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I. Overview

About WellCare

‘Ohana Health Plan (the Plan), a health plan offered by WellCare Health Insurance of Arizona, Inc., and a licensed health maintenance organization (HMO) based in Hawai‘i, is a member of the WellCare Group of Companies (WellCare). WellCare Health Plans, Inc., provides managed care services exclusively for government-sponsored Medicaid and Medicare health care programs, including prescription drug plans and health plans for families, and the aged, blind or disabled. WellCare’s corporate office is located in Tampa, Florida. As of June 30, 2014, WellCare serves approximately 3.9 million Members. Our experience and our exclusive commitment to these programs enable us to serve our Members and Providers, as well as manage our operations effectively and efficiently.

‘Ohana physical locations:

‘Ohana Health Plan – Main Office
949 Kamokila Boulevard
3rd Floor, Suite 350
Kapolei, HI 96707

‘Ohana Health Plan – Regional Sales Office
500 Ala Moana Boulevard
1 Waterfront Plaza, Suite 1D
Honolulu, HI 96813

‘Ohana Health Plan – Maui Office
285 West Ka‘ahumanu Avenue
Suite 101B
Kahului, HI 96732

‘Ohana Health Plan – Big Island Office
194 Kilauea Avenue
Suites 102 and 103
Hilo, HI 96720

For specific correspondence information, refer to the ‘Ohana Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

‘Ohana’s Medicaid Managed Service Plan
The Plan has contracted with the State of Hawai‘i, Department of Human Services Med-QUEST Division (DHS/MQD) to provide Medicaid managed care services.

Purpose of this Manual
This Provider Manual is intended for Plan-contracted (participating) Medicaid Providers providing health care service(s) to Plan Members enrolled in ‘Ohana Health Plan’s Medicaid managed care plan. This manual serves as a guide to the policies and procedures governing the administration of the Plan’s Medicaid plan and is an extension of and supplements the Participating Provider Agreement (Agreement) between the Plan and health care Providers, who include, without limitation: physicians, hospitals, facilities, behavioral health Providers and ancillary Providers (collectively, providers).

This manual replaces and supersedes any previous versions dated prior to
In accordance with Section 4.6 of the Agreement, participating plan Providers must abide by all applicable provisions contained in this manual. Revisions to this manual reflect changes made to Plan policies and procedures. The Provider Manual will be updated electronically, via the plan’s website, within five (5) days of any changes made to it. Substantive revisions shall become binding thirty (30) days after notice is provided in writing by mail (via letter or post card) or electronic means, or such other period of time as necessary for the Plan to comply with any statutory, regulatory, contractual and/or accreditation requirements.

**Eligibility**

Membership enrollment in the Plan’s Medicaid managed care plan is solely determined by DHS. For eligibility criteria, please refer to the MQD web site at [www.med-quest.us](http://www.med-quest.us).

**Covered Benefits and Services**

As of the publication date of this manual, the following core benefits and services (Covered Services) are provided to the Plan’s Medicaid Members:

- Primary and acute services;
- Diagnostic tests (labs, imaging services);
- Dialysis;
- Durable medical equipment (DME) and medical supplies;
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- Emergency and post-stabilization services; Habilitation services;
- Hospice services;
- Immunizations;
- Inpatient hospital days for medical and surgical care to include:
  - Post-stabilization services,
  - Maternity and newborn care, or
  - Sterilization and hysterectomies*;
- Non-emergency transportation;
- Outpatient hospital procedures or ambulatory surgery center procedures to include but not limited to:
  - Sleep laboratory services, and
  - Surgeries performed in a free-standing ambulatory surgery center (ASC) and hospital ASC;
- Outpatient medical or behavioral health visits to include:
  - Family planning,
  - Home health,
  - Medical services related to dental needs,
  - Nutrition counseling,
  - Other practitioner services,
  - Physician services,
  - Podiatry,
  - Post-stabilization services, if applicable,
  - Preventive services,
  - Smoking cessation,
  - Urgent care,
• Vision and hearing services;
• Pregnancy-related services;
• Prescription drugs include medications that are determined medically necessary to optimize the member’s medical condition, including behavioral health prescription drugs for children receiving services from CAMHD, medication management and patient counseling; and
• Rehabilitation services, both inpatient and outpatient to include cognitive rehabilitation services.

'Ohana will be responsible for corneal transplants and bone grafts. These require Prior Authorization.

**Sterilizations**

Prior Authorization is not required for sterilization procedures. However, the Plan will deny any Provider claims submitted without the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.

The Plan will not and is prohibited from making payment for sterilizations performed on any person who:

• Is under twenty-one (21) years of age at the time she or he signs the consent;
• Is not mentally competent; or
• Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility.

The required *DSSH-1146 Consent Form* must be completed and submitted to the Plan.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is thirty (30) calendar days.

The signed consent form expires one-hundred eighty (180) calendar days from the date of the Member's signature.

In the case of premature delivery or emergency abdominal surgery performed within thirty (30) calendar days of signed consent, the physician must certify that the sterilization was performed less than thirty (30) calendar days, but not less than seventy-two (72) hours after informed consent was obtained.

In the case of premature delivery or emergency abdominal surgery, the sterilization consent form must have been signed by the Member thirty (30) calendar days prior to the originally planned date of sterilization. A sterilization consent form must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to the Plan. The Member must sign the consent form at least thirty (30) calendar days, but not more than one-hundred eighty (180) calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

**Hysterectomies**
Prior Authorization is required for the administration of a hysterectomy to validate medical necessity. The Plan reimburses Providers for hysterectomy procedures only when the following requirements are met:

- The Provider ensured that the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- Prior to the hysterectomy, the Member/individual and the attending physician must sign and date the *Patient’s Acknowledgement of Prior Receipt of Hysterectomy Information, Form DSSH-1145 and DSSH-1146 Consent Form*.
- In the case of prior sterility or emergency hysterectomy, a Member is not required to sign the consent form; and
- The Provider submits the properly executed *Form DSSH-1145* with the claim prior to submission to the Plan.

The Plan will deny payment on any claims submitted without the required documentation or with incomplete or inaccurate documentation. The Plan does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for medical necessity and not for the purpose of family planning, sterilization, purpose of cancer prophylaxis in the absence of the Member having the BRCA gene, hygiene or mental incompetence. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

All forms are located on the Plan’s website at [www.ohanahealthplan.com/provider/medicaid/forms](http://www.ohanahealthplan.com/provider/medicaid/forms).

**Long Term Services and Supports (LTSS)**

- Home and Community-Based Services (HCBS):
  - Adult day care,
  - Adult day health,
  - Assisted living services,
  - Community Care Management Agency (CCMA) services,
  - Counseling and training,
  - Environmental accessibility adaptations,
  - Home-delivered meals,
  - Home maintenance,
  - Moving assistance,
  - Non-medical transportation,
  - Personal assistance services – Level I and Level II,
  - Personal Emergency Response Systems (PERS),
  - Residential care including E-ARCH and CCFFH;
  - Respite Care;
  - Skilled (or private-duty) nursing, and
  - Specialized medical equipment and supplies.
- Institutional services:
  - Acute Waitlisted ICF/SNF,
Criteria for each of these services and State approval must be met in order to qualify.

**At-Risk Services**

Some 'Ohana Members may be assessed to be at risk for deteriorating to an institutional level of care, based on a functional assessment, if certain LTSS are not provided. To be eligible, the Member must reside in his/her home, is not required to be homebound and cannot be residing in a care home, foster home, hospital, nursing facility, hospice facility or intermediate care facility for persons with intellectual disabilities (ICF/DD).

Member must live at home or in a community shelter (e.g., YMCA, YWCA, IHS) and need to meet the “At Risk” criteria. An assessment is completed by the Member’s physician or Service Coordinator with documentation to support the functional status and needs. Services will be based on medical necessity and needs of the member and must consider natural support systems of the member.

At-risk services may include:
- Home Delivered meals
- Personal Emergency Response System (PERS)
- Personal Care Services (Level I and/or Level II)
- Adult Day Care or Adult Day Health
- Skilled (or Private Duty) Nursing Services

Members that meet nursing facility level of care (NFLOC) and are receiving services in an institutionalized setting such as in a nursing facility, hospital, hospice facilities do not qualify for “At-Risk” services.

Criteria for each of these services and MQD approval through a Form 1147 must be met in order to qualify for these services.

**Early Periodic Screening, Diagnostic and Treatment (EPSDT) Covered Services**

EPSDT services include medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a), for all Members up to the age of twenty-one (21).

For the most up-to-date information on Covered Services, refer to the MQD website at [www.med-quest.us](http://www.med-quest.us).

**Non-Covered Services**

The following list is representative of non-Covered Services and procedures, and is not meant to be exhaustive. (The Plan will review a treatment or service for medical necessity upon request.)

- Services not considered to be medically necessary;
- Any laboratory service performed by a Provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual Providers of any laboratory service;
- Investigational or experimental services such as new treatment that has not been accepted universally as a form of treatment;
• Cosmetic procedures or services performed solely to improve appearance;
• Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
• Medical or surgical treatment of infertility (e.g., the reversal of sterilization, in-vitro fertilization, etc.);
• All procedures listed in the CPT or HCPCS description as “unlisted” or “unspecified”;
• Educational supplies; medical testimony; special reports; travel by the physician; no-show or canceled appointments; additional allowances for services provided after office hours or between 10 p.m. and 8 a.m. or on Sundays and holidays; calls, visits or consultations by telephone and other related services;
• Biofeedback or hypnotherapy;
• Services provided free of charge to Hawaiʻi Medicaid members by county health departments, free clinics, or state laboratories, e.g., metabolic screens for Members younger than one year of age, etc.;
• Services and/or procedures performed without regard to the policies contained in this manual;
• Hospital visits if the hospital admission and/or length of stay are disallowed by the Plan;
• Tubal anastomosis;
• Penile prosthesis;
• Infertility procedures and related services other than assessment;
• Thermography;
• Sensitivity training, encounter groups or workshops;
• Sexual competency training;
• Education testing and diagnosis;
• Paternity testing;
• Postmortem services;
• Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental in nature;
• Sterilization of a mentally incompetent or institutionalized Member;
• Services provided in countries other than the United States;
• Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Hawaiʻi Medicaid program regulations referenced herein; and
• Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.

Services Covered by Other Agencies or Other Entities

• ITOP
The Plan is not responsible for covering any Intentional Terminations of Pregnancy (ITOP). The Provider is to contact Xerox for guidance on coverage and claims submission of this service. DHS shall cover all procedures, medications, transportation, meals, and lodging associated with ITOPs. All costs associated with ITOPs shall be covered with state funds only. Contact Community Case Management Corp. for transportation and lodging at 1-808-792-1070 (Oahu) and toll-free at 1-888-792-0712.

The Plan will cover treatment of medical complications occurring as a result of an elective termination and treatments for spontaneous, incomplete or threatened
terminations for ectopic pregnancies. Members may use their Medicaid card and the doctor of their choice. We do not cover this service.

- **State of Hawai‘i Organ and Tissue Transplant (SHOTT) Program**
The DHS will provide transplants through the SHOTT program that are not experimental or investigational and not covered by the health plan. The SHOTT program covers adults and children (defined as those from birth through the month of their twenty-first [21st] birthday) for liver, heart, heart-lung, lung, kidney, kidney-pancreas and allogeneic and autologous bone marrow transplants. In addition, children will be covered for transplants of the small bowel, with or without liver.

Children and adults must meet specific medical criteria as determined by the state and the SHOTT program contractor. The state and the SHOTT program contractor will determine eligibility of individuals for transplants except those transplants provided by the Plan. If the DHS and the SHOTT program contractor determine the individual meets the transplant criteria, the individual will be disenrolled from the Plan and transferred to the SHOTT program.

The health plan shall work with the transplant facility to submit a request for an evaluation by the SHOTT Program, to include the referral request as well as complete supporting documentation. For adult Members, the Plan will only submit a referral request (DHS 1144) with complete supporting documentation; the Plan will not submit an ADRC packet for disability determination. For children, the ADRC packet may be required to be submitted with the DHS Form 1144 to request SHOTT program services. Based on the information provided, the ADRC shall 1) make a disability determination, and 2) The MQD and the SHOTT contractor shall evaluate the Member as a potential transplant candidate.

The Plan will notify the Member that he or she should submit a Prior Authorization Form 1144 to the DHS Med-Quest Division (MQD) for authorization for an evaluation by SHOTT. The Plan will provide assistance to the Member as needed. The Plan may resubmit the Member for reconsideration if the Member’s condition changes to make him or her a better candidate for a transplant. The Plan will continue to provide medical services to the Member until acceptance into the SHOTT program.

**Provider Services**
‘Ohana’s Provider Services Department is comprised of two teams that serve all islands: Provider Relations and Provider Operations. The Provider Relations team manages Provider education, recruitment, contracting, new Provider orientation, monitoring of quality and regulatory standards such as HEDIS®, and investigation of Member complaints. The Provider Operations team manages contract operations, including collection of credentialing and re-credentialing documents, and claims research and resolution.

The Plan offers an array of Provider services that includes initial orientation and education, either one-on-one or in a group setting, for all Providers. These sessions are hosted by the Plan’s Provider Relations representatives. Ongoing education sessions are provided every six (6) months or as necessary in the event Providers are not fulfilling program requirements as outlined in the Agreement and/or the Provider Manual.
Phone numbers to contact Provider Relations or other departments at the Plan can be found in the *Quick Reference Guide* which is posted on the Plan’s website at [www.ohanahealthplan.com/provider/medicaid/resources](http://www.ohanahealthplan.com/provider/medicaid/resources).

**Our Website**
Through the Plan’s website ([www.ohanahealthplan.com](http://www.ohanahealthplan.com)), Providers have access to a variety of easy-to-use tools created to streamline day-to-day administrative tasks with the Plan. Additional public resources found on the website include:

- Provider Manuals
- Quick Reference Guides
- Clinical Coverage Guidelines
- Clinical Practice Guidelines
- Forms and documents
- Pharmacy and Provider look-up (directories)
- Newsletters
- Training materials and job aids
- Member rights and responsibilities
- Preventive health guidelines
- Privacy Statement and Notice of Privacy Practices

**Key Features and Benefits of Registering for the Plan’s Provider Portal**
The secure, online Provider Portal of the Plan’s website provides immediate access to what Providers need most. All participating Providers who create a login and password using the Plan’s Provider Identification (Provider ID) number can leverage the following features:

**Claims Submission Status and Inquiry**
- Submit a claim
- Check the status of a claim
- Customize and download reports

**Member Eligibility** – Verify Member eligibility.

**Authorization Requests** – Providers may submit authorization requests online, attach clinical documentation and check authorization status. Providers may also print and/or save copies of the authorization form.

**Pharmacy Services & Utilization** – View and download a copy of the Plan’s preferred drug list (PDL), see drug recalls, access pharmacy utilization reports and obtain information about Plan pharmacy services.

**Provider News** – View and download the latest announcements to all Providers.

**Provider Inbox** – A Provider-specific inbox to receive notices and key reports regarding claims, eligibility inquiries and authorization requests

**Your Registration Advantage**
The Plan website allows Providers to have as many administrative users as needed and can tailor views, downloading options and email details. Providers may also set up individual sub-accounts for their staff, and keep separate billing and medical accounts.
Once registered for the Plan’s secure portal website, Providers should retain login and password information securely for future reference.

**How to Register**
To register, refer to the Plan’s Medicaid *Provider Resource Guide* which is posted at [www.ohanahealthplan.com/provider/medicaid/job_aids](http://www.ohanahealthplan.com/provider/medicaid/job_aids). For more information on the Plan’s web capabilities, please contact Provider Services or contact Provider Relations to schedule a website in-service.
II. Provider and Member Administrative Guidelines

Overview

This section is an overview of guidelines for which all participating Plan Medicaid Managed Care Providers are accountable. Please refer to the Participating Provider Agreement (Agreement) or contact your Provider Relations representative for clarification of any of the following:

Participating Plan Medicaid Providers, must in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act, the Age Discrimination Act, the Americans with Disabilities Act, and the Rehabilitation Act;
- Agree to cooperate with the Plan in its efforts to monitor compliance with its Medicaid contract(s) and/or DHS rules and regulations, and assist in complying with corrective action plans necessary to comply with such rules and regulations;
- Retain all agreements, books, documents, papers and medical records related to the provision of services to Plan Members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii).];
- Use physician extenders appropriately; Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs) should provide direct Member care within the scope or practice established by the rules and regulations of DHS and Plan guidelines;
- Assume full responsibility to the extent of the law when supervising PAs and APRNs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician extender titles (examples: APRN, PA) to Members and to other health care professionals;
- Honor at all times any Member request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any Member in need of health care services;
- Maintain the confidentiality of Member information and records;
- Allow the Plan to use Provider performance data for quality improvement activities;
- Respond promptly to the Plan’s request(s) for medical records in order to comply with regulatory requirements;
- Maintain accurate medical records and adhere to all Plan policies governing the content and confidentiality of medical records as outlined in Section VII Quality Improvement and Section X Compliance;
- Ensure that: (a) all employed Providers and other health care practitioners comply with the terms and conditions of the Agreement between the Provider and the Plan; and (b) the Provider maintains written agreements with employed Providers and other health care practitioners, which agreements contain similar provisions to the Agreement. Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer
of clinical information to the Plan, the Member or the requesting party at no charge, unless otherwise agreed;

- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimens;
- Not discriminate in any manner between Plan Medicaid Members and non-Plan Medicaid Members;
- Ensure that the hours of operation offered to Plan Members are no less than those offered to commercial Members;
- Not deny, limit or condition the furnishing of treatment to any Plan Medicaid Member on the basis of any factor that is related to health status, including but not limited to, the following: a) medical condition, including mental as well as physical illness; b) claims experience; c) receipt of health care; d) medical history; e) genetic information; f) evidence of insurability, including conditions arising out of acts of domestic violence; or g) disability;
- Freely communicate with and advise Plan Members regarding the diagnosis of the Member’s condition and advocate on Member’s behalf for Member’s health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;
- Identify Members that are in need of services related to children’s health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, Providers must refer Members to Plan-sponsored or community-based programs; and
- Must document the referral to Plan-sponsored or community-based programs in the Member’s medical record and provide the appropriate follow-up to ensure the Member accessed the services.

**Excluded or Prohibited Services**

Providers must verify patient eligibility and enrollment prior to service delivery. The Plan is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Non-Covered Services are services not covered in the Member’s Plan contract.

The DHS shall provide dental services to health plan Members through the month of their twenty-first (21st) birthday.

The DHS shall provide emergency dental services for adult Members age twenty-one (21) years and older. Covered adult dental emergencies are services to: relieve dental pain, eliminate infections, and treat acute injuries to teeth and supporting structures.

**Responsibilities of All Providers**

The following is a summary of responsibilities specific to all Providers who render services to Plan Members. These are intended to supplement the terms of the Agreement, not replace them:

- Comply with all responsibilities set forth in this Provider Manual;
- Make available treatment for any Member in need of health care services they provide;
- Refer Members with problems outside of the Provider’s normal scope of practice for consultation and/or care to appropriate specialists contracted with the Plan;
• Ensure Members utilize network Plan Providers, except when they are not available or in an emergency. If unable to locate a participating Plan Provider for services required, contact Provider Services for assistance. The phone number for Provider Services is in the Plan’s Quick Reference Guide which is posted at www.ohanahealthplan.com/provider/medicaid/resources;
• Admit Members only to participating hospitals, skilled nursing facilities (SNFs) and other inpatient care facilities, except in an emergency;
• Fully disclose to Members their treatment options and allow them to be involved in treatment planning;
• Freely communicate with Members about their treatment, regardless of benefit coverage limitations;
• Provide access to the Plan or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;
• Comply with the state and federal Provider regulatory reporting obligations;
• Inform the Plan in writing within twenty-four (24) hours of any revocation or suspension of the Bureau of Narcotics and Dangerous Drugs numbers and/or suspension, limitation or revocation of the Provider’s license, certification or other legal credential authorizing medical practice in the state of Hawai‘i;
• Submit an encounter for each visit where the Provider sees the Member or the Member receives a HEDIS® (Health Plan Employer Data and Information Set) service;
• Submit encounters. For more information on encounters, refer to Section III Claims;
• Comply with and participate in corrective action and performance improvement plan(s); and
• Continually educate Members on how to access services through the Plan.

The Right to Inspect, Evaluate and Audit
The Centers for Medicare & Medicaid Services (CMS), the State Medicaid Fraud Control Unit and DHS, or their designee, have the right to inspect, evaluate and audit any pertinent books, financial records, medical records, documents, papers and records of any Provider involving financial transactions related to the Hawai‘i Contract to monitor the quality of care being rendered without the specific consent of the Member. Providers are required to submit annual cost reports to DHS, if applicable.

Providers are prohibited from employing or subcontracting with individuals or entities whose owner or managing employees are on the state or federal exclusions list, and from making referrals for designated health services to health care entities with which the Provider or a Member of the Provider’s family has a financial relationship.

For more information on medical records requirements, refer to Section VII Quality Improvement and Section X Compliance. For more information on subcontractors, refer to Section IX Delegated Entities.

