Provider Manual
Section 5.0
Utilization Management

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5.0 Utilization Management

5.1 Utilization Management

Utilization Management (UM) is the evaluation of the medical necessity, quality, appropriateness and efficiency of the use of health care services, procedures and facilities under the provisions of the applicable health plan benefits. Medically Necessity is defined under 907 KAR 3:130 or other applicable Kentucky Laws or Regulations and provided in accordance with 42 CFR 440:230, including children's services pursuant to 42 U.S.C. 1396d(r).

Utilization Management decision making is based only on appropriateness of care and service, existence of coverage and available criteria. Passport does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or services and Passport does not encourage decisions that result in under-utilization.

All Passport participating providers are required to obtain prior authorization from the Plan's UM department for inpatient services and specified outpatient services. Failure to submit a request for authorization may result in a denial.

Because of frequent changes in member eligibility for Medicaid coverage, providers should verify continued eligibility via the Plan's web site, www.passporthealthplan.com or by calling Provider Services at (800) 578-0775.

Hours of Operation

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

Department	Phone Number	Fax Number
General Number	(800) 578-0636	(502) 585-7989
Concurrent Review	(502) 585-7331	(502) 585-7989
Retrospective Review	(502) 585-7972	(502) 585-8207
Home Health	(502) 585-7320	(502) 585-8204
Home Infusion	(502) 585-8285	(502) 213-8958
DME	(502) 585-7310	(502) 585-7990
Prescribed Pediatric Extended Care (PPEC)	(502) 585-8286	(502) 213-8921
Cosmetics Request can be sent via confidential email to: Passport UMCosmetics@Passporthealthplan.com	(502) 585-7069	(502)213-8998

The following services are administered in partnership with eviCore:

Radiology	(877) 791-4099	(888) 693-3210
Outpatient Therapy (PT OT Speech)	(877) 791-4099	(855) 774-1319
Chiropractic *	(877) 791-4099	(855) 774-1319
Pain Management Injections	(877) 791-4099	(800) 540-2406

Authorization for Radiology, Therapy, Chiropractic or Pain Management Service may be requested on-line at WWW.Medsolutionsonline.com

*****Chiropractic: 26 visit limit; all visits require authorization

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

5.2 Review Criteria

The UM Department utilizes InterQual® Criteria during the review process. In the event InterQual® Criteria is not available for a specific request, the reviewer may use internal medical policies which are reviewed and approved by actively practicing practitioners in the community. The Quality Medical Management Committee (QMMC) approves both the use of InterQual Criteria® and Medical Polices.

Criteria for which a decision was based may be requested by a provider. Criteria are made available as allowed under copyright limitations and trademark considerations. To request the criteria for which a decision was based, you may contact the UM Department at (800) 578-0636.

5.3 Authorization Requirements

Services Requiring Authorization	
All Inpatient Admissions (see exclusions below)	Inpatient Rehabilitation
Prescribed Pediatric Extended Care (PPEC)	DME Rental / Purchase > $500.00 All E1399 DME Codes
Orthotics / Prosthetics > $500.00	Enteral Products > $500.00
Home Infusion / Home I.V. Therapy (IVT)	Home Health Services / Private Duty Nursing (PDN - 2,000 hours per year)
High cost Medications > $400.00 including Synagis (Excludes chemotherapy)	Ocular Photodynamic Therapy/with Verteporfin (Visudyne)
Neuropsychological Testing	Stem Cell/Progenitor Cell Retrieval
Radiology: PET, MRA, MRI, CTA, CT, Select Cardiac Imaging (Authorization not required if performed: While Inpatient, In the E.R., Observation)	Outpatient Therapy: Physical, Occupational and Speech
Pain Management Injections (see codes below)	Chiropractic (26 visits per year limit; All visits require authorization)
Outpatient Cardiac / Pulmonary Rehabilitation	Abortion / Termination of Pregnancy
Cosmetic Procedures / Services	EPSDT Special Services
Experimental / Investigational Procedures or Services	Services performed by a non-participating provider including MD office visits

All requests are subject to coverage, benefits and eligibility

Provider Notification Requirements

Providers must notify the UM department within the required times frames; failure to notify the UM

department may result in an administrative denial of the request. An administrative denial may be appealed.

- Elective : Prior to the elective / scheduled procedure / service
- Urgent / Emergent Admission: Within one business day of the admission

The UM Department will accept the hospital's or the attending physician's request for prior authorization; however, neither party should assume that the other has obtained prior authorization.

Providers may contact the UM Department by phone or fax. Fax forms are available on the Passport Website; requests may be submitted using the Passport fax forms or the Universal Fax form.

Information required for review

When requesting a review, at a minimum, documentation must include:

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

Requests not meeting the established medical necessity criteria will be referred to Passport's Medical Director for further review and evaluation.

