



Passport to Health



Medicaid and Healthy Montana Kids Plus

This publication supersedes all previous Passport to Health guides and manuals. First published by the Department of Public Health and Human Services, December 2003.

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My NPI:

My Passport Number:

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Key Contacts and Websites

See the Contact Us link on the Montana Healthcare Programs Provider Information [website](#) for additional contact and website information.

Contact hours are 8 a.m. to 5 p.m. Monday–Friday, Mountain Standard Time, unless otherwise stated. The phone numbers designated *In state* will not work outside Montana. The numbers designated *TDD* and *TTY* have a telecommunication device for people who need assistance hearing. Persons with disabilities who need an alternative accessible format of this information, or who require some other reasonable accommodation to participate in Medicaid/HMK *Plus*, should contact DPHHS through the Passport to Health program.

Fair Hearing or Administrative Review Request

To request a fair hearing or administrative review, deliver or mail the request to the address below.

406-444-2470
hhsofh@mt.gov

Office of Fair Hearings
DPHHS
P.O. Box 202953
Helena MT 59620-2953

Health Improvement Program (HIP)

For questions regarding HIP, contact:

406-444-4540
406-444-1861 Fax

Health Improvement Program Officer
Member Health Management Bureau
DPHHS
P.O. Box 202951
Helena MT 59620-2951

Interpreter Services

For forms and information on providing interpretive services to members, call the Medicaid/HMK *Plus* at 406-444-4540

Montana Relay Services

Telecommunications assistance for the hearing impaired.

800-833-8503 Voice, TTY
406-444-1335 Voice, TTY
relay@mt.gov

Nurse First Program

For questions regarding the Nurse First Advice Line, 1.800.330.7847, contact:

406-444-4455 Phone
406-444-1861 Fax

Nurse First Program Officer
Member Health Management Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Office of Human Resources and Office for Civil Rights

For complaints about alleged discrimination because of race, color, national origin, age or disability, or other protected classes hours are 8 a.m. to 4 p.m. Mountain Standard Time.

406-444-0262

Member Complaint Coordinator
Office of Human Resources
DPHHS
P.O. Box 4210
Helena, MT 59620-4210

800-368-1019

800-537-7697 TDD

Passport to Health

Members who have general Medicaid/HMK *Plus* questions, are looking for a provider, or want to choose a Passport provider may call the Montana Medicaid/HMK *Plus* Help Line, **1-800-362-8312** (in/out of state).

Providers with questions regarding Passport may contact the Xerox Passport Provider Lead or the Passport program officer.

Xerox Passport Provider Lead

406-457-9558

406-442-2328 Fax

Passport to Health Program
P.O. Box 254
Helena MT 59624-0254

Passport Program Officer

406-444-4540

406-444-1861 Fax

Passport to Health Program Officer

Providers who have policy or program questions and concerns or need to report errors, omission, or discrepancies in member utilization and cost reports may contact the Passport to Health program officer.

406-444-4540

406-444-1861 Fax

Passport to Health Program Officer
Medicaid Services Bureau
DPHHS
P.O. Box 202951
Helena MT 59620-2951

Team Care Program

For questions regarding the Team Care Program:

406-444-4540

406-444-1861 Fax

Team Care Program Officer
Member Health Management Bureau
P.O. Box 202951
Helena MT 59620-2951

Program Overview

Passport to Health Program

Passport to Health is the primary care case management (PCCM) program for Montana Medicaid and HMK *Plus* members. The Passport to Health program provides case management related services that include locating, coordinating, and monitoring primary healthcare services. To achieve this, the Passport program works with the state's other care coordination programs:

- Nurse First Advice Line
- Team Care
- Health Improvement Program (HIP)

Medicaid and HMK *Plus* members who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK *Plus* members are eligible). See page 6.3 for a list of members who are ineligible for Passport. Each member has a designated Passport provider such as a physician, midlevel practitioner, or primary care clinic.

The Passport provider delivers PCCM services to their members. This means they provide or coordinate the member's care and make referrals to other Montana Medicaid/HMK *Plus* providers when necessary. With some exceptions, all services to Passport members must be provided or approved by the member's Passport provider or Medicaid/HMK *Plus* will not reimburse for those services. The member's Passport provider is also referred to as the primary care provider (PCP).

The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as “deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”

The PCCM model facilitates a strong patient–provider relationship by providing primary, preventive, and routine services; managing and coordinating the member's services; and acting as the front door to Medicaid services.

To be an effective PCP, a provider's office or facility must be:

- **Accessible.** How long does it take for a member to get an appointment to see you? Can they e-mail you? Call you?
- **Continuous.** Do you watch your members grow?

- **Comprehensive.** Do you offer as many services as possible to your members in-house?
- **Coordinated.** For example, do you have an effective method for determining when a diabetic patient is due for a foot exam or when a child needs immunizations?
- **In the Context of Family and Community.** How do you encourage family health and support? Are you aware of specialists and services available to your members in your area?