No-Show Fees
Providers are prohibited from imposing a no-show fee for Members who were scheduled to receive a Medicaid Covered Service.
Living Will and Advance Directives
Members have the right to control decisions relating to their medical care, including the
decision to withhold or remove medical or surgical means or procedures to not prolong
their life. Providers must comply with the advance directives requirements for hospitals,
nursing facilities, Providers of home and health care hospices and HMOs specified in 42

Each Member age eighteen (18) years or older and of sound mind, should receive
information regarding living wills and advance directives. They have the right to also
designate another person to make a decision should they become mentally or physically
unable to do so. The Plan provides information on advance directives in the Member
Handbook.

Information regarding living wills and advance directives should be made available in
Provider offices and discussed with Members. Completed forms should be documented
and filed in Members’ medical records.

A Provider shall not, as a condition of treatment, require a Member to execute or waive
an advance directive. Any complaints regarding advance directives should be filed with
the Department of Health, Office of Health Care Assurance (OHCA):

Department of Health
Office of Health Care Assurance
Medicare Section
601 Kamokila Boulevard, Suite 395
Kapolei, HI 96707
1-808-692-7420

Provider Billing and Address Changes
Written advance notice must be sent to your Provider Relations representative when any
of the following changes occur:
- 1099 mailing address;
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required);
- Group name or affiliation;
- Physical or billing address;
- Telephone and fax number;
- Panel changes; and/or
- Directory listing.

Failure to notify the Plan prior to these changes will result in a delay in claims processing
and payment.

Provider Termination
In addition to the Provider termination information included in the Agreement, Providers
must adhere to the following terms:
- Any contracted Providers must give at least ninety (90) days prior written notice
  (one hundred eighty (180) days for a hospital) to the Plan before terminating their
  relationship with the Plan “without cause,” unless otherwise agreed to in writing.
  This ensures adequate notice may be given to Members regarding your
  participation status with the Plan. Please refer to the Agreement for details
regarding the specific required number of days for giving termination notice, as Providers may be required by contract to give more notice than listed above; and

• Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.

In the event a Provider voluntarily terminates during the course of a Member’s treatment, the Provider may continue to provide treatment to that Member until the current course of treatment is completed or care has been transitioned to another Provider.

In the case of Plan- or DHS-initiated termination for adverse reasons on the part of the Provider, the Plan may transition a Member to another Provider.

The Health Plan shall immediately transfer a Member to another PCP, Health Plan or Provider if the Member’s health and safety is in jeopardy.

Please refer to Section IV Credentialing of this manual for specific guidelines regarding rights to appeal plan termination (if any).

**Note:** The Plan will notify in writing all appropriate agencies and/or Members the termination effective date of a participating Primary Care Provider (PCP), hospital, specialist or significant ancillary Provider within the service area as required by state Medicaid program requirements and/or regulations and statutes.

**Out-of-Area Member Transfers**
Providers should assist the Plan in arranging and accepting the transfer of Members receiving care out of the service area, if the transfer is considered medically acceptable by the Provider and the out-of-network attending physician/Provider. In the same regard, when a Member needs to transfer care to an out-of-area Provider, the Plan Provider(s) should assist with arranging and providing clinical information to the out-of-area Provider.

**Members with Special Health Care Needs**
Members with Special Health Care Needs (SHCN) include individuals with the following conditions:

• Chronic physical or behavioral conditions that require services of a type or amount beyond that required by adults generally; and/or

• Chronic physical, developmental, behavioral or emotional conditions that require services of a type or amount beyond that required by children generally.

Examples may include:

• Intellectual disability or related conditions;

• Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders;

• Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes;

• Children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and

• Related populations eligible for SSI.
The following is a summary of responsibilities specific to Plan Providers who render services to Members who have been identified with special health care needs:

- Assess Members and develop plans of care for those Members determined to need courses of treatment or regular care;
- Participate in Interdisciplinary Care Team meetings, upon request.
- Coordinate treatment plans with Members, family and/or specialists caring for Members;
- Plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;
- Allow Members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the Members’ conditions or needs;
- Coordinate with the Plan, if appropriate, to ensure that each Member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the health care services furnished;
- Coordinate services with other third party organizations to prevent duplication of services and share results on identification and assessment of the Member’s needs; and
- Ensure the Member’s privacy is protected as appropriate during the coordination process.

For more information on Utilization Management for Individuals with Special Health Care Needs (SHCN), refer to Section V Utilization Management and Disease Management.

Primary Care Providers (PCPs)

A PCP is a Provider licensed in Hawai‘i and is (a) a physician, either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician/gynecologist (for women, especially pregnant women) or geriatrician; (b) an APRN with prescriptive authority who is a registered professional nurse authorized by the State to practice as a nurse practitioner in accordance with State law and Section 16-89, Subchapter 16, HAR or c) a PA recognized by the State Board of Medical Examiners as a licensed PA.

The Plan allows selected specialists or other health care practitioners to serve as PCPs for Members with chronic conditions, provided:

- The Member has selected a specialist with whom s/he has a historical relationship as their PCP; and
- The specialist agrees, in writing, electronically or verbally to assume responsibility as their PCP.

The Plan submits to the DHS prior to implementation a plan for monitoring their performance as PCPs.

The Plan also allows a clinic to serve as a PCP as long as the clinic is appropriately staffed to carry out PCP functions and so long as the clinic agrees, in writing, to assume the responsibilities of a PCP.

In the event the specialist/clinic agrees to assume the responsibilities of a PCP for a Plan Member, s/he must adhere to the PCP requirements stated below.
The Plan will maintain a Member-to-PCP ratio of less than or equal to one to 300. However, the Plan cannot restrict Members from choosing a PCP who exceeds the one-to-300 ratio.

Responsibilities of PCPs
The following is a summary of responsibilities specific to PCPs who render services to Plan Members. These are intended to supplement the terms of the Agreement, not replace them.

- Coordinate, monitor and supervise the delivery of medically necessary primary care services for each Member, including EPSDT services for Members up to the age of twenty-one (21);
- See Members for an initial office visit and assessment, including EPSDT screenings, within the first ninety (90) days of enrollment in the Plan; for pregnant women, the first fourteen (14) days of enrollment; for newborns, within the first twenty-four (24) hours of birth;
- Coordinate and initiate referrals for specialty care/services as medically necessary (both in- and out-of-network);
- Maintain continuity of each Member’s health care and maintain the Member’s health record (this includes documentation of services provided by the PCP as well as any specialty services);
- Participate in the service plan development process coordinated by the Service Coordinator in conjunction with the Member and, as needed, specialty Providers. As appropriate, and to the extent desired by the Member, the Plan will allow the participation of family members, significant others, caregivers, etc., in the service plan development process. For more information, refer to Section VI Service Coordination;
- Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infants and Children (WIC) program for nutritional assistance;
- Provide or arrange for coverage of services, consultation or approval for referrals twenty-four (24) hours per day, seven (7) days per week. To ensure accessibility and availability, PCPs must provide one of the following:
  - A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP;
  - Answering system with option to page the physician for a return call within a maximum of thirty (30) minutes; or
  - An advice nurse with access to the PCP or on-call physician within a maximum of thirty (30) minutes.
- The PCP must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the Member’s needs; and
- The Plan shall monitor Providers against these standards to ensure Members can obtain needed health services within the acceptable appointments and in-office waiting times and after-hours. The Plan is required to submit, on a quarterly basis, timely access reports to monitor the time elapsed between a Member’s initial request for an office appointment and the date of the appointment. Providers not in compliance with these standards will be required to implement corrective actions set forth by the Plan:

<table>
<thead>
<tr>
<th>Emergency Care (without Prior Authorization)</th>
<th>Immediate care 24 hours per day, 7 days per week</th>
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</thead>
</table>

*Ohana Health Plan Provider Manual
Medicaid
Effective: January 1, 2015
Provider Services: (toll-free): 1-888-846-4262
<table>
<thead>
<tr>
<th>Service</th>
<th>Time limit</th>
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</thead>
<tbody>
<tr>
<td>PCP – Urgent Care</td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td>(child and adult)</td>
<td></td>
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<tr>
<td>PCP – Child Sick Care</td>
<td>&lt; 24 hours</td>
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<tr>
<td>PCP – Adult Sick Care</td>
<td>&lt; 72 hours</td>
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<tr>
<td>PCP – Routine Care (child and adult)</td>
<td>&lt; 21 days</td>
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<tr>
<td>Specialist Care</td>
<td>&lt; 4 weeks</td>
</tr>
<tr>
<td>Non-Emergency Hospital Stay</td>
<td>&lt; 4 weeks</td>
</tr>
<tr>
<td>Behavioral Health – Routine Care (child and adult)</td>
<td>&lt; 21 days</td>
</tr>
</tbody>
</table>

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are provided to eligible children up to their twenty-first (21st) birthday. Any Provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide EPSDT screening services, is responsible for:

- Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible Members in accordance with the periodicity schedule provided by the American Academy of Pediatrics (AAP);
- Referring the Member to an out-of-network Provider for treatment if the service is not available within the Plan’s network and requesting prior approval for such;
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines;
- Providing vaccinations in conjunction with EPSDT/Well-child visits. Providers are required to use vaccines available without charge under the Vaccines for Children (VFC) program for Medicaid children twenty-one (21) years old and younger;
- Addressing unresolved problems, referrals and results from diagnostic tests, including results from previous EPSDT visits;
- Requesting a Prior Authorization for medically necessary EPSDT special services in the event other health care, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Hawaiʻi Medicaid program;
- Monitoring, tracking and following up with Members:
  - Who have not had a health assessment screening; and
  - Who miss appointments to assist them in obtaining an appointment.
- Ensuring Members receive the proper referrals to treat any conditions or problems identified during the health assessment, including tracking, monitoring and following up with Members to ensure they receive the necessary medical services; and
- Assisting members with transitioning to other appropriate care for children who age out of EPSDT services.

Providers will be sent a monthly membership list which specifies the health assessment eligible children who have not had an encounter within one-hundred twenty (120) days of joining the Plan or are not in compliance with the EPSDT Program.

The Provider’s compliance with Member monitoring, tracking and follow-up will be assessed through random medical record review audits conducted by the Plan’s Quality
Improvement (QI) Department, and corrective action plans will be required for Providers who are below eighty percent (80%) compliance with all elements of the review.

In the event a Member transfers between health plans and maintains the same PCP in both plans, the EPSDT visit does not need to be repeated; however, the PCP should submit a copy of the EPSDT 8015 or 8016 to the Plan to ensure the Member’s immunization rates and preventive visits have been recorded.

For more information on EPSDT Covered Services, refer to Section I Overview. For more information on the Hawai’i Medicaid EPSDT periodicity schedule, refer to the DHS website at www.med-quest.us. For more information on the periodicity schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at www2.aap.org/healthtopics/immunizations.cfm.

Primary Care Offices
PCPs provide comprehensive primary care services to Plan Members. Primary care offices participating in the Plan’s Provider network have access to the following services:

- Support of the Provider Relations, Provider Services, Health Services and Marketing and Sales departments, as well as the tools and resources available on the Plan’s website at www.ohanahealthplan.com/provider/default; and
- Information on Plan network Providers for the purposes of referral management and discharge planning.

Closing of Provider Panel
When requesting closure of a Provider panel to new and/or transferring Plan members, PCPs must:

- Submit the request in writing at least sixty (60) days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel;
- Maintain the panel to all ‘Ohana Health Plan Members who were provided services before the closing of the panel; and
- Submit written notice of the re-opening of the panel, including a specific effective date.

Covering Providers
In the event participating Providers are temporarily unavailable to provide care or referral services to Plan Member, Providers should make arrangements with another Plan-contracted Medicaid (participating) and credentialed Provider to provide services on their behalf, unless there is an emergency.

Covering Providers should be credentialed by the Plan, and are required to sign an agreement accepting the negotiated rate and agreeing to not balance-bill Plan Members. For additional information, please refer to Section IV Credentialing.

In non-emergency cases, a covering Provider who is not contracted and credentialed with the Plan should contact the Plan for approval. For more information, refer to the Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

Termination of a Member
A Plan Provider may not seek or request to terminate his/her relationship with a Member, or transfer a Member to another Provider of care, based upon the Member’s
medical condition, amount or variety of care required or the cost of Covered Services required by the Plan’s Member. Reasonable efforts should always be made to establish a satisfactory Provider and Member relationship in accordance with practice standards. The Provider should provide adequate documentation in the Member’s medical record to support his/her efforts to develop and maintain a satisfactory Provider and Member relationship. If a satisfactory relationship cannot be established or maintained, the Provider shall continue to provide medical care to the Plan Member until such time written notification is received from the Plan stating the Member has been transferred from the Provider’s practice, and such transfer has occurred.

In the event a participating Provider desires to terminate his/her relationship with a Plan Member, the Provider should submit adequate documentation to support that even though they have attempted to maintain a satisfactory Provider and Member relationship, the Member’s non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the Member effectively.

The Provider should complete a *PCP Request for Transfer of Member* form or a written notification on letterhead, attach supporting documentation, and fax the form to the Plan’s Customer Service. A copy of the form is available on the Plan’s website at [www.ohanahealthplan.com/provider/medicaid/forms](http://www.ohanahealthplan.com/provider/medicaid/forms).

**Smoking Cessation**
PCPs should direct Members who smoke and wish to quit smoking to call the Plan’s Customer Service and ask to be directed to the Disease Management Department. A Disease Management nurse will educate the Member on national and community resources that offer assistance, as well as smoking cessation options available to the Member through the Plan.

**Adult Health Screening**
An adult health screening should be performed by a physician to assess the health status of all Plan Members age twenty-one (21) and older. The adult Member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the adult preventive health guidelines and the Member physical screening tool, both located on the Plan’s corporate website at [www.wellcare.com/provider/ccgs](http://www.wellcare.com/provider/ccgs).

**Member Administrative Guidelines**

**Overview**
The Plan will make information available to Members on the role of the PCP, how to obtain care, what Members should do in an emergency or urgent medical situation, as well as Members’ rights and responsibilities. The Plan will convey this information through various methods, including a Member Handbook.

**Member Handbook**
All newly enrolled Members will receive a Member Handbook within ten (10) calendar days of receiving the notice of enrollment from DHS. The Plan will mail all enrolled Members a Member Handbook annually thereafter.

**Enrollment**
Membership enrollment in the Plan is voluntary, as Members may select other Medicaid Managed Care Organizations (MCOs) or may be randomly assigned to an MCO by the State. The Plan must obey laws that protect against discrimination or unfair treatment. The Plan does not discriminate based on a person’s race, disability, religion, sex, health, ethnicity, creed, age or national origin.

Enrollment in the Plan will be effective on the day DHS determines eligibility, which will either be: (a) the date of the application; (b) any date specified by the applicant in which appropriate medical expenses were incurred within the immediate five (5) days prior to the date of application; or (c) the first day of the subsequent month in which the applicant has met all eligibility requirements if unable to meet those requirements at the time of application.

There may be exceptions to enrollment/eligibility per DHS. Please refer to the state website www.med-quest.us.

Upon enrollment in the Plan, Members are provided with the following:
- Terms and conditions of enrollment;
- Description of Covered Services in-network and out-of-network (if applicable);
- Information about PCPs, such as location, telephone number and office hours;
- Information regarding out-of-network emergency services;
- Grievance and disenrollment procedures; and
- Brochures describing certain benefits not traditionally covered by Medicaid and other value-added items or services, if applicable.

**Member Identification Cards**

Member identification (ID) cards are intended to identify Plan Members, the type of plan they have, and to facilitate their interactions with health care Providers. Information found on the Member ID card may include the Member’s name, identification number, plan type, PCP’s name and telephone number, effective date, health plan contact information and claims filing address. Members enrolled in a Medicare Advantage plan as their primary insurance are not required to choose a PCP with ‘Ohana; however, members with fee-for-service Medicare shall choose a PCP even if not in ‘Ohana’s provider network.

Possession of the Member ID card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

**Eligibility Verification**

A Member’s eligibility status can change at any time. Therefore, all Providers should consider requesting and copying a Member’s ID card, along with additional proof of identification such as a photo ID, and file them in the patient’s medical record.

Providers may do one of the following to verify eligibility:
- Access the secure, online Provider Portal of the Plan website at www.ohanahealthplan.com/provider/default;
- Access the Plan’s Interactive Voice Response (IVR) system; and/or
- Contact Provider Services.

You will need your Provider ID or Tax ID/TIN number to access Member eligibility through the avenues listed above. Verification is always based on the data available at
the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See your Agreement for additional details.

**Member Rights and Responsibilities**

Plan members, both adults and children, have specific rights and responsibilities. These are included in the Member Handbook.

Plan Members have the right to:

- Be treated with respect and with due consideration for their dignity and privacy;
- Receive information about the Plan, its services and its PCPs, and health care Provider and Member rights and responsibilities;
- Have the protections listed in the Patients’ Bill of Rights and Responsibilities Act (HRS Chapter 432E);
- Participate in decisions regarding their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion as a means of force, discipline, convenience or retaliation;
- Request and receive a copy of their medical records, and request that they be amended or corrected;
- Exercise their rights and that the exercise of these rights will not adversely affect the way the Plan or DHS treats the Member;
- Have their privacy protected;
- Know the names and titles of the Providers who take care of them;
- Talk openly about care needed for their health conditions regardless of the cost or benefit coverage;
- Talk openly about care options and risks involved, and to have this information shared in a way they understand;
- Know what to do for their health after they leave the hospital or office;
- Refuse to take part in medical research;
- Complain or file an appeal about the Plan or the care provided by its network of Providers and to know that if they do, it will not affect how they are treated;
- Create an advance directive;
- Have input in the Plans’ Member rights and responsibilities policy;
- Have all Plan staff Members observe their rights;
- Have all these rights apply to the person who can legally make health care decisions for the Member;
- Use these rights no matter what their sex, age, race, ethnic, economic, educational or religious background;
- Receive health care services that are accessible, comparable in amount, duration and scope to those provided under Medicaid Fee-for-Service (FFS) and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished;
- Receive appropriate services that are not denied or cut back just because of diagnosis, type of illness or medical condition;
- Receive all information in a way the Member can easily understand, in alternative formats and in a manner that takes into consideration their special needs (such as reading level and translated materials);
- Have oral translation for all non-English languages (not just those that are most common) and sign language services at no cost to the Member;
• Be informed that oral translation and sign language services are available, and how to access;
• Receive information on:
  o The basic features of managed care;
  o Who may or may not join the program; and
  o The Plan’s responsibilities for coordination of care in a timely manner in order to make an informed choice (potential Members);
• Receive a complete description of their right to leave the plan at least once a year;
• Receive notice of any major change in benefits at least thirty (30) days before the change is to go into effect;
• Receive full information about emergency and after-hours services;
• Receive the Plan’s policy on referrals for specialty care and other benefits that are not provided by the Member’s PCP;
• Have direct access to a women’s health specialist within the Plan’s network of Providers;
• To receive a second opinion at no cost to the Member;
• To receive services in accordance with 42 CFR Sections 438.206 through 438.210:
  o Out-of-network if the Plan is unable to provide them in-network for as long as the Plan is unable to provide them in-network. In this case, the Member will not pay more than they would have paid if services were provided in-network;
  o According to the appointment waiting-time standards;
  o In a culturally competent manner; and
  o In a coordinated manner;
• Be included in service plan development;
• Have direct access to specialists in the event the Member has a special health care need;
• Choose between institutional care and Home- and Community-Based Services (HCBS), if determined cost-neutral by the Plan;
• Receive a description of cost-sharing responsibilities, if any; and
• Not be held liable for:
  o The Plan’s debts in the event of insolvency;
  o Covered Services provided to the Member:
    ▪ By the Plan for which DHS does not pay the Plan;
    ▪ For which DHS or the Plan does not pay the Provider that furnished the services; and
  o Payments of Covered Services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the Plan provided the services directly.

Plan Members also have certain responsibilities. These include the responsibility to:
• Know how the Plan works by reading the Member Handbook;
• Carry their Plan ID card and Medicaid ID card with them at all times and to present them prior to receiving health care services;
• Notify the Plan if they lose their Member ID card;
• Be on time for appointments;
• Cancel or set a new time for appointments ahead of time;
• Provide information needed to treat them;
• Ensure their Provider has their previous medical records;
• Give information that ‘Ohana and the Member’s doctors and Providers need to provide care;
• Understand their health problems;
• Help set treatment goals that they agree to with their Provider;
• Follow the treatment plan they agree to with their Provider;
• Know the medicine they take, what it is used for and how to take it;
• Schedule appointments for all non-emergency care through their PCP;
• Obtain a referral from their PCP for specialty care;
• Cooperate with the Providers providing their health care;
• Not be disruptive in any Provider’s office;
• Respect the:
  o Rights of all Providers;
  o Property of all Providers; and
  o Rights of other patients.
• Inform the Plan within forty-eight (48) hours, or as soon as they can, if they are in a hospital or go to an emergency room.

**Assignment of Primary Care Provider (PCP)**
Hawaiʻi Medicaid Members enrolled in a Medicaid plan who do not have Medicare or other health insurance as their primary coverage must choose a PCP within ten (10) calendar days from the date displayed on the Member enrollment packet. Otherwise they will be assigned to a PCP within the Plan’s network based on the geographic location in which the Member resides. To ensure quality and continuity of care, the PCP is responsible for arranging all of the Member’s health care needs from providing primary care services to coordinating referrals to specialists and Providers of ancillary or hospital services. If Members do not select a PCP, within the designated time frame, they will be auto assigned to an open panel participating PCP.

