'Ohana Provider Resource Guide

'Ohana Health Plans, Inc., ('Ohana) understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks. This guide will explain the services that 'Ohana offers to assist with those routine tasks. In this guide you will find information related to:

- Provider Portal
- *Quick Reference Guide*
- Verifying Member Eligibility

- Prior Authorizations
- Claims
- Appeals

Provider Portal

The Provider Portal offers providers the convenience of exchanging healthcare service information directly with 'Ohana. The Provider Portal, which is offered at no cost, features:

- The ability to verify member eligibility and co-pay information
- The ability to request authorizations and check status
- Claims submissions – look up claims status and inquiry
- The ability to use PaySpan Health's Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)
- The ability to take training and complete attestations online
- An inbox for messages from 'Ohana
- Provider news

Quality care is a team effort.
Thank you for playing a starring role!

Register for the Provider Portal

There are two types of users: administrative users and sub-accounts. Administrative users oversee additional website users (sub-accounts) in their practice or department.

Create a New Account

Administrative users can register by visiting our provider website: **www.ohanahealthplan.com/registration/provider**.

You will need the following to register:

- 'Ohana-issued Provider ID number (located in your welcome packet or on your Explanation of Payment)
- Primary address ZIP code (the ZIP code submitted on your credentialing packet)
- Tax Identification Number (TIN)

Complete the registration form by submitting your:

- Provider ID
- ZIP code
- TIN

Then provide us with information regarding your organization and users. You will be prompted to complete a profile and accept HIPAA Terms and Conditions. You will then select a username and select a security question and answer. A confirmation page will be displayed. Within 24 hours of registration, you will receive an email with a temporary password. Use this password (within 30 days) to log in to the website and create a new password. Be sure to keep your username and password for future reference.

Verifying Member Eligibility

You can search, view, save and print member-specific 'Ohana eligibility and enrollment information using the Provider Portal.

- Log in at **www.ohanahealthplan.com/login/provider**
- Click the *Eligibility* tab
- Enter the Member ID number
- Click the *Show Eligibility Co-pay* button

If you don't have the Member ID on hand, you may use the *Lookup Member* tool on the website. In addition to validating member eligibility on our Provider Portal, you may also validate eligibility and claim status through one of our real-time vendors. Please refer to the Real-Time Services section of this guide for more information.

Prior Authorizations

Requesting an Authorization

Providers must obtain prior authorizations for certain services and procedures. Authorizations can be requested via the secure online Provider Portal, via fax or via telephone. For details regarding services that require authorization and how to submit authorizations, please refer to the QRG.

The following information is generally requested for all authorizations:

- Member name
- Member identification number
- Provider ID and National Provider Identifier (NPI) number or name of the treating physician
- Facility ID and NPI number or name where services will be rendered (when appropriate)
- Provider and/or facility fax number
- Date(s) of service
- Diagnosis and diagnostic codes
- CPT codes
- Any relevant clinical information to support medical necessity of request

Standard, Expedited and Extensions of Service Authorization Decisions

Decisions Time Frames		
Type of decisions	Time Frame	Extension
Standard Pre-service	14 calendar days	Additional 14 calendar days
Expedited Pre-service	3 business days	Additional 14 calendar days
Post-service	30 calendar days	14 calendar days

Via Provider Portal

Registered providers may log in, click the *Authorizations* tab, then select *Authorization Request*.

For authorizations, please supply your phone and fax numbers. You can attach up to 10 clinical files. You can also add relevant clinical information by typing it into the text box.

Via Fax

Complete the appropriate 'Ohana notification or authorization form for the type of care needed. Forms are found at **www.ohanahealthplan.com/provider** in the Resources area under Medicaid, Medicare or Community Care Services. Fax the completed form and any supporting documentation to the fax number listed on the QRG.

