Provider Manual
Section 3.0
Provider Roles and Responsibilities

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PASSPORT HEALTH PLAN

3.0 Provider Roles and Responsibilities

3.1 Confidentiality

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

All providers must comply with state and federal laws and regulations and Passport Health Plan's policies on the confidential treatment of member information in all settings.

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

Providers are authorized to share members' protected health information with Passport Health Plan for the purposes of treatment, payment, and health care operations recognized as receiving a request to process claims and administer reimbursement for the same.

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

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

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

Provider agrees to cooperate with Passport's Quality Management Program and all other quality management activities, including the use of performance data. Practitioner performance data may include, but is not limited to, medical records, practitioner experience, patient experience, and

claims. The data received will be used in the development or improvement of activities and initiatives, credentialing activities, and public reporting to consumers. Passport Health Plan will use member information for quality studies, health outcomes measurements, and other aspects of health plan operations and will de-identify the information as dictated by federal privacy legislation.

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

Passport Health Plan members are permitted to access, copy, and inspect their medical records upon request. One copy of a member's complete medical record must be made available from the provider upon request at no charge and in accordance with KRS 422.317.

3.2 The Role of the Primary Care Provider (PCP)

A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals.

Additionally, an Obstetrician/Gynecologist can serve as a PCP to a member with obstetrical or gynecologic health care needs, disability or chronic illness provided the specialist agrees to provide and arrange for all appropriate primary and preventive care. Passport Health Plan provides instructional materials that encourage members to seek their PCP's advice before accessing medical care from any other source except for direct access services and emergency services. It is imperative the PCP's staff fosters this idea and develops a relationship with the member that will be conducive to continuity of care.

Primary care physician residents may function as PCPs. The PCP serves as the member's initial and most important point of contact with Passport Health Plan. This role requires a responsibility to both Passport Health Plan and the member. Although PCPs are given this responsibility, Passport will retain the ultimate responsibility for monitoring PCP actions to ensure they comply with Passport and DMS policies.

Specialty providers may serve as PCPs under certain circumstances, depending on the member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the member or family, the specialist, and Passport's medical director. The member has the right to appeal such a decision in the formal appeals process.

Passport will monitor the PCP's actions to ensure he/she complies with Passport and DMS policies including but not limited to the following:

- Maintaining continuity of the member's health care;

- Exercising primary responsibility for arranging and coordinating the delivery of medically-necessary health care services to members;
- Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within Passport's network;
- Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services, including periodic preventive and well-care services, and providing appropriate and timely reminders to members when services are due;
- Discussing Advance Medical Directives with all members as appropriate. See Section 3.4.4. Advanced Directives;
- Providing primary and preventative care, recommending or arranging for all necessary preventive health care, and adhering to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule and the Vaccines For Children (VFC) immunization schedule for each Passport Health Plan member younger than 21 years of age. Documenting all care rendered in a complete and accurate medical record that meets or DMS specifications;
- Screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders;
- Arranging and referring members when clinically appropriate, to behavioral health providers;
- Providing periodic physical examinations as outlined in the Preventive Health Guidelines;
- Providing routine injections and immunizations;
- Providing or arranging 24-hours a day, seven days a week access to medical care. For additional information, see Section 4.2 – Office Standards;
- Arranging and/or providing necessary inpatient medical care at participating hospitals.
- Providing health education and information; and,
- Passport members have the right to a second opinion. If the member requests a second opinion, the PCP should complete a referral to a participating specialist. If there is not a specialist within the network, the PCP must call Passport's Utilization Management department at (502) 578-0636 to request an authorization to a non-participating specialist.

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

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

Dual eligible members, members who are presumptively eligible - pregnant, disabled children, and foster care children are not required to have a PCP but may request a PCP. All other members either make a selection or have Passport select a PCP for their medical home. The name and telephone number of the PCP or group selected appears on the member's Passport Health Plan

Identification Card. Please see Section 2.4.1 for more information about member eligibility and identification.

Each PCP receives a monthly member panel list of those members who have selected or been assigned to him or her. It is advisable to verify eligibility at, or before, the time of service using one of the online eligibility tools, (NaviNet or KyHealth Net). Even with this verification, there are times when DMS retroactively terminates eligibility for certain members. In these circumstances, Passport may decide to recoup any amounts paid for these patients.

Coordination between Primary Care and Behavioral Health providers is a critical component of promoting health and wellness for Passport Health Plan members. We encourage primary care providers to review the behavioral health section of this provider manual for more information about the covered benefits, authorization requirements and other important behavioral health issues. Members never need a referral for behavioral health services. If you need assistance establishing behavioral health services for a Passport member, we encourage you to call our 24-hour Behavioral Health Services Hotline at 855-834-5651.

To support our goal of integrated behavioral and physical health care, we offer a comprehensive prescription drug intervention program designed to alert our primary care providers of sub-optimal dosing, polypharmacy or other key issues for members who are prescribed psychotropic medications.

The incorporation of comprehensive Behavioral and Mental Health Services brings about many changes. Working with the DMS and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Passport will highlight the expectations for screening for behavioral health disorders by PCP's in numerous settings. PCP's may continue to provide any clinically appropriate Behavioral Health Services within the scope of their practice. The training sessions that are offered will review this in greater detail.