**Changing Primary Care Providers**
Members may change their PCP selection at any time by calling Customer Service. The requested change will be effective the first day of the following month of the request if the request is received after the tenth (10th) day of the current month. Providers may change a Member’s PCP via the **PCP Change Form**. A copy of the form is available on the Plan’s website at [www.ohanahealthplan.com/provider/medicaid/forms](http://www.ohanahealthplan.com/provider/medicaid/forms).

**Women’s Health Specialists**
PCPs may also provide routine and preventive health care services that are specific to female Members. If a female Member selects a PCP who does not provide these services, she has the right to direct in-network access to a women’s health specialist for Covered Services related to this type of routine and preventive care.

**Hearing-Impaired, Interpreter and Sign Language Services**
Hearing-impaired, interpreter and sign language services are available to Plan Members through the Plan’s Customer Service. PCPs should coordinate these services for Plan Members and contact Customer Service if assistance is needed. Please refer to the **Quick Reference Guide** for the Customer Service telephone numbers which may be found on the Plan’s website at [www.ohanahealthplan.com/provider/medicaid/resources](http://www.ohanahealthplan.com/provider/medicaid/resources).
III. Claims

Overview
The focus of the Plan’s Claims department is to process claims in a timely manner. The Plan has established a toll-free telephone number for Providers to call the Customer Service Department (found at the bottom of this page). For more information, refer to the Quick Reference Guide which may be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

Timely Claims Submission
Unless otherwise stated in the Agreement, Providers must submit claims (initial, corrected and voided) within twelve (12) months from the date of service. When Medicare or any other Third Party Liability (TPL) is primary, Providers must submit claims within six (6) months from the date of the Explanation of Payment (EOP) or twelve (12) months from the date of service, whichever is greater, as stated in the Hawaiʻi Med-QUEST Provider Manual, Claims Payment, Section 4.3.5. Unless prohibited by federal law or CMS, the Plan may deny payment for any claims that fail to meet the Plan’s submission requirements for Clean Claims or that are received after the time limit in the Agreement for filing Clean Claims.

The following items can be accepted as proof that a claim was submitted timely:
- A clearinghouse electronic acknowledgement indicating the claim was electronically accepted by the Plan;
- A Provider’s electronic submission sheet with all the following identifiers – patient name, Provider name, date of service to match EOP/claim(s) in question, prior submission bill dates and the Plan product name or line of business;
- Proof of retro-enrollment from DHS; and/or
- Rejection letters from WellCare, Administer/Legacy and/or Imagenet.

The following items are examples of what is not acceptable as evidence of timely submission:
- Strategic National Implementation Process (SNIP) Rejection Letter; and/or
- A copy of the Provider’s billing screen.

Tax ID and NPI Requirements
The Plan requires the payer-issued Tax Identification (Tax ID/TIN) and National Provider Identifier (NPI) on all claim submissions. The Plan will reject claims without the Tax ID and/or NPI. More information on NPI requirements, including the Health Insurance Portability and Accountability Act of 1996’s (HIPAA) NPI Final Rule Administrative Simplification, is available on the CMS website at www.cms.hhs.gov.

Taxonomy
Providers are encouraged to submit claims with the correct taxonomy code consistent with Provider demographic information for the Covered Services being rendered in order to be reimbursed at the appropriate rate. The Plan may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted.

Prior Authorization Number
If a Prior Authorization number was obtained, Providers must include this number in the appropriate data field on the claim.
National Drug Codes (NDC)
The Plan follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS.

Strategic National Implementation Process (SNIP)
All claims and encounter transactions submitted via paper, Direct Data Entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines.

If a claim is rejected for lack of compliance with the Plan’s claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information on Encounters, see page 29.

Claims Submission Requirements
Providers using electronic submission shall submit all claims to the Plan, or its designee, as applicable, using HIPAA compliant 837 electronic format, or a CMS-1500 and/or UB-04, or their successors. Claims shall include the Provider’s NPI (exceptions are made for Atypical Providers), Tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the Member’s medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider, with the exception of Member expenses and/or non-Covered Services. For more information on paper submission of claims, refer to the Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources. For more information on Covered Services under the Plan’s Medicaid plan, refer to the Plan’s website at www.ohanahealthplan.com.

Electronic Claims Submissions
The Plan accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to the Plan must be in the ANSI ASC X12N format, version 5010. For more information on EDI implementation with the Plan, refer to the Plan’s Companion Guides which may be found on the Plan’s website at www.ohanahealthplan.com/provider/claims_updates.

Clearinghouses can exchange data with one another; Providers should work with their existing clearinghouse, or a Plan-contracted clearinghouse, to establish EDI with the Plan. For a list of Plan-contracted clearinghouse(s), information on the unique Plan Payer Identification (Payer ID) numbers used to identify the Plan on electronic claims submissions, or to contact the Plan’s EDI team, refer to the Provider Resource Guide, which may be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/job_aids.

HIPAA Electronic Transactions and Code Sets
HIPAA Electronic Transactions and Code Sets is a federal mandate that requires health care payers such as WellCare, as well as Providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA-designated content and format.
Specific Plan requirements for claims and encounter transactions, code sets and SNIP validation are described as follows: to promote consistency and efficiency for all claims and encounter submissions to the Plan, it is the Plan’s policy that these requirements also apply to all paper and DDE transactions.

For more information on EDI implementation with the Plan, refer to the Plan Companion Guides on the Plan’s website at www.ohanahealthplan.com/provider/claims_updates.

Paper Claims Submissions
The Plan does accept paper claims; however, for timelier processing of claims, Providers are encouraged to submit electronically. For assistance in creating an EDI process, contact the Plan’s EDI team by referring to the Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

If permitted under the Agreement and until the Provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500 or their successors) must contain the required elements and formatting described below:

- Paper claims must only be submitted on original (red ink on white paper) claim forms.
- Any missing, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per CMS guidelines, the following process should be used for claims submission:
  - The information must be aligned within the data fields and must be:
    - Typed;
    - In black ink;
    - Large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type; and
    - In capital letters.
  - The typed information must not have:
    - Broken characters;
    - Script, italics or stylized font;
    - Red ink;
    - Mini font; or
    - Dot matrix font.

Other Claims Submissions
Providers who render non-traditional HCBS or related services (i.e., home modification) to our Members may submit their claims to the Plan by invoice. Invoices must be mailed, faxed or emailed to the Plan’s Provider Relations Department. For more information on submitting claims via methods other than electronic or CMS-1500 or UB-04 forms, contact your local Provider Relations representative or contact Provider Services. Please refer to the Quick Reference Guide for contact information.

Claims Processing
Readmission
The Plan may choose to review claims if data analysis deems it appropriate. The Plan may review hospital admissions on a specific Member if it appears that two (2) or more admissions are related based on the data analysis. Based upon the claim review
(including a review of medical records if requested from the Provider), the Plan will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Providers who do not submit the requested medical records or who do not remit the overpayment amount identified by the Plan may be subject to a recoupment.

**Disclosure of Coding Edits**
The Plan uses claims editing software programs to assist in determining proper coding for Provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS, such as the National Correct Coding Initiative (NCCI), the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines and regulations. These software programs may result in claim edits for specific procedure code combinations. These claims editing software programs may result in an adjustment of the payment to the Provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to the Plan. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

**Prompt Payment**
The Plan shall ensure that clean claims are paid within thirty (30) days of the date of receipt by the Plan. The Plan and the Provider may, however, agree to an alternative payment schedule, provided the alternative payment schedule is reviewed and approved by DHS. The Plan shall pay interest (according to the interest rate provided by DHS) for all clean claims that are not paid within these required time frames.

**Coordination of Benefits (COB)**
The Plan shall coordinate payment for Covered Services in accordance with the terms of a Member’s benefit plan, applicable state and federal laws, and CMS guidance. Providers (contracted and non-contracted) shall bill primary insurers (i.e., Medicare) for items and services they provide to a Member before they submit claims for the same items or services to the Plan. Any balance due after receipt of payment from the primary payer should be submitted to the Plan for consideration, and the claim must include information verifying the payment amount received from the primary plan, as well as a copy of the EOP. The Plan may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow Plan policies and procedures regarding subrogation activity.

**Encounters Data**

**Overview**
This section is intended to provide delegated vendors and delegated Providers with the necessary information to allow them to submit encounter data to the Plan. If encounter data does not meet the Service Level Agreements (SLAs) for timeliness of submission, completeness or accuracy, DHS has the ability to impose significant financial sanctions on the Plan. The Plan requires all delegated vendors and delegated Providers to submit encounter data, even if they are reimbursed through a capitated arrangement.
Timely and Complete Encounters Submission
Unless otherwise stated in the Agreement, vendors and Providers should submit complete and accurate encounter files to the Plan as follows:

- Encounters submission will be weekly
- Capitated entities will submit within ten (10) calendar days of service date
- Non-capitated entities will submit within ten (10) calendar days of the paid date

The above apply to both corrected claims (error correction encounters) and cap-priced encounters.

Accurate Encounters Submission
All encounter transactions submitted via Direct Data Entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. SNIP Levels 1 through 7 shall be maintained. Once the Plan receives a delegated vendor’s or Provider’s encounters, the encounters are loaded into the Plan’s encounters system and processed. The encounters are subjected to a series of SNIP edits to ensure the encounter has all the required information and the information is accurate.

For more information on WEDI SNIP Edits, refer to their Transaction Compliance and Certification white paper at www.wedi.org.

For more information on submitting encounters electronically, refer to the Plan Companion Guides which may be found on the Plan’s website at www.ohanahealthplan.com/provider/claims_updates.

Vendors are required to comply with any additional encounters validations as defined by the State and/or CMS.

Encounters Submission Methods
Delegated vendors and Providers may submit encounters using several methods: electronically, through the Plan’s contracted clearinghouse(s), via DDE or using WellCare’s Secure File Transfer Protocol (SFTP) process.

Submitting Encounters Using WellCare’s SFTP Process (Preferred Method)
The Plan accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using the Plan’s SFTP process. Refer to the Plan’s ANSI ASC X12 837I, 837P and, 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP. For more information on EDI implementation with the Plan, refer to the Plan’s website at www.ohanahealthplan.com/provider/news.

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse or a Plan-contracted clearinghouse, to establish EDI with the Plan. For a list of Plan-contracted clearinghouses, refer to the Plan Job Aids and Resource Guides, which may be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/job_aids.

A unique Plan payer ID was included in the welcome letter from the Plan. This Plan payer ID must be used to identify the Plan on electronic claims submissions. For more
information on the Plan payer IDs or to contact the Plan’s EDI team, refer to the Quick Reference Guide which may be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

Submitting Encounters Using Direct Data Entry (DDE)
Delegated vendors and Providers may submit their encounter information directly to the Plan using the Plan’s DDE portal. The DDE tool can be found on the Provider Portal at www.ohanahealthplan.com/provider/default. For more information on free DDE options, refer to the Hawai’i Medicaid Provider Resource Guide, which may be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/job_aids.

Encounters Data Types
There are four (4) encounter types for which delegated vendors and Providers are required to submit encounter records to the Plan. Encounter records should be submitted using the HIPAA standard transactions for the appropriate service type. The four (4) encounter types are:
- Dental – 837D format;
- Professional – 837P format;
- Institutional – 837I format; and
- Pharmacy – NCPDP format.

This document is intended to be used in conjunction with the Plan’s ANSI ASC X12 837I, 837P and, 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides.

Encounters submitted to the Plan from a delegated vendor or Provider can be a new, voided or a replaced/overlaid encounter. The definitions of the types of encounters are as follows:
- New Encounter – an encounter that has never been submitted to the Plan previously.
- Voided Encounter – an encounter that the Plan deletes from the encounter file and is not submitted to the State.
- Replaced or Overlaid Encounter – an encounter that is updated or corrected within the Plan system.

Balance Billing
Providers shall accept payment from the Plan for Covered Services provided to Plan Members in accordance with the reimbursement terms outlined in the Agreement. Payment made to Providers constitutes payment in full by the Plan for covered benefits, with the exception of Member expenses. For Covered Services, Providers shall not balance-bill Members any amount in excess of the contracted reimbursement amount in the Agreement. An adjustment in payment as a result of the Plan’s claims policies and/or procedures does not indicate that the service provided is a non-covered service, and Members are to be held harmless for Covered Services.

Providers may not bill Plan Members for:
- The difference between actual charges and the contracted reimbursement amount;
- Services denied because of timely filing requirements;
- Services denied due to failure to follow Plan procedures;
• Covered Services for which a claim has been returned and denied for lack of information;
• Remaining or denied charges for those services where a contracted Provider fails to notify the plan of a service that required Prior Authorization. Payment for that service will be denied;
• Covered Services that were not medically necessary in the judgment of the Plan unless, prior to rendering the service, the Provider obtains the member’s informed written consent and the Member receives information that they would be financially responsible for the specific services; and
• Sales tax or GET on services rendered.

Providers may bill Plan Members only:
• If a Member self-refers to a specialist or other network Provider without following Plan procedures (e.g., without obtaining Prior Authorization) and the Plan denies payment to the Provider; and
• If the Provider and Member agree in advance to a non-covered service or self-referral and the Member is given information about the cost of the procedure and the payment terms at the time of service.

**Hold Harmless Dual Eligibles**
Those dual eligible Members whose Medicare Part A and B Member expenses are identified and paid for at the amounts provided for by Hawai‘i Medicaid shall not be billed for such Medicare Part A and B Member expenses, regardless of whether the amount a Provider receives is less than the allowed Medicare amount or Provider charges are reduced due to limitations on additional reimbursement provided by Hawai‘i Medicaid. Providers shall accept the Plan’s payment as payment in full.

**Cost Share**
For Hawai‘i Medicaid Members, some Members may have a share of cost. For Members receiving long-term care services (Community Care Foster Home, EARCH, nursing home, personal care assistance, skilled nursing, or Adult Day Health/Care), it is up to the Provider to ensure the Member cost share has been collected. All other Members with a cost share will be responsible for paying the health plan each month.

A Member’s cost share is available on the DHS eligibility site or by contacting the Plan’s Customer Service Department. The Provider will collect the amount from the Member and remit the full amount due to the Plan. The remittance is due to the Plan by the end of the statement month. The standard process is through inclusion of cost share on the claim (FL 29 for Professional (CMS 1500) claim forms and value code 23 in FL 39-41 for Institutional (UB-04) claim forms).

**Non-Covered Services**
Plan Members may be billed for non-Covered Services like cosmetic procedures and items of convenience (i.e., televisions). If the Provider bills a Member for non-Covered Services, s/he shall inform the Member and obtain prior written agreement from the Member regarding the cost of the procedure and the payment terms at the time of service.

**Claims Payment Disputes**
The claims payment dispute process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-
covered codes, etc. Claim payment disputes must be submitted to the Plan in writing within one hundred and twenty days (120) of the date of denial of the EOP.

Documentation consists of: (a) Date(s) of service; (b) Member name; (c) Member ID number and/or date of birth; (d) Provider name; (e) Provider tax ID; (f) total billed charges; (g) the Provider’s statement explaining the reason for the dispute, and; (h) supporting documentation when necessary (e.g., proof of timely filing, medical records).

To initiate the process, please mail to the address or fax to the fax number listed in your Quick Reference Guide located on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

**Corrected Claims or Voided Claims**

Corrected and/or voided claims are subject to timely claims submission (i.e., timely filing) guidelines.

To submit a corrected or voided claim electronically:

- For institutional claims, the Provider must include the original claim number for the claim adjusting or voiding in the REF*F8 (loop and segment) for any 7 (replacement for prior claim) or 8 (void/cancel of prior claim) in the standard 837 layout.
- For professional claims, the Provider must have the frequency code marked appropriately as 7 (replacement for prior claim) or 8 (void/cancel of prior claim) in the standard 837 layout.

These codes are not intended for use for original claim submission or rejected claims.

**To Submit a Corrected or Voided Claim Via Paper:**

- For institutional claims, the Provider must include the original Plan claim number and bill frequency code per industry standards.

Example:

**Box 4 – Type of Bill:** the third character represents the “Frequency Code”

<table>
<thead>
<tr>
<th>Type of Bill</th>
<th>Frequency Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>117</td>
</tr>
</tbody>
</table>

**Box 64 – Place the Claim number of the Prior Claim in Box 64**

<table>
<thead>
<tr>
<th>Claim Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>298370064</td>
</tr>
</tbody>
</table>

- For professional claims, the Provider must include the original Plan claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:
Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

The correction or void process involves two transactions:

1. The original claim will be negated – paid or zero payment (zero net amount due to a co-pay, coinsurance or deductible)) – and noted “Payment lost/voided/missed.” This process will deduct the payment for this claim or zero net amount if applicable.

2. The corrected or voided claim will be processed with the newly submitted information and noted “Adjusted per corrected bill.” This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.

The payment reversal for this process may generate a negative amount, which will be seen on a later EOP than the EOP that is sent out for the newly submitted corrected claim.

**Reimbursement**

The Plan applies the CMS site-of-service payment differentials in its fee schedules for Current Procedural Terminology (CPT) codes based on the place of treatment (physician office services versus other places of treatment).

**Surgical Payments** — Reimbursement to the surgeon for surgical services includes charges for pre-operative evaluation and care, surgical procedures and post-operative care. The following claims payment policies apply to surgical services:

- **Incidental Surgeries/Complications** — A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by a Plan Medical Director on whether the proposed complication merits additional compensation above the usual allowable amount.

- **Admission Examination** — One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.

- **Follow-up Surgery Charges** — Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.

- **Multiple Procedures** — Payment for multiple procedures is based on current CMS percentages methodologies. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service or when multiple surgical procedures are performed on the same day and by the same surgeon.

- **Assistant Surgeon** — If there are no reimbursement guidelines on the Hawai’i Medicaid website for payment of assistant-at-surgery services, payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is
based on current CMS percentages methodologies. The Plan uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as “sometimes,” CMS is used as the secondary source.

- **Co-Surgeon** – If there are no reimbursement guidelines on the Hawai‘i Medicaid website for payment of co-surgery procedures, payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his/her distinct, operative work by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure, as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier ‘62’ added.

**Modifier**

If there are no reimbursement guidelines specific to a modifier(s) on the Hawai‘i Medicaid website, the Plan follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

**Allied Providers**

If there are no reimbursement guidelines on the Hawai‘i Medicaid website specific to payment for non-physician practitioners or allied health professionals, the Plan follows CMS reimbursement guidelines regarding allied health professionals.

**Overpayment Recovery**

The Plan strives for one-hundred percent (100%) payment quality, but recognizes that a small percent of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as retroactive Member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, and other reasons.

The Plan will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, the Plan will limit its notice of overpayment to eighteen (18) months from the last payment date. The Plan or its designee will provide a written notice to the Provider identifying the specific claims, overpayment reason and amount, contact information, and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the Member. The notice will also provide the carrier address the Plan has on file; but the Plan recognizes that the Provider may use the carrier address it has on file. The standard request notification provides forty-five (45) days for the Provider to send in the refund, request further information or dispute the overpayment.

Failure of the Provider to respond within the above time frames will constitute acceptance of the terms in the letter and will result in offsets to future payments. Once the overpaid balance has been satisfied, an EOP will be issued. In situations where future billing is not enough to offset the entire overpaid amount, an EOP will not be sent identifying the negative balance. Instead, the Provider will need to contact his/her Provider representative for account information. In situations where the overpaid balance
has aged more than three (3) months, the Provider may be contacted by the Plan or its

designee to arrange payment.

If the Provider independently identifies an overpayment, s/he can either: (a) send a
corrected claim (refer to the Corrected Claims section of the manual); (b) send a refund
and explanation of the overpayment to:

‘Ohana Health Plan, Inc.
Recovery Department
P.O. Box 31584
Tampa, FL 33631-3584

Or (c) contact Provider Services to arrange an off-set against future payments. For more
information on contacting the Plan’s Provider Services Department, refer to the Quick
Reference Guide on the Plan’s website at
www.ohanahealthplan.com/provider/medicaid/resources.
IV. Credentialing

Overview
Credentialing is the process by which the appropriate peer review bodies of the Plan evaluate the credentials and qualifications of practitioners, including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations. For purposes of this Credentialing section, all references to “practitioners” shall include Providers providing health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations.

This review includes (as applicable to practitioner type):
- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner’s ability to provide health care;
- Accreditation status, as applicable to non-individuals; and
- Clinical Laboratory Improvement Amendment (CLIA Certificate of Waiver).

Practitioners are required to be credentialed prior to being listed as participating network Providers of care or services to Plan Members.

The Credentialing Department or its designee is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:

Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and Plan policy and procedure requirements, and include a query to the National Practitioner Data Bank.

Physicians, allied health professionals and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network Providers of services to Plan Member.

Satisfactory site inspection evaluations are required to be performed in accordance with state, federal and accreditation requirements.

After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider.
Credentialing may be done directly by the Plan or by an entity approved by the Plan for delegated credentialing. In the event that credentialing is delegated to an outside agency, that agency shall be required to meet the Plan’s criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and Plan requirements.

All participating Providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures and credentialing forms and files.

**Practitioner Rights**
Practitioner rights are listed below and included in the application/re-application cover letter.

**Practitioner’s Right to Be Informed of Credentialing/Re-Credentialing Application Status**
Written requests for information may be emailed to credentialinginquiries@wellcare.com. Upon receipt of a written request, the Plan will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within fifteen (15) business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification of information received, compared with the information provided by the practitioner.

