



PROVIDER RESPONSIBILITIES

Section 2

Overview

This section of the Provider Manual addresses the respective responsibilities of participating providers.

Primary Care Providers

A Primary Care Provider or PCP, is a provider licensed in Hawai'i and is 1) 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; or 2) an advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to the member, for initiating referrals and maintaining the continuity of member care.

The Plan allows specialists or other healthcare practitioners to serve as PCPs for members with chronic conditions, provided:

- The member has selected a specialist with whom he or she has a historical relationship as PCP; and
- The specialist agrees, in writing, to assume responsibility as PCP.

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.

Primary Care Offices

Primary care providers (PCPs) provide comprehensive primary care services to 'Ohana (the Plan) members. Primary care offices participating in the Plan provider network have access to the following Plan services:

- Support of the Provider Relations, Customer Service, Health Services, Community and Member Outreach teams;
- Information on Plan network providers for the purposes of referral management and discharge planning.



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Primary Care Provider Responsibilities

Following is a summary of responsibilities specific to PCPs who render services to Plan members. Please also refer to the listing of responsibilities for all physicians. These are intended to supplement the terms of the provider agreement. PCPs must:

- Coordinate, monitor and supervise the delivery of primary care services for each member.
- Participate in the care 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 care plan development process.
- Arrange for on-call and after-hours coverage in accordance with the after-hours service as outlined in this section.
- Continually educate members regarding how to access services through 'Ohana customer service. Examples of services available through our customer service line are public transportation information (where available), and non-emergency transportation (NET), the nurse advice line, and others.
- Provide the Plan or its designee access to examine the primary care offices, 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.
- 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.

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- Follow the guidelines as outlined in the **Claims Submission** section of this manual.
- Ensure that members utilize network providers. If unable to locate a participating provider for services required, contact the Plan's Customer Service department for assistance.
- See members for an initial office visit and assessment within the first 90 days of enrollment with the plan; for pregnant women, the first 14 days of enrollment.
- Ensure sufficient supply and provide immunizations in accordance with the childhood immunization schedule as approved by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service and the American Academy of Pediatrics, or when it is shown to be medically necessary for the child's health. For a copy of the immunization schedule by the Advisory Committee on Immunization Practice (ACIP), refer to the **Provider Education Materials** section of this manual.
- Have the following equipment available to adequately perform Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) screening exams:
 - i. Weight scale for infants;
 - ii. Weight scale for children and adolescents;
 - iii. Measuring board or device for measuring length or height in the recumbent position for infants and children up to age 2;
 - iv. Measuring board or device for measuring height in the vertical position for children two years old or older;

- v. Blood pressure apparatus with infant, child and adult cuffs;
 - vi. Screening audiometer;
 - vii. Centrifuge or other device for measuring hematocrit or hemoglobin;
 - viii. Eye charts appropriate to children by age;
 - ix. Developmental and behavioral screening tools; and
 - x. Ophthalmoscope and otoscope.
- Participate in the Vaccines for Children (VFC) program for all children younger than 19 enrolled in the QUEST Expanded Access (QExA) program.

Second Medical Opinion

A second medical opinion may be requested at no cost to the member in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. A second opinion may be requested by any member of the health care team, a member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

The second opinion must be provided by a qualified health care professional within the network. If there is not a participating provider with the expertise required for the condition, please contact the Utilization Management department for an authorization

Members With Chronic or Life-Threatening Conditions

Members with chronic conditions are defined as adults and children who have:

- Any ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities;

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- An expected duration of at least 12 months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is normally considered routine.

Physicians who render services to members who have been identified with chronic or life-threatening conditions should:

- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the member's condition or needs;
 - To obtain a standing authorization request the provider should complete the Outpatient Authorization Request Form, located in the forms section of this manual, and document the need for a standing authorization request under the pertinent clinical summary area of the form.
- Coordinate with the Plan 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 to the member.

