

Montana Medicaid & Healthy Montana Kids Plus Provider Guide



Passport to Health Mission Statement

Manage the delivery of health care to Montana Medicaid and Healthy Montana Kids *Plus* members to improve quality and access, while optimizing the use of health care resources.”



September 2013

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Program Overview



Passport to Health Program

Passport to Health is the primary care case management program for Montana Medicaid and HMK *Plus* members. Our Passport programs encourage and support Medicaid and HMK *Plus* members and providers in establishing a medical home:

- Primary Care Case Management
- Nurse Advice Line
- Team Care
- Health Improvement Program

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 9 for a listing 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 Primary Care Case Management (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 members' Passport providers or Medicaid/HMK *Plus*

will not reimburse for those services. The member's Passport provider is also referred to as the Primary Care Provider or PCP.

The Primary Care Case Management model promotes the Medical Home. The Medical Home is a concept which encourages a strong doctor/patient relationship.

An effective Medical Home is:

Accessible

How long does it take for a member to get an appointment to see you? Can they email 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 to determine when a diabetic patient is due for a foot exam, or when a child needs immunizations?

In the Context of Family & Community

How do you encourage family health and support? Are you aware of specialists and services available to your members in your community?

Program Goals

- **Assure access** to primary care
- Establish a '**medical home**' for the Medicaid/HMK *Plus* member
- Improve the **continuity of care**
- Encourage **preventive** health care
- Promote Early and Periodic Screening Diagnosis and Treatment (**EPSDT**)
- **Reduce inappropriate use** of medical services and medications
- **Decrease** non-emergent care in the Emergency Department (**ED**)
- **Reduce and control health care 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 (see Key Websites). Paper copies of rules are available through the Secretary of State's office (see Key Contacts). 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 Medicaid Care Management section, under the Department of Public Health and Human Services (DPHHS), administers the Passport to Health program and determines services and policy. For program policy information, see the Program Policy Information table in the Introduction chapter of the General Information for Providers manual. Manuals and other information are available on the Provider Information website (see Key Websites).

The Montana Medicaid/HMK *Plus* 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, eligibility, and addresses provider concerns. Providers may also call the Xerox Passport Lead (see Key Contacts) to discuss problems or questions regarding Passport members or to enroll in Passport. Providers should keep up with changes and updates to the Passport program by reading the Claim Jumper, Montana Medicaid's monthly online newsletter. Providers should also visit the Provider Information website for Passport and Medicaid/HMK *Plus* information. See the Passport Key Contacts and Key Website sections in this manual for phone numbers, addresses, and website information.

Role of the Passport Provider



Becoming a Passport Provider

A primary care provider (PCP) can be a physician or a mid-level practitioner who provides primary care case management by agreement with the Department. The Department allows any provider who has primary care within his or her professional scope of practice to be a PCP. The Department does, however, recognize that certain specialties are more likely to practice primary care. The Department actively recruits these providers. (ARM 37.86.5112)

Dr...is always very friendly and interactive with my children. He treats them and our ailments with confidence and patience. Also I am very grateful and appreciative to have Medicaid Coverage.

Comment from Medicaid Member survey

Passport Provider Enrollment

To enroll in Passport, Medicaid/HMK *Plus* providers must sign a Passport provider agreement. The Passport provider agreement and this handbook are available on the Provider Information website (see Key Websites). Providers may also call Provider Relations (see Key Contacts) 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 Services (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 of referrals during normal business hours. Passport providers must also provide 24-hour availability of information regarding how to seek emergency services.

Normal Office Hours Coverage Sources

Suitable coverage for normal office hours may consist of an answering service, call forwarding, provider on-call coverage, or any appropriate method that provides ready access to someone who can reach the PCP, or

someone who can render a clinical decision. 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.

Vacation, Illness, and Other Absences

During periods of absence, providers must arrange for coverage for 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.

Direction and Education for Emergency Care

Passport providers must provide direction to members in need of emergency care 24 hours each day, seven days a week. 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 an emergency, hang up and either call 911 or go to the emergency department."

Passport providers are encouraged to provide education to their members regarding the appropriate use of the emergency department (ED) including using Montana Medicaid's nurse advice line, Nurse First, before going to the ED. This education can be verbal or written materials. The Department may be contacted at 444-4540 to obtain Nurse First educational materials.

He is a wonderful doctor. His staff is patient, friendly and knowledgable. Dr...is concerned about the whole family and listens to my concerns. He is supportive of family voice and choice.