Program Goals

- **Ensure access** to primary care.
- Establish a **partnership** with the Medicaid/HMK *Plus* member.
- Provide **continuous and coordinated** care to maximize health outcomes.
- Improve the **continuity of care**.
- Encourage **preventive** healthcare.
- Promote Early and Periodic Screening, Diagnostic, and Treatment (**EPSDT**) services.
- **Reduce inappropriate use** of medical services and medications.
- **Decrease** non-emergent care in the emergency department (ED).
- **Reduce and control healthcare costs.**

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid/HMK *Plus* program. Provider manuals assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. Links to rules are available on the Provider Information [website](#).

Paper copies of rules are available through the Secretary of State's office. In addition to the general Medicaid rules outlined in the *General Information for Providers* manual and the rules outlined in each program manual, the following rules and regulations are also applicable to the Passport to Health program:

- **Code of Federal Regulations (CFR)**
 - 42 CFR 438 Managed Care
- **Montana Code Annotated (MCA)**
 - MCA 53-6-116 – 53-6-117 Medicaid Managed Care – Capitated Health Care, Participation Requirements
 - MCA 53-6-701 – 53-6-706 Medicaid Managed Care
- **Administrative Rules of Montana (ARM)**
 - ARM 37.86.5101 – 37.86.5120 Passport to Health Program

Getting Questions Answered

The Member Health Management Bureau, under the Department of Public Health and Human Services (DPHHS), administers the Passport to Health program and determines services and policy. Manuals and other information are available on the Provider Information [website](#).

The Montana Medicaid/HMK *Plus* Member Help Line assists members with Passport to Health enrollment, helps them locate or change providers, and answers their Medicaid/ HMK *Plus* and Passport questions.

Provider Relations answers provider questions about Medicaid/HMK *Plus* services, claims, and eligibility, and addresses provider concerns.

Providers may also call the Xerox Passport Provider Lead to discuss problems or questions regarding Passport members or to enroll in Passport. See the Key Contacts and Websites chapter.

Providers should keep up with changes and updates to the Passport program by reading the *Claim Jumper*, Montana Medicaid's monthly online newsletter, and any Passport provider notices issued.

Providers should also visit the Provider Information [website](#) for Passport and Medicaid/HMK *Plus* information.

See the Key Contacts and Websites chapter in this manual and the Contact Us link on the Provider Information [website](#) for a list of contacts and their addresses and telephone numbers.

Role of the Passport Provider

Becoming a Passport Provider

A PCP can be a physician or a mid-level practitioner who provides PCCM services by agreement with the Department. The Department allows any provider who has primary care within his/her professional scope of practice to be a PCP. However, the Department does recognize that certain specialties are more likely to practice primary care, and actively recruits these providers.

Passport Provider Enrollment

To enroll in Passport, Medicaid/HMK *Plus* providers must meet the following requirements. (ARM 37.86.5111)

- Enroll or be enrolled as a Medicaid provider.
- Provide primary care services.
- Sign a Passport provider agreement.
- Keep a paper or electronic log, spreadsheet, or other record of all Passport referrals given and received.

The Passport provider agreement and this manual are available on the Provider Information [website](#). Providers may also call the Xerox Passport Provider Lead for information on becoming a Passport provider and to get the Passport provider agreement.

Solo Passport Provider

A solo Passport provider is enrolled in the program as an individual provider with one Passport number. The solo provider is listed as the member's Passport provider. The solo provider is responsible for managing his or her individual Passport caseload. For details on referral documentation, see the Passport Referral chapter in this manual. Case management fees are paid to the individual provider under the solo provider's Passport number in addition to the fee-for-service reimbursement.

Group Passport Provider

A group Passport provider is enrolled in the program as having one or more Medicaid providers practicing with one Passport number. The group name will be listed as the member's Passport provider and could be a private group clinic, rural health clinic, federally qualified health center, or Indian Health Service (IHS) clinic. All participating providers sign the Passport agreement group signature page and are responsible for managing the caseload. With a group provider, members may visit any provider within the group practice without a Passport referral. Case management fees are paid to a group under the group Passport number in addition to the fee-for-service reimbursement.

Suitable Coverage

Passport providers must provide or arrange for suitable coverage for needed services, consultation, and approval or denial of referrals during posted normal business hours. If another provider is covering, the covering provider need not be enrolled as a Passport provider, but must be a Medicaid provider. Coverage can be provided by a physician, mid-level practitioner, or registered nurse. The covering provider must have the authority to give the Passport provider's number for claims.

Posted Normal Office Hours Coverage

May consist of a receptionist or equivalent, telephone system that will get the member to medical staff, or any appropriate method that provides the member access to the PCP or someone who can make medical decisions.

24-Hour Coverage

Passport providers must provide direction to members in need of emergency care 24/7/365. Acceptable direction includes an answering service, call forwarding, provider on-call coverage, or answering machine message. When a message is used, it should state at a minimum: *If this is a medical emergency, hang up and either call 911 or go to the emergency department.*

Passport providers are required to provide education to their members regarding the appropriate use of the emergency department including using Montana Medicaid's nurse advice line, Nurse First, before going to the emergency department. This education can be verbal or through written materials. To obtain Nurse First educational materials, contact DPHHS at 406-444-4540.

Vacation, Illness, and Other Absences

During periods of absence, providers must arrange for coverage for posted normal office hours as specified above. Passport members must have access to services or referrals from the covering provider(s).

