

## MAC Binder Section 3B – Corrective Action Plans

### Table of Contents with Document Summary

Located online at <http://chfs.ky.gov/dms/mac.htm>

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#### **18 – PHP CAP Response IPRO PHP2014IPRO-GS:**

Passport response to corrective action plan – Non-compliance and/or minimal compliance in the area of grievance system; updated policy to reflect grievance and appeal files be retained for ten years and updated policy to include member rights to request protected information.

#### **19 – PHP CAP Response IPRO PHP2014IPRO-MI:**

Passport response to corrective action plan – Non-compliance and/or minimal compliance in the area of measurement and improvement. PHP implemented a two-step review and approval process for all DMS reports to include both the staff preparer and a management representative review process prior to submission; and they updated member educational material policy to reflect QMAC review of member material.

#### **20 – PHP CAP Response IPRO PHP2014IPRO-MR:**

Passport response to corrective action plan – Non-compliance and/or minimal compliance in the area of medical records; drafted updates to compliance policies to include language specific to confidentiality of services to minor.

#### **21 – PHP CAP Response IPRO PHP2014IPRO-UM#1:**

Passport response to corrective action plan – Non-compliance and/or minimal compliance in the area of utilization management. PHP developed a new desktop procedure: utilization management program modifications and by adding language to both the utilization management and clinical programs description; and the UM/Clinical program description has been reviewed and/or modified to ensure and/or incorporate the requirements.

#### **22 – PHP CAP Response IPRO PHP2014IPRO-UM#2:**

This document is a supplement to item #21.

## Grievance System

Unique Identifier	Requirements	Corrective Action(s)	Business Area	Completion Date
PHP2014IPRO-GS-1	All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.	<p>Passport Health Plan has acted upon IPRO's recommendation by updating Policy UM 30.0 to reflect that grievance and appeal files be retained for ten (10) years.</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">  <span style="font-size: 8px;">F:\Groups\ Compliance\2014\ Audits &amp; Reviews\3</span> </div>	Utilization Management	
PHP2014IPRO-GS-2	Documentation regarding the grievance shall be made available to the Member, if requested.	<p>Passport Health Plan has acted upon IPRO's recommendation by updating Policy MS 16.0 to include members' rights to request protected information. Passport Health Plan is in the process of consolidating Use &amp; Disclosure Policies. Once completed, the attached Policy will reflect reference to the new Policy &amp; PHP 23 will be retired. This will be completed by 2/15/2015.</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">  <span style="font-size: 8px;">F:\Groups\ Compliance\2014\ Audits &amp; Reviews\4</span> </div>	Member Services	12/9/2014

		Policy/Procedure
Policy Name: <b>Grievance Intake Process</b>		Policy Number: <b>MS 16.0</b>
Date of Next Annual Review: <b>December 10, 2015</b>		Original/Issue Date: <b>August 01, 1999</b>
Approved By: <b>Judy Palmer</b>		Title: <b>Director of Provider/Member Services</b>
Signature: Signature On File		Date Approved: <b>08/28/2014</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
New (Date policy was created)	<input type="checkbox"/>	
Reviewed (No changes to policy)	<input type="checkbox"/>	
Revised (Content changes made to policy)	<input checked="" type="checkbox"/>	December 10, 2014
Retired (Policy no longer active)	<input type="checkbox"/>	
<b>APPLICABILITY</b>		

Member Services and Passport Associates working on Grievances

**PURPOSE**

To define the process that ensures the member's right file a grievance.

**POLICY**

Member Service representatives are responsible for identifying, responding to and referring member grievances to the appropriate internal sources in order to facilitate a positive outcome and to meet all contractual and regulatory requirements. At no time will a member be discriminated against based on the fact that he/she has filed a grievance. The department will ensure this policy is being followed by the Trainer/Auditor via phone monitoring live and recorded.

**DEFINITION(S)**

**Action or Adverse Action-** 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; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; failure to act with specified timeframes; denial of a request to obtain services outside the network for specific reason.

**Appeal-** The request for review of an action or a decision by Passport related to covered services.

**SF-** Service Form. An electronic form generated within the EXP system used to document, track or view scanned images that result from contact with a member or provider.

**EXP-** A computerized administrative system used electronically to document, track, or scan all member and provider inquiries and services, which also allows for real-time on-line communication between departments.

**Special Support Technician-** Person or Persons who research grievances.

**Grievance/Complaint-** A verbal or written expression of dissatisfaction by or on behalf of a Medicaid member or provider, regardless of whether the communication requires remedial action.

## PROCEDURE

1. When a Member Service representative receives a verbal grievance from a member, the following procedures are initiated:
  - a. The call is transferred to a Special Support Technician.
  - b. All grievances will be documented in the EXP system and include:
    - Information to identify the grievances.
    - Member's ID number.
    - Individual and group Provider ID number.
    - The caller's name, relationship to the member, and phone number.
    - Member's current PCP ID number and name.
    - Member's county of residence.
    - Date received.
    - The type of grievance being filed.
    - Nature of the grievance.
    - Notice to member of receipt.
    - All correspondence between Passport and the member.
    - Resolution Date.
    - Decision.
    - Notice of final decision to member.
2. In describing the nature of the grievance a full narrative description of the issue will be documented with specific details pertaining to the issue, such as dates, provider name and provider ID number when available.
3. A full investigation shall be completed by the Special Support Technician including any provider contacts, claim research, etc.
4. Documentation of referral to another department/subcon if necessary.
5. The details of the most appropriate type of grievance being filed.
6. Specific documentation of the decision to include communication with the member – including the date the decision was communicated.
  - a. If the Special Support Technician needs assistance from another department the grievance is routed by EXP to the appropriate department for resolution within thirty calendar days.
  - b. All grievances related to the following are routed to Provider Relations via EXP:  
(see PR policy 52.0)
    - Appointment access complaints that are unable to be resolved by Special Support Technician and not in compliance with Plan appointment access standards.
    - After-hours access complaints not in compliance with Plan policy.
    - Telephone access complaints not in compliance with Plan policy.
    - Facility access complaints not in compliance with Plan policy.

- Misplaced/lost medical records and/or failure to forward medical records to other providers.
  - Race, ethnicity and language for targeted grievances.
7. All grievances related to the following are routed to Quality of Care via EXP for a nurse review including PCP change request that are based on care concerns: (See Policy QM 15.00 and QM 16.00)
- Any aspect of clinical care including diagnosis and treatment concerns – all concerns/grievances in regards to symptoms, diagnosis, diagnostic procedures, and medical condition.
  - Environmental Concerns – condition of office, office equipment, office parking lot, office odors, uncomfortable temperature in waiting area or patient exam rooms, and equipment malfunction.
  - Safety Concerns – medication errors, any accident or injury while at the provider’s office, improper disposal of biohazard materials, and poor or no infection control practices.
8. All grievances related to the following are routed to Compliance for review;
- HIPAA Privacy Concerns – other patient medical records in view, any loud conversations overheard about other patients.
  - Potential HIPAA Violations.
9. All grievances related to the following are routed to Public Affairs for review;
- Advertisement concerns
  - Marketing Materials.
  - Member Communications
10. All grievances related to the following are routed to Care Coordination for review;
- Care Coordination Staff Rude
  - Care Coordination Unprofessional Communication
  - Care Coordination Communication Unclear/Untimely
11. The Special Support Technician will confirm a complete resolution.
12. The Special Support Technician will mail an acknowledgment letter within five business days of receipt of the grievance. The acknowledgment letter will include written notice that the grievance has been received and the expected date of its resolution.
13. The Special Support Technician will mail a resolution letter upon resolution of the grievance. This resolution letter may not take the place of the acknowledgement letter, unless the resolution of the grievance has been completed and can be communicated to the member in the same correspondence acknowledging receipt of the grievance. The resolution letter shall include, but not be limited to, the following:
- Information considered in investigating the grievances;
  - Findings and conclusions based on the investigation; and
  - The disposition of the grievance.

14. When a Special Support Technician receives a written grievance, the following procedures are initiated:
  - a. The Special Support Technician will contact the member by telephone within twenty-four (24) hours of receiving and document the grievance in EXP and policy is followed.
  - b. If the Special Support Technician cannot contact the member after three attempts, the written information provided will be documented in EXP.
    - If the information provided can be resolved without contact with the member the grievance will be filed on a 1300 MS complaint SF and policy is followed.
    - If the information provided is not sufficient the information will be documented as an inquiry and a letter will be mailed advising them to contact the Plan.
  
15. When a Special Support Technician receives a grievance from a Subcon via secure email the following procedures are initiated:
  - a. The Special Support Technician will contact the member within twenty-four (24) hours of receiving the grievance and the grievance will be documented in EXP and policy followed.
  - b. If the Special Support Technician cannot contact the member after three attempts, the information provided by Subcon will be documented in EXP.
    - If the information provided can be resolved without contact with the member the grievance will be filed on a 1300 MS Complaint SF and policy followed.
    - If the information provided is not sufficient the information will be documented as an inquiry and a letter will be mailed advising them to contact the Plan.
  
16. All Grievances:
  - a. Grievances are documented in EXP on the 1300 MS Complaint SF, investigated, resolved, and closed within 30 calendar days.
  - b. The Special Support Technician may extend this timeframe by up to fourteen (14) calendar days if the Member requests the extension, or if the Special Support Technician determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Special Support Technician shall mail the member written notice of the reason for the extension within two (2) business days of the decision to extend the timeframe.
  - c. Alternate language services are available for members as indicated in policy MS 9.0
  - d. Grievances will be analyzed to determine if there are trends/patterns to assess whether there are issues with the network's ability to deliver appropriate care to members.
  - e. If the grievance involves an action by the Plan, the member is informed of their right to request an appeal as indicated in the Member Appeal Policy (MS 24.0).
  - f. A monthly report is produced for the Special Support Technician to review each grievance to ensure all grievance documentation standards are met.
  - g. All grievances undergo a monthly peer review.
  - h. The member services Auditor/Trainer will conduct monthly audit reviews as indicated in Policy MS 14.01.
  - i. Grievances are reported quarterly via QMAC and QSC meetings.

- j. A Member may file a grievance for any dissatisfaction within 30 calendar days of the event causing dissatisfaction.
- k. A legal guardian of a Member who is a minor or an incapacitated adult, a representative of the Member as designated in writing to Passport or a service provider acting on behalf of the Member with the Member's written consent shall have a right to file a grievance on behalf of a Member. The written consent authorizing a service provider to represent a Member shall be signed and dated by the Member no earlier than the date of activity which is the subject of the grievance.
- l. A quarterly report is produced to categorized grievances based upon the members' category of aid for tracking purposes.
  - Due Eligible
  - Foster Care (including out of home placement)
  - SSI Adults
  - SSI Children
  - Family and Children
- m. Grievance documentation will be shared in accordance with Passport Policy PHP23, Member Right to Access to Protected Health Information.

**CROSS REFERENCE/REFERENCE MATERIALS**  
 (If necessary to cite other policies or documents)

- MS 9.0 Coverage for Non-English Speaking Members
- MS 24.0 Member Appeals/Member Services
- UM 5.03 Expedited Appeals
- QM15.00 Quality of Care Review for Member Concerns.
- QM 16.00 Practitioner Office-Site Visits Related to Member Complaints
- PHP23 Member Right to Access to Protected Health Information

**REVIEW AND REVISION DATES (Annually at minimum)**

August 1999	March 02, 2011
August 2000	July 31, 2012
August 2001	November 26, 2012
August 2002	October 24, 2013
May 2004	August 28, 2014
April 2005	November 06, 2014
September 2006	
February 2008	
November 2008	
November 2009	
October, 11 2010	
December 10, 2010	

**Confidentiality and Privacy Guidelines – Utilization Management Department**

		Policy/Procedure
<b>Policy Name: Confidentiality and Privacy Guidelines – Utilization Management Department</b>		<b>Policy Number: UM 30.0</b>
<b>Date of Next Annual Review: 12.12.2015</b>		<b>Original/Issue Date: 4.1.2002</b>
<b>Approved By: Anna Page, R.N</b>		<b>Title: Director</b>
<b>Signature: Anna Page</b>		<b>Date Approved: 12.12.2014</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
New (Date policy was created)	<input type="checkbox"/>	
Reviewed (No changes to policy)	<input type="checkbox"/>	
Revised (Content changes made to policy)	<input checked="" type="checkbox"/>	12.12.2014
Retired (Policy no longer active)	<input type="checkbox"/>	
<b>APPLICABILITY</b>		

All Medical Management Associates

**PURPOSE**

This policy is intended to outline the ways in which confidential information is protected in the Utilization Management Department consistent with 1) applicable federal and state laws and regulations; 2) Passport Health Plan’s standards of conducting business without collecting or divulging more information than is necessary; and 3) Passport Health Plan’s need to do research and measure quality using aggregated or non-identifiable data whenever possible.

**POLICY**

Passport Health Plan’s (PHP) Utilization Management Department protects all confidential information collected that is used or disclosed in the course of performing job duties. The Utilization Management Department has access to certain protected health information (PHI) that is used to review medical necessity of services through prior authorization, concurrent review, retrospective review and review of appeals for members and providers. This information may be used by the Utilization Management staff to coordinate treatment, facilitate payment, and healthcare operations as outlined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Utilization Management staff uses the minimum amount of protected health information necessary to accomplish required job tasks.

All medical records, in any medium, related to the Utilization Management process are maintained in a secure environment for a minimum of 10 years following the final decision by Passport, the Department of Medicaid Services, an administrative law judge, judicial appeal, State Hearing or closure of a file, whichever occurs later. Medical records are accessible to the

## Confidentiality and Privacy Guidelines – Utilization Management Department

Department of Medicaid Services or its designee, upon request, for review. This policy does not supersede PHP's organizational policy on Privacy and Confidentiality CO 4.00.

This policy is intended to comply with current state and federal laws and regulations, as well as accreditation standards of the National Committee for Quality Assurance (NCQA). As such requirements and standards change, this policy are reviewed at least annually and revised as needed.

### DEFINITION(S)

**Confidential Information** includes, but is not limited to:

- Protected Health Information (PHI) (defined below)
- Personal information concerning employees, members, and providers
- Practitioner-specific information related to credentialing proceedings, quality reviews, malpractice suits, peer-reviewed determinations, etc.
- Financial information relating to employees, members, providers, contractors, subcontractors, vendors and consultants
- Proprietary business information and trade secrets

**De-Identified Information** - means information from which the following identifiers have been removed or otherwise concealed by a person with appropriate knowledge and experience, and there is no reason to believe that any anticipated recipient of the information could use the information, alone or in combination with other information, to identify an individual:

- Name
- All geographic subdivisions smaller than State level, including street address, city, state, zip code
- Names of relatives
- Name of employer
- All elements of dates (except year) for dates directly related to the individual
- Telephone numbers
- Fax numbers
- Electronic mail (e-mail) addresses
- Social Security number
- Medical record number
- Health plan member number
- Account number
- Certificate/License number
- Any vehicle or other device serial number
- Web Universal Resource Locator (URL)
- Internet Protocol (IP) address number
- Biometric identifiers (such as voice or finger prints)
- Photographic images

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- Any other unique identifying number, characteristic or code that may be available to an anticipated recipient of the information

**Healthcare Operations** - means any of the following activities of the covered entity to the extent that the activities are related to covered functions, and any of the following activities of an organized healthcare arrangement in which the covered entity participates:

- Conducting quality assessment and improvement activities or population-based activities relating to improving health or reducing costs, protocol development, case management and care coordination, and related functions that do not include treatment;
- Reviewing the competence or qualifications of healthcare professionals;
- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits;
- Conducting or arranging for medical review, legal services, and auditing functions;
- Business planning and development;
- Business management and general administrative activities, such as: management activities, customer service, internal grievance resolution, due diligence in connection with the sale of assets, creating de-identified health information, fundraising, and marketing.

**Medical Record** - as used in this policy, means a permanent or long-lasting account of the specific health problems of the patient, including the presenting problems, the diagnosis, the plan of care, the progress notes (which document the observations, assessments, nursing care plans, physician's orders, etc. of all healthcare personnel directly involved in the care of the patient). This record is generated by the provider.

**Minimum Necessary** – The Privacy Rule requires a covered entity to make reasonable efforts to limit use, disclosure of, and requests for PHI to only the necessary amount to accomplish the intended purpose

**Privacy Authorization** - is the mechanism for obtaining consent for the use and disclosure of Protected Health Information (PHI) in instances other than treatment, payment, and healthcare operations.

**Protected Health Information (PHI) or Individually Identifiable Health Information** - as used in this policy, means health information (including demographic information) collected about an individual that:

- Is received from the individual, the Department for Medicaid Services, a health care provider, another health plan, health care clearinghouse or created by Passport Health Plan itself; and
- Relates to the past, present or future physical or mental health or condition of an individual, provision of health care to that individual, or the past, present or future payment for the provision of health care to the individual, and that identifies or with respect to which there is a reasonable basis to believe the information can be used to

## Confidentiality and Privacy Guidelines – Utilization Management Department

identify the individual. [Note: the information could be identifiable either explicitly, by linking health information to an individual's name, or implicitly, by providing information that could be combined with other information to identify the individual, such as a Social Security number, date of birth, etc.]

Protected Health Information (PHI) includes, but it is not limited to medical records, claims and utilization management records.

### PROCEDURE

#### Access to Data, Files and Records

All Utilization Management staff, including the Department Director, Department Manager, Utilization Management Supervisor, Precertification staff, Concurrent and On-site staff, Appeals and Denial staff, and Utilization Management Data Analyst have access to member specific information in order to perform job functions.

The Utilization Management staff is permitted access to Passport Health Plan systems that contain Protected Health Information (PHI) to coordinate treatment and facilitate payment and healthcare operations.

The Utilization Management Department uses and discloses Protected Health Information (PHI) internally and externally for the purposes of:

- Conducting medical necessity reviews for requested services to provide utilization management decisions to members and providers
- Conducting medical record review to resolve an appeal of a denied service
- Authorizing services for members
- Making and reviewing referrals for members
- Directing members to the most appropriate level/type of care

Except as otherwise required by law, regulations or contractually, access to such information shall be limited by Passport and the Department (DMS) to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.

PHI may be used by Medical Management staff to coordinate treatment and facilitate payment and healthcare operations as outlined in the Health Insurance Portability and Accountability Act of 1996. Medical Management staff uses the minimum amount of PHI necessary to accomplish required job tasks.

The Utilization Management Department has access to and/or needs to request member medical records. A copy of the member's medical record or portions of the medical record may be requested by the Utilization Management Department for review to determine the medical

## **Confidentiality and Privacy Guidelines – Utilization Management Department**

necessity of requested services for precertification, concurrent review, retrospective review and review of appeals. All submitted materials are scanned into the system and maintained electronically. All electronic documentation for approvals and denials are maintained in the Medical Management Review system permanently. Approved fax requests for services are maintained electronically for 1-year. Denials are retained electronically for a period of 10-years. After 10-years of electronic storage, denied faxes are deleted.

### **Committees**

Members of the Utilization Management Department may be asked to chair, attend or supply information for various Passport Health Plan committees. If a committee consists of members who are not Passport Health Plan employees, those external members are asked to read and sign the PHP Confidentiality Agreement. The Confidentiality Agreement outlines the committee member's responsibilities for protecting information confidentiality. The Confidentiality Agreement is reviewed and signed annually. The nature of some committee discussion requires that member information is not blinded. Whenever possible, member information is blinded for committee discussion.

### **General Utilization Management Departmental Privacy and Confidentiality Guidelines**

Passport Health Plan (PHP) collects, processes, transmits, maintains and provides access to large amounts of information, much of it sensitive, about members, employees and providers, and about the business and administrative functions of the company. PHP uses this information to oversee the delivery of care, compensate healthcare providers, and measure and improve care. In addition, laws, regulations and accreditation standards that relate to confidentiality and privacy issues must be followed. Members, employees, providers, and the company should be able to expect that privacy and confidentiality is respected and protected.

- All faxes sent by the Utilization Management Department that contain confidential information are sent with a confidential cover letter from Right Fax.
- Information of a confidential nature is not left unattended or in plain sight in any work area. Confidential information should be removed in a timely fashion from printer output bins, fax machines and copiers. Computers are logged out of at the close of business each day and are password protected.
- Any member-related information obtained in connection with performing job responsibilities is not shared with other Passport Health Plan associates unless the information is necessary to the performance of the associate's job duties.
- Confidential information on paper is stored in locked file drawers at the close of business each day. Confidential information on paper that does not need to be saved is placed in a confidential bin for shredding.

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- Communications with providers, hospitals, subcontractors and other agencies is limited to the acceptance/disclosure of the minimum necessary Protected Health Information to accomplish the purpose.
- Communications with individuals about whom the Protected Health Information is referring are not limited to minimum necessary.

It is not permitted for Utilization Management staff to use or disclose a member's PHI for reasons other than to coordinate treatment and facilitate payment and healthcare operations without obtaining a written privacy authorization from the member. Any Utilization Management associate who receives a request for information that requires a privacy authorization must contact the Privacy Officer before this information is disclosed (CO 4.01 Authorization Policy).

### Confidentiality Statement

All Utilization Management staff must read and sign Passport Health Plan's Confidentiality Agreement and related Privacy and Confidentiality Policies upon hire. Temporary employees, consultants or student workers/interns working in the Utilization Management area must also read and sign the Confidentiality Agreement and Privacy Policies. It is the responsibility of the Human Resource (HR) Manager and Passport Health Plan Management staff to ensure all permanent and temporary staff sign the Confidentiality Agreement.

### Sanctions

Any suspected violations of this policy should be reported to the Manager and/or Director of Utilization Management Department, and the Privacy Officer. If the violation involves accidental or negligent misuse of confidential information, an investigation may be conducted, and progressive disciplinary actions may follow in accordance with Human Resources' guidelines. Intentional misuse of confidential information is not tolerated by Passport Health Plan and may result in suspension or termination.

### **CROSS REFERENCE/REFERENCE MATERIALS** (If necessary to cite other policies or documents)

HIPAA Privacy Regulations: 45 CFR 160 and 164  
Standards for Privacy and Individually Identifiable Health Information; Final Rule

Passport Health Plan: Authorization Policy CO 4.01  
Privacy Policy CO 4.00

### **REVIEW AND REVISION DATES (Annually at minimum)**

July 3, 2008  
June 26, 2009

## Confidentiality and Privacy Guidelines – Utilization Management Department

August 1, 2009  
August 1, 2010  
August 1, 2011  
August 14, 2012  
July 30, 2013  
March 20, 2014  
September 17, 2014  
December 12, 2014

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END OF POLICY



**Development and Approval of Member Educational Material**

		<b>Policy/Procedure</b>
<b>Policy Name: Development and Approval of Member Educational Material</b>		<b>Policy Number: CC 27.01</b>
<b>Date of Next Annual Review: 12-08-15</b>		<b>Original/Issue Date: 12/11/12</b>
<b>Approved By: Sherry Rumbaugh, RN BSN</b>		<b>Title: Director, Care Coordination/Quality Improvement</b>
<b>Signature: SIGNATURE ON FILE</b>		<b>Date Approved: 12-11-12</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
<b>New</b> (Date policy was created)	<input type="checkbox"/>	
<b>Reviewed</b> (No changes to policy)	<input type="checkbox"/>	
<b>Revised</b> (Content changes made to policy)	<input checked="" type="checkbox"/>	12-8-14
<b>Retired</b> (Policy no longer active)	<input type="checkbox"/>	
<b>APPLICABILITY</b>		

This policy is applicable for all member educational materials developed by the health plan for the purpose of education related to the member’s health and well being

**PURPOSE**

To provide a standard mechanism for development and approval process of member education materials.