Comment from Medicaid Member survey

Role of the Passport Provider

- Must be enrolled as a Montana Medicaid provider. Providers may download the provider enrollment information from the Provider Information website or contact Medicaid Provider Relations (see Key Contacts and Key Websites).
- Sign and agree to the terms of the Passport provider agreement.
- Must meet the requirements listed in the Provider Requirements and Passport to Health chapters of the General Information for Providers manual.
- Accept enrollees in the order in which members are enrolled. Providers are automatically assigned Passport enrollees as long as they have openings and the enrollees meet the PCP-defined restrictions.

- Provide primary care, preventive care, health maintenance, treatment of illness and injury, and coordination of members access to medically necessary specialty care by providing referrals and follow-up.
- 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.
- Educate and assist members in finding services that don't require Passport referral, e.g., family planning, mental health services, and other services.
- Educate members about appropriate use of the emergency department (ED).
- Provide or arrange for Well Child check ups, EPSDT services, lead screenings, and immunizations.
- Maintain a unified patient medical record for each Passport enrollee. 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 primary care provider 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, timely, reasonably priced, quality services are being provided to Montana Medicaid/HMK *Plus* members.
- May not discriminate against protected classes or in the enrollment/disenrollment of Passport members.
- 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 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 (see Key Contacts) of changes that include (but are not limited to) the following:

- Address changes
- Phone number changes
- Ownership changes
- Change of providers who are participating under a group Passport agreement

Passport Provider Termination

When a provider wishes to terminate his or her Passport to Health enrollment, the Department requires a written notification at least 30 days before the termination date. Written notification is sent to Provider Relations (see Key Contacts). 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' utilization patterns are analyzed on a regular basis. When a provider's average rates for service utilization are consistently high or low, the provider may be asked to furnish information regarding unusual practice patterns. (ARM 37.86.5112)

Other Passport Programs



Team Care

Team Care is a companion program of Passport to Health designed to educate members on 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 primary care provider (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. For more information on Team Care, see the General Information for Providers manual, Passport and Prior Authorization chapter. 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

The Health Improvement Program (HIP) is a companion program of Passport to Health 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 and 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 screening and medical visits.



Medicaid uses predictive modeling software to identify chronically ill members. This software uses medical claims, pharmacy and 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 not received a diagnosis or generated claims. PCPs may also identify and recommend Passport members at high risk for chronic health conditions who would benefit from care management from HIP using the HIP referral form can be found in the forms section at the back of this guide or included at the Health Improvement Program link on the provider information website.



When checking Medicaid/HMK *Plus* 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 both Passport referral and prior authorization. Prior authorization is obtained through a Department contractor, Mountain Pacific Quality Health. Different codes are issued for Passport referral and prior authorization, and both codes must be recorded on the requesting provider's claim. For more information on prior authorization, see the Passport and Prior Authorization chapter in the Medicaid billing manual for your provider type.

Member Cost Sharing

Cost sharing rules are the same for Passport members and non-Passport members. For more information on member cost sharing, see the Medicaid billing manual for your provider type.

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 (see Key Websites).

Managing Your Passport Caseload



Enrollee List

A monthly Passport enrollee list will be mailed 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.

Please take the opportunity to contact new members setting up an appointment establishing care with you. Please introduce new members to your practice, office policies and your staff. If a member has been on your list before but is shown as a new member, he or 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) will accompany your Passport enrollee list as applicable.

Passport Enrolled Member List					
Member Name	Medicaid/HMK <i>Plus</i> 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, SONNY	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

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 and Passport. If eligible for 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 phone, web 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

My Passport provider along with the entire children's clinic is amazing! The quality of care is always 100%. The pediatricians are knowledgeable, thorough and friendly. I am very blessed to be able to have my children taken care of by...

Comment from Medicaid Member survey

Selecting a Passport Provider

Each family member may select a Passport provider. 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. Passport to Health will automatically assign members, after this time, 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 who live in a county where there is an Indian Health Services 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 ten days in advance of the effective assignment 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 may not be effective until the following month, 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 three phone attempts to verbally explain the Passport program, answer questions, and take enrollment information over the phone. An education script is followed during these outreach calls to ensure that all members receive the same information about Passport to Health and Medicaid/HMK *Plus*. Members have additional resources to help them use their Medicaid/HMK *Plus* services and understand the Passport to Health program. See the table on the next page.