Inability to Perform Services

The Department requires verification in the event that a solo Passport provider is unable to make medical decisions or arrange for coverage of their members. Upon verification, the provider's members are disenrolled retroactive to the beginning of the month in which the provider was unable to make appropriate arrangements.

If the provider's office provides documentation that coverage arrangements were made in advance, his or her members will not be disenrolled for a reasonable time. In such instances, the Department will work closely with the provider's office to determine if the condition will be long term and will require disenrollment.

Members will not be disenrolled from a group Passport provider if one provider becomes unable to provide or refer members for services.

Passport Marketing Materials

Passport providers may not distribute any marketing materials without first obtaining approval from the Department. Any marketing plans must also be submitted to the Department for prior written approval. Providers may not conduct direct or indirect marketing activities that are intended to influence member's to enroll with the PCP or disenroll from another PCP.

Requirements of the Passport Provider

- Must be enrolled as a Montana Medicaid provider. Providers may download provider enrollment information from the Provider Information [website](#) or by contacting Medicaid Provider Relations.
- Must comply with all applicable federal and state laws and regulations.
- Sign and agree to the terms of the Passport provider agreement.
- Must meet the requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.
- Notify the Department of any changes to status or member restrictions.
- Must accept members including voluntary and assigned, in the order in which members are enrolled. Providers are automatically assigned Passport members as long as they have openings and the member meets the PCP-defined restrictions.
- Provide primary care, preventive care, health maintenance, and treatment of illness and injury.
- Make reasonable appointment availability based on routine, preventive, urgent, or emergent care needs.
- Provide for arrangements with or referrals to physicians, or other specialists to ensure access to medically necessary care without compromising quality, promptness, or member preference.
- Work with Health Improvement Program (HIP) care managers to coordinate care for active HIP members.
- Provide an appropriate and confidential exchange of information among providers including transfer of medical records to a member's new PCP.
- Educate and assist members in finding services that do not require Passport referral (e.g., family planning, mental health services, and other services).
- Educate members about appropriate use of the emergency department.
- Provide or arrange for well-child checkups, EPSDT services, screenings, and immunizations in accordance with the American Academy of Pediatrics periodicity schedule.
- Maintain a unified patient medical record for each Passport member. This must include a record of all approved referrals given to or received from other providers. Providers must transfer a copy of the member's medical record to a new PCP if requested in writing and authorized by the member.

- Provide all documentation requested by the Department (or its designee). The Department may review provider records to assure appropriate, authorized, timely, reasonably priced, quality services are being provided to Montana Medicaid/HMK *Plus* members.
- May not discriminate against members during enrollment or disenrollment based on protected class (race, color, or national origin).
- May not discriminate on the basis of health status or need for healthcare services.
- Provide the member and the Department appropriate notice of disenrollment.
- Notify the Department of any unauthorized use of a Passport number.
- Federal regulation requires providers to offer interpreter services to all patients with limited English proficiency (LEP). Interpreter services are covered by Medicaid. For forms and information contact the Medicaid/HMK *Plus* program at 406-444-4540.

Caseload Limits

Passport providers may serve as many as 1,000 members per full-time physician or mid-level practitioner. Passport providers may encourage Medicaid/HMK *Plus* members to enroll with them under the Passport program. Passport providers who reach their caseload capacity have the opportunity to increase capacity by a minimum of 10% or more in order to have more Passport members choose or be assigned to them.

Reporting Changes

Providers must notify Provider Relations in writing within 30 days of changes that include, but are not limited to, the following:

- Address
- Phone/fax number
- Ownership
- Business hours
- Change of providers who are participating under a group Passport agreement
- Provider enrollment restrictions

Passport Provider Termination

When a provider wishes to terminate his/her Passport to Health enrollment, the Department requires a written notification at least 30 days in advance of the desired termination or removal date. Written notification is sent to Provider Relations. It is important to also give members at least 30 days' notice before termination to allow them enough time to choose another Passport provider. To ensure continuity of care during these 30 days, the provider must continue to treat the members or refer them to another provider.

Utilization Review

Passport providers are subject to utilization review to verify the care and services provided through the program are fulfilling the requirements of the Passport provider agreement. (ARM 37.86.5111)

Other Passport Programs

Team Care

Team Care is a companion program of Passport to Health designed to educate members how to appropriately and effectively access medical care. Members enrolled in Team Care are also enrolled in Passport. Enrollment in Team Care is based on utilization that is found to be excessive, inappropriate, or fraudulent with respect to need. Medicaid/HMK *Plus* members can be referred to Team Care by Drug Utilization Review Clinical Case Managers, PCPs, pharmacists, hospitals or from claims data mining.

Team Care follows the same Passport rules and guidelines for referrals, enrollment/ disenrollment, prior authorization, and billing processes. However, members enrolled in Team Care are restricted from changing their PCP without good cause and are restricted to one pharmacy.

Providers are encouraged to make a referral to the Team Care program officer if they feel one of their members is appropriate for the program. A Passport provider receives an enhanced case management fee of \$6 per member per month for Team Care members.

