

Passport Advantage Provider Manual Section 5.0 Utilization Management

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5.0 Utilization Management

5.1 Utilization Management

Utilization Management (UM) is the process of influencing the continuum of care by evaluating the necessity and efficiency of health care services and affecting patient care decisions through assessments of the appropriateness of care. The UM department helps to assure prompt delivery of medically-appropriate health care services to Passport Advantage members and subsequently monitors the quality of care.

All participating providers are required to obtain prior authorization from the Plan's Utilization Management (UM) department for inpatient services and specified outpatient services listed in Section 5.3, "Prior-Authorization Requirements."

The UM department is available Monday through Friday, 8:00 a.m. to 5:30 p.m. EST, (except designated holidays and weekends). All requests for authorization of services may be received during these hours of operation by calling (800) 578-0636. Requests for the following services may be faxed to:

Precertification	(502) 585-7989
DME	(502) 585-7990
Home Health	(502) 585-8204
Skilled Nursing Facility	(502) 585-8206
Retrospective Review	(502) 585-8207

Passport Advantage provides the opportunity for the provider to discuss a decision with the Medical Director, to ask questions about a UM issue, or to seek information from the nurse reviewer about the UM process and the authorization of care by calling (800) 578-0636. After business hours or on holidays, a provider may leave a message, and a representative will return the call the next business day.

5.2 Review Criteria/Standards for Review

Passport Advantage will abide by Medicare's local and national coverage determinations. For policies not covered by these determinations, Passport Advantage will utilize criteria such as InterQual Level of Care Criteria® and medical policies approved through physician quality committees and the Partnership Council. Appropriate actively practicing providers are involved in the development, adoption and review of criteria and policies. A copy of the policies and procedures regarding the use and revision of criteria and/or medical policies is available from the UM department or the office of the Chief Medical Officer.

These guidelines are only made available to participating and non-participating providers as allowed under licensing restrictions, copyright limitations, trademark consideration or materials labeled "for internal use only."

At the request of the provider, the UM department or the Chief Medical Officer will provide a copy of up to three criteria. If the guidelines are not available for distribution or the number of guidelines exceeds the copyright limit, the practitioner has the option to request the guideline be read over the telephone, or review the guidelines at the Passport Advantage office.

Medical policies are available upon request and by accessing Secured Services on the Passport Advantage web site, www.passportadvantage.org.

Passport Advantage may develop recommendations or clinical guidelines for the treatment of specific diagnoses and procedures or for utilization of specific drugs not otherwise covered by national or local guidelines. These recommendations and clinical guidelines will be reviewed and approved by the appropriate physician quality committee and will be communicated to providers via the Passport Advantage web site.

Passport Advantage is equally concerned with and monitors for over and under-utilization of health care services. UM decision-making is based only on appropriateness of care and service and existence of coverage. Passport Advantage does not specifically reward providers or other individuals conducting utilization review for issuing denials. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

5.3 Prior Authorization Requirements

The UM department hours of operation are Monday through Friday, 8:00 a.m. to 5:30 p.m. EST, (except designated holidays). The UM department can be reached at (800) 578-0636. The following list of services and procedures require authorization from Passport Advantage prior to the delivery of the service:

- Inpatient hospitalization (including observation), rehab, skilled nursing facilities, chemical dependency.
- Inpatient behavioral health (includes mental health and substance abuse).
- Cosmetic Procedures.**
- DME rental or purchase of \$500 or greater (see below for more information).
- Home Health Care (for Enterals, see below).
- Home Infusion Services.
- High Cost Medications (>\$400 per dose).***
- Investigational/Experimental Procedures.
- Observation.
- Prosthetics/Orthotics (\$100 or greater).***
- All Therapy Services (excluding Cardiac and Pulmonary Rehab).
- Transplants.

PLEASE NOTE: All services and supplies are subject to review for medical necessity with audits performed retrospectively. Benefit inclusions/exclusions must be considered in determining eligibility for coverage for individual cases. To determine if a service or supply, such as a cosmetic procedure, is considered a benefit exclusion, please contact the UM department.

** Coverage for a cosmetic procedure is not normally a covered benefit. Coverage is based on medical necessity. For example, a request for breast reduction must be reviewed and medical necessity met prior to being a covered benefit.