**POLICY**

All member educational materials must be based on sound medical information and must go through an internal approval process as well as review and approval by the Department of Medicaid Services (DMS) prior to being utilized by the health plan.

**DEFINITION(S)**

**Clinical practice guideline-** Systematically developed descriptive tools or nationally recognized standardized specifications for care to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

**Project request form-** the form utilized by health plan staff to inform the Public Affairs team the information relevant to the specific project scope/goal. Including but not limited to: project name, due date, cost center, audience, and distribution.

**Originator-** the clinical health plan staff that researches and develops educational material. The originator is the subject matter expert and is responsible for ensuring the content is in agreement with Passport’s contract with the Commonwealth, Clinical Practice Guidelines, and Passport policies and procedures.

## Development and Approval of Member Educational Material

**Project lead-** the assigned Public Affairs staff that oversees the project. The project lead is responsible for editing, designing and/or polishing the originator's submission and coordinating the project through the entire approval, print, mailing, and/or web posting process, as needed.

### PROCEDURE

1. As the need arises to develop a new member educational material, the originator starts by reviewing any pertinent Passport approved Clinical Practice guideline (CPG). The CPG serves as a tool to frame the educational material. Both member and provider materials should not conflict with Passport approved CPGs.
2. The originator researches for any .gov materials that may be available for the topic desired.
3. If there are no .gov materials that are applicable, the originator researches for nationally recognized sources to use to develop the material that are experts in the specific topic. Example: for a diabetes educational material regarding HbA1c testing utilize the recommendations of the American Diabetes Association or the Kentucky Diabetes Network as a reference.
4. The originator develops the educational material from the reference(s).
5. The Care Coordination Administrator formats a rough draft of the educational material in required 14 point font.
6. The Care Coordination Administrator determines the readability of the educational material via Microsoft Word Flesch-Kincaid Grade Level and prints out the readability score.
7. If the material is above the required 6<sup>th</sup> grade readability the originator re-evaluates the content and makes adjustments to reduce the readability. If the developer of the educational material is unable to reduce the readability, they may utilize the assistance of the Public Affairs department.
8. Once an educational material is in the draft format it is reviewed again for final content by the originator, the originator's Manager, and the Director of Care Coordination and Quality. Any changes made by these reviewers are completed by the Care Coordination Administrator.
9. Once the educational material is in a final draft state, a Project Request Form (PRF) *Attachment 1* is completed by the originator and sent to the Public Affairs Administrator along with the final draft and reference list. Public Affairs works with the originator to ensure the educational material meets its scope/goal and is appropriate for the target audience.

## **Development and Approval of Member Educational Material**

10. The Public Affairs Administrator logs the project into tracking system and assigns a project lead.
11. The project lead edits project and starts the internal review process. The project leads verifies with the originator that scope/purpose and together the lead and originator make changes as needed to the material.
12. The project leads initiates the internal review process. Public Affairs is responsible for editing, grammar, and layout of the material.
13. Internal reviewers of the educational material are the project lead, Director of Public Affairs, originator, originator's manager, Director of Care Coordination, and the Chief Medical Officer.
14. If any updates are made by a reviewer the folder is returned to the project lead to update and route to the next reviewer.
15. Once an educational material has completed the internal review process, the project lead prepares the material to be forwarded to DMS for review.
16. If DMS has required changes or suggestions, the project lead coordinates with the originator to make changes as required. If changes are needed, the updated document is forwarded back to DMS for a second review and approval.
17. Once an educational material is approved by DMS, the project lead continues to oversee the fulfillment process.
18. Once the educational material has completed final layout and design it is placed on the agenda of Quality Member Access Committee (QMAC) and sent for review.

### **CROSS REFERENCE/REFERENCE MATERIALS**

**(If necessary to cite other policies or documents)**

PA 13.0 Member Information Materials

Communication Manual at

phpfile01\Passport\ktydata\EVERYONE\Web\1300\_\pdfs\depts\publicaffairs\Comm-Manual-2011.pdf

### **REVIEW AND REVISION DATES (Annually at minimum)**

12-11-12

End of Policy

## HEDIS 2013 Reported Measures for Effectiveness of Care and Access/Availability of Care

<i>ABA</i>	Adult BMI Assessment
<i>AAB</i>	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
<i>AAP</i>	Adults' Access to Preventive/Ambulatory Health Services
<i>ADD</i>	Follow-Up Care for Children Prescribed ADHD Medication
<i>ADV</i>	Annual Dental Visit
<i>AMM</i>	Antidepressant Medication Management
<i>AMR</i>	Asthma Medication Ratio
<i>ART</i>	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
<i>ASM</i>	Use of Appropriate Medications for People With Asthma
<i>BCS</i>	Breast Cancer Screening
<i>CAP</i>	Children and Adolescents' Access to Primary Care Practitioners
<i>CBP</i>	Controlling High Blood Pressure
<i>CCS</i>	Cervical Cancer Screening
<i>CDC</i>	Comprehensive Diabetes Care
<i>CHL</i>	Chlamydia Screening in Women
<i>CIS</i>	Childhood Immunization Status
<i>CMC</i>	Cholesterol Management for Patients With Cardiovascular Conditions
<i>CWP</i>	Appropriate Testing for Children With Pharyngitis
<i>HPV</i>	Human Papillomavirus Vaccine for Female Adolescents
<i>IMA</i>	Immunizations for Adolescents
<i>LBP</i>	Use of Imaging Studies for Low Back Pain
<i>LSC</i>	Lead Screening in Children
<i>MMA</i>	Medication Management for People With Asthma
<i>MPM</i>	Annual Monitoring for Patients on Persistent Medications
<i>PBH</i>	Persistence of Beta-Blocker Treatment After a Heart Attack
<i>PCE</i>	Pharmacotherapy Management of COPD Exacerbation
<i>PPC</i>	Prenatal and Postpartum Care
<i>SAA</i>	Adherence to Antipsychotic Medications for Individuals w/ Schizophrenia
<i>SMC</i>	Cardiovascular Monitoring for People w/ Cardiovascular Disease and Schizophrenia
<i>SMD</i>	Diabetes Monitoring for People w/ Diabetes and Schizophrenia
<i>SPR</i>	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
<i>SSD</i>	Diabetes Screening for People w/Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
<i>URI</i>	Appropriate Treatment for Children With Upper Respiratory Infection
<i>WCC</i>	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

# Medical Records

Unique Identifier	Requirements	Corrective Action(s)	Business Area	Completion Date
PHP2014PRO-MR-1	<p>The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.</p>	<p>Passport Health Plan has reviewed all of our Compliance policies and have made draft updates to CO 12 (previously submitted) and CO 1 to include KRS 214.85 language specific to confidentiality of services to minor who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification. Passport Health Plan is in the process of consolidating Use &amp; Disclosure, and Privacy Policies. Once completed, the attached Policy CC22.0 will reflect reference to the new Policy, and Policies CO 1 and CO 12 will be retired. This will be completed by 2/15/15. In addition, we are including our Care Management policy that includes the process for all staff to verify they are speaking with the correct person when conducting any care coordination services that includes follow up with minor that do not require parental consent.</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; text-align: center;">  <p>F:\Groups\A Compliance\2014\A Audits &amp; Reviews\</p> </div> <div style="border: 1px solid black; padding: 2px; text-align: center;">  <p>\np\p\p\p\1\users\A Sfumbal\CO 12.docx</p> </div> <div style="border: 1px solid black; padding: 2px; text-align: center;">  <p>F:\CC 22.0 Confidentiality Privacy and</p> </div> </div>	<p>Ci department</p>	<p>12/31/2014</p>

**Confidentiality, Privacy and Disclosure Guidelines for Care Coordination**

		Policy/Procedure
<b>Policy Name: Confidentiality, Privacy, and Disclosure Guidelines for Care Coordination</b>		<b>Policy Number: CC 22.0</b>
<b>Date of Next Annual Review: 12/9/2015</b>		<b>Original/Issue Date: 9/14/10</b>
<b>Approved By: Renee White, RN MSN CPHQ</b>		<b>Title: Director, Care Coordination</b>
<b>Signature: SIGNATURE ON FILE</b>		<b>Date Approved:</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
New (Date policy was created)	<input type="checkbox"/>	
Reviewed (No changes to policy)	<input type="checkbox"/>	
Revised (Content changes made to policy)	<input checked="" type="checkbox"/>	Reactivated 12/9/2014
Retired (Policy no longer active)	<input type="checkbox"/>	

**APPLICABILITY**

Confidentiality, Privacy, and Disclosure Guidelines for Care Coordination (policy) applies to all associates in the *Passport Health Plan* Care Coordination Department.

**PURPOSE**

The policy defines the guidelines to define the process utilized for confidentiality and privacy of member’s protected health information (PHI). Passport Health Plan collects, processes, transmits, maintains, and provides access to large amounts of information, much of it sensitive, about members, employees, and providers, and about the business and administrative functions of the company. Passport Health Plan uses this information to over-see the delivery of care, compensate health care providers, and measure and improve care. In addition, laws, regulations, and accreditation standards that relate to confidentiality and privacy issues must be followed. Members, employees, providers, and the company are expected to ensure that privacy and confidentiality is respected and protected.

This policy is intended to outline the parameters under which authorization from a member is required before personal health information can be used, to outline ways in which confidential information is protected in the Care Coordination Department, and to describe the process for obtaining an authorization for storing and tracking authorizations consistent with the following:

- 1) Applicable federal and state laws and regulations
- 2) Passport Health Plan’s standards of conducting business without collecting or divulging more information than is necessary
- 3) Passport Health Plan’s need to do research and measure quality using aggregated or non-identifiable data whenever possible

**POLICY**

Passport Health Plan has defined procedures for the protection of all collected “confidential information” that is used or disclosed in the course of performing job duties. The Care Coordination staff has access to certain protected health information (PHI) that is used to review

## **Confidentiality, Privacy and Disclosure Guidelines for Care Coordination**

the medical necessity of services through prior authorization, concurrent review, retrospective review, and review of appeals for members and providers. This information may be used by the Care Coordination staff to coordinate treatment and facilitate payment and health care operations as outlined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Care Coordination staff uses the minimum amount of protected health information (PHI) necessary to accomplish required job tasks.

All Care Coordination staff must read and sign the Passport Health Plan's Confidentiality Agreement and related Privacy and Confidentiality Policies upon hire. Temporary employees, consultants or student workers/interns working in the Care Coordination Services area must also read and sign the Confidentiality Agreement and Privacy Policies. It is the responsibility of the Human Resource (HR) Manager and the Care Coordination Managers to ensure all permanent and temporary staff working in the Care Coordination Department signs the Confidentiality Agreement.

It is not permitted for Care Coordination staff to use or disclose a member's protected health information (PHI) for reasons other than to oversee the delivery of healthcare services to the member, arrange for payment and/or carry out routine healthcare operations unless there is express written authorization from the member to do so, or where required by law. Any Care Coordination associate who receives a request for information that requires a privacy authorization must contact their respective manager and/or the Privacy Officer before this information is disclosed (refer to Passport Health Plan's Policy CO 12).

Passport Health Plan protects the confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. When contacting these members, efforts are made by Passport Health Plan associates to contact the member via their preferred method of contact. No PHI is left on an answering machine. If the member prefers to be contacted by mail, correspondence is addressed to the member.

At the time of enrollment in Case Management/Care Coordination, if the member is receiving services with statutory requirements requiring member consent to share (i.e., behavioral health, alcohol/substance abuse, HIV/AIDS, or sexually transmitted diseases) the Case Manager/Care Coordinator informs the member verbally and in writing of the parameters for routine uses and disclosures of personal health information. The Case Manager/Care Coordinator sends the member an Authorization for Release of Protected Health Information form for completion for any release of PHI outside the parameters allowed per federal and state regulations (i.e., for treatment, payment and operations). Passport Health Plan honors the member's decision to permit or refuse the disclosure of protected health information. A member may revoke any authorization at any time. Passport Health Plan does not condition provision of treatment, payment, or eligibility for any benefits to a member on the provision of an authorization.

This policy does not supersede Passport Health Plan's organizational policy on Privacy and Confidentiality (refer to Privacy and Confidentiality Policy CO 1).

## Confidentiality, Privacy and Disclosure Guidelines for Care Coordination

This policy is intended to comply with current state and federal laws and regulations, as well as accreditation standards of the National Committee for Quality Assurance (NCQA). As such requirements and standards change, this policy is reviewed at least annually and revised as needed.

### DEFINITION(S)

- 1) **Confidential Information – includes, but is not limited to:**
  - a) Protected health information (PHI) (defined below)
  - b) Personal information concerning employees, members, and providers
  - c) Personal information concerning minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185
  - d) Practitioner-specific information related to credentialing proceedings, quality reviews, malpractice suits, peer-reviewed determinations, etc
  - e) Financial information relating to employees, members, providers, contractors, subcontractors, vendors, and consultants
  - f) Proprietary business information and trade secrets
  
- 2) **De-Identified Information – means information from which the following identifiers have been removed or otherwise concealed by a person with appropriate knowledge and experience, and there is no reason to believe that any anticipated recipient of the information could use the information, alone or in combination with other information, to identify an individual:**
  - a) Name
  - b) All geographic subdivisions smaller than state level, including street address, city, state, and zip code
  - c) Name of relatives
  - d) Name of employer
  - e) All elements of dates (except year) for dates directly related to the individual
  - f) Phone numbers, including telephone, fax, cell, etc.
  - g) Electronic mail (E-mail) addresses
  - h) Social security number
  - i) Medical record number
  - j) Health plan member number
  - k) Account number
  - l) Certificate/License number
  - m) Any vehicle or other device serial number
  - n) WEB Universal Resource Locator
  - o) Internet Protocol (IP) address number
  - p) Biometric identifiers (such as voice or finger prints)
  - q) Photographic images

## Confidentiality, Privacy and Disclosure Guidelines for Care Coordination

- r) Any other unique identifying number, characteristic or code that may be available to an anticipated recipient of the information.
- 3) **Emancipated minor** – A child released from the control of parents or a guardian, and those minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185; and those minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185.
- 4) **Health Care Operations** – means any of the following activities of the covered entity to the extent that the activities are related to covered functions and any of the following activities of an organized health care arrangement in which the covered entity participates:
- a) Conducting quality assessment and improvement activities or population-based activities relating to improving health or reducing costs, protocol development, Care Coordination Services, and related functions that do not include treatment
  - b) Reviewing the competence or qualifications of health care professionals
  - c) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits
  - d) Conducting or arranging for medical review, legal services, and auditing functions
  - e) Business planning and development
  - f) Business management and general administrative activities, such as:
    - 1) Management activities, customer service, internal grievance resolution, due diligence in connection with the sale of assets, creating de-identified health information, fundraising, and marketing.
- 5) **Medical Record** – as used in this policy, means a permanent or long-lasting account of the specific health problems of the patient, including the presenting problems, the diagnosis, the plan of care, the progress notes (which document the observations, assessments, nursing care plans, physician’s orders, etc. of all health care personnel directly involved in the care of the patient). The provider generates this record.
- 6) **Minimum Necessary** – The Privacy Rule requires a covered entity to make reasonable efforts to limit the use, disclosure of and requests for protected health information (PHI) to only the necessary amount to accomplish the intended purpose.

## Confidentiality, Privacy and Disclosure Guidelines for Care Coordination

- 7) **Privacy Authorization** – is the mechanism for obtaining consent for the use and disclosure of protected health information in instances other than treatment, payment and health care operations.
- 8) **Protected Health Information (PHI) or Individually Identifiable Health Information** – as used in this policy, means health information (including demographic information) collected about an individual:
  - a) From a provider, another health plan, health care clearinghouse, or created by Passport Health Plan itself.
  - b) That relates to the past, present, future physical or mental health or condition of an individual, provision of health care to that individual, or the past, present, future payment for the provision of health care to the individual, and that identifies, or with respect to which there is a reasonable basis to believe the information can be used is received from the individual, the Department for Medicare/Medicaid Services (DMS), a health care identify the individual.
  - c) Which could be identifiable either explicitly, by linking health information to an individual’s name, or implicitly, by providing information that could be combined with other information to identify the individual, such as a Social Security, date of birth, etc. Protected health information (PHI) includes, but is not limited to, medical records, claims, and utilization management records.
- 9) **Psychotherapy Notes** – are notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. The term “psychotherapy notes” excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms prognosis, and progress to date. The term does not include notes in a medical record that describe a condition or behavior observed in the course of a physical examination or a psychiatric consultation performed for a placement/admission in a facility.

### PROCEDURE

- 1) **Access to Data, Files, and Records:**
  - a) All Care Coordination staff, including the Department Director, Department Managers, Case Managers/Care Coordinators, and Case Management Technicians (CMT) staff for the above department has access to member specific information in order to perform job functions.

## Confidentiality, Privacy and Disclosure Guidelines for Care Coordination

- b) The Care Coordination Services staff is permitted access to Passport Health Plan systems, as well as internal databases that contain protected health information (PHI) to coordinate treatment and facilitate payment and health care operations (TPO).

### **The Care Coordination Department uses and discloses protected health information (PHI) internally and externally for the purposes of:**

- 1) Assigning an internal Case Manager/Care Coordinator to any member determined to be high risk, in need of coordination of services, or is receiving out of network treatment from non-par providers or facilities.
  - 2) Obtaining pertinent information about the member through risk assessment, office visits, and notification forms. This information is received from providers, social workers, and other community agencies.
  - 3) Making and reviewing referrals for members.
  - 4) Performing outreach to members and providers to participate in Case Management/Care Coordination Services/Programs.
  - 5) Directing members to the most appropriate level/type of care.
  - 6) Medical record documentation review and continuity and coordination of care review.
- c) The Care Coordination staff only requests protected health information from another entity if they have a demonstrated need to know, and may only request the minimum amount of protected health information necessary for the specific purpose. Care Coordination staff who receive requests for member information from outside practitioners, providers, or facilities must take steps to make sure the information requested and disclosed is only the minimum necessary for the request.
- d) Care Coordination staff also make referrals on behalf of the member to non-covered entities. These referrals may include PHI. Examples used include:
- St. Vincent De Paul
  - Dare to Care/Kentucky Harvest Distribution Site
  - Churches for food, clothing, etc.
  - CPS/APS
  - Housing Authority (Section 8)
  - Lions Club
  - Community Action Agency
  - Center for Accessible Living
  - Tenants Association
  - 7-Counties
  - Government programs (SSI/WIC, HANDS, Healthy Start etc.)

## Confidentiality, Privacy and Disclosure Guidelines for Care Coordination

- Housing for medical treatment reasons (Ronald McDonald House)
- Non-contracted, commercial vendors (LG&E/Phone company/landlords)
- Family, emergency contact of persons of members
- Community interpreters
- TARC 3 and other transportation vendors
- School systems
- Non-profit private funding sources
- Homeless shelters
- Department of Health (DOH) (*Mommy & Me* home referral, EPSDT home referral)

These activities are listed in Passport Health Plan's Notice of Privacy Practices\*, which is distributed to members upon enrollment and located on the *Passport Health Plan* website. The Notice of Privacy Practices informs the member how their information may be used in the Care Coordination program and how the member may opt-out of this practice if requested.

(\*The Notice of Privacy Practices is a requirement of the Health Information Portability and Accountability Act of 1996. Passport Health Plan and all other covered entities complied by April 2003).

### 2) Committees:

- a) Care Coordination staff are asked to chair, attend, or supply information for various Passport Health Plan committees. If a committee consists of members who are not Passport Health Plan employees, those external members are asked to read and sign the Passport Health Plan's Confidentiality Agreement. The Confidentiality Agreement outlines the committee member's responsibilities for protecting information confidentiality. The Confidentiality Agreement is reviewed and signed annually. The nature of some committee discussion requires that member information be not blinded. Whenever possible, member information is blinded for committee discussion.

### 3) General Care Coordination Privacy and Confidentiality Guidelines:

- a) All faxes sent by this department that contain confidential information are sent with a confidential cover letter from a fax machine located in a secure area. The sender will take steps to ensure that the intended recipient received the faxed information.
- b) Information of a confidential nature is not left unattended or in plain sight in any work area. Confidential information is removed in a timely

## Confidentiality, Privacy and Disclosure Guidelines for Care Coordination

fashion from printer output bins, fax machines, and copiers. Computers are logged off at the close of business each day.

- c) Any member-related information obtained in connection with performing job responsibilities is not shared with other Passport Health Plan associates unless the information is necessary to the performance of the associate's job duties.
- d) Confidential information, required to be retained on paper is stored in locked file drawers at the close of business each day. Filed information in the Care Coordination Department is purged annually, on a rolling calendar and stored in a locked area off-site for a total of seven years. Confidential information on paper that does not need to be saved is placed in a confidential bin for shredding.
- e) Communications with providers, hospitals, subcontractors, and other agencies is limited to the acceptance/disclosure of the minimum necessary protected health information to accomplish the purpose.
- f) Communications with individuals about whom the protected health information (PHI) is referring are not limited to minimum necessary.
- g) Identification verification procedures must be followed **every time** Care Coordinators are contacted by a member or member's representative, or **every time** they contact a member or member's representative. The process is as follows:
  - 1. The identity of the member or member's representative is verified by asking for **at least three** of the following identifying information:
    - a. Social Security Number;
    - b. *Passport Health Plan* Identification Number;
    - c. Birth date;
    - d. Address,
    - e. Phone number; or
    - f. Zip code of member.

\*\*\*In an effort to remain sensitive to member concerns in relation to behavioral healthcare issues, and in regards to personal information concerning minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185, the Case Manager/Care Coordinator assesses the member's willingness to disclose PHI when attempting to verify at least 3 pieces of identifying information. If the Care Coordinator, in his/her professional opinion feels they have not adequately established the identity of the person to whom they are speaking, they do not proceed.

## Confidentiality, Privacy and Disclosure Guidelines for Care Coordination

2. The Case Manager/Care Coordinator may ask for more than three identifying pieces of information listed above if there is a question to whom they are speaking.
- h) Leading questions are not asked to determine caller identity. The identity of a personal representative or guardian of the member must be documented and the same caller verification process followed. This procedure must be repeated with every telephone contact.
  - i) If the member is unable to communicate with the Case Manager/Care Coordinator on an ongoing basis due to a disability, physical or mental limitations, the member must designate a personal representative.
  - j) If the personal representative has a valid durable power of attorney, proof of legal guardianship or other legal documentation showing they are authorized to represent the member, a copy of the document must be maintained in the Care Coordination file.
  - k) If the member's personal representative does not have legal documentation to verify they are authorized to represent the member, then a Personal Representative Form is sent to the member to be signed by the member and returned to the Case Manager/Care Coordinator to document the personal representative can receive confidential information regarding the member (see *Attachment C – Appointment of Personal Representative Form*). A member may designate one or more personal representatives on this form. When the signed form is received from the member appointing a personal representative(s), the form is maintained in the member's file and the personal representative(s) who are authorized to discuss the member's case is documented in the dedicated Medical Management system.
  - l) When leaving voice messages for members on a recording device, such as a telephone answering machine, the Case Manager/Care Coordinator may only leave his or her name and phone number. No other information concerning the member's health information may be left on the recording device.
  - m) The E-mailing of PHI to external entities is not permitted unless adequate levels of encryption are used.
  - n) All requests by Care Coordination staff for Passport Health Plan participation in research projects that involve member information is forwarded to the Privacy Officer for prior approval. Member information is not given to any outside entity for research purposes without the written privacy authorization of the member.