**Practitioner’s Right to Review Information Submitted in Support of Credentialing/ Re-Credentialing Application**
The practitioner may review documentation submitted by him/her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies and certification boards, subject to any Plan restrictions. The Plan or its designee will review the corrected information and explanation at the time of considering the practitioner’s credentials for Provider network participation or re-credentialing.

The Provider may not review peer review information obtained by the Plan.

**Right to Correct Erroneous Information and Receive Notification of the Process and Time Frame**
In the event the credentials verification process reveals information submitted by the practitioner differs from the verification information obtained by the Plan, the practitioner has the right to review the information that was submitted in support of his/her application, and has the right to correct the erroneous information. The Plan will provide written notification to the practitioner of the discrepant information.

The Plan’s written notification to the practitioner includes:
- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
• The format for submitting corrections;
• The time frame for submitting the corrections;
• The addressee in Credentialing to whom corrections must be sent;
• The Plan's documentation process for receiving the correction information from the Provider; and
• The Plan's review process.

Baseline Criteria
Baseline criteria for practitioners to qualify for Provider network participation:

License to Practice – Practitioners must have a current, valid, unrestricted license to practice.

Drug Enforcement Administration Certificate – Practitioners must have a current, valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current CDS or CSR certificate (applicable for MD/DO/DPM/DDS/DMD).

Work History – Practitioners must provide a minimum of five (5) years’ relevant work history as a health professional.

Board Certification – Physicians (M.D., D.O., D.P.M.) must maintain board certification in the specialty being practiced as a Provider for the Plan or must have verifiable educational/training from an accredited training program in the specialty requested.

Hospital-Admitting Privileges – Specialist practitioners shall have hospital-admitting privileges at a Plan-participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another Plan-participating Provider who has admitting privileges at a Plan-participating hospital for the admission of Members.

Ability to Participate in Medicaid and Medicare – Providers must have the ability to participate in Medicaid and Medicare as applicable. Any individual or entity excluded from participation in any government program is not eligible for participation in any WellCare Company plan, including ‘Ohana Health Plan. Existing Providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with Plan policies and procedures.

Providers must furnish copies of their current professional liability insurance certificate to the Plan, concurrent with expiration.

Site Inspection Evaluation (SIE)
Site Inspection Evaluations (SIEs) are conducted in accordance with federal, state and accreditation requirements. Focusing on quality, safety and accessibility, performance standards and thresholds were established for:

• Office-site criteria
  o Physical accessibility;
  o Physical appearance; and
  o Adequacy of waiting room and examination room space.
• Medical/treatment record keeping criteria.
SIEs are conducted for:

- Unaccredited facilities; and
- When a complaint is received relative to office site criteria.

In those states where initial SIEs are not a requirement for credentialing, there is ongoing monitoring of Member complaints. SIEs are conducted for those sites where a complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality-of-care concern if the severity of the issue is determined to warrant an onsite review.

**Covering Providers**

PCPs in solo practice must have a covering physician who also participates with or is credentialed with the Plan.

**Allied Health Professionals**

Allied Health Professionals (AHP), both dependent and independent, are credentialed by the Plan.

Dependent AHPs include the following and are required to provide collaborative practice information to the Plan:

- Advanced Practice Registered Nurse (APRNs) if no prescriptive authority;
- Certified Nurse Midwife (CNM);
- Physician Assistant (PA); and
- Osteopathic Assistant (OA).

Independent AHPs include, but are not limited to the following:

- Advanced Practice Registered Nurse with prescriptive authority (APRN-Rx);
- Licensed clinical social worker;
- Licensed mental health counselor;
- Licensed marriage and family therapist;
- Physical therapist;
- Occupational therapist;
- Audiologist; and
- Speech/language therapist/pathologist.

**Ancillary Health Care Delivery Organizations**

Ancillary and organizational applicants must complete an application and, as applicable, undergo a SIE if unaccredited. The Plan is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status and liability insurance coverage, prior to accepting the applicant as a Plan Provider.

**Re-Credentialing**

In accordance with regulatory, accreditation and Plan policies and procedures, re-credentialing is required at least once every three (3) years.

**Updated Documentation**

In accordance with contractual requirements, Providers should furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to Provider type) to the Plan, prior to or concurrent with expiration.
Office of Inspector General Medicare/Medicaid Sanctions Report
On a regular and ongoing basis, the Plan or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, System for Award Management (SAM), Social Security Death Master File (SSDMF) and National Plan & Provider Enumeration System (NPPES) for the most current available information. This information is cross-checked against the network of Providers. If Providers are identified as being currently sanctioned, such Providers are subject to immediate termination and notification of termination of contract in accordance with Plan policies and procedures.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials
On a regular and ongoing basis, the Plan or its designee contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of Plan Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with Plan policies and procedures. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Plan policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the Provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to whether the Provider should continue participation or termination should be initiated.

Participating Provider Appeal through the Dispute Resolution Peer Review Process
The Plan may immediately suspend, pending investigation, the participation status of a participating Provider who, in the opinion of the Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of Members. In such instances, the Medical Director investigates on an expedited basis.

The Plan has a Participating Provider Dispute Resolution Peer Review Panel process in the event the Plan chooses to alter the conditions of participation of a Provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider Dispute Resolution Peer Review process has two (2) levels. All disputes in connection with the actions listed below are referred to as a first-level Peer Review Panel consisting of at least three (3) qualified individuals of whom at least one (1) is a participating Provider and a clinical peer of the practitioner that filed the dispute.

The practitioner also has the right to consideration by a second-level Peer Review Panel consisting of at least three (3) qualified individuals of which at least one (1) is a participating Provider and a clinical peer of the practitioner that filed the dispute. The second-level panel is comprised of individuals who were not involved in earlier decisions.
The following actions by the Plan entitle the practitioner affected thereby to the Provider Dispute Resolution Peer Review Panel Process:

- Suspension of participating practitioner status for reasons associated with clinical care, conduct or service;
- Revocation of participating practitioner status for reasons associated with clinical care, conduct or service; or
- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct, service or excessive claims, and/or sanction history.

Notification of the adverse recommendation, together with reasons for the action and the practitioner’s rights and process for obtaining the first and/or second level Dispute Resolution Peer Review Panel processes, are provided to the practitioner. Notification to the practitioner will be mailed by overnight recorded or certified return-receipt mail.

The practitioner has a period of up to thirty (30) days in which to file a written request via recorded or certified return receipt mail to access the Dispute Resolution Peer Review Panel process.

Upon timely receipt of the request, the Medical Director or his/her designee shall notify the practitioner of the date, time and telephone access number for the Panel hearing. The Plan then notifies the practitioner of the schedule for the Review Panel hearing.

The practitioner and the Plan are entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn there from, are arbitrary, unreasonable or capricious.

The Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five (5) business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first-level Panel hearing. In the event the findings are positive for the practitioner, the second-level review shall be waived.

In the event the findings of the first-level Panel hearing are adverse to the practitioner, the practitioner may access the second-level Peer Review Panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first-level Peer Review Panel.

Within ten (10) calendar days of the request for a second-level Peer Review Panel hearing, the Medical Director or his/her designee shall notify the practitioner of the date, time and access number for the second-level Peer Review Panel hearing.

The second-level Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five (5) business days after final adjournment of the second-level Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the second-level Panel hearing via certified or overnight recorded delivery mail. In the event the findings of the second-level Peer Review Panel result in an adverse determination for the practitioner, the findings of the second-level Peer Review Panel shall be final.
A practitioner who fails to request the Provider Dispute Resolution Peer Review process within the time frame and manner specified waives any right to such review to which s/he might otherwise have been entitled. The Plan may proceed to implement the termination and make the appropriate report to the National Practitioner Data Bank and state licensing agency as appropriate and if applicable, including DHS.

**Delegated Entities**

All Participating Providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis, and formal audits are conducted annually. Please refer to the Section IX Delegated Entities section in this Provider manual for further details.
V. Utilization Management (UM) and Disease Management (DM)

Utilization Management

Overview
The Plan’s Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and the Department while providing Members access to high-quality, cost-effective medically necessary care. For purposes of this section, terms and definitions may be contained within this section, within the Medicaid definitions section, or both.

The focus of the UM program is on:
- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the Member’s diagnosis and level of care required;
- Providing access to medically appropriate, cost-effective health care services in a culturally sensitive manner and facilitating timely communication of clinical information among Providers;
- Reducing overall expenditures by developing and implementing programs that encourage preventive health care behaviors and Member partnership;
- Facilitating communication and partnerships among Members, families, Providers, delegated entities and the Plan in an effort to enhance cooperation and appropriate utilization of health care services;
- Reviewing, revising and developing medical coverage policies to ensure Members have appropriate access to new and emerging technology;
- Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical health care services; and
- Ensuring that Providers are participating and contracted with the Plan.

Medically Necessary Services
The determination of whether a Covered Service is Medically Necessary will comply with the requirements established in the Hawai‘i Revised Statutes (HRS) 432E-1.4. To be Medically Necessary or a Medical Necessity, a Covered Service shall:

(A) For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care Provider, and determined by the health plan's medical director to be medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.

(B) A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care Provider, is approved by the health plan's medical director or physician designee, and is:

(1) For the purpose of treating a medical condition;
(2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;

(3) Known to be effective in improving health outcomes; provided that:

   (a) Effectiveness is determined first by scientific evidence;

   (b) If no scientific evidence exists, then by professional standards of care; and

   (c) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and

(4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

The Plan’s UM program includes components of Prior Authorization, prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of health care and services based on Plan Members’ coverage and the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.

The Plan does not reward its associates or any Providers or other individuals or entities performing UM activities for issuing denials of coverage, services or care. Financial incentives, if any, do not encourage or promote under-utilization.

Criteria for UM Decisions
The Plan’s UM program uses nationally recognized review criteria based on sound scientific medical evidence. Physicians with an unrestricted license in the State of Hawai‘i with professional knowledge and/or clinical expertise in the related health care specialty, actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.

The UM program uses numerous sources of information, including but not limited to the following when making coverage determinations:

- InterQual™,
- Plan Clinical Coverage Guidelines;
- Medical Necessity;
- State Medicaid contract;
- State Provider Manuals, as appropriate;
- Local and federal statutes and laws;
- Medicaid and Medicare guidelines; and
- Hayes Health Technology Assessment.

The nurse reviewer and/or Medical Director involved in the UM process apply Medical Necessity criteria in context with the Member’s individual circumstance and the capacity of the local Provider delivery system. When the above criteria do not address the individual Member’s needs or unique circumstance, the Medical Director will use clinical judgment in making the determination.
The review criteria and guidelines are available to Providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by contacting the UM Department via Customer Service. The phone number is listed on the Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

**UM Process**
The UM process is comprehensive and includes the following review components:

- Notifications;
- Referrals;
- Prior Authorizations;
- Concurrent review;
- Discharge Planning;
- ICN Nurse Review; and/or
- Retrospective review.

Decision and notification time frames are determined by regulatory requirements, contractual requirements or a combination of both.

Plan forms for the submission of notifications and Authorization requests can be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/forms.

**Notification**
Notifications are communications to the Plan with information related to a service rendered to a Member or a Member’s admission to a facility. Notification is required for:

- Prenatal services. OB Providers are required to notify the Plan of pregnancies via fax using the *Prenatal Notification Form* within thirty (30) days of the initial visit. This process will expedite claims reimbursement; and
- A Member’s unplanned admission to a hospital. This allows the Plan to log the hospital admission, create an authorization and follow up with the facility on the following business day to receive clinical information. The notification should be received by secure electronic delivery, fax or telephone and include Member demographics, facility name and admitting diagnosis.

**Referrals**
For an initial referral to a Participating Provider, the Plan does not require Prior Authorization as a condition of payment. Certain diagnostic tests and procedures considered by the Plan to be routinely part of an office visit may be conducted as part of the initial visit without an Authorization.

Services that require a referral:

- Services that a PCP does not perform
- Specialist visits and specialty care at an office or free-standing clinic

Members can go to any in-network Provider to obtain a referral for the services listed above.

Services available without a referral:

- Emergency and urgent care services
- Post-stabilization services
- Family planning services
• Routine checkups and treatment from PCP
• Well-child, EPSDT and treatment visits for children up until their 21st birthday
• Annual wellness visits for women, including a Pap smear
• Mammograms
• Lab tests ordered by participating Providers
• Basic X-rays ordered by participating Providers
• Routine vision
• Routine behavioral health outpatient services
• Disease management with the Plan

While the Plan does not require submission of referrals as a condition for payment, there is an expectation the referring Provider will document the referral and reason for referral in the medical record. Female members have direct access to a women’s health specialist within the network for Covered Services necessary to provide routine and preventive health care. This includes, but is not limited to, breast cancer screening (clinical breast exam), Pap smears and pelvic exams. Referrals by the PCP for these services are not required.

Medical records may be audited by the Plan to ensure that referrals to specialists were made by the PCP.

Prior Authorization
Prior Authorization allows for efficient use of Covered Services and ensures that Members receive the most appropriate level of care within the most appropriate setting. Prior Authorization may be obtained by the Member’s PCP, treating specialist or facility.

Reasons for requiring Prior Authorization may include:
• Review for Medical Necessity;
• Appropriateness of rendering Provider;
• Appropriateness of setting; and/or
• Service Coordination and disease management considerations.

Prior Authorization is required for elective or non-emergency services as designated by the Plan. Guidelines for Prior Authorization requirements by service type may be found on the Plan’s:
• Quick Reference Guide on the website at [www.ohanahealthplan.com/provider/medicaid/resources](http://www.ohanahealthplan.com/provider/medicaid/resources);
• The Authorization Lookup tool at [www.ohanahealthplan.com/auth_lookup](http://www.ohanahealthplan.com/auth_lookup); or
• By calling Provider Services.

Some Prior Authorization guidelines to note:
• The Prior Authorization request should include the diagnosis to be treated and the CPT code describing the anticipated procedure. If the procedure performed and billed is different from that on the request but within the same family of services, a revised request is not required.

• An Authorization may be given for a series of visits or services related to an episode of care. The Prior Authorization request should outline the plan of care, including the frequency and total number of visits requested and the expected duration of care.
• The attending Physician or designee is responsible for obtaining the Prior Authorization of an elective or non-urgent admission. Refer to the Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources and/or the Authorization Lookup tool at www.ohanahealthplan.com/auth_lookup for a list of services requiring Prior Authorization.

Prior Authorization requests may be submitted to the Plan via fax or mail. Fax numbers and mailing addresses are located on the Prior Authorization forms. Plan forms for the submission of notifications and authorization requests can be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/forms.

Concurrent Review
Concurrent review activities involve the evaluation of a continued hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review or Inpatient Care Nurse follows the clinical status of the Member through telephonic or onsite chart review and communication with the attending physician, hospital UM, CM staff or hospital clinical staff involved in the Member’s care.

Concurrent review is initiated as soon as the Plan is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan and discharge planning activity. The continued length of stay Authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay to:

• Ensure that Services are provided in a timely and efficient manner;
• Make certain that established standards of quality care are met;
• Implement timely and efficient transfer to a lower level of care when clinically indicated and appropriate;
• Complete timely and effective discharge planning;
• Identify referrals appropriate for DM or quality-of-care review; and
• Identify cases appropriate for follow up by the Service Coordinator.

The concurrent review process incorporates the use of InterQual™ criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the Plan Medical Director.

To ensure the review is completed timely, Providers must submit notification and clinical information on the next business day after the admission, as well as upon request of the Plan review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

Discharge Planning
Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues that will need post-hospital intervention. The concurrent review or Inpatient Care Nurse works with the attending Physician, hospital discharge planner, ancillary Providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the Member to the appropriate level of care. An inpatient review nurse may refer an inpatient Member with identified complex discharge needs to Service Coordination for in-facility outreach for complex discharges.
Inpatient Care Nurse (ICN) Review
The Utilization Management department’s role is designed to identify and outreach to Members in the hospital who are at high risk for readmission to the hospital. The program is a two-fold process. It may begin with a pre-discharge screening to identify Members with complex discharge needs and will assist with the development of a safe and effective discharge plan.

The ICN’s work includes, but is not limited to screening for Member needs, education, coordination of services, medication reconciliation and referrals to community-based services. Timely follow-up is critical to quickly identify and alleviate any care gaps or barriers to care.

The goal of the program is to assure that complex, high-risk Members are discharged with a safe and effective plan in place, to promote Members’ health and well-being and reduce avoidable readmissions. The ICN will refer Members with long-term needs or complex discharges to a Community Service Coordinator and/or DM.

Retrospective Review (Post-Service Review)
A retrospective review is any review of Services that have already been provided. There are two types of retrospective reviews which the Plan may perform:

- Retrospective Review initiated by the Plan
  The Plan requires periodic documentation including, but not limited to the medical record, UB and/or itemized bill to complete an audit of the Provider-submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to the Plan to support accurate coding and claims submission.

- Retrospective Review initiated by Providers
  The Plan will review post-service requests for authorization of inpatient admissions or outpatient services only if, at the time of treatment, the Member was not eligible, but became eligible with the Plan retroactively or in cases of emergency treatment and the payer is not known at the time of service. The review includes making coverage determinations for the appropriate level of Services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the Member’s needs at the time of service. The Plan will also identify quality issues, utilization issues and the rationale behind failure to follow the Plan’s Prior Authorization/pre-certification guidelines.

The Plan will give a written notification to the requesting Provider and Member within thirty (30) calendar days of receipt of a request for a UM determination. If the Plan is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to fourteen (14) calendar days from the post-service request.

The Member or Provider may request a copy of the criteria used for a specific determination of Medically Necessary Services by contacting the UM Department via Customer Service. Refer to the Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

Peer-to-Peer Reconsideration of Adverse Determination
An adverse determination may be issued following a Medical Necessity review, and in such cases, a Notice of Action is sent to the Provider. If the Provider disagrees with the decision to deny Services, they may request a peer-to-peer reconsideration by calling the toll-free number listed on the Notice of Action and requesting a conference with the Plan Medical Director who made the denial determination. Peer-to-peer reconsideration is offered within seven (7) business days following the receipt of the Notice of Action by the Provider. After this time has lapsed, the Provider may request an appeal through the formal mechanism. (See Appeals)

A Member or Provider may speak to someone in the UM Department regarding an Authorization request or UM issue by contacting Customer Service and requesting the UM Department. Refer to the Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources for contact information.

**Services Requiring No Authorization**
To facilitate timely and effective treatment of Members, the Plan has determined that many routine procedures and diagnostic tests are allowable without Medical Necessity review, including:

- Certain diagnostic tests and procedures that are routinely part of an office visit, such as colonoscopies, hysteroscopies and plain film X-rays;
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a CLIA waiver. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:
  - Reproductive laboratory tests;
  - Molecular laboratory tests; and
  - Cytogenetic laboratory tests; and
- Certain tests described as CLIA-waived that may be conducted in the Provider’s office if the Provider is authorized through the appropriate CLIA certificate (a copy of which must be submitted to the Plan).

All services performed without Authorization are subject to retrospective review by the Plan.

For a listing by code of services that may or may not require a Prior Authorization, refer to the Authorization Lookup tool at www.ohanahealthplan.com/auth_lookup. The list is subject to change without prior notice.

**Plan Proposed Actions/Notice of Action (NOA)**
A proposed action is conducted by the Plan to deny a request for Services. The Plan will notify the Member in writing of the proposed action. The notice will contain the following:

- The action the Plan has taken or intends to take;
- The reasons for the action;
- The Member’s right or Provider’s right to Appeal;
- The Member’s or Provider’s right to an Appeal with the Plan;
- The Member’s right to request a State Administrative Hearing;
- The Member’s right to representation;
- Procedures for exercising Member’s rights to Appeal or file a Grievance;
- Member may represent himself or use legal counsel or an authorized representative.
• Circumstances under which expedited resolution is available and how to request it;
• Circumstances under which a State Administrative Hearing will be granted when action is based upon a change in federal and state law, as applicable; and
• The Member’s rights to request, and have Services continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these Services.

**Second Medical Opinion**
A second medical opinion may be requested in any situation where there is a question related to options for surgical procedures, diagnosis, or treatment of complex and/or chronic conditions. A second opinion may be requested by any Member of the health care team – a Member, parent(s) and/or legal guardian(s) or a DHS social worker exercising a custodial responsibility.

The second opinion must be provided at no cost to the Member by a qualified health care professional within network, or an authorized non-participating Provider, if there is not a Participating Provider with the expertise required for the condition within the service area (the service area is the State of Hawai‘i). The order of search is initially the Member’s home island, then the neighboring islands and then out-of-state as a last resort. When referring a Member to a non-participating Provider, the referring Provider must ensure Prior Authorization is requested, with documentation that there is no Participating Provider that can provide similar services.

**Standard, Expedited and Extensions of Service Authorization Decisions**

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<thead>
<tr>
<th>Decision Time Frames</th>
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<tr>
<td>Type of Decision</td>
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<tr>
<td>Standard Pre-service</td>
<td>Fourteen (14) days</td>
<td>Additional fourteen (14) days</td>
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<tr>
<td>Expedited Pre-service</td>
<td>Three (3) days</td>
<td>Additional fourteen (14) days</td>
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<tr>
<td>Post-service</td>
<td>Thirty (30) days</td>
<td>Fourteen (14) days</td>
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**Standard Service Authorization**
The Plan is committed to a fourteen (14) calendar day turn-around-time on Prior Authorization requests. The Plan will respond by fax to the fax number(s) included on the Prior Authorization request form. An extension may be granted for an additional fourteen (14) calendar days if the Member or Provider requests an extension, or if the Plan justifies a need for additional information, and the extension is in the Member’s best interest.