*** This applies to high-cost medications billed to Passport Advantage excluding chemotherapy medications. This does not apply to the pharmacy benefit. The prior authorization requirement is based on the allowed amount. Therefore, medications with an allowed amount of \$400 or greater will require prior authorization.

Authorization requirements for DME purchases are based on total monthly cost or monthly quantity of items purchased.

DME items with a reimbursement rate of \$500 or greater, require an authorization. Authorization requirements of rentals are determined by the purchase price of the item being rented. If the purchase price of the rental has a reimbursement rate less than \$500, no authorization is required. If the purchase price of the rental has a reimbursement rate of \$500 or greater, an authorization is required.

If the rental or purchase price of a prosthetic/orthotic device is \$100 or less, no authorization is required.

All items requiring customization or accessories require prior authorization.

Enteral Products

Enteral products with a reimbursement rate of \$500 or more for a month's supply require an authorization.

5.4 Prior Authorization of Outpatient Services

For authorization of those outpatient services listed in Section 5.3, "Prior-Authorization Requirements," the member's physician, or provider who is ordering the service notifies Passport Advantage through a telephonic-authorization process. The provider's office contacts Passport Advantage's UM department by telephone to report the type of procedure(s) requested and the facility at which the member will access the services. The provider provides UM with the clinical information to support the medical-necessity criteria of the service. Requests for prior authorization of elective services should be received by UM fourteen (14) days prior to the date the requested service will be performed. Services that require prior authorization must be authorized before the procedures are rendered. Requests for authorization of urgent and emergent services must be submitted to UM within one (1) business day of the procedure being performed.

The assigned prior-authorization number should be provided on the claim form. If providers wish to confirm authorization, they may contact Utilization Management at (800) 578-0636. The call will be expedited if the member's Passport Advantage identification number and the prior-authorization number (if available) are provided at the time of the call.

5.4.1 Home Health /Home Infusion Services

When medically appropriate and a member is confined to his/her home, home health care may be a good alternative. Prior authorization of all home health services is required.

Initial authorizations for home health services may be obtained from the UM department at (800) 578-0636. Subsequent requests should be faxed to the Home Health department at (502) 585-8204.

In response to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the Centers for Medicare & Medicaid Services (CMS) requires **DMEPOS suppliers to be accredited in order to maintain valid Medicare billing identification and to receive Medicare Part B reimbursement.**

5.5 Inpatient Admissions/Observation

5.5.1 Prior Authorization of Elective Inpatient/Observation Hospital Services

Providers are required to obtain prior authorization for all elective inpatient and observation hospital services from the UM Department.

Prior authorization is mandatory for elective hospital observation services to qualify for payment.

Passport Advantage will accept the hospital's or the attending physician's request for prior authorization of elective hospital admissions and hospital observation services. However, neither party should assume that the other has obtained prior authorization.

5.5.2 Emergency Admissions

For an urgent or emergent admission or observation at an acute-care facility, the facility must provide notice within one (1) business day of the admission by calling the Plan's UM department. For weekend admissions to a hospital or for services delivered on the weekend or after normal business hours, authorization must be obtained within one business day of the service being provided. Clinical information must be provided at the time of the notification.

To receive authorization for services, please call the Passport Advantage UM Department at (800) 578-0636 or fax the request to (502) 585-7989, Monday through Friday between the hours of 8:00 a.m. and 5:30 p.m. EST (except designated holidays and weekends).

No authorization is required for services rendered in an emergency room or urgent care center.

5.6 Inpatient Rehabilitation Admissions

If a member requires an inpatient rehabilitation admission to a rehabilitation hospital, the rehabilitation hospital must contact Passport Advantage at (800) 578-0636 prior to admission. The

admission will be reviewed utilizing national and local coverage determinations, InterQual Level of Care Criteria® or applicable medical policy.

5.7 Inpatient Skilled Nursing Facility

An admission to a Medicare certified Skilled Nursing Facility will be reviewed by Passport Advantage for medical necessity. These admissions and continued stays will be reviewed to determine the need for skilled nursing care or rehabilitation services that can only be provided on an inpatient basis in a skilled nursing facility under the supervision of professional or technical personnel. These will be reviewed utilizing InterQual Level of Care Criteria® and/or medical policy as appropriate.

