2024 Hawai'i Medicaid QUEST Integration Provider Manual

'ohana health plan™

OhanaHealthPlan.com

Partners in Quality Care

Dear Provider Partner:

At ‘Ohana 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.

‘Ohana’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 ‘Ohana provider partner!

Sincerely,

‘Ohana Health Plan

Quality Highlights

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- Responsibilities of all Providers
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Date	*Section*	*Comments*	*Page Number*	*Change*
01/03/2023	*Section 2: Provider and Member Administrative Guidelines*	*Access Standards*	*26*	*Corrected Access Standard for Behavioral Health follow-up Routine Care*
9/4/2024	*Section 2: Quality Improvement*	*Diamond Designation Program*	*43-44*	*Updated program information*

Section 1: Welcome to ʻOhana

Overview

ʻOhana Health Plan (ʻOhana) is a wholly owned subsidiary of Centene Corporation, a leading multi-line healthcare enterprise. Centene provides managed care services exclusively for 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:

ʻOhana Health Plan – Main Office
949 Kamokila Blvd.
3rd Floor, Suite 350
Kapolei, HI 96707

ʻOhana Health Plan – Maui Office
285 W. Kaʻahumanu Ave.
Suite 101B
Kahului, HI 96732

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

For specific correspondence information, refer to the ʻOhana Quick Reference Guide at ***www.ohanahealthplan.com/provider/medicaid/resources****.*

ʻOhana's Medicaid Managed Service Plan

ʻOhana has contracted with the State of Hawaiʻi, Department of Human Services Med-QUEST Division (DHS/MQD), to provide Medicaid managed care services.

Purpose of this Manual

This Provider Manual is intended for ʻOhana QUEST Integration (QI)-contracted (participating) Medicaid Providers providing healthcare service(s) to enrolled ʻOhana QI Members.

This Manual serves as a guide to the policies and procedures governing the administration of ʻOhana's Medicaid plan and is an extension of and supplements the Participating Provider Agreement (Agreement) between ʻOhana and healthcare Providers, who include, without limitation: physicians, hospitals, facilities, behavioral health Providers and ancillary Providers (collectively, Providers). ***This Manual replaces and supersedes any versions dated before September 4, 2024, and is at*** ***www.ohanahealthplan.com/provider/medicaid/resources****. A paper copy may be obtained at no*

*charge upon request by contacting Customer Service at **1-888-846-4262** or a Provider Relations representative. ʻOhana will provide a paper copy within thirty (30) days.*

*In accordance with Section 4.6 of the Agreement, participating plan Providers must abide by all applicable provisions contained in this Manual. Revisions to this Manual reflect changes made to ʻOhana policies and procedures. The Provider Manual will be updated on ʻOhana's website within five days of any changes. Substantive revisions shall become binding 30 days after notice is provided in writing by mail (via letter or postcard) or electronic means, or such other period of time as necessary for ʻOhana to comply with any statutory, regulatory, contractual and/or accreditation requirements. A paper copy may be obtained at no charge upon request by contacting Customer Service at **1-888-846-4262** or a Provider Relations representative.*

Eligibility

*Membership enrollment in ʻOhana's Medicaid managed care plan is solely determined by DHS. For eligibility criteria, please refer to the MQD website at **https://medquest.hawaii.gov**.*

Covered Benefits and Services

As of the publication date of this Manual, the following core benefits and services (Covered Services) are provided to ʻOhana's Medicaid Members:

- *Primary and acute services*
- *Dental*
    - *Fluoride varnish for children 1-6 years old*
- *Diagnostic tests (labs, imaging services)*
- *Dialysis*
- *Diabetes Self-Management Education (DSME)*
- *Durable medical equipment (DME) and medical supplies*
- *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including the diagnosis and Intensive Behavioral Therapy (for example, Applied Behavior Analysis or ABA) services for Members with an Autism Spectrum Disorder (ASD)*
- *Emergency and post-stabilization services*
- *Habilitation services*
- *Hospice services*
- *Immunizations*
- *Inpatient hospital days for medical and surgical care to include:*
    - *Post-stabilization services*
    - *Maternity and newborn care*
    - *Sterilization and hysterectomies**
- *Mosquito repellant*
- *Non-emergency transportation*
- *Outpatient hospital procedures or ambulatory surgery center procedures to include but not limited to:*
    - *Sleep laboratory services*