New expectations extend to Behavioral Health specialists in that they are expected to communicate to the PCP the initial evaluation. Additionally, they are expected to provide, at minimum, quarterly reports of the member's condition with the consent of the member or their legal guardian.

3.3 The Role of Specialists and Consulting Practitioners

Specialty care practitioners provide care to members referred by their PCP. The specialty care practitioner must coordinate care through the PCP and must obtain necessary prior authorization for hospital admissions or specified diagnostic testing procedures. Refer to Section 5.3, "Authorization Requirements," for a complete listing of procedures requiring prior authorization from Passport Health Plan's Utilization Management department.

Except for Direct Access Services and a few other services (see Section 6.1, "Member Self-Referral (Direct Access)," all members must obtain a valid referral from the PCP prior to receiving services from most specialty care providers/practitioners.

Specialty practitioners must review the referral section of the PCP referral form to determine which services have been referred. The specialist must contact the PCP if he or she intends to provide services in excess of those initially requested. In these cases, the PCP must generate a second referral to cover the additional services.

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

For electronic referral submission guidelines via NaviNet, please refer to Section 6.3.

3.4 Responsibilities of All Providers

3.4.1 Provider and Member Communications

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

3.4.2 Medical Records

Documentation in the medical record shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided to the member. The member record shall be signed by the provider of service.

Medical record confidentiality policies and procedures shall comply with state and federal guidelines, HIPAA and Passport Health Plan policy. HIPAA privacy and security audits will be performed to assure compliance as required by Passport Health Plan's contract with the DMS.

If a member were to change PCP's, medical records should be forwarded to the new PCP within ten (10) days' of receipt of a signed request.

See Section 4.5 for additional detail regarding Medical Record Keeping

3.4.3 Treatment Consent Forms

Treatment consent forms for specific procedures must be completed and signed by the member. A copy of the appropriate treatment consent form must be maintained in the member's record. The following original treatment consent forms must be sent to the Plan, along with a copy of the claim, as required by state and federal laws. In accordance with Title VI, all vital documents (i.e. treatment and consent forms) must be translated into patient's preferred language. These treatment consent forms are available from DMS and in Section 19 of this *Provider Manual*:

MAP-250 Consent for Sterilization
MAP-251 Hysterectomy Consent Form
MAP-235 Certification Form for Induced Abortion or Induced Miscarriage
MAP-236 Certification Form for Induced Premature Birth

For additional information on completion of the above forms, please contact Passport Utilization Management at (800) 578-0636 Additional information on family planning services is located in Section 17.

3.4.4 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. Matters regarding application of advanced directives and related legal matters are defined in Kentucky Statutes, some of which are outlined in greater detail below; however, these should not be considered exhaustive lists. State and federal laws also provide guidance to these policies. Policies will be updated as soon as possible after guidance from these organizations is received.

A member who is 18 years of age or older and who is of sound mind may make a written advance 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 living will form is included in KRS 311.625. The form can be reviewed at http://www.lrc.ky.gov/krs/311%2D00/625.pdf.

A copy of the living will may also be obtained through the Office of the Attorney General website at http://ag.ky.gov/civil/consumerprotection/livingwills.htm. Advance directives may be revoked

in writing, by an oral statement, or by tearing up the written living will. The revocation is effective immediately.

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

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

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

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

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

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

3.4.5 Suspected Child or Adult Abuse or Neglect

Cases of suspected child or adult abuse or neglect might be uncovered during examinations. Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is an act of

commission or neglect.

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

To facilitate the reporting of suspected child abuse and neglect cases, legislation affecting the reporting of child abuse (KRS 620.030) is printed on the reverse of the Child Abuse Reporting Form (DSS-115). These forms may be obtained from the local Department for Social Services office.

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

3.4.6 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 prohibit 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 in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the claim.

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 and/or Medicare

programs.

Passport has developed a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. Our plan includes:

- Enforcement of standards through disciplinary guidelines;
- Provisions for internal monitoring and auditing of the member and provider;
- Provisions for internal monitoring and auditing of subcontractors. Should issues be identified, the subcontractor shall be placed on a corrective action plan (CAP). DMS will be notified of the CAP.
- Processes to collect outstanding debt from providers;
- Procedures for appeals;
- Compliance with the expectations of 42 CFR 455.20 by employing a method of verifying with the member whether the services billed by the provider were received by randomly selecting a minimum sample of 500 Claims on a monthly basis; and,
- Programs that run algorithms and edits on Claims data to identify outliers and patterns and trends.

Passport's Program Integrity Unit (PIU) conducts fraud, waste and abuse investigations for Passport. The PIU is comprised of staff from a broad range of Passport departments. All Passport fraud, waste and abuse activity is reported to the DMS. PIU staff meeting regularly with the state Medicaid Fraud Control Unit (MFCU) which includes representatives from the DMS, the Office of the Inspector General (OIG) and the Office of the Attorney General (OAG).

Providers are required to cooperate with the investigation of suspected Fraud and Abuse. If you suspect fraud, waste or abuse by a Passport member or provider, it is your responsibility to report this information immediately. Please contact:

Passport Health Plan Compliance Hotline: (855) 512-8500