**Expedited Service Authorization**
In the event the Provider indicates, or the Plan determines, that following the standard time frame could seriously jeopardize the Member’s life or health, the Plan will make an expedited authorization determination and provide notice no later than three (3) business days of the request. **Requests for expedited Prior Authorization decisions should be made by telephone, fax with a telephone call, or submission through the website with a telephone call.**
The Plan may extend the three (3) business day time frame by up to an additional fourteen (14) calendar days if the Member requests an extension, or if the Plan justifies to DHS a need for additional information and the extension is in the Member’s best interest. If the Plan extends the time frame, it shall give the Member written notice of the reason for the decision to extend the time frame and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

Please refer to the Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources for the appropriate contact information.

**Emergency/Urgent Care and Post-Stabilization Services**

Emergency Medical Services are not subject to Prior Authorization requirements and are available to our Members manifesting an Emergency Medical Condition twenty-four (24) hours a day, seven (7) days a week. Urgent Care Services should be provided within twenty-four (24) hours. See Section XIV Definitions for definitions of “Emergency Medical Services” and “Urgent Care Services”.

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- Placing the physical or mental health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions:
  - There is adequate time to effect a safe transfer to another hospital before delivery; or
  - Transfer may pose a threat to the health or safety of the woman or her unborn child.

Urgent Care means care for a condition not likely to cause death or lasting harm, but for which treatment should not wait for a normally scheduled appointment. Urgent care Services should be provided within twenty-four (24) hours.

Post-stabilization Services are Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, as prescribed in 42 CFR § 438.114, to improve or resolve the Member’s condition. The Plan is responsible for providing post-stabilization care Services twenty-four (24) hours a day, (7) seven days a week, both inpatient and outpatient.

Once the Member’s condition is stabilized, the Plan may require pre-certification for hospital admission or Prior Authorization for follow-up care. The Plan is financially responsible for post-stabilization Services that are not Prior Authorized or pre-certified by an in-network Provider or Plan representative, regardless of whether the services are provided in or out of network and are rendered to maintain, improve or resolve the Members’ stabilized condition if:
• The Plan does not respond to the Provider’s request for pre-certification or Prior Authorization within one (1) hour;
• The Plan cannot be contacted; or
• The Plan’s representative and the attending Provider cannot reach an agreement concerning the Member’s care and a Plan Provider is not available for consultation. In this situation, the Plan shall give the treating Provider the opportunity to consult with an in-network Provider, and the treating Provider may continue with care of the Member until a Plan Provider is reached or one of the criteria outlined below is met.

The Plan’s responsibility for post-stabilization Services that it has not approved will end when:
• An in-network Provider with privileges at the treating hospital assumes responsibility for the Member’s care;
• An in-network Provider assumes responsibility for the Member’s care through transfer;
• The Plan’s representative and the treating Physician reach an agreement concerning the Member’s care; or
• The Member is discharged.

In the event the Member receives post-stabilization Services from a Provider outside of the Plan’s network, the Plan is prohibited from charging the Member more than he or she would be charged if he or she had obtained the Services through an in-network Provider.

**Transition of Care**

**Transition to New Plan Members**

Transition of Care (TOC) applies to Members newly enrolled into the Plan. If a new Member has an existing relationship with a Provider who is not a participating Plan Provider, the Plan will continue to be responsible for the costs of continuation of Medically Necessary Covered Services, including those provided during prior period coverage and retroactive enrollment, without any form of prior approval and without regard to whether such services are being provided within or outside the Plan’s network. Such Services will be covered for at least 45 days or until the Member’s medical needs have been assessed or reassessed by the PCP who has authorized a course of treatment (see below for Members in the 2nd and 3rd trimester of prenatal services).

Note that notification to the Plan is necessary to properly document these services and determine any necessary follow-up care.

For Members enrolled with the DOH-CAMHD, the TOC period shall be 90 days or until the Member has had an assessment from his or her case manager or has an ITP developed and has been seen by his or her behavioral health specialist. All non-contract Providers shall be reimbursed at the Medicaid FFS rates in effect at the time of the Service delivery. Individuals who are receiving services from DOH-CAMHD, and will no longer be eligible for services (after age 21) with CAMHD, will also need to be transitioned to the BHO, if determined to have a SMI/SPMI diagnosis, or back to their health plan if they are determined to no longer require behavioral health services.
After the initial TOC requirements are completed, Providers are required to follow the Plan’s Prior Authorization or concurrent review requirements.

**Transition from the Plan**

If a Member moves to a different service area in the middle of the month and enrolls in a different health plan, the Plan shall remain responsible for the care and the cost of the inpatient Services provided, if the Member is hospitalized at the time of transition until discharge or level of care changes, whichever occurs first. Otherwise, the new health plan shall be responsible for all Services to the Member as of date of enrollment. If the Member moves to a different service area (within Hawai‘i) and remains with the Plan, the Plan shall remain responsible for the care and cost of the services provided to the Member.

**Pregnant Women**

In the event the Member entering the Plan is in her second or third trimester of pregnancy and is receiving prenatal Medically Necessary Covered Services the day before enrollment, the Plan shall be responsible for providing continued access to the prenatal care Provider (whether contract or non-contract) through the postpartum period.

When relinquishing Members, the Plan will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other Provider.

When the Plan becomes aware that a covered Member will be disenrolled from the Plan and will transition to a Medicaid fee-for-service (FFS) program or another managed care plan, a Plan Review Nurse who is familiar with that Member will provide a TOC report to the receiving plan, or appropriate contact person for the designated FFS program.

If a Provider receives an adverse claim determination which they believe was a TOC issue, the Provider should fax the adverse claim determination to the Appeals Department. Refer to the *Quick Reference Guide* on the Plan’s website at [www.ohanahealthplan.com/provider/medicaid/resources](http://www.ohanahealthplan.com/provider/medicaid/resources) for the appropriate contact information.

**Authorization Request Forms**

The Plan requests Providers use our standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to your request, including:

- *Inpatient Authorization Request Form* is used for services such as planned elective/non-urgent inpatient, observation, and skilled nursing facility and rehabilitation authorizations.
- *Outpatient Authorization Request Form* is used for services such as follow-up consultations, consultations with treatment, diagnostic testing, office procedures, ambulatory surgery, home care services, radiation therapy, out-of-network services and TOC.
- *Ancillary Authorization Request Form* is used for services such as Durable Medical Equipment (DME), dialysis, Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and TOC. All Ancillary Authorization Request Forms for non-urgent/elective ancillary services should be submitted via fax to the number listed on the form.

To ensure timely and appropriate claims payment, the form must:
• Have all required fields completed;
• Be typed or printed in black ink for ease of review; and
• Contain a clinical summary or have supporting clinical information attached.

Incomplete forms are not processed and will be returned to the requesting Provider. If Prior Authorization is not granted, all associated claims will not be paid.

A Prenatal Notification Form should be completed by the OB/GYN Provider during the first visit and faxed to the Plan within thirty (30) days of initial visit. Notification of OB services enables the Plan to identify Member for inclusion into the Prenatal Program and/or Member who might benefit from the Plan’s High Risk Pregnancy Program.

All forms are located on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/forms. All forms should be submitted via fax to the number listed on the form.

Hawai‘i Delegated Entities
The Plan does not delegate any UM activities to external entities.

Service Coordination Program for Hawai‘i Medicaid Members

Overview
The Plan offers comprehensive Service Coordination (SC) services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. The Plan trusts Providers will help coordinate the placement and cost-effective treatment of patients who are eligible for the Plan’s SC Programs. The SC program at ‘Ohana is called Service Coordination and Disease Management Services. (See section called Disease Management for more information about that program).

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care Providers, service coordination is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet a Member’s health care needs using communication and all available resources to promote quality outcomes.

Service coordination emphasizes continuity of care for a Member through the coordination of care among physicians and other Providers. Proper care coordination occurs across a continuum of care, addressing the ongoing individual needs of a Member rather than being restricted to a single practice setting.

The Plan’s service coordination system is built around the individual Member, their goals, desired outcomes and service needs. The Plan uses a patient-centered, holistic, service-delivery approach to coordinating Member benefits across all Providers and settings.

The Plan’s Service Coordination (SC) teams are led by health care professionals, such as specially trained Nurses, Social Workers, and Behavioral Health Specialists who assess the Member’s risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcomes for possible revisions of the service plan.
The Service Coordinators work collaboratively with PCPs to coordinate care for the Member and expedite access to care and needed services.

The Plan’s SC teams also serve in a support capacity to the PCP and assist in actively linking the Member to Providers, medical services, residential, social and other support services, as needed. The Provider may request SC services for any Plan Member at any time.

The SC process illustrates the formation of one seamless Program and begins with Member identification, and follows the Member until discharge from the Program. Members may be identified for service coordination through numerous ways, including: (a) a referral from a Member’s PCP; (b) self-referral; (c) referral from a family member; (d) after completing a Health Risk Assessment (HRA); and (e) data mining for Members with high utilization.

The Plan’s philosophy is that the SC Program is an integral management tool in providing a continuum of care for Plan Members. Once a Member is enrolled into SC, key elements of the SC process include:

- **Clinical Assessment and Evaluation** – a comprehensive assessment of the Member is completed to determine where s/he is in the health continuum. This assessment gauges the Member's support systems and resources and seeks to align them with appropriate clinical needs;
- **Service Planning** – collaboration with the Member and/or caregiver to identify the best way to fill any identified gaps or barriers to improve access and adherence to the Provider’s plan of care;
- **Service Facilitation and Coordination** – working with community resources to facilitate Member adherence with the plan of care. Activities may be as simple as reviewing the plan with the Member and/or caregiver or as complex as arranging services, transportation and follow-up; and
- **Member Advocacy** – advocating on behalf of the Member within the complex labyrinth of the health care system. Service Coordinator assists Member with seeking the services to optimize their health. SC emphasizes continuity of care for Member through the coordination of care among physicians and other Providers.

**Individuals with Special Health Care Needs**

Individuals with Special Health Care Needs (SHCN) are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological or emotional conditions, and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. Members with SHCN may have an increased need for health care or related services due to their respective conditions.

Providers who render services to Members who have been identified as having chronic or life-threatening conditions should:

- Allow the Members needing a course of treatment or regular care monitoring to have direct access through a standing Authorization or approved visits, as appropriate for the Member’s condition or needs:
  - To obtain a standing Authorization, the Provider should complete the *Outpatient Authorization Request Form* and document the need for a
standing authorization under the pertinent clinical summary area of the form.
  o The authorization request should outline the plan of care, including the frequency, total number of visits and the expected duration of care.

- Coordinate with the Plan to ensure each Member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Member; and
- Ensure that Members requiring specialized medical care over a prolonged period of time have access to a specialty care Provider:
  o Members will have access to a specialty care Provider through standing authorization requests, if appropriate.

Members may be directly referred into the SHCN program by Providers, the Plan, or external case managers, or may directly self-refer.

Members deemed SHCN by the Plan will be assigned a Service Coordinator (SC) to assist them in planning and coordinating care for the duration of time that they require service coordination. The SC will assist with coordinating services with Medicare, DOH programs excluded from the QUEST Integration program, other services such as Child Welfare Services and Adult Protective Services, and other community services to the extent they are available and appropriate for the Member.

Each Member identified as having a special health care need (SHCN Member), receiving HCBS services, receiving self-direction services, and/or residing in an institutional setting (Long-Term Services and Support [LTSS]) will be assigned an SC who will assist in planning and coordinating his/her care.

Other Member commonly identified for the Plan’s SC Program include:
- Catastrophic – head injury, near drowning, burns;
- Multiple Chronic Conditions – multiple co-morbidities such as diabetes, COPD, and hypertension, or multiple intricate barriers to quality health care (i.e., AIDS);
- At Risk screening – potential for hospitalization or institutionalization if certain additional services are not provided; and
- Complex Discharge Needs – Member discharged home from acute inpatient or SNF with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated, non-healing wounds, advanced illness, etc.

SCs work closely with the Provider on when to discharge the Member from the SC Program. Reasons for discharge from SC include the Member: (a) is meeting primary service plan goals; (b) has declined additional services; (c) has disenrolled from health plan; and (d) is unable to be contacted by the Plan.

In addition to the above, Service Coordinator responsibilities for nursing-facility-level-of-care (NF LOC) Member include:
- Completing NF LOC assessments (Hawai‘i DHS Form 1147) and submitting to PCP for signature and review;
- Sending the completed NF LOC assessments to DHS or its designee for a functional eligibility determination;
- Providing options for counseling regarding institutional placement and HCBS alternatives; and
• Assisting Members in transitioning to and from nursing facilities/residential-care facilities.

Hawai‘i DHS Form 1147 – At Risk or Nursing Facility Level of Care
If a Member is awaiting placement in a facility, is at a potential NF LOC or “At Risk” for institutionalization or hospitalization (see definition), the Service Coordinator either will complete the *DHS Form 1147* (if s/he is a registered nurse), coordinate the completion of the 1147 with the PCP or hospital, or make a referral for an LOC assessment to be performed. The form, when completed, will be forwarded to the Member’s PCP for signature and submitted in accordance with DHS policies and procedures.

**Service Plan Development**
A service plan will be developed by the Service Coordinator, for each Member in the program, in collaboration with the Member’s PCP. The Service Coordinator will obtain existing service plans for each Member, as applicable. The service planning process will begin at the time of the initial HFA. Based on the results of the HFA and subsequent consultation with the Member’s Providers and existing case managers, if applicable, a comprehensive service plan will be developed.

**Service Plan Components**
At a minimum, all service plans will include information regarding:
- Member measurable goals and desired outcomes;
- Current medical conditions and associated medically necessary services;
- Other service needs and authorized service units/budgets; and
- Medications and medication management.

**Interdisciplinary Care Team (ICT)**
The greater complexity of an “average” service plan for a Member with SHCN may be evident in the creation of an ICT. The ICT could include PCP/other Providers, family members, caregivers, cultural leaders and others that a Member designates. If such a team is assembled, the Member or designee will be invited to attend any meetings held by the team. Homebound Members are given the option of having the meetings occur in their homes. The PCP may be asked to participate in the ICT either in person, via telephone, or through participation in the service planning process.

**Reviewing Service Plans**
Upon completion, the service plan will be signed and dated by the Service Coordinator and the Member, and his or her representative or surrogate.

**Updating Service Plans**
Service plans will be reviewed and updated:
- When significant events occur in the life of a Member, to include but not limited to, (a) the death of a caregiver; (b) change in health status; (c) change in living arrangement; (d) institutionalization; and/or (e) change in Provider, i.e., if the Provider change affects the service plan; or
- When the next due date of the goal is to be reviewed; or
- When closing SC services.

The Service Coordinator will provide updates to the PCP concerning any changes in the Member’s health or significant developments that may require a change in the Member’s service plan.
Provider Access to Service Coordination
Refer to Access to Service Coordination and Disease Management Programs in the Disease Management section on page 58.

Disease Management Program

Overview
The Disease Management (DM) program proactively identifies Members with certain chronic diseases and educates Members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management. The program also focuses on educating the Provider with regards to the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of Members, improve health outcomes, and decrease medical costs. In addition, the Plan makes available to Providers and Members general information regarding health conditions on the Plan’s website at www.ohanahealthplan.com.

The Plan’s DM program incorporates culturally appropriate interventions, including but not limited to taking into account the multilingual, multicultural nature of the Member population.

The program’s focus is on educating Members and their caregivers regarding the standards of care for chronic diseases, specific triggers to avoid, appropriate medications and interventions that exist in their communities. The DM nurse also educates the Member on appropriate action plans, preventing reoccurrences and all measures that will decrease the likelihood of adverse outcomes.

Additionally, the program also focuses on providing technical support and educational opportunities to the Provider to ensure they are using the most current and nationally recognized standards of care for chronic diseases and current treatment recommendations. Intervention and education will improve the quality of life of Members, improve health outcomes and decrease medical costs.

The DM program covers some of the most commonly managed disease states that are prevalent in Hawai‘i today:
- Coronary Artery Disease (CAD);
- Diabetes;
- Depression;
- Smoking Cessation; and
- Asthma.

Candidates for Disease Management
The Plan encourages referrals from Providers, Members, hospital discharge planners and others in the health care community.

Interventions for identified Members vary depending on their level of need and stratification level. Interventions are based on industry-recognized Clinical Practice Guidelines (CPGs). Members identified at the highest stratification levels receive a comprehensive assessment by a DM nurse, disease-specific educational materials,
identification of a service plan and goals and follow-up assessments to monitor adherence to the plan and attain goals.

Disease-specific CPGs adopted by the Plan may be found on the Plan’s corporate website at www.wellcare.com/provider/cpgs.

**Access to Service Coordination and Disease Management Programs**

If you would like to refer a Plan Member as a potential candidate to the DM Program or SC Program, or would like more information about one of the programs, you may call Customer Service or complete and fax the *SC/Disease Management Referral Form* which can be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/forms.
VII. Quality Improvement

Overview
The Plan’s Quality Improvement (QI) Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services. Strategies are identified and activities implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas that include, but are not limited to:

- Quantitative and qualitative improvement in Member outcomes;
- Coordination and continuity of care with seamless transitions across health care settings/services;
- Cultural competency;
- Credentialing;
- Quality of care/service;
- Patient Safety and confidentiality;
- Preventive health;
- Complaints/grievances;
- Appeals;
- Adverse events;
- Network adequacy;
- Disease Management and Service Coordination;
- Behavioral Health services;
- Medical and Pharmacy utilization;
- Member and Provider satisfaction; and
- Regulatory/federal/state/accreditation requirements.

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS measures, and/or medical record audits. The organization’s Board of Directors has delegated authority to the QI Committee to approve specific QI activities, including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective action plans when appropriate, when the results are less than desired or when areas needing improvement are identified.

Medical Records
Medical records should be comprehensive, reflecting all aspects of care for each Member. Records are to be maintained in a secure, timely, legible, current, detailed and organized manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Complete medical records include, but are not limited to: medical charts, prescription files, hospital records, Provider specialist reports, consultant and other health care professionals’ findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided. Medical records must be signed and dated.

To comply with regulatory and accreditation requirements, the QI department may conduct annual medical record audits in physician offices. A patient’s record will be reviewed for content and evidence that care and screenings have been documented, as
Physicians will be given results at the time of the audit, and a corrective action plan will be required if the score is not higher than eighty percent (80%).

The goal of conducting medical record reviews is multifold, including the ability for the Plan to assess the level of Provider compliance to documentation standards and clinical guidelines (disease and preventive), and to gauge quality of care and patient safety practices.

All medical records, including all entries in the medical record, for Hawai‘i Medicaid Member:

- Should be organized in a manner to enable easy access to its content: neat, complete, clear, concise, detailed, comprehensive and timely and include all recommendations and essential findings in accordance with good professional practice;
- Must be maintained in a manner that permits effective professional medical review and medical audit processes;
- Must be maintained in a manner that facilitates an adequate system for follow-up treatment;
- Must be signed;
- Must include the name and profession of the practitioner rendering services; for example, RN, MD, DO, including signature or initials of practitioner;
- Must be legible to readers and reviewing parties and maintained in an orderly and detailed manner;
- Must be dated and recorded in a timely manner. Late entries should include date and time of occurrence and date and time of documentation;
- Should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed;
- Should only include standard abbreviations and symbols;
- Must include the patient’s name or ID number on each page of the electronic or paper record;
- Should include the following personal and biographical data in the record: (a) name; (b) Member ID; (c) age; (d) date of birth; (e) sex; (f) address; (g) home and work telephone numbers; (h) emergency contact; (i) legal guardianship; (j) marital status; (k) name of spouse; (l) next of kin or closest relative; (m) employer; (n) insurance information or family history as applicable;
- Must reflect the primary language spoken by the Member and translation or communication needs of the member. Translation or communication needs could reflect the need for an interpreter, sign language or Braille materials, etc., as appropriate;
- Must prominently note any adverse drug reactions and/or food allergies or “no known allergies” and known reactions to drugs. This may include a sticker inside of the chart or prominent notation in a conspicuous place in the record;
- Must easily identify the past medical history, including serious accidents, hospitalizations, operations, illness, prenatal care and birth as appropriate. As appropriate, medical records from the previous Provider have been obtained and are easily accessible. Old records include past medical history, physical examinations, necessary tests and possible risk factors for the Member relevant to treatment and are used to assess the periodicity schedule and maintain continuity of care;
- Must maintain a current immunization record in the chart;
• Must provide a current medication list in the chart. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications;
• Must provide a problem list, with past and current diagnoses and procedures used to provide continuity of care in the chart. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, health maintenance concerns, etc.;
• Must contain information about consultations, referrals and specialist reports;
• Must include notations on all forms or notes regarding follow-up care, calls or visits, when indicated;
• Must include a screening for substance abuse of tobacco, alcohol and drugs with appropriate counseling/referrals if needed, and follow-up must be documented;
• Must include documentation of screening for domestic violence with appropriate counseling/referrals if needed and follow-up;
• For all Members older than eighteen (18), must provide evidence the Member was asked about or executed an advance directive, including a mental health directive, and there is documentation of acceptance or refusal. **Note:** The record must contain evidence that the Member was provided written information concerning the Member’s rights regarding advance directives and whether or not the Member has executed an advance directive. The Member does not have to have an advance directive completed. A signed statement that the Member has been asked if he or she has a directive if not, offering one will suffice. A stamp may be utilized. The Provider shall not, as a condition of treatment, require the Member to execute or waive an advance directive; and
• Must detail informed consent discussions, where appropriate.