The Plan allows specialists or other healthcare practitioners to serve as PCPs for members with chronic conditions, provided:

- The member has selected a specialist with whom he or she has a historical relationship as PCP; and
- The specialist agrees, in writing or verbally, to assume responsibility as PCP.

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.

- Ensure that members requiring specialized medical care over a prolonged period of time have access to a specialty care center.
 - Members will have access to a specialty care center through standing authorization requests, if appropriate.

Domestic Violence and Substance Abuse Screening

Physicians should identify indicators of substance abuse or domestic violence. The screening tools for domestic violence and substance abuse are located in the **Provider Education Materials** section of this manual. Should a member need assistance regarding domestic violence, the PCP should direct the member to contact Customer Service and ask to speak with the Service Coordination department.

If a member needs assistance regarding substance abuse, the PCP should direct the member to call the toll free Behavioral Health line for the Plan. Refer to the **Quick Reference Guide** for telephone numbers.

Adult Health Screening

An adult health screening should be performed by a physician to assess the health status of a member 21 or 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 in the 'Ohana Health Plan website and **Provider Education Materials** section of this manual respectively.

EPSDT Guidelines

Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) services shall be provided to QExA-eligible children up to the twenty-first (21st) birthday. All newly enrolled children must receive an initial health and screening visit within 90 calendar days of enrollment and within 24 hours of birth for all newborns. In the case

where the member transfers between QExA 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 'Ohana Health Plan to ensure that the member's immunization rates and preventive visits have been recorded.

EPSDT services include outreach and informing, screening, tracking and diagnostic and treatment services.

Outreach and Education

EPSDT services include:

- Importance of preventive care;
- Periodicity schedule and the depth and breadth of services;
- How and where to access services, including necessary transportation and scheduling services; and
- Services provided without cost.

Newly enrolled families with EPSDT-eligible children will be informed about the program within 60 calendar days of enrollment. This includes informing pregnant women within 21 days after confirmation of pregnancy and new mothers within 14 days after birth that EPSDT services are available.

The Plan will send all PCPs a monthly listing of their EPSDT-eligible children who have not had an EPSDT visit during the initial 180 calendar days of enrollment, and/or are not in compliance with the EPSDT periodicity schedule. PCPs are required to contact the members' parents or guardian by telephone or mail to schedule an appointment.

Screening

Such screens must include all of the following:

- A comprehensive health and developmental history;
- Developmental assessment, including mental, emotional and behavioral health using a validated screening tool recommended by AAP (PEDS or ASQ is recommended);
- Autism screening (18m/24m): use CHAT or MCHAT recommended
- Measurements (including head circumference for infants, Blood Pressure for 3 years and older, BMI and BMI%);
- An assessment of nutritional status;
- A comprehensive unclothed physical exam;
- Immunizations according to the Advisory Committee on Immunization Practices (ACIP);
- Certain laboratory tests (including the federally required blood lead screening);
- Anticipatory guidance and health education;
- Vision screening;
- Tuberculosis and lead risk screening;
- Hearing and language screening;
- Dental and oral health assessment;
- Psychosocial/behavioral assessments for adolescents: alcohol/drug use screening
- Identify children with elevated blood lead levels and recommend follow-up treatment and education; and

- Identify and refer children who may qualify to the Zero-To-Three Program and the Healthy Start Program which the Hawai'i Department of Health (DOH) administers and manages. The Zero-To-Three program provides services for the developmentally delayed, biologically at risk and environmentally at risk children ages 0 to 3. The services are for screening and assessment and home visitation services.

If you would like assistance with referrals to an agency or specialist or with Care Coordination, please call the Health Plan number listed on the EPSDT 8015 forms. Or you may call Customer Service at any time.

Tracking

The Plan will utilize provider encounter data to track information on compliance with EPSDT requirements. The Plan will track at minimum:

- Initial newborn EPSDT visit occurring in the hospital;
- Periodic and preventive/well-child screens and visits as prescribed by the periodicity schedule;
- Diagnostic and treatment services, including referrals;
- Immunizations, lead, tuberculosis and dental services; and
- A reminder/notification system.