Member Education Resources		
Resource	Description	Where to Find
Member Medicaid/HMK Plus Handbook 	All eligible Medicaid and HMK <i>Plus</i> members are sent a postcard informing them how to find the member handbook online or how to order 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 medicaid.mt.gov
Montana Medicaid/HMK Plus Help Line 	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> Helpline 1-800-362-8312
Preventative Materials 	Preventative 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 also available on our website.	Montana Medicaid/HMK <i>Plus</i> Helpline 1-800-362-8312 medicaid.mt.gov
Nurse First 	The Nurse First Advice Line 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 to triage members over the phone and recommend appropriate care. Health coaches are also available to answer general health or medication questions. The NAL will fax a triage report to PCPs when one of their members calls to be triaged.	1-800-330-7847

Members Ineligible for Passport

The Department has determined the following categories of members are ineligible for Passport enrollment:

- Living in a nursing home or other institution
- Eligible for Medicare
- Eligible for Medicaid with a spend down (medically needy)
- Receiving Medicaid for less than three months
- Eligible for foster care
- Eligible for Medicaid adoption assistance or guardianship
- Retroactive Medicaid eligibility
- Receiving Medicaid home and community based services
- Residing out of state
- Eligible for Plan First
- Receiving Medicaid under a presumptive eligibility program



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 document Passport referrals, given or received, in the member's records, a spreadsheet, or in a log book. 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 in forms section at the back of this guide and on the Provider Information website (see Key Websites).

Guidance for Appropriate Care

If you are seeing a member for a routine visit or you see the member frequently and you are not that member's Passport provider, talk to the member about the importance of having a medical home. It is okay to deny service if the member is able to see his or her Passport provider. Conversely, the Passport provider is under no obligation to provide a referral if the member is able to see them. Please suggest to the member that he/she sees their Passport provider every time they are sick or hurt; it is also okay to suggest that the member changes to your clinic as their Passport provider. To change, the member can call the Medicaid/HMK *Plus* Member Help Line from your office or fax us a Provider Change Form in the Forms Section at the back of this guide. See Key Contacts for fax and member help line numbers.

It is best to get a Passport referral in advance, in writing, and specific to service(s) and

date(s). If a provider accepts a member as a Medicaid or HMK *Plus* member and provides a service requiring a Passport referral without the member's Passport provider's referral, Medicaid will deny the claim. 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 the Medicaid billing manual for your provider type.

Passport referrals and prior authorization are different. See the Additional Medicaid/HMK *Plus* Requirements for Passport Members chapter in this manual, and the Medicaid billing manual for your specific provider type for more information on prior authorization and Passport. The Medicaid Covered Services table in the General Information for Providers manual is an overview of services with prior authorization and Passport indicators.



Establishing Care and Referrals

Establishing care with a provider helps assure Medicaid/Healthy Montana Kids *Plus* members receive effective, quality medical care. The Passport to Health program recommends that

in most cases Passport referrals should not be given to specialists or other primary care providers if the member has not established care with their PCP. In most cases, care should start with and be coordinated by the Passport PCP. Please encourage the member to establish a relationship with you for services.

If you consistently receive requests for referrals for a member you have never seen, it is acceptable to disenroll them from your Passport caseload. It is also acceptable to disenroll established patients who are consistently seeking primary care elsewhere or specialty care that requires your referral. See the Disenrolling Passport or Team Care Members section in this manual for more details.

Referral Without Established Care

There are some instances where the Passport to Health 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.
- Foster care child has been moved to another city.
- 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. Please refer to the Medicaid billing manual for your provider type for more information on completing a claim.



Indian Health Services

All Native Americans are entitled to health services through Indian Health Services (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 or 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 him or her, 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 him or her.
- ◆ The Passport provider's 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 or 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 Provider Relations (see Key Contacts).
- ◆ Make copies of the referral form found at the back of this guide in the Forms Section. Use it to refer members for necessary services you cannot perform, and keep a copy in the member's file.
- ◆ You can suggest a member change his or her Passport provider to your practice if you see them frequently and you believe they would benefit. The member can call the Medicaid/HMK *Plus* Member Help Line from your office or fax or send the Member Passport Provider Change Form found at the back of this guide in the forms section. (see Key Contacts for phone number, fax and address of Xerox-Passport)

...is an amazing provider who takes the time to listen to all we have to say. She always offers numerous options for us to utilize and has become a dear friend to our family. Thank you for providing our children with medical coverage. What a relief to know they are taken care of....