When checking Medicaid/HMK *Plus* eligibility on the web portal, a Team Care member's provider and pharmacy will be listed. You must write all Medicaid/HMK *Plus* prescriptions to the designated pharmacy. (ARM 37.86.5303)

Health Improvement Program (HIP)

HIP is a companion program of Passport for members with chronic illnesses or risks of developing serious health conditions. HIP is operated statewide through a regional network of 14 community and tribal health centers. Medicaid/ HMK *Plus* members eligible for the Passport program are enrolled and assigned to a health center for care management.

Current Passport members stay with their PCPs for primary care, but are eligible for care management services through HIP. Nurses and health coaches certified in professional chronic care conduct health assessments work with PCPs to develop care plans, educate members in self-management and prevention; provide pre- and post-hospital discharge planning, help with local resources, and remind members about scheduling, needed screenings, and medical visits.

Medicaid uses predictive modeling software to identify chronically ill members. This software uses medical claims, pharmacy data, and member demographic information to generate a risk score for each member. Although the software will provide a great deal of information for interventions, it will not identify members

who have no claims to generate a risk score or have not been diagnosed with an illness. PCPs may also identify and recommend Passport members, who are at high risk for chronic health conditions. These members would benefit from care management services that HIP offers using the HIP referral form. The referral form can be found on the Health Improvement Program page of the Provider Information [website](#).

When checking Medicaid/HMK *Plus* member eligibility on the web portal, a HIP member's regional HIP provider will be listed.

Additional Passport Information

Prior Authorization

Passport referral and prior authorization are different. Passport referral is a referral to visit another provider; prior authorization refers to a list of services that require Department authorization before they are performed. Some services may require a Passport referral and/or prior authorization. Prior authorization is obtained through a Department contractor, Mountain-Pacific Quality Health (MPQH).

Different numbers are issued for Passport referral and prior authorization, and if required, both numbers must be listed on the requesting provider's claim. For more information on prior authorization, see the Prior Authorization chapter in the *General Information for Providers* manual, your provider type manual, and the Prior Authorization page on the Provider Information [website](#).

Member Cost Sharing

Cost sharing rules are the same for Passport members and non-Passport members. For more information on who or what services are exempt from cost share, see your provider type manual and the *General Information for Providers* manual, both available on the Provider Information [website](#).

Service Limits

Service limits are the same for Passport members and non-Passport members. For more information on service limits, see the Medicaid billing manual for your provider type and the *General Information for Providers* manual, both available on the Provider Information [website](#)

Managing Your Passport Caseload

Enrollment List

A monthly Passport enrollee list is sent to each Passport provider by the first day of each month to assist Passport providers in managing their Passport members. Below is a sample enrollee list.

Providers should contact new members to set up an appointment to establish care and introduce new members to their practice, office policies, and staff. If a member has been on a provider’s list before but is shown as a new member, he/she may have lost Medicaid/HMK *Plus* eligibility for a period of time.

Team Care

A monthly Team Care enrollee list, which includes the member’s lock-in pharmacy, accompanies the provider’s Passport enrollee list, as applicable.

Passport Enrolled Member List					
Member Name	Medicaid/HMK Plus ID	Birth Date	Address	Phone	New Enrollee
GUNDER, HANS	XXXXXXXXXX	5/30/1980	PO BOX 1584, HELENA, MT, 59601	406-XXX-XXXX	No
IMSEN, RAGA	XXXXXXXXXX	2/7/1969	822 HENRY, HELENA, MT, 59601	406-XXX-XXXX	Yes
LANTZ, SUNNY	XXXXXXXXXX	11/11/2000	677 1ST AVE, HELENA, MT, 59601	406-XXX-XXXX	No
OSTER, FELIX	XXXXXXXXXX	12/4/1989	11 SADDLE RD, HELENA, MT, 59601	406-XXX-XXXX	No
POLLY, PENNY	XXXXXXXXXX	9/15/1976	27 SADDLE RD, HELENA, MT, 59601	406-XXX-XXXX	No
TURNER, SAM	XXXXXXXXXX	4/29/1955	646 STURN LN, HELENA, MT, 59601	406-XXX-XXXX	Yes

Member Enrollment and Education

Member Enrollment

Most Montana Medicaid and HMK *Plus* members are required to enroll in Passport to Health. Members who are not required to enroll in Passport are considered either exempt or ineligible. If participation in Passport causes a medical hardship, members may petition the state for an exempt status.

A member's County Office of Public Assistance determines Medicaid eligibility. If the member's eligibility requires him/her to participate in Passport, the information is sent to the Passport to Health enrollment broker, who begins member enrollment and education.

New members receive an enrollment packet containing the following information:

- A letter instructing the member to select a Passport provider by telephone, the web portal, or by mail.
- A Passport enrollment form.
- How to access or obtain the Medicaid/HMK *Plus* handbook, which includes Passport information.
- Information on the Nurse First program.
- A transportation services brochure.
- A billing rights notice.

Selecting a Passport Provider

In most cases members choose their Passport provider. The whole family can have the same Passport provider or everyone can have a different Passport provider based on individual needs. Members are not auto-assigned to a Passport provider unless they have not chosen a provider themselves. Members receive a reminder letter, an outreach call, and are given 45 days to select a provider. After 45 days, Passport to Health automatically assign members to a provider appropriate to the member's age, sex, and location based on the following criteria (in order):

- Previous Passport enrollment.
- Claims information.
- Family Passport enrollment.
- Native American members who have declared a tribal enrollment, and who live in a county where there is an Indian Health Service Passport provider.
- Randomly, to a provider in the member's geographic area who is accepting new members.