    - *Surgeries performed in a free-standing ambulatory surgery center (ASC) and hospital ASC*
- *Outpatient medical or behavioral health visits to include:*
    - *Family planning*
    - *Home health*
    - *Medical services related to dental needs*
    - *Nutrition counseling*
    - *Other practitioner services*
    - *Physician services*
    - *Podiatry*
    - *Post-stabilization services, if applicable*
    - *Preventive services*
    - *Smoking cessation*
    - *Urgent care*
    - *Vision and hearing services*
- *Pregnancy-related services*
- *Prescription drugs include medications that are determined Medically Necessary to optimize the Member's medical condition, including behavioral health prescription drugs for children receiving services from CAMHD, medication management and patient counseling*
- *Rehabilitation services, both inpatient and outpatient, to include cognitive rehabilitation services*

'Ohana is responsible for corneal transplants and bone grafts. These require prior authorization.

***Sterilizations**

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

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

- *Is younger than 21 years of age at the time she or he signs the consent*
- *Is not mentally competent*
- *Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility*

The required DHS-1146 Consent Form must be completed and submitted to 'Ohana.

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

The signed consent form expires 180 calendar days from the date of the Member's signature.

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

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

***Hysterectomies**

Prior authorization is required for the administration of a hysterectomy to validate Medical Necessity. 'Ohana reimburses Providers for hysterectomy procedures only when the following requirements are met:

- *The Provider ensured that the Member was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing. This does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy*
- *Prior to the hysterectomy, the Member and the attending physician must sign and date the Patient's Acknowledgement of Prior Receipt of Hysterectomy Information, Form DHS-1145 and DHS-1146 Consent Form*
- *In the case of prior sterility or emergency hysterectomy, a Member is not required to sign the consent form*
- *The Provider submits the properly executed Form DHS-1145 with the claim prior to submission to 'Ohana*
- *An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to the Member who is visually impaired, hearing impaired, or otherwise disabled*
- *If the Member is incapacitated pursuant to HRS §560:5-102, then a court order pursuant to HRS §§560:5-601 through 608 is required and the required amount of time shall pass pursuant to HRS §560:5-609.*

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

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

*All forms are on 'Ohana's website at **www.ohanahealthplan.com/providers/medicaid/forms**.*

Telehealth Services

'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 provide Members with the flexibility to interact with Providers and improve health outcomes in the state.

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

- *Telehealth services are provided by a licensed healthcare Provider working within the scope of their practice.*
    - *Telehealth services 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 Provider-patient relationships may be established via telehealth services if the patient is referred by the patient's established PCP, unless excluded by the patient's health plan*
    - *Out-of-network telehealth services will only be covered if the health plan referral requirements of the patient's plan 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 ʻOhana coverage criteria.*
- *Documentation supporting Medical Necessity should be legible and maintained in the patient's medical record and made available to ʻOhana upon request. ʻOhana 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 the patient's health plan and healthcare Provider's contract, if applicable.*
- *Emergency department telehealth services for QUEST Integration 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.*

Long Term Services and Supports (LTSS)

- *Home and Community-Based Services (HCBS):*
    - *Adult day care*
    - *Adult day health*
    - *Assisted living services*
    - *Attendant Care*
    - *Community Care Management Agency (CCMA) services*
    - *Counseling and training*
    - *Environmental accessibility adaptations*
    - *Home-delivered meals*
    - *Home maintenance*
    - *Moving assistance*
    - *Non-medical transportation*
    - *Personal assistance services – Level I and Level II*
    - *Personal Emergency Response Systems (PERS)*
    - *Residential care including E-ARCH and CCFFH*
    - *Respite care*
    - *Skilled (or private duty) nursing*
    - *Specialized medical equipment and supplies*
- *Institutional services:*
    - *Acute Waitlisted ICF/SNF*

- *Nursing Facility (NF), Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF) and Subacute facility services*

Specific criteria must be met to receive these services and must have prior authorization.