5.8 Behavioral Health

5.8.1. Hospitalizations and Home Health Services

Through care coordination, the Behavioral Health Care Coordinators have access to a variety of UM tools. The staff depend primarily on the InterQual Level of Care Criteria® for the management of all admissions. Preauthorization reviews completed via telephone prior to the provision of clinical services ensure the review of intensive services by objective clinical professionals for adequacy of level of care and appropriateness of services.

Inpatient behavioral health hospitalization, detoxification and home health services require prior authorization from the Plan.

Reviews for behavioral health and substance abuse services are conducted through preauthorization, concurrent, and/or retrospective reviews.

5.8.2 Behavioral Health Care Coordination

The primary components of the Behavioral Health Care Coordination program include:

- The management of the member's care (where and when appropriate) according to the identified medically necessary need and clinical criteria. These efforts will supplement any services already provided by the member's provider—whether he/she is an individual provider, or a community mental health center (CMHC).
- Active and ongoing participation and involvement of the member and family members (where and when appropriate) including adults where consent is given by the adult member for involvement in the development and management of the treatment plan and overall plan of care.
- Assuring the provision of services based on access timeframes as determined by community standards within the Passport Advantage region.
- Ongoing collaboration and cooperation (where and when appropriate) among the various entities and agencies involved in the member's care.

- Whenever possible, the provision of treatment services according to best practices methodologies.

The Care Coordination functions incorporate the needs of members, ranging from those with minor behavioral health illnesses who live functional independent lives within the community to those with severe mental illnesses or severe emotional disabilities requiring ongoing individual supervision at all times. These functions will be reflected in the Behavioral Health Level of Care Criteria utilized to guide the activities of the Passport Advantage Care Coordination staff.

The criteria and other UM/Care Coordination information will be disseminated, in part or in whole, to providers, members, community stakeholders, family members and Passport Advantage clinical staff through handbooks, manuals, forums, newsletters, sessions, and the Passport Advantage web site, www.passportadvantage.org.

An effective system is needed to support clinically effective and rational clinical guidelines and protocols. Specifically, guidelines will provide valuable information and support to providers to improve their clinical effectiveness in medication prescribing. All pharmacological interventions are designed to support providers' autonomy, provide best practices, medication education, and minimize administrative requirements or delays for providers and members.

5.9 Organization Determinations

A request for a service authorization may be denied for failure to meet local and national guidelines, protocols, or medical policies outlined in the Provider Agreement or this Provider Manual. All medical policies are posted on the Secured Services of the Passport Advantage web site, www.passportadvantage.org, for reference by the provider.

Administrative Organization Determinations

Failure to provide notification within **one business day** of an emergency admission/23-hour observation or **7-days** prior to an elective service may result in an administrative organization determination of the requested admission or elective service. It is the normal business practice of Passport Advantage to review requests for authorization of services which fall outside the parameters set forth within this policy before rendering any decisions.

5.9.1 Initial Decisions and Medical Necessity Denials

Administrative Adverse Determination

According to Passport Advantage policy, all requests for authorization of services must be received during normal business hours. Requests must be within **1-business day** of an emergency admission or observation, and **7-days** prior to an elective service being performed. Failure to provide this notification, within the **1-business day** timeframe of an admission results in an administrative denial of the requested admission or elective service. It is the normal business practice of Passport Advantage to provide retrospective review for authorizations of services which fall outside the parameters set forth within this policy before rendering any decision.

Adverse Determination

An adverse determination is when Passport Advantage decides not to provide or pay for a requested service, in whole or in part, or if it Passport Advantage discontinues or reduces a service.

UM/Care Coordination utilizes criteria, medical policies, protocols, and industry standard guidelines to render review decisions. Requests not meeting the guidelines, protocols, or policies are referred to a Medical Director reviewer for clinical review. A Passport Advantage Medical Director will render all denial decisions. Whenever a denial is issued, UM provides the name, telephone number, title, and office hours of the Medical Director who rendered the decision. The Passport Advantage Medical Director is available to discuss any decision rendered with the attending provider. To speak with the Medical Director or to the nurse reviewer, please contact UM at (800) 578-0636.

Expedited Organization Determinations

An enrollee, or any physician (regardless of whether the physician is affiliated with Passport Advantage), may request that the Plan expedite an organization determination when the member or his/her physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

Grievance

A grievance is any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Passport Advantage or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member or his/her representative may make the complaint or dispute, either orally or in writing, to Passport Advantage, a provider, or a facility. An expedited grievance may also include a complaint that a Passport Advantage refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

Independent Review Entity (IRE)

The independent review entity is contracted by CMS to review Passport Advantage' adverse reconsiderations of organization determinations.

