2024 ʻOhana Community Care Services Provider Manual

ʻohana health plan™

OhanaHealthPlan.com

Partners in Quality Care

Dear Provider Partner:

At ʻOhana Health Plan, we value everything you do to deliver quality care to our members – your patients. Through our combined efforts we ensure that our members continue to trust us to help them in their quest to lead longer and more satisfying lives.

We're committed to quality. That pledge demands the highest standards of care and service. We are constantly investing in people and programs, innovating, and working hard to remove barriers to care.

ʻOhana's dedication to quality means that we are also committed to supporting you. We want to make sure that you have the tools you need to succeed. We will work with you and your staff to identify members with outstanding care gaps, and we will reward you for closing those gaps.

The enclosed provider manual is your guide to working with us. We hope you find it a useful resource, and the areas highlighted below are sections of the manual that directly address our mutual goal of delivering quality care.

Thank you again for being a trusted ʻOhana provider partner!

Sincerely,

ʻOhana Health Plan

Quality Highlights

Section 2

- Responsibilities of All Providers
- Continuity and Coordination of Care Between Medical and Behavioral Health Care
- Member Rights and Responsibilities

Section 3

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Date	Section	Comments	Page	Change
02/19/2024	Section 3: Quality Improvement	Diamond Designation™ Program	42	Updated description

Section 1: Welcome to ʻOhana

ʻOhana Health Plan (ʻOhana) is a wholly-owned subsidiary of Centene Corporation, a leading multi-line healthcare enterprise. Centene provides managed care services targeted exclusively to government-sponsored healthcare programs. Centene serves approximately 26.5 million Members. Centene's experience and exclusive commitment to these programs enable ʻOhana to serve its Members and Providers as well as manage its operations effectively and efficiently. For the purpose of this Manual, ʻOhana and/or its constituent health plan(s) may be referred to herein as "'Ohana," or, as applicable, "Health Plan."

ʻOhana physical locations:

Effective 3/1/2023, the ʻOhana Health Plan – Main Office location is:

ʻOhana Health Plan – Main Office
820 Mililani Street, Suite 200,
Honolulu, HI 96813

Prior to 3/1/2023, the ʻOhana Health Plan – Main Office location is:

ʻOhana Health Plan – Main Office
949 Kamokila Blvd., Suite 350
Kapolei, HI 96707

ʻOhana Health Plan – Big Island Office
88 Kanoelehua Ave.
Suite A105
Hilo, HI 96720

Purpose of this Manual

This Provider Manual is intended for ʻOhana Community Care Services (CCS)-contracted (participating) Medicaid Providers providing healthcare service(s) to enrolled ʻOhana CCS Members.

This Manual serves as a guide to Providers and their staff to comply with the policies and procedures governing the administration of ʻOhana's Medicaid Health Plan and is an extension of, and supplements, the Provider Contract entered into with ʻOhana. **This Provider Manual replaces and supersedes any previous versions dated prior to May 31,2024 and is available** at **www.ohanahealthplan.com/providers/medicaid/community-care-services**. A paper copy is available at no charge to Providers upon request.

Participating Providers must abide by all applicable provisions contained in this Manual. Revisions to this Manual reflect changes made to ʻOhana's policies and procedures.
As policies and procedures change, updates will be issued by ʻOhana in the form of Provider Bulletins and will be incorporated into subsequent versions of the Manual. Unless otherwise provided in the Provider Contract, ʻOhana will notify Providers of changes to the Manual through a Table of Revisions in the front of the Manual, Provider Bulletin posted to the provider portal on ʻOhana's website, and in the quarterly provider newsletter. For material changes, ʻOhana will send a formal notice in accordance with the terms of the Provider Contract.

‘Ohana Community Care Services Program

‘Ohana has contracted with the state of Hawai‘i, Department of Human Services Med-QUEST Division (DHS) to provide the Community Care Services (CCS) program. The CCS program is specifically designed for QUEST Integration Medicaid Members who are 18 years of age or older and determined to have a qualifying Serious Mental Illness (SMI/SPMI) by the DHS and in need of specialized behavioral health services. Upon enrollment in the CCS program, the QUEST Integration health plan is no longer responsible for the Member’s behavioral health services, but shall remain responsible for provision of medical services. Until the CCS enrollment date, the QUEST Integration plan retains responsibility for providing the Member’s behavioral health services.

Members may choose not to participate in the CCS program.

The purpose of ‘Ohana’s CCS program is to assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet a Member’s behavioral healthcare needs using communication and all available resources to promote quality outcomes. 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 CCS program emphasizes continuity of care for Members through the coordination of care among medical and behavioral health Providers.

The CCS program will identify and facilitate options and services for meeting each Member’s behavioral healthcare needs, while decreasing fragmentation and duplication of care.

‘Ohana’s CCS program is built around the individual Member, his or her recovery goals, desired outcomes and service needs. ‘Ohana uses a patient-centered, holistic service delivery approach to coordinate Member benefits across all Providers and settings. Community-based behavioral health case managers, working in tandem with the Member and the Member’s family, care providers and community resources, are responsible and accountable for the entire care management cycle, from identification of needs, to individualized treatment plan (ITP) development, requesting authorization of services, and monitoring/reassessing needs.

Eligibility

Membership enrollment in the ‘Ohana CCS program is solely determined by DHS.
For eligibility criteria, please refer to the DHS website at **www.medquest.hawaii.gov**.

Adults with a SMI/SPMI diagnosis who are unstable and moderate-high risk can get these additional intensive behavioral health services if the Medicaid beneficiary:

- Demonstrates the presence of a qualifying diagnosis for at least 12 months or is expected to demonstrate the qualifying diagnosis (as found in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders*) for the next 12 months
- Meets at least one of the criteria demonstrating instability and/or functional impairment:
    - Clinical records demonstrate that Member is unstable under current treatment or plan of care
    - Requires protective services or intervention by housing/law enforcement officials

Eligible diagnoses include:

1) Substance Induced Psychosis

ICD-10	Alcohol-Induced Psychosis	F10.15x, F10.25x, F10.95x
	Opioid-Induced Psychosis	F11.15x, F11.25x, F11.95x
	Cannabis-Induced Psychosis	F12.15x, F12.25x, F12.95x
	Sedative-Induced Psychosis	F13.15x, F13.25x, F13.95x
	Cocaine-Induced Psychosis	F14.15x, F14.25x, F14.95x
	Other-Stimulant Induced Psychosis	F15.15x, F15.25x, F15.95x
	Hallucinogen-Induced Psychosis	F16.15x, F16.25x, F16.95x
	Inhalant-Induced Psychosis	F18.15x, F18.25x, F18.95x
	Other Substance Induced Psychosis	F19.15x, F19.25x, F19.95x

2) PTSD
   ICD-10 F43.1x
3) Schizophrenia
   ICD-10 F20.x, includes schizophreniform disorder F20.81
4) Schizoaffective Disorder
   ICD-10 F25.x
5) Delusional Disorder
   ICD-10 F22
6) Bipolar Disorder
   ICD-10 F30.xx, F31.xx
7) Major Depressive Disorder, Severe
   ICD-10 F32.3, F33.2, F33.3
8) Borderline Personality Disorder
   ICD-10 F60.3

Medicaid beneficiaries who do not meet the eligibility criteria, but are still felt by the Med-QUEST Division's (MQD) medical director or designee that additional services are Medically Necessary for the Medicaid beneficiary's health and safety, will be evaluated on a case-by-case basis for provisional eligibility. If Medicaid beneficiaries do not meet the eligibility criteria, QUEST Integration health plans are responsible for administering behavioral health services.

Serious Mental Illness or Serious and Persistent Mental Illness

Persons who are determined to have a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) are defined as adults who, as the result of a mental disorder, exhibit emotional, cognitive, or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. People afflicted with SMI or SPMI have mental disability(ies) that is (are) severe and persistent and result in long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment and recreation.

Please note that uninsured individuals or those that are legally encumbered with SMI or SPMI receive specialized behavioral health services through the Hawaii State Department of Health Adult Mental Health Division.

Benefits and Services

As of the publication date of this Manual, the following benefits and services (Covered Services) are provided, as Medically Necessary, to 'Ohana's CCS Members:

Services	Coverage and Limits
Inpatient Psychiatric Hospitalization Services	• Room and board • Nursing care • Medical supplies, equipment and drugs • Diagnostic services • Psychiatric services • Other practitioner services as needed • Physical, occupational, speech and language therapy • Post-stabilization services • Other Medically Necessary services
Emergency Department (ED) Services	• Any covered inpatient and outpatient services rendered by a qualified Provider needed to evaluate or stabilize an emergency medical condition • Emergency medical condition must be a result of serious mental illness (SMI) or serious and persistent mental illness (SPMI) diagnosis • ʻOhana will not deny payment for these services when a Provider instructed the Member to seek ED services
Ambulatory – Behavioral Health	• 24 hours, 7 days a week emergency/crisis intervention • Mobile crisis response • Crisis stabilization • Crisis hotline • Crisis residential services
Medication Management	• Medication evaluation • Medication counseling and education • Psychotropic medications
Diagnostics	• Psychological testing • Psychiatric or psychological evaluation and treatment (including neuropsychological evaluation) • Psychosocial history • Screening for and monitoring treatment of substance use disorders and mental illness (includes tobacco and alcohol use disorders) • Other Medically Necessary behavioral health diagnostic services to include labs

Services	Coverage and Limits
All Medically Necessary Substance Use Disorder Services	• Specialized residential treatment for SUD • Intensive Outpatient Program (IOP) • Methadone management services that include the provision of methadone or a suitable alternative (i.e., LAAM or buprenorphine) as well as outpatient counseling services
Intensive Case Management	• Case assessment • Case planning (treatment planning, service planning) • Outreach • Ongoing monitoring and care coordination • Coordination with Member's Behavioral Health Providers, QI health plan and PCP
Partial Hospitalization or Intensive Outpatient Hospitalization including:	• Medication management • Prescribed drugs • Medical supplies • Diagnostic tests • Therapeutic services including individual, family and group therapy, and aftercare • Other Medically Necessary services
Psycho-Social Rehabilitation/ Clubhouse Services including:	• Intensive day treatment • Residential Treatment services • Day treatment • Social/recreational therapy services
Supported Employment Services including:	• Work assessment service; • Pre-employment service; and • Job coaching.
Behavioral Health Outpatient Services also include:	• Treatment/service planning; • Individual/group therapy and counseling; • Family and collateral therapeutic support and education; • Continuous treatment teams; and • Other Medically Necessary therapeutic services.
Prescription Drugs	'Ohana covers drugs listed on our Preferred Drug List (PDL). This list will also have drugs that may have limits such as Prior Authorization, quantity limits,

Services	Coverage and Limits
	step therapy, age limits or gender limits. Alternate drugs may be covered with a Prior Authorization.
Transportation	Provides for both emergency and non-emergency ground and air services to and from Medically Necessary Provider appointments for Members who: • Have no means of transportation • Reside in areas not served by public transportation • Cannot access public transportation due to his or her mental condition • Do not live in a community care foster family home, adult residential care home, expanded adult residential care home, or domiciliary home Transportation is not provided to day programs that are not Medically Necessary. Authorization is required for any ground transportation to a location greater than 50 miles from pickup location. May require Prior Authorization.
Out-of-State and Off-Island Coverage	Provides for any Medically Necessary Covered Services that are prearranged when not available on the Member's island or in Hawai'i. This includes: • Referrals to an out-of-state or off-island specialist or facility • Transportation to and from the referral destination • Lodging & meals • Member attendant (if authorized) May require Prior Authorization
Supportive Housing (CIS)	**Pre-tenancy Services** • Identify eligible individuals • Screening/Assessments • Develop housing support plan • Housing search • Applications prep and submission • Identify resources/costs for startup needs • Identify equipment, technology, and other modifications needed • Ensure housing is safe • Moving assistance • Individualized housing crisis plan • Skill and acquisition development • Independent living skills/Financial literacy

Services	Coverage and Limits
	Tenancy Services • Individual Housing and Tenancy Sustaining Services • Community Transition Services (CTS) • Early identification/intervention for negative behaviors • Education/Training roles and responsibilities of tenant/landlord • Coach on development/maintenance of relationships between landlords/property managers • Dispute resolution with landlords/neighbors • Advocate & link with advocacy groups to help prevent eviction • Housing recertification process • Update/Maintain housing support and crisis plans • Development of daily living skills and maintaining a residence skills to sustain residency • Service Care Coordination • Housing crisis management • Training/Education • Financial literacy • Relationship building and maintenance **Other Housing & Tenancy Services** • Job skills training/Employment activities • Peer supports • Non-medical transportation • Support groups • Caregiver/family support • Outreach services • Health management • Counseling and therapies • Service assessments • Service plan development • Independent living skills/Financial literacy • Equipment, technology and other modifications • Home management • Other supplemental services as needed
Urgent Care Services	Covered as Medically Necessary. No Prior Authorization is required.
Other Services	• Other Medically Necessary practitioner services provided by licensed and/or certified healthcare Providers • Other Medically Necessary therapeutic services including services that would prevent institutionalization • Maintenance of Member's medical assistance eligibility • Representative payee (financial services) • Peer Specialist

Telehealth Service

Services will be rendered according to the Hawaii Revised Statutes (HRS § 346-59.1)

'Ohana will cover telehealth services, subject to Limitations and Administrative Guidelines. Telehealth services provide the Member with enhanced healthcare services and information when meeting face to face is unavailable. Telehealth services provides Members with the flexibility to interact with Providers and improves health outcomes in the state.

Telehealth services are covered (subject to Limitations and Administrative Guidelines) when all of the following criteria are met:

- Telehealth services are provided by a licensed healthcare Provider working within the scope of their practice.
    - Telehealth may be used to establish a Primary Care Provider (PCP)-patient relationship when a PCP has a license to practice in Hawai'i and is in-network
    - In-network Behavioral Health Provider-patient relationships may be established via telehealth
    - Out-of-network telehealth services will only be covered if 'Ohana Health Plan referral requirements are met prior to the services being rendered
- The telehealth service is covered if it would have been covered for an in-person encounter.
- The telehealth services are provided through one of the following methods, including but not limited to:
    - Real-time video conferencing-based communication
    - Secure interactive and non-interactive online communication
    - Secure asynchronous information exchange to transmit patient medical information including diagnostic quality digital images and laboratory results for medical interpretation and diagnosis
- Telehealth services must include a documented patient evaluation, including history and a discussion of physical symptoms adequate to establish a diagnosis and treatment plan. The documentation must be consistent with standards as defined by Current Procedural Terminology (CPT).

Telehealth services are covered (subject to Limitations and Administrative Guidelines) without geographic restrictions on a patient's or healthcare Provider's location.

The use of a telehealth modality to prescribe controlled substances or medical marijuana is covered (subject to Limitations and Administrative Guidelines) only when a physician-patient relationship has been previously established through an in-person encounter.

- An in-person visit is required at least every six months for opioid prescriptions for chronic conditions
- Telehealth prescriptions for doses beyond plan formulary quantity limits are not allowed

Limitations

- Standard telephone contact, facsimile transmission, or email – in combination or individually – does not constitute a telehealth service and is not covered.

- Issuing a prescription based solely on an online questionnaire does not constitute a telehealth service and is not covered.

Administrative Guidelines

- Services that require precertification when rendered in-person also require precertification when rendered via telehealth. Providers are to follow ‘Ohana coverage criteria.
- Documentation supporting Medical Necessity should be legible and maintained in the patient's medical record and made available to ‘Ohana upon request. ‘Ohana reserves the right to perform retrospective reviews using the above criteria to validate if services rendered met Payment Determination Criteria.
- All telehealth services provided must be consistent with all federal and state privacy, security, and confidentiality laws, and all state and federal laws governing telehealth services.
- All telehealth services provided must be consistent with all terms and conditions of ‘Ohana Health Plan and healthcare Provider’s contract, if applicable.
- Emergency department telehealth services for CCS do not require referral from a PCP.
- Telehealth services may be billed with place of service code 02, defined as:
    - The location where health services and health-related services are provided or received, through the telecommunication system

The listing of CPT codes that may be used for reporting telemedicine services when appended by modifier 95 for CPT approved codes or modifier GT or GQ for CMS approved codes may be found in Addendum A.

Behavioral Health Care Management

The ‘Ohana CCS Behavioral Health Care Managers (CMs) coordinate care at the point of healthcare decision-making and bring Members (and their families) and Providers of care together to facilitate treatment decisions that are in the Member’s best interest. CMs work primarily with complex and chronic care management focusing simultaneously on achieving health, maintaining wellness, and containing costs. Involvement of Behavioral Health Care Management in programs of care will decrease fragmentation, improve clinical and financial outcomes of care, and increase satisfaction. The CM identifies, plans, monitors, and mobilizes resources to facilitate cost-effective outcomes for Members with complex or ongoing healthcare needs.