Via Telephone

Emergent or Urgent Authorizations Only

Authorization requests that are emergent or urgent should be submitted via telephone. Emergent or urgent requests should only be submitted when the standard time frame could seriously jeopardize the member's life or health. Requests for expedited authorization will receive a determination within three business days. Contact Provider Services at the phone number listed on the QRG to request an expedited authorization.

> **Please note:** Authorization/Certification determinations are made based on medical necessity and appropriateness, and reflect the application of 'Ohana's review criteria guidelines. Once you complete each authorization request via the Provider Portal, you can download or print a summary report for your records.
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> Authorizations are valid for the time noted on each authorization response. 'Ohana may grant multiple visits under one authorization when a plan of care shows medical necessity for this request. Failure to obtain the necessary prior authorization from 'Ohana could result in a denied claim. Authorization does not guarantee payment. All services or procedures are subject to benefit coverage, limitations and exclusions as described in applicable plan coverage guidelines.

Checking Authorization Status Online

'Ohana encourages you to check the status of your authorization requests via our secure provider portal at **www.ohanahealthplan.com.**

Simply log in and click the *Authorizations* tab, then select *Authorization Status*. Use the *Find By* menu to search by *Provider ID* or *Member ID*.

Enter the appropriate number in the *Provider ID* or *Member ID* box (depending on the option chosen). Please note that you can click *Lookup Provider* or *Lookup Member* if you do not know the ID number.

Select one of the service date ranges from within the dropdown box or enter any 30-day date range in the From option.

Click the *Find Authorizations* button. The results are displayed at the bottom of the page.

Claims

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

'Ohana has partnered with PaySpan Health, a company with more than 25 years of experience in developing payment solutions, to provide EFT/ERA solutions.

Register for Electronic Funds Transfer at PaySpan Health

Create a New Account

'Ohana has instituted additional security measures to ensure your EFT is secure. New users must first contact PaySpan Health to request a registration code. Call **1-877-331-7154** or email **providersupport@payspanhealth.com**. To prevent fraud, 'Ohana will contact you before you receive the code to verify that you requested it. PaySpan Health will email instructions on how to register online.

Enter Your Registration Code

Once you receive your code, you can register at **www.payspanhealth.com** by selecting the *Register Now* button. Follow all the prompts and complete the required registration questions. You will need:

- Your Vendor/Provider Identification Number (PIN) and TIN
- A valid email address
- An account name (to identify the receiving account). Note: Providers typically use the account name to specify the payee designation. Each payee will have a separate registration code and can therefore have a separate receiving account established. The same routing and account number can be used for multiple receiving accounts.

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- Bank routing number
- Bank account number

Your email address will become your username when logging in to PaySpan Health. After completing your registration, you will receive an email from PaySpan Health. In a few days, you will need to verify that a small deposit has been made to your bank account by PaySpan Health. This deposit amount will be used to confirm your electronic payments are properly set up. The deposit does not need to be returned to PaySpan Health.

Filing a Claim

All claims must have complete and compliant data including:

- Current CPT and ICD-10 codes (or their successors)
- TIN
- NPI number(s)
- Provider and/or practice name(s) matching the W-9 initially submitted to 'Ohana

General Definitions:

- **Paid claims** – claims that have at least one line item designated as payable
- **Pending claims** – claims that require additional review and/or claims that are held due to a member's failure to pay his/her premium (these claims remain in a pending status until the member pays his/her premium)
- **Denied claims** – services indicated on the submitted claims are not covered, did not receive authorization and/or the member is not eligible
- **Rejected claims** – claims that have missing or invalid information, such as invalid code sets or required data elements, which will not pass 'Ohana's front-end edit process. You will need to correct the data and resubmit a new claim.

Electronic Claims

'Ohana accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to 'Ohana must be in the ANSI ASC X12N format, version 5010A1 or its successor. This is less costly than billing with paper and, in most instances, allows for quicker claims processing. For more information on EDI implementation with 'Ohana, refer to the Claims/Encounter Companion guides located at **www.ohanahealthplan.com** in the Resources area under Medicaid, Medicare or Community Care Services.