Members who are assigned to a Passport provider are notified at least 10 days in advance of the effective assignment date to allow members to notify Passport to Health if they would like to select a different provider.

Members may change their Passport provider up to once per month but the change will not be effective until the following month at the earliest, depending on the date the choice is made. (ARM 37.86.5103-5104)

Member Outreach and Education

In addition to the enrollment packet, all families with an active telephone number receive up to 3 telephone attempts to verbally explain Medicaid benefits and the Passport program, answer questions, and take enrollment information over the telephone.

An education script is followed during these outreach calls to ensure that all members receive the same information about Medicaid/HMK *Plus* and Passport. Members have additional resources to help them use their Medicaid/HMK *Plus* services and understand the Passport to Health program.

Member Education Resources

Resource	Description	Where to Find
Member Medicaid/ HMK <i>Plus</i> Handbook	All eligible Medicaid/HMK <i>Plus</i> members are sent a postcard informing them how to find the member handbook online or how to request a paper copy. This handbook, which includes a section on the Passport program, is an excellent resource for members enrolled in Montana Medicaid/HMK <i>Plus</i> .	Call the Medicaid/HMK <i>Plus</i> Help Line 1-800-362-8312 http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MemberServices
Montana Medicaid/ HMK <i>Plus</i> Help Line 1-800-362-8312	The toll-free Montana Medicaid/HMK <i>Plus</i> Help Line is available to answer members' questions and enroll them with a PCP. The Help Line may direct members to other Montana Medicaid/HMK <i>Plus</i> resources or entities.	Montana Medicaid/HMK <i>Plus</i> Help Line, 1-800-362-8312
Preventive Materials	Preventive healthcare letters are mailed yearly to youth with HMK <i>Plus</i> , just before their birthday. The mailing includes an immunization and well-child exam schedule. The schedule is available on our website.	Montana Medicaid/HMK <i>Plus</i> Help Line, 1-800-362-8312 http://dphhs.mt.gov/MontanaHealthcarePrograms/WellChild
Nurse First	The Nurse First Advice Line (NAL) is a service available to all Montana Medicaid/HMK <i>Plus</i> and Healthy Montana Kids members. There is no charge to members or providers. Members are encouraged to use this resource as their first nurse line resource when they are sick or hurt. Registered nurses are available 24/7/365 to triage members over the phone and recommend appropriate care. Health coaches are also available to answer general health or medication questions. The NAL faxes a triage report to PCPs when one of their members calls to be triaged.	1-800-330-7847 http://dphhs.mt.gov/MontanaHealthcarePrograms/NurseFirst

Passport Member Eligibility

The Department requires Medicaid members to enroll and participate in the Passport program, unless exempt from or ineligible for participation.

Members Ineligible for Passport

The Department has determined the following categories of members are not eligible to participate in the Passport program:

- Living in a nursing home or other institutional setting.
- Eligible for Medicare.
- Eligible for Medicaid with a spend-down (medically needy).
- Receiving Medicaid for less than three months.
- Eligible for Medicaid foster care.
- Eligible for Medicaid adoption assistance or guardianship.
- Retroactive Medicaid eligibility.
- Receiving Medicaid home and community-based services for persons who are aged or disabled.
- Residing out of state.
- Eligible for a non-Medicaid plan.
- Receiving Medicaid under a presumptive eligibility program.

Members Exempt from Passport

The Department has determined members who are eligible to participate in the Passport program may request an exempt status for the following reasons:

- Members who are able to establish that participating in the program would be a hardship.
- Members who have third party coverage that provides case management services.
- Members unable to find a PCP willing to provide case management.
- Members residing in a county where there are not enough PCPs to serve the population.

The Department has the discretion to determine hardship and to place time limits on all exemptions on a case-by-case basis. Members who are exempt from participation may elect to re-enroll in the Passport to Health program.

Passport Referrals

Passport referral is needed for most medically necessary services that the member's Passport provider does not provide. Referrals can be made to any other provider who accepts Montana Medicaid/HMK *Plus*. Referrals can be verbal or in writing, and must be accompanied by the provider's Passport referral number.

Providers are required to keep a paper or electronic log of all Passport referrals given or received in the member's records, a spreadsheet, or other record. The Passport provider establishes the parameters of referrals, which may be for a one-time visit, a time specific period, or the duration of a condition. An optional referral form is available on the Provider Information [website](#).

Guidance for Appropriate Care

If a provider sees a member for a routine visit or sees the member frequently and is not that member's Passport provider, the provider should talk to the member about the importance of having a medical home.

It is acceptable to deny service if the member is able to see his/her Passport provider. Conversely, the Passport provider is under no obligation to provide a referral if the member is able to see them. Suggest to the member that he/she see their Passport provider every time they are sick or hurt; it is also acceptable to suggest that the member changes to your clinic as their Passport provider. To change their provider, the member can call the Medicaid/HMK *Plus* Member Help Line from your office or have the provider fax a Provider Change Form (available on the [website](#)) signed by the member.