Documentation indicating diagnostic or therapeutic intervention as part of a clinical research study is clearly contrasted from those entries pertaining to usual care.

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to the Plan, or its representatives without a fee to the extent permitted by state and federal law. Records remaining under the care, custody, and control of the physician or health care Provider shall be maintained for a minimum of seven (7) years from the date of when the last professional service was provided. For minors, the health plan shall retain all medical records during the period of minority plus a minimum of seven (7) years after the age of majority. Providers should have procedures in place to permit the timely access and submission of medical records to the Plan, DHS, or to the new PCP, upon request, within sixty (60) days from receipt of the request. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

For more information on the confidentiality of Member information and release of records, refer to Section IX Compliance.

**EPSDT Screen Periodicity Schedule**
The preventive pediatric health care guidelines for children are located on our corporate website at [www.wellcare.com/provider/cpqs](http://www.wellcare.com/provider/cpqs).
The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age four (4), then the next periodic screening is performed at age five (5).

A Member should have an initial health check screening in the following situations:
- Within ninety (90) days of entering the Plan or upon change to a new PCP, if prior medical records do not indicate current compliance with the periodicity schedule; and
- Within twenty-four (24) hours of birth for newborns.

The medical record must contain documentation of a comprehensive health history in addition to an unclothed physical examination to determine if the child’s development is within the normal range for the child’s age and health history.

Each Provider office is required to have the following equipment to provide a complete health check:
- Weight scale for infants;
- Weight scale for children and adolescents;
- Measuring board or device for measuring length or height in the recumbent position for infants and children up to age two (2);
- Measuring board or device for measuring height in the vertical position for children who are two (2) years old or older;
- Blood pressure apparatus with infant, child and adult cuffs;
- Screening audiometer;
- Centrifuge or other device for measuring hematocrit or hemoglobin;
- Eye charts appropriate to children by age;
- Developmental and behavioral screening tools; and
- Ophthalmoscope and otoscope.

Additional points of emphasis regarding EPSDT screens include the following:

- **Immunizations** are administered at required age parameters and intervals with dates documented. If the immunizations are not up-to-date according to age and health history, the Provider should document why immunizations were not given at the time of the EPSDT screen. For the immunization schedule, refer to the preventive pediatric health care guidelines for children located on our corporate website at [www.wellcare.com/provider/cpgs](http://www.wellcare.com/provider/cpgs). Note that certain immunizations may not be covered in the context of covered benefits.
- A PCP is responsible to perform all required components of an EPSDT health screen, as per the AAP and Advisory Committee on Immunization Practices (ACIP) periodicity schedules, and document appropriately in the Member’s medical record. If a PCP chooses not to provide the immunization component of the screen, s/he has accountability to refer the Member to another network Provider such as a health department entity who can provide this service in a timely manner. The Plan will expect the PCP to follow up with the referred Provider to receive documentation regarding the provision of the immunization(s) in order to maintain an accurate and complete medical record.
- The Plan will monitor for compliance to these requirements by:
  - Reviewing immunization rates by PCP,
In the event the immunization rate of the PCP is less than the network average, the Plan will:

- Assess for practice access and availability by:
- Conduct an audit to verify compliance with access and availability;
- Require adoption of a corrective action plan (CAP) if access and availability standards are not met;
- Perform a focused medical record review;
- Based on negative findings, a CAP will be requested;
- If compliance to the CAP is not demonstrated, assess for a fee reduction;
- If lack of compliance continues, petition for removal from network participation.

- **Lead Risk Assessment** is done at each screening between thirty-six (36) to seventy-two (72) months of age. Any resulting risk identified through lead risk assessment should be documented both in the medical record and acted on by obtaining a blood lead level.

- **Annual Tuberculosis (TB) skin testing** is done if the Member is in a high-risk category. Only those children locally identified as high-risk for TB disease should be tested. Results of TB risk assessment and testing as needed should be documented in the child’s medical record.

- **Developmental Delay** is to be assessed by use of a formalized tool at nine (9) and eighteen (18) months and at two (2) and three (3) years.

- **180-day Non-Compliant Report** – the Plan will send Providers a monthly membership list of EPSDT-eligible children who have not had a screen within one-hundred eighty (180) days of enrolling in the Plan or are not in compliance with the EPSDT periodicity schedule. The PCP shall contact these Members’ parents or guardians to schedule an appointment. The Plan will also send letters to the parents and guardians of EPSDT-eligible children to remind them of preventive services needed based on the child’s age.

### Provider Participation in the Quality Improvement Program

Network Providers are contractually required to cooperate with QI activities. Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, EPSDT assessments and feedback/input via satisfaction surveys, grievances, and calls to Customer Service. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

Information regarding the QI Program, available upon request, includes a description of the QI Program and a report assessing the progress in meeting goals. WellCare, including ‘Ohana Health Plan, evaluates the effectiveness of the QI Program on an annual basis. An annual report is summarized detailing a review of completed and continuing QI activities that address the quality of clinical care and service, trending of measures to assess performance in quality of clinical care and quality of service, any corrective actions implemented, corrective actions which are recommended or in progress, and any modifications to the program.

On an annual basis, the Plan or State conducts a member satisfaction survey of a representative sample of Members. Satisfaction with services, quality, and access is
evaluated. The results are compared to the Plan’s performance goals, and improvement action plans are developed to address any areas not meeting the standard.

**Patient Safety to Include Quality of Care (QOC) and Quality of Service (QOS)**

Programs promoting patient safety are a public expectation, a legal and professional standard, and an effective risk-management tool. As an integral component of health care delivery by all inpatient and outpatient Providers, the Plan supports identification and implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the health care network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues/quality of service issues and grievances related to safety.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups for adults and children;
- Prenatal care for pregnant women;
- Well-baby care;
- Immunizations for children, adolescents, and adults; and
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, Pap smears, and mammograms.

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and the Member’s needs. Prevention activities are reviewed and approved by the UM Medical Advisory Committee with input from Participating Providers and the QI Committee. Activities include distribution of information, encouragement to use screening tools and ongoing monitoring and measuring of outcomes. While the Plan can and does implement activities to identify interventions, the support and activities of families, friends, Providers and the community have a significant impact on prevention.

**Clinical Practice Guidelines (CPGs)**

The Plan adopts validated evidence-based CPGs and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede CPGs, the guidelines provide clinical staff and Providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations. The CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the UM Medical Advisory Committee. CPGs, to include Preventive Health guidelines, may be found on the Plan’s website at [www.wellcare.com/provider/cpgs](http://www.wellcare.com/provider/cpgs).

**HEDIS®**

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than ninety percent (90%) of America’s health plans to measure performance on important dimensions of care and service. The tool comprises seventy-one (71) measures across eight (8) domains of care, including:

- Effectiveness of care;
- Access and availability of care;
• Satisfaction with the care experience;
• Use of services;
• Cost of care;
• Health plan descriptive information;
• Health plan stability; and
• Informal health care choices.

HEDIS is a mandatory process that occurs annually. It is an opportunity for the Plan and Providers to demonstrate the quality and consistency of care that is available to Members. Medical records and claims data are reviewed for capture of required data. Compliance with HEDIS standards is reported on an annual basis with results available to Providers upon request. Through compliance with HEDIS standards, Members benefit from the quality and effectiveness of care received and Providers benefit by delivering industry-recognized standards of care to achieve optimal outcomes.

Web Resources
The Plan periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on the Plan website. Please check the Plan’s website frequently for the latest news and updated documents at www.ohanahealthplan.com/provider.
VIII. Appeals and Grievances

**Member Grievances**

A grievance is an expression of dissatisfaction from a Member, Member’s representative or Provider on behalf of a Member about any matter other than an action.

A Member may file a grievance either verbally or in writing about any matter related to their coverage or care, without concern of reprisal from the Company, its employees or Providers. A Member, Member’s representative or Provider, acting on behalf of the Member, with the consent of the Member may file a grievance or complaint either verbally or in writing. A verbal request may be followed up with a written request, but the time frame for resolution begins the date the Plan receives the verbal filing.

Written grievances may be mailed to:

‘Ohana Health Plan  
Attn: Grievance Department  
949 Kamokila Boulevard, Suite 350  
Kapolei, HI 96707

If the Member wishes to appoint another person as his/her representative, he/she must complete an appointment of representative (AOR) statement, available on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/forms. The Member and the person who will be representing the Member must sign the statement.

Grievances include but are not limited to:

- The quality of care or quality of service given by a Provider;
- Rudeness of a Provider or a Provider’s employee; or
- Failure to respect the Member’s rights.

A Member, Member’s representative or Provider on behalf of a Member shall file the Grievance through an established toll-free telephone number with the Plan’s Customer Service Department (found at the bottom of this page). Refer to the *Quick Reference Guide* which may be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

In fulfilling the Grievance process requirements, the Plan shall:

- Send a written acknowledgement of the Grievance within five (5) business days. Convey a disposition, in writing, of the Grievance resolution within thirty (30) calendar days of the initial expression of dissatisfaction. This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent, then one letter shall be sent which includes the acknowledgement and the decision letter. The resolution letter will include the results/finding of the resolution, all information considered in the investigation of the Grievance, and the date of the Grievance resolution.
- The resolution letter must include clear instructions as to how to access the State’s Grievance review process on the written disposition of the Grievance.
The Member is made aware of their rights to have an authorized representative and appropriate toll-free numbers, as well as TTY numbers in the Member Handbook. Customer Service will serve as the intake point of Grievance submission and to provide appropriate assistance with language support in accordance with all Customer Service policies.

The Member may request a MQD grievance review, within thirty (30) calendar days of the Grievance decision from the Plan. A request for a MQD grievance review may be made by contacting the MQD office at or mailing a request to:

**Med-QUEST Division**  
**Health Care Services Branch**  
**PO Box 700190**  
**Kapolei, HI 96709-0190**  
Or call: **1-808-692-8094**

The Plan will in no way discriminate against either Members or Providers for filing or supporting a Grievance or Appeal. The Plan (and its employees and agents) shall not take any punitive, retaliatory or adverse action against a:

- Member who requests to file a Grievance or Appeal; or
- Provider who files a Grievance on behalf of the Member or who supports a Member’s appeal

There is not a time frame for a Member to file a Grievance.

The MQD grievance review determination made by MQD is final.

**Grievances Filed Against a Provider**

If a Member files a Grievance against a Provider in reference to the quality of care or service provided, the Plan will call, fax and/or mail a request to the Provider for a response. The Provider is given ten (10) business days to respond and/or submit medical records for review. If a Provider has not responded within ten (10) business days, a second call, fax and/or letter is sent giving an additional five (5) business days to respond.

Continued failure to respond may result in the Provider’s panel being closed to new patients and/or will be interpreted to mean that the Provider does not disagree with the Member’s issue. The case is then forwarded to the QI Department for further investigation.

For Quality of Service issues, a Provider Relations representative will be required to reach out to the Provider to discuss the issue. A site visit may be necessary to validate/dispute the Grievance. Findings from the research will be forwarded back to the Grievance coordinator for closure/resolution.

For Quality of Care issues, the case is then referred to a QI nurse who reviews the medical records to determine if a quality issue exists. If the nurse feels a quality issue exists, the case is referred to the Plan Medical Director for review. If he/she determines a quality issue exists, the case is referred to the UM Medical Advisory Committee (UMAC) which serves as the peer review committee for further investigation. If no quality
issue is identified, the case is entered into the Plan’s database for tracking and trending purposes. If the Quality of Care issue has been substantiated by the peer review committee, the Provider will be notified in writing within thirty (30) calendar days of the closure of the committee. The quality information may be submitted to the Provider’s quality file and discussed during re-credentialing of the Provider. For issues that require immediate action, the issue will be brought before the Board of Directors for further action and potential termination of the contract with the Provider.

**Member Appeals Process**

An Appeal is a request that is made when the Member, Member’s authorized representative or Provider (on behalf of the Member with consent) requests a review for reconsideration of any adverse decision or action. A request for an Appeal can be made for the following actions:

- The Plan denies or limits a service requested by the Provider or Member
- The Plan reduces, suspends or stops a previously authorized service
- The Plan does not pay for the health care services that were rendered
- Failure to authorize services in the required time frames
- Failure to render a decision on an appeal in the required time frame
- Failure to provide a resolution on a Grievance in the required time frame
- Failure to let a Member see a non-participating Provider if Member lives in rural area or in an area with limited Providers that cannot meet Member’s medical needs

The Plan established and maintains a system for the resolution of Appeals initiated by the Member, Member’s authorized representative or Provider, acting on behalf of a Member and with the Member’s consent, with respect to the denial, termination or other limitation of covered health care services.

If the Member wishes to appoint another person as his/her representative, he/she must complete an appointment of representative (AOR) statement, available on the Plan’s website at [www.ohanahealthplan.com/provider/medicaid/forms](http://www.ohanahealthplan.com/provider/medicaid/forms). The Member and the person who will be representing the Member must sign the statement.

An Appeal may be filed when the Plan issues a Notice of Action to a Plan Member. A Member, Provider or authorized representative on behalf of the Member with the Member’s consent, may request a review for reconsideration of any adverse decision within thirty (30) calendar days of the Notice of Action. A verbal Appeal may be submitted in order to establish the Appeal submission date; however, this must be followed by a written request. The Plan will assist the Member, Provider or authorized representative in this process.

Appeals may be verbal (followed up in writing) or written to:

*ʻOhana Health Plan  
PO Box 31368  
Tampa, FL 33631-3368  
Toll Free: 1-888-846-4262*

The Plan will resolve the Appeal and provide a written Notice of Disposition to the parties as expeditiously as the Member’s health condition requires, but no more than thirty (30) calendar days from the day the Plan receives the Appeal.
If the denial is overturned, the Provider and Member will be notified of this decision in writing. The Plan will issue an Authorization for the pre-service request.

Post-service/retrospective Appeals are typically requests for payment for care or services that the Member has already received. Accordingly, a post-service Appeal would never result in the need for an expedited review. If the Plan overturns its adverse organization determination denying a Member’s or Provider’s request for payment, the Plan will issue its reconsidered determination and send payment for the Service.

The Plan may extend the resolution time frame by up to fourteen (14) calendar days if the Member requests the extension, or the Plan shows (to the satisfaction of the MQD, upon its request for review) that there is need for additional information and how the delay is in the Member’s interest. For any extension not requested by a Member, the Plan will give the Member written notice of the reason for the delay.

The Plan will include the following in the written notice of the resolution:

- The results of the Appeal process and the date it was completed;
- The specific reason for the Appeal decision in easily understandable language with reference to the benefit provision, guideline, protocol or other similar criteria on which the Appeal decision was based;
- For Appeals not resolved wholly in favor of the Member:
  - The right to request a State administrative hearing, and clear instructions about how to access this process;
  - The right to representation;
  - The right to request an expedited State administrative hearing if applicable;
  - The right to request to receive Services while the hearing is pending and how to make the request; and
  - A statement that the Member may be held liable for the cost of those Services if the hearing decision upholds the Plan’s action.

The Plan shall notify the Member, Member’s representative, and Provider in writing within thirty (30) calendar days of the resolution.

For denials based on medical necessity, the criteria used to make the decision will be provided in the letter. The Provider may also request a copy of the clinical rationale used in making the Appeal decision by sending a written request to the Appeals address listed in the decision letter.

**Expedited Appeal Process**

The Plan maintains an expedited review process for Appeals. The Member, Member’s authorized representative or a Provider acting on behalf of the Member with the Member’s consent may file an expedited Appeal either verbally or in writing. No additional written follow-up will be required. An expedited appeal is only appropriate when the Plan determines or the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member’s life, health or ability to attain, maintain or regain maximum function. A request for payment of Services already provided to a Member is not eligible to be reviewed as an expedited Appeal.
The Plan ensures that punitive action is not taken against a Provider who requests an expedited resolution or who supports a Member’s Appeal.

For expedited resolution of an Appeal, the Plan will resolve the Appeal and provide written notice to the affected parties as expeditiously as the Member’s health condition requires, but no more than three (3) business days from the time the Plan received the Appeal. The Plan will make reasonable efforts to also provide verbal notice to the Member with the Appeal determination.

The Plan may extend the expedited Appeal resolution time frame by up to fourteen (14) calendar days if the Member requests the extension or the Plan needs additional information and demonstrates to the MQD that the extension of time is in the Member’s interest.

The Plan will notify the MQD by phone and in writing within twenty-four (24) hours regarding expedited Appeals if an expedited Appeal has been granted by the Plan or if an expedited Appeal time frame has been requested by the Member or the Plan.

The Plan will provide the reason it is requesting a fourteen (14) additional day extension to the MQD. The Plan will notify the MQD within twenty-four (24) hours (or sooner if possible) from the time the expedited Appeal is upheld.

For any extension not requested by the Member, the Plan will give the Member written notice of the reason for the delay. If the Plan denies a request for expedited resolution of an Appeal, it will:

- Transfer the Appeal to the time frame for standard resolution;
- Make reasonable efforts to give the Member prompt oral notice of the denial;
- Follow-up within two (2) calendar days with a written notice; and
- Inform the Member verbally and in writing that they may file a Grievance with the Plan for the denial of the expedited process.

Reversal of Denial of an Expedited Appeal Decision
If the Plan overturns its initial action and/or the denial, it will issue authorization to cover the requested Service, and notify the Member verbally followed with written notification of the Appeal decision within three (3) business days of receipt of the expedited Appeal request.

Affirmation of Denial as an Expedited Appeal Decision
If the Plan affirms its initial action and/or denial (in whole or in part), it will:

- Issue a Notice of Adverse Action (Final Appeal Denial Notice) to the Member and/or appellant, the Member’s appointed representative, if applicable, the Member’s Provider and all parties involved;
- Include in the Notice the specific reason for the Appeal decision in easily understandable language with reference to the benefit provision, guideline, protocol or other similar criteria on which the Appeal decision was based; and
- Inform the Member:
  - Of the right to request a State Administrative Hearing and how to do so;
  - Of the right to representation;
  - Of the right to continue to receive benefits pending a State Administrative Hearing (if applicable); and
That the Member may be liable for the cost of any continued benefits if the Plan’s action is upheld.

The Plan will provide the Member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The Plan will inform the Member of limited time available to present this information.

**DHS Administrative Hearing for Regular Appeals**

If the Member is not satisfied with the Plan’s written Notice of Disposition of the Appeal, he or she may file for a DHS administrative hearing within thirty (30) calendar days of the final decision by the Plan. At the time of the denied Appeal determination, the Plan will inform the Member, the Member’s authorized representative, the Provider acting on behalf of the Member or the representative of a deceased Member’s estate that he or she may access the DHS administrative hearing process. The Member has a right to representation at the DHS administrative hearing to include, at a minimum, the Member themselves or they may use legal counsel, a relative, a friend, or other spokesperson.

The Member, or his or her authorized representative, may access the State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) within thirty (30) calendar days of receipt of the Member’s Appeal determination of the following address:

**State of Hawai‘i Department of Human Services**

**Administrative Appeals Office**

PO Box 339
Honolulu, HI 96809-0339

The State will reach its decision within ninety (90) calendar days of the date the Member filed the request for an administrative hearing with the DHS.

The disposition of the Appeal at the DHS administrative hearing level shall take precedence over the Plan’s decision of the Appeal.

**Expedited DHS Administrative Hearings**

The Member may file for an expedited DHS administrative hearing only when the Member requested or the Plan has provided an expedited Appeal process and the Appeal decision was determined to be adverse to the Member (denied). In these situations, the Plan will inform the Member that he or she must submit a letter to the AAO within thirty (30) calendar days from the receipt of the Member’s Appeal determination.

An expedited DHS administrative hearing must be heard and determined within three (3) business days after the date the Member filed the request for an expedited State administrative hearing with no opportunity for extension on behalf of the State. The Plan will collaborate with the State to ensure that the best results are provided for the Member and to ensure that the procedures are in compliance with State and Federal regulations.

In the event of an expedited DHS administrative hearing, the Plan will submit information that was used to make the determination, e.g., medical records, written documents to and from the Member, Provider notes, etc. The Plan will submit this information to the MQD within twenty-four (24) hours of the decision to deny the expedited Appeal.
Continuation of Benefits During an Appeal or DHS Administrative Hearing

The Plan will continue the Member’s benefits if:

- The Member requests an extension of benefits;
- The Appeal or request for State administrative hearing is filed in a timely manner, meaning on or before the later of the following:
  - Within ten (10) calendar days of the Plan mailing the notice of adverse action;
  - The intended effective date of the Plan’s proposed adverse action;
- The appeal or request for State administrative hearing involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider; and
- The original authorization period has not expired.

If the Plan continues or reinstates the Member’s Services while the Appeal or DHS administrative hearing is pending, the Plan will continue all benefits until one of the following occurs:

- The Member withdraws the appeal;
- The Member does not request a State administrative hearing within ten (10) calendar days from when the Plan mails a notice of adverse action;
- A State administrative hearing decision adverse to the Member is made; or
- The authorization expires or authorization service limits are met.