The CMs are a multidisciplinary group of clinicians that includes licensed registered nurses, licensed practical nurses (LPNs), licensed social workers, licensed behavioral health clinicians and other clinical specialists supervised by a licensed clinician.

Each CCS Member will be assigned, by acuity level and with consideration for Member choice, to a Case Management Agency that will be indicated on the Member’s ID card. The agency will assign a dedicated community based case manager to help coordinate benefits to meet the Member’s behavioral healthcare needs. Members are allowed to change agencies up to three times per year.

Chronic Care Management Programs

As a part of ‘Ohana’s services, Chronic Care Management Programs (CCMP) are also offered to Members. Chronic Care Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic care management supports the physician or practitioner/Member relationship and plan of care, emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Not all participants identified with specific targeted diagnoses will be enrolled in the CCMP. Participants with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk participants with co-morbid or complex conditions will be referred for care management program evaluation. Complex case management is considered an opt-out program such that all eligible Members have the right to decline to participate.

To refer a Member for chronic care management:

- Call ‘Ohana toll-free at **1-866-401-7540**
- Go to **www.ohanahealthplan.com/providers/medicaid/community-care-services/forms**

Assessments

‘Ohana and contracted case management agencies will use a standardized comprehensive behavioral health assessment, and will ensure the current level of assessment quality is maintained and standardized across agencies.

A comprehensive multi-axial, bio-psychosocial assessment is the cornerstone of effective recovery for individuals with an SMI/SPMI. The behavioral health assessment is completed within 21 days of enrollment for all new CCS Members. ‘Ohana’s philosophy and approach emphasizes that an assessment is an ongoing and dynamic process that is regularly updated. Members will be assessed by the Case Manager to whom they are assigned. The assessment includes:

- History of hospitalizations; requirement for institutional care; incarcerations; availability of supports within the community; and housing status.

The comprehensive behavioral health assessment also includes the following fundamental elements:

- Family history:
    - Intellectual disability, psychiatric illness, neurological or other relevant illness
    - The quality of important relationships between the Member and other family members
- Personal and developmental history:
    - Developmental years, including milestones
    - Education and job history
    - History of interpersonal relationships
    - Personality and behavior prior to the onset of psychiatric illness
    - Psychosexual history
    - Notable life events, especially loss, abuse and change in placement or caregivers
- Medical history:

    - Past and present physical illness, with particular attention to high risk co-morbid conditions such as congestive heart failure (CHF), obesity, asthma or diabetes
    - History of intellectual or developmental disability
    - Impairment of vision, hearing, speech or mobility
    - Psychiatric history
    - Previous history of contact with services and diagnoses
    - Risk assessment (harm to self and/or others)
    - History of outpatient treatment and inpatient hospitalizations
    - Substance and alcohol use
- Social/cultural/spiritual history:
    - Current and previous social circumstances (e.g., marital and employment status)
    - Current and previous living arrangements (e.g., group home, family home, independent living, etc.)
    - Current and previous social support
    - Current cultural beliefs that may impact recovery
    - Spiritual or religious beliefs
- Pharmaceutical history:
    - Past and present medications (psychiatric and primary medical, including dosage, route and frequency)
    - Drug adverse effects
    - Recent change in medication
    - Known drug allergies
- Forensic history:
    - Past and present history of involvement with the legal system
- Financial:
    - Income/support
    - Benefits
    - Monthly expenses

Individualized Treatment Plan

Each Member shall have a single, coordinated individualized treatment plan (ITP). The ITP is based on information obtained from the assessment described above, and contains evidence of the Member's input into all aspects of treatment planning, including service-related decisions. Through the ITP, the Member and the Member's treatment team will work together to set goals toward recovery. The ITP will help each member of the care management team know what the other team members are doing to help the Member.

The ITP will describe the need for case management assistance, psychotherapy, medication, clinical services, general health services, dental services, legal assistance and living-support service needs. The treatment planning also will address crisis response and will include the preferences of the Member and detail the steps to be taken by the case management team, the Member, and Member supports if a crisis occurs. Each Member's ITP will guide service delivery even if the Member changes Providers.

ITPs will be developed using a multidisciplinary team approach. The multidisciplinary team must include, at a minimum, the following:

- The Member and, as appropriate, family members and significant others

- A psychiatrist who shall guide the treatment team and will offer clinical expertise for all authorization decisions. (The psychiatrist meets with the Member at a minimum of one time a month for at least 15 minutes per visit.)
- Other behavioral, medical and social service Providers
- A CM, who shall be responsible for coordinating the development of and monitoring the implementation of the ITP, and shall act as the care and communications liaison for the case management team both internally and externally with respect to the ITP
- A QUEST Integration service coordinator shall be included as members of the care management team when the Member has significant medical issues

The ITP is a standardized document that all case managers will use and shall be completed within 14 calendar days of completion of the behavioral health assessment. The following are required components of the individualized treatment plan:

- A description of the assessments as well as the services offered in measurable behavioral terminology
- All Member needs identified in the assessment and the stated needs of the Member. A written explanation of any need not addressed shall be in the plan. Identified needs should include any significant medical/dental problems, as well as immediate needs and strengths of the person, to include follow-up actions that are needed immediately
- A crisis plan may also accompany the ITP, the goal of which is to prevent hospitalization, to stabilize, and to manage and reduce risk of harm to the Member. This plan will also be used to help avoid displacement from housing or other negative consequences that may affect personal functioning and community tenure. The crisis plan shall include:
    - Identification of early signs of relapse, steps to prevent crisis, identification of people, places or events that trigger responses and increase risk for relapse, and identification of strengths and natural resources
    - A Wellness Recovery Action Plan (WRAP) may be included to inform the crisis interventions required, when necessary
- All treatments by need area with goals and objectives, key supports with contact information and time frames
- Documentation of key indicators to be measured to monitor the course and responsiveness to treatment
- The treatment plan must be in accord with any applicable state quality assurance and utilization review standards

Interventions While the Member Is in Inpatient Treatment

An essential part of the CM role is to proactively collaborate with facilities and/or Providers to anticipate, plan for, and address the Member's potential treatment gaps and needs while the Member is in inpatient treatment. The CM partners with the 'Ohana concurrent review nurse, facility, and/or Providers to help ensure the Member's behavioral health benefits are being used thoughtfully and with longer term post-facility discharge planning needs in mind. Some of the CM strategies when reviewing care for Members who are in a higher level of care include, without limitation:

- Requesting permission to participate by telephone in treatment team meetings
- Offering assistance in identifying other Covered Services and/or community resources early in the admission
- Identifying and contacting the facility's discharge planner
- Collaborating with the social worker at the facility regarding proactive discharge planning

- Arranging to speak to the attending psychiatrist directly if the facility's review representative cannot provide adequate information at any point during the admission
- Looking for opportunities to provide education and information to Members and Providers as needed
- Requesting a peer-to-peer review with the attending psychiatrist and the medical director if the treatment plan does not meet Medical Necessity or does not have necessary documentation to support the Member's care
- Coordinating with and/or assigning an external community case manager for the Member

Post-Discharge Interventions

Members shall receive a in-person case manager visit within two calendar days of discharge from an inpatient psychiatric hospitalization and a visit with their behavioral health Provider within seven calendar days following discharge. Members shall receive a in-person case manager visit within 72 hours of discharge from an Emergency Department visit, and a visit with their behavioral health provider within seven (7) calendar days following discharge.

As part of the ongoing treatment planning process after discharge from higher levels of care, the CM will identify individualized interventions targeted to help the Member sustain treatment gains and return to a more stable level of functioning. Post-discharge interventions may include, but are not limited to, the following:

- Referral to residential treatment
- Referral to stable housing
- Referral to routine outpatient treatment
- Follow-up with Primary Care Provider (PCP)
- Coordination with QUEST Integration health plan
- Ensure appropriate discharge medications are available and reconciled with pre-admit medications

Addressing Barriers

Another important function of CMs is ensuring proper follow-up for Members. To that end, CMs will:

- Assist the Member in development of a calendar to track important appointments
- Review potential financial issues, transportation problems, lack of understanding and/or reduced readiness for change
- Review the name, address and phone number of the Provider and the appointment schedule with the Member to confirm the Member's knowledge of the appointment and ability to contact the Provider if needed
- Review the expectations of the appointment's outcome so the Member understands the purpose of the appointment and how to ask meaningful questions during the appointment
- Contact the Member's family to discuss the plan and engage their support in the area of compliance
- Collaborate with all care providers involved in the Member's treatment for behavioral and physical health integration

To address barriers to medication compliance and the risk of misuse, CMs will:

- Review the names and doses of medications so the Member is knowledgeable about his or her medication

- Review the doctor and pharmacy phone numbers to make sure the Member can call them as needed
- Assess the internal and external motivators, insight and capability of the Member's engagement in process
- Review the importance of using one pharmacy to fill all prescriptions to ensure that the pharmacist can schedule for refills and be aware of all Member medications and possible side effects and drug interactions
- Send educational information to the Member and/or significant others involved in the Member's care to promote an understanding of the importance of compliance with medication and treatment
- Review the importance of the Member informing the psychiatrist or PCP of any side effects that he or she may experience or concerns he or she has about the treatment
- Encourage the Member to write down important side effects or questions the Member may have about various appointments
- Suggest the use of a pill box, if applicable

ʻ**Ohana Online Tools for Providers**

ʻOhana offers technology options to save Providers time using the secure online portal, Chat and IVR (Interactive Voice Response System) self-service tools. These self-service tools help Providers do business with ʻOhana. We want your interactions with us to be as easy, convenient and efficient as possible. Giving Providers and their staff self-service tools and access is a way for us to accomplish this goal. Providers can access this information below or at **www.ohanahealthplan.com**, then click on Overview from the drop-down menu under Providers.

Secure Provider Portal: Key Features and Benefits of Registering

ʻOhana's secure online provider portal offers immediate access to what Providers need most. All participating Providers who create an account and are assigned the appropriate role/permissions can use the following features:

- **Claims Submission, Status, Appeal, Dispute –** Submit a claim, check status, appeal or dispute claims, and download reports;
- **Member Eligibility, Co-Pay Information and More –** Verify Member eligibility, and view co-pays, benefit information, demographic information, care gaps, health conditions, visit history and more;
- **Authorization Requests –** Submit authorization requests, attach clinical documentation, check authorization status and submit appeals. Providers may also print and/or save copies of the authorization;
- **Pharmacy Services and Utilization –** View and download a copy of ʻOhana's preferred drug list (PDL), view Member prescription history, and access pharmacy utilization reports;
- **Chat** – Live chat for assistance with all of the above
- **Visit Checklist/Appointment Agenda –** Download and print a checklist for Member appointments, then submit online to get credit for Partnership for Quality (P4Q);
- **Secure Inbox –** View the latest announcements for Providers and receive important messages from the Health Plan.

Provider Registration Advantage

The secure provider portal allows Providers to have one username and password, and be affiliated with multiple Providers/offices. Administrators can easily manage users and permissions. Once registered for ʻOhana's portal, Providers should retain their username and password information for future reference.

How to Register
To create an account, please refer to the *Provider Resource Guide* at **www.ohanahealthplan.com/providers/medicaid/community-care-services**. For more information about ʻOhana's online capabilities, please call Customer Service or contact Provider Relations to schedule online in-service training.

Additional Resources
The following resources are at **www.ohanahealthplan.com/providers/medicaid/community-care-services**. To access them, select *Overview* under the *Providers* drop-down menu:

- The ***Provider Resource Guide*** contains information about the secure online provider portal, Member eligibility, authorizations, filing paper and electronic claims, appeals, and more. For more specific instructions on how to complete day-to-day administrative tasks, please see the *Medicaid Resource Guide*.
- The ***Quick Reference Guide*** contains important addresses, phone/fax numbers and authorization requirements.

Website Resources

ʼOhana's website, **www.ohanahealthplan.com/providers/medicaid/community-care-services**, offers a variety of tools to assist Providers and their staff. Resources include:

- Provider Manuals
- *Quick Reference Guides*
- Clinical Practice Guidelines
- Clinical Coverage Guidelines
- ʻOhana Companion Guide
- Forms and documents
- Pharmacy and Provider lookup (directories)
- Searchable Preferred Drug List (PDL)
- Authorization look-up
- Training materials and job aids
- Newsletters
- Member rights and responsibilities
- Privacy statement and notice of privacy practices

Using Chat: Get to Know the Benefits of Chat
Faster than email and easier than phone calls, Chat is a convenient way to ask simple questions and receive real-time support. Providers now can use our Chat application as an alternative to calling and speaking with agents. Our Chat support can help you and your staff with online support assistance and real-time claim adjustments. Explore the benefits you will experience by using live Chat:

- **Convenience**
  - Live Chat offers the convenience of getting real-time help and answers
- **Documentation of Interaction**

    - Unlike phone support, live Chat software gives you the option of receiving a transcription of the conversation.
- **Access Chat through the portal**
    - The *Chat Support* Icon is on our secure provider portal. From there, you can:
        - Log on to the provider portal at **https://provider.wellcare.com/ohanacare**
        - Access the "Help" section
        - Select the desired Chat topic
        - If the Chat agent cannot resolve the issue, the issue will be routed to the right team for further assistance

Customer Service

Interactive Voice Response (IVR) System

- Technology to expedite Provider verification and authentication within the IVR
- Provider/Member account information is sent directly to the agent's desktop from the IVR validation process, so Providers do not have to re-enter information
- Full speech capability, allowing Providers to speak their information or use the touch-tone keypad

Self-Service Features

- Ability to receive Member co-pay benefits
- Ability to receive Member eligibility information
- Ability to request authorization and/or status information
- Unlimited claims information on full or partial payments
- Receive status for multiple lines of claim denials
- Automatic routing to the Provider Claims Support (PCS) claims adjustment team to dispute a denied claim
- Rejected claims information is now available through self-service

TIPS for using our IVR

Providers should have the following information available with each call:

- 'Ohana Provider ID number
- NPI or Tax ID for validation, if Providers do not have their 'Ohana ID
- For claims inquiries – provide the Member's ID number, date of birth, date of service and dollar amount
- For authorization and eligibility inquiries – provide the Member's ID number and date of birth

Benefits of using Self-Service

- 24/7 data availability
- No hold times
- Providers may work at their own pace
- Access information in real time
- Unlimited number of Member claim status inquiries
- Direct access to PCS – No transfers

The *Phone Access Guide* is at **www.ohanahealthplan.com/provider/medicaid/resources.**

Providers may contact the appropriate departments at ʻOhana by referring to the *Quick Reference Guide* at **www.ohanahealthplan.com/provider/medicaid/resources**.

A hard copy of Provider directories and Manuals may also be requested. Providers may contact Provider Relations representatives at **1-866-401-7540**.

CCS Hotline Number (toll-free): **1-866-401-7540**

Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

This section is an overview of guidelines for which all participating ʻOhana Medicaid Managed Care Providers are accountable. Providers can refer to the Provider Contract or contact their Provider Relations representative for clarification of any of the following. Providers, in accordance with generally accepted professional standards, must:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973
- Agree to cooperate with ʻOhana in its efforts to monitor compliance with its Medicaid contract(s) and/or DHS rules and regulations, and assist ʻOhana in complying with corrective action plans necessary for it to comply with such rules and regulations
- Retain all agreements, books, documents, papers and medical records related to the provision of services to Members as required by state and federal laws
- Provide Covered Services in a manner consistent with professionally recognized standards of healthcare [42 C.F.R. § 422.504(a)(3)(iii).]
- Use physician extenders appropriately. Physician assistants (PA) and advanced practice registered nurses (APRN) should provide direct Member care within the scope or practice established by the rules and regulations of DHS and ʻOhana 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: M.D., D.O., APRN, PA) to Members and to other healthcare professionals
- Honor at all times any Member's 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 healthcare services
- Maintain the confidentiality of Member information and records
- Respond promptly to ʻOhana's request(s) for medical records in order to comply with regulatory requirements
- Maintain accurate medical records and adhere to all ʻOhana policies governing the content and confidentiality of medical records as outlined in *Section 3: Quality Improvement* and *Section 8: Compliance*
- Allow ʻOhana to use Provider performance data for quality improvement activities
- Ensure that:
    - All employed physicians and other healthcare practitioners and Providers comply with the terms and conditions of the Provider Contract between the Provider and ʻOhana
    - To the extent the physician maintains written agreements with employed physicians and other healthcare practitioners and Providers, such agreements contain similar provisions to the Provider Contract
    - Physician maintains written agreements with all contracted physicians or other healthcare practitioners and Providers, which agreements contain similar provisions to the Provider Contract

- 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 ʻOhana, 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 ʻOhana CCS Medicaid Members and non-ʻOhana CCS Medicaid Members
- Ensure that the hours of operation offered to ʻOhana Members are no less than those offered to commercial Members
- Not deny, limit or condition the furnishing of treatment to any 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 healthcare; d) medical history; e) genetic information; f) evidence of insurability, including conditions arising out of acts of domestic violence; or g) disability
- Consider Member rights when furnishing services
- Freely communicate with and advise Members regarding the diagnosis of the Member's condition and advocate on the Member's behalf for the 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 who are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance use disorders. If indicated, Providers must refer Members to ʻOhana-sponsored or community-based programs
- Document the referral to ʻOhana-sponsored or community-based programs in the Member's medical record and provide the appropriate follow-up to ensure the Member accessed the services
- Comply with disclosure requirements identified in accordance with 42 CFR Part 455, Subpart B found in Section 40

Excluded or Prohibited Services

Providers must verify patient eligibility and enrollment prior to service delivery. ʻOhana 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 contract.