Diagnostic and Treatment Services

If through the screening examination a problem is suspected, the child shall be evaluated as necessary for further diagnosis as deemed medically necessary. Such medically necessary diagnostic and treatment services must be provided regardless of whether such services are covered by the state Medicaid plan, as long as they are



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Medicaid-covered services as defined in Title XIX of the Social Security Act.

'Ohana will periodically evaluate member medical records to ensure compliance to EPSDT screening guidelines are met. Providers are randomly selected for chart review based on EPSDT claim submissions. The Medical Records section of this manual provides further information on EPSDT and the scope of the review.

Member Rights and Responsibilities

Plan members have specific rights and responsibilities. These are available to all members in the 'Ohana Member Handbook and are also listed in the Member Services section of this manual. These may be posted in your office for all members to see.

Living Will and Advance Directive

Members have the right to control decisions relating to their medical care, including the decision to withhold or remove medical or surgical procedures to not prolong their life.

Each Plan member 18 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.

Advance Directive forms should be made available in provider's offices, and discussion with the member as well as the completed forms should be documented and filed in the member's medical record. A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

After-Hours Services

The PCP must be available after regular office hours to offer advice and to assess any condition that might require immediate care.

To ensure accessibility and availability, PCPs must provide one of the following:

- A 24-hour answering service to contact the physician; (an answering machine telling members



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to go to the Emergency Room is not appropriate)

- Answering system with option to page the physician; or
- An advice nurse with access to the PCP or on-call physician.

Closing of Physician Panel

When requesting closure of their panel to new and/or transferring Plan members, PCPs must:

- Obtain a waiver from DHS and provide a copy to the Plan.
- Submit the request to the Plan (local Provider Relations), in writing, at least 60 days prior to the effective date of closing his/her panel (or such other period of time provided in their Provider Agreement);
- Maintain his or her panel open to all Plan members who were provided services before the closing of his/her panel; and
- Submit written notice of the re-opening of his/her panel including a specific effective date.

Terminating Physician

Physicians who have chosen to terminate with the Plan will submit the request to the Plan, in writing, at least 60 days prior to the effective date. The Plan will work with the provider to transition the members to another participating provider. During this transition period, the provider may continue to see the member until..... (Jayme/Julie/Kerry, can you help me with this section?)_ need to follow NCQA requirements

Out-of-Area Member Transfers

Participating physicians and 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 Plan physician and/or provider and the out-of-network attending physician. In the same regard, when a member needs to

**PCP Request
for Transfer
of a Member**

transfer care to an out-of-area provider, the participating physicians and providers should assist the Plan in arranging and providing clinical information to the out-of-area provider.

A Plan physician or provider may not seek or request to terminate their 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.

A Plan physician or provider must accept all individuals without restrictions and does not discriminate against individuals on the basis of religion, gender, race, color or national origin and will not use any policy or practice that has the effect of discriminating on the basis of religion, gender, race, color or national origin or on the basis of health, health status, pre-existing condition or need for health care services.

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 or 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 render medical care to the Plan member. Services to the member shall continue until such time written notification is received from the Plan stating that the member has been transferred from the physician's practice.

In the event a participating provider desires to terminate their relationship with a Plan member, the provider should submit adequate documentation to support that they have attempted to maintain a satisfactory provider and member relationship and that the member's non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively.

The provider completes a PCP Request for Transfer of



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Responsibilities of All Providers

Member form, attaching supporting documentation and faxes the form to the Customer Service department. A copy of the form is available in the **Forms** section of this manual.

The remainder of this section of the manual is an overview of responsibilities for which all Plan providers are accountable. Please refer to the Provider Agreement or contact a Provider Relations representative for clarification on any of the following.