At-Risk Services

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

Members must live at home or in a community shelter (for example, YMCA, YWCA, IHS) and need to meet the "At-Risk" criteria. An assessment is completed by the Member's physician or health coordinator with documentation to support the functional status and needs. Services will be based on Medical Necessity and needs of the Member. The plan must consider natural support systems of the Member.

At-risk services may include:

- *Home-delivered meals*
- *Personal Emergency Response System (PERS)*
- *Personal care services (Level I and/or Level II)*
- *Adult day care or adult day health*
- *Skilled (or private duty) nursing services*

Members who meet nursing facility level of care (NFLOC) and receive services in an institutionalized setting such as in a nursing facility, hospital, or hospice facilities do not qualify for "At-Risk" services.

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

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services include Medically Necessary healthcare, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a), for all Members younger than the age of 21.

For the most up-to-date information on Covered Services, refer to the MQD website at ***https://medquest.hawaii.gov****.*

Extra Benefits

- *Free over the counter (OTC) supplies. Members can get $10 credit for OTC items every month, for a total of $120 per year. Members can order items such as diapers, sunscreen, aspirin and more. The items can be mailed directly to the Member's home.*
- *Free General Education Diploma (GED) Exam. Members 18 and older who don't have a high school diploma can take the GED tests at no cost to them.*

Non-Covered Services

The following list represents non-Covered Services and procedures and is not meant to be exhaustive. ('Ohana will review a treatment or service for Medical Necessity upon request.)

- *Services not considered to be Medically Necessary*
- *Any laboratory service performed by a Provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual Providers of any laboratory service*
- *Investigational or experimental services such as new treatment that has not been accepted universally as a form of treatment*
- *Cosmetic procedures or services performed solely to improve appearance*
- *Hysterectomy procedures, if performed for hygienic reasons or for sterilization only*
- *Medical or surgical treatment of infertility (for example, the reversal of sterilization, in-vitro fertilization, etc.)*
- *All procedures listed in the CPT or HCPCS description as "unlisted" or "unspecified"*
- *Educational supplies; medical testimony; special reports; travel by the physician; no-show or canceled appointments; additional allowances for services provided after office hours or between 10 p.m. and 8 a.m. or on Sundays and holidays; calls, visits or consultations by telephone and other related services*
- *Biofeedback or hypnotherapy*
- *Services provided free of charge to Hawai'i Medicaid Members by county health departments, free clinics, or state laboratories, for example, metabolic screens for Members younger than 1 year of age, etc.*
- *Services and/or procedures performed without regard to the policies contained in this Manual*
- *Hospital visits if the hospital admission and/or length of stay are disallowed by 'Ohana*
- *Tubal anastomosis*
- *Penile prosthesis*
- *Infertility procedures and related services other than assessment*
- *Thermography*
- *Sensitivity training, encounter groups or workshops*
- *Sexual competency training*
- *Education testing and diagnosis*
- *Paternity testing*
- *Postmortem services*
- *Services, including but not limited to drugs, which are investigational, mainly for research purposes or experimental in nature*
- *Sterilization of a mentally incompetent or institutionalized Member*
- *Services provided in countries other than the United States*

- *Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Hawai'i Medicaid program regulations referenced herein*
- *Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage*

Services Covered by Other Agencies or Other Entities

- ***ITOP***
  'Ohana is not responsible for covering any Intentional Terminations of Pregnancy (ITOP). The Provider is to contact the DHS fiscal agent for guidance on coverage and claims submission of this service. DHS shall cover all procedures, medications, transportation, meals, and lodging associated with ITOPs. All costs associated with ITOPs shall be covered with state funds only. Call the DHS at ***1-808-692-8124*** *(Oahu) and toll-free at* ***1-800-316-8005*** *for transportation and lodging.*

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

- ***State of Hawai'i Organ and Tissue Transplant (SHOTT) Program***
  The DHS will provide transplants through the SHOTT program that are not experimental or investigational and not covered by the health plan. The SHOTT program covers adults and children (defined as those from birth through the month of their 21st birthday) for liver, heart, heart-lung, lung, kidney, kidney-pancreas and allogeneic and autologous bone marrow transplants. In addition, children will be covered for transplants of the small bowel, with or without liver. Children and adults must meet specific medical criteria as determined by the state and the SHOTT program contractor. The state and the SHOTT program contractor will determine eligibility of individuals for transplants.