HIPAA Electronic Transactions and Code Sets

Please follow the HIPAA transaction and code set requirements as found in the National Electronic Data Interchange Transaction Set Implementation Guides available at **www.wpc-edi.com**.

Fee-For-Service Clearinghouse Submitters

All Fee-for-Service (FFS) providers and vendors must send claims through a clearinghouse. 'Ohana has partnered with Change Healthcare, as our preferred EDI clearinghouse. 'Ohana only accepts electronic claims through Change Healthcare.

If you have any questions regarding submission of EDI transactions directly through Change Healthcare, please call **1-877-411-7271**. Clearinghouses, practice management vendors or billing services should call **1-800-527-8133** for assistance with EDI transactions.

▶ If your clearinghouse or billing system **is not** connected to Change Healthcare and requires five-digit Payer IDs, please use the following codes according to the file type (FFS or Encounters).

ʻOhana Payer IDs

14163 **Fee-For-Service – Professional or Institutional**	59354 **Encounters – Professional or Institutional**

▶ If your clearinghouse or billing system **is** connected to Change Healthcare and uses their four-digit CPID, please use the following codes according to the file type (FFS or Encounters).

Change Healthcare CPIDs

1844 **Fee-For-Service Professional**	3211 **Encounters Professional**
8551 **Fee-For-Service Institutional**	4949 **Encounters Institutional**

Real-Time Services

Real-time HIPAA 270/271 eligibility transactions and 276/277 claim statuses are available to providers via the following vendors:

- AdminisTEP.com — **1-888-751-3271**
- Availity — **1-800-282-4548**
- eSolutions (f.k.a. Dorado Systems, LLC) — **1-866-633-4726**, prompt 2
- Change Healthcare — **1-877-363-3666** prompt 1
- TransUnion Healthcare — **1-877-732-6853**

These services improve data interchanges, provide innovative solutions to provider requests and will be leveraged to implement other HIPAA-compliant transactions in the future.

- Real-time eligibility and claim status information – no waiting on the phone
- Low or no cost to the provider community
- Increase office productivity
- One-stop shopping – view eligibility and claim status information for all participating health insurance companies from a single website with a single login

Electronic Claims – Direct Data Entry (DDE)

Via **www.ohanahealthplan.com** in the Resources area under Medicaid, Medicare or Community Care Services.

Registered users can log in and directly enter professional and/or institutional claims and encounters into ʻOhana's Provider Portal. Once logged in, select the *Claims* tab, and then click on *Claims Submission* (single). Follow the prompts to complete your individual claims or encounters submission.

Alternative Solution - Free Direct Data Entry (DDE) & Small Batch File Solutions

Change Healthcare's Connect Center™ for physicians offers a web browser for direct data entry (DDE) or batch upload capability at no cost to you. To sign up, go to **https://physician.connectcenter. changehealthcare.com**. For registry questions, submitter/clients may contact Provider Connectivity Services at **1-877-411-7271**. Direct questions regarding functionality of Connect Center to the clearinghouse at **1-800-527-8133**, option 2.

- Providers must enter a credit card upon initial enrollment to verify them as valid submitter.
- Only WellCare Health Plans, a Centene company, submissions are free of charge. Please ensure you use vendor code 212750 when you register.

- Providers must use the Plan's payer ID 14163 for fee-for-service submissions when using Connect Center free DDE or batch upload services.

AdminisTEP offers a web browser for single submission direct data entry (DDE) or batch upload for professional and institutional submissions, claim status, reporting and inquiry functions at no cost to you for WellCare Health Plans members' submissions. To sign up, please go to: **http://www.administep.com/Signup.aspx**, or call **201-888-751-3271**.