Initial Decisions

The "initial decision" is the first decision Passport Advantage makes regarding coverage or payment for care.

A decision to determine if Passport Advantage will cover medical care can be a "standard decision" that is made within the standard timeframe (typically within 14 days) or it can be an expedited decision that is made more quickly (typically within 72 hours).

A member can ask for an expedited decision only if the member or any provider believes that waiting for a standard decision could seriously harm the member's health or ability to function. If a provider requests an expedited decision, or supports a member in asking for one, and the provider indicates that waiting for a standard decision could seriously harm the member's health or ability to function, Passport Advantage will automatically provide an expedited decision.

Medicare Appeals Council (MAC)

The MAC provides the final administrative reviews of claims for entitlement to Medicare and individual claims for Medicare coverage and payment filed by beneficiaries or health care providers and suppliers.

Organization Determination

An organization determination is any determination made by the Plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; **or**
- Payment for any other health services furnished by a provider other than Passport Advantage that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Passport Advantage; **or**
- The Plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare; **or**
- Discontinuation of a service if the enrollee believes that continuation of the services is medically necessary; **or**
- Failure of Passport Advantage to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

A request for an organization determination may be approved or denied for failure to meet local and national coverage determination guidelines, protocols, plan criteria or medical policies outlined in the Provider Agreement or this Provider Manual. All medical policies are posted for the provider's reference on Secured Services of the Plan's web site, www.passportadvantage.org.

Quality Improvement Organization (QIO)

The QIO is an organization comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Passport Advantage members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities (SNF), home health agencies (HHA) and comprehensive outpatient rehabilitation facilities (CORF).

5.10 Appeals

Passport Advantage offers five levels of appeals available to Medicare members enrolled in Medicare Advantage Organizations after an adverse organization determination has been made. These levels are followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity. Section 5.10 describes the member appeal process. Please see section 11.1.3 for information regarding provider/claim appeals.

5.10.1 Definitions

Administrative Law Judge (ALJ) - A Hearing Officer who presides over appeal conflicts between providers of services, or beneficiaries, members, and Medicare contractors. The member or his/her authorized representative, or the non-contract provider may request an appeal of the Maximus reconsideration determination before an Administrative law judge of the Social Security Administration. The ALJ hears the appeal if the amount in question is \$120.00 or more.

Appointed Representative - An individual authorized by a member, or under state law, to act on his or her behalf in dealing with any of the levels of the Medicare appeal process. The member may appoint a representative for the appeal process by providing the Plan with a statement signed by both parties. A physician may file an expedited appeal on the member's behalf without a signed statement from the member. The appointment of a Representative is the type of documentation that authorizes the representative to act on behalf of the member.

Expedited Appeals - A request for reconsideration provided as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.

Grijalva/Fast Track - Passport Advantage will provide members a two-day advance written notice prior to termination of health care coverage for services from a home health agency, skilled nursing facility, and comprehensive outpatient rehabilitation facility. Members can choose to appeal termination decisions regarding these services to the Independent Review Entity (IRE) under contract with CMS. If the member makes a timely appeal, health care coverage will continue for those services until noon following the day a decision is issued by the IRE, or until the termination date called for by Passport Advantage, whichever is later.

Grievance - Any complaint or dispute other than one involving an organization determination. The Passport Advantage Plan member has the right to file a grievance/complaint about any unresolved dispute regarding a non-covered benefit, a complaint about a provider including quality of care or quality of service issues that would be referred to the Quality Management Department for review. The members can dispute any dissatisfaction regarding their Plan coverage and benefits.

Independent Review Entity (IRE) - The entity under contract with CMS to perform reconsideration of denials upheld at the Passport Advantage level reconsideration.

Medicare Appeals Council (MAC) - Federal regulations permit either party to an ALJ hearing to request a further hearing before the Medicare Appeals Council for review by a Federal Court Judge. The Federal Court Judge will only review cases when the amount involved is \$1000.00 or more.

Quality Improvement Organization (formerly Peer Review Organization-PRO) - A group of doctors and health professional who review medical care provided and handle certain types of complaints from patients with Medicare. The QIO monitors the quality of care provided to Medicare beneficiaries.