## Confidentiality, Privacy and Disclosure Guidelines for Care Coordination

- 4) The member or the member's authorized representative must sign and date the authorization, which must include the following:
- The specific purpose for use or disclosure of PHI;
  - The description of the information to be used or disclosed;
  - The name or function of the person or entity authorized to disclose the information;
  - A specific date or specific event after which the person or entity is no longer authorized to disclose the health information;
  - A statement that the member signing the authorization can see and copy information described on the form and receive a copy of the form after they sign it;
  - A statement of the individual's right to revoke the authorization in writing, listing any exceptions to the right to revoke, and a description of how the individual may revoke the authorization;
  - A statement that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by PHI; and
  - If a personal representative signs the authorization, a description of the representative's authority to act for the individual.

A member has the right to refuse to provide the above authorization. Passport Health Plan does not condition enrollment or payment on the declined provision by the member of a requested authorization for use or disclosure of Protected Health Information.

- 5) A member may revoke an authorization at any time. The revocation must be in writing. If Passport Health Plan has already used or disclosed the PHI based on the initial authorization, the revocation cannot be made retroactive. From the point Passport Health Plan receives the revocation, Passport Health Plan ceases and desists using the PHI.

### 6) Sanctions:

- a) Any suspected violations of this policy should be reported to the department manager and/or director, and the Privacy Officer. If the violation involves accidental or negligent misuse of confidential information, an investigation is conducted and progressive disciplinary actions may follow in accordance with Human Resource (HR) guidelines. Intentional misuse of confidential information will not be tolerated by Passport Health Plan, and may result in suspension or termination.

<b>CROSS REFERENCE/REFERENCE MATERIALS</b> <b>(If necessary to cite other policies or documents)</b>
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HIPAA Privacy Regulations: 45 CFR Sections 160 and 164, Standards for Privacy and Individually Identifiable Health Information: Final Rule

## Confidentiality, Privacy and Disclosure Guidelines for Care Coordination

Reviewed 45 CFR 3164.402

National Committee for Quality Assurance (NCQA)

KRS 214.185 Diagnosis and treatment of disease, addictions, or other conditions of a minor

Passport Health Plan:

Authorization for Non-Routine Use and Disclosures of PHI, Policy No. CO 11

Personal Representatives and Identify Verification of Individuals Requesting PHI, Policy No. CO 12

Disclosures of PHI to Regulators, Policy No. CO 15

Uses and Disclosures of PHI without Privacy Authorization to Avert a Serious Threat to Health or Safety, Policy No. CO 17

Disclosures of PHI to Business Associates and Other Contractors, Policy No. CO 23

*Attachment A* – Authorization for Release of Protected Health Information

*Attachment B* – Instructions for Release of Protected Health Information Form

*Attachment C* – Appointment of Personal Representative Form

### **REVIEW AND REVISION DATES (Annually at minimum)**

9/14/10

9/14/11

9/14/12

10/30/13 – Retired – Using Company Policy

12/9/2012 Reactivated

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End of Policy

# Authorization for Release of Protected Health Information



Passport Health Plan needs your permission to get and to share some of your personal health information. This will only be done with the providers you choose. This is to help you get the best health care. For us to do this, you (or your representative) must read and complete this form.

**If you do not sign and return this form, we will not be able to share information with your provider(s). Not signing this form will not affect your plan eligibility.**

## Section A: Must be completed for Passport Health Plan to get and to share some of your personal health information.

1. I give my permission for some of my personal health information to be shared. This is information about my mental health; alcohol/substance abuse; HIV/AIDS; sexually transmitted diseases. **Initials X** \_\_\_\_\_
2. I am aware this information will only be used for coordination of my health care. **Initials X** \_\_\_\_\_
3. I am aware that I do not have to fill out and sign this form. I will still be a member of Passport Health Plan. **Initials X** \_\_\_\_\_
4. I am aware that I will get a copy of this form after I sign it. **Initials X** \_\_\_\_\_
5. I am aware my permission will continue for as long as I am a member of Passport Health Plan or until \_\_\_\_\_ **Initials X** \_\_\_\_\_
6. I am aware I can stop my permission any time. I can do this by writing Passport Health Plan. The address is 5100 Commerce Crossings Drive; Louisville, Kentucky 40229. **Initials X** \_\_\_\_\_
7. I am aware Passport Health Plan will not get money for my personal health information. **Initials X** \_\_\_\_\_

Signature of Member: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Representative: \_\_\_\_\_ Date: \_\_\_\_\_

*Please continue to page 2*

**Section B:** Must be completed for Passport Health Plan to get and to share some of your personal health information.

The information will only be used for coordination of my health care.

Section 1

I give Passport Health Plan my permission to get and to share information about my:

- Physical Health Information
- Mental Health Information
- Sexually Transmitted Disease
- Alcohol/Substance Abuse
- HIV/AIDS

Section 2

I give Passport Health Plan my permission to get and to share information with:

- |   |  |
|---|--|
| <input type="checkbox"/> University of Louisville Hospital  | <input type="checkbox"/> Jewish Hospital                             |
| <input type="checkbox"/> Norton Hospital                    | <input type="checkbox"/> Suburban Hospital                           |
| <input type="checkbox"/> Audubon Hospital                   | <input type="checkbox"/> Baptist Hospital East                       |
| <input type="checkbox"/> St. Mary's and Elizabeth Hospital  | <input type="checkbox"/> Hardin Memorial Hospital                    |
| <input type="checkbox"/> Kosair Children's Hospital         | <input type="checkbox"/> Baptist Hospital Northeast                  |
| <input type="checkbox"/> Breckinridge Memorial Hospital     | <input type="checkbox"/> Carroll County Memorial Hospital            |
| <input type="checkbox"/> Caverna Memorial Hospital          | <input type="checkbox"/> Ephraim McDowell Regional Medical Center    |
| <input type="checkbox"/> Flaget Memorial Hospital           | <input type="checkbox"/> Harrison County Hospital                    |
| <input type="checkbox"/> Jewish Hospital – Shelbyville      | <input type="checkbox"/> New Horizons Medical Center                 |
| <input type="checkbox"/> Spring View Hospital               | <input type="checkbox"/> St. Luke Hospital                           |
| <input type="checkbox"/> Taylor Regional Hospital           | <input type="checkbox"/> The James B Haggin Memorial Hospital        |
| <input type="checkbox"/> Twin Lakes Regional Medical Center | <input type="checkbox"/> Central State Hospital                      |
| <input type="checkbox"/> Lincoln Trail                      | <input type="checkbox"/> Our Lady of Peace: Adult                    |
| <input type="checkbox"/> Wellstone                          | <input type="checkbox"/> Our Lady of Peace: Geriatrics (65 or older) |
| <input type="checkbox"/> The Broeck Dupont                  | <input type="checkbox"/> Frazier Rehabilitation Hospital             |
| <input type="checkbox"/> Ten Broeck KMI                     | <input type="checkbox"/> Kindred Hospital                            |
| <input type="checkbox"/> Other _____                        | <input type="checkbox"/> Other _____                                 |
| <input type="checkbox"/> Other _____                        | <input type="checkbox"/> Other _____                                 |

\* Other is any physician, specialist, or facility not listed on this form.

Signature of Member: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Please continue to page 3

## Section C: STOP!

Finished? Did you initial each blank line and sign on page 1? Did you check the boxes and sign on page 2?

Member Name (print): \_\_\_\_\_

Signature of Member: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Representative: \_\_\_\_\_

Date: \_\_\_\_\_

If you have any questions, please call the Care Coordination Team at 1-877-903-0082.

Passport Health Plan  
5100 Commerce Crossings Drive  
Louisville, Kentucky 40229  
1-800-578-0603  
TDD/TTY 1-800-648-6056

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**Authorization for  
Release of Protected  
Health Information  
Instruction Sheet**



Passport Health Plan needs your permission to get and share some of your personal health information. This information will only be shared with the providers you choose. This is to help you get the best health care.

If you or your representative needs help with this form, please call the Care Coordination Team at 1-877-903-0082. We will be happy to help.

**If you do not sign and return this form, we will not be able to share your personal health information with your provider(s). Not signing this form will not affect your plan eligibility.**

**Section A:**

1. Please read each sentence and initial that you agree.
2. On question number 5, enter a date if you **do not** want us to share your personal health information for the entire time you are eligible.
3. Sign your full name and write in the date at the end of Section A.
4. If your representative completed the form, they must sign their full name and write in the date.

**Section B:**

1. In Section 1, tell us what information we can share by checking the correct box or boxes.
2. In Section 2, tell us who we can share the information with by checking the correct box or boxes.
3. In Section 2, if other is checked please write in the physician, specialist, or facility full name.
4. Sign your full name and write in the date at the end of Section B.
5. If your representative completed the form, they must sign their full name and write in the date.

**Section C:**

1. Print your full name.
2. Sign your full name and write in the date at the end of Section C.
3. If your representative completed the form, they must sign their full name and write in the date.

*Attachment B*

**Confidentiality, Privacy and Disclosure Guidelines for Care Coordination**

**Appointment of Personal Representative Form**

I, \_\_\_\_\_ hereby appoint  
(Name of Member)

\_\_\_\_\_  
(Name, Address and Phone Number of Personal Representative)

to be my Personal Representative and allow *Passport Health Plan, Inc.* to give out my Protected Health Information to the personal representative listed above. This includes but is not limited to, information concerning any past, present or future physical or mental health condition, of whatsoever nature or kind, including any substance abuse, chemical dependency, HIV/AIDs or other confidential health information.

I hereby release *Passport Health Plan, Inc.*, its respective successor and assigns, heirs, executors, administrators and personal representatives, employees, officers, agents, against any loss from any and all claims, demands or actions in law or equity, whatsoever, that may subsequently be brought by anyone, and I waive any and all rights which I may be entitled under any state or federal law for reimbursement or indemnity.

This Appointment of Personal Representative starts on the date written below and will remain in effect until revoked by me.

\_\_\_\_\_  
Member's Signature

Member's Address:

\_\_\_\_\_  
\_\_\_\_\_

Member's Social Security Number or  
Passport Health Plan Identification Number:

\_\_\_\_\_

Date: \_\_\_\_\_

Witness:  
\_\_\_\_\_

*Attachment C*

Personal Representatives and Identity Verification of Individuals Requesting PHI

		<b>Policy/Procedure</b>
<b>Policy Name: Personal Representatives and Identity Verification of Individuals Requesting PHI</b>		<b>Policy Number: CO 12</b>
<b>Date of Next Annual Review: 12/8/2015</b>		<b>Original/Issue Date: 5/15/02</b>
<b>Approved By: David Henley, JD, CCEP, CHIE, FLMI</b>		<b>Title: VP &amp; Chief Compliance Officer</b>
<b>Signature: <i>Signature on File</i></b>		<b>Date Approved:</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date:</b>
<b>New</b> (Date policy was created)	<input type="checkbox"/>	
<b>Reviewed</b> (No changes to policy)	<input type="checkbox"/>	
<b>Revised</b> (Content changes made to policy)	<input checked="" type="checkbox"/>	December 8, 2014
<b>Retired</b> (Policy no longer active)	<input type="checkbox"/>	

**APPLICABILITY**

This policy applies to all Passport Health Plan (Passport) associates.

**PURPOSE**

To establish guidelines for the verification and identification of Member Personal Representatives for members who are unable to make decisions about their Protected Health Information.

**DEFINITION(S)**

**Advance Directive** – A written document in which a competent individual gives instructions about his/her healthcare that will be implemented at some future time should that person lack the ability to make health care decisions for himself or herself.

**Emancipated minor** – A child released from the control of parents or a guardian, and those minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185; and those minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185.

**Individual** – The person who is the subject of Protected Health Information.

**In loco parentis** – In the position or place of a parent.

**Member** – A person enrolled in Passport Health Plan.

**Personal Representative** – A person who is designated by the member or authorized by law to make decisions about the member’s protected health information.

**Power of Attorney** – Legal instrument authorizing one to act as another's attorney or agent.

**Protected Health Information (PHI) or Individually Identifiable Health Information**, as used in this policy, means health information (including demographic information, race, ethnicity and language) that:

- ◆ Is created or received from the individual, by a health care provider, the Department for Medicaid Services, Passport, another health plan, an employer, or a health care clearinghouse;
- ◆ Relates to the past, present or future physical or mental health or condition of an individual, provision of health care to that individual, or the past, present or future payment for the provision of health care to the individual, and that identifies or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. [Note: the information could be identifiable either explicitly, by linking health information to an individual’s name, or implicitly, by providing information that could be combined with other information to identify the individual, such as a Social Security number, date of birth, etc.]; and
- ◆ Relates to services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185.

PHI includes, but it is not limited to, medical records, claims and utilization management records.

**Unemancipated Minor** – A child under the control of parents or a guardian.

<b>POLICY</b>
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It may be necessary for Passport to communicate with an individual other than the member about the member’s protected health information. The member may designate a personal representative to make decisions about protected health information if the member lacks the ability or is unable to give consent or authorization. Passport will consider a personal representative the same as the member with respect to the member’s PHI. Passport may also disclose to a family member, other relative or a close personal friend of the member, or any other person identified by the member, the PHI directly relevant to such person’s involvement with the

member's care or payment related to the member's health care if the member is present to agree or object to such disclosure. If such a person has not been identified in advance by the member or the member is not present or is otherwise incapable of agreeing or objecting to such a disclosure, Passport may use its discretion to disclose certain protected health information to persons assisting in the care of a member or payment of the member's health care. Passport will take steps to verify the identity of persons requesting PHI for or on behalf of the member.

Adequate provisions are taken for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185.

## PROCEDURE

**A Passport Health Plan member has the right to designate a personal representative to make decisions about protected health information in the event the member is unable to or lacks the ability to do so.**

**Passport Health Plan will consider a personal representative the same as the member with respect to the member's PHI. The personal representative has the right to:**

- ◆ Approve or deny a request for authorization to disclose the member's PHI for reasons other than facilitation of treatment, payment or health care operations, or as otherwise required or permitted by law;
- ◆ Request an accounting of disclosures of PHI on behalf of the member;
- ◆ Request that the member's PHI be restricted for (i) the use or disclosure of some or all of their PHI in the course of carrying out treatment, payment or health care operations purposes, (ii) disclosures to persons involved in the member's care or payment for their care, and (iii) uses and disclosures for notification purposes;
- ◆ Access the member's designated record set;
- ◆ Request an amendment to the member's PHI in a designated record set; and
- ◆ Exert any other right that would be available to the member if the member had the capacity to make his or her own decision.

### **1. Adults and Emancipated Minors**

A person may be granted authority to act on behalf of a member who is an adult or an emancipated minor in making decisions related to health care. Passport will consider such person as a personal representative with respect to the member's protected health information

If an adult member, who does not have decisional capacity and has not executed an Advance Directive, or to the extent that the Advance Directive does not address the decision that must be made, any one of the following responsible parties, in the following order of priority, shall be authorized to make health care decisions on behalf of the member:

- ◆ The judicially appointed guardian of the member, if medical decisions are within the scope of the guardianship;
- ◆ The attorney in fact named in a Durable Power of Attorney, if it specifically authorizes health care decisions;
- ◆ The spouse of the member;
- ◆ The adult child of the member (if more than one adult child, the majority of the adult children reasonably available for consultation);
- ◆ The parents of the member
- ◆ The nearest living relative of the member (if more than one relative of the same relation is reasonably available for consultation, a majority of them).

## 2. Unemancipated Minors

- A. A parent, guardian or other person acting *in loco parentis* has authority to act on behalf of a member who is an unemancipated minor in making decisions related to health care. This authority is also granted to the foster parent or adoptive parent of an unemancipated minor. Passport will consider that person as a personal representative with respect to protected health information relevant to such personal representation.
- B. However, the person may not act as a personal representative of the unemancipated minor and the minor has the authority to act as an individual with respect to his or her own protected health information pertaining to a health service if:
- ◆ The minor consents to such health care service; no other consent to such health care service is required by law, regardless of whether the consent of another person has also been obtained; and the minor has not requested that such person be treated as the personal representative.
  - ◆ The minor may lawfully obtain such health care service without the consent of the parent, guardian, or other person acting *in loco parentis*, and the minor, a court or other person authorized by law consents to such health care service: or
  - ◆ A parent, guardian, or other person acting *in loco parentis* assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.
- C. Notwithstanding any of the exceptions listed in (B) above:
- ◆ Passport may disclose or provide access to PHI about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis* if applicable state case or statutory law or other applicable law explicitly permits or requires disclosure.
  - ◆ Passport may not disclose or provide access to PHI about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis* if applicable state case or statutory law or other applicable law explicitly prohibits disclosure.
  - ◆ If applicable state case or statutory law or other applicable law is silent as to whether disclosure of PHI about an unemancipated minor is required, permitted, or prohibited to be made to a parent, guardian or other person acting *in loco parentis*, then Passport may provide or deny access to PHI about an unemancipated minor to a parent,

guardian, or other person acting *in loco parentis* if the parent, guardian, or other person acting *in loco parentis* is not a personal representative because one of the exceptions in (B) above applies and if allowing or denying such access is consistent with state case or statutory law or other applicable law, provided that the decision to allow or deny access must be made by a licensed health care professional in the exercise of professional judgment.

**However, Passport protects the confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185.**

### **3. Foster Care and Adoptive Assistance**

An adult acting as the foster parent or adoptive parent of a member has the authority to act on behalf of, or to have access to information about a minor member.

### **4. Deceased Individuals**

An executor, administrator, or other person permitted by State law, has the authority to act on behalf of a deceased member or of the member's estate. Passport will consider such person a Personal Representative with respect to protected health information relevant to such personal representation.

### **5. Abuse, Neglect and Endangerment Situations**

Passport may elect not to recognize a person as the personal representative of a member if there is a reasonable belief that:

- ◆ The member has been or may be subjected to domestic violence, abuse, or neglect by such person; or
- ◆ Treating such person as the personal representative could endanger the member;

AND

- ◆ An agent of Passport, in the exercise of professional judgment, decides that it is not in the best interest of the member to treat the person as the member's personal representative.

## **Verification of the Personal Representative or Others Requesting Protected Health Information**

### **1. Verifying Personal Representatives**

Passport requires verification of the identity of the personal representative. Passport may either require:

- ◆ Proof of guardianship;
- ◆ Proof of Power of Attorney;
- ◆ Death certificate and order of court appointing personal representative as administrator or recognizing Personal Representative as executor;
- ◆ Proof of permission from an unemancipated minor, or a minor who consented to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addition, contraception, or pregnancy or childbirth without parental notification or consent (KRS 214.185); or
- ◆ Ask questions to determine that a person acting for a young child or a person acting on behalf of a member that is unable to make decisions about their own PHI, has the requisite relationship to the member. Passport will ask the person at a minimum the following questions:
  - a. Member's social security number;
  - b. Member's date of birth; and
  - c. Member's address
- ◆ If the person calling on behalf of the member cannot provide proof or give the answers to these questions, Passport will not give out any protected health information about the member.
- ◆ The name and relationship to the member will be documented in the EXP system for each inquiry.

### **2. Verifying Persons assisting in a Member's Care or Payment for a Member's Health Care**

If the individual is not present for, or does not have the opportunity to agree or object to the use or disclosure, or such agreement or objection cannot practicably be provided because of the individual's incapacity or an emergency circumstance, Passport, in exercise of professional judgment, will determine whether the disclosure is in the best interest of the member and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the member's care or payment related to the member's health care or needed for notification purposes.

Passport may use its professional judgment to disclose certain protected health information to family members, relatives, close friends, and other persons assisting in the care of a member.

Passport will document the disclosure of PHI to a person assisting in the member's care in the EXP system.

### 3. Verifying the Individual Member

Passport is required to give members access to PHI about themselves, under most circumstances. Passport is required to take reasonable steps to verify the identity of the member making the request. Passport may ask the member, at a minimum:

- ◆ Passport Health Plan Identification Number;
- ◆ Social Security Number;
- ◆ Phone Number; and
- ◆ Address

The member will be required to answer the verification questions before Passport will disclose the member's protected health information.

### 4. Identity and Authority Verification

Prior to any allowable disclosure, Passport will verify the identity of the person requesting PHI and the authority of any such person to have access to PHI under the Privacy Rule, if the identity of such person is not known to Passport. Passport will also obtain documentation, statements, or representations, either oral or written, from the person requesting the PHI when documentation, statements, or representations are a condition of the disclosure under the Privacy Rule. (an example of a condition of the disclosure under HIPAA regulations would be an administrative subpoena.) For specific guidance on verifying the authority and identity of public officials, see 45 CFR §164.514(h)(2)(ii)-(iii).

<b>CROSS REFERENCE/REFERENCE MATERIALS</b> (If necessary to cite other policies or documents)
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HIPAA Privacy Regulations: 45 CFR §§ 164.502, 164.510, 164.514  
Standards for Privacy of Individually Identifiable Health Information; Final Rule  
KRS 214.185 Diagnosis and treatment of disease, addictions, or other conditions of a minor

Attachment I – Appointment of Personal Representative Form  
CO 1 Confidentiality Policy  
CO 11 Privacy Authorizations Policy  
Previously CO 4.02

<b>REVIEW AND REVISION DATES</b> (Annually at Minimum)
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May 15, 2002  
May 30, 2003  
Jan. 1, 2004

Personal Representatives and Identity Verification of Individuals Requesting PHI

April 1, 2005

June 2, 2006

June 1, 2007

July 1, 2008

April 1, 2010

September 9, 2011

August 2012

September 2013

December 8, 2014

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End of Policy

		<b>Policy/Procedure</b>
<b>Policy Name: Privacy/Confidentiality</b>		<b>Policy Number: CO 1</b>
<b>Date of Next Annual Review: 3/31/2015</b>		<b>Original/Issue Date: 1/1/02</b>
<b>Approved By: David Henley</b>		<b>Title: VP &amp; Chief Compliance Officer</b>
<b>Signature: <i>Signature on File</i></b>		<b>Date Approved: 3/31/2014</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date:</b>
<b>New</b> (Date policy was created)	<input checked="" type="checkbox"/>	
<b>Reviewed</b> (No changes to policy)	<input type="checkbox"/>	
<b>Revised</b> (Content changes made to policy)	<input checked="" type="checkbox"/>	3/31/2014
<b>Retired</b> (Policy no longer active)	<input type="checkbox"/>	

**APPLICABILITY**

This policy applies to all Passport Health Plan (Passport) associates.