Comment from Medicaid Member survey

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



Early and Periodic Screening, Diagnosis and Treatment

EPSDT is a benefit package for all HMK *Plus* members designed to ensure that children receive comprehensive health care. 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/ click the Clinical Practice Tab/choose Recommendations for Preventive Pediatric Health Care. 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 Screening
- Immunization
- Laboratory Tests, including lead testing for children ages 12 and 24 months.

A Well Child Screen Recommendations chart is included in the forms section in the back of this guide to help providers track well child checkups. The chart also provides more specific guidance on each screening.

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. For a list of services, see the General Information for Providers manual, Appendix A. Covered Services.

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 and the How Payment is Calculated chapter in the Medicaid billing manual (both available on the Provider Information website, see Key Websites).



Member Case Management Fee

In addition to fee-for-service reimbursement, Passport providers receive a case management fee of \$3.00 per member per month, and an enhanced fee totaling \$6.00 per member per month for each enrolled Team Care member. This fee is in a separate check 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 to providers by their Passport number. The fees are listed as a procedure code (G9008) for each Passport enrollee on the provider's Remittance Advice (RA). 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

Remember to 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 the Medicaid billing manual.

Billing Medicaid/HMK Plus Members

To bill a Medicaid/HMK *Plus* member, a private pay agreement must be signed by the member in advance of services. Members may be billed for:

- ✦ Non-covered services
- ✦ Covered but medically unnecessary services
- ✦ When provider is unable to get the Passport referral from the Passport PCP

Members may not be balance billed for more than the amount Medicaid pays.

Co-pays or bills owed to a provider do not affect the Passport relationship. A member may not be denied services or disenrolled by the Passport provider due to unpaid bills.

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 abusive
- 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:

- Because of an adverse change in the enrollee's health status
- Member's utilization of medical services
- Member's diminished mental capacity
- 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 (see Key Contacts).
- Any reason that may be considered discrimination (see the Complaints, Administrative Reviews and Fair Hearings chapter in this manual)
- Failure of member to pay co-pay or other bills

Member Notification

A written disenrollment notification must be sent to the member at least 30 days prior

to disenrollment. 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. 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

Sample letter:

Dear Medicaid member,

This is a letter 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

A copy of the member's disenrollment notification must be mailed or faxed to Xerox-Passport to Health (see Key Contacts). 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 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 to Health will assist the member in selecting a new PCP.

Complaints, Administrative Reviews and Fair Hearings



Member Complaints

If a complaint is filed against a provider, the Department conducts an investigation. The investigation may include a phone call to the provider and/or a chart review. The provider will receive notice that a complaint has been filed against him or her and another notice when the complaint has been closed.

Responses may include, but are not limited to:

- Clarification of Passport policy to parties who have not acted in accordance with policy
- Advising members how to change providers
- Advising providers how to disenroll members
- Advising providers on proper billing practices

A written report is prepared and a response is sent to the involved parties. The person who reported the complaint is advised, in writing, about appeal rights through the Department. The final report is usually sent within 15 days of receipt of the complaint.

Administrative Reviews and Fair Hearings

(ARM 37.5.310 and 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 (see Key Contacts).

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 (see Key Contacts) 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, physical or mental disability, sexual orientation, 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 (see Key Contacts).

If you wish to file a complaint with the Office of Civil Rights, contact them at the address or phone number shown in Key Contacts. 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.

Key Websites



Provider Information Website

www.mtmedicaid.org

- Verify Medicaid/HMK *Plus* Eligibility
- Look up a member's PCP
- Medicaid information
- Provider manuals
- Notices and manual replacement pages
- Fee schedules
- Remittance advice notices
- Forms
- Provider enrollment
- Frequently asked questions (FAQs)
- Upcoming events
- Electronic billing information
- Medicaid newsletters
- Key contacts
- Links to other websites and more

- Find a Montana Medicaid/HMK *Plus* provider
- Member handbook
- Member resources
- Member notices & information
- Frequently asked questions



Healthy Montana Kids hmk.mt.gov

Information on the Healthy Montana Kids Coverage Plan (HMK)

Centers for Disease Control and Prevention (CDC) website

www.cdc.gov

Immunization and other health information

Provider Web Portal

accesstohealth.mt.gov

- Member eligibility & PCP enrollment
- Provider payment summary
- Claim status and payment amounts
- Electronic health record
- Remittance advice
- Claims-based medical history
- Ask Provider Relations

