consent forms, available on the Kentucky Department for Medicaid Services (DMS) web site, <http://chfs.ky.gov>.

As a provider, you must complete and comply with all terms and conditions of the DMS consent forms thirty days prior to a procedure being provided. You must also ensure non-English speaking, visually impaired and/or hearing-impaired members understand what they are signing.

Once you have submitted a family planning claim to AmeriHealth HMO, Inc., you may review the status of your claim via one of the following methods:

- **Status Report** – review your claim status in the AmeriHealth HMO, Inc. biweekly Acknowledgement Report. This report is distributed by mail, in conjunction with routine reimbursement checks, and lists each claim by member name, including claim number, date of service, date received, and claim status.
- **Online** – access your claims at the summary or detail level via the AmeriHealth HMO, Inc. web site, which is available 24 hours a day, 7 days a week. To check your claim status online, follow these steps:

- Visit the following web site: <http://www.amerihealth.com/providers>
- Select "Claims and Billing" from the middle of the page.
- Select "Kentucky Family Planning" from the middle of the page.
- Click "Login Here" to enter the logon screen.
- Use your federal tax ID number (TIN) as your provider ID and provider password.
- From the Group Logon screen, enter your provider ID as the group ID.
- When logon is complete, the "Claims Status Inquiry" will display.
- Follow the prompts to search for claims by Member ID and date of service.

### Questions

We are dedicated to helping you achieve maximum claims processing efficiency. Please contact AmeriHealth HMO, Inc. Family Planning at (800) 541-4560 with any questions or concerns regarding family planning claims and/or services.

## CORRECTED CLAIM SUBMISSION PROCEDURES

Corrected claims for Passport Health Plan (PHP) are handled through a special process. To reduce duplicate denials and prevent multiple claim rejections, follow the claims submission instructions below:

### Passport Health Plan (PHP)

Send corrected claims to PHP on paper to Passport Health Plan, P.O. Box 7114, London, KY 40742, with one of the following noted, as appropriate:

| Situation  | Submission Instructions                                       |
|--|---|
| You are returning claims originally denied for "missing/invalid information" or "inappropriate coding," or previously-submitted claims with incorrect information (i.e. units, date of service, charges) | Write "Corrected Claim" and circle the corrected information. |
| You are returning claims originally denied for "additional information needed."  | Write "Resubmitted" and attach the requested information.     |

Note: Corrected and resubmitted claims are scanned during reprocessing. Please remember to use blue or black ink only, and refrain from using red ink and/or highlighting that could affect the legibility of the scanned claim.

### Questions

If you have any questions or concerns regarding this communication, please contact the Provider Claims Service Unit (PCSU) at (800) 578-0775.

# BONUS OPPORTUNITIES FOR PRIMARY CARE PRACTITIONERS (PCP)

## Comprehensive Services Payment

The Comprehensive Services Payment is an additional payment for eligible primary care practitioners (PCP). Eligible PCPs will receive this additional payment to their base capitation rates (as outlined in the PCP Provider Contract) and will be placed into one of two tiers\*.

### \*First Tier

Providers receive a payment of \$2.00 per member per month (PMPM) if they have at least 75 members for a consecutive two (2) month period and meet all of the following service criteria for members:

- Office has a system to remind members of appointments and to follow up with members who do not show up for appointments.
- Office is open to treat members a minimum of 44 hours each week.
- Office is open to treat members a minimum of three (3) non-traditional hours (morning, evening or weekend) each week. Morning hours are defined as before 8 a.m. Evening hours are defined as after 6 p.m.

### \*Second Tier – in addition to Tier 1

Providers who meet the above requirements may receive an additional payment of \$1.50 PMPM if they have at least 75 members for a consecutive two (2) month period and meet all of the following service criteria for members:

- Office has a system to remind members of appointments and to follow up with members who do not show up for appointments.
- Office is open to treat members a minimum of 52 hours each week.
- Office is open to treat members a minimum of eight (8) non-traditional hours (morning, evening or weekend) each week. Morning hours are defined as before 8 a.m. Evening hours are defined as after 6 p.m.