  The health plan shall work with the Providers to submit a request for an evaluation by the SHOTT Program, to include the referral request as well as complete supporting documentation. 'Ohana will provide assistance to the Member as needed. 'Ohana may resubmit the Member for reconsideration if the Member's condition changes to make them a better candidate for a transplant. 'Ohana will continue to provide medical services to the Member until acceptance into the SHOTT program.

Provider Services

Providers may contact Customer Service at ***1-888-846-4262*** *Monday through Friday, 7:45 a.m. to 4:30 p.m. Customer Service agents are available to assist with Provider inquiries. Providers may also find*

important ʻOhana addresses, phone numbers, fax numbers and authorization requirements by referring to the Quick Reference Guide which may be found at ***www.ohanahealthplan.com/provider/medicaid/resources****.*

ʻOhana 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;*
- ***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/provider/medicaid/resources****. For more information about ʻOhana's*

online capabilities, please call Customer Service or contact Provider Relations to schedule a website in-service training.

Additional Resources

*The following resources are at **www.ohanahealthplan.com**. 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

*'Ohana's website, **www.ohanahealthplan.com**, offers a variety of tools to assist Providers and their staff. Resources include:*

- *Provider Manuals*
- *Quick Reference Guides*
- *Clinical Practice Guidelines*
- *Clinical Coverage Guidelines*
- *'Ohana Companion Guide*
- *Forms and documents*
- *Pharmacy and Provider lookup (directories)*
- *Authorization look-up tool*
- *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

Chat is a convenient way to ask simple questions and receive real-time support. Providers can use our Chat application as an alternative to calling and speaking with agents. Here are some ways our Chat support can help you and your staff: authorizations, claims, benefits, eligibility, appeals, web support assistance and real-time claim adjustments. Explore the benefits of 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.*
- ***You can 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 is unable to resolve the issue, the issue is routed to another team for further assistance*

Customer Service

Customer Service can help you with all provider service questions, such as claims, eligibility, benefits, authorizations, grievances and appeals, 7:45 a.m.to 4:30 p.m. HST, Monday through Friday, excluding State holidays. Our self-service features as listed below are available 24-7 and can be accessed when convenient for you.

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 **1-888-846-4262**.*

*Customer Service phone number (toll-free): **1-888-846-4262***

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. Please refer to the Participating Provider Agreement (Agreement) or contact a Provider Relations representative for clarification of any of the following:

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

- *Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act, the Age Discrimination Act, the Americans with Disabilities Act, and the Rehabilitation Act*
- *Agree to cooperate with ʻOhana in its efforts to monitor compliance with its Medicaid contract(s) and/or DHS rules and regulations, and assist in complying with corrective action plans necessary to comply with such rules and regulations*
- *Retain all agreements, books, documents, papers and medical records related to the provision of services to ʻOhana 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 (PAs) and Advanced Practice Registered Nurses (APRNs) should provide direct Member care within the scope or practice established by the rules and regulations of DHS and 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: APRN, PA) to Members and to other healthcare professionals*
- *Honor at all times any Member request to be seen by a physician rather than a physician extender*
- *Administer, within the scope of practice, treatment for any Member in need of healthcare services*
- *Maintain the confidentiality of Member information and records*
- *Allow ʻOhana to use Provider performance data for quality improvement activities*
- *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 the Quality Improvement section and Compliance section*
- *Ensure that: (a) all employed Providers and other healthcare practitioners comply with the terms and conditions of the Agreement between the Provider and ʻOhana; and (b) the Provider maintains written agreements with employed Providers and other healthcare practitioners, which agreements contain similar provisions to the Agreement. Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene*