Medicaid Mental Health and Mental Health Services Plan

mentalhealth.mt.gov

Mental Health Services information for Medicaid and MHSP

Nurse First Advice Line

medicaid.mt.gov/nursefirst

- Member confidential nurse triage line
- Staffed by licensed-registered nurses
- Follow nationally recognized Barton Schmitt/David Thompson guidelines
- Safely reduces avoidable visits and admissions
- Decreases evening and weekend on-call traffic

Member Information Website

medicaid.mt.gov

- Medicaid/HMK *Plus* program information including Team Care, Nurse First and Health Improvement Programs
- Choose or change a Passport provider

Key Contacts



The hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain 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 in order to participate in Medicaid/HMK *Plus*, should contact the Montana Department of Public Health and Human Services through the Passport to Health Program (see Xerox-*Passport to Health* below for phone number and address).

Xerox- Passport to Health

Members who have general Medicaid or HMK *Plus* questions, are looking for a provider, or would like to choose a Passport Provider may call the Montana Medicaid/HMK *Plus* Help Line:

(800) 362-8312 in and out-of-state

Providers with questions regarding Passport to Health can call the Xerox Passport Lead:

(406) 457-9558

(406) 442-2328 Fax

Or the State of Montana Passport Program Officer (below) or write to:

Passport to Health Program,
PO Box 254
Helena MT 59624-0254

State of Montana Passport Program Officer

Passport providers can contact the program officer with policy or program questions/concerns, to report errors, omission, or discrepancies in member utilization and cost reports.

(406) 444-4540

(406) 444-1861 Fax

Passport Program Officer DPHHS
Medicaid Services Bureau
PO Box 202951
Helena MT 59620-2951

Member Eligibility

For member eligibility, see the Member Eligibility and Responsibilities chapter in the General Information for Providers manual on the Provider Information website (see Key Websites).

Provider Relations

Contact Provider Relations for questions about Medicaid/HMK *Plus*, MHSP, and Healthy Montana Kids eyeglass and dental. Provider Relations can answer questions regarding payments, denials, eligibility, general claims questions, and Medicaid/HMK *Plus* enrollment questions:

(800) 624-3958 in- and out-of-state

(406) 442-1837 Helena

(406) 442-4402 Fax

Send written inquiries to:

Provider Relations Unit
PO Box 4936
Helena MT 59604

Send e-mail inquiries to:

MTPRHelpdesk@xerox.com

Medicaid/HMK Plus Policy Questions

Providers who have Medicaid/HMK *Plus* policy questions may contact the appropriate division

of the Department of Public Health and Human Services; see the Introduction chapter in the General Information for Providers manual on the Provider Information website (see Key Websites).

Office for Civil Rights
US Department of Health & Human Services
999 18th ST Suite 417
Denver CO 80202

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2034

Secretary of State
PO Box 202801
Helena MT 59620-2801
<http://sos.mt.gov/ARM/index.asp>

Healthy Montana Kids Program

For questions about the Healthy Montana Kids Health Coverage Plan:

(877) 543-7669 Phone toll-free
(406) 444-6971 Phone in Helena
(406) 444-4533 Fax in Helena
(877) 418-4533 Fax Toll-free

HMK
PO Box 202925
Helena MT 59620-2951
hmk@mt.gov

Office of Human Resources & Office for Civil Rights

For complaints about alleged discrimination because of race, color, national origin, age or disability, or other protected classes hours are 8:00 a.m. to 4:00 p.m. mountain standard time

(406) 444-0262

DPHHS, Office of Human Resources
Member Complaint Coordinator
PO Box 4210
Helena, MT 59620-4210
(800) 368-1019
(800) 537-7697 TDD

Montana Relay Services

Telecommunications assistance for the hearing impaired.

(800) 833-8503 Voice, TTY

(406) 444-1335 Voice, TTY

relay@mt.gov

Fair Hearing or Administrative Review Request

To request a fair hearing or administrative review, deliver or mail the request to the following address:

(406) 444-2470

DPHHS
Office of Fair Hearings
PO Box 202953
Helena MT 59620-2953
hhsafh@mt.gov

Team Care Program Officer

For questions regarding the Team Care Program or Nurse First advice line:

(406) 444-4540

(406) 444-1861 Fax

Team Care Program Officer DPHHS
Managed Care Bureau
PO Box 202951
Helena MT 59620-2951

Interpreter Services

For forms and information on providing interpretive services to members call the Medicaid/HMK *Plus* program at:

(406) 444-4540

Definitions and Acronyms



This section contains definitions, abbreviations, and acronyms used in this manual.