If you are interested in the Comprehensive Services Payment, ask your Provider Relations representative about the Plan's qualification criteria and requirements. He or she will evaluate your practice during a site visit to determine if you meet the above requirements. If you are eligible, your Provider Relations representative will ask you to sign an Amendment to your PHP PCP Agreement. The effective day for your additional payment will be prospective and recorded in the Amendment.

## Encounter Bonus Payment

For non fee-for-service PCP procedures performed, claims must still be submitted to receive a monthly encounter bonus payment of \$1.00 for each member encounter reported in which you administered non-billable basic health services. The encounter bonus is included in the monthly capitation check and reported as a separate line item on the capitation payment roster.

## The PCP Provider Recognition Program

The Passport Health Plan PCP Provider Recognition Program rewards providers who demonstrate improvement and/or excellence in performance in the categories of cost containment, member satisfaction, access to care and health outcomes.

### Reimbursement Methodology

Please note that our methodology for reimbursement rewards excellence and improvement. Passport Health Plan utilizes the National Committee for Quality Assurance (NCQA) methodology for achieving statistically significant improvement.

### Program Design

The Provider Recognition Program furthers the Plan's mission of improving the health and quality of life of our members. The program is composed of clinically sound measures relevant to the needs of the Plan's population. The Provider Recognition Program also employs sound methodology in order to be fair and equitable to all practitioners, and takes national initiatives into consideration.

The Provider Recognition Program measures:

- PCP Profile
- EPSDT Screening Rate
- EPSDT Participation Rate
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- ER Utilization
- Member Satisfaction

Provider Recognition Program rewards are paid out in February, May, September, and November of each year.

### Additional Resources

Please note we offer a broad array of resources to supplement your efforts in increasing preventive screenings and reducing non-emergent ER utilization. These programs provide important utilization information and health education/reminders.

Our web site, [www.passporthealthplan.com](http://www.passporthealthplan.com), also provides more information about how we may assist practitioners with:

- Breast Cancer Screening Rates
- Cervical Cancer Screening Rates
- Chlamydia Screening Rates
- EPSDT Screening and Participation Rates
- Emergency Room Utilization
- Improving Member Satisfaction

We encourage all of our PCPs to utilize these resources and to become involved in this exciting program.

### Requests for Training

If you have any questions or concerns, or you would like to request training on the Provider Recognition Program, please contact your Provider Relations representative or the Provider Relations department at (502) 585-7943.

# Special Programs

As quality health care continues to emphasize preventive care, Passport Health Plan (PHP) is committed to working with providers to keep our members healthy. Our Health & Disease Management programs strive to prevent or minimize progression of illnesses using comprehensive, integrated approaches to care.

We invite you to learn more about our programs and how they may assist you with continuity and coordination of care for our members. For additional information regarding our programs, please contact the Health & Disease Management Department, available Monday through Friday, 8 a.m. to 4:30 p.m., by calling (800) 578-0636.

## CASE MANAGEMENT

### **Assisting Practitioners in Improving the Health of Members with Complex Medical Needs**

The Case Management program assists members who have one-time or ongoing complex medical needs by establishing goals, coordinating appointments, assisting with psychosocial needs, durable medical equipment (DME), and the use of community resources. By sharing the member's plan of care with his/her primary practitioner, Case Management complements the practitioner's care and removes barriers so the practitioner's care plan works more effectively.

### **Questions or Suggestions about Case Management?**

If you have any questions about the Case Management program, or suggestions about how the program can better assist you, please contact the Case Management department at (800) 578-0636 ext. 77915.