**PURPOSE**

Passport collects, processes, transmits, maintains and provides access to large amounts of information, much of it sensitive, about Members, associates and providers, and about the business and administrative functions of the Company. Passport uses this information to oversee the delivery of care, compensate health care providers and measure and improve care. In addition, laws, regulations and accreditation standards that relate to confidentiality and privacy issues must be followed. Members, associates, providers and the Company should be able to expect that privacy and confidentiality will be respected and protected.

This policy is intended to protect the confidentiality of private information consistent with (1) applicable federal and state laws and regulations; (2) Passport’s contractual obligations and standards of conducting business without collecting or divulging more information than is necessary; and (3) Passport’s need to do research and measure quality using aggregated or de-identified data whenever possible.

**DEFINITION(S)**

**Breach** means the acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted by the HIPAA Privacy Rule which compromises the security or privacy of the PHI. Breach excludes:

- (1) Any unintentional acquisition, access, or use of PHI by a Passport associate or person acting under the authority of Passport or a Business Associate of Passport, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in a further use or disclosure that would violate the HIPAA Privacy Rule. Example: A claims employee receives and opens an e-mail containing PHI about a member whom a provider sent to the claims employee. The claims employee notices that he is not the intended recipient, alerts the provider

of the misdirected e-mail, and then deletes it. In this case, notification of the error must be made to the Privacy Officer for documentation, but this is not considered a Breach.

(2) Any inadvertent disclosure by a person who is authorized to access PHI at Passport or at a Business Associate of Passport to another person authorized to access PHI at Passport or at the same Business Associate of Passport, or an organized health care arrangement in which Passport participates, and the information received as a result of such disclosure is not further used or disclosed in a manner which would violate the Privacy Rule. Example: A claims employee of Passport mistakenly sends PHI to another claims employee of Passport. The receiving employee does not disclose or use the PHI in any way. Although this is not a Breach, the employees must report the incident to the Privacy Officer for documentation.

(3) A disclosure of PHI where Passport or a Business Associate of Passport has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain the PHI. Example: An Explanation of Benefits is mistakenly sent to the wrong individual. It is returned by the post office, unopened, as undeliverable. Passport can reasonably conclude that the addressees could not have read or otherwise retained the information. Thus, no Breach has occurred. However, the incident should be reported to the Privacy Officer for documentation.

**Business Associate** is a person or entity who performs functions or activities on behalf of, or certain services for, Passport that involves the use or disclosure of protected health information (PHI). Business Associates include persons or entities who are not considered part of Passport's workforce who: (1) create, receive, maintain or transmit PHI for payment and health care operations activities, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, certain patient safety activities, billing, benefit management, practice management, and/or re-pricing; or (2) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services where the provision of the service involves the disclosure of PHI from Passport or another Passport Business Associate.

**Confidential Information** includes, but is not limited to the following:

- Protected Health Information (defined below)
- Personal information concerning associates, Members, and providers
- Provider-specific information related to credentialing proceedings, quality reviews, malpractice suits, peer-reviewed determinations, etc.
- Financial information relating to associates, Members, providers and subcontractors
- Proprietary Information

**De-Identified Information** means health information that does not identify an individual and with respect to which there is no reason to believe that the information can be used to identify an individual. De-identification can be achieved by using one of two methods: (1) a formal written determination by a qualified statistical and scientific expert; or (2) the removal of specified individual identifiers as well as absence of actual knowledge by Passport that the remaining information could be used alone or in combination with other information, to identify the individual.

To use the second method, the following identifiers of the individual and of the individual's relatives, employers, or household members must be removed:

- Names;
- All geographic subdivisions smaller than State level, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census: (a) the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (b) the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000;
- All elements of dates (except year) for dates directly related to the individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
- Telephone numbers;
- Fax numbers;
- Electronic mail (e-mail) addresses;
- Social Security numbers;
- Medical record numbers;
- Health plan Member/beneficiary numbers;
- Account numbers;
- Certificate/License numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Web Universal Resource Locators (URLs);
- Internet Protocol (IP) address numbers;
- Biometric identifiers (such as voice or finger prints);
- Full face photographic images and any comparable images (e.g., identifying tattoos);
- Any other unique identifying number, characteristic or code, except for a re-identification code that complies with 45 CFR 164.514 (c).

**Discovered or Discovery** means, in the context of a Breach, the first day on which such Breach is known to Passport or, by exercising reasonable diligence, would have been known to Passport. Passport is deemed to have knowledge of a Breach if such Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is a workforce member or agent of Passport.

**Proprietary Information** is information which Passport owns, develops, pays another person or organization to develop, possesses and/or to which it has an exclusive right, including trade secrets, confidential and proprietary business and strategic plans, health service programs, formulae, methods and other products and information relating to the business and activities of Passport.

**Protected Health Information (PHI) or Individually Identifiable Health Information**, as used in this policy, means health information (including demographic information, race, ethnicity and language) that:

- Is created or received from the individual, by a health care provider, the Department for Medicaid Services, Passport, another health plan, an employer, or a health care clearinghouse; and
- Relates to the past, present or future physical or mental health or condition of an individual, provision of health care to that individual, or the past, present or future payment for the provision of health care to the individual, and that identifies or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. [Note: the information could be identifiable either explicitly, by linking health information to an individual's name, or implicitly, by providing information that could be combined with other information to identify the individual, such as a Social Security number, date of birth, etc.]

PHI includes, but it is not limited to, medical records, claims and utilization management records.

**Provider-Specific Information** means information directly related to a particular health care provider, including but not limited to: name, medical license number, tax identification number, DEA number, any ABMS certifications, data submitted to NPDB and contained within provider files relating to any malpractice suits, as well as from quality reviews, peer reviews, credentialing proceedings, etc. The term "Provider" is used in this policy to cover both facilities and practitioners.

**Subcontractor** means a person to whom a Passport Business Associate delegates a function, activity or service, other than in the capacity of a member of the workforce of such Business Associate. A subcontractor is a Business Associate where that function, activity or service involves the creation, receipt, maintenance or transmission of PHI of Passport Members.

**Unsecured PHI** means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services (HHS).

The two approaches currently approved by HHS are:

Encryption:

- Data at Rest: Encryption must be consistent with National Institute of Standards and Technology (NIST) Special Publication 800-111; and
- Data in Motion: Encryption must be consistent with the applicable NIST Special Publication 800-52, 800-77, 800-113, or others which are Federal Information Processing Standards 140-2 validated

Destruction:

- Paper, film or other hard copy media have been shredded/destroyed so that the PHI cannot be read or otherwise reconstructed (redaction is not acceptable); or
- Electronic media have been cleared, purged or destroyed consistent with NIST Special Publication 800-88 such that the media cannot be retrieved.

**Vendor** means a seller of goods or services that are not directly related to the provision of Covered Services to Members.

## **POLICY**

Confidential Information in any medium (electronic, paper, oral, etc.) shall be protected from unauthorized or inappropriate access, modification, destruction, use or disclosure, whether intentional or accidental.

Passport will implement and monitor consistent policies and procedures for the collection, use, transmission, storage, access to and disclosure of Confidential Information to protect the privacy and confidentiality rights of Passport members, health care providers, subcontractors and Passport Associates and to help to ensure the appropriate use and disclosure of the information.

Neither Passport nor any of its associates or subcontractors will intentionally share, sell or otherwise use any Confidential Information for any purpose not necessary to provide health care services to Members, arrange for payment and/or carry out routine health care operations, unless there is express written consent from the Member to do so, or where required or permitted by law.

## **PROCEDURE**

### **1. Communication of Policy**

Passport will communicate this policy to all regular associates and all temporary associates who will have access to Confidential Information. Passport will also communicate this policy to independent contractors who will have access to Confidential Information. Passport will require all such associates and contractors to sign a confidential statement at the beginning of employment or the engagement stating that they have read, understand and agree to abide by this policy. Contracts for vendors and Business Associates will also have provisions for privacy and confidentiality practices.

### **2. Handling of Confidential Information**

Passport will maintain the privacy of all Confidential Information, including but not limited to: PHI, Provider-Specific Information and Proprietary Information, through the adoption, implementation and ongoing review and revision of its Privacy/Confidentiality Policies and department-specific policies and procedures. Passport will make reasonable efforts to limit the collection, use or disclosure of, or requests for, Confidential Information, including Protected Health Information, to those individuals with a need to know the information, and to limit the collection, use or disclosure of, or requests for, such information to the minimum amount of information necessary to accomplish the intended purpose.

### **3. Notification of Routine Uses and Disclosures**

Passport makes no eligibility determinations and receives all recipient information on its Members from the Kentucky Department for Medicaid Services (DMS). DMS is

responsible for signature collection on the application for coverage. At the time Passport receives record of enrollment, Passport will provide the Member with a statement of the intended uses and disclosures of Protected Health Information (Notice of Privacy Practices) which are identified in Section 4.0 (Use and Disclosure of Protected Health Information) below. The routine notification is intended to cover future, known or routine needs for the use or disclosure of a Member's Protected Health Information. Passport will mail its current Notice of Privacy Practices to Members at least annually.

#### 4. Use and Disclosure of Protected Health Information

As a result of the Member's enrollment in Passport, the Member's PHI may be collected, used and/or disclosed:

- **For Treatment, Payment and Healthcare Operations Purposes.** Passport may use or disclose Member PHI for purposes of treatment, payment or healthcare operations:

**Examples** of such use and disclosure include the following:

- (a.) Diagnosis or treatment of the Member;
  - (b.) Determination of responsibility for payment of claims for health care services;
  - (c.) Payment of claims for health care services;
  - (d.) Disclosure to entities that provide claims management or other administrative services to Passport;
  - (e.) Review of health care services with respect to medical necessity, level of care, quality of care or justification of charges;
  - (f.) Review of the competence or qualifications of health care providers;
  - (g.) Disclosure to entities contracting with Passport to provide disease management programs, provided that the disease management services and care are covered and authorized by a treating physician;
  - (h.) General administration of the health plan; or
  - (i.) On-site review by any private or public body responsible for licensing or accreditation of Passport (records may not be removed from Passport premises).
- **Disclosed to the Member.** At the request of the Member, disclosures of the Member's PHI may be made by Passport to the Member in Passport's discretion.
  - **As Required by Law.** If a disclosure of PHI is required by law, such use or disclosure will be made in compliance with such law and limited to the relevant requirements of the law.

- **For Public Health Activities.** Passport may disclose Member PHI for public health activities and purposes to (a) a public health authority that is permitted by law to collect or receive the information for the purpose of preventing or controlling disease, injury or disability; (b) a public health authority or other government authority that is authorized by law to receive reports of child abuse or neglect; (c) a person subject to the jurisdiction of the Food and Drug Administration (FDA) for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products and defects or problems with FDA-related products; (d) a person who may be at risk of contracting or spreading disease, if such disclosure is authorized by law; or (e) to a Member's school if the information is limited to proof of immunization and the school is required by law to have such proof prior to admitting the Member. Passport will obtain and document the Member's (or parents') agreement to such disclosures.
- **Victims of Abuse or Neglect.** Passport may disclose PHI of a Member that Passport believes is a victim of abuse, neglect or domestic violence to the governmental agency authorized to receive such information. If the Member does not agree to this disclosure, then the disclosure will be made consistent with the requirements of applicable federal and state laws, and only if required or authorized by law.
- **Health Oversight Activities.** Passport may disclose Member PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and entities subject to the civil rights laws.
- **Judicial and Administrative Proceedings.** Passport may use or disclose Member PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, or in certain conditions in response to a subpoena, discovery request or other lawful purpose not accompanied by an order of a court or administrative tribunal.
- **Medical and Administrative Appeals** – Passport may use or disclose Member PHI to make appeal decisions.
- **Law Enforcement** - Passport may give out Member PHI for a law enforcement purpose to a law enforcement official if certain conditions are met (see 45 CFR 164.512(f), CO15).
- **Coroners, Medical Directors and Funeral Directors** - Passport may disclose Member PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death or performing other duties authorized by law. Passport may also disclose Member PHI to funeral directors, consistent with applicable law, where such information is necessary to carry out the funeral directors' duties with respect to the deceased.

- **Organ Donation** – Passport may disclose Member PHI for purposes of communicating with organizations involved in procuring, banking or transplanting organs, eyes or tissues.
- **Research** – Passport may use or disclose Member PHI for research purposes, if certain conditions are met (see 45 CFR 164.508(b) and 45 CFR 164.512(i)).
- **Avert a Serious Threat** – Passport may, consistent with applicable law and ethical conduct, use or disclose Member PHI if we believe that it is necessary to prevent or lessen a serious threat to the health and safety of a person or the general public; provided that, if such a disclosure is made, it must be to a person(s) reasonably able to prevent or lessen the threat (that meets the requirements of CO 17). Passport may also use or disclose Member PHI if it believes that the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual who: (i) admits to participation in a violent crime that Passport reasonably believes caused serious physical harm to the victim, or (ii) appears to have escaped from a correctional institution or lawful custody.
- **Military Activities** – Passport may use or disclose PHI of Members who are Armed Services personnel or foreign military personnel to the appropriate authorized authorities for activities deemed necessary to assure proper execution of military missions, provided certain conditions are met (see 45 CFR 164.512(k)(1)).
- **National Security and Intelligence** - Passport may disclose Member PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by the National Security Act and implementing authority. Passport may also disclose Member PHI to authorized federal officials for the protection of the President or other persons, or for certain federal investigations.
- **Inmates** – Passport may disclose the health information of a Member who is an inmate or otherwise in lawful custody of a law enforcement official if necessary for the Member's health, the health and safety of other inmates or law enforcement, and the safety of the institution at which the Member is in custody.
- **Workers Compensation Purposes** – Passport may disclose Member PHI to the extent authorized by and necessary to comply with the laws relating to worker's compensation or to other similar programs established by law.
- **Business Associates** – Passport may disclose Member PHI to its Business Associates, that have signed a Business Associates Agreement (BAA), and allow them to create, use and disclose Member PHI to do their jobs for us. To protect Member PHI, Passport will seek assurances from these organizations that they have implemented appropriate safeguards to protect member PHI.

- **Appointment Reminders** – Passport may use Member PHI to send Members reminders of needed services or treatments.
- **Health Promotion and Disease Prevention** – Passport may use Member PHI to send Members information about disease prevention and health care. Passport may also work with other agencies on good health and disease prevention programs; however, we must obtain written permission (a Privacy Authorization) from the Member if we want to share Member PHI with other agencies for things other than normal health care business.
- **Friends and Family Members** – Passport may disclose Member PHI to (a) friends or family members who are involved in a Member’s care, or to disaster relief authorities so that a Member’s family can be notified of the Member’s condition and location; (b) a family member, personal representative or other person responsible for the Member’s care about the Member’s location, general condition or death; and (c) if deceased, to a friend or family member who was involved in the Member’s care or payment of the Member’s care prior to their death, limited to information relevant to that person’s involvement in their care or payment for care, unless doing so is inconsistent with wishes that the Member expressed to us during his or her life. Passport is required to protect Member PHI in accordance with the Federal HIPAA Privacy Rule for 50 years after the Member’s death.
- **Member and Provider Claims Services Department** - Passport’s Member Services and Provider Claims Services are trained to answer calls that may involve reviewing Member PHI.

## 5. Specific Authorization

Certain uses and disclosures of Member PHI require that we obtain the Member’s prior written authorization or, if the Member is unable to give an authorization, the Member’s authorized representative. These include the following:

- **Psychotherapy Notes** - If Psychotherapy Notes are created for a Member’s treatment, we must obtain the Member’s prior written authorization before using or disclosing them, except (1) if the creator of those notes needs to use or disclose them for treatment, (2) for use or disclosure in our own supervised training programs in mental health, or (3) for use or disclosure in connection with Passport’s defense of a proceeding brought by the Member. “Psychotherapy Notes” means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. “Psychotherapy Notes” excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following

items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. The term does not include notes in a medical record that describe a condition or behavior observed in the course of a physical examination or a psychiatric consultation performed for a placement/admission in a facility. Given that Passport does not provide treatment, it is unlikely we would have these, but if we do, we will follow the rules for their use and disclosure set out in this paragraph.

- **Marketing** - A written authorization is required for the use and disclosure of Member PHI for marketing purposes, unless the communication is made face to face by Passport to the Member, or is a promotional gift of nominal value.
- **Sale of Member PHI** – If a disclosure of Member PHI would constitute a sale of it, then Passport must obtain the Member’s prior written authorization prior to its disclosure. Sale of PHI does not include a disclosure of PHI for (a) public health purposes; (b) research purposes where the only remuneration received by the Passport or its Business Associate is a reasonable cost-based fee to cover the cost to prepare and transmit the PHI for such purposes; (c) treatment and payment purposes; (d) the sale, transfer, merger or consolidation of all or part of Passport and for related due diligence; (e) to or by a Business Associate for activities that the Business Associate undertakes on behalf of the Passport or on behalf of the Business Associate in the case of a subcontractor, and the only remuneration provided by Passport to its Business Associate, or by the Business Associate to the Subcontractor, is for performance of the activities; (f) to a Member, when requested under the access or accounting of disclosures rules; (g) as required by law; or (h) for any other purpose permitted by and in accordance with the applicable requirements of the HIPAA Privacy Rule, where the only remuneration received by Passport or its Business Associate is a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by other law.

**Note:** For additional information see Passport Health Plan’s Authorization for Non-Routine Use and Disclosures of PHI - Policy CO 11 and Personal Representatives and Identity Verification of Individuals Requesting PHI - Policy CO 12.

## 6. Prohibited Disclosures

Passport will not use or disclose Member PHI that is genetic information for underwriting purposes including, but not limited to, the following: determination of or eligibility for, or determination of, benefits under the plan, coverage or policy (including changes to deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); the computation of the premium or contribution under the plan, coverage or policy (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); the application of any pre-existing condition exclusion under the plan, coverage or policy; or other activities related to the creation, renewal or replacement of a contract for health

insurance or health benefits. “Underwriting purposes” does not include determinations of medical appropriateness where a Member seeks a benefit under the plan, coverage or policy.

## **7. Disclosures to Business Associates**

Passport may disclose PHI to a Business Associate, whom have signed a BAA, and may allow a Business Associate to create, receive, maintain or transmit PHI on its behalf, if Passport obtains satisfactory assurance in the form of a written agreement or other written arrangement (that meets the requirements of CO 23: Disclosures of PHI to Business Associates and Other Contractors) that the Business Associate will appropriately safeguard the information. From the Business Associate’s Contractor, Passport is not required to obtain such satisfactory assurances from a Business Associate who is a subcontractor.

## **8. Protection of Individually Identifiable Information**

Passport ensures the protection of our Member’s PHI by performing the following:

- 8.1 Protection of Information.* Passport will protect the confidentiality of Members’ PHI and will not use such information in violation of this policy or disclose any such information to any other party except as provided in this policy.
- 8.2 Need to Know.* Only authorized individuals and/or entities with a need to know the information will have access to PHI.
- 8.3 Aggregated or De-identified Information.* Aggregated information or de-identified information will be used for research for quality measurement purposes whenever possible. The use of such aggregated, de-identified information is not subject to all of the privacy restrictions outlined in this policy.
- 8.4 Agreements with Third Parties.* All new agreements or BAAs with third party organizations who may receive or have access to Protected Health Information, including but not limited to, contracting health care providers, vendors and consultants, will include a provision obligating the organization to maintain the confidentiality of any Protected Health Information that may be accessed or obtained, and to restrict its use to the purpose for which it was disclosed.
- 8.5 Disclosure to Contractors.* In some circumstances, Passport may need to disclose Protected Health Information to its contractors and/or consultants. Whenever possible, de-identified information should be used. However, if identifiable information must be shared with a contractor for legitimate business reasons to carry out functions other than treatment listed in Section 4.0, a Business Associate Agreement must be signed by the contractor prior to release of the information.
- 8.6 Treatment Setting.* The Provider Relations Department will establish standards for maintaining confidentiality of Member information in treatment settings to contracting health care providers. These

standards are to be communicated to all providers.

8.7 *Maintenance, Storage and Destruction of Information.* Passport will maintain, store and destroy medical records and other PHI in a manner that preserves the confidentiality of these records.

## 9. **Member Access to Personal Information**

In most cases, Members have the right to access their PHI, such as name, address and records in a designated record set. Passport's designated record set includes enrollment, claims, payment, case management, and utilization management information. Access may be denied, in whole or in part, in certain circumstances described below. Otherwise, access will be granted pursuant to the Member's written request and Passport will release PHI requested to the Member or the Member's personal representative in accordance with this section.

If the information is maintained electronically and the Member requests an electronic copy, Passport will provide the Member with an electronic copy in the form and format requested by them, if it is readily producible in that form and format (if it is not, then Passport will agree with the Member on a readable electronic form and format).

The Member can direct Passport to transmit the copy directly to another person by submitting a signed written request to the Privacy Officer that identifies the person to whom the Member wants the copy sent to and the address where to send it.

If the Member would like a copy of their information contained in Passport's designated record set, the Member must send a written request to Passport's Privacy Officer. Passport will answer the Member's written request in thirty (30) days. Passport may ask for an extra 30 days if necessary and will inform the beneficiary if extra time is required. If the Member requests copies, Passport may charge the Member a reasonable cost-based fee for the labor involved in copying the information, the supplies for creating the paper copy or cost of the portable media, postage, and any summary of their records, if a summary is requested.

This right of access does not extend to: (a) Psychotherapy Notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding involving the individual; or (c) to PHI maintained by Passport that is subject to the Clinical Laboratory Improvements Amendments of 1988 (CLIA), 42 U.S.C. 263a, to the extent the provision of access to the individual would be prohibited by law, or exempt from CLIA, pursuant to 42 CFR 493.3(a)(2).

There are some grounds for denial of access that are not reviewable. These include: where the PHI is excepted from the right of access (see paragraph immediately above); if the PHI is contained in records subject to the Privacy Act, 5 USC 552a, if the denial of access under the Privacy Act would meet the requirements of that law; or if the PHI was obtained from someone other than a health care provider under a promise of

confidentiality and the access requested would be reasonably likely to reveal the source of the information.

There are other grounds for denial of access that are reviewable. Access may be denied by the Privacy Officer if:

- A licensed health care professional employed by or contracted with Passport determines, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the Member or another person;
- The PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional employed by or contracted with Passport has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- The request for access is made by the Member's personal representative and a licensed health care professional employed by or contracted with Passport has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

If access is denied, Passport will provide the Member the reasons for any denial in writing. Passport will also give the Member information about how an appeal can be filed if they are not satisfied with Passport's decision and there are reviewable grounds for denial.

## **10. Monitoring**

The Passport Privacy Officer is responsible for reviewing and approving confidentiality policies and reviewing practices regarding the collection, use, transmission, storage, access to and disclosure of PHI. The Privacy Officer considers existing and potential disclosures of data within and outside the organization from the Member's perspective and strives to ensure that Passport collects and discloses the minimum amount of personal data necessary for the purposes of appropriate care management and that personal information entrusted to Passport is protected.

## **11. Member/Associate Complaints Concerning Privacy**

Passport members and associates have the right to file a written complaint with Passport or the HHS Secretary if the individual believes his/her privacy rights have been violated. To file a complaint with Passport concerning the violation of a privacy right, send the complaint in writing to:

Passport Health Plan

Attn: Privacy Officer  
5100 Commerce Crossings Drive  
Louisville, KY 40229

For questions concerning the filing of a complaint concerning privacy, Passport members and associates may call (502) 585-8239.