- **Administrative Review** - Administrative reviews are the Department's effort to resolve a complaint about a Department decision in order to avoid a hearing. The review includes an informal conference with the Department to review facts, legal authority, and circumstances involved in the adverse action by the Department.
- **Administrative Rules of Montana (ARM)** - The rules published by the executive departments and agencies of the state government.
- **Basic Medicaid** - Patients with Basic Medicaid have limited Medicaid services.
- **Centers for Medicare and Medicaid Services (CMS)** - Administers the Medicare program and oversees the state Medicaid program; formerly the Health Care Financing Administration (HCFA).
- **Cosmetic** - Serving to modify or improve the appearance of a physical feature, defect, or irregularity.
- **Cost sharing** - The member's financial responsibility for a medical bill, usually in the form of a flat fee.
- **DPHHS, State Agency** - The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid/HMK *Plus* program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37; Chapter 86.
- **Early and Periodic Screening Diagnosis and Treatment (EPSDT)** - This program provides HMK *Plus*-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.
- **Emergency Services** - Emergency medical services are those services required to treat and stabilize an emergency medical condition.
- **Fair Hearing** - Providers may request a fair hearing when the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. Fair hearings include a hearing officer, and can include attorneys, and witnesses for both parties.
- **Full Medicaid** - Patients with Full Medicaid have a full scope of Medicaid/HMK *Plus* benefits.
- **Group Passport Provider** - A Group Passport to Health provider is enrolled in the program as having one or more Medicaid/HMK *Plus* providers practicing under one Passport number.
- **Healthy Montana Kids Program (HMK)** - This plan covers some children whose family incomes make them ineligible for Healthy Montana Kids *Plus*. DPHHS sponsors the program, which is administered by Blue Cross Blue Shield of Montana.
- **Healthy Montana Kids Plus Program** - Health coverage program for low-income children in Montana operated by DPHHS.
- **Indian Health Services (IHS)** - IHS provides federal health services to American Indians and Alaska Natives.
- **Montana Access to Health Web Portal** - A secure website on which providers may view a member's medical history,

verify member eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

- **Medicaid** - A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.
- **Medically Necessary** - A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.
- **Medicare** - The federal health insurance program for certain aged or disabled members.
- **Member** - An individual enrolled in a Department medical assistance program.
- **Passport Referral Number** - This is the number the Passport provider gives to other providers when referring a member for services. This is a seven-digit number issued to the Passport provider by the Department and must be on the requesting provider's claim or Medicaid/HMK *Plus* will deny the service.
- **Prior Authorization (PA)** - The authorization process required before certain services or supplies are paid by Medicaid. PA must be obtained before

providing the service or supply, through the Mountain Pacific Quality Health Foundation.

Very satisfied. He listens to my symptoms and asks about things I may be feeling. If I have questions he always explains in a way that I can understand and draws pictures for better understanding...

Comment from Medicaid Member survey

- **Provider or Provider of Service** - An institution, agency, or person having a signed agreement with the Department to furnish medical care and goods and/or services to members; and who is eligible to receive payment from the Department.
- **Retroactive Eligibility** - When a member is determined to be eligible for Medicaid/HMK *Plus* effective prior to the current date.
- **Sanction** - The penalty for noncompliance with laws, rules, and policies regarding Medicaid/HMK *Plus*. A sanction may include withholding payment from a provider or terminating Medicaid/HMK *Plus* enrollment.
- **Solo Passport Provider** - A solo Passport to Health provider is enrolled in the program as an individual provider with one Passport number.
- **Team Care** - A program designed to educate members on how to effectively use the Medicaid system. Team Care members are managed by a "team" consisting of a Passport PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.
- **Well Child Check Up** - A well child check up is an important way to monitor growth and development of your young patients. Regular checkups provide an opportunity for you to develop a strong relationship with your patients.

Medicaid Forms



The last pages of this guide contain forms you will use frequently. If you are viewing these forms in print, you may copy these forms to distribute them. If you prefer, you may go to the website and print them from the online copy of this guide. These forms may be filled out online but cannot be submitted electronically because of HIPAA regulations related to personally identifiable member information.



Passport to Health Referral Form

This form may be used when referring a member to any other medical provider. For more guidance on referrals, the table of contents can guide you to the Passport Referral Section.

Health Improvement Program Referral Form

Medicaid uses predictive modeling software to identify chronically ill members. This software uses medical claims, pharmacy and 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 not received a diagnosis or generated claims. You may also identify and recommend Passport members at high risk for chronic health conditions if you feel they would benefit from care management from HIP. To refer a patient, use the HIP referral form in this section.

