

Passport Advantage  
Provider Manual  
Section 3.0  
Provider Roles and Responsibilities

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# 3.0 Provider Roles and Responsibilities

## 3.1 Confidentiality

In accordance with federal and state laws, Passport Advantage has established confidentiality policies and practices for its own operation and to outline expectations to its provider network. To obtain a copy of Passport Advantage's Notice of Privacy Practices, please visit the Member Center of [www.passportadvantage.org](http://www.passportadvantage.org).

All providers are to understand and comply with Passport Advantage'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/practitioners are authorized to share members' protected health information with Passport Advantage for the purposes of treatment, payment, and health care operations according to the member signature on the Medicaid and Medicare applications.

Passport Advantage and its providers/practitioners 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 Advantage 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 Advantage to another organization as permitted by routine or special consent will be protected and secured according to Passport Advantage's privacy policies and procedures.

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

Passport Advantage 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 state administrative regulations.

To obtain a copy of Passport Advantage's Notice of Privacy Practices (NPP), please visit the Member Center of [www.passportadvantage.org](http://www.passportadvantage.org).

## **3.2 Reporting and Compliance Obligations**

### **Cooperation in Meeting Centers for Medicare & Medicaid Services (CMS) Requirements**

Passport Advantage must provide to CMS information necessary for CMS to administer and evaluate the Medicare Advantage program and establish and facilitate a process for current and prospective members to exercise a choice in obtaining Medicare services. Such information includes Plan quality and performance indicators such as disenrollment rates, information on member satisfaction, and information on health outcomes. Participating providers must cooperate with Passport Advantage in its data reporting obligations by providing Passport Advantage with any information needed to meet its obligations.

### **Certification of Diagnostic Data**

Passport Advantage is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member and a supplier, practitioner, physician, or other provider (encounter data). Participating providers who furnish diagnostic data to assist the Plan in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

## **3.3 The Role of the Provider of Choice**

Passport Advantage members are not required to select a Primary Care Provider (PCP), but members are encouraged to choose a Provider of Choice.

Provider of Choice means a licensed or certified health care provider, including: a doctor of medicine; a doctor of osteopathy; an advanced registered nurse practitioner, including a nurse practitioner, nurse midwife and clinical specialist; or a clinic (including a primary care center and rural health clinic). The Provider of Choice is to function within his/her scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a practitioner possessing admitting privileges, and agrees to provide primary health care services to members 24 hours a day, seven days a week. For a member who has gynecological or obstetrical health care

needs, disability or chronic illness, the Provider of Choice may be a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

The Provider of Choice serves as the member's initial and most important contact for receiving medically necessary covered services. The Provider of Choice provides or coordinates care for each member. This includes:

- maintaining continuity of care for all members by serving as Provider of Choice.
- exercising primary responsibility for arranging and coordinating the delivery of medically-necessary health care services to members.
- maintaining a current medical record for each member, including documentation of all medical services (Provider of Choice and specialty) provided to the member.
- providing periodic physical examinations as outlined in the Preventive Health Guidelines.
- providing routine injections and immunizations.
- providing or arranging 24-hours a day, 7 days a week access to medical care.
- assisting members to needed specialty care and other medically necessary services.
- arranging and/or providing necessary inpatient medical care at participating hospitals.
- providing health education and information.
- discussing advance medical directives with all members as appropriate, and documenting in medical records (in a prominent place) if a member has executed advanced directives.
- maintaining records of periodic preventive services and providing appropriate timely reminders to members when services are due.

All member education materials encourage members to seek their Provider of Choice's advice before accessing medical care from any other source, except for emergency services.

Referral forms are not required for Passport Advantage members. Members can access services from both network and non-participating Medicare providers who accept Kentucky Medicaid. As appropriate, the Provider of Choice is requested to maintain specialist reports in the member's central medical record and take steps to ensure that any required follow-up care is provided.

### **3.4 The Role of Specialists and Consulting Providers**

Specialty care providers deliver services beyond the scope of primary care to members. For members who have a Provider of Choice, the specialty care provider is encouraged to coordinate care through the member's Provider of Choice. Necessary prior authorization for hospital admissions or specified diagnostic testing procedures must be obtained. Refer to Section 5.3, "Prior-Authorization Requirements," for a complete listing of procedures requiring prior authorization from the Passport Advantage Utilization Management department.

It is important for the specialty care provider to communicate regularly with the Provider of Choice regarding any specialty treatment. Specialists are encouraged to report the results of their services to the member's Provider of Choice. The specialist should copy all test results in a written report to the Provider of Choice.

## 3.5 Responsibilities of All Providers

### 3.5.1 Professional Manner

The provider must provide services in a manner consistent with professionally recognized standards of care and in a culturally competent manner.

### 3.5.2 Provider and Member Communications

Providers must provide appropriate and adequate medical care to all Passport Advantage members. No action of Passport Advantage, 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 members under the provider's care. Passport Advantage agrees that regardless of the coverage limitations of the Plan, the provider may freely communicate with members regarding available treatment options and nothing in this Provider Manual shall be construed to limit or prohibit open clinical dialogue between the provider and the member.

### 3.5.3 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 42 CFR 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.