Passport members and associates may also file a complaint with HHS. Complaints should be submitted to the Office of Civil Rights (OCR). The complaint form and submission instructions can be found online at:

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf>

Written complaints should be submitted to:

Office for Civil Rights, DHHS  
61 Forsyth Street, SW. – Suite 16T70  
Atlanta, GA 30303-8909  
(404) 562-7886; (404) 562-7884 (TDD)  
(404) 562-7881 FAX

## **12. Resolution of Complaints**

All privacy complaints received by the Passport Privacy Officer shall be resolved by written letter to the member or associate filing the complaint within thirty (30) calendar days of receipt of the complaint.

## **13. Anti-Retaliation Policy**

A Passport member or associate may exercise their rights under HIPAA, including filing a complaint with the HHS Secretary, testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing without being subject to intimidation, threat, coercion, discrimination or retaliatory action for exercising these rights. An individual may exercise these rights provided the individual has a good faith belief that the practice opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI in violation of HIPAA regulations. Members will not lose their Passport membership or health care benefits as the result of filing a privacy complaint.

### **Disclaimer:**

Passport Health Plan is committed to providing all Members meaningful access to benefits and services without regard to race, color, national origin, language, disability, or sexual orientation.

**CROSS REFERENCE/REFERENCE MATERIALS**

HIPAA Privacy Regulations: 45 CFR Parts 160 and 164  
Standards for Privacy and Individually Identifiable Health Information; Final Rule  
Reviewed 45 CFR 3164.402  
National Committee for Quality Assurance (NCQA)

Passport Health Plan:

- Authorization for Non-Routine Use and Disclosures of PHI, Policy No. CO 11
- Personal Representatives and Identify Verification of Individuals Requesting PHI, Policy No. CO 12
- Disclosures of PHI to Regulators, Policy No. CO 15
- Uses and Disclosures of PHI without Privacy Authorization to Avert a Serious Threat to Health or Safety, Policy No. CO 17
- Disclosures of PHI to Business Associates and Other Contractors, Policy No. CO 23

Individual departmental confidentiality and privacy policies under General Department Privacy and Confidentiality Guidelines: CM 22; CO 4; EP 13; FI 4.01; HR 4; IS 3; MM 16; MS 60; ME 12.01; PA 14; PC 3; PR 40; QM 3.01; RD 1; UM 30  
Previously CO 4

**REVIEW AND REVISION DATES (Annually at Minimum)**

January 1, 2002	September 1, 2007	March 2014
January 1, 2003	September 1, 2008	
January 1, 2004	September 1, 2009	
April 1, 2005	September 2011	
June 1, 2006	October 2013	

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End of Policy



		<b>DESK TOP PROCEDURE</b>	
<b>Desk Top Procedure Name: Utilization Management Program Modifications</b>			
<b>Department: Utilization Management</b>			
<b>Date of Development: 08.22.2014</b>		<b>Date(s) of Revision:</b>	
<b>Developed By: Anna Page</b>		<b>Title: Director, UM and Clinical Programs</b>	
<b>Signature: Anna Page</b>			
<b>APPLICABILITY</b>			

All Medical Management Associates

**DEFINITION(S)**

**DMS:** Department for Medicaid Services

**Utilization Management:** the process of evaluating the medical necessity, appropriateness, and efficiency of health care services.

**QMMC:** Passport’s Quality Committee comprised of internal Medical Associates, clinical specialists and actively practicing physicians responsible for approval of proposed criteria as dictated by NCQA.

**PROCEDURE**

1. The Passport Utilization Management Program Director / Manager is responsible for collecting, analyzing and trending of medical management data to evaluate the effectiveness and efficiencies of the Utilization Management Program.
2. Program data is monitored monthly, quarterly annually and on an as needed basis.
3. Based on data and current health care trends, the Utilization Management Director / Manager may determine modifications to the review requirements are warranted.
4. These modifications may be additions or elimination of review requirements or modifications to the Utilization Management review structure.

Examples:

Program Additions	Adding an authorization requirement to a service that previously did not require authorization
Program Eliminations	Eliminating an authorization requirement for a service that previously had an authorization requirement
Program Modifications	Applying a “Gold Card” review status for a provider with acceptable utilization patterns (Example Only)

5. After evaluation, the Utilization Management Director will submit a proposal for program changes to the Vice President of Operations and Chief Medical Officer for approval. The proposal will contain:
  - The proposed modification
  - Data and analyses to support the modification
  - The proposed outcome of the modification (i.e. Cost Savings)
  - Impact to the organization and/or other department (i.e. Staff re-allocation)
  - Time line for implementation
  - Project Plan, if warranted
6. If the modification is more restrictive in nature, the proposal must be approved by QMMC.
7. Once the final approval for program modifications has been obtained, the Utilization Management Director is to submit the approved proposal to the Chief Compliance Office and Director for submission to DMS for review and / or approval. (Program modifications that are more restrictive in nature require approval from DMS).
  - All submissions to DMS are maintained within the Passport Compliance Department.
  - All approvals / rejections documentation are filed and maintained within the Passport Compliance Department
8. Once approval, if required, is obtained from DMS notification of program modifications is sent to providers, Passport associates and all other applicable personnel.
9. Provider notification may be in the form of verbal notification, mail, email or Passport Website. Modifications to the Utilization Management that are more restrictive in nature require a 30 day notification to providers.

**REVISION DATES**

Date Revised	Revised by	Document revision

		<b>DESK TOP PROCEDURE</b>	
<b>Desk Top Procedure Name: Cultural Competence</b>			
<b>Department: Utilization Management</b>			
<b>Date of Development: 08.22.2014</b>		<b>Date(s) of Revision:</b>	
<b>Developed By: Anna Page</b>		<b>Title: Director, UM and Clinical Programs</b>	
<b>Signature: Anna Page</b>			
<b>APPLICABILITY</b>			

All Medical Management Associates

**DEFINITION(S)**

**Culture:** pattern of learned beliefs, values and behaviors that are shared among groups. They include thoughts, styles of communication, ways of interacting, views on roles and relationships, practices and customs.

**Cultural Competence:** defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.

**LEP - Limited English Proficient-** A member who requests or receives services in their preferred language.

**PROCEDURE**

Passport member present a broad range of perspectives regarding health and illness that are oftentimes shaped by their social and cultural backgrounds.

Understanding member’s diverse cultures is integral to eliminating health care disparities and providing high-quality patient care. Culture shapes individuals' experiences, perceptions, decisions and how they relate to others. It influences the way patients respond to medical services and preventive interventions and impacts the way physicians deliver those services.

1. Medical Management Associates are responsible for assuring members receive from all providers’ effective, understandable, and respectful care that is provided in a manner compatible with their cultural beliefs and practices and preferred language.
  - Effective health care is care that successfully restores the member to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention, and wellness interventions.
  - Understandable care focuses on the need for members to fully comprehend questions, instructions, and explanations from clinical, administrative, and other staff.

- Respectful care includes taking into consideration the values, preferences, and expressed needs of the member.
- 2. Medical Management Associate may refer to Cultural Competency policies and procedures for guidance in ensuring members receive effective, understandable and respectful health care.
  - CLAS 1.01 Use of Language Waiver Form
  - CLAS 1.02 Member Communications grievances and Inquiries.
  - CLAS 1.04 Plan Tele-Communications for Limited English Speaking Members and Non-English Speaking
  - CLAS 1.05 Translator/Interpreter Services for communication with LEP members
  - CLAS 1.06 Request for Member Materials in Preferred Language and/or Alternate Formats
  - CLAS 1.08 Gathering and Assessment of Member Race, Ethnicity and Language
  - CLAS 1.09 Provider and Associate Training
  - CLAS 1.10 Vital Document Guidance

Passport also offers language assistance services at no cost to the member.

All associates receive cultural competency and diversity training on an annual basis.

Resources:

National Culturally and Linguistically Appropriate Services (CLAS) Standards

**REVISION DATES**

Date Revised	Revised by	Document revision

		Policy/Procedure
<b>Policy Name: Review Process</b> Replaces UM 7.01 Prior (Prospective) Authorization) Replaces UM 7.02 Admission Review Replaces UM 7.03 Inpatient Concurrent Review Replaces UM 8.01 Retrospective Review		<b>Policy Number: UM 35.00</b>
<b>Date of Next Annual Review: 08.22.2015</b>		<b>Original/Issue Date: 12.5.2012</b>
<b>Approved By: Anna Page, R.N</b>		<b>Title: Director</b>
<b>Signature: Anna Page</b>		<b>Date Approved: 08.22.2014</b>
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
New (Date policy was created)	<input type="checkbox"/>	
Reviewed (No changes to policy)	<input type="checkbox"/>	
Revised (Content changes made to policy)	<input checked="" type="checkbox"/>	08.22.2014
Retired (Policy no longer active)	<input type="checkbox"/>	
<b>APPLICABILITY</b>		

All Medical Management Associates

**PURPOSE**

To define the processes utilized to evaluate a proposed treatment plan, appropriate location, level of care, and duration of service as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.

**POLICY**

PHP requires submission of clinical documentation of proposed services to ensure medical necessity, appropriate level of care and length of stay for the requested service. Services require authorization prior to the service being rendered, after admission to a facility, concurrent services and/or retrospective services. A decision on which medical necessity is determined is based upon the application of recognized clinical criteria and internal medical policies.

This policy will be evaluated for effectiveness by:

- Quality Audits; Internal and External
- Turnaround Time reports
- Managerial Oversight

## DEFINITION(S)

**Administrative Denial** – Denial of a service for failure to comply with the provider agreement regarding notification of service.

**Appeal** - Request for review of an action or a decision by the contractor related to covered services or services provided.

**Authorized Representative** – The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to Passport, or a provider acting on behalf of the Member with the Member's written consent. A Provider shall not be an authorized representative without the Member's written consent for the specific action that is being appealed or that is the subject of a state fair hearing. The written consent shall be signed and dated by the Member no earlier than the date of the action taken by Passport. Passport shall consider the member, representative, or estate representative of a deceased Member as parties to the appeal.

**Benefit Denial** - Denial for services that are not covered by Passport Health Plan.

**Business Day** - Monday through Fridays, 8:00am-5:30pm excluding weekends and holidays.

**Care Coordination** - is a process that links members with special health care needs and their families and/or caregivers to services and resources in a coordinated effort to maximize the potential of the member, and provide them with optimal health care. Members with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by individuals generally. Care coordination is a collaborative process that promotes quality care and cost effective outcomes which enhance the physical, psychosocial and vocational health of members.

**Case Management** - collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

**Co-morbidity** - the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.

**Concurrent Review** - aspects of utilization management that take place during an inpatient level of care or during an ongoing outpatient course of treatment.

**CPT** - A systematic listing and coding of procedures/services performed by US physicians; a physician-related procedure identification system that serves as the basis for health care billing

**Discharge Plans** - Development of an individualized discharge plan for the patient prior to leaving the hospital, to ensure that patients are discharged at an appropriate time and with provision of adequate post-discharge services. A process used to decide what a patient needs for a smooth move from one level of care to another.

**Elective (Scheduled) Admission** - In medicine, something chosen (elected). An elective procedure / admission is one that is chosen (elected) by the patient or physician that is advantageous to the patient but is not urgent.

**ICD9** – Official system used in the United States to classify and assign codes to health conditions and related information.

**Intake Specialist** – Non-clinical personnel who assist the Nurse Reviewer in obtaining non-clinical information; Intake Specialist do not render medical necessity determinations

**Internal Medical Policies** - Criteria developed by Passport when no other criteria exist.

**InterQual™ Guidelines** - a clinical decision support tool that is utilized for adult and pediatric services; criteria that supports clinical decision-making, reviewer consistency, efficient operations, and reporting.

**Level of Care:** The intensity of medical care being provided by the physician or health care facility

**Medical Necessity** - (State of Kentucky's definition of "medical necessity")

Passport Health Plan reviews all requests for services pursuant to the authority granted to it in accordance with 907 KAR 17:025. Passport Health Plan is required to provide only medically necessary health services as defined by the Kentucky Administrative Regulations. 907 KAR 3:130 states "medical necessity means a covered benefit is: Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; Clinically appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 139d(r) and 42 CFR Part 441 Subpart B for individuals under twenty-one (21) years of age; and Provided in accordance with 42 CFR 440.230

**Retrospective (retro)-eligibility** - Medicaid applicant who did not apply for assistance until after they received care, either because they were unaware of Medicaid or because the nature of their illness prevented the filing of an application.

**Retrospective Review** – Assessment of the appropriateness of medical services on case-by-case basis after the services have been rendered.

**Site of Service / Place of Service:** In health care informatics, concrete designation of the physical area wherein a service is performed (e.g., hospital, physician's office, patient's home, long-term care facility). (The Department for Medicaid Services has a complete list of place of service codes utilized for reimbursement)

**Triage** - the sorting of patients (as in an emergency room) according to the urgency of their need for care

**Urgent / Emergent Review** - case in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

**Utilization Management** - the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan; guides the member through the many options available in the healthcare delivery system so that appropriate treatment or diagnostic evaluation is provided in a timely manner, by the appropriate provider(s), at the appropriate level(s) of care, for the appropriate length of time or number of encounters.

**PROCEDURE**

**Inpatient Admission (Elective / Scheduled / Urgent / Emergent) and Outpatient Review Requests**

Services requiring a review:

Type of Service	Provider Requirements for notifying UM
Inpatient admission*	
Elective / Scheduled	Prior to the admission
Urgent / Emergent	Within 1 business day of the admission
Outpatient**	Prior to the requested services

\*Normal Vaginal Deliveries within ICD9 code range 644.xx – 665.xx and with a length of stay of 3 days or less do not require an authorization

\*\*Outpatient review is required for select services

Providers may notify the Utilization Management Department via phone, fax, mail or secure email

1. Upon receipt of the request: Intake Specialist verifies the member's eligibility and the provider's participating status utilizing the Medical Management System.  
See UM 40.00 for review of non-participating providers
2. The Intake Specialist initiates the case by obtaining demographic data, date of admission and ICD9 / CPT codes if available and routes the case to the appropriate Nurse Reviewer via the Medical Management system.
3. The Nurse Reviewer who receives the initial request documents the clinical information regarding the request into the Medical Management System. This may include depending on review type but is not limited to:
  - A. Diagnosis and co-morbidities
  - B. Site / Place of Service
  - C. Duration of illness and prior treatment, if applicable
  - D. Presenting signs and symptoms
  - E. Age, vital signs
  - F. Laboratory results
  - G. Invasive and non-invasive testing,
  - H. Treatment plan related to the request
  - I. Level of care
  - J. Progress / nursing notes for pertinent clinical information
  - K. Information on consultations with the treating provider
  - L. Operative and pathological reports; photographs
  - M. Member psychosocial history:
    - Cultural and linguistic barriers
    - Member characteristics and information (i.e. educational level that may present barriers to care)
    - Information regarding responsible family members; home environment (i.e. Is the home safe for discharge. Are family members available to assist with after-care.)
  - N. Information regarding benefits for services or procedures, if applicable
  - O. Information regarding the local delivery system and alternative services
  - P. Discharge plans

The Nurse Reviewer performing the review also takes into account age, co-morbidities, and complications, progress of treatment, psychosocial and home environment, as well as other individual needs and availability of alternative services within the physician and provider network.

The Nurse Reviewer considers availability of community resources, skilled nursing facilities, sub-acute care facilities or home care in Passport Health Plan's service area to support the member after hospital discharge if applicable (benefit coverage of skilled nursing facilities and sub-acute care facilities are provided through the traditional Medicaid program through the State of Kentucky).

The Nurse Reviewer takes into consideration local hospital's ability to provide all recommended services within the estimated length of time.

If additional information is needed, the hospital and/or attending physician are notified via phone, fax or voice mail of the information that is needed to complete the review. If these entities fail to return calls or no additional information is available, the determination is based on the information available.

4. The Nurse Reviewer evaluates the clinical information received, site of service, level of care and length of stay request and determines medical necessity utilizing InterQual™ Guidelines or internal medical polices.

On the initial request, the site of service is evaluated to determine the appropriateness of the setting or place of service the request is to be rendered. Common Sites of Service are: Inpatient hospital, Outpatient hospital, Hospital emergency room, Observation, Ambulatory surgical center, Hospice, Skilled nursing facility, Residential treatment facility (mental health), Rehabilitation facility, Physician office. Appropriate sites of service are identified in InterQual™ Guidelines.

On initial and subsequent requests, the level of care is evaluated to assure the intensity of services correlates with the clinical scenario of the member. The level of care is evaluated by utilizing InterQual™ Guidelines and the clinical condition of the member. Examples of levels of care: Acute inpatient, Rehabilitation, Skilled nursing facility. In general, as the member's health condition increases or decreases in severity, complexity, and / or duration, the expected types, amounts, and duration of services will also increase or decrease. Members may move from a high level to low level of care (Acute Inpatient to Rehab) or from a low level to high level of care (Medical floor to ICU) depending on intensity and severity of their condition.

The Nurse Reviewer may also triage their cases according to urgency of the requested service. Triage or screening means the assessment of a member's symptoms and requested services via information submitted from a provider for the purpose of determining the urgency of the member's need for care.

Discharge planning should begin on the initial request of service and should be documented on each subsequent review. See UM 9.01 Discharge Planning.

5. If the request meets criteria for admission or the requested service, the Nurse Reviewer may authorize the admission / service and appropriate days / units / visits per criteria / guidelines. Inpatient cases are routed for concurrent review. The provider is notified of the authorization via telephone, voice mail or fax.
6. If the request does not meet criteria, the case is routed to the Medical Director or his/her designee, in accordance with the Medical Director Review Policy (see UM 4.01 - Medical Director Review).

If the request does not meet IQ criteria and additional clinical is required, the Nurse Reviewer must contact the physician for the additional information.

If the request does not meet IQ and the clinical information is sufficient, then the case may be referred without contacting the MD.

Examples:

Clinical Scenario	Call to MD required?
Inpatient IQ states member must have + chest x-ray; No chest x-ray documented	Yes -Call to physician required for chest x-ray
Inpatient IQ states member must have + chest x-ray; chest x-ray documented and is negative	No - Refer to Medical Director as criteria not met
Therapy IQ states member cannot ambulate less than 10 feet; ambulation ability not documented	Yes - Call to physician / therapist required for documentation of ambulation ability
Therapy IQ states member cannot ambulate less than 10 feet; ambulation ability is documented as 20 feet	No - Refer to Medical Director as criteria not met

In the event the Medical Management computer system is unavailable and a case needs to be routed to the Medical Director for a medical necessity determination, the Nurse Reviewer completes a Medical Director Referral Form and forwards it to the Medical Director to review.

Only a Medical Director may issue a medical necessity denial.

7. If the Medical Director determines the request meets medical necessity, the decision to authorize is entered into the Medical Management system and the case is routed to the Nurse Reviewer for case completion and the case is then routed for concurrent review. The provider is notified of the authorization via telephone, voice mail or fax.
8. If the Medical Director's determination is to deny the request, the decision to deny is entered into the Medical Management system and the case is routed to the Nurse Reviewer for case completion. The provider is notified via telephone, voice mail or fax of the denial, of the provider's right to an expedited appeal, and the availability to discuss the case with the Medical Director who made the determination.

The provider(s) are informed of the Medical Director's name, business phone number and office hours.

9. The determination to approve or deny an urgent admission request is provided within one (1) business day (13) of the submitted request.

The determination to approve or deny an elective / scheduled admission request is provided within 2 business days of the submitted request.

Written confirmation of a denial is made within 1-business day of the determination. Copies of denial letters are sent to the member, the attending physician, and the facility (see UM 11.01 – Denial of Services Based on Lack of Medical Necessity).

In the event a member or provider requests written confirmation of an approval, Passport provides written confirmation of the organization determination within one business day of notification of the approval.

10. If the Nurse Reviewer identifies Case Management, Care Coordination or Behavioral Health Needs the case information is forwarded by the Nurse Reviewer to the Case Management Department or Behavioral Health Department for evaluation and assistance.

Case Management / Care Coordination indicators include, but are not limited to:

- Chronic and progressive illness; – HIV, Cancer, Asthma, Diabetes, COPD, Sickle Cell
- Significant change in health status – CVA, Major Trauma
- Cognitive or motor deficits
- Individuals with chronic mental health illness
- Medical condition documented by a physician that may become unstable and change abruptly resulting in a life-threatening situation
- Severe disability that requires technological assistance
- Need for a special service or ongoing medical support
- Need for twenty-four (24) hour care by a physician or licensed nurse
- Homelessness
- Multiple providers; multiple services
- Social Issues – abuse, no known support, neglect
- Repeated admissions
- Need for post-acute transfer
- Financial issues
- Cultural and linguistic barriers

Additionally, the Nurse Reviewer will assist in Care Coordination when they identify a member requiring additional needs post care but not requiring Case Management services. Care Coordination in utilization management is typically episodic and is a request for services beyond those authorized. Example: Member leaving an acute hospitalization requiring home health services.

11. If a member is discharged and readmitted within 23-hours of discharge from an acute care setting, the review for medical necessity is conducted as a continuation of the original admission utilizing the original authorization number.

12. If a member is currently inpatient under an approved inpatient stay or receiving outpatient services and terminates from Passport, Passport Health Plan coverage stops. The Nurse

Reviewer notifies the provider, makes a notation in the Medical Management system and closes the case.

13. If a prior authorization request is received for a Behavioral Health related service, the member/provider will be directed to contact Beacon Health Strategies at 1-855-834-5651

All other questions should be referred to the Department of Medicaid Services Member Service line at 1-800-635-2570.

### **Concurrent Review – Inpatient**

1. In the event the member is still inpatient after the initial authorization of days, the Concurrent Review Nurse evaluates the necessity for continued inpatient days.
2. The Concurrent Review Nurse evaluates clinical information to support the need for on-going inpatient days that include but is not limited to:
  - A. Continued signs and symptoms
  - B. Invasive and non-invasive testing,
  - G. Ongoing treatment plan related to the request
  - H. Changes to treatment
  - H. Progress / nursing notes for pertinent clinical information
  - I. Information on consultations with the treating provider
  - J. Operative and pathological reports; photographs
  - K. Member psychosocial history
    - Cultural and linguistic barriers
    - Member characteristics and information (i.e. educational level that may present barriers to care)
    - Information from responsible family members; home environment (i.e. is the home safe for discharge. Are family members available to assist with after-care.)
  - L. Information regarding benefits for services or procedures, if applicable
  - M. Information regarding the local delivery system and alternative services
  - N. Discharge plans

The Nurse Reviewer performing the review also takes into account age, co-morbidities, and complications, progress of treatment, psychosocial and home environment, as well as other individual needs and availability of alternative services within the physician and provider network.

The Nurse Reviewer considers availability of community resources, skilled nursing facilities, sub-acute care facilities or home care in Passport Health Plan's service area to support the member after hospital discharge (benefit coverage of skilled nursing facilities and sub-acute care facilities are provided through the traditional Medicaid program through the State of Kentucky).

The Nurse Reviewer takes into consideration local hospital's ability to provide all recommended services within the estimated length of time.