## HEALTH MANAGEMENT/DISEASE MANAGEMENT

### **Assisting Practitioners in Attaining and Maintaining the Member's Optimum Level of Wellness**

PHP has a comprehensive Health Management department. You do not need to do anything to use our disease management services. Members with qualifying diagnoses are automatically enrolled in our programs, and may "opt out" either verbally or in writing. Members who "opt out" may "re-enter" the programs at anytime, either verbally or in writing.

Here's information on how these programs assist practitioners in improving the health of our members:

## Asthma Disease Management

### Assisting Practitioners in Improving the Health of Members with Asthma

The goal of the Asthma Disease Management Program is to work with our practitioners and members to improve asthma care.

#### The Asthma Disease Management Program offers the following:

- The **Asthma Provider Report** provides information on members' inpatient admissions and emergency room visits, adherence to treatment plan, compliance with asthma medications, and related co-morbidities, such as diabetes. The report alerts the practitioner if the member is due for EPSDT immunizations, is pregnant, or is a smoker.
- **Member educational materials** - accessible via the Plan's web site, [www.passporthealthplan.com](http://www.passporthealthplan.com), or by calling the Asthma Disease Care Managers.
- **PHP Clinical Practice Guidelines**, which are based on the National Institute of Health (NIH) Guidelines, are accessible via [www.passporthealthplan.com](http://www.passporthealthplan.com), or by calling the Asthma Disease Care Managers.
- **Asthma Disease Care Managers** are available to assist practitioners with achieving positive health outcomes for our members with asthma. These managers provide educational in-services for office staff, supply resources such as the Asthma Pocket Guide (lists asthma medications covered on the PHP formulary), conduct inhaler demonstrations, and answer practitioner questions regarding the care of our members. Asthma Disease Care Managers may be reached at (502) 585-8311, (502) 585-8307, or (800) 578-0636, ext. 78311 or 78307.

## Diabetes Disease Management

### Assisting Practitioners in Improving the Health of Members with Diabetes

The goal of the Diabetes Disease Management Program is to support participating practitioners and provide education and outreach to PHP members with diabetes.

#### The Diabetes Disease Management Program offers the following:

- The **Diabetes Provider Report** provides information regarding completion of recommended screenings for members with diabetes, the use of injectable, oral, or both types of diabetic medications by individual members, the use of ACE inhibitors, and reported comorbidities.
- **Member educational materials** - accessible via [www.passporthealthplan.com](http://www.passporthealthplan.com), or by calling the Diabetes Disease Care Manager.
- **PHP's Diabetes Clinical Practice Guidelines**, which are based on The American Diabetes Association (ADA) Guidelines, are accessible via [www.passporthealthplan.com](http://www.passporthealthplan.com), or by calling the Diabetes Disease Care Manager.

- **Diabetes Disease Care Manager** is available to assist practitioners with achieving positive health outcomes for our members with diabetes. The care manager provides educational in-services for office staff, supplies resources such as the Diabetes Care Tool, and answers practitioners' questions regarding the care of our members. The Diabetes Disease Care Manager may be reached at (502) 585-7074 or (800) 578-0636, ext. 77074.

## The Mommy & Me Program

### Assisting Practitioners with the Care of Pregnant Women.

The goal of the Mommy & Me Program is to work with our practitioners and members to improve prenatal, infant and maternal outcomes for pregnant members.

#### The Mommy & Me Program offers the following:

- The **Mommy & Me Provider Report** provides practitioners with information regarding their antepartum members' emergency room, 23-hour observation, and inpatient stays during pregnancy. It also alerts practitioners to other risk factors or co-morbidities, such as diabetes, asthma, smoking, or extreme maternal age (younger or older).
- **Member educational materials** - accessible via [www.passporthealthplan.com](http://www.passporthealthplan.com), or by contacting the Plan's Mommy & Me Program staff.
- **PHP Perinatal Clinical Practice Guidelines**, which are based on the recommendations of the American College of Obstetricians and Gynecologists are also available via [www.passporthealthplan.com](http://www.passporthealthplan.com).
- **Mommy & Me Perinatal Care Managers** are available to assist practitioners by working one-on-one with their high-risk members, assisting with education and resources for all pregnant members, and answering practitioners' questions regarding the care of our members. Mommy & Me Perinatal Care Managers may be reached at (502) 585-7908 or (800) 578-0636, ext. 77908.