**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.

**Artificially Provided Nutrition and Hydration.** The health care surrogate may authorize the withdrawal or withholding of artificially provided nutrition and hydration only in one or more of the

following circumstances:

- When inevitable death is imminent (i.e., reasonable medical judgment indicates that death will occur within a few days).
- When a patient is in a permanently unconscious state, and the grantor has authorized an advance directive authorizing such withdrawal or withholding.
- When the provision of artificial nutrition cannot be physically assimilated by the person.
- When the burden of the provision of artificial nutrition and hydration itself shall outweigh its benefit.

Artificially provided nutrition and hydration cannot be withheld or withdrawn if it is needed for comfort or the relief of pain.

**Pregnant Women.** Advance directives must not be followed for a pregnant woman except under very limited circumstances. Advance directives will be followed only when the pregnant woman's attending physician and one other physician who has examined the woman certify that any life-sustaining treatment and/or artificially-provided treatment will not sustain the woman in a way to permit the continuing development and live birth of the unborn child, will be physically harmful to the woman, or will prolong severe pain which cannot be alleviated by medication.

**No Directive.** What happens if an adult patient 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 patient.
- Spouse of the patient.
- Adult child of the patient (or the majority of the children).
- Parents of the patient.
- Nearest living relative.

**Conscientious Objections.** What happens if the provider or health care facility does not want to comply with the advance directive because of matters of conscience? The provider should notify the patient and cooperate with the patient in transferring the patient with all his or her medical records to another provider. The provider must also clarify any differences between institutional conscientious objections and those that may be raised by individual providers. Also, the provider 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 Directive Act, providers should:

- On the first visit, as well as during routine office visits when appropriate, discuss the patient's wishes regarding advance directives for care and treatment.
- Document in the patient's medical record the discussion and whether the patient has executed an advance directive.
- If asked, provide the patient with information about advance directives.

- Upon receipt of an advance directive from the patient, file the advance directive in the patient's record.
- Not discriminate against a patient because he or she has or has not executed an advance directive.
- Communicate to the patient if the provider has any conscientious objections to the advance directive as indicated above.

### **3.5.4 Sanctions Under Federal Health Programs and State Law**

Participating providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or other Federal Health Care Programs are employed or subcontracted by the participating provider.

As more fully stated in your contract, participating providers must disclose to Passport Advantage whether the provider or any staff member or subcontractor has any prior violation, fine, suspension, termination, or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of Kentucky; the federal government, or any public insurer. Participating providers must notify Passport Advantage immediately if any such sanction is imposed on the provider, a staff member, or subcontractor.

The following resources are available to providers to facilitate their compliance with the above requirements:

- The Health and Human Services Office of Inspector General (HHS OIG) List of Excluded Individuals and Entities (LEIE) lists individuals and entities that are excluded from participating in the Medicare, Medicaid, and all other Federal health care programs. The LEIE may be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>.
- The General Services Administration (GSA) web site maintains a list of individuals and entities that have been excluded throughout the U.S. Government from receiving Federal contracts or certain subcontracts and from certain types of Federal financial and non-financial assistance and benefits. The Excluded Parties List System (EPLS), housed on the GSA web site is accessible at <https://www.epls.gov>.

### **3.5.5 Suspected Child or Adult and Elder Abuse or Neglect**

Cases of suspected child or adult and elder abuse or neglect might be uncovered during examinations. 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; local law enforcement agency or the Kentucky State Police; the Commonwealth's Attorney or the County Attorney.

To facilitate 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 dysfunction is unable to manage his [or her] own resources or carry out the activity of daily living or protect himself [or 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.”

### **3.5.6 Fraud, Waste 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 Advantage. 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, waste and abuse. If you suspect fraud, waste and abuse by a Passport Advantage member or provider, it is your responsibility to report this immediately by calling one of the telephone numbers listed below:

Plan's Fraud, Waste and Abuse Hotline:	(866) 833-9718
Office of the Inspector General (OIG)	
Medicare Fraud, Waste and Abuse Hotline	(800) 447-8477
KyHealth Choices Medicaid Fraud Hotline:	(800) 372-2970
Passport Advantage Compliance Department:	(502) 585-7900

### 3.5.6.1 Fraud, Waste, and Abuse Training

Effective for 2009, the Centers for Medicare & Medicaid Services (CMS) requires annual Fraud, Waste and Abuse (FWA) training for all entities partnering to provide Medicare Part C and/or Part D benefits or services. **Passport Advantage (PAD) is a Medicare Advantage Special Needs Plan, and therefore our providers are required to conduct FWA training annually.**

All PAD providers are required to **maintain in-office training records**, including signatures, and provide those records to the Plan upon request.

**PAD offers a provider-focused *FWA Training and Education Tool*** for providers' use. This presentation is available on the Plan's web site at [www.passportadvantage.org](http://www.passportadvantage.org) and may be accessed by selecting "Providers" and then choosing the "Provider References" link from the menu on the left.

### 3.5.7 Balance Billing

As outlined in the PAD Provider Agreement, providers are prohibited from billing or charging PAD members, except as required in relation to supplemental charges, copayments, or non-covered services.