If additional information is needed, the hospital and/or attending physician are notified via phone, fax or voice mail of the information that is needed to complete the review. If these entities fail to return calls or no additional information is available, the determination is based on the information available.

3. During the concurrent review process, Case Management / Care Coordination indicators are continually evaluated and appropriate referrals made.
4. The concurrent review is completed utilizing InterQual™ Guidelines and / or Internal Medical Policies to approve further inpatient days.
5. The Concurrent Review Nurse is to complete the continued stay review within 1-business day after receipt of information or chart review and prior to the time upon which a previous authorization for hospital stay will expire.
6. For concurrent review that falls on a weekend or holiday, the review occurs prior to the close of business on the day prior to the weekend or holiday and the Nurse Reviewer communicates the approval or denial to the provider/facility by phone, fax or secure voicemail.
7. If discharge is expected over the weekend or holiday, the PHP nurse informs the provider/facility via phone or voice mail, and documents in the dedicated Medical Management system, "if progress in acute medical condition continues, it is anticipated that the member will be discharged by the evening of (fill in date)."
8. Follow Steps 7 through 12; Inpatient Admission – Elective Admission or Urgent Review for approval / denial of a concurrent review request.
9. Once a denial of a continued inpatient stay is issued, no further review of the member information occurs, unless there is a change in the member's condition or treatment plan that would warrant continued stay review. The provider is to notify the Utilization Management Department of any change in the member's medical condition.
10. The Concurrent Review Nurse or Embedded Nurse Reviewer updates the Medical Management system with the discharge date once the member has been discharged.

### **Retrospective Review**

1. Requests for retrospective review are received in writing from the provider, either by fax, mail or secure email.
2. If a request for a retrospective review is received AND the member was eligible at the time the service was rendered, an administrative denial is issued to the provider. (See UM P/P 11.11 Non-Medical Denial of Services).

3. For a member who is Medicaid retro-eligible and a request for a retrospective review is received:
  - A. The provider must request a retrospective review within 60 calendar days of the date of eligibility OR within 60 calendar days of the date of the card issuance. (Failure to notify Passport within 60 calendar days may result in an administrative denial)
  - B. If the retro eligibility period covers all dates of service, the admission / service date of the case can be back-dated.
  - C. If the retro eligibility period does not cover all dates of service, the admission / service date is back dated to the first effective date of eligibility
  - D. If the member is still receiving services at the time retro eligibility was issued, the case is reviewed from the day of admission / date of service or the day of eligibility, whichever date is appropriate for that member. The review would include prior, current and future days / dates of service.
  
4. Requests for retrospective review for services that have been rendered within the previous 10 calendar days are reviewed by the Nurse Reviewer receiving the request. However, if the member was in a period of retro-eligibility, the request is given to the Retro Review Nurse to be reviewed.
  
5. Requests must include all necessary documentation to support medical necessity as indicated in the Admission and Concurrent review processes.
  
6. The request is to be reviewed as outlined in the Admission / Concurrent review processes.
  
7. Decisions for a retrospective review are rendered within 30 calendar days of receipt of the request.
  
8. In the case of an approval, the approval notification is faxed back to the practitioner within 1 business day of the approval decision.
  
9. In the case of denial of services written notification is provided to the practitioner, with copies to the facility and within 1 business day of the determination. (see UM 11.01 Denial of Services Based on Lack of Medical Necessity).

#### **Miscellaneous**

1. The provider may request an appeal for Administrative Denials (See CP 5.14 Provider Administrative Appeal)
  
2. A member or authorized representative may request an appeal for a medical necessity denial or a benefit denial.

#### **Proprietary & Confidential**

3. Utilization Management decision making is based only on appropriateness of care and services and existence of coverage.
4. Passport does not reward practitioners, or other individuals, conducting utilization reviews for issuing denials of coverage or service care.

Materials received (letters, Records etc.) in the Utilization Management Department via mail / fax / email should be date stamped and legible

**CROSS REFERENCE/REFERENCE MATERIALS**  
(If necessary to cite other policies or documents)

UM 4.01 Medical Director Review  
UM 11.11 Non-Medical Denial of Services  
CP 5.14 Provider Administrative Appeal  
UM 40.00 Out of Network Providers

**REVIEW AND REVISION DATES (Annually at minimum)**

12.19.2013  
6.12.2014 – changed review complete to 30 calendar days  
8.22.2014 – Added Site of Service, Triage, Level of Care  
End of Policy

		Policy/Procedure
Policy Name: Discharge Planning		Policy Number: UM 9.01
Date of Next Annual Review: 8.14.2015		Original/Issue Date: 5.17.1999
Approved By: Anna Page, R.N		Title: Director
Signature: <i>Anna Page</i>		Date Approved: 8.14.2014
<b>Policy Action</b>	<b>(Check One)</b>	<b>Date</b>
New (Date policy was created)	<input type="checkbox"/>	
Reviewed (No changes to policy)	<input type="checkbox"/>	
Revised (Content changes made to policy)	<input checked="" type="checkbox"/>	8.14.2014
Retired (Policy no longer active)	<input type="checkbox"/>	
<b>APPLICABILITY</b>		

All Medical Management Associates

**PURPOSE**

To define the process of discharge planning for members where post discharge care is necessary.

**POLICY**

Passport Health Plan (PHP) discharge planning begins at admission for all inpatient cases to ensure the most effective and efficient use of resources has been implemented and to determine if post discharge care will be necessary to ensure continuity of care.

**DEFINITION(S)**

**Discharge Planning** – Discharge Planning is the development of an individualized discharge plan for the patient prior to leaving the hospital, to ensure that patients are discharged at an appropriate time and with provision of adequate post-discharge services. A process used to decide what a patient needs for a smooth move from one level of care to another.

**PROCEDURE**

1. The Utilization Management (UM) RN will assist with the discharge planning process of Passport Health Plan (PHP) members. The PHP UM nurse will work in conjunction with, not in place of, the hospital discharge planner.
2. For PHP members, the UM nurse will perform discharge planning for members who meet the following conditions:
  - a. If the member is admitted for a short stay for an acute condition and no discharge needs are identified, the DC planning process may end. (Example: One day admit for appendectomy, no complications, no discharge needs)
  - b. The PHP nurse will focus on members with:
    - i. A length of stay > 7 days
    - ii. Chronic conditions
    - iii. Major acute event (i.e. MVA)
    - iv. Illness or injury impacting the member's prior level of function
3. The PHP UM nurse is to evaluate for discharge needs upon member admission. The evaluation shall include an assessment of the following (this information is to be added to the Medical Management notes):
  - a. Primary and secondary diagnoses
  - b. Pertinent past medical history
  - c. Cognitive status
  - d. Functional status
  - e. Psychosocial status
  - f. Discharge needs:
    - i. PCP assignment
    - ii. Specialist referral
    - iii. Medication Management
    - iv. Post discharge medical support (Home Health, DME, Therapy, Rehab)
4. The UM Nurse is to assist in the authorization process for those discharge needs that require a PHP certification. Requests for Home Health Services and/or Durable Medical Equipment are referred to the appropriate Nurse Reviewer in Utilization Management for review of the requested service(s).
5. The UM nurse is to identify and document any issues / barriers identified in achieving a successful discharge.
  - Barrier / issues include but are not limited to:
  - Member does not have or know PCP or Specialist; Member does know PCP or Specialist demographics; Member does not have transportation to follow up visits

## Discharge Planning

- Member does not have a pharmacy; Member cannot afford medications
- Member requires wound care / unable to provide
- Member with psychosocial issues

6. If barrier / issues cannot be resolved prior to discharge or the member requires additional support, the UM Nurse is to refer the case to Care Coordination / Rapid Response for evaluation.

7. For those cases where discharge needs are ongoing, the Nurse Reviewer completes a Care Coordination/Case Management referral and coordinates the discharge needs with the assigned Care Coordinator/Case Manager.

8. Integration with Care Coordination / Health and Disease Management and Behavioral Health:

Care Coordination is the process that links members with special health care needs and their families and/or caregivers to services and resources in a coordinated effort to maximize the potential of the member and provide them with optimal health care.

Health / Disease Management is an approach to healthcare that teaches patients how to manage a chronic disease and to prevent or decrease exacerbation of an illness by a comprehensive, integrated approach to care.

Behavioral Health Management focuses on improving the quality of life for people suffering from mental health or substance abuse issues and is a key aspect of a person's overall health and wellbeing.

Utilization Management will evaluate all members for potential Care Coordination / Disease Management / Behavioral Health Management services.

The guidelines to assist in determining if a referral to Care Coordination is appropriate are:

- A new diagnosis of a chronic or catastrophic illness.
- Non-compliance with medical regimen.
- Multiple services / multiple providers.
- Frequent hospitalizations and or emergency room use.
- Psychosocial issues that hinder medical care.
- Over/Under-utilization of services.
- Members at risk for chronic physical, developmental, behavioral or emotional conditions.
- Member with special health care needs beyond that required by individuals generally.
- Request from providers for intervention by Care Coordination.

The guidelines to assist in determining if a referral to Health / Disease Management is appropriate are:

- Members with a diagnosis of:

## Discharge Planning

- Diabetes
- Chronic Respiratory Disease
- Congestive Heart Failure
- Pregnancy
- Obesity

The guidelines to assist in determining if a referral to Behavioral Health Management is appropriate are:

- Children, youth, and adults with multiple health conditions, who are chronically at risk for hospitalization or other out-of-home placement
- Members with histories of behavioral health utilization/diagnoses

Additionally, members may be referred to additional Passport Resources such as the 24 Hour Nurse Line, Tiny Tots Program, EPSDT programs, Smoking Cessation.

<b>CROSS REFERENCE/REFERENCE MATERIALS</b> (If necessary to cite other policies or documents)
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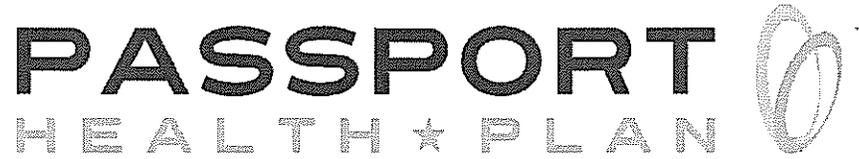
None

<b>REVIEW AND REVISION DATES (Annually at minimum)</b>
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February 8, 2009  
February 8, 2010  
May 5, 2010  
May 5, 2011  
May 1, 2012  
April 26, 2013  
August 14, 2014

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End of Policy



**2014**  
**Utilization Management and  
Clinical Programs Description**

*Our mission is to improve the health and  
quality of life of our members*

**PASSPORT HEALTH PLAN  
2014 UTILIZATION MANAGEMENT AND CLINICAL PROGRAMS DESCRIPTION**

- Introduction**
- I. Program Staffing**
- II. Medical Policy**
- III. New Technology**
- IV. Clinical Criteria Requests**
- V. Inter-rater Reliability (IRR)**
- VI. Training and Education**
- VII. Response Standards and Service Level Agreements (SLAs)**
- VIII. Utilization Analysis**
- IX. Utilization Management Activities**
- X. Delegated Utilization Management Services**
- XI. Denials**
- XII. Appeals**
- XIV. State Fair Hearing**
- XV. Clinical Initiatives**
- XVI. Program Satisfaction**
- Acknowledgement and Approvals**

## Introduction (2)

The purpose of the Passport UM and Clinical Programs is to safeguard against unnecessary and inappropriate medical care. The programs allow Passport to review patient care from perspectives of medical necessity, quality of care, appropriateness of decision-making, place of service, and length of hospital stay.

Utilization Management (UM) includes or involves the evaluation of the medical necessity, and the appropriateness and efficiency of the use of healthcare services, procedures and facilities under the provisions of the benefit plan. The UM and Clinical Programs Department implements comprehensive processes to monitor and control the utilization of health care resources. These programs assist in ensuring services are available in a timely manner, provided in the appropriate settings, and services are planned, individualized and evaluated for effectiveness.

### Program Goals, Objectives and Functions

#### Program Goals

The goals of the UM and Clinical Program Department are to:

- Ensure Contractual Service Level Agreements are met on a consistent basis
- Ensure regulatory compliance
- Evaluate the appropriateness, medical need and efficiency of healthcare services according to established criteria and policies
- Monitor and report practice patterns of participating providers
- Evaluate for program modification based upon data and health care trends
- Ensure consistency amongst reviewers and Medical Director's aptitude at applying criteria and protocols in a consistent manner through auditing
- Evaluate provider satisfaction with the Utilization Management program
- Evaluate subcontracted activities as it relates to Utilization Management
- Implement training initiatives
- Facilitate integration and communication between all departments within Passport to include:

Department	Integration Points
Care Coordination / Case Management / Rapid Response	Member identification; Case collaboration; Training initiatives
Condition Management (Disease Management and Behavioral Health)	Member identification; Case collaboration; Training initiatives
Pharmacy	Member identification; Case collaboration; Training initiatives
Compliance	Regulatory requirements; Policy development; contractual obligations; Confidentiality
Quality Improvement	Data exchange; Clinical initiatives
Member Services	Member inquiries; Questions regarding prior authorization, denials and appeals
Provider Services / Claims Reimbursement	Provider issues; Provider appeals
Public Affairs	Member and provider communications

#### Program Objectives

The objectives of the UM and Clinical Program Department are to:

- Ensure compliance with the State contractual and Department of Medicaid Services (DMS) regulations and NCQA guidelines

- Develop policies to maintain compliance with the State contractual and Department of Medicaid Services (DMS) regulations and NCQA guidelines
- Evaluate, monitor and oversee healthcare services for quality and medical necessity
- Review utilization data, identifying over-and under-utilization practices, and identifying and implementing programmatic improvements encouraging appropriate utilization
- Ensure subcontracted activities are within compliance with all state, federal, regulatory and contractual obligations
- Evaluate and implement new systems / technology
- Manage training and education initiatives
- Maintain documentation consistency

#### Program Functions

The functions of the UM and Clinical Program Department are to:

- Conduct clinical review for:
  - Prospective/prior authorization review
  - Precertification review
  - Concurrent review
  - Retrospective review
  - Appeals
- Conduct internal auditing
- Conduct inter-rater reliability/consistency review testing and reporting
- Review, revise and develop policies and procedures
- Evaluate, test and implement Medical Management systems
- Develop clinical initiatives
- Conduct data analysis for potential over-and under-utilization and provider trending
- Evaluate satisfaction with the Utilization Management Program using member and provider input
- Approve and monitor subcontracted activities
- Evaluate for program effectiveness

The UM and Clinical Programs Department's activities are evaluated annually. The annual evaluation is designed to:

- Evaluate the overall effectiveness of the UM and Clinical Programs.
- Assure systematic re-evaluation of the policies and procedures currently in force
- Evaluate consistency amongst Medical Management associates
- Evaluate compliance with policies, procedures and regulations related to the appeals process
- Evaluate documentation consistency amongst Medical Management associates
- Evaluate clinical initiatives efficiency and effectiveness
- Evaluate program objectives, activities, and targets for the coming year
- Results are included in the annual evaluation of the UM and Clinical Programs.

The UM and Clinical Programs Department description and the annual evaluation are reviewed and approved by the Passport Health Plan Quality Medical Management Committee (QMMC) and the Partnership Council. The program is subject to continuous review to assure it meets the needs of Passport Health Plan. Select data from the evaluation is also submitted to the Quality Department on a quarterly basis for submission to DMS' (Department for Medicaid Services) Quality Work Plan.

QMMC is a committee including actively participating physicians who have professional knowledge or clinical expertise in the area(s) being reviewed.

The Partnership Council is a broad coalition of consumers and providers, including physicians, nurses, hospitals, health departments and ancillary providers. The Partnership Council is led by a 30 member Board of Directors representing the full spectrum of providers and including Medicaid consumer representatives. The Board of Directors helps govern the operations of Passport's Managed Care program

Modifications to any program are reviewed and approved by the Chief Medical Officer, Vice President of Operations, Quality Medical Management Committee (QMMC), Board of Directors and Partnership Council and the Department of Medicaid Services as applicable. Modifications to the Utilization Review program / review requirements will

be submitted to DMS for informational purposes and / or approval. (1)

## I. Program Staffing (2a)

### Staff

The UM and Clinical Programs Department is comprised of the following staff:

- Executive Management Team
  - Chief Medical Officer
  - Vice President of Operations
- Senior Management Team
  - Director of Utilization Management and Clinical Programs
  - Managers of UM and Clinical Programs
  - Medical Directors
- Clinical Team
  - Utilization Review Nurses
  - Onsite Review Nurses
  - Tiny Tots Nurses
  - Emergency Room (E.R.) Navigators
- Non-clinical Team
  - Intake Specialists
  - On-site Coordinator
  - Denial Research Specialist
  - Research Appeals Coordinators
  - Tiny Tots Coordinator
  - Emergency Room (E.R.) Coordinators
- Support Team
  - Clinical Programs Coordinator
  - Medical Systems Analyst
  - Data / Business Analyst
  - Medical Management Trainer
  - Medical Management Auditor

### Qualifications & Responsibilities

Title	Reports to:	Qualifications	Responsibilities
<b>Executive Management Team</b>			
Chief Medical Officer	CEO	Physician licensure in the state of Kentucky Board certification 5 years Medical Management / 5 years of progressive business experience A Primary Care discipline	Direct the implementation and oversight of all programs under Medical Operations
Vice President Operations	CEO	14 years progressive experience in business 10 years management experience required 6-8 years Managed Care experience Bachelor's degree in business or health related discipline	Direct the implementation and oversight of all programs under Medical Operations
<b>Senior Management Team</b>			
		8-10 years progressive experience in healthcare delivery 5 years' experience in managed	

Director of Utilization Management and Clinical Programs	CMO	healthcare preferred 5 years managerial experience Registered Nurse	Direct the implementation and oversight of Utilization Management and Clinical Programs Departments
Managers	Director	8 years progressively responsible experience in a clinical environment 3 + years of management experience Registered Nurse	Oversee daily operations of the Utilization Management and Clinical Programs Departments
Medical Directors	CMO	Physician Licensure in the State of Kentucky Board Certification 5 years of Medical Management experience Primary Care discipline in Internal Medicine, Pediatrics or Family Practice	Serve as consultant to the Medical Management associates Conduct denials when serving as a clinical reviewer
<b>Clinical Team</b>			
Utilization Review Nurses Embedded and In-house	Manager	Active, unrestricted Kentucky Nursing License 3 year clinical experience Experience in Utilization Management preferred	Perform medical necessity review Ensure compliance with policies, procedures and regulations Refer for higher level of care Identify potential fraud, waste and abuse
Tiny Tots Nurses	Manager	Active, unrestricted Kentucky Nursing License 5 years' experience in NICU, or appropriate specialty area. Experience in Utilization Management preferred	Conduct concurrent review and care coordination Acts as a member of the healthcare team to coordinate activities with physician, NICU staff, and caregiver
E.R. Navigators	Manager	Active, unrestricted Kentucky Nursing License 5 years' experience in Emergency Room Experience in Utilization Management preferred	Conduct member interviews Evaluate the member's discharge needs Provide member education Track and trend E.R. utilization
<b>Non-Clinical Team</b>			
Intake Specialists	Manager	3-5 years of experience in the medical field 3-5 years progressively responsible administrative experience	Provide non-clinical support to the clinical staff
On-site Coordinator	Manager	3-5 years of experience in the medical field 3-5 years progressively responsible administrative experience	Provide non-clinical support to the clinical staff
Denial Research Specialist	Manager	3-5 years of experience in the medical field 3-5 years progressively responsible administrative experience	Provide non-clinical support to the clinical staff
Research Appeals Coordinators	Manager	3-5 years of experience in the medical field 3-5 years progressively responsible administrative experience	Provide non-clinical support to the clinical staff
		3-5 years of experience in the medical field 3-5 years progressively responsible	Provide non-clinical support to the

Tiny Tots Coordinator	Manager	administrative experience	clinical staff
Emergency Room (E.R.) Coordinators	Manager	3-5 years of experience in the medical field 3-5 years progressively responsible administrative experience	Provide non-clinical support to the clinical staff
<b>Support Team</b>			
Clinical Programs Coordinator	Manager	Bachelor's degree preferred Knowledge of NCQA preferred Knowledge of Medicaid required	Coordinate Medical Management activities to achieve NCQA compliance Develop records and testing tool for Medical Management audit Assist with implementation of new programs and program changes
Medical Systems Analyst	Manager	High School Degree College degree or equivalent experience preferred Demonstrates knowledge of medical terminology, ICD-9 and CPT-coding, principles and practices of health information record systems, medical records and office procedures	Maintain a current knowledge base with regards to rules, all Federal and State regulations, DMS contract requirements Develop, edit and maintain multiple Medical Management systems Assist with the development and delivery of system training programs and processes
Data / Business Analyst	Manager	High School Degree College degree or equivalent experience preferred Demonstrates knowledge of medical terminology, ICD-9 and CPT-coding, principles and practices of health information record systems, medical records and office procedures Demonstrate knowledge of medical data reports	Assist in the development of reporting and analysis of medical data, metrics and measures Assist with clinical and physical data modeling to support medical management initiatives Develop weekly, monthly, quarterly and annual medical management reports and results
Medical Management Trainer	Manager	Current KY RN license or Social Worker license 4-5 years clinical experience 4-5 years Managed Care experience	Assess training needs and methods of instruction Develop, implement and maintain training strategies for both short-term and long-term training goals and initiatives Develop and maintain training material Serves as the training liaison between Medical Management and other departments within Passport Health Plan
			Perform internal chart audits on Medical Management associates for completeness and accuracy Perform internal chart audits on Medical Management associates to ensure compliance with criteria, regulations, NCQA requirements and policy and procedures Develop and maintain clinical and non-clinical audit tool Prepare audit reports

Medical Management Auditor	Manager	Active, unrestricted Registered Nurse license 2-years progressively responsible experience in medical records or chart auditing	Assist in the development of individual / team corrective action plans based upon audit results
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Non-clinical and Support Staff are restricted from making any medical necessity review determinations.

## II. Medical Policy

The following criteria are utilized during the review process to evaluate for medical necessity of a proposed service:

- InterQual™ Guidelines.
- Internally developed medical policies
- Medicare and Medicaid criteria/guidelines
- Statutory / Regulatory Guidelines

InterQual™ Guidelines is the clinical decision support tool, approved and recommended for use by DMS, utilized by Passport for medical necessity review of requested adult and pediatric services; and is the criteria supporting clinical decision-making, reviewer consistency, efficient operations and reporting.

Internal medical policies are developed by Passport Health Plan Medical Directors when no other criteria exist within InterQual™ Guidelines. Internal medical policies are derived from one or more of the following:

- Current approved medical literature and peer reviewed publications
- Commercially available policy models
- Physician comments and/or recommendations
- Community standards of medical practice
- Accepted standards of practice of health contractors
- Medicaid Guidelines

Internal policies are submitted to the Quality Medical Management Committee (QMMC) and the Partnership Council for final approval.

All internal medical policies and guidelines are reviewed and approved at least annually.

Prior to implementation of criteria, the Medical Management staff participates in educational programs related to the approved policies and protocols, guidelines, and review criteria as needed. Member and provider education regarding additions/changes to the criteria, medical policy or protocols, or guidelines is provided as needed through member newsletters and provider newsletters/manuals as well as direct mailings, community outreach, and postings on the Passport Health Plan website.