Reopening - An action taken, after all appeal rights are exhausted, to re-examine or question the correctness of a determination, a decision, or cost report otherwise final.

Representative - An individual appointed by a member or other party, or authorized under State or other applicable law, to act on behalf of a member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process.

5.10.2 Steps of the Appeals Process

Step 1: Standard Appeals and Expedited Appeals

Submitting a Request for Reconsideration: If the member is dissatisfied with an organization determination made by Passport Advantage, he or she is instructed to submit an appeal in writing to the Medicare Member Appeal and Grievance Unit within 60 days after the Initial Organization Determination notice (filing extensions are granted for good cause). The member may also file an appeal if she or he believes Passport Advantage neglected to furnish him or her with a written Initial Organization Determination.

The 60 calendar-day limit may be extended for good cause. If the member chooses to do this, he/she must include in his/her written request the reason why he/she could not file within the 60 calendar-day timeframes.

Opportunity to Present Evidence: The Appeals Department will send a letter to the member acknowledging receipt of the appeal. In accordance with the Centers for Medicare & Medicaid Services (CMS), members have an opportunity to present evidence in person or in writing. Any evidence presented will be taken into account when making a decision. Similarly, the Plan must comply with the member's request for a copy of the case file, including but not limited to a copy of supporting medical records and other pertinent information used to support the decision. The Plan abides by all applicable Federal and state laws regarding confidentiality and disclosure of members' health information.

Appropriate Expertise: Passport Advantage reconsideration decisions will be made by a person(s) not involved in the initial decision. All reconsiderations of adverse organization determinations based on "lack of medical necessity" must be made by a physician with appropriate expertise in the field of medicine appropriate for the services at issue.

Review: The member or his/her authorized representative may submit relevant facts and/or additional evidence verbally or in writing to Passport Advantage.

All standard appeal reviews will be completed within 30 calendar days of receipt.

If Passport Advantage does not find completely in the member's favor, the Appeal Department will notify the member in writing that his/her appeal has been denied, and will forward the case to CMS's contractor for an appeals review.

Denied requests for expedited reconsideration, will be automatically transferred to the standard reconsideration process, and Passport Advantage will make the determination as expeditiously as the member's health condition requires, within 30 calendar days from the date Passport Advantage

received the request for expedited reconsideration. Passport Advantage will promptly give oral notice of the denial of the request and within three (3) calendar days of the oral notification, mail a written letter that:

- Explains that Passport Advantage will automatically transfer and process the request using the 30-day time frame for standard reconsiderations;
- Informs the member of the right to file an expedited grievance if he or she disagrees with the organization's decision not to expedite the reconsideration;
- Informs the member of the right to resubmit a request for an expedited reconsideration and that if the member gets any physician's support indicating that applying the standard time frame for making a determination should seriously jeopardize the member's life, health, or ability to regain maximum function, the request will be expedited automatically; and
- Provides instructions about the grievance process and its time frames.

Time extensions from the 72-hour timeframe must be extended by up to 14 calendar days if the member requests the extension.

If Passport Advantage does not find completely in the member's favor, the Appeals Specialist will forward the case to CMS's contractor for appeal review within 24 hours of the determination. The Appeals Specialist will notify the member by phone immediately and then follow-up in writing within 24 hours to explain that the case has been forwarded to the contractor.

Step 2: Independent Review of the Appeal

When Passport Advantage affirms the adverse organization determination (in whole or in part), a written explanation with the complete case file will be submitted by Passport Advantage to the Independent Review Entity (IRE) within the appropriate timeframes. The hard copy case file will be submitted by overnight delivery service.

The member and/or representative will be informed of how to contact the Independent Review Entity if he/she wants to submit additional evidence

- Standard requests: within 30 calendar days
- Expedited reconsiderations: no later than 24 hours of affirmation of the adverse expedited organization determination
- Requests for payment: no later than 60 calendar days from the date it receives the request for a standard reconsideration

If the Independent Review Entity upholds the Passport Advantage decision, the notice will inform the member of his/her right to a hearing before an Administrative Law Judge of the Social Security Administration (see below for further levels of appeal).

Step 3: Administrative Law Judge

If the amount in controversy is \$120 or greater, the member may further appeal the case by requesting a hearing with an Administrative Law Judge (ALJ). To request a hearing, the member notifies the Independent Review Entity in writing within 60 calendar days from the letter.

A request for a “good cause” extension must be in writing and state the reasons why the request was late. The ALJ may grant an extension.