Responsibilities of All Providers

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

- Comply with all responsibilities set forth in this Provider Manual
- Make available treatment for any Member in need of the healthcare 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 ʻOhana

- Ensure Members use network Providers, except when they are not available or in an emergency. If unable to locate a Participating ʻOhana Provider for services required, contact Customer Service for assistance. Refer to the *Quick Reference Guide* on ʻOhana's website
- Admit Members only to participating hospitals, skills 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 ʻOhana 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 ʻOhana in writing within 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 Hawaiʻi
- Submit an encounter for each visit where the Provider sees the Member or the Member receives a HEDIS®[1] service
- Submit encounters. For more information on encounters, refer to *Section 5: Claims*
- Comply with and participate in corrective action and performance improvement plan(s)
- Continually educate Members regarding how to access services through ʻOhana's Customer Service

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 Hawaiʻi Contract and for the monitoring of 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 healthcare 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 3: Quality Improvement* and *Section 8: Compliance.* For more information on subcontractors, refer to *Section 9: Delegated Entities.*

No-Show Fees

Providers are prohibited from imposing a no-show fee for CCS program Members who were scheduled to receive a Medicaid Covered Service.

Advance Directive

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 healthcare hospices and HMOs specified in 42 CFR Part 489, subpart I, and 42 CFR Section 417.436(d).

Each Member 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. ʻOhana 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 the 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 Office of Health Care Assurance (OHCA).

Provider Billing and Address Changes

Providers are required to give prior notice to their Provider Relations representative or Customer Service for telephone and fax number changes, and written prior notice for any of the following changes:

- 1099 mailing address
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Panel changes
- Directory listing

Failure to notify ʻOhana 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 Provider Contract, Providers must adhere to the following terms:

- Any contracted Providers must give at least 90 calendar days' prior written notice (180 calendar days for a hospital) to ʻOhana before terminating their relationship with ʻOhana "without cause," unless otherwise agreed to in writing. This ensures that adequate notice may be given to Members regarding Provider participation status with ʻOhana. Please refer to the Provider Contract for the details regarding the specific required days for providing termination notice, as Providers may be required by contract to give more notice than listed above
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month

If 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 ʻOhana- or DHS-initiated termination for adverse reasons on the part of the Provider, ʻOhana may transition a Member to another Provider or Case Management Agency.

ʻOhana shall immediately transfer a Member to another Provider if the Member's health and safety is in jeopardy.

Please refer to *Section 6: Credentialing* of this Manual for specific guidelines regarding rights to appeal ʻOhana termination (if any).

ʻOhana will notify in writing all appropriate agencies and/or Members prior to the termination effective date within the service area as required by state Medicaid program requirements and/or regulations and statutes.

Closing of Provider Panel

When requesting closure of their panel to new and/or transferring ʻOhana Members, Providers must:

- Submit the request in writing at least 60 calendar days (or such other period of time provided in the Provider Contract) prior to the effective date of closing the panel
- Maintain the panel to all Members who were provided services before the closing of the panel
- Submit written notice of the reopening of the panel, including a specific effective date

Covering Providers

If Participating Providers are temporarily unavailable to provide care or referral services to Members, Providers should arrange with another ʻOhana-contracted Medicaid (Participating) and credentialed Provider to provide services on their behalf, unless there is an emergency.

Covering Providers should be credentialed by ʻOhana, and must sign an agreement accepting the negotiated rate and agreeing to not balance bill Members. For additional information, please refer to *Section 6: Credentialing*.

In non-emergency cases, should a Provider have a covering Provider who is not contracted and credentialed with ʻOhana, contact ʻOhana for approval. For contact information, refer to the *Quick Reference Guide* on ʻOhana's website.

Out-of-Area Member Transfers

Providers should assist ʻOhana in arranging and accepting the transfer of Members receiving care out of the service area if the transfer is considered medically acceptable by the ʻOhana Provider and the out-of-network attending physician/provider. Also, when a Member needs to transfer care to an out-of-area Provider, the Participating Provider(s) should assist ʻOhana in arranging and providing clinical information to the out-of-area Provider.

Access Standards

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Member's needs.

'Ohana shall monitor Providers against these standards to ensure Members can obtain needed behavioral health services within the acceptable appointment time frames, in-office waiting times and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions.

Type of Appointment	Access Standard
Emergency	Immediate Care – 24 hours per day, 7 days per week
Non-Life-Threatening Emergency	Within 6 hours
Urgent Care	Within 72 hours
Standard Initial Routine Care	Within 21 calendar days
Follow-up Routine Care	Within 21 calendar days

Discharge Appointments

All Members receiving inpatient psychiatric services must be scheduled for psychiatric 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 calendar days from the date of discharge.

If a Member misses an appointment, the behavioral health Provider must contact the Member within 24 hours to reschedule. Providers may contact 'Ohana for assistance in contacting Members when needed.

Responsibilities of Behavioral Health Providers/External Community Case Managers

Responsibilities of external community behavioral health case managers include:

- Providing the Member with clear and adequate information on how to obtain services and make informed decisions about his or her own behavioral health needs
- Providing comprehensive case assessment, case planning, ongoing quarterly monitoring of progress toward goals, and support towards reaching those goals
- Completing in-person comprehensive assessments on a new 'Ohana CCS Member within 21 calendar days of enrollment into the program. In-person reassessments shall be completed at least annually or sooner if Medically Necessary
- Ensuring the development of the ITP. The initial ITP shall be developed within 14 calendar days of completing the in-person comprehensive assessment after enrollment into the program
- ITPs shall be updated every six months or sooner if Medically Necessary to include a significant change
- The LOCUS Acuity Level tool should be completed along with the in-person comprehensive assessment within 21 calendar days of enrollment into the program and updated every six months or sooner when a significant change occurs.
- Coordinating services with other Providers such as QUEST Integration Service Coordinators, Medicare, the Hawai'i Department of Health (DOH) programs excluded from QUEST Integration, Hawaii CARES, Medicare Advantage plans, other MCO Providers, behavioral

health and DOH Providers who treat developmentally delayed/intellectually disabled Members
- Providing skills development in problem-solving and other skills to remain in/return to the community
- Ensuring crisis resolution
- Coordinating and integrating the Members' medical and behavioral healthcare and services with their QI health plan, behavioral health Provider, and Primary Care Provider
- Achieving continuity of Members' care and cost-effective delivery of services
- Assisting the Member in obtaining behavioral health interventions, as prescribed by the interdisciplinary team as appropriate, and ensure that these services are received and provided in a timely manner
- Ensuring that an active, assertive system of outreach is in place to provide the flexibility needed to reach those Members such as the homeless or others, who require services, but who might not access services without intervention due to language barriers, acuity of condition, dual diagnosis, physical/visual/hearing impairments, mental retardation, lack of transportation, etc.
- Facilitating Member compliance with recommended medical and behavioral health treatment
- Assisting Members with accessing appropriate DHS benefits and eligibility requirements (verifications, etc.) and compliance

Case Management Service Frequency and Intensity Requirements

All 'Ohana behavioral health Providers are required to adhere to the designated case management frequency requirements, as described below. 'Ohana requires Providers to use the LOCUS tool to make acuity determinations.

Service Level	Minimum Service Contact Requirement
5. Specialized Intensity	In-person three times per week
4. High Intensity	In-person two times per week
3. Intensive	In-person one time per week
2. Intermediate	In-person every other week
1. Routine	In-person one time per month

The clinical status and recovery plan of all Members receiving case management will be formally reviewed by the external community case management agency every six months. More frequent review will be required when significant changes occur in the overall condition or functioning of a Member. All recovery plan reviews will be documented in the Member's care management record.

While in-person visits will be required as above, a full and comprehensive assessment will be required for every CCS Member during one of these visits at least annually. It is not expected that a full assessment be completed during each visit; however, 'Ohana will monitor external community case managers to ensure these assessments are done annually and after any significant change in behavioral or physical health status, such as after acute hospitalization or change in psychotropic medication.

Continuity and Coordination of Care Between Medical 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 healthcare services if they are Medically Necessary and when they are licensed to do so within the scope of their practice. Behavioral Providers must use the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* when assessing the Member for behavioral health services and to document the 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 semi-annual summary report of the Member's behavioral health status to the PCP. Communication with the PCP should occur more frequently if clinically indicated. 'Ohana encourages behavioral health Providers to pay particular attention to communicating with PCP's at the time of discharge from an inpatient hospitalization.

'Ohana strongly encourages open communication between PCPs and behavioral health Providers to help guide and ensure the delivery of safe, appropriate, efficient and quality clinical healthcare. If a Member's medical or behavioral condition changes, 'Ohana 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 both Providers receive Member's consent to share information.

Effective communication of care is dependent upon clear and timely communication and allows for better decision-making regarding treatment interventions, decreases the potential for fragmentation of treatment and improves Member health outcomes.
To maintain continuity of care, patient safety and Member well-being, communication between behavioral healthcare Providers and medical care Providers is critical, especially for Members with comorbidities 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.

Termination of a Member

A Provider may not seek or request to terminate his or her relationship with a Member, or transfer a Member to another Provider for care, based upon the Member's medical condition, amount or variety of care required or the cost of Covered Services required by the Member.

Reasonable efforts should always be made to establish a satisfactory Provider and Member relationship in accordance with practice standards. If a Participating Provider wants to terminate his or her relationship with a Member, the Provider should submit adequate documentation to support that although he or she has 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. If a satisfactory relationship cannot be established or maintained, the Provider shall continue to provide medical care for the Member until such time that written notification is received from 'Ohana stating that the Member has been transferred from the Provider's practice, and such transfer has occurred.

Request for transfer of Members should be submitted via 'Ohana's secure provider portal by users who have Administrator rights for their contract or sub-group. After logging in, Providers should access the My Patients area, search for the Member, select Request Member Transfer from the Select Action menu, then complete and submit the form.

Member Administrative Guidelines

Overview

ʻOhana 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. ʻOhana will convey this information through various methods including a Member Handbook.

Member Handbook

All newly enrolled Members will receive a Member Handbook within 10 calendar days of receiving the notice of enrollment from ʻOhana. ʻOhana will mail all enrolled Members a Member Handbook annually thereafter.

Enrollment

Potential Members of ʻOhana's CCS program may be:

- Referrals from the QUEST Integration health plan
- Referrals from the Hawaii State Hospital who are being discharged
- Referrals from the Department of Health, Adult Mental Health Division (AMHD) or Child and Adolescent Mental Health Division (CAMHD), DOH-DDD (Developmental Disabilities Division)
- Referrals from the Department of Public Safety being discharged from their correctional facilities
- Referrals from the Department of Human Services for those young adults (18 years old) being discharged from the Hawaiʻi Youth Correctional Facilities
- Individuals self-referring to ʻOhana or making first contact with ʻOhana through crisis services

Upon determination that a QUEST Integration Member would benefit from CCS services, an 1157 CCS Referral form is completed by a licensed BH provider or MD and submitted to the QUEST Integration health plan. The QUEST Integration health plan will submit eligible referrals to MedQUEST for determination. Upon submission of the referral, the determination will be made within 30 calendar days. The enrollment date will be five (5) working days after the notification of approval to the BHO, or earlier, based upon the Member's behavioral health needs.

ʻOhana must obey laws that protect from discrimination or unfair treatment. ʻOhana is prohibited from:

- Discriminating against enrolled Members on the basis of health status or need for health care services.
- Discriminating against enrolled Members on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability; and
- Using any policy or practice that has the effect of discriminating against enrolled Members on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

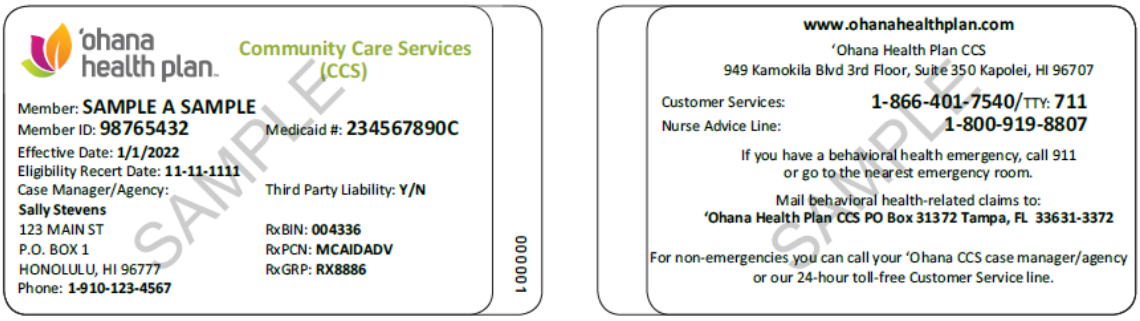
ʻOhana CCS Members are provided with the following within 15 calendar days of enrollment:

- 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
- 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 Members, the type of plan they have, and to facilitate their interactions with healthcare Providers. Information found on the Member identification card may include the Member's name, identification number, plan type, PCP's name and telephone number, co-payment information, 'Ohana Health Plan contact information and claims filing address.



Possession of the Member identification 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 identification card, along with additional proof of identification such as a photo ID, and filing them in the Member's medical record.

Providers may do one of the following to verify eligibility:

- Access 'Ohana's secure, online provider portal at **www.ohanahealthplan.com/providers/medicaid/community-care-services**
- Access 'Ohana's Interactive Voice Response (IVR) system
- Contact Customer Service

Providers will need their Provider ID number or Tax ID Number (TIN) 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 the Provider Contract for additional details.

Member Rights and Responsibilities

'Ohana CCS Members have specific rights and responsibilities. These are included in the Member Handbook.

Members have the right:

- To get information about ‘Ohana CCS, its services, its practitioners and its Providers.
- To get information about Member rights and responsibilities as required by 42 CRF §§ 438.10.
- To have the protections listed in the Patients’ Bill of Rights and Responsibilities Act (HRS Chapter 432E).
- To know the names and titles of the Providers who take care of them.
- To be treated with respect.
- To be treated with dignity.
- To privacy.
- To decide with their Provider on the care they get.
- To talk about the care they need as it is related to their health conditions. This includes the choices and risks involved, regardless of the cost or benefit coverage. The Member must get this information in a way they understand.
- To know about their healthcare needs after they get out of the hospital or leave a Provider’s office.
- To refuse care, as long as they agree to be responsible for their decision.
- To not take part in any medical research.
- To file a grievance and/or an appeal about ‘Ohana CCS or the care it provides. And to know that if they do, it will not affect how they are treated.
- To be free from any form of restraint or seclusion as a means of force, discipline, convenience or retaliation.
- To request and get a copy of their behavioral health records pursuant to 45 CFR Parts 160 and 164, subparts A and E
- To request to amend or correct their behavioral health records as specified in 45 CFR §§ 164.524 and 164.526
- To have their records kept private.
- To make their healthcare wishes known by using advance directives.
- To have input in the ‘Ohana CCS Member Rights and Responsibilities.
- To use these rights no matter their sex, age, race, ethnicity, income, education or religion.
- To have all ‘Ohana CCS employees honor their rights.
- To get healthcare services that are accessible, comparable in amount, duration and scope to those provided under Medicaid Fee-for-Service and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To get appropriate services that are not denied or cut back just because of diagnosis, type of illness or mental health condition.
- To get all information in a way that they can easily understand, in alternative formats and in a manner that takes into consideration their special needs.
- To get help in understanding the rules and benefits of ‘Ohana CCS.
- To get verbal interpretation services at no cost. This is for all non-English languages, not just those that are most common.
- To be told that verbal interpretation is available to them, and how to get this service.
- To get information about:
    - The basic features of managed care.
    - Who may or may not join the program.
    - ’Ohana CCS’s responsibilities for coordination of care in a timely manner in order to make an informed choice (potential members).
- To get a complete description of their right to leave ‘Ohana CCS.