Within the scope of the program, providers are required to;

- participate in QI and HEDIS Activities;
- Allow 'Ohana Health Plan, or its representative, access to medical records without a fee, to the extent permitted by state and federal law; and
- Maintain the confidentiality of medical records.
- Comply with professional practice standards and preventive health guidelines for clinical and disease management
- Use appropriate tools to identify early, timely and age-appropriate interventions
- Include the member in development of the treatment process; and
- Comply with the State and Federal Provider regulatory reporting obligations

Providers must, in accordance with generally accepted professional standards:

- Ensure the availability of physician services to members is in accordance with appointment scheduling as outlined in this section.
- Use physician extenders appropriately. Physician assistants (PA) and advanced registered nurse practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the state and Plan guidelines.

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- The sponsoring physician will assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
- ARNPs and PAs should clearly identify their titles to members as well as to other health care professionals.
- Any member request to be seen by a physician, rather than a physician extender, must be honored at all times.
- Make available treatment for any member in need of health care services they provide.
- Refer Plan members with problems outside of their normal scope of practice for consultation and/or care to appropriate specialists contracted with Plan.
- Refer members to participating physicians or providers, except when they are not available or in an emergency.
- Admit members only to participating hospitals, skilled nursing facilities and other inpatient care facilities, except in an emergency.
- Respond promptly to Plan requests for medical records in order to comply with regulatory requirements.
- Inform the Plan in writing within 24 hours of any revocation or suspension of the Bureau of Narcotics and Dangerous Drugs number, and/or suspension, limitation or revocation of his or her license, certification or other legal credential authorizing medical practice in the state of Hawai'i.
- Consistent with the Plan's credentialing and re-credentialing policies, inform the Plan in writing prior to changes in licensure status, tax

identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change that would affect his or her status with Plan. Failure to notify the Plan prior to these changes will result in a delay in claims processing and payment.

- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Plan member, subscriber or enrollee or fees for non-covered services furnished on a “fee-for-service” basis. Non-covered services are services not covered in the member’s Plan contract.
- Maintain the privacy of our member’s Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI includes verbal, written or electronic information that can be used to identify the member and has been created or received about their past, present or future health or condition, the provision of health care or the payment for their health care.
- Apply for and maintain a current a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Maintain accurate medical records and adhere to all Plan policies governing the content and confidentiality of medical records as outlined in the Plan’s Quality Improvement Guidelines. All entries in the member record must identify the date and the rendering provider. Any late entries should include date and time of documentation. Records should not be altered. Corrections should be made by a single line through the inaccurate material, dated and initialed.
- 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 clinical information among Plan providers in a timely manner. 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 upon.
- 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 regimen.
- Not discriminate in any manner between members and non-members.
- 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
- Inform member of specific health care needs that require follow-up and provide, as appropriate, training in self-care and other measures members may take to promote their own health.
- Encourage members to utilize the Personal Health Advisor line (Plan's telephone-based triage program) for free, medical advice 24 hours a day, seven days a week. After the assessment, the health advisor may suggest that the member call or make an appointment to see the PCP. Please refer to the **Quick Reference Guide** for the Plan's Personal Health Advisor telephone number.
- 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.

- The provider 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.
- Consistent with the terms of the provider contract, notice of termination of network participation should be submitted in writing to Plan (local Provider Relations Department) at least 90 days prior to the termination effective date.

During the notice period, the terminating physician(s) must continue to fulfill the obligations of the provider contract and maintain access to care for Plan members including, but not limited to, services defined in the Provider Manual.

The Plan will notify affected members who have been under the ongoing care of the terminating physician(s) no later than 30 days prior to the termination effective date and assist with selection of a new physician as needed.

Continuity of care obligations following contract termination include continuation of active treatment for up to 90 calendar days after the date of termination or until conclusion of the postpartum period for members in the second or third trimester of pregnancy and such other pregnant members as may be required under applicable law.

Specialist Responsibilities

Specialists are responsible for treating Plan members referred to them by the PCP and communicating with the Plan's Health Services department for authorizations. If a specialist becomes a member's PCP, the Specialist is required to follow the requirements of the PCP stated above.



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Confidentiality of Member Information & 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 of the Health Insurance Portability and Accountability Act of 1996, as may be amended (HIPAA).