Step 4: Medicare Appeals Council (MAC) Review

Any of the parties may request a review of the case after the ALJ’s ruling by making their request to the Appeals Council. The MAC may grant or deny the request for review. If it grants the request, it may either issue a final decision or dismissal, or remand the case to the ALJ with instructions on how to proceed with the case.

Step 5: Judicial Review

Any of the parties may also request a judicial review of the case if the amount in controversy is \$1,000 or more, (the \$1,000 limit includes the same member claims that Medicare Appeals Council (MAC) has acted on and must be within the 60 calendar-day filing time limit for all claims) or when the MAC denied the parties request for review.

A party may not obtain judicial review unless the MAC has acted on the case –either in response to a request for review or on its own motions.

Judicial review cases are brought before the appropriate Federal District Court of the United States in which the member lives or where Passport Advantage has its principal place of business and must be filed within 60 calendar days from the Appeals Council decision.

Special Procedure for Hospital Discharge Decisions

Members have the right to an immediate QIO review if they believe Passport Advantage has made a decision to discharge them prematurely from the hospital. Members are informed of their rights to QIO review in writing by the hospital when they are admitted, and when they receive a notice of non-coverage (NONC) from Passport Advantage upon adverse discharge notice.

Special Procedure for Termination of Skilled Nursing Facilities, Home Health and Outpatient Services

Members have the right to an immediate QIO review if they believe Passport Advantage has made a decision to terminate these services prematurely. The provider informs members of their rights to QIO review in writing when the services begin, if services are less than two (2) days, or two (2) days before services are ending.

Appeals Records

Passport Advantage maintains a record of all appeal cases for at least ten (10) years. The

Administrative/Benefits Appeals Committee performs ongoing reviews of appeal records to determine patterns of concern and identify need for corrective action.

Member Administrative/Benefit Appeals

Member administrative/benefit appeals include, but are not limited to, appeals for requested services and appeals. The member, an authorized representative of the member, or a provider acting on behalf of the member may file a member administrative/benefit appeal.

Appeals filed by the provider on the member's behalf require the member's written consent. If the member's written consent is not received within 30 calendar days of the action then no appeal will be initiated.

The appeal must be filed in writing, and the Plan must receive it within 30 calendar days of the date of a notice of an action by the Plan. A 14 calendar day extension will be granted at the member's request. Within three calendar days of receipt of the written appeal, the Plan will send a letter to the member acknowledging receipt of the appeal and advising of the date the appeal will be heard. The member may present supporting documentation or evidence in person or in writing on or before the date that the appeal is to be heard. The Administrative/Benefit Appeals Committee reviews all administrative/benefit denial appeals. The Plan will communicate to the member an appeal decision within 30 calendar days of receipt of the appeal.

Provider Appeals

A provider appeal is a request for review of a Passport Advantage action related to the medical necessity of service provided and the provider has documented and agreed to waive the right to pursue reimbursement from the member. An action is defined as the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension, or termination of a previously-authorized service; failure to provide services in a timely manner; failure to act within specified timeframes; denial of a request to obtain services outside the network for specific reasons. All appeals must be received in writing.

Please address Provider Appeals related to medical necessity to:

Passport Advantage
Attn: Appeals Coordinator
305 W. Broadway, 3rd Floor
Louisville, KY 40202

5.11 Notice of Medicare Non-Coverage (NOMNC)

All Passport Advantage Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), and Comprehensive Outpatient Rehabilitation Facilities (CORF) providers must deliver the Notice of Medicare Non-Coverage (NOMNC) to Passport Advantage members (or their authorized representative) as follows:

- Use the Passport Advantage NOMNC form, located on the Provider Center of the Plan's web site, www.passportadvantage.org.

- No later than two (2) days before the proposed end of coverage.
- At the time of admission if the member's covered services are expected to be less than two (2) days in duration.
- Providers are to fax the NOMNC to Passport Advantage:

Home Health	(502) 585-8204
Skilled Nursing Facilities	(502) 585-8206
Comprehensive Outpatient Rehabilitation Facilities	(502) 585-8205

If a member refuses to sign the notice, the provider may annotate the NOMNC to indicate the refusal, and the date of refusal is considered the date of receipt of the notice. If the NOMNC is signed by an authorized representative, the Plan will need documentation from the provider regarding the authorized representative.