Member's Provider Change/Enrollment Form

If a member wishes to choose you as their Passport to Health provider, they can use this form to do so. Parents or guardians may change providers for the entire family. Members may also change providers by calling the Medicaid and HMK *Plus* Help Line at 1-800-362-8312 or by logging on to medicaid.mt.gov. It's never been easier to choose a provider for quality care.

Well Child Screen Recommendations

The Well Child Screen Recommendations chart is included in this section to help you track well child checkups. The chart also provides more specific guidance on each screening.



Montana Medicaid/HMK Plus Passport to Health Referral Form



Passport Provider's Name & Phone _____

Patient's Name: _____

Patient's Member Number: _____ Date of Birth: _____

Name of provider referred to: _____

Specialty: _____ Phone Number: _____

Diagnosis/problem: _____

Services Requested:

(Please check all that apply)

- Evaluate and recommend treatment (1 visit)
- Initiate treatment and refer back to me (2-3 visits)
- Continued Supervision (Circle number of visits: 4 5 6)
- Specific Procedures _____
- Surgery (Please Specify) _____
- Other _____

Length of Referral:

- 15 Days
- 30 Days
- _____

Please attach pages if necessary for the following

Limitations (Please Specify): _____

Follow-up Instructions: _____

Remarks: _____

Passport Provider Signature

Passport Referral #

Date Referral Authorized

Note to referred-to provider: in all cases, please communicate your assessment and recommendation back to the passport provider. If services beyond those authorized are needed, call passport provider for additional authorization. Retain this form in the member's file.



Medicaid & Healthy Montana Kids *Plus* Health Improvement Program Provider Referral Form



The Health Improvement Program (HIP) serves Medicaid and HMK Plus patients with chronic illnesses or risks of developing serious health conditions. HIP service providers are Community and Tribal Health Centers. [Click this link to see a map of the providers.](#)

Patients who are eligible for Passport are enrolled and assigned to a health center for possible care management. ***Your current Passport patients will stay with you for their primary care, but are eligible for care management through one of the participating health centers.*** Nurses and health coaches certified in Professional Chronic Care will

- conduct health assessments
- work with you to develop care plans
- educate patients in self management and prevention
- provide pre and post hospital discharge planning
- help with local resources
- and remind patients about scheduling needed screening and medical visits

Montana uses predictive modeling software to identify chronically ill patients. This software uses medical claims, pharmacy and demographic information to generate a risk score for each person. Although the software will provide a great deal of information for interventions, it will not identify patients who have not received a diagnosis or generated claims. If you have ***Passport*** patients at high risk for chronic health conditions that would benefit from case management, please complete the following form and ***fax*** it to:

Wendy Sturn, Program Officer ♦ Health Improvement Program ♦ **Fax #** (406) 444-1861

PCP Name:	_____
Address:	_____ _____ _____
Telephone Number:	_____
Passport Number:	_____
<i>Patient Name:</i>	_____
<i>Address:</i>	_____ _____ _____
<i>Telephone Number:</i>	_____
<i>Patient Medicaid or HMK Plus ID Number:</i>	_____
<i>Chronic Disease(s) for which Patient is at Risk:</i>	_____
Signature of Referring Provider:	_____
Date of Referral:	_____

Passport to Health • Member's Provider Change/Enrollment Form

Questions?

Call the Help Line:
1-800-362-8312

To change a Passport provider: Fill out this form and put a check (✓) next to the reason for changing (see below) or you can call the Medicaid/HMK Plus Help Line at 1-800-362-8312 to change.

If you are enrolling with a Passport

provider: Call the Help Line at 1-800-362-8312 or you may fill out this form and mail it.



To complete this form:

- Write the name, Medicaid /HMK Plus ID number, and date of birth for each member you are enrolling. Look at your Medicaid/HMK Plus card to find each member's number. Choose a Passport provider for each member.
- Write your name, address, and telephone number or message telephone number.

Mail the form to:
Passport to Health
PO Box 254
Helena MT 59624-9910
Or fax to 406-442-2328

Name of Member(s) Changing Provider	Medicaid /HMK Plus ID Number(s)	Date(s) of Birth	Passport Provider (choose one for each member)
1.			
2.			
3.			
4.			
5.			
6.			