## EPSDT Program for Members Ages Birth to 21 Years

### Assisting Practitioners with the Care of Children and Adolescents

The EPSDT Program provides education and outreach to caregivers for members from birth to age 21 to ensure the early diagnosis and treatment of medical conditions which, if undetected, could result in serious medical conditions and to promote preventive health screenings and immunizations. The comprehensive EPSDT benefits include periodic well-child medical, dental, vision and hearing assessments (health screenings), immunizations, laboratory tests, health education, developmental assessment and anticipatory guidance.

### The EPSDT Program offers the following:

- Outreach and education emphasizing the importance of prevention to parents, EPSDT practitioners, and community organizations.
- A monthly report to practitioners identifying their members due for EPSDT screens and/or immunizations.
- Member educational materials – accessible via [www.passporthealthplan.com](http://www.passporthealthplan.com) or by contacting an EPSDT Outreach Representative.
- PHP's Child and Adolescent Preventive Health Clinical Practice Guidelines/ EPSDT Periodicity Schedule, based on the recommendations of the American Academy of Pediatrics (AAP) Standards of Care, are also available via [www.passporthealthplan.com](http://www.passporthealthplan.com).
- EPSDT Outreach Representatives may be reached at (502) 585-8210 or (800) 578-0636, ext. 78210.

#### Please Note:

Many of the member education materials are also available in Spanish and may be downloaded from Passport Health Plan's web site at [www.passporthealthplan.com](http://www.passporthealthplan.com).

### Yes, You Can! Program (Smoking Cessation)

#### Assisting Practitioners in Improving the Health of our Members Who Smoke

The goal of the Yes, You Can! Program is to help our members become and remain smoke free through a coordinated team approach, including pharmacological and behavioral components.

The Yes, You Can! Program offers the following:

- The Yes, You Can! Progress Report outlines individual members' compliance with the smoking cessation program.
- Member educational materials – accessible via the Plan's web site, [www.passporthealthplan.com](http://www.passporthealthplan.com), or by calling the Yes, You Can! program coordinators.

If you know a non-pregnant Passport Health Plan adult (over age 18 years) who would benefit from this program, please submit his/her information on [www.passporthealthplan.com](http://www.passporthealthplan.com) or call us at (800) 578-0636, ext. 78366 or 78361.

#### Questions or Suggestions?

Call your Provider Relations representative or the Provider Relations department at (502) 585-7943 or the Health Management Department Manager at (502) 585-8364.

Please note: Many member education materials are also available in Spanish and may be downloaded from the Plan's web site at [www.passporthealthplan.com](http://www.passporthealthplan.com).

# Get Involved – Join a Passport Health Plan Committee

We are always working to improve our provider relationships, while also enhancing our services to members. One way we combine these efforts is to collaborate with participating practitioners on our various clinical committees. We value input from our practitioners and we encourage you to join any of the following committees:

## **Quality Medical Management Committee (QMMC)**

- Provide direction and oversight for clinical care and services.
- Review and approve Quality Improvement (QI) and Utilization Management (UM) program descriptions.
- Review and approve clinical and preventive health guidelines and administrative policies.
- Review member complaints for quality of care and sentinel events with the potential for adverse effects on members.
- Review aggregate data and determine corrective actions for member complaints, transfers, surveys and provider audits results.

## **Women’s Health Committee**

- Provide direction regarding health care services for women, including perinatal care.
- Review and approves medical and administrative policies, clinical guidelines, work plans and programs that impact the health care of female members.
- Review sentinel events having the potential for adverse effects on members.
- Review maternal and fetal deaths.
- Review issues and results of the Mommy & Me program, including participation rates, birth outcomes and health outcome results.

