

'Ohana Provider Resource Guide



OhanaHealthPlan.com

'Ohana Health Plan ('Ohana) understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks. This guide explains the services that 'Ohana offers to assist with those routine tasks. This guide gives you 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 is offered at no cost and lets you:

- ✓ Verify member eligibility and copayment information
- ✓ Request authorizations and check status
- ✓ Use PaySpan Health's Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)
- ✓ Take training and complete attestations online
- ✓ Look up status of claims submissions and inquire about those submissions

The Portal also gives you:

- ✓ An inbox for messages from 'Ohana
- ✓ Provider news

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.



Quick Reference Guide (QRG)

The **Quick Reference Guide** lists important mailing addresses, phone and fax numbers, and authorization requirements. The QRG is at www.ohanahealthplan.com/provider in the Resources area under Medicaid, Medicare or Community Care Services.

Create a New Account

Administrative users can register by visiting:

provider.wellcare.com/Provider/Accounts/Registration.

You 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

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

Then provide us with information about your organization and users. You will be prompted to complete a profile and accept HIPAA Terms and Conditions. You then choose 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.

- 1 Log in at **provider.wellcare.com**
- 2 Click the *Eligibility* tab
- 3 Enter the Member ID number
- 4 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, fax or telephone. For details about 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

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

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 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 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 on the QRG to request an expedited authorization.

Please note: Authorization/Certification determinations are 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.



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.

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

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:

- 1 Your Vendor/Provider Identification Number (PIN) and TIN
- 2 A valid email address
- 3 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.
- 4 Bank routing number
- 5 Bank account number

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

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

Fee-For-Service Clearinghouse Submitters

All Fee-for-Service (FFS) providers and vendors must send claims through a clearinghouse. 'Ohana only accepts electronic claims through Availity, our preferred EDI clearinghouse.

If you have any questions regarding submission of EDI transactions directly through Availity, please call **1-800-282-4548**.

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

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

| ‘Ohana Payer IDs | |
|--|---|
| 14163 Fee-For-Service – Professional or Institutional | 59354 Encounters – Professional or Institutional |

Real-Time Services

Real-time HIPAA 270/271 eligibility transactions and 276/277 claim statuses are available to providers via our preferred clearinghouse, Availity.

| | |
|-----------------|-----------------------|
| Availity | 1-800-282-4548 |
|-----------------|-----------------------|

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

- ✓ Real-time eligibility and claim status information — no waiting on the phone
- ✓ 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 ‘Ohana’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

Availity Essentials offers direct data entry (DDE) or batch upload capability at no cost to you. To sign up, go to www.availity.com/essentials-portal-registration. For registry questions, submitter/clients may contact Provider Connectivity Services at **1-800-282-4548**.

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

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:

- ✓ Availity
- ✓ ‘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.

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.

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

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 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.

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



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.

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