Inpatient Authorization Exclusions: Maternity & Newborns

- Normal Vaginal Delivery: If the inpatient stay is less than or equal to 3 days, no authorization is required
- Authorization is required for:
  - All Cesarean Sections
  - All Scheduled inductions
  - All Non-par providers, regardless of delivery type
- An infant born by Normal Vaginal Delivery (NVD) does not require authorization until day four (4). If an infant born via NVD stays <= 3 days, authorization is not required.
- An infant born by C-Section does not require authorization until day six (6). If an infant born via C-Section stays <= 5 days, authorization is not required.

Observation Stays

Observation at a participating facility does not require authorization. Observation is defined as one overnight. If a member is admitting following an observation stay, the date of the inpatient authorization begins on the date the inpatient order is written.

Pain Management CPT Codes requiring authorization

CPT Codes					
27096	62365	64490	62350	63685	64495
62310	63650	64491	62351	63688	64510
62311	63655	64492	62355	64479	64520
62318	63663	64493	62360	64480	64633
62319	63664	64494	62361	64483	64634
62362	64484	64635	64636		

Durable Medical Equipment (DME)

DME Purchase

DME items with billable charges greater than $500 require an authorization. Requests for authorization of purchase MUST be received PRIOR to the end of the rental period.

DME Rental

Authorization requirements of rentals are determined by the billable price of the item being rented. Rental charges will be applied to purchase price.

Miscellaneous DME

- All items requiring customization or accessories require prior authorization.
- All mini-nebulizers will be a purchase only item and do not require prior authorization.
- Maintenance, repair, or replacement in excess of $500 must have prior authorization from the UM department.
- Enteral products with allowable amounts greater than $500 for a month's supply require an authorization.

The following is a list of purchases with authorization requirements by quantity; Authorization is required is quantity is exceeded:

Description	Quantity, per month
Adult disposable brief / diaper / pull on	192
Pediatric disposable brief / diaper / pull on	192
Youth disposable brief / diaper / pull on	192
Disposable under pad	150
Disposable incontinence liner / shield / guard / pad / undergarment	192

This is not an all-inclusive list. Check DMS DME fee schedule as limits are subject to change

Inpatient Only Codes:

In accordance with the Centers for Medicare and Medicaid Services (CMS) billing requirements, select surgical procedures must be performed in the inpatient setting.

Please reference the current Medicare IP Only list for appropriate codes.

5.4 Retrospective Authorization

Retrospective review of inpatient services is performed when the patient was not a member of Passport prior to or at the time of the service. Outpatient services do not require retrospective review by Utilization Management for members whose eligibility is determined retrospectively.
Providers have 60 days from the notification of eligibility on retrospectively enrolled members to submit medical records for review and utilization management authorization request. A decision and written notification is provided within thirty days of receipt of the medical information for the retrospective review request. An administrative denial is issued for retrospective requests when the provider fails to request a utilization management review of the medical record within the timeframe specified.

The provider is notified of all decisions regarding retrospective reviews. In cases of denial, a written notification is provided.

Requests received beyond 60 days from the card issue date or from the provider's documentation of the date when they were aware of the member's eligibility will be administratively denied.

Send requests for retrospective review to:

Utilization Management Retrospective Review
5100 Commerce Crossings Drive
Louisville, KY 40229

The phone number for retrospective review is: (502) 585-7972 or fax to: (502) 585-8207 (for large chart review, please send records via mail).

5.5 Denials

An authorization request for a service may be denied for failure to meet guidelines, protocols, medical policies, or failure to follow administrative procedures outlined in the Provider Contract or this Provider Manual. If pre-authorization criteria are not met resulting in a denied claim, members must be held harmless for denied services.

A Passport Medical Director renders all medical necessity denial decisions. Whenever a denial is issued, Utilization Management provides the name, telephone number, title, and office hours of the Medical Director who rendered the decision. The Passport Medical Director is available to discuss any decision rendered with the attending practitioner.

An administrative denial is issued for those services for which the provider has not followed the requirements set forth in the Provider Contract or this Provider Manual. For example, an administrative denial may be issued for failure to prior authorize an elective service, procedure, or admission. It may also be issued for failure to notify Utilization Management within one business day of an emergency service, procedure, or admission.

A provider may appeal an administrative denial by submitting the appeal request in writing to:

Clinical Appeals Department
5100 Commerce Crossings Drive
Louisville, KY 40229

To speak with the Medical Director or to the nurse reviewer regarding a denial, please contact Utilization Management at (800) 578-0636.

5.6 Prior Authorization for Members with Medicare / Tricare / Other Carrier

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

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

Authorization is required for members with other carrier as primary except for Medicare / Tricare.

5.7 Inpatient Skilled-Nursing Facility

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