### Supplementary Information

Along with the use of approved criteria, when evaluating requests for services, at a minimum, the following information is considered:

- Patient demographics and eligibility information
- History of symptoms and results of physical examination
- Results of clinical evaluation including appropriate lab and radiology results
- Cultural diversity
- Other information as required by criteria

Criteria based on individual needs assessment of the local delivery system is also applied during the review process. When applying the guidelines to a specific request for service for a member, the following factors are considered:

- Age
- Co-morbidities
- Complications

- Progress of treatment
- Psychosocial situation
- Home environment
- Cultural diversity

Characteristics which are specific to our local healthcare delivery system when considering a specific request for services are also applied during the review process. These include:

- Availability of skilled nursing or sub-acute care facilities or home care in the organization's service area to support the patient after hospital discharge
- Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed
- Local hospitals' ability to provide all recommended services within the estimated length of stay

### **Cultural Competency (4)**

Medical Management Associates are responsible for assuring members receive from all providers' effective, understandable, and respectful care that is provided in a manner compatible with their cultural beliefs and practices and preferred language.

- Effective health care is care that successfully restores the member to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention, and wellness interventions.
- Understandable care focuses on the need for members to fully comprehend questions, instructions, and explanations from clinical, administrative, and other staff.
- Respectful care includes taking into consideration the values, preferences, and expressed needs of the member.

Medical Management Associate may refer to Cultural Competency policies and procedures for guidance in ensuring members receive effective, understandable and respectful health care.

### III. New Technology

Passport is responsible for identifying new technologies and new applications of existing technologies when they provide a demonstrable benefit for a particular illness or disease; are scientifically proven to be safe and efficacious; and there is no equally effective or less costly alternative.

Passport Health Plan evaluates and approves coverage of new technologies and new applications of existing technologies when they demonstrate an improvement in health outcomes, health risk and health benefits when compared with established procedures and products. Passport also reviews to determine the new technologies are scientifically proven to be safe and effective.

The technology assessment process includes the reviewing of pharmaceuticals, biological, devices, diagnostics, or procedures. Emerging and innovative technologies are monitored by Passport Health Plan Medical Directors through review of trend reports from technology assessment bodies; government publications; medical journals; and information provided by providers and professional societies.

New technology assessments are reviewed by the Medical Directors, Chief Medical Officer, Quality Medical Management Committee (QMMC) and the Partnership Council level for approval.

Once final approval is achieved, the UM and Clinical Programs Department:

- Develops or modifies an applicable policy
- Forwards to Public Affairs Department to be placed on Passport's website for provider review and feedback for 30-days, if applicable
- Trains all Medical Management associates

#### IV. Clinical Criteria Requests

Passport is responsible for monitoring and tracking provider or member requests for clinical criteria utilized during the review determination process.

Members or providers may request, at any time and free of charge, the clinical criteria utilized during the review process. The UM and Clinical Programs Department monitors all requests for clinical criteria.

Members or providers may request statutory / regulatory guidelines, InterQual™ Guidelines, internally developed medical policies, or Medicare and Medicaid criteria/guidelines.

If a member or provider requests a copy of InterQual™ Guidelines, the Department is to send only the smallest increment or portion feasible under the circumstances, or as legally required for disclosure. In connection with each disclosure/distribution, all clinical content related to a specific medical necessity decision or any copies of the clinical content from the book or software shall prominently display on the cover page and/or introductory screen InterQual™ Guidelines, the InterQual™ Guidelines Statement of Disclosure, and copyright notices and Proprietary Notice.

**Statement of Disclosure** – "The Clinical Content reflects clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provides the sole basis for definitive decisions. The Clinical Content is intended solely for use as screening guidelines with respect to medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient; all ultimate care decisions are strictly and solely the obligation and responsibility of your health care provider.

The Clinical Content you are receiving is confidential and proprietary information and is being provided to you solely as it pertains to the indication discussed with your healthcare provider. Under copyright law, the Clinical Content may not be copied."

All clinical criteria requested are tracked and trended on an annual basis.

## **V. Inter-rater Reliability (IRR)**

An annual consistency review is conducted to demonstrate the Nurse Reviewers and Medical Directors' aptitude at applying criteria and protocols in a consistent manner.

The Director, Manager, Trainer and Auditor identify the method used to ensure consistency among associates concerning the application and utilization of medical policies, protocols, criteria and guidelines.

The Director, Manager, Trainer and Auditor define the process utilized to monitor the application of decision-making compared to Utilization and Care Coordination policies, medical policies, guidelines and protocols, criteria such as InterQual™ Guidelines.

The Director, Manager, Trainer and Auditor identifies both global and individual areas requiring improvement and assist in the development of a correction action plan to address areas of deficiency.

Annual analysis of results is presented by the Director to the Quality Medical Management Committee (QMMC).

## **VI. Training and Education**

A formal orientation and training program is provided for all positions within the UM and Clinical Programs Department.

The new associate orientation and training program is initiated with the Human Resources Department in conjunction with the UM and Clinical Programs Department.

Ongoing educational opportunities are provided and/or offered to all associates within Passport. The UM and Clinical Programs Department provides education, development and training for all medical and non-medical Passport associates.

The Trainer oversees the ongoing education for Passport associates. Ongoing education include educational forums with associated Continuing Education (CE) credits and training sessions (clinical and nonclinical), which are formulated by analyzing the needs of the staff and the relativity of the content of the training.

The Trainer develops and deploys ongoing education opportunities for Passport Associates as applicable. The proposed educational / training sessions are reviewed and approved by the following:

- Director
- Clinical Programs Manager

The Trainer designs/plans trainings and approves the educators and their curriculum. The Clinical Programs Manager reviews feedback and evaluations of current trainings and review ideas and qualifications of future trainers for upcoming professional development offerings.

**VII. Response Standards and Service Level Agreements (SLAs)**

The following response standards have been established per Kentucky State statute and/or NCQA guidelines for case determinations and notifications:

- The decision for urgent requests must occur and the decisions communicated via telephone, voice mail, or fax within 1 business day of receipt of the request.
- The decision for non-urgent requests must occur, and the decision communicated to the requestor via telephone, voice mail, or fax within 2 business days of the receipt of the request. These requests are considered for scheduled / non urgent requests.
- The decision for a covered member's continued hospital stay must occur, and the decision communicated to the requestor via telephone, voice mail, or fax within 1 business day of receipt of the request for review, and prior to the time when a previous authorization for hospital care expires.
- The decision for a retrospective review must be completed and the decision communicated within 10 business days of the receipt of the medical information.
- If the review results in an adverse determination, a letter must also be sent within the time frames indicated above.
- The decision for an expedited appeal must be completed no later than 3 working days from the request.
- The decision for a standard appeal request must be completed within 30 days of the receipt of the request.

The Department is responsible for ensuring all contractual service level agreements related to the Utilization Management Program are met.

Service level agreements for the Utilization Management are:

	Description	SLA
<b>Telephone</b>		
ASA	Average speed to answer inbound calls	2 minutes or less
AR	Abandonment Rate on inbound calls	10 % or less
<b>Case Turn Around Times for Review Determination</b>		
Urgent	Case Types	1 Business Day
Non-Urgent		2 Business Days
Retrospective		10 Business Days

In the event a SLA is not met on a quarterly basis, the Director will develop and submit to the Passport Executive team a Corrective Action Plan (CAP) to assess and correct the deficiency(ies).

### VIII. Utilization Analysis

The UM and Clinical Programs Departments are responsible for evaluating medical data, analyzing trends and modifying program requirements as applicable.

Medical data is evaluated in the following areas:

	Description
Inpatient Admissions per 1,000 members	An indicator calculated by taking the total number of inpatient admissions for a specific period of time (usually one year), dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000.
Inpatient days per 1,000 members	An indicator calculated by taking the total number of inpatient days for a specific period of time (usually one year), dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000.
Average length of stay (ALOS)	Average length of stay is computed by dividing the number of days stayed (from the date of admission by the number of discharges during the year.
Utilization by Category of Aid (CoA)	Resource utilization by eligibility type under Medicaid
Utilization by MDC	Resource utilization by Major Diagnostic Category
Outpatient	Analysis of outpatient trends

Medical data is analyzed and tended to evaluate for program efficiency and effectiveness and over / under- utilization trends. Modifications to the Utilization Management Program and Program recommendations are made to improve outcomes and manage costs and ensure quality healthcare for our members and providers.

Any modifications to the Utilization Management Program are reviewed and approved by the Chief Medical Officer, Vice President of Operations, Quality Medical Management Committee (QMMC), Board of Directors and Partnership Council, as applicable, and the Department of Medicaid Services.

## **IX. Utilization Management Activities**

### **Medical Necessity**

Utilization Management is responsible for the medical necessity determination of select services.

The State of Kentucky's definition of "medical necessity":

Passport Health Plan reviews all requests for services pursuant to the authority granted to it in accordance with 907 KAR 17:025. Passport Health Plan is required to provide only medically necessary health services as defined by the Kentucky Administrative Regulations. 907 KAR 3:130 states "medical necessity means a covered benefit is: Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; Clinically appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 139d(r) and 42 CFR Part 441 Subpart B for individuals under twenty-one (21) years of age; and Provided in accordance with 42 CFR 440.230."

### **Inpatient Pre-Admission Review**

The Utilization Review Nurse conducts pre-admission review for all elective admissions to determine the medical necessity and appropriateness of inpatient stays. Evaluation is made using authorized clinical criteria to determine the medical necessity of all requests and whether the treatment could be rendered in an alternative level of care. Pre-admission review authorizations are completed by the First Level Reviewer (Utilization Review Nurse) and if required, the case may be referred to the Medical Director if criteria are not met. Only the Medical Director can make medical denial determinations.

In evaluating each inpatient admission request, the following standards should be met:

- The services are medically necessary
- The services can be provided for the member safely and effectively only in an inpatient hospital setting
- The services cannot be provided in an alternative setting
- The member's medical condition and treatment require daily or more frequent physician contact
- The medical condition and treatment requires constant availability of medical services and equipment ordinarily available only in the inpatient setting
- The type of diagnostic test, observation, equipment, etc., needed to perform a work-up cannot be done on an outpatient basis
- Discharge planning is initiated
- Opportunities for case management and disease management intervention are identified

The review completion time for Inpatient Pre-admission review request is 2 business days.

### **Inpatient or Outpatient Urgent Review**

The Utilization Review Nurse conducts reviews for all urgent admissions and urgent outpatient service requests which require authorization. The review is to determine the medical necessity and appropriateness of urgent inpatient stays and outpatient services. Evaluation is made using authorized clinical criteria to determine the medical necessity of all requests and, if inpatient, whether the treatment could be rendered in an alternative level of care.

Urgent admissions and urgent outpatient service requests are completed by the First Level Reviewer (Utilization Review Nurse) and if required, the case may be referred to the Medical Director if criteria are not met. Only the Medical Director can make medical denial determinations.

In evaluating each inpatient admission request, the following standards should be met:

- The services are medically necessary
- The services can be provided for the member safely and effectively only in an inpatient hospital setting
- The services cannot be provided in an alternative setting
- The member's medical condition and treatment require daily or more frequent physician contact
- The medical condition and treatment requires constant availability of medical services and equipment ordinarily available only in the inpatient setting
- The type of diagnostic test, observation, equipment, etc., needed to perform a work-up cannot be done on an outpatient basis
- Discharge planning is initiated
- Opportunities for case management and disease management intervention are identified

In evaluating each outpatient request, the following standards should be met:

- The service, equipment or procedure is medically necessary
- The service, equipment or procedure is clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- The service, equipment or procedure reflects the most efficient and cost-effective application of patient care
- Opportunities for case management and disease management intervention are identified

Additional considerations to evaluate during the review process include:

- Triage or screening for the purpose of determining the urgency of the member's need for care (3D)
- Appropriateness of Site / Place of Service (3B)
- Level of care (3C)
- Cultural and linguistic barriers

- Member characteristics and information (i.e. educational level that may present barriers to care)
- Information regarding responsible family members; home environment (i.e. Is the home safe for discharge. Are family members available to assist with after-care.)
- Information regarding benefits for services or procedures, if applicable
- Information regarding the local delivery system and alternative services
- Discharge plans

The review completion time for Inpatient & Outpatient Urgent review requests is 1business day.

### **Concurrent Review**

Concurrent review is performed to determine medical necessity and appropriateness of a continued inpatient stay. Evaluation is made using authorized clinical criteria to determine the medical necessity of all concurrent review requests.

Concurrent review requests are completed by the First Level Reviewer (Utilization Review Nurse) and if required, the case may be referred to the Medical Director if criteria are not met. Only the Medical Director can make medical denial determinations.

Assessments are conducted on-site, by telephone, or fax. In evaluating each concurrent review request, the following standards should be met:

- The continued need for hospital level-of-care is medically necessary
- There is not an inappropriate delay of necessary hospital care
- Discharge planning is initiated
- Opportunities for case management and disease management intervention are identified

The review completion time for concurrent review requests is 1business day after receipt of information and prior to the time upon which a previous authorization for hospital stay will expire.

### **Outpatient Prior Authorization**

Prior authorization provides an opportunity to determine medical necessity and appropriateness of services, procedures, and equipment prior to utilization. Evaluation is made using authorized clinical criteria to determine the medical necessity of all outpatient prior authorization requests.

Prior authorizations are completed by the First Level Reviewer (Utilization Review Nurse) and if required, the case may be referred to the Medical Director if criteria are not met. Only the Medical Director can make medical denial determinations.

In evaluating the requested service, equipment or procedure, the following standards should be met:

- The service, equipment or procedure is medically necessary
- The service, equipment or procedure is clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- The service, equipment or procedure reflects the most efficient and cost-effective application of patient care

- Opportunities for case management and disease management intervention are identified

The review completion time for Outpatient Prior Authorization requests is 2 business days.

### **Retrospective Review**

The retrospective review process consists of reviewing records for healthcare services rendered for which previous authorization and coverage determinations had not been established. Retrospective review is conducted utilizing InterQual® Criteria, Utilization Management policies and Medical Management policies. The need for retrospective review may be due to a service rendered after business hours, out-of-area care, or it may be due to retrospective eligibility.

The review completion time for Retrospective requests is 10 business days.

Utilization Management decision making is based only on appropriateness of care and services and existence of coverage.

### **Discharge Planning (3A)**

Discharge planning supports the continuity of healthcare, between the health care setting and the community, based on the individual needs of the patient.

Discharge planning during the review process functions as a conduit for the discharge planning process within a health facility, providing education and support to hospital staff in the development and implementation of discharge plans. Discharge planning assists to coordinate all services allowing member to transition to the next level of care.

### **Integration with Care Coordination, Health and Disease Management, and**

### **Behavioral Health Management (3)**

Care Coordination is the process linking members with special health care needs and their families and/or caregivers to services and resources in a coordinated effort to maximize the potential of the member and provide them with optimal health care.

Health / Disease Management are an approach to healthcare teaching patients how to manage a chronic disease and to prevent or decrease exacerbation of an illness by a comprehensive, integrated approach to care.

Behavioral Health Management focuses on improving the quality of life for people suffering from mental health or substance abuse issues and is a key aspect of a person's overall health and wellbeing.

Utilization Management will evaluate all members for potential Care Coordination / Disease Management / Behavioral Health Management services.

The guidelines to assist in determining if a referral to Care Coordination is appropriate are:

- A new diagnosis of a chronic or catastrophic illness
- Non-compliance with medical regimen

- Multiple services / multiple providers
- Frequent hospitalizations and or emergency room use
- Psychosocial issues hindering medical care
- Over/under-utilization of services
- Members at risk for chronic physical, developmental, behavioral or emotional conditions
- Member with special health care needs beyond that required by individuals generally
- Request from providers for intervention by Care Coordination

The guidelines to assist in determining if a referral to Health / Disease Management is appropriate are:

- Diabetes
- Chronic Respiratory Disease
- Congestive Heart Failure
- Pregnancy
- Obesity
- Coronary Artery Disease

The guidelines to assist in determining if a referral to Behavioral Health Management is appropriate are:

- Children, youth, and adults with multiple health conditions, who are chronically at risk for hospitalization or other out-of-home placement
- Members with histories of behavioral health utilization/diagnoses

#### **Coordination with Special Programs**

The Utilization Management Department works in conjunction with other Passport Health Plan programs to ensure members receive the optimum benefits Passport Health Plan has to offer.

When appropriate, the Utilization Management staff will refer members to the following programs for evaluation and intervention:

- EPSDT Services - all Passport Health Plan members under the age of 21 are eligible for EPSDT services. EPSDT services are defined as Early, Periodic, Screening, Diagnosis and Treatment
- Rapid Response and Outreach Team - rapid triage of the member to identify any urgent needs, both clinical and non-clinical not managed within the Utilization Management Department

#### **Transition of Care**

The Utilization Management Department assists with a member's transition to other care when benefits have ended, a provider terminates a contract or if the member is prepared to transition to a lower level of care.

If a member's coverage for services ends and the member continues to require certain care or services, education regarding alternatives for continuing appropriate care and avenues to obtain care are provided to the member. Utilization Management will collaborate with the Care Coordination Department to ensure the member's health care needs are met.

authorized representative without the member's written consent for the specific action being appealed or is the subject of a State Fair Hearing. The written consent shall be signed and dated by the member no earlier than the date of the action taken by Passport. Passport shall consider the member, representative, or estate representative of a deceased Member as parties to the appeal.

**Medical Necessity - (State of Kentucky's definition of "medical necessity")**

Passport Health Plan reviews all requests for services pursuant to the authority granted to it in accordance with 907 KAR 17:025. Passport Health Plan is required to provide only medically necessary health services as defined by the Kentucky Administrative Regulations. 907 KAR 3:130 states "medical necessity means a covered benefit is: Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; Clinically appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 139d(r) and 42 CFR Part 441 Subpart B for individuals under twenty-one (21) years of age; and Provided in accordance with 42 CFR 440.230."

#### **XIV. State Fair Hearing**

A member may request a State Fair Hearing if he or she is dissatisfied with an action taken by the Contractor within 45 days of the final appeal decision. The member must complete all Passports internal appeal processes before requesting a State Fair Hearing. A member may request a State Fair Hearing for an action taken by the Contractor denying or limiting an authorization of a requested service or reduces, suspends, or terminates a previously authorized service. Passport is required to follow the applicable regulations as it pertains to a member's request for a State Administrative Hearing from any adverse action.

All Passport members are informed of their right to a Cabinet Level State Administrative Hearing of an adverse action. Notification of the right to a State Administrative Hearing is sent to the member in conjunction with the Passport adverse action letter.

Members must notify the Kentucky Department for Medicaid Services (DMS) to request a State Administrative Hearing.

The member must complete all Passports internal appeal processes before requesting a State Fair Hearing. In the event a member elects a State Administrative Hearing, DMS Administrative Hearings Branch notifies the Passport Appeals Coordinator of the appeal request. The Passport Appeals Coordinator accesses the member's electronic file containing all Passport records relating to the adverse action. The file and all internal appeal records are sent by secure email to the DMS Administrative Hearings Branch within 5 calendar days of receipt of notice from the DMS a hearing has been filed.

The Appeals Coordinator notifies the Passport Legal Counsel, located within the Passport Compliance Department, of the Hearing request. The Notice of a Scheduled Hearing will be sent to the Passport Appeals Coordinator by the Hearing Officer at the DMS Administrative Hearings Branch. The notice will contain the date, time and location the Hearing is to be held. Passport's Legal Counsel files a Notice of Entry of Appearance of Counsel.

The Passport Legal Counsel and, as necessary, the Appeals Coordinator represent Passport at all State Fair Hearings and arrange for those giving testimony on behalf of Passport to appear at the hearing. Failure to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an action taken by Passport or to appear and present evidence will result in an automatic ruling in favor of the member.

Upon receipt of the Findings of Fact, Conclusions of Law, and Recommended Decision from the Hearing Officer all appropriate action is taken by the Legal Counsel and the Appeals Coordinator. Upon receipt of the Final Order signed by the Secretary of the Cabinet, all appropriate action is taken as required by the Order.

The Hearing Officer at the DMS Administrative Hearings Branch is to send the final decision letter to the member within 30 days.

The member may contact Kentucky's Ombudsman or Passport Member Services for assistance at any time during the appeal process.

## XV. Clinical Initiatives

The UM and Clinical Programs Departments evaluate trends in utilization, medical spend and DMS regulations to determine clinical projects/initiatives.

Clinical initiatives are evaluated based on Departmental and Corporate objectives, utilization trends, business objectives and DMS initiatives or regulations.

### Tiny Tots

The department will continue to administer the Tiny Tots Program which assists members with the transition of newborns from the hospital to home after the newborn's medical condition has been stabilized.

#### Project Rationale

- One in nine babies born in the United States are premature
- Almost two-thirds of all childhood hospital stays are for newborns (babies up to 30 days old)
- Three of the top 10 diagnoses with the longest length of stay are conditions originating in the newborn period: prematurity, respiratory distress, and cardiac and circulatory birth defects

#### Project Objectives

- Identify and educate members on the importance of follow up care
- Ensure a secure and healthy transition of the detained newborn from hospital to home
- Ensure compliance with follow-up visits for detained newborns

#### Project Strategies

Identify detained newborns and primary caregiver at point of initial hospitalization

#### Goal:

- Provide early education regarding care of medically fragile infant
- Coordinate a safe transition to home
- Assist in arranging discharge needs when medically stable

#### Identify gaps in care

- Ensure adherence to after care instructions
- Ensure adherence to scheduled physician appointments
- Ensure appropriate interventions are followed

#### **Definitions:**

**Detained Newborn:** Infant in the first 28 days of life that remained hospitalized after birth mother has been discharged

### Reduction in Emergency Room Utilization

The department implemented and will continue to administer various Emergency Room (E.R.) programs to decrease the use of the Emergency Room for non-urgent diagnosis and to outreach, follow-up and provide education to our members.

#### Project Rationale

- Passport's Emergency Room costs are in excess of 3 million dollars per month
- Kentucky has been chosen to collaborate on a project to design better ways to provide responsible medical care to so-called "super-utilizers" – people who

frequently use emergency rooms for regular health care instead of lower-cost alternatives

- Kentucky Medicaid spent more than \$219 million on Emergency Room use in 2012. In that 12-month span, 4,400 Medicaid recipients used the E.R. 10 or more times.

#### Project Objectives

- Decrease E.R. utilization for non-urgent diagnosis by 2%
- Identify and educate members who utilize the E.R. for non-urgent diagnosis
- Coordinate with Passport alternative programs (Case Management; Disease Management; Behavioral Health)

#### Project Strategies

Implement E.R. Lock-in in accordance with Regulation 907KAR 1:67

##### Goal:

- Identify members eligible for E.R. lock-in
- Assign member to a designated facility
- Inform member they may be financially liable for ER services beyond those of triage for a non-urgent diagnosis

#### Continue E.R. Coordinator Program

##### Goal:

- Work in collaboration with facilities to identify Passport members utilizing the E.R.
- Outreach and educate members and providers

#### Implement E.R. Coordinator

##### Goal:

- Identify members who utilize the emergency room for non-urgent medical conditions through hospital E.R. data
- Identify needs for health education based on obtained data
- Outreach to members to educate on proper utilization of the E.R.
- Enable individuals to use knowledge in ways transforming unhealthy habits into healthy habits

#### Definitions:

**Non-Urgent medical condition:** The member's life or health or ability to attain, maintain, or regain maximum function is not at risk

**Urgent / Emergent medical condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

#### Reduction in cesarean sections (C-sections) and early elective inductions

Passport will evaluate the C-section rates as it pertains to our members and providers who induce members prior to 39 weeks gestation.