Providers should obtain a Passport referral in advance, in writing, and specific to services and dates. If a provider accepts a member as a Medicaid/HMK *Plus* member and provides a service requiring a Passport referral without the member's Passport provider's referral, Medicaid will deny the claim. When a provider bills Medicaid for services rendered to a member, the provider has accepted the member as Medicaid and cannot bill the member for services. If a provider tried unsuccessfully to get approval from the PCP, the provider cannot bill the member unless the member agreed to pay privately before services were rendered. (ARM 37.85.406)

For details on when providers can bill Medicaid/HMK *Plus* members, see the Billing Procedures chapter in your provider type manual or the *General Information for Providers* manual; both are available on the [website](#).

Passport referrals and prior authorization are different. For more information, see the Additional Medicaid/HMK *Plus* Requirements for Passport Members chapter in this manual and Prior Authorization chapters in your provider type manual and the *General Information for Providers* manual.

Establishing Care and Referrals

Establishing care with a provider helps ensure Medicaid/Healthy Montana Kids *Plus* members receive effective, quality medical care. The Passport program recommends that in most cases, Passport referrals should not be given to specialists or other PCPs if the member has not established care with their PCP. In most cases, care should start with and be coordinated by the Passport PCP. Encourage the member to establish a relationship with their PCP for services.

If a provider consistently receives requests for referrals for a member that the provider has never seen, it is acceptable for the provider to disenroll the member from his/her Passport caseload. It is also acceptable to disenroll established patients who are consistently seeking primary care elsewhere or specialty care that requires provider referral. See the Disenrolling Passport or Team Care Members chapter in this manual for more details.

Referral without Established Care

There are some instances where the Passport program requests that the Passport PCP provide a referral, even when care has not been established. The member's access to care, whether or not the member has established care, is a responsibility of the member's PCP.

A referral determination should be based on whether it is reasonable for the PCP to provide, and the member to access, that care in a specific situation. Some examples in which referrals are needed in order to ensure access to needed care are:

- Member has moved away and chose a new provider.
- Member is sick or injured and far from home.
- Member is sick or injured and PCP is unable to see promptly.
- Follow-up care with doctor seen initially through an ED admittance and surgery.
- Inpatient psychiatric medical care.

Passport Referral Number

The Passport referral number is the number the PCP gives to providers when approving services. This is a number issued to the Passport provider and must be on the requesting provider's claim or Medicaid will deny the service if it requires a Passport referral.

The Passport referral number is recorded in Box 17a on a CMS-1500 claim and Box 7 on a UB-04 claim. The referring provider's NPI is not required.

Services Exempt from Passport Approval

Members must obtain services directly from or through a Passport referral, except for:

- Ambulance
- Anesthesiology
- Audiology
- Blood lead testing
- Case management
- Dental
- Dialysis
- Durable medical equipment
- Emergency
- Eye exams and eyeglasses
- Family planning
- Hearing exams and aids
- Home and community-based
- Home infusion therapy
- Home support services and therapeutic foster care
- Hospice
- Hospital swing bed
- Immunizations
- Inpatient lab and x-ray
- Inpatient professional services
- Intermediate care facility
- Institution for mental disease
- Laboratory/Pathology tests
- Licensed social workers
- Licensed professional counselors
- Mental health centers
- Nursing facilities
- Obstetrical (inpatient and outpatient)
- Optometrist or ophthalmologist
- Personal assistance
- Pharmacy
- Psychiatric residential treatment facility
- Psychologists

- Radiology (Some services may require Passport approval; see appropriate fee schedule.)
- School-based
- STD testing and treatment
- Substance dependency treatment
- Transportation (commercial and specialized non-emergency)

Indian Health Service (IHS)

All Native Americans are entitled to health services through Indian Health Service (IHS). When Native Americans are eligible for Medicaid/HMK *Plus*, Medicaid will pay for services provided through an IHS as well as other Medicaid/HMK *Plus* providers. A Native American Medicaid/HMK *Plus* member who is enrolled in Passport to Health may choose an IHS to be the primary care provider if the IHS is a Passport provider. The member may alternatively choose a Passport provider other than an IHS. If the member chooses a Passport provider other than an IHS, he/she may go to an IHS as well without a referral from the Passport provider. However, if an IHS refers the member to a third provider, the Passport provider must first provide a referral to the third provider, or Medicaid will not pay for the services.

Passport Referral Tips

- Before referring a Passport member to another provider, verify that the provider accepts Medicaid.
- Passport referrals may be provided by the Passport provider, a medical professional covering for the Passport provider, or designated office staff. Many Passport referral requests are administrative in nature and may be provided by designated non-medical staff. Passport referrals that require medical judgment, such as referrals to specialists, must be initiated by the PCP or a medical professional covering for the Passport provider.
- The Passport referral number may be given verbally or in writing, but the referral must be documented and maintained in the member's file or in a log. All referrals, given or received, must be logged.
- A provider should not "piggy back" referrals. Once a Passport provider gives a referral, the provider who requested the referral cannot refer the member to a third provider. The Passport provider must refer the member to the third provider.
- Passport providers should not give their Passport referral numbers for "blanket" referrals, such as a referral for any member for any service.
- A facility or non-Passport provider is not authorized to pass on a Passport referral number. Doing so may be considered fraud.