- To get a notice of any major change in benefits. The Member must get this at least 30 days before the change is to go into effect.
- To get full information about emergency and after-hours services.
- To get the ʻOhana CCS policy on referrals for specialty care and other benefits that are not provided by the Member's case manager/agency or healthcare Provider.
- To have all these rights apply to the person the Member legally appoints to make decisions about their healthcare.
- To freely exercise their rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way they are treated.
- To receive a second opinion at no cost to the Member.
- To receive services out of network if ʻOhana CCS is unable to provide them in network for as long as ʻOhana CCS is unable to provide them in network and not pay more than he or she would have if services were provided in network.
- To receive services according to the appointment waiting time standards.
- To receive services in a culturally competent manner.
- To receive services in a coordinated manner.
- To have their privacy protected.
- To be included in individualized treatment plan (ITP) development.
- To have access to Providers contracted with ʻOhana CCS.
- To be informed regarding the restrictions on freedom of choice among network Providers.
- To not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness or condition.
- To receive a description of cost-sharing responsibilities, if any.
- To not be held liable for:
    - ʻOhana Health Plan's debts in the event of insolvency.
    - The covered services provided to the Member by ʻOhana CCS for which Med-QUEST Division does not pay ʻOhana CCS.
    - Covered services provided to the Member for which Med-QUEST Division or ʻOhana CCS does not pay the healthcare Provider that furnishes the services; and 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 ʻOhana CCS provided the services directly.
- To only be responsible for cost-sharing as described by ʻOhana CCS in accordance with 42 CFR Section 447.50.
- To be provided with written notice of any significant change related to Member rights, responsibilities and procedures at least 30 days before the intended effective date of the change.
- Receive information in accordance with information requirements (42 CFR §§ 438.10).
- Be furnished healthcare services in accordance with requirements for timely access and Medically Necessary coordinated care (42 CFR §§ 438.206 through 42 CFR §§ 438.210).

ʻOhana CCS Members also have certain responsibilities. These include the responsibility to:

- Give information that ʻOhana CCS and its Providers need to give care
- Follow plans and instructions for care that is agreed on with their case manager/agency or healthcare Provider
- Understand their health problems
- Help set treatment goals with their case manager/agency or healthcare provider

- Read the Member Handbook to understand how ʻOhana CCS works
- Always carry their ʻOhana CCS Member ID card
- Show their Member ID card to each Provider
- Notify ʻOhana CCS if their Member ID card is lost
- Schedule appointments for all non-emergency behavioral healthcare through the Member's case manager/agency or healthcare Provider
- Get a referral from their case manager/agency or healthcare Provider for specialty care
- Cooperate with the people providing healthcare to the Member
- Be on time for appointments
- Notify the Provider's office if they need to cancel or change an appointment
- Respect the rights of all Providers
- Respect the property of all Providers
- Respect the rights of other patients
- Not be disruptive in any Provider's office
- Know the medicine they take, what it is for and how to take the medicine the right way
- Help the case manager/agency or healthcare Provider obtain copies of all previous health records
- Let ʻOhana CCS know within 48 hours, or as soon as possible, if they are admitted to the hospital or gets emergency room care
- Call ʻOhana CCS to get information or get the Member's questions answered. The Customer Service toll-free phone number is **1-866-401-7540** (TTY **711**).

Hearing-Impaired, Interpreter and Sign Language Services

Hearing-impaired, interpreter and sign language services are available to Members through ʻOhana's Customer Service. Providers are required to offer access to interpretation services for Members who have a Limited English Proficiency (LEP) at no cost to the Member, and to document the offer and provision of interpreter services. Providers are required to offer access to auxiliary aids and services at no cost for Members living with disabilities, and to document the offer and provision of auxiliary aids. Providers should coordinate these services for Members and contact Customer Service if assistance is needed.

Section 3: Quality Improvement

Overview

'Ohana's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral healthcare 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 healthcare settings/services
- Cultural competency
- Credentialing
- Quality of care/service
- Patient safety and confidentiality
- Preventive health
- Complaints/grievances
- Appeals
- Adverse events
- Network adequacy
- Care management
- Behavioral health services
- Behavioral health and pharmacy utilization
- Member and Provider satisfaction
- Regulatory/federal/state/accreditation requirements

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS) measures, and/or medical record audits. The organization's board of directors has delegated authority to the Quality Improvement Committee (QIC) 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 that 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: medication lists, documentation of inpatient admissions, specialty consults appointment documentation care, and other documentation sufficient to disclose the quantity, quality appropriateness, and timeliness of service provided. Medical records must be legible, signed and dated.

To comply with regulatory and accreditation requirements, the QI Department may conduct annual medical record audits in Providers' offices or medical records are requested to be submitted to 'Ohana for the medical record review. A patient's record will be reviewed for content and evidence

that care and screenings have been documented, as applicable. Providers will be given results at the time of the audit, and a corrective action plan will be required if the score is less than 80%.

The goal of conducting medical record reviews is multifold, including the ability for ʻOhana 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 CCS Members:

- 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 provide Members with the right to request and receive a copy of his or her medical records, and to request they be amended, as specified in 45 CFR Part 164; and allow for paper or electronic record keeping.
- 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 legible, signed and dated
- Must include the name and profession of the practitioner rendering services; for example, RN, M.D., D.O., 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:
    - Name
    - Member ID
    - Age
    - Date of birth
    - Sex
    - Address
    - Home and work telephone numbers
    - Emergency contact
    - Legal guardianship
    - Marital status
    - Name of spouse
    - Next of kin or closest relative
    - Employer
    - Insurance information or family history as applicable
- Must reflect the primary language spoken by the Member and the 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 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 include a problem list, past and current diagnoses, and procedures. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, health maintenance concerns, significant illnesses, etc.
- All medical records include the provisional and confirmed diagnosis(es)
- Must contain information about consultations, referrals and specialist reports
- All medical records contain information about emergency care rendered with a discussion of requirements for Provider follow-up
- Must include notations on all forms or notes regarding follow-up care, calls or visits, when indicated
- All medical records contain discharge summaries for:
    - All hospital admissions that occur while the Member is enrolled
    - Prior admissions as appropriate
- All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of Medical Necessity
- Must include a screening for substance use disorder 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
- Members must provide evidence the Member was asked about or executed an advance directive, including an advance mental healthcare 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 used. The Provider shall not, as a condition of treatment, require the Member to execute or waive an advance directive
- Must detail informed consent discussions, where appropriate
- All medical records shall contain documented patient visits, which includes, but is not limited to:
    - A history and physical exam
    - Treatment plan, progress and changes in treatment plan
    - Laboratory and other studies ordered, as appropriate
    - Working diagnosis(es) consistent with findings
    - Treatment, therapies, and other prescribed regimens
    - Documentation concerning follow-up care, telephone calls or visits, when indicated

- Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits
- Documentation of any referrals and results thereof, including evidence that the ordering Provider has reviewed consultation, lab, X-ray and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note Provider follow-up plans
- Hospitalizations and/or emergency room visits, if applicable
- All other aspects of patient care, including ancillary services

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 ʻOhana, 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 healthcare Provider shall be maintained for a minimum of 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. For minors, ʻOhana shall retain all medical records during the period of minority plus a minimum of 10 years after the age of majority. Providers should have procedures in place to permit the timely access and submission of medical records to ʻOhana or DHS, within 60 calendar days from receipt of the request. Information from the medical records review may be used in the recredentialing process as well as quality activities. Providers shall facilitate the transfer of the Member's medical records (or copies) to the new Provider within seven business days from receipt of the request

For more information on the confidentiality of Member information and release of records, refer to *Section 8: Compliance*.

Practitioner and Provider Participation in the Quality Improvement Program

Network Practitioners and Providers are contractually required to cooperate with quality improvement activities to improve the quality of care and services and Member experience. This includes the collection and evaluation of performance data and participation in ʻOhana's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow ʻOhana the use of their performance data for quality improvement activities. Avenues for participation include committee representation, quality/performance improvement projects, 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 the annual evaluation of progress toward goal. ʻOhana evaluates the effectiveness of its QI Program on an annual basis. An annual report is published which reviews completed and continuing QI activities that addresses the quality of clinical care and service, trends measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions which are recommended or in progress, and identifies any modifications to the QI Program. This report is available as a written document and is posted to the provider portal annually.

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

Reporting Adverse Events

Adverse events include, but are not limited to:

- Suicide or attempted suicide of a Member
- Homicide of a Member
- Homicide by a Member
- Medication error – any Member death, paralysis, coma or permanent loss of function associated with a Provider medication error
- Serious Member injury resulting in permanent loss of limb or function, or risk thereof
- Suspected sexual abuse or neglect of a Member
- Attempted homicide of or by a Member
- Elopement from a crisis shelter, residential facility or group home that posed signification personal/public safety risk
- Physical assault by a Member resulting in a permanent loss of limb or function thereof
- Altercation with law enforcement personnel including incarceration
- Involvement with Adult Protective Services
- Unknown death of a Member
- Accidental death of a Member
- Unanticipated death of a Member, that may have resulted from lack of treatment, or otherwise not clearly and primarily related to the natural course of the Member’s medical illness
- Injuries requiring medical attention
- Loss of housing

Providers are required to notify CCS via the *Adverse Event Immediate Notification* form, which is at **www.ohanahealthplan.com/providers/medicaid/community-care-services/forms.**

Notification must be given within 24 hours of the time the Provider is made aware of the incident or the next working day if the event notification occurs on a weekend.

Clinical Practice Guidelines

‘Ohana adopts validated evidence-based *Clinical Practice Guidelines* and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede *Clinical Practice Guidelines*, 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 *Clinical Practice Guidelines* are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the *Clinical Practice Guidelines* occurs through the Corporate Clinical Policy Committee and the Utilization Management Medical Advisory Committee at least annually. *Clinical Practice Guidelines*, to include preventive health guidelines, is at **www.ohanahealthplan.com/providers/tools/clinical-guidelines/clinical-coverage-guidelines.**

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of healthcare performance measures in the United States and is a tool developed by the National Committee for Quality Assurance (NCQA) to measure performance on important dimensions of care and service. HEDIS is published across several volumes. HEDIS MY 2020 includes 92 measures and HEDIS MY 2021 includes 91 measures across six domains:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Measures collected using electronic clinical data systems

HEDIS is a mandatory process that occurs annually. It is an opportunity for ʻOhana 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.

Diamond Designation™ Program

The Diamond Designation™ Program provides ratings on the quality and efficiency of care across 14 different specialty areas; however, specialties vary per market. The specific specialties included for ʻOhana Medicaid are listed below. The Program emphasizes quality over efficiency. Provider ratings are determined and reported at a medical practice/group level based on Tax Identification Number.

We aim to update the Diamond Designation™ Program at least every two years with the Program Year 2024 update becoming effective during the first half of 2024.

Specialty Types Included in the Program Year 2024 ʻOhana Medicaid

Specialty Types	
Cardiology	Obstetrics/Gynecology
Counselors	Orthopedic Surgery
Endocrinology	Podiatry
Gastroenterology	Psychiatry
General Surgery	Psychology
Nephrology	Pulmonology
Neurology	

Some primary care providers want to understand more about the quality and efficiency of specialty physicians and other clinicians. Rating results from the Program are made available to our primary care providers to potentially consider as they refer patients to specialty care. Individuals are advised to consider all relevant factors and that Program ratings should not be the sole basis of their decision-making.

The Diamond Designation™ Program methodology for evaluation is based on national standards and incorporates feedback from physicians and other clinicians as well as members. The health plan seeks to produce evaluation results that are as accurate as possible. Ratings from the Diamond Designation™ Program are only a partial evaluation of quality and efficiency and should not solely serve as the basis for specialist provider selection (as such ratings have a risk of error). Other factors may be important in the selection of a specialist. The Program and its results are not utilized to determine payment under pay-for-performance programs. Specialty Provider groups evaluated within the Program have the opportunity to request a change or correction to information used in determining their efficiency or quality scores.

For additional information regarding the Diamond Designation™ Program, please visit **DiamondDesignation.com.** This site includes a description of the most current methodology used in determining Program ratings and specific instructions for Providers to submit requests for reconsideration of their results. The health plan values Provider feedback and welcomes comments and questions. Please send them by email to **ContactUs@DiamondDesignation.com.**

Online Resources

'Ohana periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on 'Ohana's website. Please check **www.ohanahealthplan.com/providers/medicaid/community-care-services** frequently for the latest news and updated documents.

Section 4: Utilization Management (UM)

Overview

‘Ohana’s Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and DHS 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 to:

- Evaluate requests for services by determining the Medical Necessity, efficiency, appropriateness and consistency with the Member’s diagnosis and level of care required
- Provide access to medically appropriate, cost effective healthcare services in a culturally sensitive manner and facilitating timely communication of clinical information among Providers
- Reduce overall expenditures by developing and implementing programs that encourage preventive healthcare behaviors and Member partnership
- Facilitate communication and partnerships among Members, families, Providers, delegated entities and ‘Ohana in an effort to enhance cooperation and appropriate utilization of healthcare services
- Review, revise and develop medical coverage policies to ensure Members have appropriate access to new and emerging technology
- Enhance the coordination and minimizing barriers in the delivery of behavioral and medical healthcare services
- Ensure that Providers are Participating and contracted with ‘Ohana

Medically Necessary Services

The determination of whether a covered benefit or 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 benefit shall:

(a) Be based on an individualized assessment of the recipient’s medical needs; and
(b) Comply with the requirements established in this paragraph. To be Medically Necessary or a Medical Necessity, a covered benefit shall be:
    - Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability or other medical condition
    - Appropriate in terms of the service, amount, scope and duration based on generally accepted standards of good medical practice
    - Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the healthcare Provider
    - Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided
    - Needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard
    - Provided in accordance with 42 C.F.R. 440.230

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

‘Ohana does not reward its associates or any practitioners, physicians 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 underutilization.

Criteria for UM Decisions

‘Ohana’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 healthcare 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:

- MCG (Milliman Clinical Guidelines)
- American Society of Addiction Medicine (ASAM)
- Clinical Coverage Guidelines
- Medical Necessity
- State Medicaid contract
- State Provider Manuals, as appropriate
- Local and federal statutes and laws
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment

The clinical 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 the Providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by contacting the Utilization Management Department via Customer Service. The phone number is listed on the *Quick Reference Guide* on ‘Ohana’s website.

Utilization Management Process

The UM process is comprehensive and includes the following review processes:

- Notifications
- Referrals
- Prior Authorizations
- Concurrent review
- Retrospective review

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

Notification forms and authorization requests are at **www.ohanahealthplan.com/providers/medicaid/community-care-services/forms.**

Notification

Notifications are communications to ʻOhana with information related to a service rendered to a Member or a Member's admission to a facility. Notification is required for:

- A Member's admission to a hospital. This allows ʻOhana 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.
- ʻOhana requires notification of a non-scheduled admission within 24 hours of the Member's admission to the hospital. Failure to notify ʻOhana is grounds for an administrative denial.

Referrals

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

While ʻOhana 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.

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

Prior Authorization is **required** for elective or non-emergency services as designated by ʻOhana. Guidelines for Prior Authorization requirements by service type are listed on ʻOhana's *Quick Reference Guide* on the website or by calling Customer Service.

Some Prior Authorization guidelines to note are:

- 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 authorization is 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 the elective or non-urgent admission. Refer to the *Quick Reference Guide* on 'Ohana's website for a list of services requiring Prior Authorization

Providers may submit requests for authorization by:

- Submitting an online authorization request via 'Ohana's secure provider portal at **www.ohanahealthplan.com/login/provider** (this option provides faster service);
- Faxing a properly completed *Inpatient or Outpatient Authorization Request Form*; or
- Calling 'Ohana for inpatient notifications and urgent outpatient services.

See *Standard, Expedited and Extensions of Service Authorization Decisions* section below for decision time frames. Fax numbers and mailing address are on the Prior Authorizations forms. Notification forms and authorization requests are at **www.ohanahealthplan.com/providers/medicaid/community-care-services.**

Concurrent Review

Concurrent review activities involve the evaluation of a continued inpatient stay or certain ongoing outpatient services for clinical appropriateness, utilizing appropriate criteria. The concurrent review or 'Ohana CCS care manager follows the clinical status of the Member through telephonic or remote access 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 'Ohana 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 MCG (Milliman Clinical Guidelines) or other approved 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 lower level of care when clinically indicated and appropriate
- Complete timely and effective discharge planning
- Identify referrals appropriate for disease management or quality of care review
- Identify cases appropriate for follow-up by the service coordinator or referral to CM

The concurrent review process incorporates the use of MCG (Milliman Clinical Guidelines) or other approved criteria to assess quality and appropriate level of care for continued treatment. Reviews are performed by licensed clinicians under the direction of 'Ohana 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 'Ohana review clinician. 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 'Ohana CCS care manager 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. ʻOhana CCS care managers conducts interdisciplinary treatment (IDT) team meetings for an inpatient Member with identified complex discharge needs.