## **Child & Adolescent Health Committee**

- Provide direction regarding the care provided to newborns and children up to age 21.
- Review and approve medical and administrative policies, clinical guidelines, workplans, and programs that impact the health care of newborns and children up to 21 years old.
- Review member complaints for quality of care and sentinel events having the potential for adverse effects on children and adolescents.
- Review all unexpected deaths.
- Review issues and results of the EPSDT program, including immunizations, preventive health visits and special studies.

## **Medical Criteria/Policy Review Committee**

- Review, approve and provide recommendations for adoption of new technologies and new applications of existing technology. Review procedures for applying the criteria and/or policies.
- Review, approve, and provide recommendations for adoption of medical criteria, guidelines, medical policies, and protocols.

### **Pharmacy Committee**

- Oversee and provide direction regarding pharmacy issues.
- Review and approve the preferred drug list as defined by the Plan, including clinical guidelines, work plans, pharmacy program design and outcomes, and quality and utilization management pharmacy-related issues.
- Analyze clinical quality and drug categories.

### **Credentialing Committee**

- Implement all credentialing/recredentialing processes for practitioners in accordance with Passport Health Plan and NCQA (National Committee for Quality Assurance) standards.
- Review all practitioner applications.
- Administer credentialing/recredentialing policies, trends and credentialing issues.

### **How to Join**

To join a committee or for more information, please contact Jacqueline R. Simmons, M.D., MPH, C.P.E., Chief Medical Officer, at (502) 585-7065.

### PASSPORT HEALTH PLAN CAPITATION PAYMENT ROSTER

Report generated: April 06, 2009 for Capitation Cycle 4/1/2009

| CHECK REFERENCE ID: | 2609084350209864 | CAPITATION TYPE:         | Primary         | LINE OF BUSINESS: | 1300 | CHECK DATE: | 4/1/2009 | NET AMT:      | \$8270.85 |
|---------------------|------------------|--------------------------|-----------------|-------------------|------|-------------|----------|---------------|-----------|
| PAYEE:              | 50001527         | DR. PAYNE AND ASSOCIATES | 1000 SHADY LANE | LOUISVILLE        |      | KY          | 40202    | PAYEE TAX ID: | 611368595 |
| NPI ID:             | 1958383455       |                          |                 |                   |      |             |          |               |           |