- Passport numbers should not be stored and re-used by a referred-to provider, but should be destroyed after use as prescribed by the referral. Storing Passport numbers may also be considered fraud. If a provider suspects that his/her Passport number is being used without a referral, providers are encouraged to contact the Department. Providers may also request their Passport number be changed by contacting the Xerox Passport Provider Lead.
- Passport providers can suggest that a member change to the Passport provider's practice if they see the member frequently and believe he/she would benefit from the change. The member can call the Medicaid/HMK *Plus* Member Help Line from the provider's office or fax or mail the Member's Passport Provider Change Form, signed by the member.

EPSDT Services

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Program

EPSDT is a benefit package for all HMK *Plus* members designed to ensure that children receive comprehensive healthcare. The provider is encouraged to actively screen for specific pediatric problems, order diagnostic tests as indicated, and treat problems found, or if necessary, refer members to other providers for treatment.

The Well-Child Checkup

All children should have regular well-child checkups beginning at birth and through age 20. The Passport program sends reminders to Passport members advising them that they are due for a well-child checkup.

The Passport program encourages providers to conduct well-child checkups according to a specific schedule.

Montana Medicaid has adopted the Bright Futures/American Academy of Pediatrics periodicity schedule. The national schedule can be found at brightfutures.aap.org. In addition to these scheduled visits, well-child screenings should be incorporated into every visit if possible.

Well-child checkups include the following:

- Comprehensive health and developmental history
- Unclothed physical examination
- Vision screening
- Hearing screening
- Oral health screening
- Developmental/behavioral
- Anticipatory guidance
- Immunization
- Laboratory tests, including testing for children ages 12 and 24 months.

Diagnostic Testing and Referrals

If a screening indicates the need for further diagnostic testing or treatment, those services should be provided without delay. If the service cannot be provided by the Passport provider, a referral must be made.

Medicaid covers all services that are determined to be medically necessary to members under age 21, even if those services are not covered for adults. Examples of additional services for pediatric members include chiropractic treatment, nutrition, private duty nursing, residential treatment, respiratory therapy, school-based services, and substance abuse inpatient and day treatment.

Billing and Reimbursement

Member Service Reimbursement

Reimbursement for Passport member services are the same as Medicaid fee-for-service reimbursement. This allows providers the opportunity to become actively involved in cost containment and quality of care without financial risk. For more information on reimbursement, see the Department's fee schedule available on the Provider Information [website](#).

Member Case Management Fee

In addition to fee-for-service reimbursement, Passport providers receive a case management fee of \$3 per member per month, or an enhanced fee totaling \$6 per member per month for each enrolled Team Care member.

This fee is in a separate payment from the fee-for-service reimbursement and is paid regardless of whether the member is seen during the month. The monthly case management fee is paid with the expectation that the items listed in the provider requirements of this manual are completed as needed for member's coordination of care. The monthly case management fee is paid to providers by their Passport number. The fees are listed with procedure code (G9008) for each Passport enrollee on the provider's remittance advice. The date of service for the code is shown as the first of the month for which the fee is being paid.

Passport Billing Tips

Verify member eligibility and Passport provider at each visit before treating the member. Contact Provider Relations for information on Medicaid claims.

Do not bill for case management fees; they are paid automatically to the provider each month. Team Care is a component of the Passport program; therefore, Team Care billing procedures are the same as Passport.

For additional instructions on billing Medicaid, refer to your provider type manual.

Billing Medicaid/HMK *Plus* Members

To bill a Medicaid/HMK *Plus* member, an agreement must be signed by the member in advance of services. There are two types of member agreements:

- **Private-pay agreements.** State the member is not being accepted as a Medicaid member and will be responsible to pay for the services received.
- **Custom agreements.** Include specific dates of services, actual services or procedures, and the cost to the member, and states the services will not be covered by Medicaid and the member will be responsible to pay for the services received.

Providers may not bill a member when the provider has informed the member that Medicaid may not pay or when the agreement is contained in a form that provider routinely requires members to sign. Members may be billed for:

- Non-covered services.
- Covered but medically unnecessary services, including services that Medicaid has denied payment for lack of medical necessity.
- When provider is unable to get the Passport referral from the Passport PCP.
- Services received when the provider does not accept the member as a Medicaid member.
- Copayments.

Providers are required to accept the amount paid by Montana Medicaid as payment in full. Unless an agreement is signed, members may not be billed for:

- Any payment in addition to or in lieu of the amount paid by Medicaid.
- Covered services denied by Medicaid.
- Services Medicaid does not pay as a result of the provider's failure to comply with enrollment, prior authorization, billing, or other requirement necessary to receive payment.

When a member is accepted as a Medicaid member in a service setting (e.g., facility, institution), all other providers performing services for the member will be deemed to have accepted the member as Medicaid.

Acceptance of a member as Medicaid applies to all services provided by the provider. A provider may not accept Medicaid for some covered services but refuse Medicaid for other covered services.

If a member has agreed prior to services that payment will be made from a source other than Medicaid but is later determined retroactively eligible for Medicaid, the provider may choose to accept the individual as Medicaid or seek payment in accordance with the original payment agreement.

A provider who bills Medicaid for services will be deemed to have accepted the member as Medicaid.