ʻOhana CCS Care Management

The ʻOhana CCS Care 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 to assist with the development of a safe and effective discharge plan.

The ʻOhana CCS care manager'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 ʻOhana CCS care manager will refer Members with long-term needs or complex discharges to their external community case manager and QI Plan Health Coordinator.

Retrospective Review (Post-Service Review)

A retrospective review is any review of care or services that already have been provided. All requests for retrospective review can be requested up to one year from the date of service. There are two types of retrospective reviews that ʻOhana may perform:

- Retrospective Review initiated by ʻOhana:
    - ʻOhana 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 ʻOhana to support accurate coding and claims submission
- Retrospective Review initiated by Providers:
    - ʻOhana 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 ʻOhana 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. ʻOhana will also identify quality issues, utilization issues and the rationale behind failure to follow ʻOhana's Prior Authorization/precertification guidelines

ʻOhana will give a written notification to the requesting Provider and Member within 14 calendar days of receipt of a request for a UM determination. If ʻOhana cannot decide because of matters beyond its control, it may extend the decision time frame once, for up to 14 calendar days of 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 Clinical Services' Utilization Management Department via Customer Service. Refer to the *Quick Reference Guide* on 'Ohana's website for contact information.

Peer-to-Peer Review of Proposed Adverse Determination

In the event of a proposed adverse determination following a Medical Necessity review, Peer-to-Peer Review is offered to the treating physician via telephone or fax. The treating physician is provided a toll-free number to the medical director hotline to request a discussion with the medical director.

Services Requiring No Authorization

'Ohana has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of Members including:

- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a CLIA waiver do not require Prior Authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:
    - Molecular laboratory tests
    - Cytogenetic laboratory tests
- Certain tests described as CLIA-waived 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 'Ohana.

All services performed without Prior Authorization are subject to retrospective review by 'Ohana.

Proposed Actions/Notice of Adverse Benefit Determination (NOABD)

A proposed action is conducted by 'Ohana to deny a request for services. 'Ohana will notify the Member in writing of the proposed action. The notice will contain the following:

- The action 'Ohana has taken or intends to take
- The reasons for the action
- The Member's or Provider's right to appeal
- The Member's or Provider's right to an appeal with 'Ohana
- The Member's right to request a state 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 hearing will be granted when action is based upon change in federal and state law, as applicable
- The Member's rights to have benefits continue pending the 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

‘Ohana shall provide for a second opinion in any situation when there is a question concerning a diagnosis, the options for the treatment of a behavioral health condition when requested by the Member, any Member of the health care team, a parent(s) or legal guardian(s), or a DHS social worker exercising custodial responsibility. A qualified health care professional within the network shall provide the second opinion or ‘Ohana shall arrange for the Member to obtain a second opinion outside the provider network. The second opinion shall be provided at no cost to the Member.

Standard, Expedited and Extensions of Service Authorization Decisions

Type of Decision	Time Frames	Extension
Standard Pre-Service	14 calendar days	Additional 14 calendar days
Expedited Pre-Service	72 hours	Additional 14 calendar days
Post-Service	14 calendar days	14 calendar days

Standard Service Authorization

‘Ohana is committed to a maximum of 14 calendar day turn-around time on requests for Prior Authorizations. ‘Ohana will fax an authorization response to the Provider fax number(s) included on the authorization request form. An extension may be granted for 14 calendar days if the Member or the Provider requests an extension, or if ‘Ohana justifies a need for additional information and the extension is in the Member’s best interest.

Expedited Service Authorization

If the Provider indicates, or ‘Ohana determines, that following the standard time frame could seriously jeopardize the Member’s life or health, ‘Ohana will make an expedited authorization determination and provide notice within 72 hours of the request. **Requests for expedited decisions for Prior Authorization should be requested by telephone,** fax with a telephone call or submission through the website with a telephone call. Refer to the *Quick Reference Guide* on ‘Ohana’s website for the appropriate contact information.

Emergency/Urgent Care and Post-Stabilization Services

Emergency services are not subject to Prior Authorization requirements and are available to Members 24 hours per day, 7 days per week. Urgent care services should be provided within 24 hours. See *Section 12: Definitions* for definitions of “emergency” and “urgent.”

An emergency medical condition is:

- A medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention to result in:
    - Placing the health of the individual in serious jeopardy
    - Danger to self and others

Emergency services include inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson’s standard. The services must also be furnished by a Provider who is qualified to furnish such services.

‘Ohana shall base coverage decisions for initial screening examinations to determine whether an emergency medical condition exists on the severity of the symptoms at the time of presentation and shall cover these examinations when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

The emergency room physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on ‘Ohana, which shall be responsible for coverage and payment. ‘Ohana may deny reimbursement for any services provided on an emergent basis to a Member after the Provider could reasonably determine that the individual did not have an actual emergency medical condition.

If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability for the screening examination shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. In that case, ‘Ohana shall be responsible for payment for the behavioral health screening examination and other Medically Necessary emergency services, without regard to whether the condition meets the prudent layperson standard.

The Member who has an emergency medical condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. Emergency services are covered up to the point ‘Ohana Health Plan is notified that the Member’s condition has stabilized.

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 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 improve, or resolve the Member’s condition. ‘Ohana is responsible for providing post-stabilization care services 24 hours day, 7 days a week, both inpatient and outpatient.

Once the Member’s condition is stabilized, ‘Ohana may require precertification for hospital admission or Prior Authorization for follow-up care. ‘Ohana is financially responsible for post-stabilization services obtained from any Provider that are not prior authorized or precertified by a Provider or organization representative, regardless of whether the Provider is within or outside ‘Ohana’s Provider network, if these services are rendered to maintain, improve, or resolve the Members’ stabilized condition in the following situations:

- ‘Ohana does not respond to the Provider’s request for precertification or Prior Authorization within one hour
- ‘Ohana cannot be contacted
- ‘Ohana’s representative and the attending physician cannot reach an agreement concerning the Member’s care, and a physician is not available for consultation. In this situation, ‘Ohana shall give the treating physician the opportunity to consult with an in-network physician, and the treating physician may continue with the care of the Member until a physician is reached or one of the criteria outlined below are met

‘Ohana’s responsibility for post-stabilization services that it has not approved shall 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
- 'Ohana's representative and the treating physician reach an agreement concerning the Member's care
- The Member is discharged

If the Member receives post-stabilization services from a Provider outside of 'Ohana's network, the Member cannot be charged more than he or she would be charged if he or she had obtained the services through an in-network Provider.

Psychological Testing

Prior Authorization is required for psychological testing. A medical director will review the authorization request. The 'Ohana CCS care manager will work with the Member to locate a network psychologist who specializes in psychological testing.

Transition of Care

'Ohana will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside 'Ohana's network until such time as 'Ohana can reasonably transfer the Member to a service and/or network Provider without impeding service delivery that might be harmful to the Member's health. However, notification to 'Ohana is necessary to properly document these services and determine any necessary follow-up care.

After the initial transition of care requirements are completed, Providers are required to follow 'Ohana's Prior Authorization or concurrent review requirements.

If a Provider receives an adverse claim determination they believe was a transition-of-care issue, the Provider should fax the adverse claim determination to the Appeals Department. Refer to the *Quick Reference Guide* on 'Ohana's website for the appropriate contact information.

Authorization Request Forms

'Ohana requests Providers use standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to requests, including:

- *Inpatient Authorization Request Form* is used for services such as planned elective/non-urgent inpatient, and observation
- *Outpatient Authorization Request Form* is used for services such as partial day treatment, follow-up consultations, consultations with treatment, diagnostic testing, office procedures, out-of-network services and transition of care
- *Psychosocial Rehab (PSR) Authorization Request Form* is used for services such as initial and ongoing psychosocial rehab
- *Licensed Crisis Residential Authorization Request Form* is used for services such as residential treatment and crisis mobile outreach
- *Specialized Residential Treatment Authorization Request Form* is used to services such as initial and ongoing residential treatment

- *Case Management Authorization Request Form* is used for such services as case management, supported employment, supportive housing, and peer support
- *Intensive Outpatient Authorization Request Form* is used for such services as initial and ongoing intensive outpatient treatment

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
- 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.

All forms are at **www.ohanahealthplan.com/providers/medicaid/community-care-services/forms.** All forms should be submitted via fax to the number listed on the form.

Section 5: Claims

Overview

The focus of ʻOhana's Claims Department is to process claims in a timely manner. ʻOhana has a toll-free number for Providers to access a representative in the Customer Service department. For further information, refer to the *Quick Reference Guide* on ʻOhana's website.

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

ʻOhana (in partnership with PaySpan) has implemented an online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

Once registered, this no-cost secure service offers Providers a number of options to view and receive remittance details. ERAs can be imported directly into practice management or patient accounting system, eliminating the need to rekey remittance data.

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers do not receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from PaySpan's website once registration is completed.

Providers can register using PaySpan's enhanced Provider registration process at **payspan.com.** How to Register with PaySpan webinars are offered. Providers can register for the date and time that works best for them by contacting PaySpan directly.

PaySpan Health Support can be reached at **providersupport@payspanhealth.com**, at **1-877-331-7154** or at **payspanhealth.com.**

Timely Claims Submission

Unless otherwise stated in the Provider Contract, Providers must submit claims (initial, corrected and voided) within 12 months from the date of service. For Members who have been enrolled with a retroactive eligibility date Providers must submit claims (initial, corrected and voided) within 12 months of the date of service. When Medicare or any other Third Party Liability (TPL) are primary, Providers must submit claims within six months from the date of the Explanation of Benefits (EOB) or 12 months from the date of service, whichever is greater, as stated in the *Hawai'i Med-Quest Provider Manual* Claims Payment Section 4.3.5. Unless prohibited by federal law or CMS, ʻOhana may deny payment for any claims that fail to meet ʻOhana's submission requirements for Clean Claims or that are received after the time limit in the Provider Contract for filing Clean Claims.

The following items can be accepted as proof that a claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by ʻOhana
- A Provider's electronic submission sheet with all the following identifiers, including patient name, Provider name, date of service to match EOB/claim(s) in question, prior submission bill dates; and ʻOhana product name or line of business
- Proof of retro-enrollment from DHS

The following items are examples of what is not acceptable as evidence of timely submission:

- Rejection letters from the Health Plan Administep, Legacy and/or Imagenet including Strategic National Implementation Process (SNIP) Rejection Letter
- A copy of the Provider's billing screen

Tax Identification (TIN) and National Provider Identifier (NPI) Requirements

'Ohana requires the payer-issued Tax Identification (Tax ID/TIN) and National Provider Identifier (NPI) on all claim submissions. 'Ohana 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 at **https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index.html.**

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. 'Ohana 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

'Ohana follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS.

Strategic National Implementation Process

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 'Ohana's claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information on Encounters see the *Encounters Data* section below.

Claims Submission Requirements

Providers are required to certify in writing at the time of submission to 'Ohana or its designee that all data including but not limited to, Encounter Data and other information that DHS may specify, is truthful, reliable, accurate and complete.

Providers using electronic submission shall submit all claims to ʻOhana, or its designee, as applicable, using HIPAA-compliant 837 electronic format, or paper submission on a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider's NPI, Tax ID and the valid Taxonomy code that most accurately describes the services reported on the claim. ʻOhana requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. ʻOhana requires all diagnosis coding to be ICD-10-CM or its successor, as mandated by CMS. *Refer to Compliance section for additional information.* In addition, CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) are required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the Provider must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be used rather than reporting the tests or procedures individually.

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 Guid*e on ʻOhana's website.

For more information on Covered Services under ʻOhana's Medicaid plans, go to **www.ohanahealthplan.com/providers/medicaid/community-care-services**.

Electronic Claims Submissions

ʻOhana accepts electronic claims submission through electronic data interchange (EDI) as its preferred method. All files submitted to ʻOhana must be in the ANSI ASC X12N format, version 5010. For more information on EDI implementation with Ohana, refer to ʻOhana's *Companion Guides* at **www.ohanahealthplan.com/providers/medicaid/community-care-services/claims.**

Clearinghouses can exchange data with one another; Providers should work with their existing clearinghouse, or an ʻOhana-contracted clearinghouse, to establish EDI with ʻOhana. ʻOhana's preferred EDI partner is RelayHealth (McKesson). The EDI unique plan payor ID #14163 is used to identify ʻOhana on electronic claims submissions. Contact ʻOhana's EDI team or refer to the *Provider Companion Guides* at **www.ohanahealthplan.com/providers/medicaid/community-care-services/forms**.

275 Claim Attachment Transactions via EDI

Providers may submit unsolicited attachments **(related to preadjudicated claims**). In addition, the Plan may solicit claims attachments via 275 transactions through the clearinghouse to the billers that use the clearinghouse. At this time, electronic attachments (275 transactions) are not intended to be used for appeals, disputes or grievances.

What are Acceptable Electronic Data Interchange Healthcare Claim Attachment 275 Transactions?

Electronic attachments (275 transactions) are supplemental documents providing additional patient medical information to the payer that cannot be accommodated within the ANSI ASC X12, 837 claim format. Common attachments are certificates of medical necessity (CMNs), discharge summaries and

operative reports to support a healthcare claim adjudication. The 275 transaction is not intended to initiate Provider or Member appeals, grievances or payment disputes.

For more information on EDI implementation with `Ohana, refer to the *`Ohana Companion Guides* at **www.ohanahealthplan.com/provider/medicaid/resources**.

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires healthcare payers such as ʻOhana, 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 ʻOhana 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 ʻOhana, it is ʻOhana's policy that these requirements also apply to all paper and DDE transactions.

Paper Claims Submissions

ʻOhana does accept paper claims; however, for timelier processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties as specified in the Provider Contract. For help in creating an EDI process, contact ʻOhana's EDI team by referring to the *Quick Reference Guide* on ʻOhana's website.

If permitted under the Provider Contract 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, illegible, 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:
        - On an original red ink on white paper claim form
        - Typed. Do not print, hand-write or stamp any extraneous data on the form
        - In black ink
        - A large, dark font such as Pica/Arial 10-, 11- or 12-point type
        - In capital letters
    - The typed information must not have:
        - Broken characters
        - Script, italics or stylized font
        - Red ink
        - Mini font
        - Dot matrix font

CMS Fact Sheet about UB-04 and CMS-1500:
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts

Claims Processing

Readmission

'Ohana may choose to review claims if data analysis deems it appropriate. 'Ohana may review hospital admissions on a specific Member if it appears that two 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), 'Ohana will make all necessary adjustments to the claim, including recovery of payments that 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 'Ohana, may be subject to a recoupment.

Disclosure of Coding Edits

'Ohana uses claims editing software programs to assist in determining proper coding for Provider claims payment. Such software programs use industry-standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and state-specific regulations. These software programs may result in claim edits for specific procedure code combinations. They may also result in adjustments to the Provider's claims payment or a request for review of medical records, prior to or subsequent to payment, 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 'Ohana. A reduction in payment as a result of claim policies and/or processing procedures is not an indication that the service provided is a Non-Covered Service, and thus Providers must not bill or collect payment from Members for such reductions in payment.

Prompt Payment

'Ohana shall ensure that Clean Claims are paid within 30 calendar days of the date of receipt by 'Ohana. 'Ohana and the Provider may agree to an alternative payment schedule, provided the alternative payment schedule is reviewed and approved by DHS. 'Ohana 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)

'Ohana 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 shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to 'Ohana. Any balance due after receipt of payment from the primary payer should be submitted to 'Ohana for consideration and the claim must include information verifying the payment amount received from the primary plan as well as a copy of the Explanation of Benefits (EOB). Payment is never to exceed the Medicaid or Provider-contracted allowable. 'Ohana 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 'Ohana policies and procedures regarding subrogation activity.

Encounters Data

Overview

This section is intended to provide delegated vendors and delegated Providers and independent physician associations (IPAs) with the necessary information to allow them to submit Encounter Data to ʻOhana. If Encounter Data do not meet the service level agreements for timeliness of submission, completeness or accuracy, DHS can impose significant financial sanctions on ʻOhana. ʻOhana 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 Provider Contract, vendors and Providers should submit complete and accurate encounter files to ʻOhana as follows:

- Capitated entities will submit on a monthly basis

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

Accurate Encounters Submission

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements.
Once ʻOhana receives a delegated encounters from vendors or Providers, the encounters are loaded into ʻOhana's Encounters System and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on Workgroup for Electronic Data Interchange (WEDI), refer to **www.wedi.org**.
For more information on submitting encounters electronically, refer to ʻOhana *Companion Guides* at **www.ohanahealthplan.com/providers/medicaid/community-care-services/forms.**

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 ʻOhana's contracted clearinghouse(s), via DDE or using ʻOhana's Secure File Transfer Protocol (SFTP) and process.