- *Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to 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 regimens*
- *Not discriminate in any manner between ʻOhana Medicaid Members and non-ʻOhana 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 ʻOhana Medicaid Member on the basis of any factor that is related to health status, including but not limited to, the following: a) medical condition, including mental as well as physical illness; b) claims experience; c) receipt of 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 ʻOhana Members regarding the diagnosis of the Member's condition and advocate on the Member's behalf for Member's health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services*
- *Identify Members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, Providers must refer Members to 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*

`Ohana will provide one on one training to Providers if the full array of services to support Members and Providers are not being accessed as needed. These include:

- ***Community Integration Services** – Pre-tenancy supports and tenancy sustaining services that support individuals to be prepared and successful tenants in housing that is owned, rented, or leased*
- ***Collaboration of Care Model** – Allows for the primary care physician to bill for consults with behavioral health providers*
- ***Comprehensive Service Center** – For people who are deaf, hard of hearing or deaf-blind*
- ***Regional Health Partnerships** – To improve the care for high cost, high need patients who have many non-medical needs*
- ***Project ECHO** – Designed to build primary care physicians' skills and improve access to and capacity for specialty care*
- ***Regional Enhanced Referral Network** – `Ohana's has a commitment to ensure referrals for Members can be made successfully.*

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 ʻOhana contract.

The DHS shall provide dental services to health plan Members through the month of their 21st birthday.

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

Responsibilities and Expectations of All Providers

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

- *Comply with all responsibilities set forth in this Provider Manual*
- *Make available treatment for any Member in need of 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 utilize network ʻOhana Providers, except when they are not available or in an emergency. If unable to locate a participating ʻOhana Provider for services required, call Customer Service at* ***1-888-846-4262*** *for assistance*
- *Admit Members only to participating hospitals, skilled nursing facilities (SNFs) and other inpatient care facilities, except in an emergency*
- *Fully disclose to Members their treatment options and allow them to be involved in treatment planning*
- *Freely communicate with Members about their treatment, regardless of benefit coverage limitations*
- *Provide access to 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] (Healthcare Effectiveness Data and Information Set) service*
- *Submit encounters. For more information on encounters, refer to Section III Claims*
- *Comply with and participate in corrective action and performance improvement plan(s)*
- *Continually educate Members on how to access services through ʻOhana*

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

The Right to Inspect, Evaluate and Audit

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

Providers are prohibited from employing or subcontracting with individuals or entities whose owner or managing employees are on the state or federal exclusions list, and from making referrals for designated health services to 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 Members who were scheduled to receive a Medicaid Covered Service.

Living Will and Advance Directives

Members have the right to control decisions relating to their medical care, including the decision to withhold or remove medical or surgical means or procedures to not prolong their life. Providers must comply with the advance directives requirements for hospitals, nursing facilities, Providers of home and healthcare hospices and HMOs specified in 42 CFR Part 489, subpart I, and 42 CFR Section 417.436(d).

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

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

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

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

Provider Billing and Address Changes

*Providers are required to give prior notice to their Provider Relations representative or Customer Service at **1-888-846-4262** 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 Agreement, Providers must adhere to the following terms:

- *Any contracted Providers must give at least 90 days' prior written notice (180 days for a hospital) to ʻOhana before terminating their relationship with ʻOhana "without cause," unless otherwise agreed to in writing. This ensures adequate notice may be given to Members regarding a Provider's participation status with ʻOhana. Please refer to the Agreement for details regarding the specific required number of days for giving termination notice, as Providers may be required by contract to give more notice than listed above*
- *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.

ʻOhana shall immediately transfer a Member to another Primary Care Provider (PCP), health plan or 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 plan termination (if any).

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

Out-of-Area Member Transfers

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

Members With Special Health Care Needs

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

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

Examples may include:

- *Intellectual disability or related conditions*
- *Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders*
- *Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes*
- *Children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care*
- *Related populations eligible for SSI*

The following is a summary of responsibilities specific to 'Ohana Providers who render services to Members who have been identified with special health care needs:

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

For more information on Utilization Management for Individuals with Special Health Care Needs (SHCN), refer to Section 4 Utilization Management and Disease Management.