If the final resolution of the State administrative hearing is adverse to the Member, that is, upholds the Plan’s adverse action, then the Plan may recover the cost of the appealed Services (those Services furnished to the Member at the Member’s request while the Appeal was pending).

If the Plan or the State reverses a decision to deny, limit or terminate Services that were not furnished while the Appeal was pending, the Plan will authorize or provide these disputed Services promptly, and as expeditiously as the Member’s health condition requires.

If the Plan or the State reverses a decision to deny authorization of Services and the Member received the disputed Services while the Appeal was pending, the Plan shall pay for those Services.

Provider Grievance

The Plan has a Provider Grievance process that provides for the timely and effective resolution of a Grievance submitted by a Provider. Provider Grievances include a Provider’s expression of dissatisfaction about issues related to availability of Services from the Plan to a Member, such as delays in obtaining or inability to obtain emergent/urgent services, medications, specialty care, and ancillary services such as transportation and/or medical supplies.

Provider Grievances shall be resolved within sixty (60) calendar days following the date of submission to the Plan. The Plan shall give the Provider thirty (30) calendar days from the decision of the Grievance to file an Appeal.

A Provider may file a written Grievance to dispute the Plan’s policies, procedures or any aspect of its administrative functions, including proposed actions, no later than thirty (30)
calendar days from the date the Provider becomes aware of the issue generating the grievance.

Provider Grievances may be filed in writing via mail or faxed to:

‘Ohana Health Plan  
Attn: Grievance Department  
949 Kamokila Boulevard, Suite 350  
Kapolei, HI 96707  
Fax: 1-866-388-1769

A Provider Grievance will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying the Plan’s written policies and procedures.

The Plan will also ensure that the appropriate Plan executives with the authority to implement corrective action are involved in the Provider Grievance process. In the event the outcome of the review of the Provider Grievance is adverse to the Provider, the Plan shall provide a written notice of adverse action to the Provider.

A Provider may also contact the Plan’s Customer Service Department at the toll-free telephone number (found at the bottom of this page), where dedicated Customer Service Representatives are available to answer questions, assist in filing a Provider Grievance and resolve any issues. The appropriate Customer Service Department contact information can be found in the Quick Reference Guide which is available on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

**Provider Payment Dispute/Administrative Appeals**

Although it is our intent to satisfy you as a Plan Participating Provider, the Plan recognizes that there may be instances where you need to file a Grievance or Appeal a decision. The Plan claims payment resolution procedure is outlined below and is in compliance with the State of Hawai‘i Department of Commerce and Consumer Affairs Regulations.

**Verbal Inquiries**

A Provider may make a verbal claim inquiry to check the status of a previously submitted claim by contacting Provider Services during normal business hours. Please refer to the Quick Reference Guide located on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources for contact information.

**Electronic Inquiries**

The Plan has the capability to receive an ANSI X12N 276 health claim status inquiry and generate an ANSI X12N 277 health claim status response. For more information on conducting these transactions electronically, please contact our EDI Assistance line which is listed in the Quick Reference Guide located on the Plan’s website.

**Informal Claim Payment Resolution Procedure – Adjustment Requests**

An informal claim resolution procedure precedes the formal claim resolution procedure. The informal claim resolution procedure allows Providers to make Complaints verbally, in written correspondence, faxes, Web inquires and emails.
In order to resolve claims issues, verbal or written requests by Participating Providers must be received by the Plan within one hundred and twenty (120) calendar days from receipt of the EOP. Non-participating Providers have three hundred and sixty-five (365) days from receipt of the EOP.

The informal claim resolution process can be used for the following claim issues:
- Deletions in claims payments;
- Denial of claims;
- Claims not paid correctly; and
- Any aspect of claims functions, including proposed actions.

The Plan will review the claim or claim-related issue for resolution and respond to the Provider within sixty (60) calendar days after the date of submission to the Plan.

The Plan will maintain a log of all informally filed Provider claim Grievances. The logged information will include the Provider's name, date of the Grievance, nature of the Grievance and disposition.

To initiate the informal claim resolution procedure, a Provider should contact Provider Services either verbally or in writing. The appropriate contact information is found in the Quick Reference Guide posted on the Plan’s Provider website.

**Formal Claim Resolution Procedure**

In the event the disputed claim for informal resolution is not resolved to the Provider’s satisfaction within sixty (60) calendar days after the Provider commenced the informal claim resolution procedure, the Provider will have thirty (30) calendar days from that point to submit the matter to the formal claim resolution procedure by submitting a written explanation to include additional information outlining specific details that may justify reconsideration of the disputed claim.

The Plan’s receipt of the Provider’s written notice initiates the formal claim resolution process. The Provider must submit written notice that specifies the basis of the formal claim dispute and includes the EOP to the claim Appeals fax or mailing address that appears on the Quick Reference Guide.

A panel of one or more individuals selected by the Plan will conduct the formal claim resolution procedure within ten (10) business days of receipt of the written formal review request. Any individual who has been involved in any previous consideration of the dispute may not be on the Plan panel. Panel Member must be knowledgeable about the policy, legal and clinical issues involved in the matter.

The Plan’s Medical Director or another licensed physician designated by the Medical Director may serve as a consultant to the panel. The panel will inform the Provider of the opportunity to appear in person before the panel or to communicate with the panel if the Provider is unable to appear in person.

Within ten (10) business days of the initial receipt of the Provider’s written formal review request, the panel will deliver the Plan’s written determination of the dispute to the Provider. The written determination will include, as applicable, a detailed explanation of the factual, legal policy and clinical basis of the panel’s determination.
The Plan will maintain a log of all formally filed Provider claim disputes. The logged information will include the Provider’s name, date of dispute, nature of dispute and disposition. The Plan will submit annual reports to the DHS regarding the number and type of Provider disputes.

Providers may access a timely payment dispute resolution process. A payment dispute is any dispute between the Provider and the Plan for reason(s) including, but not limited to, requests for additional explanation as to Services rendered by the Provider, inappropriate or unapproved referrals initiated by the Provider, billing disputes, timely filing and notification/preauthorization issues. No action is required by the Member.

**Administrative Appeals**

An administrative Appeal is a payment dispute between Provider and the Plan for Services already provided where the Provider does not agree with the results of the Plan’s claim adjudication. No action is required by the Member. Administrative Appeals include Appeals received from a Provider without Member consent that are related to a Medical Necessity determination.

Providers will not be penalized for filing a payment dispute. Appeals must be submitted in writing to the Plan’s Appeals Department. The letter must detail the reason for the Appeal and be accompanied by any and all supporting documentation, such as the EOP and/or medical records. The Appeals Department will receive, distribute and coordinate all administrative Appeals. Appeals may be mailed to:

‘Ohana Health Plan  
PO Box 31368  
Tampa, FL 33631-3368

The Provider should file an Appeal, which must be received within ninety (90) calendar days of the paid date of the Provider’s EOP.

The Appeals Department will research and determine the current status of a payment dispute. If additional information is needed, a letter will be sent to the Provider. If the requested information is not received within sixty (60) calendar days, the Appeals Department will send a denial letter to the Provider.

Payment disputes received with supporting clinical documentation will be retrospectively reviewed. Established clinical criteria will be applied to the payment dispute. After retrospective review, the payment dispute may be approved or forwarded to the Plan Medical Director for further review and resolution.

- The Provider must submit a written Appeal to the Appeals Department with all applicable documentation supporting the Provider’s position regarding the adjudication of the claim. The written Appeal must be received within ninety (90) calendar days of the Provider’s EOP.
- The Appeals Department will render a written determination within sixty (60) calendar days of the receipt of the Appeal.
- If additional information is requested, the Provider must submit the additional information within sixty (60) calendar days. If the information is not received within sixty (60) calendar days, the Appeal will be denied and closed because of incomplete information.
Questions regarding the Provider payment dispute process should be directed to your Provider Relations Representative, or contact Provider Services. Refer to the Quick Reference Guide for contact information.

**Submission of Provider Termination Appeal Request**

If a Provider termination is initiated by the Plan, regardless of whether the termination is for cause or not, the Plan will notify the Provider of the termination decision in writing, via certified mail, of the reason. Providers will be informed as to their right to Appeal the action and the process and timing for reconsideration of the termination decision. The Appeal request must be filed within 30 calendar days of receipt of the Plan’s termination notice. The Plan will send an acknowledgement letter to the Provider within five (5) business days of receipt of the Appeal request. The Plan may request additional information from the Provider in order to review the Appeal. If this is the case, the Provider has ten (10) business days to submit the required documentation. If the documentation is not received within ten (10) business days, the Plan will continue to process the Appeal. A panel will review the Appeal request and, upon determination, send an outcome letter to the Provider stating that the Appeal has been overturned or upheld.

**Termination Overturned**

If the Plan overturns the termination of the Provider, the Plan will ensure that there is no lapse in the period of the Provider’s participation with the Plan.

**Termination Upheld**

If the Plan upholds its termination of the Provider, the Plan will notify Members thirty (30) calendar days prior to and no later than five (5) business days after the termination effective date of their assigned PCP. Members will be requested to select a new PCP within thirty (30) calendar days. If the Member does not respond, a new PCP will be assigned to the Member. The Member will be notified in writing of their new PCP and given a choice to change their PCP by contacting Customer Service.

The Plan will also notify Members of the termination of a participating hospital, specialist or a significant ancillary Provider within the service area that has been seen two (2) or more times within the past twelve (12) months, thirty (30) calendar days prior to and no later than five (5) business days after the termination effective date.
IX. Delegated Entities

Overview
The Plan’s compliance responsibilities extend to entities that, by written contract, perform functions or services on behalf of the Plan (commonly called delegated entities). While certain activities may be delegated, the Plan is ultimately responsible and accountable to the federal and state agencies for all services performed by its delegated entities. It is the sole responsibility of the Plan to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and Plan policies and procedures.

Compliance
The Plan’s compliance responsibilities extend to delegated entities, including, without limitation:
- Compliance Plan;
- HIPAA Privacy and Security;
- Fraud, Waste and Abuse Training;
- Cultural Competency Plan; and
- Disaster Recovery and Business Continuity.

Refer to Section X Compliance for additional information on compliance requirements.

The Plan ensures compliance through the delegation oversight process and the Delegation Oversight Committee (DOC). The DOC and its committee representatives:
- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs;
- Ensure that the Plan has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and the Plan, reporting requirements, and delegated activities in a clear and understandable manner;
- Ensure that the appropriate Plan associates have properly evaluated the entity’s ability to perform the delegated activities prior to delegation;
- Provide formal audits and ongoing monitoring of the entity’s performance at least annually, including evaluation to ensure quality of care and quality of service are not compromised by financial incentives;
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity’s performance is inadequate;
- Assure the delegated entity is in compliance with the requirement in 42 CFR 438.8;
- Assure that each delegated subcontract:
  - Incorporates all the provisions of the Hawai’i Contract to the fullest extent applicable to the service or activity delegated pursuant to the delegated subcontract, including without limitation, the obligation to comply with all applicable federal and state law and regulations, all rules, policies and procedures as defined in the Hawai’i Contract, and all standards governing the provision of Covered Services and information to Member, all QUEST Integration Program requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of Finance, the MQD, the OIG, the Attorney General, and other authorized federal and state agents to inspect,
investigate, monitor and audit operations, all indemnification and insurance requirements, and all obligations upon termination;

- Provides for the Plan to monitor the delegated subcontractor’s performance on an ongoing basis, including those with accreditation; the frequency and method of reporting to the Plan, the process by which the Plan evaluates the delegated subcontractor’s performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;

- Provides a process for the delegated subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action;

- Specifies the remedies up to and including, revocation of the delegated subcontract available to the Plan if the delegated subcontractor does not fulfill its obligations;

- Requires the subcontractor submit to the Plan a tax clearance certificate from the Director of DOTAX, State of Hawai‘i, showing that all delinquent taxes, if any, levied or accrued under state law against the subcontractor have been paid;

- Fulfills the requirements of 42 CFR 434.6 that are appropriate to the service delegated under the subcontract;

- Track and report complaints against them to the Plan;

- Fully adheres to the privacy, confidentiality and other related requirements stated in the Hawai‘i contract and in applicable federal and state law;

- Notifies the Plan of all breaches of confidential information relating to Plan Member;

- Specifies that delegated subcontractor agrees to submit encounter records in the format specified by MQD so that the Plan can meet the State’s specifications required by the State Contract;

- Specifies that a delegated subcontractor with NCQA®, URAC, or other national accreditation shall provide the Plan with a copy of its current certificate of accreditation together with a copy of the survey report; and

- Contains provisions that suspected fraud and abuse be reported to the Plan.
X. Compliance
‘Ohana Health Plan’s Compliance Program

Overview
The Plan maintains a Corporate Compliance Program that promotes ethical conduct in all aspects of the company’s operations and ensures compliance with Plan policies and applicable federal and state regulations. The Compliance Program includes information regarding the Plan’s policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by the Plan, Plan employees, contractors (including delegated entities), and business partners in an ethical and legal manner. All Providers, including Provider employees and Provider subcontractors and their employees, are required to comply with the Plan’s compliance program requirements.

The Plan’s compliance-related training requirements include, but are not limited to, the following initiatives:

- Corporate Integrity Agreement (CIA) Training
  - Effective April 26, 2011, the Plan’s CIA with the OIG of the United States Department of Health and Human Services (DHHS) requires that the Plan maintain and build upon its existing Compliance Program and corresponding training.
  - Under the CIA, the degree to which individuals must be trained depends on their role and function at the Plan.

- HIPAA Privacy and Security Training
  - To encompass privacy and security requirements in accordance with the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
  - Must include, but not limited to:
    - Uses and Disclosures of PHI;
    - Member Rights; and
    - Physical and technical safeguards.

- Fraud, Waste and Abuse (FWA) Training
  - Must include, but not limited to:
    - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.);
    - Obligations of the Provider including Provider employees and Provider sub-contractors and their employees to have appropriate policies and procedures to address fraud, waste, and abuse;
    - Process for reporting suspected fraud, waste and abuse;
    - Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
    - Types of fraud, waste, and abuse that can occur.

- Cultural Competency Training
  - Programs to educate and identify the diverse cultural and linguistic needs of the Members Providers serve.

- Disaster Recovery and Business Continuity
  - Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short-term or long-term interruption of services.
Providers, including Provider employees and/or Provider sub-contractors, must report to the Plan any suspected fraud, waste or abuse (FWA), misconduct or criminal acts by the Plan, or any Provider, including Provider employees and/or Provider sub-contractors, or by Plan Members. Reports may be made anonymously through the Plan FWA hotline at 1-866-678-8355.

Details of the corporate ethics and compliance program may be found on the Plan’s corporate website at [www.wellcare.com/aboutus](http://www.wellcare.com/aboutus).

**Marketing Hawai‘i Medicaid Plans**
The Plan is required to submit marketing materials to DHS for approval prior to use or distribution. Participating Providers are required to submit to the Plan any marketing materials developed and distributed related to the Medicaid program.

The Department holds the Plan responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting Providers. Providers are not authorized to engage in any marketing activity on behalf of the Plan without the express written consent of an authorized Plan representative, and then only in strict accordance with such consent.

Providers should act within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member’s health status, medical care or treatment or non-treatment options, including any alternative treatment options, including those that may not be covered by the Plan.

**Code of Conduct and Business Ethics**

**Overview**
The Plan has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. The Plan’s Code of Conduct and Business Ethics policy can be found on the Plan’s corporate website at [www.wellcare.com/aboutus](http://www.wellcare.com/aboutus).

The Code of Conduct and Business Ethics is the foundation of iCare, the Plan's Corporate Ethics and Compliance Program. It describes the Plan's firm commitment to operate in accordance with the laws and regulations governing our business and accepted standards of business integrity. All Providers should familiarize themselves with the Plan's Code of Conduct and Business Ethics. Participating Providers and other contractors of the Plan are encouraged to report compliance concerns and any suspected or actual misconduct. Report suspected fraud, waste and abuse by calling the Plan FWA hotline at 1-866-678-8355.

**Fraud, Waste and Abuse (FWA)**
The Plan is committed to the prevention, detection and reporting of health care FWA according to applicable federal and state statutory, regulatory and contractual requirements. The Plan has developed an aggressive, proactive FWA program designed to collect, analyze and evaluate data in order to identify suspected FWA. Detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.
Federal and state regulatory agencies, law enforcement, and the Plan vigorously investigate incidents of suspected fraud, waste and abuse. Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians’ CPT, the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, Providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in FWA may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

Participating Providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504), Providers and their employees must complete an annual FWA training program.

To report suspected FWA, call our confidential and toll-free Plan compliance hotline 1-866-678-8355. Details of the corporate ethics and compliance program, and how to contact the Plan FWA hotline, may be found on Plan’s corporate website at www.wellcare.com/aboutus.

Confidentiality of Member Information and Release of Records
Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Member or his/her case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the HIPAA privacy and security rules and regulations, as may be amended. All Provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of Members’ medical records and other PHI; and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every Provider practice is required to provide Members with their Notice of Privacy Practices (NPP). The NPP advises Members how the Provider’s practice may use and share a Member’s PHI and how a Member can exercise his or her health privacy rights. Employees who have access to Member records and other confidential information are required to sign a Confidentiality Statement.

Examples of confidential information include, but are not limited to the following:
- Medical records;
• Communication between a Member and a Provider regarding the Member’s medical care and treatment;
• All personal and/or protected health information as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
• Any communication with other clinical persons involved in the Member’s health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number [SSN], etc.);
• Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
• Any communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

The NPP informs the Member of their rights under HIPAA and how the Provider and/or the Plan may use or disclose the Members’ PHI. HIPAA regulations require each covered entity, such as health care Providers, to provide a NPP to each new patient or Member.

Disclosure of Information
Periodically, Members may inquire as to the operational and financial nature of their health plan. The Plan will provide that information to the Member upon request. Members can request the above information verbally or in writing.

For more information on how to request this information, Members may contact the Plan’s Customer Service using the toll-free telephone number found on the Member’s ID card. Providers may contact the Plan’s Customer Service by referring to the Quick Reference Guide which may be found on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

Cultural Competency Program and Plan

Overview
The purpose of the Cultural Competency program is to ensure that the Plan meets the unique, diverse needs of all Members, to ensure that the associates of the Plan value diversity within the organization, and to see that Members in need of linguistic services have adequate communication support. In addition, the Plan is committed to having our Providers fully recognize and care for the culturally diverse needs of the Member they serve.

The objectives of the Cultural Competency program are to:
• Identify Members that have potential cultural or linguistic barriers for which alternative communication methods are needed;
• Utilize culturally sensitive and appropriate educational materials based on the Member’s race, ethnicity and primary language spoken;
• Make resources available to meet the unique language barriers and communication barriers that exist in the population;
• Help Providers care for and recognize the culturally diverse needs of the population;
• Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served; and
• Decrease health care disparities in the minority populations we serve.
Culturally and linguistically appropriate services (CLAS) are health care services that are respectful of, and responsive to, cultural and linguistic needs. The delivery of culturally competent health care and services requires health care Providers and/or their staff to possess a set of attitudes, skills, behaviors and policies which enable the organization and staff to work effectively in cross-cultural situations.

The components of the Plan's Cultural Competency program include:

- **Data Analysis**
  - Analysis of claims and encounter data to identify the health care needs of the population; and
  - Collection of Member data on race, ethnicity and language spoken.

- **Community-Based Support**
  - Outreach to community-based organizations which support minorities and the disabled to ensure that the existing resources for Member are being used to their full potential.

- **Diversity and Language Abilities of Health Plan Staff**
  - Non-Discriminating – The Plan may not discriminate with regard to race, religion or ethnic background when hiring associates;
  - Recruiting – The Plan recruits diverse talented associates in all levels of management; and
  - Multilingual – The Plan recruits bilingual associates for areas that have direct contact with Members to meet the needs identified, and encourages Providers to do the same.

- **Diversity of Provider Network**
  - Providers language abilities are captured upon credentialing and this information is made available in the Provider Directory so that Member can choose a Provider that speaks their primary language; and
  - Providers are recruited to ensure a diverse selection of Providers to care for the population served.

- **Linguistic Services**
  - Providers will identify Members that have potential linguistic barriers for which alternative communication methods are needed and will contact the Plan to arrange appropriate assistance;
  - Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer Service Department;
  - Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by the Plan's Customer Service Department; and
  - Written materials are available for Members in large print format, and certain non-English languages, prevalent in the Plan's service areas.

- **Electronic Media**
  - Telephone system adaptations – Members have access to the TTY line for hearing impaired services. The Plan’s Customer Service Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY telephone number can be found on the Member identification card.

- **Provider Education**
o The Plan’s Cultural Competency Program provides a Cultural Competency Checklist to assess the Provider office’s Cultural Competency;

o For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training on the Plan’s website at www.ohanahealthplan.com/provider;

o A paper copy, at no charge, may be obtained upon request by contacting Customer Service or your Provider Relations representative; and

o Providers must adhere to the Cultural Competency Program as set forth above.

Cultural Competency Survey
You may access the Cultural Competency Survey on the Plan’s corporate website at www.ohanahealthplan.com/provider/medicaid/forms.
XI. Behavioral Health

Overview
The Plan provides a behavioral health benefit for Medicaid Members. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Some specialty behavioral health services may be provided outside of the health plan benefit. The Plan can assist with coordination and/or referral to these services.

Behavioral Health Program
Behavioral health services requiring Prior Authorization include:
- Acute Inpatient;
- Partial Hospitalization Program;
- Intensive Outpatient Program;
- ECT treatment; and
- Psychological testing.