Submitting Encounters Using ʻOhana's SFTP Process (Preferred Method)

ʻOhana accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using ʻOhana's SFTP process. Refer to ʻOhana'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 ʻOhana, refer to
www.ohanahealthplan.com/providers/medicaid/community-care-services/claims.

A unique Payer ID was included in ‘Ohana’s welcome letter. This Payer ID must be used to identify ‘Ohana on electronic claims submissions. For more information on the Payer IDs or to contact ‘Ohana’s EDI team, refer to the *Quick Reference Guide* on ‘Ohana’s website.

Submitting Encounters Using Direct Data Entry (DDE)

Delegated vendors and Providers may submit their encounter information directly to ‘Ohana using the DDE portal. The DDE tool can be found on the provider portal at **https://provider.wellcare.com/ohanacare.**

Encounters Data Types

Delegated vendors and Providers are required to submit four encounter types to ‘Ohana. Encounter records should be submitted using the HIPAA-standard transactions for the appropriate service type. The four encounter types are:

- Dental 837D format
- Professional – 837P format
- Institutional – 837I format
- Pharmacy – NCPDP format

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

Encounters submitted to ‘Ohana from a delegated vendor or Provider can be a new, voided or a replaced/overlaid encounter. The definitions of the types of encounters are:

- New Encounter – A new encounter is an encounter that has never been submitted to ‘Ohana previously
- Voided Encounter – A voided encounter is an encounter that ‘Ohana deletes from the encounter file and is not submitted to the state
- Replaced or Overlaid Encounter – A replaced or overlaid encounter is an encounter that is updated or corrected within ‘Ohana system

Balance Billing

Providers shall accept payment from ‘Ohana for Covered Services provided to Members in accordance with the reimbursement terms outlined in the Provider Contract. Payment made to Providers constitutes payment in full by ‘Ohana 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 Provider Contract. An adjustment in payment as a result of ‘Ohana’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 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 ‘Ohana 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 ʻOhana 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 ʻOhana, unless prior to rendering the service, the Provider obtained the Member's informed written consent and the Member received information that they would be financially responsible for the specific services
- Sales tax or GET on services rendered
- Member no-show fees

Providers may bill Members only:

- If a Member self-refers to a specialist or other network
- Provider without following ʻOhana procedures (e.g., without obtaining Prior Authorization) and ʻOhana denies payment to the Provider
- 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

Disputed Claims

The claims appeal process is designed to address claim denials for issues related to:

- Payment disputes or any other administrative dispute
- Untimely filing
- Incidental procedures
- Bundling
- Unlisted procedure codes
- Non-covered codes
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a healthcare Provider
- Inappropriate or unapproved referrals initiated by a Provider
- Any other reason for billing disputes
- No action or payment is required of the enrollee due to any of the disputes listed on this page.

Provider shall have the right to contest the denial of any claim in accordance with HI Chapter 4 Medicaid Provider Manual Claims Payments, Section 4.3.8 and HI Administrative Rule §17-1739.1-16. Claim payment disputes must be submitted to ʻOhana in writing within 120 calendar days of the date of denial on the EOP. Any appeal or grievance between a Provider and ʼOhana requires no action of the Member.

Such procedures shall not be applicable to any disputes that may arise between ʼOhana and any Provider regarding the terms, conditions, or termination or any other matter arising under contract between the Provider and ʼOhana.

Documentation must include:

- Date(s) of service
- Member name
- Member ʼOhana CCS ID number and/or date of birth
- Provider name
- Provider Tax ID/TIN

- Total billed charges
- Provider's statement explaining the reason for the dispute
- Supporting documentation when necessary (e.g., proof of timely filing, medical records)

To initiate the process, please fax request to **1-877-277-1808** or mail to:

'Ohana Health Plan
Attn: Claim Payment Disputes
P.O. Box 31370
Tampa, FL 33631-3370

Note: Any appeals related to claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification must be sent to the Appeals (Medical) address in Section 7: Appeals and noted below:

'Ohana Health Plans
Attn: Medical Appeals Dept.
P.O. Box 31368
Tampa, FL 33631-3368
Fax: **1-866-201-0657**

Examples include exclusion codes listed on the Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE; however this is not an all-encompassing list of codes addressed by the medical appeals department. Anything else related to authorization, or Medical Necessity that is in question should be sent to the Appeals PO Box, noted above, with all substantiating information like a summary of the appeal, relevant medical records and Member specific information.

Disputes for payment policy-related issues (EOB Codes beginning with IHXXX, MKXXX or PDXXX) must be submitted in writing to 'Ohana within the time frame as indicated in the 'Ohana Provider Manual or as specified in your Provider Contract. Please provide all relevant documentation (please do not include image of Claim), which may include medical records, to facilitate the review.
Mail or fax all disputes related to payment policy issues to:

'Ohana Health Plan
Attn: Payment Policy Disputes Department
PO Box 31426
Tampa, FL 33631-3426

Hold Harmless Dual-Eligible Members

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 'Ohana's payment as payment in full.

Non-Covered Services

Members may be billed for Non-Covered Services. If the Provider bills a Member for Non-Covered Services, she or he shall inform the Member and obtain prior written agreement from the Member regarding the cost of the procedure and the payment terms at time of service.

Corrected or Voided Claims

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

How to submit a corrected or voided claim electronically:

- Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8' – indicating to replace '7' or void '8'
- Loop 2300 Segment REF element REF01 should be 'F8' indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment REF element REF02 should be 'the original claim number' – the control number assigned to the original bill (original claim reference number for the claim Providers are intended to replace.)
- Example: REF✻F8✻WellCare Claim number here~

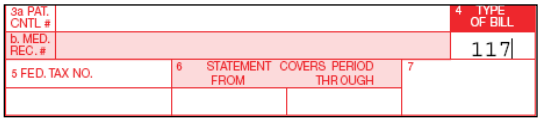
These codes are not intended for use for original claim submission or rejected claims.

To submit a Corrected or Voided Claim Via Paper

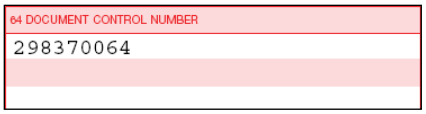
- For institutional claims, Provider must include the original 'Ohana claim number and bill frequency code per industry standards

Example:

Box 4 – Type of bill: the third character represents the "frequency code"



Box 64 – Place the claim number of the prior claim in Box 64



- For professional claims, Provider must include the original 'Ohana 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

ʻOhana 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).

Modifier

If there are no reimbursement guidelines specific to a modifier(s) on the Hawaiʻi Medicaid website, ʻOhana 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 Hawaiʻi Medicaid website specific to payment for non-physician practitioners or Allied Health Professionals, ʻOhana follows CMS reimbursement guidelines regarding Allied Health Professional.

Overpayment Recovery

ʻOhana strives for 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.

ʻOhana will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, ʻOhana will limit its notice of overpayment to 18 months from the last payment date. ʻOhana, 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 ʻOhana has on file but recognizes that the Provider may use the carrier address it has on file. The standard request notification provides 45 calendar 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 its Provider representative for account information. In situations where the overpaid

balance has aged more than three months, the Provider may be contacted by ʻOhana, or its designee, to arrange payment.

If a Provider independently identifies an overpayment, ʻOhana requires the Provider to 1) report that an overpayment has been received; 2) return the overpayment within 60 calendar days of the date the overpayment was identified; and 3) notify ʻOhana in writing as to the reason for the overpayment to:

ʻOhana Health Plan
Recovery Department
PO Box 31584
Tampa, FL 33631-3584

Providers with any questions about this can call Customer Service toll-free at **1-866-401-7540**. For more information on contacting ʻOhana's Provider Service Department, refer to the *Quick Reference Guide* at **www.ohanahealthplan.com/providers/medicaid/community-care-services**.

Section 6: Credentialing

Overview

Credentialing is the process by which the appropriate peer review bodies of ʻOhana evaluate the credentials and training qualifications of practitioners, including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations. For purposes of this Credentialing section, all references to "practitioners" shall include Providers providing health or health-related services including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare 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 that may affect a practitioner's ability to provide healthcare
- Accreditation status, as applicable to non-individuals
- Clinical Laboratory Improvement Amendment (CLIA Certificate of Waiver)
- Listing of disclosed owners

Practitioners are required to be credentialed prior to being listed as Participating Network Providers of care or services to 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 ʻOhana policy and procedure requirements, and include a query to the National Practitioner Data Bank
- Physicians, allied health professionals and ancillary facilities/healthcare delivery organizations are required to be credentialed in order to be network Providers of services to Members
- Satisfactory site inspection evaluations are required to be performed in accordance with state, federal and accreditation requirements

ʻOhana shall ensure that its Providers submit full disclosures as identified in 42

CFR Part 455, Subpart B. Disclosures shall include:

- The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and post office box address
    - Date of birth and Social Security Number of each person with an ownership or control interest in the disclosing entity
    - Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a 5% or more interest
- Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling
- The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest
- The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity
- The identity of any individual who has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs
- ʻOhana Health Plan shall obtain disclosures from its Providers at the following times:
    - When the provider submits a provider application
    - Upon execution of the Provider Contract
    - During recredentialing
    - Upon request from ʻOhana Health Plan or DHS
    - Within 35 calendar days after any change in ownership of the disclosing entity information to ʻOhana Health Plan
- The Provider shall submit, within 35 calendar days of the date on a request by ʻOhana Health Plan, the DHS, or the Secretary full and complete information about:
    - The ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request
    - Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five-year period ending on the date of the request

`Ohana may refuse to enter into or renew an agreement with a Provider if any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. In addition, ʻOhana may refuse to enter into or may terminate a Provider Contract if it determines that the Provider did not fully and accurately make any disclosure required above.

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 ʻOhana or by an entity approved by ʻOhana for delegated credentialing. If that credentialing is delegated to an outside agency, that agency shall be required to meet ʻOhana's criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and ʻOhana 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/reapplication cover letter.

Practitioner's Right to Be Informed of Credentialing/Recredentialing Application Status
Written requests for information may be emailed to **credentialinginquiries@wellcare.com.** Upon receipt of a request, ʻOhana will provide written information to the practitioner on the status of the credentialing/recredentialing application, generally within 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 information received compared with the information provided by the practitioner.

Practitioner's Right to Review Information Submitted in Support of Credentialing/Recredentialing Application
All practitioners participating within the ʻOhana network have the right to review information obtained by ʻOhana that is used to evaluate their credentialing and/or recredentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, malpractice insurance carriers and state licensing agencies.

The practitioner may review documentation submitted by her or him in support of the application/recredentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies and certification boards, subject to any restrictions. ʻOhana, or its designee, will review the corrected information and explanation at the time of considering the practitioner's credentials for Provider network participation or recredentialing.

The Provider may not review peer review information obtained by ʻOhana, such as references, personal recommendations, or other information.

Right to Correct Erroneous Information and Receive Notification of the process and Time Frame
If the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by ʻOhana, 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. ʻOhana will provide written notification to the practitioner of the discrepant information.

ʻOhana'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
- ‘Ohana’s documentation process for receiving the correction information from the Provider
- ‘Ohana’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 M.D./D.O./D.P.M./D.D.S./D.M.D.).

Work History – Practitioners must provide a minimum of five 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 ‘Ohana 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 an ‘Ohana-participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another ‘Ohana Participating Provider who has admitting privileges at a 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 Centene 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 ‘Ohana policy and procedure.

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

Site Inspection Evaluation

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
    - Physical accessibility
    - Physical appearance
    - Adequacy of waiting room and examination room space

- Medical/treatment record-keeping criteria

SIEs are conducted for:

- Unaccredited facilities
- 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 ‘Ohana.

Allied Health Professionals

Allied health professionals (AHPs), both dependent and independent, are credentialed by ‘Ohana. Dependent AHPs are required to provide collaborative practice information to ‘Ohana.

Examples of Allied Health Professionals include the following:

- Advanced practice registered nurse;
- Certified nurse midwife
- Nurse practitioner
- Certified registered nurse anesthetist
- Clinical nurse specialist
- Osteopathic assistant
- Physician assistant
- Licensed clinical social workers
- Licensed mental health counselors
- Licensed marriage and family therapists
- Physical therapists
- Occupational therapists
- Audiologists
- Speech/language therapists/pathologists

Ancillary Health Care Delivery Organizations

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

Recredentialing

In accordance with regulatory, accreditation and ʻOhana policies and procedures, recredentialing is required at least once every three 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 ʻOhana, prior to or concurrent with expiration.

Office of Inspector General Medicare/Medicaid Sanctions Report

On a monthly basis, ʻOhana 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 ʻOhana policies and procedures.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials

On a monthly basis, ʻOhana 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 ʻOhana Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with ʻOhana 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 ʻOhana policies and procedures.

If 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 determines whether the Provider should continue participation or termination should be initiated.

Participating Provider Appeal through the Dispute Resolution Peer Review Process

ʻOhana 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.

ʻOhana has a Participating Provider Dispute Resolution Peer Review panel process if it 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 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 qualified individuals of whom at least one 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 qualified individuals of which at least one 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 ʻOhana 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
- Non-renewal of participating practitioner status at time of recredentialing 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 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 30 calendar days to file a written request via recorded or certified return receipt mail to access the Dispute Resolution Peer Review 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. ʻOhana then notifies the practitioner of the schedule for the Review panel hearing.

The practitioner and ʻOhana 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 shall consider and decide the case objectively and in good faith. The medical director, within five business days after final adjournment of the Dispute Resolution Peer Review hearing, shall notify the practitioner of the results of the first-level panel hearing. If the findings are positive for the practitioner, the second-level review shall be waived.

If 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 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 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. If 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 and in the manner specified waives any right to such review to which s/he might otherwise have been entitled. ʻOhana 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 9: Delegated Entities* section in this Provider Manual for further details.

Section 7: 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 Adverse Benefit Determination.

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 'Ohana, 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 'Ohana receives the verbal filing.

Written grievances may be mailed to:

'Ohana Health Plan
Attn: Grievance Department
949 Kamokila Blvd., Suite 350
Kapolei, HI 96707

If the Member wishes to appoint another person as his/her representative, he or she must complete an *Appointment of Representative* (AOR) statement, available at **www.ohanahealthplan.com/providers/medicaid/community-care-services.** The Member and the person who will represent 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
- 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 'Ohana's Customer Service Department or directly to any 'Ohana employee at **1-866-401-7540**. Refer to the *Quick Reference Guide* at **www.ohanahealthplan.com/providers/medicaid/community-care-services.**

In fulfilling the grievance process requirements, 'Ohana shall:

- Send a written acknowledgement of the grievance within five business days. Convey a disposition, in writing, of the grievance resolution within 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 that 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 TTY numbers in the Member Handbook. Customer Service will serve as the intake point of grievance submission and to provide appropriate assistance with, forms and language support, but not limited to, auxiliary aids, such as providing interpreter capability in accordance with all Customer Service policies.

The Member may request a MQD grievance review within 30 calendar days of the grievance decision from ʻOhana. A request for a MQD grievance review may be made by contacting the MQD office 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**

ʻOhana will in no way discriminate against either Members or Providers for filing or supporting a grievance or appeal. ʻOhana (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
- 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 or authorized representative 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, ʻOhana will call, fax and/or mail a request to the Provider for a response. The Provider is given 10 business days to respond and/or submit medical records for review. If a Provider has not responded within 10 business days, a second call, fax and/or letter is sent giving an additional five 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 ʻOhana medical director for review. If the medical director 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 ʻOhana'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 30 calendar days of the closure of the committee. The quality information may be submitted to the Provider's quality file and discussed during recredentialing 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 Benefit Determination. A request for an Appeal can be made for the following actions:

- 'Ohana denies or limits a service requested by the Provider or Member
- 'Ohana reduces, suspends or stops a previously authorized service
- 'Ohana does not pay for the healthcare services that were rendered
- 'Ohana does not authorize services in the required time frames
- 'Ohana does not render a decision on an appeal in the required time frame
- 'Ohana does not provide a resolution on a grievance in the required time frame
- 'Ohana does not let a Member see a non-participating provider if Member lives in rural area or in an area with limited Providers who cannot meet Member's medical needs
- 'Ohana denies your request to dispute a financial liability.

'Ohana 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 healthcare services.

If the Member wishes to appoint another person as his/her representative, he/she must complete an *Appointment of Representative* (AOR) statement, available at **www.ohanahealthplan.com/providers/medicaid/community-care-services.** The Member and the person who will be representing the Member must sign the statement.

There is only one level of appeal with 'Ohana. An appeal may be filed when 'Ohana issues a Notice of Adverse Benefit Determination to a 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 60 calendar days of the notice of Adverse Benefit Determination. A verbal or written appeal may be submitted. 'Ohana will assist the Member, Provider or authorized representative in this process.