#### Project Rationale:

- Passport's C-section rate averages 31%

- Five physicians with greater than 100 deliveries annually were identified as having a 40% or higher C- section rate
- CMS has launched an initiative in 2012 to improve perinatal health outcomes. One initiative, Strong Start for Mothers and Newborns, led by the CMS Innovation Center (CMMI) working in partnership with the Center for Medicaid and CHIP Services (CMCS), includes testing ways to encourage best practices for reducing the number of early elective deliveries lacking medical indication across all payer types

**Project Objectives:**

- Reduce the C-section rate by 2%
- Adopt a hard stop policy on early elective inductions
- Identify and educate providers and members

**Project Strategies**

Identify physicians with above average C-section rate

**Goal:**

- Identify providers with C-section rate greater than 31%
- Analyze provider induction / C-section protocol
- Provide education

Evaluate coverage for alternative birthing methods

**Goal:**

- Identify alternative birthing methods
- Analyze results of alternative birthing methods
- Provide education

Incorporate perinatal core measures in Passport’s provider contracts

**Goal:**

- Obtain facility’s outcomes on core measures
- Identify variances
- Provide education
- Incorporate core measures in provider performance standards

**Definitions:**

**Early Elective Deliveries:** non-medically indicated labor inductions prior to 39 weeks gestation

**Perinatal core measure:** Starting January 2014, the Joint Commission will require U.S. hospitals with more than 1,100 births per year to work towards reducing the C-section rate in first-time mothers.

Starting in 2014, hospitals who are accredited by the Joint Commission will be required to publicly report on 5 outcomes, known as the “perinatal core measure” set. These outcomes include:

1. Decreasing the early elective birth rate (before 39 weeks)
2. Decreasing the C-section rate in low risk women (first-time moms with a single baby who is head-down at term)
3. Increasing the use of prenatal steroids for babies who are born pre-term
4. Reducing bloodstream infections in newborns
5. Increasing exclusive breastfeeding rates during hospitalization

Reduction in avoidable hospital re-admissions

Passport will evaluate avoidable hospital re-admissions.

Project Rationale:

- Passport's re-admission overall rate averages 15% - 20%
- Beginning in fiscal year 2013, the HRRP (Medicare Hospital Readmissions Reduction Program) imposed a financial penalty on hospitals with excess Medicare readmissions for heart attack, heart failure, and pneumonia
- Re-admissions for Passport members with a diagnosis of a circulatory disease (including heart attack and heart failure) was 38.46%
- Re-admissions for Passport members with a diagnosis of respiratory disease (including pneumonia) was 30.77%

Project Objectives:

- Reduce avoidable re-admission rate by 2%
- Identify and educate providers and members
- Implement Utilization Management Discharge Planning

Project Strategies

Identify providers with above average re-admission rate

Goal:

- Identify providers with re-admission rate greater than 15%
- Analyze provider re-admission protocol
- Provide education

Identify target diagnosis

Goal:

- Identify diagnosis with high re-admission rate
- Evaluate avoidable versus non-avoidable re-admissions
- Incorporate HRRP (Medicare Hospital Readmissions Reduction Program) financial penalties in provider contract

**Definitions:**

**Avoidable hospital re-admissions:** readmission is considered to be clinically related to a prior admission and potentially preventable if there was a reasonable expectation it could have been prevented by one or more of the following: (1) the provision of quality care in the initial hospitalization, (2) adequate discharge planning, (3) adequate post discharge follow-up, or (4) improved coordination between inpatient and outpatient health care teams.

**DRG**

The department will implement a modified review process for DRG facilities.

Project Rationale

- Passport will utilize the DRG payment methodology in 2014
- The review process will be modified to meet the varying payment methodology for DRG reimbursement

Project Objectives

- Implement modified review process to perform initial medical necessity review and concurrent review on for outlier cases
- Evaluate 14 and 30 day re-admission rates by provider
- Evaluate providers for DRG "creep" or up-coding

Project Strategies

Implement modified review process

## **XVI. Program Satisfaction**

The Utilization Management – Clinical Programs Departments monitor the level to which the network serves the needs of our members and providers by analyzing the following data at least annually:

- Provider Satisfaction Survey

Data collection and evaluation provider satisfaction are conducted primarily through the Quality Improvement Department (QMMC) with input from the Utilization Management Department.

Analysis of provider satisfaction are tracked and analyzed to promote effective organizational changes, and to develop quality improvement plans and interventions. These activities are reported to the Quality Medical Management Committee with input requested from that committee.

**Acknowledgement and Approval**

This PHP 2014 Utilization Management and Clinical Programs Description is submitted by:

Anna Page, RN  
Director, Utilization Management and Clinical Programs

Date

Approvals:

		<b>Policy/Procedure</b>	
<b>Policy Name: Coordination of Care with First Steps for Non-School Aged Children &amp; for children receiving school-based services and Early Intervention Services</b>		<b>Policy Number: UM 31.02</b>	
<b>Date of Next Annual Review: 08/26/15</b>		<b>Original/Issue Date: 1.5.2006</b>	
<b>Approved By: Anna Page, R.N</b>		<b>Title: Director</b>	
<b>Signature:</b> <i>Anna Page</i>		<b>Date Approved: 11.12.2013</b>	
<b>Policy Action</b>		<b>(Check One)</b>	
<b>New</b> (Date policy was created)		<input type="checkbox"/>	
<b>Reviewed</b> (No changes to policy)		<input type="checkbox"/>	
<b>Revised</b> (Content changes made to policy)		<input checked="" type="checkbox"/>	
<b>Retired</b> (Policy no longer active)		<input type="checkbox"/>	
<b>Date</b>		08/26/14	
<b>APPLICABILITY</b>			

All Medical Management Associates

**PURPOSE**

The purpose of this policy is to coordinate services for children with developmental or physical disabilities or delays with the First Steps program or School Based Services.

**POLICY**

To describe the coordination process of physical therapy, speech therapy, and/or occupational therapy with the First Steps program, for non-school aged children (0-3rd birthday) (early intervention services), School Based Services and / or Early Intervention Services to prevent duplication of services.

**DEFINITION(S)**

**Appeal** - Request for review of an action or a decision by the contractor related to covered services or services provided.

**Authorized Representative** – A guardian; a parent of a minor or disabled child; an adult child for a parent; and/or any other individual who has legal authority to act on behalf of another.

**Early Intervention Services** - Services provided to young children designed to help them avoid or overcome physical or emotional development disabilities. Early intervention services provide the help children need to keep pace with other children their age, both socially and academically.

**First Steps Program** – an entitlement program established by the Federal Individuals with Disabilities Act (IDEA) and is funded by federal, state, and local funds. The goal of the program is to provide early intervention services to children from birth up to age three (3rd birthday) who

have developmental disabilities or delays. The intended outcome of the program is to ensure maximum amelioration of the impact of developmental disabilities or delays on infants and toddlers by early and ongoing provision of rehabilitation services.

First Steps is administered by the Kentucky Department for Public Health in the Cabinet for Health and Family Services

**HANDS:** voluntary intensive home visitation program for first-time parents that provides services from the prenatal period to the child's third birthday.

**Home Based Therapy** - Home Based Therapy is made available especially to families or individuals who have a difficult time accessing therapy, or who would benefit from having the therapist come to them.

**Individualized Educational Plan (IEP)** - An document developed to meet the special education needs of the child; specific academic goals are set for the child.

**Long Term Goal** - goal that is the ultimate results desired when a plan is established or revised.

**Medical Necessity (therapy)** - Care is prescribed by a physician in order to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, injury or surgical procedure.

**Physical Therapy** - The treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise; focuses specifically on one injury or set of injuries; work to rebuild muscle groups.

**Plan of Care** - written document that outlines the progression of therapy; Documentation of Presenting Problem - A brief description of the main issue or issues; Goals of Therapy - list of both the overall goal(s) and the interim goal(s) of therapy; Methods - list of the techniques that will be used to achieve the goals; Time Estimate - estimate of the length of time and/or number of sessions needed

**Occupational Therapy** - therapy based on engagement in meaningful activities of daily life, especially to enable or encourage participation in such activities in spite of impairments or limitations in physical or mental functions; focus on a person's functional abilities; helps optimize their independence and ability to accomplish daily activities.

**School Based Services** - are partnerships created by schools and community health organizations to provide on-site medical and mental health services that promote the health and educational success of school-aged children and adolescents.

**Short Term Goal** - goals that can be achieved in a limited period of time and frequently lead to the achievement of a long term goal.

**Speech Therapy** - The treatment of speech and communication disorders

## PROCEDURE

### *Coordination with First Steps*

1. A request is received for therapy services (Physical, Occupational or Speech) for a member between the ages of 0 to 3 (3<sup>rd</sup> birthday). Requests may be received via:
  - a. Phone
  - b. Fax
  - c. Mail
  - d. Secure email
2. The request is referred to the Medical Director for medical necessity determination
  - a. All requests for therapy services for members zero (0) to three (3) years of age are referred to the Medical Director for review determination
3. The Passport Health Plan Medical Director reviews the request for medical appropriateness of the proposed treatment plan and setting.
4. The Medical Director determines if First Steps is an appropriate alternative to traditional therapy services. First Steps eligibility:
  - Serve children from birth to age 3 and their families
  - Eligibility for the program is determined two ways:
    - By developmental delay - A child may be eligible for services if an evaluation shows that a child is not developing typically in at least one of the following skill areas: communication, cognition, physical, social and emotional or self-help.
    - Automatic entry - A child may be eligible if he or she receives a diagnosis of physical or mental condition with high probability of resulting developmental delay, such as Down Syndrome. (see appendix A for established risk conditions that make children automatically eligible for First Steps)
      - Automatic entry does not necessarily mean child is will remain in the First Steps program. These families will have the option to continue with First Steps and be monitored during their 6 month IFSP (individualized family service plan), or they can opt out of the program since it is voluntary
6. If the requested services are those that can be administered **solely** through the First Steps program, the request may be denied by the Medical Director.
7. If a member is eligible for First Steps but requires services beyond what First Steps offers, the Medical Director may approve the request for therapy. If a member is not eligible for First Steps, the Medical Director may approve the request if medically necessary.

A member may receive services through First Steps and services through Passport concurrently.

All requests are evaluated on a case by case basis.

8. If the request is denied, the denial rationale should contain the referral information to First Steps (Anyone can refer a child for First Steps services by calling 877-417-8377 or 877-41 STEPS)

A member or authorized representative may appeal the denial.

9. After the Medical Director has made his/her review determination, the case is routed back to the Nurse Reviewer for completion.

### *Coordination with School Based Services or Early Intervention Services*

1. A request is received for therapy services (Physical, Occupational or Speech) for a school aged member. Requests may be received via:
  - a. Phone
  - b. Fax
  - c. Mail
  - d. Secure email

2. The Nurse Reviewer is to evaluate the request to determine if the member is receiving services through the school system or another Early Intervention program. The nurse Reviewer is to ask the requestor if the member is receiving services through any other organization.

If no, the nurse reviewer may proceed with the request.

3. If the member is receiving services through the school system or through another Early Intervention Program, the request is to be referred to the Medical Director.

The Medical Director will determine if the request is a duplication of services. Duplication of services may result in a denial of the request.

A member or authorized representative may appeal the denial.

4. After the Medical Director has made his/her review determination, the case is routed back to the Nurse Reviewer for completion.
5. In situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, Passport is responsible for providing all Medically Necessary Covered Services.

Std 32.8

School Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage.

Coordination between the schools and Passport shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.

For any service, the Utilization Management (UM) Nurse obtains the necessary clinical information that includes:

- Diagnosis and co-morbidities
- Duration of illness / injury and prior treatment, if applicable
- Prior function
- Therapy Evaluation: date of evaluation and results
- Signs and symptoms; Functional limitations; Impairments; Deficits
- Plan of care – Should be ongoing, (i.e., updated as the patient's condition changes), and treatment should demonstrate reasonable expectation of improvement
- Long-term and short-term goals that are specific, quantitative and objective and a reasonable estimate of when the goals will be reached;
- The frequency and duration of treatment and modalities
- Short term and long term goals
- Psychosocial history
- Cultural and linguistic barriers
- Information from responsible family members; Home environment

The Nurse Reviewer along with the Department of Health/School Based Services Manager will assist to coordinate the care provided through all programs as children who are receiving these services are identified and to share information with early intervention/school-based service providers with appropriate permission from parents.

Std 32.8

Services provided under HANDS shall be excluded from coverage. HANDS is a home visitation program for first-time parents. It services children under three (3) years of age and it promotes good parenting skills.

**CROSS REFERENCE/REFERENCE MATERIALS**  
(If necessary to cite other policies or documents)

None

**REVIEW AND REVISION DATES (Annually at minimum)**

January 10, 2008  
January 10, 2009  
January 10, 2010  
January 10, 2011  
January 10, 2012  
November 28, 2012  
November 12, 2013  
August 26, 2014

End of Policy  
 Appendix A – First Steps Established Risk Conditions

**First Steps: Established Risk Conditions**

Aase-Smith Syndrome (Diamond-Blackfan Anemia)	Aase Syndrome
Acrocallosal Syndrome	Acrodysostosis
Acro-Fronto-Facio-Nasal Dysostosis	Adrenoleukodystrophy
Agenesis of the Corpus Callosum	Agyria
Aicardi Syndrome	Alexander's Disease
Alper's Syndrome	Amelia
Angelman Syndrome	Aniridia
Anophthalmia/Microphthalmia	Antley-Bixler Syndrome
Apert Syndrome	Arachnoid cyst with neuro-developmental delay
Arhinencephaly	Arthrogryposis
Ataxia	Atelosteogenesis
Autism	Baller-Gerold Syndrome
Bannayan-Riley-Ruvalcaba Syndrome	Bardet-Biedl Syndrome
Bartoskas-Papas Syndrome	Beals Syndrome (congenital contractual arachnodactyly)
Bixler Syndrome	Blackfan-Diamond Syndrome
Bobble Head Doll Syndrome	Borjeson-Forsman-Lehmann Syndrome
Brachial Plexopathy	Brancio-Oto-Renal (BOR) Syndrome
Campomelic Dysplasia	Canavan Disease
Carbohydrate Deficient Glycoprotein Syndrome	Cardio-Facio-Cutaneous Syndrome
Carpenter Syndrome	Cataracts-Congenital
Caudal Dysplasia	Cerebro-Costo-Mandibular Syndrome
Cerebellar Aplasia/Hypoplasia/Degeneration	Cerebral Atrophy
Cerebral Palsy	Cerebro-oculo-facial-skeletal syndrome
CHARGE Association	Chediak Higashi Syndrome
Chondrodysplasia Punctata	Christian Syndrome
Chromosome Abnormality <ul style="list-style-type: none"> <li>a. Unbalanced numerical (autosomal)</li> <li>b. Numerical trisomy (chromosomes 1-22)</li> <li>c. Sex chromosomes XXX; XXXX; XXXXX; XXY; XXXY</li> </ul>	CNS Aneurysm with Neuro-Developmental Delay
CNS Tumor with Neuro-Developmental Delay	Cockayne Syndrome
Coffin Lowry Syndrome	Coffin Siris Syndrome
Cohen Syndrome	Cone Dystrophy
Congenital Cytomegalovirus	Congenital Herpes
Congenital Rubella	Congenital Syphilis
Congenital Toxoplasmosis	Cortical Blindness
Costello Syndrome	Cri Du Chat Syndrome
Crylophthalmos	Cutis Laxa
Cytochrome-c Oxidase Deficiency	Dandy Walker Syndrome
DeBary Syndrome	DeBoquois Syndrome
Dejerine-Sottas Syndrome	DeLange Syndrome
DeSanctis Cacchione Syndrome	Diastrophic Dysplasia
DiGeorge Syndrome	Distal Arthrogryposis
Donohue Syndrome	Down Syndrome
Dubowitz Syndrome	Dyggve Melchor-Calusen Syndrome
Dyssegmental Dysplasia	Dystonia
EEC (Ectrodactyly-ectodermal dysplasia-clefting) Syndrome	Endephalocele
Encephalo-Cranio-Cutaneous Syndrome	Encephalomalacia
Facio-Auriculo-Radial Dysplasia	Facio-Cardio Renal (Eastman-Bixler) Syndrome
Familial Dysautonomia (Riley-Day Syndrome)	Fanconi Anemia
Farber Syndrome	Femoral Hypoplasia
Fetal Alcohol Syndrome/Effects	Fetal Dyskinesia

Fetal Hydantoin Syndrome	Fetal Valproate Syndrome
Fetal Varicella Syndrome	FG Syndrome
Fibrochondrogenesis	Floating Harbor Syndrome
Fragile X Syndrome	Freeman-Sheldon (Whistling Facies) Syndrome
Fryns Syndrome	Fucosidosis
Galactosemia	Glaucoma-Congenital
Glutaric Aciduria Type I and II	Glycogen Storage Disease
Goldberg-Shprintzen Syndrome	Grebe Syndrome
Hallermann-Streif Syndrome	Hays-Wells Syndrome
Head Trauma with Neurological Sequelae/Developmental Delay	Hearing Loss (25dB or greater in better ear as determined by ABR audiometry or audiometric behavioral measurements)
Hemimegalencephaly	Hemiplegia/Hemiparesis
Hemorrhage-Intraventricular Grade III and IV	Hereditary Sensory & Autonomic Neuropathy
Hereditary Sensory Motor Neuropathy (Charcot Marie Tooth Disease)	Herrmann Syndrome
Heterotopias	Holoprosencephaly (Aprosencephaly)
Holt-Oram Syndrome	Homocystinuria
Hunter Syndrome (MPS II)	Hurler Syndrome (MPS I)
Hyalinosis	Hydranencephaly
Hydrocephalus	Hyperpipecolic Acidemia
Hypomelanosis of ITO	Hypophosphotasis-Infantile
Hypoxic Ischemic Encephalopathy	I-Cell (mucopolidosis II) Disease
Incontinentia Pigmenti	Infantile Spasms
Iniencephaly	Isovaleric Acidemia
Jarcho-Levin Syndrome	Jervell Syndrome
Johanson-Blizzard Syndrome	Joubert Syndrome
Kabuki Syndrome	KBG Syndrome
Kenny-Caffey Syndrome	Klee Blattschadel
Klippel-Feil Sequence	Landau-Kleffner Syndrome
Lange-Nielsen Syndrome	Langer Giedion Syndrome
Larsen Syndrome	Laurin-Sandrow Syndrome
Leber's Amaurosis	Legal Blindness (bilateral visual acuity of 20/200 or worse corrected vision in the better eye)
Leigh Disease	Lennox-Gastaut Syndrome
Lenz Majewski Syndrome	Lenz Microphthalmia Syndrome
Levy-Hollister (LADD) Syndrome	Lesch-Nyhan Syndrome
Leukodystrophy	Lissencephaly
Lowe Syndrome	Lowry-Maclean Syndrome
Maffucci Syndrome	Mannosidosis
Maple Syrup Urine Disease	Marden Walker Syndrome
Marshall Syndrome	Marshall-Smith Syndrome
Maroteaux-Lamy Syndrome	Maternal PKU Effects
Megalencephaly	MELAS
Meningocele (cervical)	MERRF
Metachromatic Leukodystrophy	Metatropic Dysplasia
Methylmalonic Acidemia	Microcephaly
Microtia-Bilateral	Midas Syndrome
Miller (postaxial acrofacial-dysostosis) Syndrome	Miller-Dieker Syndrome
Mitochondrial Disorder	Mobius Syndrome
Morquio Syndrome	Moya-Moya Disease
Mucopolidosis II and III	Multiple congenital anomalies (major organ birth defects)
Multiple Pterygium Syndrome	Muscular Dystrophy
Myasthenia Gravis-Congenital	Myelocystocele
Myopathy -Congenital	Myotonic Dystrophy
Nager (Acrofacial Dysostosis) Syndrome	Nance Horan Syndrome

NARP	Neonatal Meningitis/Encephalitis
Neuronal Ceroid Lipofuscinoses	Neuronal Migration Disorder
Nonketotic Hyperglycinemia	Noonan Syndrome
Ocular Albinism	Oculocerebrocutaneous Syndrome
Oculo-Cutaneous Albinism	Optic Atrophy
Optic Nerve Hypoplasia	Oral-Facial digital Syndrome, Types I-VII
Osteogenesis Imperfecta, Types III and IV	Osteopetrosis (Autosomal Recessive)
Oto-Palato-Digital Syndrome, Types I and II	Pachygyria
Pallister Mosaic Syndrome	Pallister-Hall Syndrome
Pelizaeus-Merzbacher Disease	Pendred's Syndrome
Periventricular Leukomalacia	Pervasive Developmental Disorder
Peters Anomaly	Phocomelia
Poland Sequence	Polymicrogyria
Popliteal Pterygium Syndrome	Porencephaly
Prader-Willi Syndrome	Progeria
Propionic Acidemia	Proteus Syndrome
Pyruvate Carboxylase Deficiency	Pyruvate Dehydrogenase Deficiency
Radial Aplasia/Hypoplasia	Refsum Disease
Retinoblastoma	Retinoic Acid Embryopathy
Retinopathy of Prematurity, Stages III and IV	Rett Syndrome
Rickets	Rieger Syndrome
Roberts SC Phocomelia	Robinow Syndrome
Rubinstein-Taybin Syndrome	Sanfilippo Syndrome (MPS III)
Schizel-Giedion Syndrome	Schimmelpenning Syndrome (Epidermal Nevus Syndrome)
Schizencephaly	Schwartz-Jampel Syndrome
Seckel Syndrome	Septo-Optic Dysplasia
Shaken Baby Syndrome	Short Syndrome
Sialidosis	Simpson-Golabi-Behmel Syndrome
Sly Syndrome (MPS IV)	Smith-Fineman-Myers Syndrome
Smith Limitz-Opitz Syndrome	Smith-Magenis Syndrome
Sotos Syndrome	Spina Bifida (Meningocele)
Spinal Muscular Atrophy	Spondyloepiphyseal Dysplasia Congenita
Spondylometaphyseal Dysplasia	Stroke
Sturge-Weber Syndrome	TAR (Thrombocytopenia-Absent Radii Syndrome)
Thanatophoric Dysplasia	Tibial Aplasia (Hypoplasia)
Toriello-Carey Syndrome	Townes-Brocks Syndrome
Trecher-Collins Syndrome	Trisomy 13
Trisomy 18	Tuberous Sclerosis
Urea Cycle Defect	Valocardiofacial Syndrome
Wildervanck Syndrome	Walker-Warburg Syndrome
Weaver Syndrome	Wiedemann-Rautenstrauch Syndrome
Williams Syndrome	Winchester Syndrome
Wolf Hirschhorn Syndrome	Yunis-Varon Syndrome
Zellweger Syndrome	