Copayments or bills owed to a provider do not affect the Passport relationship. A member may not be denied services or be disenrolled by the Passport provider due to unpaid bills. (ARM 37.86.402)

Disenrolling Passport or Team Care Members

Disenrollment

A provider **may disenroll** a Passport or Team Care member for the following reasons:

- Provider–patient relationship is mutually unacceptable.
- Member has not established care.
- Member is seeking primary care elsewhere.
- Member fails to follow prescribed treatment.
- Member is physically or verbally abusive and poses a threat to providers or other members.
- Member could be better treated by a different type of provider, and a referral process is not feasible.
- Member consistently fails to show up for appointments.

A provider **cannot disenroll** a Passport or Team Care member for the following reasons:

- An adverse change in the enrollee’s health status.
- Member’s utilization of medical services.
- Member’s diminished mental capacity.
- Uncooperative or disruptive behavior as a result of the member’s special needs. The exception is if enrollment seriously impairs the PCP’s ability to furnish care to the member or other members. If this is the case, disenrollment must be approved by the Passport program officer.
- Any reason that may be considered discrimination. (See the Complaints, Administrative Reviews, and Fair Hearings chapter in this manual.)
- Failure of member to pay copayment or other bills.

Member Notification

A written disenrollment notification must be sent to the member and Xerox by providing 30 days’ notice.

Verbal notification to the member does not constitute disenrollment; the provider remains responsible for the care of the member until the disenrollment process is complete.

Reasons for disenrollment must be explained in writing, must be non-discriminatory, must be generally applied to the provider's entire patient base, and must be approved by Xerox.

At a minimum, the letter must:

- Identify the member as your Passport patient.
- Specify the reason for disenrollment.
- Indicate notification of continuing care for 30 days.

A copy of the member's disenrollment notification must be mailed or faxed to the Xerox Passport to Health Lead. During these 30 days, the provider must continue to treat the member or refer the member to another provider. The provider's 30-day care obligation does not start until a copy is received by Xerox Passport to Health. The Department makes exceptions to this rule only under extreme circumstances.

Providers may call the Xerox Passport Provider Lead with questions about the disenrollment process. The Passport program will not disenroll members from a PCP without written notification from the provider. Passport will assist the member in selecting a new PCP.

A sample disenrollment letter is below.

Sample Disenrollment Letter

Dear Medicaid member,

This letter is to notify you that we are disenrolling you as our Passport patient due to consistently seeking primary care elsewhere. We will continue to provide you care or referrals to care for the next 30 days as you transition to a new provider.

Sincerely,

Care Clinic

Complaints, Administrative Reviews, and Fair Hearings

Member Complaints

Formal complaints filed against a provider or healthcare facility for improper care or unsafe conditions will be forwarded to the proper state licensing agency. Informal member complaints or grievances about healthcare services rendered by a provider or professional will be forwarded to the program officer with knowledge of the program. Informal member complaints will be addressed by the program officer within 7 business days.

Administrative Reviews and Fair Hearings (ARM 37.5.310 and ARM 37.86.5120)

If a provider believes the Department has made a decision that fails to comply with applicable laws, regulations, rules, or policies, the provider may request an administrative review or fair hearing. Requests must be addressed to the Office of Fair Hearings. A copy must also be delivered or mailed to the division that issued the contested determination.

To request an administrative review, state in writing the objections to the Department's decision and include substantiating documentation for consideration in the review.

The Department must receive the request within 30 days from the date the Department's initial determination was mailed. Providers may request extensions in writing within these 30 days. If the provider is not satisfied with the Department's administrative review results, a fair hearing may be requested. Fair hearing requests must contain concise reasons the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules, or policies. This document must be signed and received by the Office of Fair Hearings within 30 days from the date the Department mailed the administrative review determination.

Non-Discrimination (ARM 37.85.402)

The Department does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, age, sex, religion, creed, disability, marital status, or political beliefs.

Discrimination may not occur regarding admission to, participation in, or receipt of services or benefits of any of its programs, activities, or employment, whether carried out by the Department or through a contractor or other entity. In case of questions or in the event that you wish to file a complaint alleging violations please contact DPHHS, Office of Human Resources.

If you wish to file a complaint with the Office of Civil Rights, contact them at the address or telephone number on the Contact Us page of the Provider Information [website](#). A person does not have to go through the administrative review or fair hearing process to file a complaint with the Office for Civil Rights.

Appendix A: Forms

The forms listed below and others are available on the Forms page of the Montana Healthcare Programs Provider Information [website](#).

- Passport to Health Referral Form
- Health Improvement Program (HIP) Referral Form
- Member's Provider Change/Enrollment Form

Definitions and Acronyms

This section contains definitions and acronyms specific to Passport provider. Additional definitions and acronyms are found on the Definitions and Acronyms page of the Provider Information [website](#).

Group Passport to Health Provider

A group Passport provider is enrolled in the program as having one or more Medicaid/HMK *Plus* providers practicing under one Passport number.

Solo Passport to Health Provider

A solo Passport provider is enrolled in the program as an individual provider with one Passport number.

Well-Child Checkup

A well-child checkup is an important way to monitor growth and development of young patients. Regular checkups provide an opportunity for providers to develop a strong relationship with their patients.

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