Appeals may be written to:

'Ohana Health Plan
PO Box 31368
Tampa, FL 33631-3368
Toll Free: 1-866-401-7540

'Ohana will acknowledge all standard appeal request within five business days from the receipt of the request for appeal. We 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 30 calendar days from the day 'Ohana receives the appeal.

If the denial is overturned, the Member and Provider on behalf of the Member will be notified of this decision in writing. If the request is approved, ʻOhana 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 ʻOhana overturns its adverse determination denying a Member's or Provider's request for payment, then ʻOhana will issue its reconsidered determination and send payment for the service.

ʻOhana may extend the resolution timeframe by up to 14 calendar days if the Member requests the extension, or ʻOhana 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, ʻOhana will attempt to give the Member verbal notice and give the Member written notice within two calendar days of the reason for the delay.

ʻOhana shall notify the Member, Member's representative and Provider in writing within 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.

ʻOhana 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
    - A statement that the Member may be held liable for the cost of those services if the hearing decision upholds ʻOhana's action

Expedited Appeal Process

ʻOhana 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 ʻOhana 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.

‘Ohana 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, ‘Ohana 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 72 hours from the time ‘Ohana received the appeal. ‘Ohana will make reasonable efforts to also provide verbal notice to the Member with the appeal determination.

‘Ohana may extend the expedited appeal resolution time frame by up to 14 calendar days if the Member requests the extension or ‘Ohana needs additional information and demonstrates to the MQD that the extension of time is in the Member’s interest.

‘Ohana will notify the MQD by phone and in writing within 24 hours regarding expedited appeals if an expedited appeal has been granted by ‘Ohana or if an expedited appeal time frame has been requested by the Member or ‘Ohana.

‘Ohana will provide the reason it is requesting a 14-day extension to the MQD. ‘Ohana will notify the MQD within 24 hours (or sooner if possible) from the time the expedited appeal is upheld.

For any extension not requested by the Member, ‘Ohana will make reasonable efforts to give the Member verbal notice of the extension and give the Member written notice of the reason for the delay.

If ‘Ohana 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 calendar days with a written notice
- Inform the Member verbally and in writing that they may file a grievance with ‘Ohana for the denial of the expedited process

Reversal of Denial of an Expedited Appeal Decision

If ‘Ohana 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 72 hours of receipt of the expedited appeal request.

Affirmation of Denial of an Expedited Appeal Decision

If ‘Ohana 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
- 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)

- That the Member may be liable for the cost of any continued benefits if ‘Ohana’s action is upheld

‘Ohana will provide the Member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing for all appeals. ‘Ohana will inform the Member of limited time available to present this information for expedited appeals. Members also have the right to request a copy of their appeal file free of charge anytime during and/or after the completion of the appeal.

DHS Administrative Hearing for Regular Appeals

If the Member is not satisfied with ‘Ohana’s written Notice of Disposition of the appeal, he or she may file for a DHS administrative hearing within 120 calendar days of the final decision by ‘Ohana. At the time of the denied Appeal determination, ‘Ohana 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 120 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 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 ‘Ohana’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 ‘Ohana has provided an expedited appeal process and the appeal decision was determined to be adverse to the Member (denied). In these situations, ‘Ohana will inform the Member that he or she must submit a letter to the AAO within 120 calendar days from the receipt of the Member’s appeal determination.

An expedited DHS administrative hearing must be heard and determined within three 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. ‘Ohana 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, ‘Ohana will submit information that was used to make the determination (e.g., medical records, written documents to and from the Member,

Provider, provider notes, etc.). ʻOhana will submit this information to the MQD within 24 hours of the decision to deny the expedited appeal.

Continuation of Benefits During an Appeal or DHS Administrative Hearing

ʻOhana will continue the Member's benefits if:

- The Member or the Member's authorized representative requested an appeal within 60 calendar days from the date on the Notice of Adverse Benefit Determination Letter
- The Member or the Member's authorized representative timely files for continuation of benefits on or before the later of the following:
    - Within 10 calendar days of ʻOhana mailing the Notice of Adverse Benefit Determination
    - The intended effective date of ʻOhana's proposed Adverse Benefit Determination
- The appeal or request for state administrative hearing involves the termination, suspension or reduction of a previously authorized services
- The services were ordered by an authorized Provider
- The original authorization period has not expired

If ʻOhana continues or reinstates the Member's benefits while the appeal or DHS administrative hearing is pending, ʻOhana will continue all benefits until one of the following occurs:

- The Member withdraws the appeal or requests for a State administrative hearing
- The Member does not request a state administrative hearing within 10 calendar days from when ʻOhana mails a Notice of Adverse Benefit Determination
- A state administrative hearing decision adverse to the Member is made

If the final resolution of the state administrative hearing is adverse to the Member, that is, upholds ʻOhana's Adverse Benefit Determination, then ʻOhana may recover the cost of the appealed services (those services furnished to the Member at the Member's request while the appeal or State administrative hearing were pending), to the extent that they were furnished solely because of the requirements of this section.

If ʻOhana or the State reverses a decision to deny, limit or terminate services that were not furnished while the appeal was pending, ʻOhana will authorize or provide these services no later than 72 hours from the date ʻOhana receives the notice reversing the decision.

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

Provider Grievances

ʻOhana 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 ʻOhana 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 60 calendar days following the date of submission to ʻOhana. ʻOhana shall give the Provider 30 calendar days from the decision of the grievance to file an appeal.

A Provider may file a written grievance to dispute ʻOhana's policies, procedures or any aspect of its administrative functions, including proposed actions, no later than 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:

ʻOhana Health Plan
Attn: Grievance Department
949 Kamokila Blvd., 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 ʻOhana's written policies and procedures.

ʻOhana will also ensure that the appropriate ʻOhana executives with the authority to implement corrective action are involved in the Provider grievance process. If the outcome of the review of the Provider grievance is adverse to the Provider, ʻOhana shall provide a written notice of adverse action to the Provider.

A Provider may also call ʻOhana's Customer Service department toll-free. Customer Service representatives are available to answer questions, help file a Provider grievance and resolve issues. The appropriate Customer Service Department contact information is on the *Quick Reference Guide* on ʻOhana's website.

Provider Payment Dispute/Administrative Appeals

Although it is our intent to satisfy you as Participating Provider, ʻOhana recognizes that there may be instances where Providers need to file a grievance or appeal a decision. The ʻOhana claims payment resolution procedure is outlined below and complies with the state of Hawaiʻi 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 Customer Service during normal business hours. Please refer to the *Quick Reference Guide* on ʻOhanaʻs website.

Electronic Inquiries

ʻOhana 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 ʻOhana's EDI Assistance line, which is listed on the *Quick Reference Guide.*

Informal Claim Payment Resolution Procedure – Adjustment Requests

An informal claim resolution procedure precedes the formal claim resolution procedure. The informal claim resolution procedure lets Providers make complaints verbally, in written correspondence, faxes, online inquiries and emails.

To resolve claims issues, verbal or written requests by Participating Providers must be received by ʻOhana within 120 calendar 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
- Any aspect of claims functions, including proposed actions

ʻOhana will review the claim or claim-related issue for resolution and respond to the Provider within 60 calendar days of the day after the date of submission to ʻOhana.

ʻOhana 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 ʻOhana's Customer Service department either verbally or in writing. The appropriate contact information is on the *Quick Reference Guide* on ʻOhana's website.

Administrative Appeals

An administrative appeal is a payment dispute between Provider and ʻOhana for services already provided where the Provider does not agree with the results of ʻOhana'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 ʻOhana'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:

ʻOhana Health Plan
PO Box 31368
Tampa, FL 33631-3368

The Provider should file an appeal, which must be received within 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 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 ʻOhana's 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 90 calendar days of the Provider's EOP.
- ʻOhana's Appeals Department will render a written determination within 60 calendar days of the receipt of the appeal.
- If additional information is requested, the Provider must submit the additional information within 60 calendar days. If the information is not received within 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 local Provider Relations representative, or contact Customer Service. Refer to the *Quick Reference Guide* for contact information.

Submission of Provider Termination Appeal Request

If a Provider termination is initiated by ʻOhana, regardless of whether the termination is for cause or not, ʻOhana 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 ʻOhana's termination notice. ʻOhana will send an acknowledgement letter to the Provider within five business days of receipt of the appeal request. ʻOhana may request additional information from the Provider in order to review the appeal. If this is the case, the Provider has 10 business days to submit the required documentation. If the documentation is not received within 10 business days, ʻOhana 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 ʻOhana overturns the termination of the Provider, ʻOhana will ensure that there is no lapse in the period of the Provider's participation with ʻOhana.

Termination Upheld

If ʻOhana upholds its termination of the Provider, ʻOhana will notify Members 30 calendar days prior to and no later than five business days after the termination effective date of their assigned PCP. Members will be requested to select a new PCP within 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.

ʻOhana 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 or more times within the past 12 months, 30 calendar days prior to and no later than five business days after the termination effective date.

Section 8: Compliance

Overview

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

'Ohana's compliance-related training requirements include, but are not limited to, the following initiatives:

- HIPAA Privacy and Security Training
    - To encompass privacy and security requirements in accordance with the federal standards established pursuant to HIPAA
    - Must include, but not limited to:
        - Uses and Disclosures of PHI
        - Member rights
        - Physical and technical safeguards
- Fraud, Waste and Abuse (FWA) Training
    - Must include, but not limited to:
        - Laws and regulations related to FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.)
        - Obligations of the Provider including Provider employees and Provider subcontractors and their employees to have appropriate policies and procedures to address FWA
        - Process for reporting suspected Fraud, Waste and Abuse
        - Protections for employees and subcontractors who report suspected FWA
        - Types of FWA that can occur
- Cultural Competency Training
    - Programs to educate and identify the diverse cultural and linguistic needs of the Members who 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 'Ohana any suspected Fraud, Waste or Abuse, misconduct or criminal acts by 'Ohana, or any Provider, including Provider employees and/or Provider sub-contractors, or by Members. Reports may be made anonymously through 'Ohana's FWA Hotline at **1-866-685-8664**.

Details of the corporate ethics and compliance program may be found at **www.centene.com/who-we-are/ethics-and-integrity.html**.

Marketing Hawai'i Medicaid Plans

'Ohana is required to submit marketing materials to DHS for approval prior to use or distribution. Participating Providers are required to submit to 'Ohana any marketing materials developed and distributed related to the CCS program.

The Department holds 'Ohana 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 'Ohana without the express written consent of an authorized 'Ohana 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 'Ohana.

International Classification of Diseases (ICD)

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). 'Ohana uses ICD for all diagnosis code validation and follows all CMS mandates for any future ICD changes, which includes ICD-10 or its successor.

All Providers must submit HIPAA compliant diagnoses codes ICD-10-CM. Please refer to the CMS website for more information about ICD-10 codes at **www.cms.gov**, and the ICD-10 Lookup Tool at **www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx** for specific codes.

Information on the ICD-10 transition and codes can also be found at **www.wellcare.com/Hawaii/Providers/ICD10-Compliance.**

Code of Conduct and Business Ethics

Overview

'Ohana's **Code of Conduct and Business Ethics** outlines ethical principles to ensure that all business reflects an unwavering allegiance to ethics and compliance. 'Ohana's Code of Conduct and Business Ethics policy are at **www.centene.com/who-we-are/ethics-and-integrity.html**.

The Code of Conduct and Business Ethics is the foundation of 'Ohana's Corporate Ethics and Compliance Program. It describes 'Ohana's firm commitment to operate in accordance with the laws and regulations governing its business and accepted standards of business integrity. All Providers should familiarize themselves with 'Ohana's **Code of Conduct and Business Ethics**. Participating Providers and other contractors of 'Ohana are required to report compliance concerns and any suspected or actual misconduct to the Ethics and Compliance Hotline at **1-800-345-1642**, and may do so anonymously.

Fraud, Waste and Abuse (FWA)

‘Ohana is committed to the prevention, detection and reporting of healthcare FWA according to applicable federal and state statutory, regulatory and contractual requirements. ‘Ohana has developed an aggressive, proactive FWA prevention program designed to collect, analyze and evaluate data in order to identify suspected Fraud, Waste and Abuse. Detection tools have been developed to identify patterns of problematic healthcare service use, including overutilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement, and ‘Ohana vigorously investigate incidents of suspected FWA. 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 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 the confidential and toll-free ‘Ohana FWA Hotline at **1-866-685-8664** or send a report in writing to:

‘Ohana Health Plan
Attn: Special Investigations Unit
PO Box 31407
Tampa, Florida 33631-3407

Details of the corporate ethics and compliance program, and how to contact ‘Ohana’s FWA Hotline, may be found at **www.centene.com/who-we-are/ethics-and-integrity.html**.

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 behavioral 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, behavioral 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 NPP informs the Member of their rights under HIPAA and how the Provider and/or 'Ohana may use or disclose the Members' PHI. HIPAA regulations require each covered entity, such as healthcare 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. 'Ohana 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 'Ohana's Customer Service department using the toll-free telephone number found on their ID card. Providers may contact 'Ohana's Customer Service department by referring to the *Quick Reference Guide* on 'Ohana's website.

Cultural Competency Program and Plan

Overview

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

The objectives of the Cultural Competency program are to:

- Use culturally sensitive and appropriate educational materials based on the Member's race, ethnicity, and primary language spoken
- Make resources available to address the unique language barriers and communication barriers that exist in the population
- Decrease healthcare disparities in the minority populations ʻOhana serves

Culturally and Linguistically Appropriate Services (CLAS) are healthcare services provided that are respectful of, and responsive to, cultural and linguistic needs. The delivery of culturally competent healthcare and services requires that healthcare Providers and/or their staff possess a set of attitudes, skills, behaviors, and policies that enable the organization and staff to work effectively in cross-cultural situations.

The components of ʻOhana's Cultural Competency program include:

- Data Analysis – ʻOhana analyzes data on the populations in each region ʻOhana serves for the purpose of learning about that region's cultural and linguistic needs, as well as any health disparities specific to that region. Such analyses are performed at the time ʻOhana enters a new market and regularly thereafter, depending on the frequency with which new data become available. Data sources and analysis methods include the following:
    - State-supplied data for Medicaid and CHIP populations
    - Demographic data available from the U.S. Census and any special studies done locally
    - Claims and encounter data to identify the healthcare needs of the population by identifying the diagnostic categories that are the most prevalent
    - Member requests for assistance, or Member grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle
    - Data on race, ethnicity and language spoken for Members can be collected both electronically from the state data received and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers
- ʻOhana's success requires linking with other groups that share the same goals.
    - ʻOhana reaches out to community-based organizations that support racial and ethnic minorities, and the disabled, to help ensure that existing community resources for Members who have special needs are used to their full potential. The goal is to coordinate the deployment of both community and health plan resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.
    - ʻOhana develops and maintains grassroots sponsorships that enhance our effort to reach low-income communities. ʻOhana also provides opportunities for building meaningful relationships that benefit all members of the communities. These sponsorships are coordinated with Providers, community health fairs and public events.
- Diversity and Language Abilities of ʻOhana: ʻOhana recruits diverse talented staff to work in all levels of the organization. ʻOhana does not discriminate with regard to race, religion or ethnic background when hiring staff.
    - ʻOhana ensures that bilingual staff members are hired for functional units that have direct contact with Members to meet the needs identified. Today, one-third of our Customer Service representatives are bilingual. Spanish is the most common translation required. Whenever possible, ʻOhana will also distinguish place of origin

of our Spanish-speaking staff, to help ensure sensitivity to differences in cultural backgrounds, language idioms and accents.

- Where ‘Ohana enrolls significant numbers of Members who speak languages other than English or Spanish, ‘Ohana seeks to recruit staff Members who are bilingual in English plus one of those other languages. We do this even if the particular population is not of a size that triggers state agency mandates.
- Providers are inventoried for their language abilities. This information is listed in the Provider Directory so Members can choose a Provider who speaks their primary language.
- Providers are recruited to ensure a diverse range of Providers to care for the population served.
- Providers will identify Members who have potential linguistic barriers for which alternative communication methods are needed and will contact ‘Ohana to arrange appropriate assistance.
- Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency, and sign language for the hearing impaired. These services are provided by vendors with such expertise and coordinated by ‘Ohana's Customer Service Department.
- Written materials are available for Members in large-print format, and certain non-English languages prevalent in ‘Ohana's service areas.
- Telephone system adaptations – Members have access to the TTY line for hearing-impaired services. ‘Ohana's Customer Service Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY number can be found on the Member identification card.

- Provider Education
    - ‘Ohana's Cultural Competency Program provides a checklist to assess the cultural competency of Providers' offices.

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

For more information on the Cultural Competency Program, registered provider portal users may access the Cultural Competency training at **www.ohanahealthplan.com/providers/medicaid/community-care-services**. A paper copy, at no charge, may be obtained upon request by contacting Customer Service or a Provider Relations representative.