Features include:

- Manually input claims data for electronic submission
- Menu-driven prompts guide providers through data-entry screens
- Screens look like CMS-1500 and UB-04 forms
- View electronic rejection letter and remittance

- Manage claims electronically
- Business edits applied to claims before submission
- Online standard paper claim form for direct entry
- Online non-standard paper claim form for direct entry

Paper Claims

'Ohana encourages electronic (EDI) claim submissions; however, we also accept paper CMS-1500 and UB-04 claim forms or their successors. Paper claims should only be submitted on original claim forms (red ink on white paper). If the paper claim is not submitted on the original red and white claim form, the claim will be rejected. Please visit **www.ohanahealthplan.com/provider** in the Resources area under Medicaid, Medicare or Community Care Services for complete paper claims submission guidelines.

For more information on claims submissions, clean claims, timely filing guidelines and encounter data submission, refer to the *Claims* section of the Provider Manual at **www.ohanahealthplan.com/provider**. For the paper claims mailing address, please refer to the QRG.

For further instructions for both paper and EDI claim submission, including access to the EDI Companion Guides, visit **www.ohanahealthplan.com/provider** in the Resources area under Medicaid, Medicare or Community Care Services.

Encounters Submission

Certain delegated vendors and providers are required to submit encounters. Encounters may be submitted electronically via:

- Change Healthcare
- 'Ohana's Secure FTP (SFTP) process
- 'Ohana's Direct Data Entry (DDE)

For further details about Encounter Submissions, please refer to Encounter Companion Guides located at **www.ohanahealthplan.com/provider** in the Resources area under Medicaid, Medicare or Community Care Services.

Strategic National Implementation Process (SNIP)

All claims and encounter transactions submitted electronically, via paper or direct data entry (DDE) will be validated for transaction integrity/syntax based on the SNIP guidelines.

The SNIP validations used by 'Ohana are available at **www.ohanahealthplan.com**.

Checking Claim Status Online

'Ohana encourages you to check the status of your claims online via our secure Provider Portal at **www.ohanahealthplan.com/provider**.

Simply log in and click the *Claims* link, then access the *Search Claims* area. You can search by *Claim Number*, *Member ID*, *Member Name* and *Date of Birth*, *WellCare Control Number* (WCN), *Document Control Number* (DCN), or *Provider ID*.

Select one of the service date ranges or enter a custom date range of up to one year.

Click the *Search* button. Results are displayed at the bottom of the screen.

Claim Payment Disputes

The claim payment dispute process is designed to address claims when there is disagreement regarding reimbursement. Claim payment disputes must be submitted to 'Ohana in writing within 120 days of the date of denial on the EOP.

Refer to the QRG for mailing address and fax number. Claims disputes may also be submitted through the Provider Portal.

Claims may be denied or reduced for the following non-authorization-related reasons:

- Untimely filing
- Incidental procedures
- Bundling
- Unbundling
- Unlisted procedure codes
- Non-covered codes

Appeals

Filing an Appeal

Providers have the right to file a request for review regarding provider payment or contractual decisions.

Authorization-related denials or payment reductions are processed by appeals. Claims may be denied or reduced for the following authorization-related reasons:

- Lack of prior authorization
- Services exceeding authorization
- Lack of supporting documentation
- Late notification

Appeals must be submitted in writing within 90 calendar days of the date of the Explanation of Payment or the Provider Administrative Denial letter. If you have questions and/or concerns about the appeals process, please contact Provider Services for assistance.

You may file an appeal by mail or by fax. To file an appeal, refer to the QRG for applicable addresses and fax numbers. 'Ohana will process and finalize an appealed claim to a paid or denied status within 60 calendar days of receipt of the appealed claim.

Contacts

For Customer Service, call **1-888-846-4262** (Medicaid) or **1-888-505-1201** (Medicare). For important mailing addresses, phone numbers and fax numbers, refer to your QRG at **www.ohanahealthplan.com/provider** in the Resources area under Medicaid, Medicare or Community Care Services.

Quality care is a team effort. Thank you for playing a starring role!

Please see the Provider Manuals and/or *Quick Reference Guides* (QRG) for additional information.