Provider Manual
Section 7.0
Benefit Summary and Exclusions

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7.0 Benefit Summary and Exclusions

7.1 Benefit Summary

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

- Alternative birthing center services.
- Ambulatory surgical center services.
- Behavioral Health Services, including:
  - Community Mental Health Services.
  - Inpatient behavioral health services.
  - Outpatient Mental Health Services.
  - Psychiatric Residential Treatment Facilities (Level I and Level II.)
- Chiropractic services.
- Dental services, including oral surgery, orthodontics, and prosthodontics.
- Durable medical equipment (DME), including prosthetic and orthotic devices and disposal medical supplies.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and special services.
- End stage renal dialysis services.
- Family planning clinic services in accordance with federal and state law and judicial opinion.
- Hearing services, including hearing aids for members younger than age 21.
- Home health services. Private Duty Nursing (2,000 hours per year)
- Hospice services.
- Independent laboratory services.
- Inpatient hospital services.
- Intensive Case Management.
- Meals and lodging for appropriate escort of members.
- Medical detoxification.
- Medical services, including those provided by physicians, advanced practice registered nurses, physicians assistants and FQHCs/ primary care centers and rural health clinics.
- Organ transplant services not considered investigational by the FDA.
- Other laboratory and x-ray services.
- Outpatient hospital services.
- Pharmacy and limited over-the-counter drugs including mental/behavioral health drugs.
- Podiatry services.
- Preventive health services, including those currently provided in public health departments, FQHCs/primary care centers, and rural health clinics.
- Specialized Case Management Services for Members with Complex, Chronic Illnesses (includes adult and child targeted case management).
- Targeted Case Management.

- 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.
- Specialized Children's Services Clinics.

NOTE: Some Services require an authorization; refer to section 5 of the Provider Manual for a full list of services that require an authorization

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

7.1.1 Allergy Testing and Treatment

Consultation and testing by an allergist is covered for any member with a referral from the member's PCP. Allergy injections may be administered by either an allergist or by the member's PCP.

7.1.2 Behavioral Health Service

Passport has contracted with Beacon Health Strategies, LLC to administer comprehensive behavioral health benefits for Passport members beginning January 2013.

Section 16 of this provider manual provides comprehensive detail of this service.

7.1.3 Dental Care

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

Specialty dental services do not require a referral, for example, orthodontic evaluation (see Section 6.1, "Member Self-Referral (Direct Access)") and are only covered for children younger than age 21.

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

7.1.4 Durable Medical Equipment (DME)

Passport covers medically-necessary durable medical equipment (DME) and supplies that are covered under the fee-for-service Medicaid program. Members are required to have a

practitioner's order to receive the covered DME or supplies (see Section 5.6.3).

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

7.1.5 Family Planning Services

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

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

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

Some family planning services require authorization. For more information on benefits and/or a list of providers, refer to Section 14, "Family Planning" in this Provider Manual. Please direct members to call our Member Services department at (800) 578-0603.

7.1.6 Home Health Care

When medically appropriate, home health care may be a good alternative to hospitalization. Home health care, including skilled and unskilled nursing, may be medically appropriate at other times as well. Passport's Utilization Management department must prior authorize all home health services. Please see Section 5 for authorization requirements.

7.1.7 Laboratory Services

All laboratory work should be sent to participating laboratories. For assistance locating a participating laboratory, providers may go to our online directory at http://passport.prismisp.com/. Choose "Other Services" > Laboratory Services.

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

7.1.8 Prenatal Care

A referral is not necessary to an obstetrical provider, and a member may self-refer to any

participating obstetrical provider. The OB provider should confirm eligibility. Providers are no longer required to obtain global authorization for antepartum cases. However, you must submit the initial ACOG or ACOG-like assessment which includes the member's medical and obstetric history within two business days of a member's initial prenatal visit. You can email the completed form to Passport.GlobalAuths@passporthealthplan.com or fax it to (502) 585-7970.

7.1.9 Prescriptions

Prescription benefits are administered for Passport members through a pharmacy benefits manager (PBM). Members must have prescriptions filled at participating pharmacies. For assistance locating a participating pharmacy, members should call Member Services (800) 578-0603 or search the on-line pharmacy directory.

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

7.1.10 Presumptive Eligibility

Presumptive Eligibility (PE) is a process in Kentucky which expedites an individual's ability to receive temporary healthcare coverage under Medicaid. There are two ways an individual may be considered presumptively eligible.

- Pregnant: Women who are pregnant may receive prenatal care while their eligibility for full Medicaid benefits is determined. This can only be done at a DMS certified provider and will have defined benefits per DMS. Also member will be covered until the last day of the second month or when Medicaid application is filed and approved or denied.
- Hospital: Authorized hospital employees may deem any individual presumptively eligible to receive immediate Medicaid coverage until the last day of second month or when Medicaid application is filed and approved or denied. Same benefits as a fully eligible member just shorter time frame.

In both cases, a qualified member will be assigned to an MCO and the information should be available on Ky Health Net the following day. The member may change MCOs and it will be effective the next feasible month. The member will receive a Medicaid card at the time of service. This information is to make Providers aware of this avenue of Medicaid eligibility, but no provider action is necessary.

7.1.11 Skilled-Nursing Facility

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

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

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

7.1.12 Transportation

Emergency transportation and stretcher services are covered by Passport.

Members may be eligible for non-emergency transportation services to and from medical appointments. This is a covered benefit by DMS.

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

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

7.1.13 Vision Care

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

An annual routine eye refraction exam is covered for adult and child members. Eyeglasses are a benefit for children under age 21. Some exceptions apply to KCHIP members. Members may obtain a list of vision practitioners by calling Member Services at (800) 578-0603 or by checking the provider directory on the Plan's website at www.passporthealthplan.com.

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

7.2 Services Covered Outside Passport Health Plan

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

- Nursing facility services.
- Early-intervention services for children.
- School-based services for any child member younger than the age of 21 with an individualized education plan.
- Waiver services.
- Nonemergency transportation.

Additional information about these services can be obtained from DMS.

7.3 Non-Covered Services

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

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

The following are services currently not covered by the Kentucky Medicaid Program:

- Any laboratory service performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual providers of any laboratory service;
- Cosmetic procedures or services performed solely to improve appearance;
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization, etc.);
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions;
- Paternity testing;
- Personal service or comfort items;
- Post mortem services;
- Services including, but not limited to, drugs that are investigational, mainly for research purposes or experimental in nature;
- Sex transformation services;
- Sterilization of a mentally incompetent or institutionalized member;
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services;
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein; and,
- Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.

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