All physician 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 protected health information (PHI as defined under HIPAA); 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.

PHI includes verbal, written or electronic information that can be used to identify the member, their past, present or future health or condition, the provision of health care, or the payment for their health care. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every practice is required to provide members with information regarding their privacy practices and, to the extent required by law, with their Notice of Privacy Practices (NPP). Employees who have access to member records and other confidential information are required to sign a confidentiality statement.

Some examples of confidential information include:

- Medical records;
- Communication between a member and a physician regarding the member's medical care and treatment;

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- 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;
 - 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 Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or the Plan may use or disclose the members' PHI. HIPAA regulations require each covered entity to provide an NPP to each new patient or member.

Appointment Scheduling

Providers must adhere to the following compliance appointment requirements:

Primary Care Providers

- Provide immediate medical coverage 24 hours a day, seven days a week without prior authorization for emergencies;
- Schedule and see urgent sick appointments (emergent) immediately;
- Schedule and see pediatric urgent sick appointments (non-emergent) within 24 hours of a member's initial request;
- Schedule and see adult sick care appointments within 72 hours of a member's initial request; and

- Schedule and see routine visits (pediatric and adult) within 21 days of a member's initial request.

Specialty Care Providers

Appointments with specialists or non-emergency hospital stays should be scheduled within four weeks of a member's initial request or medical event.

Reporting Requirements

The Plan is required to submit, on a quarterly basis, timely-access reports to monitor the time lapsed between a member's initial request for an office appointment and the date of the appointment.

**Covering
Physicians**

In the event participating physicians are temporarily unavailable to provide care or referral services to Plan members, providers should make arrangements with another Plan-contracted and credentialed physician to provide services on their behalf, unless there is an emergency. In non-emergency cases, should they have a covering physician who is not contracted and credentialed with the Plan, providers must contact the Plan for approval.

The physician should be credentialed by the Plan, must sign an agreement accepting the negotiated rate and agreeing not to balance bill Plan members.

For additional information, please contact your local Provider Relations representative.

**Provider Billing
and Address
Changes**

Prior notice should be completed in writing and mailed or faxed to local Provider Relations Department for any of the following changes:

- 1099 mailing address
- Tax Identification Number or entity affiliation (W-9 required)
- Group name or affiliation



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- Physical or billing address
- Telephone and/or fax number

Marketing and Sales

Providers are required to submit any marketing materials; this includes, but is not limited to, posters, brochures, Web sites and any materials that contain statements regarding the member benefit package to the Plan. Neither the Plan nor the providers can distribute any marketing materials without prior, written approval from the State of Hawai'i Department of Human services (DHS).

Providers are required to follow all applicable federal guidelines related to Plan marketing. Please contact 'Ohana if you have any specific questions around marketing rules or guidelines.

Disclosure of Information

Periodically, members may inquire as to the operational and financial nature of their health plan. In accordance with federal and state disclosure requirements, the Plan will provide that information to the member upon request. Members can request the above information verbally or in writing. For more information about how to request this information, members should contact the Plan's Customer Service department.

Fraud and Abuse

The Plan is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements.

The Plan has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Effective 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 and abuse. Service providers are cautioned that unbundling, fragmenting, up-coding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), physicians' Current Procedural Terminology (CPT), the Health care 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 fraud and abuse 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.

To report suspected fraud and abuse, please refer to the Quick Reference Guide of this manual or call our confidential Trust Program hotline.

Fraud and Abuse Definitions

Fraud is defined as 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.

Examples of health care fraud include, but are not limited to the following:

- Falsifying any medical record, note, diagnostic test result, report, claim or any financial, administrative or clinical documents used to validate services.
- Billing for services, supplies, or equipment not actually furnished to any health plan member.