Relationship to Member Changing Provider is (check all that apply): 1. Myself 2. Member's Parent 3. Member's Guardian 4. Medical Power of Attorney

Name _____ **Street Address** _____ **City and Zip Code** _____ **Telephone or Message Number** _____

Reason for Change of Provider

- 1. My current provider is too far away.
- 2. I moved to a new town/new part of town.
- 3. I want a provider with a different specialty.
- 4. I want my family to go to the same provider.
- 5. Inconvenient appointment times.
- 6. Provider retired/moved/left practice.
- 7. Personality conflict between the provider and me.
- 8. I prefer a different provider.
- 9. Medicaid/HMK Plus assigned me to a provider; I want a different provider.
- 10. My provider asked me to choose someone else.
- 11. Other (explain) _____

* For reasons 12-15, please call the Help Line if you would like to make a complaint.

- 12. I had to wait too long for appointments.*
- 13. Provider did not explain things clearly.*
- 14. Provider and/or staff were rude.*
- 15. I feel I am not getting good medical care.*

If you call the Help Line at 1-800-362-8312 to change or enroll, you do not have to fill out this form - open 8 am to 5 pm

Healthy Montana Kids Plus Well Child Screen Recommendations

Child's Name _____ Child's DOB _____ Child's SSN _____

	Well Child Screen component	Age requirements	Date completed
A.	Initial/Interval History		
	Medical/physical history	all ages	
	Psychosocial history	all ages	
	Developmental history	all ages	
	Nutritional history	all ages	
B.	Assessments		
	Nutritional Screen	all ages	
	Developmental Screening	9 months, 18 months, 30 months	
	Motor	9 months, 18 months, 30 months	
	Social	9 months, 18 months, 30 months	
	Cognitive	9 months, 18 months, 30 months	
	Speech and language	9 months, 18 months, 30 months	
	Developmental Surveillance	all ages	
	Autism Screening	18 months, 24 months	
	Psychosocial/Behavioral Assessment	all ages	
	Alcohol and Drug Use Risk Assessment	11 years and older	
C.	Unclothed Physical Inspection		
	Height/weight/BMI	all ages	
	Head circumference	newborn through 2 years old	
	Body systems review	all ages	
	Check for signs of abuse	all ages	
	Blood pressure	3 years and older	
D.	Vision Screen		
	External inspection for gross abnormalities or obvious strabismus	all ages	
	Gross visual acuity with fixation test	birth to 2 years	
	Light sensation with papillary light reflex test	birth to 2 years	
	Observation and report of parent	birth to 2 years	
	Examination of red reflex	all ages	
	Alternate cover test	2 years to 5 years	
	Corneal light reflex	2 years to 5 years	
	Visual acuity using the Snellen chart (E chart as appropriate)	4 years and over	
	Color discrimination on all boys (once)	5 years and over	
E.	Hearing Screen		
	Newborn Hearing Screen	newborn	
	History, physical and developmental assessment	all ages	
	Middle ear exam by otoscopy	all ages	
	Assess hearing capability	all ages	

Healthy Montana Kids Plus Well Child Screen Recommendations

Child's Name _____ Child's DOB _____ Child's SSN _____

F.	Laboratory Tests (use medical judgment and risk assessment to determine need EXCEPT for blood lead and hemoglobin/hematocrit)		
	Blood Lead	12 and 24 months; by age 6 if not previously tested; other ages if indicated by risk assessment.	
	Hematocrit or hemoglobin	9-15 months	
	Urinalysis	if indicated by risk assessment	
	Tuberculin Testing	if indicated by risk assessment	
	Dyslipidemia Screening	18-20 years; other ages if indicated by risk assessment	
	Hereditary/metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia)	newborn	
	STI screening	all sexually active patients	
	Cervical dysplasia screening	all sexually active patients: 3 years after becoming sexually active or 21 years of age, whichever is first.	
	Other tests as needed		
G.	Immunizations	According to the current immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP) http://www2.aap.org/immunization/	
H.	Oral Health Screening (to be done by medical health provider)		
	Initial/interval dental history	all ages	
	Counseling on oral hygiene	all ages	
	Counseling for non-nutritive habits (thumb-sucking, etc.)	as indicated	
	Oral inspection of mouth, teeth, gums	all ages	
I.	Discussion and Counseling/Anticipatory Guidance		
	Address needs and topics appropriate for age level per risk assessment	all ages	



MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

For questions about this guide contact
Montana Department of Health and Human Services
Member Health Management Bureau
Passport to Health Program Officer
PO Box 202951
Helena MT 59620-2951

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