| MEMBER NAME                | MEMBER ID | ADDRESS           | CITY, ST, ZIP            | PHONE        | NPI ID     | PCP ID   | SEX | AGE | EFF DATE  | CAP EARN DATE | CAP AMT  | MM     |
|----------------------------|-----------|-------------------|--------------------------|--------------|------------|----------|-----|-----|-----------|---------------|----------|--------|
| <b>Current</b>             |           |                   |                          |              |            |          |     |     |           |               |          |        |
| GRAHAM, ANNA               | 60090362  | 3354 SKYLINE      | LOUISVILLE, KY 402065631 | 502-298-1384 | 1427049006 | 50001648 | F   | 1   | 12/1/2009 | 4/1/2009      | \$15.73  | 1.00   |
| OKLEY, CARRIE              | 60158432  | APT 3             | LOUISVILLE, KY 402433125 | 502-254-4215 | 1427049006 | 50001648 | F   | 1   | 12/1/2009 | 4/1/2009      | \$7.47   | 1.00   |
| POOLE, GENE                | 60343215  | 204 LAKELAND      | LOUISVILLE, KY 402102259 | 502-298-9814 | 1427049006 | 50001648 | M   | 1   | 12/1/2009 | 4/1/2009      | \$55.23  | 1.00   |
| VADLER, ELLA               | 60065314  | 11943 OLD HICKORY | LOUISVILLE, KY 402273365 | 502-246-8564 | 1427049006 | 50001648 | F   | 1   | 12/1/2009 | 4/1/2009      | \$6.54   | 1.00   |
| <b>Retrospective Adds</b>  |           |                   |                          |              |            |          |     |     |           |               |          |        |
| GRAHAM, ANNA               | 60090362  | 3354 SKYLINE      | LOUISVILLE, KY 402065631 | 502-298-1384 | 1427049006 | 50001648 | F   | 1   | 12/1/2009 | 4/1/2009      | \$0.00   | .52    |
| OKLEY, CARRIE              | 60158432  | APT 3             | LOUISVILLE, KY 402433125 | 502-254-4215 | 1427049006 | 50001648 | F   | 1   | 12/1/2009 | 4/1/2009      | \$0.00   | 1.00   |
| POOLE, GENE                | 60343215  | 204 LAKELAND      | LOUISVILLE, KY 402102259 | 502-298-9814 | 1427049006 | 50001648 | M   | 1   | 12/1/2009 | 4/1/2009      | \$0.00   | .52    |
| VADLER, ELLA               | 60065314  | 11943 OLD HICKORY | LOUISVILLE, KY 402273365 | 502-246-8564 | 1427049006 | 50001648 | F   | 1   | 12/1/2009 | 4/1/2009      | \$9.60   | .23    |
| <b>Retrospective Terms</b> |           |                   |                          |              |            |          |     |     |           |               |          |        |
| GRAHAM, ANNA               | 60090362  | 3354 SKYLINE      | LOUISVILLE, KY 402065631 | 502-298-1384 | 1427049006 | 50001648 | F   | 1   | 12/1/2009 | 4/1/2009      | \$0.00   | (.40)  |
| OKLEY, CARRIE              | 60158432  | APT 3             | LOUISVILLE, KY 402433125 | 502-254-4215 | 1427049006 | 50001648 | F   | 1   | 12/1/2009 | 4/1/2009      | (\$7.47) | (1.00) |
| POOLE, GENE                | 60343215  | 204 LAKELAND      | LOUISVILLE, KY 402102259 | 502-298-9814 | 1427049006 | 50001648 | M   | 1   | 12/1/2009 | 4/1/2009      | \$0.00   | (.25)  |
| VADLER, ELLA               | 60065314  | 11943 OLD HICKORY | LOUISVILLE, KY 402273365 | 502-246-8564 | 1427049006 | 50001648 | F   | 1   | 12/1/2009 | 4/1/2009      | \$0.00   | (.86)  |

Grand Totals for: 50001647 METRO PEDIATRIC ASSOCS PLLC  
Total Members

Total of Manual Adjustments: \$8,115.85  
Net Capitation Paid: \$8270.85

#### EXPLANATION OF MANUAL ADJUSTMENTS

| CODE | DESCRIPTION              | NPI ID     | PROVIDER ID | MEMBER ID | MEMBER NAME | EARN DATE  | AMOUNT   |
|------|--------------------------|------------|-------------|-----------|-------------|------------|----------|
| MA09 | EPCP Encounter Incentive | 1427049006 | 50001648    |           |             | 02/01/2009 | \$117.00 |
| MA09 | EPCP Encounter Incentive | 1104919281 | 50013898    |           |             | 02/01/2009 | \$38.00  |

#### Membership Summary

| AGE/GENDER Breakdown | MEMBERS |
|----------------------|---------|
| 19 - 39M             | 2       |
| 40 - 64F             | 3       |
| 40 - 64M             | 3       |
| 65+F                 | 4       |
| 65+M                 | 0       |
| Up to 1 Yr F         | 50      |
| Up to 1 Yr M         | 43      |
| 1 - 1F               | 94      |
| 1 - 1M               | 85      |
| 2 - 4F               | 84      |
| 2 - 4M               | 74      |
| 5 - 14F              | 194     |
| 5 - 14M              | 204     |
| 15 - 18F             | 49      |
| 15 - 18M             | 23      |
| 19 - 39F             | 4       |