Behavioral health services that do not require Prior Authorization:
- Psychiatric or psychological evaluation;
- Physician services including medication management;
- Outpatient counseling and therapy; and
- Methadone treatment services.

In the event the Member is in need of a referral to a behavioral health Provider, contact Customer Service.

Behavioral Health Services for Hawai‘i Medicaid Adult Members
Adult Medicaid Member aged twenty-one (21) years or older with a diagnosis of serious mental illness (SMI) or a severe and persistent mental illness (SPMI) may be eligible for additional behavioral health services from the Department of Human Services’ Community Care Services (CCS) program offered by ‘Ohana Health Plan.

CCS shall provide to its adult Member a full range of specialized behavioral health services including inpatient/outpatient therapy and tests to monitor the Member’s response to therapy. Adult Members who are receiving services through CCS that require alcohol and/or drug abuse treatment may also receive these services through CCS.

Member eligibility for additional services will be regularly assessed. Members who have not been assessed to be eligible or lose eligibility for these services may continue to utilize the standard behavioral health services offered by the Plan.

Members and Providers can contact ‘Ohana Customer Service, or get a referral to a service coordinator to inquire about a CCS eligibility determination. CCS referral packets are completed by a licensed behavioral health clinician, reviewed by the Plan for completeness and forwarded to MQD for eligibility review.

Continuity and Coordination of Care Between Medical Care and Behavioral Health Care
PCPs may provide any clinically and medically necessary appropriate behavioral health services within the scope of their practice. Conversely, behavioral health Providers may provide physical health care services if they are medically necessary and when they are licensed to do so within the scope of their practice. Behavioral Providers are required to use the DSM-IV multi-axial classification when assessing the Member for behavioral health services and document the DSM-IV diagnosis and assessment/outcome information in the Member’s medical record.

Behavioral health Providers are required to submit, with the Member’s or Member’s legal guardian’s consent, an initial and quarterly summary report of the Member’s behavioral health status to the PCP. Communication with the PCP should occur more frequently if clinically indicated. The Plan encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization (the Plan recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to the PCP). Please send this communication, with the properly signed consent, to the Member’s identified PCP noting any changes in the treatment plan on the day of discharge.

We strongly encourage open communication between PCPs and behavioral health Providers. If a Member’s medical or behavioral condition changes, the Plan expects that both PCPs and behavioral health Providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between Providers. At this time, a release of information (ROI) may need to be obtained to communicate this information. It is strongly recommended that the PCP obtain this ROI as soon as possible.

To maintain continuity of care, patient safety and Member well-being, communication between behavioral health care Providers and medical care Providers is critical, especially for Members with co-morbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and impact Member outcomes.

**Responsibilities of Behavioral Health Providers**
All Members receiving inpatient psychiatric services must be scheduled for a behavioral health outpatient follow-up and/or continuing treatment, *prior to discharge*, which includes the specific time, date, place, and name of the Provider to be seen. The outpatient treatment must occur within seven (7) days from the date of discharge.

In the event that a Member misses an appointment, the behavioral health Provider must contact the Member within twenty-four (24) hours to reschedule. Providers may contact the Plan for assistance in contacting Members when needed.
XII. Pharmacy

Overview
The Plan’s pharmaceutical management procedures are an integral part of the pharmacy program that ensure and promote the utilization of the most clinically appropriate agent(s) to improve the health and well-being of our Members. The UM tools that the Plan uses to optimize the pharmacy program include:

- Preferred Drug List (PDL);
- Mandatory Generic Policy;
- Step Therapy (ST);
- Quantity Limit (QL);
- Age Limit (AL);
- Coverage Determination Review Process;
- Pharmacy Lock-In Program;
- Network Improvement Program (NIP); and
- Exactus Pharmacy Solutions™

These processes are described in detail below. In addition, prescriber and Member involvement is critical to the success of the pharmacy program. To help your patient get the most out of their pharmacy benefit, please consider the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions, e.g., National Institutes of Health (NIH) Asthma guideline, Joint National Committee (JNC) VIII Hypertension guidelines;
- Prescribe drugs listed on the PDL;
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class; and
- Evaluate medication profiles for appropriateness and duplication of therapy.

To contact the Plan’s Pharmacy Department, please refer to the Quick Reference Guide on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/resources.

Preferred Drug List
The Plan’s PDL is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmacy and Therapeutics Committee (P&T Committee). The PDL denotes any of the pharmacy UM tools that apply to a particular pharmaceutical.

The P&T Committee selects drugs based on the drug efficacy, safety, side effects, pharmacokinetics, clinical literature and cost effectiveness profile. The medications on the PDL are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, age limitation, Prior Authorization and step therapy).

The PDL can be found on the Plan’s website at www.ohanahealthplan.com/provider/drug_list. Changes to the PDL and applicable pharmaceutical management procedures are communicated in advance to Providers as the following:

- Quarterly updates in Provider newsletters;
- Website updates, including P&T PDL Change notices; and/or
• Pharmacy and Provider communication that detail any major changes to a particular therapy or therapeutic class

Additions and Exceptions to the Preferred Drug List
Providers may request consideration for addition of a drug to the Plan’s PDL by writing to the Plan and explaining the medical justification. For contact information, refer to the Quick Reference Guide at www.ohanahealthplan.com/provider/medicaid/resources.

For more information on requesting exceptions, refer to the Coverage Determination Review Process on page 96.

State Exceptions
In accordance with Section 346-59.9, HRS, a member shall not be denied access to, or have any limitations on, any medication that is required to be covered by statute, including antipsychotic medications and continuation of antidepressant and anti-anxiety medications prescribed by a licensed psychiatrist or physician duly licensed in the State for U.S. Food and Drug Administration (FDA) approved indication as treatment of a mental or emotional disorder. Similarly, in accordance with Section 346-352, HRS, any physician licensed in the State who treats a member suffering from the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or a member in need of transplant immunosuppressives, shall be able to prescribe any medications approved by the FDA, that are eligible pursuant to the Omnibus Budget Reconciliation Rebates Act, and necessary to treat the conditions, without having to comply with the restrictions of any preauthorization procedures.

Generic Medications
The use of generic medications is a key pharmaceutical management tool. Generic drugs are equally effective and generally less costly than their brand name counterparts. Their use can contribute to cost-effective therapy.

Generic drugs must be dispensed by the pharmacist when available as the therapeutic equivalent to a brand name drug. To request an exception to the mandatory generic policy, a Coverage Determination Request form should be submitted. Clinical justification as to why the generic alternative is not appropriate for the Member should be included with the Coverage Determination Request form.

For more information on the Coverage Determination Review process, including how to access the form, see Coverage Determination Review Process on page 96.

Step Therapy
The P&T Committee has developed step therapy programs. These programs encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before stepping up to less cost-effective alternatives.

Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven, safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on our PDL have been evaluated through the use of clinical literature and are approved by our P&T Committee. Please refer to the PDL to view drugs requiring step therapy.
Quantity Limits
Quantity limits are used to ensure that pharmaceuticals are supplied in a quantity consistent with the Food and Drug Administration (FDA) approved dosing guidelines. Quantity limits can also be used to help prevent billing errors. Please refer to the PDL to view drugs with quantity limits.

Age Limits
Some medications have an age limit associated with them. The Plan uses age limits to ensure proper medication utilization when necessary. Please refer to the PDL to view drugs with age limits.

Over-the-Counter (OTC) Medications
The Plan will only pay for over-the-counter (OTC) items listed on the PDL that are prescribed to the Member. Examples of OTC items listed on the PDL include:

- Multivitamins/multiple vitamins with iron;
- Iron;
- Non-sedation antihistamines;
- Enteric coated aspirin;
- Diphenhydramine;
- Insulin;
- Topical antifungals;
- Ibuprofen;
- Permethrin;
- Meclizine;
- Insulin syringes;
- Urine test strips;
- H-2 receptor antagonists; and
- Proton Pump Inhibitors.

For a complete listing of OTC medications covered with a prescription, please refer to the PDL which can be found on our website at www.ohanahealthplan.com/provider/drug_list.

Injectable and Infusion Services
Select self-injectable and infusion drugs are covered under the outpatient pharmacy benefit. Most self-injectable products and all infusion drug requests require a Coverage Determination Review using the Injectable Infusion Form.

Approved self-injectable and infusion drugs are covered when supplied by retail pharmacies and infusion vendors contracted with the Plan. Please contact the Pharmacy department regarding criteria related to specific drugs. The specific J-codes of any self-injectable products that do not require authorization when given in a doctor's office are included on the Medical Injectables – No Authorization Required List document located in the Forms and Documents section of the website.

Refer to the Plan’s website at www.ohanahealthplan.com/provider/default for more information. Providers may access the Medical Injectables – No Authorization Required List under the Pharmacy tab on the Provider page, and access the Injectable Infusion Form in the Forms and Documents section on the Provider Resources page.
Coverage Limitations
The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

- Agents used for anorexia, weight gain or weight loss;
- Agents used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Drugs for the treatment of erectile dysfunction;
- DESI drugs or drugs that may have been determined to be identical, similar or related;
- Tuberculosis medications (these are covered by the HI State Department of Health (DOH) Tuberculosis Control program);
- Medications used for Hansen’s Disease (these are covered by the HI State DOH);
- Investigational or experimental drugs; and
- Agents prescribed for any indication that is not medically accepted.

The Plan will not reimburse for prescriptions for refills too soon, duplicate therapy or excessively high dosages for the Member.

Member Co-Payments
There are no co-payments when pharmacy is covered by the Plan for Members with Medicaid-only coverage. Please note many Plan Members will be dually enrolled in Medicare and have pharmacy coverage via their Part D plan. Co-pays under Part D Medicare plans will vary by carrier.

Coverage Determination Review Process (Requesting Exceptions to the PDL)
The goal of the Coverage Determination Review program (also known as Prior Authorization) is to ensure that medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications. The Coverage Determination Review process is required for:

- Duplication of therapy;
- Prescriptions that exceed the FDA daily or monthly quantity limit;
- Most self-injectable and infusion medications (including chemotherapy);
- Drugs not listed on the PDL;
- Drugs that have an age limit;
- Drugs listed on the PDL but still require Prior Authorization (PA);
- Brand name drugs when a generic exists; and
- Drugs that have a step therapy edit (ST) and the first-line therapy is inappropriate.

Providers may request an exception to the Plan’s PDL orally or in writing. For written requests, Providers should complete a DER Form supplying pertinent Member medical history and information. A Coverage Determination Request form may be accessed on the Plan’s website at www.ohanahealthplan.com/provider/medicaid/forms.

Upon receipt of the Coverage Determination request, a decision is completed within fourteen (14) days for a standard request and within three (3) business days for an expedited request. If authorization cannot be approved or denied, and the drug is
medically necessary, a seven (7) day emergency supply of the non-preferred drug shall be supplied to the Member.

Prior Authorization (PA) protocols are developed and reviewed at least annually by the P&T Committee. These protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). The criteria are available upon request when submitted to the Pharmacy department by the Member or Provider.

**Medication Appeals**

To request an appeal of a Coverage Determination request decision, contact the Pharmacy Appeals department via fax, mail, in person or phone. Refer to the *Quick Reference Guide* which may be found on the Plan’s website at [www.ohanahealthplan.com/provider/medicaid/resources](http://www.ohanahealthplan.com/provider/medicaid/resources).

Once the appeal of the Coverage Determination Review request decision has been properly submitted and obtained by the Plan, the request will follow the appeals process described in *Section VIII Appeals and Grievances.*

**Pharmacy Management – Network Improvement Program (NIP)**

The Pharmacy Network Improvement Program (NIP) is designed to provide physicians with quarterly utilization reports to identify over-utilization and under-utilization of pharmaceutical products. The reports will also identify opportunities for optimizing best practices guidelines and cost-effective therapeutic options. These reports are delivered by the State Pharmacy Director and/or Clinical Pharmacy Manager to physicians identified for the program.

**The Plan’s Specialty Pharmacy – Exactus Pharmacy Solutions™**

The Plan offers specialty pharmacy services to Members who are taking medications to treat long-term, life-threatening or rare conditions. The Exactus Pharmacy Solutions team is expert in the special handling, storage and administration that injectables, infusibles, orals and other medications require. This team knows the insurance process and the Member’s plan benefits. This means less chance of delays in a Member receiving needed medication(s). Prescription orders generally ship directly to the Member’s home, Provider’s office, or alternative address provided by the Member, within twenty-four (24) to forty-eight (48) hours after contacting an Exactus Pharmacy Solutions representative. The actual ship date depends on whether or not Provider discussion is needed about the prescription.

To learn more about the conditions covered under Exactus Pharmacy Solutions, or how to contact them, refer to the Exactus Pharmacy Solutions website at [www.wellcare.com/provider/exactuspharmacysolutions](http://www.wellcare.com/provider/exactuspharmacysolutions).
XIII. Plan Resources – Hawai‘i Medicaid

Medicaid Forms and Documents
www.ohanahealthplan.com/provider/medicaid/forms

Quick Reference Guides
www.ohanahealthplan.com/provider/medicaid/resources

Clinical Practice Guidelines (links to WellCare’s corporate website)
www.wellcare.com/provider/cpgs

Clinical Coverage Guidelines (links to WellCare’s corporate website)
www.wellcare.com/provider/ccgs

Job Aids and Resource Guides
www.ohanahealthplan.com/provider/medicaid/job_aids

Behavioral Health
www.ohanahealthplan.com/provider/behavioral_health

Pharmacy
www.ohanahealthplan.com/provider/pharmacy
XIV. Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the participation agreement you have with the Plan.

“Abuse” means Provider practices that are inconsistent with sound fiscal, business or medical practices that could result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. The definition also includes Member practices that result in unnecessary cost to the Medicaid program.

“Action” means, as defined in 42 CFR 438.400(b), the:
   A. Denial or limited authorization of a requested service, including the type or level of service;
   B. Reduction, suspension or termination of a service previously authorized by the Department, its agent or Contractor;
   C. Denial, in whole or in part, of payment for a service;
   D. Failure to provide services in a timely manner, as defined by the Department;
   E. Failure of an MCO or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 CFR 438.408(b); or
   F. For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside a contractor’s region.

“Appeal” means a request from a Member or Provider to change a previous decision made by the Health Plan.

“Appointed Representative” means a person who is expressly permitted by the enrollee or who has the power under Hawaiʻi law to make health care decisions on behalf of the enrolled, including:
   A. A court-appointed legal guardian;
   B. A person who has a durable power of attorney for health care; or
   C. A person who is designated in a written advance directive.

“Authorization” means an approval of a Prior Authorization request for payment of services, and is provided only after the Plan agrees the treatment is necessary.

“Benefit Plan” means a health benefit policy or other health benefit contract or coverage document (a) issued by the Plan or (b) administered by the Plan pursuant to a government contract. Benefit Plans and their designs are subject to change periodically.

“Carve-Out Agreement” means an agreement between the Plan and a third party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve-Out Agreements include agreements for behavioral health, radiology, laboratory, dental, vision or hearing services.

“Centers for Medicare & Medicaid Services (“CMS”)” means that United States federal agency which administers Medicare, Medicaid and the Children’s Health Insurance Program.
“Clean Claim” means a claim for Covered Services provided to a Member that:
(a) Is received timely by the Plan;
(b) Has no defect, impropriety or lack of substantiating documentation from the Member’s medical record regarding the Covered Services;
(c) Is not subject to coordination of benefits or subrogation issues;
(d) Is on a completed, legible CMS-1500 form or UB-04 form or electronic equivalent that follows then current HIPAA Administrative Simplification ASC X12 837 standards and additional Plan specific requirements in the Plan Companion Guide, including all then-current guidelines regarding coding and inclusive code sets; and
(e) Includes all relevant information necessary for the Plan to:
   (1) Meet requirements of laws and program requirements for reporting of Covered Services provided to Members; and
   (2) Determine epayer liability and ensure timely processing and payment by the Plan. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

“CLIA” means the federal legislation commonly known as the Clinical Laboratories Improvement Amendments of 1988, as found in Section 353 of the federal Public Health Services Act (42 U.S.C. §§ 201, 263a) and regulations promulgated hereunder.

“Companion Guide” means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to the Plan or its affiliates, as amended from time to time. The Plan’s Claims/Encounter Companion Guides are part of the Provider Manual.

“Complaint” means an expression of dissatisfaction, either oral or written.

“Co-Surgeon” means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

“Cost-Effective” means there is no other available intervention that offers a clinically appropriate benefit at a lower cost.

“Covered Services” means items and services covered under a Benefit Plan.

“DHS” means the State of Hawai‘i, Department of Human Services.

“EPSDT” means the Early and Periodic Screening, Diagnostic and Treatment program that provides medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a) to all Members up to the age of twenty-one (21).

“Emergency Medical Condition” means:
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:
• Placing the physical or mental health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
• Serious impairment to bodily functions;
• Serious dysfunction of any bodily organ or part;
• Serious harm to self or others due to an alcohol or drug abuse emergency;
• Injury to self or bodily harm to others; or
• With respect to a pregnant woman having contractions:
  o There is not adequate time to effect a safe transfer to another hospital before delivery; or
  o Transfer may pose a threat to the health or safety of the woman or her unborn child.

“Emergency Medical Services” or “Emergency Care” means services provided to a Member when the Member has symptoms of sufficient severity that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the Member’s health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death. Prior Authorization is not required for these services.

“Encounter Data” means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

“Expedited Appeal” means the internal review of a complaint or grievance of the final internal determination of a Member’s complaint or grievance, which is completed within seventy-two hours after receipt of the request for expedited appeal.

“Explanation of Payment” or “EOP,” (also known as a Remittance Advice) means a Plan-provided document used to communicate to the Provider of a claim determination. The determination may indicate a payment, denial or a request for additional information. An EOP may be accompanied by a check.

“Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

“Grievance” means any complaint or dispute, other than one that involves a Plan determination, expressing dissatisfaction with any aspect of the operations, activities or behavior of the Plan, regardless of whether remedial action can be taken. Grievances may include, but are not limited to complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

“Health Intervention” means an activity undertaken for the primary purpose of preventing, improving or stabilizing a medical condition. Activities that are primarily custodial, part of normal existence or undertaken primarily for the convenience of the patient, family or practitioner are not considered health interventions.

“Health Outcomes” means outcomes of medical conditions that directly affect the length or quality of a person’s life.
“Ineligible Person” means an individual or entity who:
   (a) Is currently excluded, debarred, suspended or otherwise ineligible to participate in:
       (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG; or
       (ii) Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration;
   (b) Has been convicted of a criminal offense subject to OIG’s mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs; or
   (c) Is currently excluded, debarred, suspended or otherwise ineligible to participate in state medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a state governmental authority.

"Internal review" means the review of a Member's complaint or grievance by the Plan.

“LTAC” means a Long-Term Acute Care hospital.

“Medical Condition” means a disease, an illness or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness or injury.

“Medically Necessary” means services that are medically necessary as defined in the Hawai‘i Revised Statutes (HRS) 432E-1.4 or health interventions that health plans are required to cover within the specified categories that meet the criteria below, whichever is least restrictive:
   • The intervention must be used for a medical or psychiatric condition;
   • There is sufficient evidence to draw conclusions about the intervention’s effects on health outcomes;
   • The evidence demonstrates that the intervention can be expected to produce its intended effects on health outcomes;
   • The intervention’s beneficial effects on health outcomes outweighs its expected harmful effects; or
   • The health intervention is the most cost-effective method available to address the medical condition.

“Member” means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

“Member Expenses” means co-payments, coinsurance, deductibles or other cost-share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

“Members with Special Health Care Needs” means Members with special needs and are defined as adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.
“MQD” means the Med-QUEST Division of DHS.

“Notification” means a communication to the Plan from the Provider, with information related to a service rendered to a Member or a Member’s admission to a facility.

“Periodicity” means the frequency with which an individual may be screened or re-screened.

“Periodicity Schedule” means the schedule which defines age-appropriate services and time frames for screenings within the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

“PCP” or “Primary Care Provider” means a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse, physician assistant or health clinic, including a Federally Qualified Health Center (FQHC), primary care center, or Rural Health Center (RHC) that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a Provider possessing admitting privileges, and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals; and for a Member who has gynecological or obstetrical health care needs, a disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

“Prior Authorization” means the process of obtaining authorization in advance of a planned inpatient admission or an outpatient procedure or service. An authorization decision is based on clinical information provided with the request. The Plan may request additional information, including a medical record review.

“Provider” or “Participating Provider” means a licensed or certified Provider of health care services or benefits, including mental health services and health care supplies, that has entered into an agreement with the Plan to provide those services or supplies to Members.

“Referral” means a request by a PCP for a Member to be evaluated and/or treated by a specialty physician.

“Screening” means the review of the health and health-related conditions of a recipient by a health care professional to determine if further diagnosis or treatment is needed.

“Service” means health care, treatment, a procedure, supply, item or equipment.

“Service Location” means any location at which a Member may obtain any Covered Services from a Provider.

“Sufficient Evidence” means evidence considered to be sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.
“**Urgent Care**” means care for a condition not likely to cause death or lasting harm, but for which treatment should not wait for a normally scheduled appointment. Urgent Care services should be provided within twenty-four (24) hours.

“**Zero Cost Share Dual Eligible Member**” means a Dual Eligible Member who is not responsible for paying any Part A or Part B cost sharing.