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- Providing false and intentionally misleading information regarding health plan coverage, limitations and exclusions to any health plan member.
- Misrepresentation of any date of service, frequency, duration or description of any service, or the identity of the recipient of such services or the identity of the service provider.
- Billing for non-covered or non-chargeable services, supplies or equipment disguised as any covered or chargeable service.
- Duplicate billings (e.g., billing more than once for the same service, multiple providers billing for the same service for the same member on the same day, billing the health plan and the member for the same services or submitting claims to both the Plan and other third parties without making full disclosure of relevant facts to all parties).
- Providing payment or other inducement to any Plan member in exchange for the use of their identification card or other member information with or without the permission of the Plan member for the purpose of obtaining wrongful payment.
- Receipt or offering of any unlawful kickback, gratuity or other inducement made with the intent to increase referrals.
- Reciprocal billing (e.g., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than claimed).
- Practicing medicine or other health care without a valid license or with an expired or revoked license, or without proper credentials or while excluded from participation in any federal or state health care program.
- Any agreement or other arrangement between a provider and a Plan member that results in claims

for unnecessary costs or charges to the health plan (e.g., providing health care services, supplies or equipment to an ineligible person that is in possession of a health plan member's identification card or any fraudulent scheme involving the use of member information to submit false claims).

- Any other intentional misrepresentation of a material fact regarding the provision of health care services for the purpose of obtaining wrongful payment.

The term abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices and that result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. The definition also includes member practices that result in unnecessary cost to the Medicaid program.

Some examples of health care abuse include, but are not limited to, the following:

- Billing for services, supplies or equipment in any amount in excess of the applicable federal and/or State fee schedules, negotiated or contract rate.
- Direct or balance billing of health plan members where prohibited.
- Billing for services that are not medically necessary, or if medically necessary, not to the extent actually provided.
- Providing health care services of an inferior quality (i.e., services that do not meet generally accepted standards of care) or in an inappropriate setting or at a level of care that is in excess to medical necessity.
- Failure to fully document services according to generally accepted standards (i.e., records must be legible, clearly document the services provided,

etc.) and maintain adequate clinical, financial and other records substantiating claims.

Special Investigations Unit

A corporate Special Investigations Unit (SIU) has been established according to federal and state statutory, regulatory and contractual requirements.

The mission of the corporate SIU is to:

- Comply with applicable federal and state statutory, regulatory, and contractual requirements regarding fraud and abuse;
- Effectively detect, investigate and report incidents of suspected fraud and abuse;
- Identify and recover overpayments caused by error, fraud or abuse;
- Assist in the development of anti-fraud plans, policies and procedures and fraud and abuse education and training materials;
- Assist in conducting education and training for associates, providers, members, first-tier, delegated and related entities on fraud and abuse awareness and other related topics, according to established training schedules; and
- Assist in conducting vulnerability assessments, auditing and monitoring activities of first-tier, delegated and related entities.

Education and Training

The Provider Relations department is responsible for distributing provider manuals and other information as well as conducting provider education and training. Providers may contact the Provider Relations department to arrange education and training or answer questions regarding health plan benefits, coverage, limitations and exclusions, policies and procedures, provider rates and contracting issues, claims, fraud and abuse awareness and other information. Contact the Plan's customer service department to arrange the education and training session.



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Section 2

Business and Medical Records

Providers are required to maintain books, records, documents and other evidence pertaining to the costs and expenses to the extent and in such detail as will properly reflect all services for which claim payments are made.

All institutional and non-institutional health care service providers are required to maintain all medical records in accordance with Hawai'i Revised Statutes (HRS) §§ 622-51 and 622-58, for a minimum of seven years from the last date of entry in the records for adults, and for minors, must preserve and maintain all medical records during the period of minority plus a minimum of seven years after the age of majority.

All providers shall maintain and retain records of members according to the standards stated in the contract and the HRS. If a provider agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for period of seven years from the date of termination or of any resulting final settlement.

All providers are further required to allow the Plan and state and federal governments' full access to such records, to the extent allowed by law. Copies of requested records will be provided to the Plan and state and federal governments upon request at no charge

Delegated Entities

All participating providers or entities delegated for Network Management and Development should meet all applicable standards and be held to the same standards as defined in this section. Reviews are performed and compliance is monitored on a regular basis.