Section 9: Delegated Entities

Overview

‘Ohana may, by written contract, delegate certain functions under ‘Ohana’s contracts with CMS and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, sales & marketing, utilization management, quality management, case management, disease management, claims processing, credentialing, network management, Provider appeals, and customer service. ‘Ohana may delegate all or a portion of these activities to another entity (a Delegated Entity).

‘Ohana oversees the provision of services provided by the Delegated Entity and/or sub-delegate, and is accountable to the federal and state agencies for the performance of all delegated functions. It is the sole responsibility of ‘Ohana to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and ‘Ohana policies and procedures.

Delegation Oversight Process

‘Ohana participates in a Delegation Oversight Committee (DOC) that was formed to be the governing body for the delegation oversight process, which provides oversight of subcontracted vendors where specific services are delegated. ‘Ohana defines a “delegated entity” as a subcontractor that performs a core function under one of ‘Ohana’s government contracts. The Delegation Oversight Committee is chaired by the Director, Corporate Compliance Oversight. The committee members include appointed representatives from the following areas: Corporate Compliance, Legal, Shared Services Operations, Clinical Services Organization, and market representatives from each Regional Area. The Chief Compliance Officer has ultimate authority as to the composition of the Delegation Oversight Committee membership. The Delegation Oversight Committee will hold monthly meetings or more frequently as circumstances dictate.

Refer to *Section 8: Compliance* for additional information on compliance requirements.

‘Ohana monitors compliance through the delegation oversight process and the Delegation Oversight Committee through the following activities:

- Validating the eligibility of proposed and existing Delegated Entities for participation in the Medicaid and Medicare programs
- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity’s ability to perform the delegated function
- Providing guidance on written agreement standards with delegated entities to clearly define and describe delegated activities, responsibilities and required regulatory reports to be provided by the entity
- Conducting ongoing monitoring activities to evaluate an entity’s performance and compliance with regulatory requirements and accreditation standards
- Conducting annual audits to verify the entity’s performance and processes support sustained compliance with regulatory requirements and accreditation standards
- The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity’s performance is substandard or terms of the agreement are violated

- Review and initiate recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements
- Track and trend compliance with oversight standards, entity performance and outcomes.

Section 10: Pharmacy

Overview

'Ohana's pharmaceutical Utilization Management (UM) 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 its Members. The utilization management tools used to optimize the pharmacy program include:

- Preferred Drug List (PDL)
- Mandatory generic policy
- Step Therapy (ST)
- Quantity Limit (QL)
- Age Limit (AL)
- Coverage determination/Prior Authorization review process (PA)
- Emergency supply (see Coverage Determination Review Process below for details)
- Pharmacy lock-in program
- Provider Education Program
- AcariaHealth™ Pharmacy

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

- Follow national standards of care guidelines for treating conditions
- Prescribe drugs listed on the PDL
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class
- Evaluate medication profiles for appropriateness and duplication of therapy

To contact 'Ohana's pharmacy services, please refer to the *Quick Reference Guide* on 'Ohana's website.

Preferred Drug List

The 'Ohana Preferred Drug List (PDL) contains information for pharmaceutical UM procedures including:

- A list of covered pharmaceuticals, including restrictions and preferences, and co-payment information, if applicable.
- How to use the pharmaceutical UM procedures including the prior authorization process and an explanation of limits or quotas on refills, doses & prescriptions.
- How to submit an exception request.
- The process for generic substitution, therapeutic alternatives, and step-therapy protocols.

The PDL is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmaceutical and Therapeutics Committee (P&T Committee).

The P&T Committee's selection of drugs is based on the drug's efficacy, safety, side effects, pharmacokinetics, clinical literature and cost-effectiveness profile. The medications on the PDL are

organized by therapeutic class, product name, strength, dosage form, and coverage details (quantity limit, age limitation, Prior Authorization and step therapy).

The PDL is at **www.ohanahealthplan.com/providers/medicaid/community-care-services/pharmacy**. Practitioners may call **1-866-401-7540** to receive a copy of the pharmaceutical management procedures and updates by mail, fax or email. Any changes to the list of pharmaceuticals and applicable pharmaceutical UM procedures are communicated to Providers via:

- Quarterly updates in Provider and Member newsletters
- Website updates, including the P&T PDL change notices
- Pharmacy and Provider communication that detail any major changes to a particular medication or therapeutic class (deletions from the PDL are communicated to providers a minimum of 30 calendar days in advance)

Additions and Exceptions to the Preferred Drug List

To request consideration for inclusion of a drug to ʻOhana's PDL, Providers may write to ʻOhana to explain the medical justification. For contact information, refer to the *Quick Reference Guide* on ʻOhana's website.

For more information on requesting exceptions, refer to the *Coverage Determination Review Process* section below.

Generic Medications

The use of generics is a key drug 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. Exceptions to the mandatory generic policy require medical justification when therapeutic equivalents are available. A *Coverage Determination Request* form should be completed when requiring an exception. 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 *Coverage Determination Request* form, see *Coverage Determination Review Process* section below.

Coverage Limitations

The following is a list of non-covered drugs and/or categories:

- Agents used to treat non-behavioral health conditions
- DESI drugs or drugs that may have been determined to be identical, similar or related
- Investigational or experimental drugs
- Agents prescribed for any indication that is not medically accepted

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

All OTC drugs listed on the PDL as covered will require a prescription for the pharmacy to dispense.

Over-the-Counter (OTC) Medications

OTC items listed on the PDL require a prescription. Examples of OTC items listed on the PDL include:

- Diphenhydramine
- Vitamin B complex
- Thiamine

For a complete list, please see the PDL at **www.ohanahealthplan.com/providers/medicaid/community-care-services/pharmacy**.

Member Co-Payments

There are no co-payment requirements for CCS Members.

Coverage Determination Review Process

The goal of the Coverage Determination Review Program (CDRP) (also known as Prior Authorization) is to help ensure that medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to Food and Drug Administration (FDA)-approved indications. The Coverage Determination Review (CDR) process is required for:

- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limit
- Drugs not listed on the PDL
- Drugs listed on the PDL, but still requiring Prior Authorization (PA)
- Drugs that have a Step Therapy edit and the first-line therapy is inappropriate
- Drugs that have an Age Limit and patient is not within limits
- Brand-name drugs when a generic exists and is covered
- Drugs used for BH conditions, not covered by primary payer (e.g., Medicare)

Providers may request an exception to ‘Ohana’s PDL orally or in writing. For written requests, Providers should complete a *Coverage Determination Request* Form, supplying pertinent Member medical history and information. A *Coverage Determination Request* form is at **www.ohanahealthplan.com/providers/medicaid/community-care-services/forms.**

Upon receipt of the *Coverage Determination Request* Form, a decision is completed within 24 hours of the receipt of the completed request. If authorization cannot be approved or denied, and the drug is Medically Necessary, a seven-day emergency supply of the non-preferred drug shall be supplied to the Member.

Medication Appeals

To submit a request to appeal a Coverage Determination Review decision, orally or in writing, refer to the contact information listed in the *Quick Reference Guide* on ‘Ohana’s website.

Once the appeal of the coverage determination review request decision has been properly submitted and obtained by ʻOhana, the request will follow the appeals process described in *Section 7: Appeals and Grievances.*

Pharmacy Management –– Provider Education Program

The Pharmacy Provider Education Program is designed to provide Providers with utilization reports to identify overutilization and underutilization of pharmaceutical products as well as medication adherence reports. The reports will also identify opportunities for optimizing best practices guidelines and cost-effective therapeutic options, and strategies to improve medication adherence. These reports are delivered by Ohana's pharmacy director and/or pharmacy staff to physicians identified for the program.

AcariaHealth™ (an Envolve Pharmacy Solution)

AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions. AcariaHealth is comprised of dedicated healthcare professionals who work closely with physician's offices, including support with referral and prior authorization processes. This collaboration allows our patients to receive the medicine they need as fast as possible.

Representatives are available from Monday–Thursday, 2 a.m. to 1 p.m., and Friday, 2 a.m. to 12 p.m. (HST).

AcariaHealth Pharmacy #26, Inc.
8715 Henderson Rd., Tampa, FL 33634
Phone: **1-866-458-9246** (TTY **1-855-516-5636**)
Fax: **1-866-458-9245**
Website: **www.acariahealth.com**

Section 11: ‘Ohana CCS Resources

‘Ohana CCS Homepage
www.ohanahealthplan.com/providers/medicaid/community-care-services

Provider Homepage
www.ohanahealthplan.com/providers/medicaid/community-care-services

Quick Reference Guide
www.ohanahealthplan.com/providers/medicaid/community-care-services

Provider Manual
www.ohanahealthplan.com/providers/medicaid/community-care-services

Forms and Documents
www.ohanahealthplan.com/providers/medicaid/community-care-services/forms

Pharmacy
www.ohanahealthplan.com/providers/medicaid/community-care-services/pharmacy Error! Hyperlink reference not valid.

Job Aids
www.ohanahealthplan.com/providers/medicaid/community-care-services

Clinical Practice Guidelines
www.ohanahealthplan.com/Providers/Clinical-Guidelines/CPGs

Clinical Care Guidelines
www.ohanahealthplan.com/providers/tools/clinical-guidelines/clinical-coverage-guidelines

Claims
www.ohanahealthplan.com/providers/medicaid/community-care-services/claims Error! Hyperlink reference not valid.

Quality
www.ohanahealthplan.com/providers/medicaid/community-care-services/quality

Training and Education
www.ohanahealthplan.com/providers/medicaid/community-care-services
A Provider must be a registered user of ‘Ohana’s secure online provider portal to access.

Section 12: Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the Provider Contract Providers have with ʻOhana.

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 healthcare. The definition also includes Member practices that result in unnecessary cost to the Medicaid program.

Adverse Benefit Determination means any of the following**:**

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the state.
- The failure of the Company to act within ninety (90) calendar days from the date the Health Plan receives a grievance, or thirty (30) calendar days from the date the Health Plan receives an appeal;
- For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network;
- and the denial of an enrollee's request to dispute a financial liability

Appeal means a request from a Member to change a previous decision made by ʻOhana.

Appointed Representative means a person who is expressly permitted by the Member or who has the power under Hawaiʻi law to make healthcare decisions on behalf of the Member, including;

- A court-appointed legal guardian
- A person who has a durable power of attorney for healthcare
- 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 ʻOhana agrees the treatment is necessary.

Benefit Plan means a health benefit policy or other health benefit contract or coverage document (a) issued by ʻOhana or (b) administered by ʻOhana pursuant to a Government Contract. Benefit plans and their designs are subject to change periodically.

Carve-Out Agreement means an agreement between ʻOhana 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 radiology, laboratory, dental, vision or hearing services.

Centers for Medicare & Medicaid Services (CMS) means the U.S. federal agency that administers Medicare, Medicaid and the Children's Health Insurance Program.

Clean Claim means a claim for Covered Services provided to a Member that:

- Is received timely by ʻOhana
- Has no defect, impropriety, or lack of substantiating documentation from the Member's medical record regarding the Covered Services
- Is not subject to coordination of benefits or subrogation issues
- 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 ʻOhana-specific requirements in ʻOhana Companion Guide, including all then current guidelines regarding coding and inclusive code sets
- Includes all relevant information necessary for ʻOhana to:
    - Meet requirements of laws and program requirements for reporting of Covered Services provided to Members
    - Determine payer liability, and ensure timely processing and payment by ʻOhana. 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 at 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 ʻOhana or its affiliates, as amended from time to time. ʻOhana's Claims/Encounter Companion Guides are part of the Provider Manual.

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

Cost-Effective means if 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 (DHS) Med-Quest Division (MQD).

EPSDT means Early Periodic Screening, Diagnosis and Treatment program that provides Medically Necessary healthcare, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a), to all Members under the age of 21.

Emergency Medical Condition means the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency services or immediate medical attention to result in:

- Placing the 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 body functions;
- Serious dysfunction of any bodily functions;

- 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 who is having contractions:
    - That there is inadequate time to affect a safe transfer to another hospital before delivery; or
    - That 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.

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 72 hours after receipt of the request for expedited appeal.

Explanation of Payment or **EOP, also known as a Remittance Advice,** means an 'Ohana-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 an 'Ohana determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of 'Ohana, 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.

ICD-10-CM means *International Classification of Diseases, 10th Revision, Clinical Modification*

Ineligible Person means an individual or entity who:

- is currently excluded, debarred, suspended or otherwise ineligible to participate in:
    - Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG

    - Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration
- has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for federal healthcare 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
- 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 ʻOhana.

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.

Medical Necessity means those procedures and services, as determined by the department, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is 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.

Medically Necessary means services that are medically necessary as defined in the Hawaiʻi Revised Statutes (HRS) 432E-1.4 for provision of behavioral health services *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
- The health intervention is the most cost-effective method available to address the medical condition

Member means an individual who meets all eligibility requirements for Community Care Services (CCS), and for whom all applicable expenditure shares have been paid.

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.

MQD means the Med-QUEST Division of the Department of Human Services (DHS).

Notification means a communication to ʻOhana, 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 that defines age-appropriate services and time frames for Screenings within the Early Periodic Screening, Diagnosis and Treatment Services (EPSDT) program.

PCP or **Primary Care Provider** means a licensed or certified healthcare practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse, physician assistant, or health clinic, including an 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 24 hours per day, 7 days per week primary healthcare services to individuals, and for a Member who has a gynecological or obstetrical healthcare needs, 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. ʻOhana may request additional information including a medical record review.

Provider or Participating Provider means any person (including physicians or other healthcare professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the state of Hawaiʻi to provide healthcare services that has contracted with ʻOhana to provide healthcare services to Members.

QUEST Integration (QI) is a statewide Medicaid demonstration project (Section 1115 waiver) that provides a package of medical, dental, behavioral health, and Long-Term Services and Support (LTSS) benefits to individuals meeting the Medicaid financial and non-financial eligibility requirements for individuals and families. Description of the individuals eligibility and benefits for QI are found in Hawaiʻi Administrative Rules, Title 17, Med-QUEST Division (1700 series).

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 healthcare professional to determine if further diagnosis or treatment is needed.

Service means healthcare, 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 that treatment should not wait for a normally scheduled appointment. Urgent care services should be provided within 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.

Addendum A: Telehealth Services CPT Codes

This is not the complete listing; additional codes may apply.

CPT Code	Description
0188T, 0189T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient
90791 -90792	Psychiatric diagnostic interview examination
90832 - 90834; 90836 -90838	Individual psychotherapy
90845, 90846, 90847	Family psychotherapy
90863	Pharmacologic management
90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961	End-Stage Renal Disease (ESRD)-related services
90963-90966	End-Stage Renal Disease (ESRD)-related services for home dialysis per full month
90967-90970	End-Stage Renal Disease (ESRD)-related home services
92227, 92228	Remote imaging detection of retinal disease
93228	External mobile cardiovascular telemetry with electrocardiographic recording
93229	Technical support for connection and patient instructions for use
93268, 93270-93272	External patient and, when performed, auto activated electrocardiographic rhythm
93298, 93299	Implantable loop recorder system
96040	Medical genetics and genetic counseling services
96116	Neurobehavioral status examination
96150-96154	Individual and group health and behavior assessment and intervention
97802-97804	Medical nutrition therapy face-to-face with patient, each 15 minutes
98960-98962	Education and training for patient self-management
99201 -99215	Office or other outpatient visits
99231 -99233	Subsequent hospital care services
99241 -99245	Office consultation for a new or established patient
99251 -99255	Inpatient consultation for a new or established patient
99307-99310	Subsequent nursing facility care services
99354-99357	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service
99406, 99407	Smoking cessation services
99408, 99409	Alcohol and substance abuse services
99495, 99496	Transitional care management services
99497, 99498	Advanced care planning

This listing is a summary of HCPCS codes that may be used for reporting telemedicine services when appended by modifier GT or GQ:

HCPCS Code	Description
G0108-G0109	Individual and group diabetes self-management training services
G0270	Individual and group medical nutrition therapy
G0396-G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services
G0406 -G0408	Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs
G0420- G0421	Individual and group kidney disease education services
G0425-G0427	Telehealth consultations, emergency department or initial inpatient
G0438, G0439	Annual wellness visit
G0442	Annual alcohol misuse screening
G0443	Brief face-to-face behavioral counseling for alcohol misuse
G0444	Annual depression screening
G0445	High-intensity behavioral counseling to prevent sexually transmitted infection
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease
G0447	Face-to-face behavioral counseling for obesity
G0459	Telehealth pharmacologic management
G0508	Telehealth consultation, initial critical care
G0509	Telehealth consultation, subsequent critical care

References:

1. Act 226 (July 7, 2016) (to be codified at HRS Chapters 346, 431, 432, 453, 457, 671).
2. CPT 2017 Standard.

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