Primary Care Providers (PCPs)

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

'Ohana allows selected specialists or other healthcare practitioners to serve as PCPs for Members with chronic conditions, provided:

- *The Member has selected a specialist with whom they have a historical relationship as their PCP*
- *The specialist agrees, in writing, electronically or verbally to assume responsibility as their PCP*

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

In the event the specialist/clinic agrees to assume the responsibilities of a PCP for an 'Ohana Member, they must adhere to the PCP requirements stated below.

'Ohana will maintain a Member-to-PCP ratio of less than, or equal to, 1:300. 'Ohana cannot restrict Members from choosing a PCP who exceeds the 1:300 ratio.

Responsibilities of PCPs

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

- *Coordinate, monitor and supervise the delivery of Medically Necessary primary care services for each Member, including EPSDT services for Members younger than the age of 21*
- *See Members for an initial office visit and assessment, including EPSDT screenings, within the first 90 days of enrollment in 'Ohana; for pregnant women, the first 14 days of enrollment; for newborns, within the first 24 hours of birth*
- *Coordinate and initiate referrals for specialty care/services as Medically Necessary (both in- and out-of-network)*
- *Maintain continuity of each Member's healthcare and maintain the Member's health record (this includes documentation of services provided by the PCP as well as any specialty services)*
- *Participate in the service plan development process coordinated by the health coordinator in conjunction with the Member and as needed, specialty Providers. As appropriate, and to the extent desired by the Member, 'Ohana will allow the participation of family members, significant others, caregivers, etc., in the service plan development process. For more information, refer to Section VI* Health *Coordination*
- *Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infants and Children (WIC) program for nutritional assistance*
- *Provide or arrange for coverage of services, consultation or approval for referrals 24 hours per day, 7 days per week. To ensure accessibility and availability, PCPs must provide one of the following:*
    - *A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP*

    - *Answering system with option to page the physician for a return call within a maximum of 30 minutes*
    - *An advice nurse with access to the PCP or on-call physician within a maximum of 30 minutes*
- *The PCP must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the Member's needs*
- *'Ohana shall monitor Providers against these standards to ensure Members can obtain needed health services within the acceptable appointments and in-office waiting times and after-hours. 'Ohana is required to submit, on a quarterly basis, timely access reports to monitor the time elapsed between a Member's initial request for an office appointment and the date of the appointment. Providers not in compliance with these standards will be required to implement corrective actions set forth by 'Ohana:*

Type of Appointment	*Access Standard*
PCP – Urgent Care (child and adult)	*< 24 hours*
PCP – Child Sick Care	*< 24 hours*
PCP – Adult Sick Care	*< 72 hours*
PCP – Regular and Routine Care (child and adult)	*< 21 days*
PCP – After-hours Care	*Immediate care 24 hours per day, 7 days per week*
Specialist Care – High Volume	*< 4 weeks*
Specialist Care – High Impact	*< 4 weeks*
Non-Emergency Hospital Stay	*< 4 weeks*
Behavioral Health – Non-Life-Threatening Emergency	*Within 6 hours*
Behavioral Health – Initial Routine Care (child and adult)	*Within 10 business days*
Behavioral Health – Urgent Care	*Within 48 hours*
Behavioral Health – Follow-up Routine Care	*Within 21 calendar days*

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are provided to eligible children younger than 21 years of age. Any Provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide EPSDT screening services, is responsible for:

- *Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible Members in accordance with the periodicity schedule provided by the American Academy of Pediatrics (AAP)*
- *Referring the Member to an out-of-network provider for treatment if the service is not available within Ohana's network and requesting prior approval for such*
- *Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines*
- *Providing vaccinations in conjunction with EPSDT/Well-child visits. Providers are required to use vaccines available without charge under the Vaccines for Children (VFC) program for Medicaid children 20 years old and younger*
- *Addressing unresolved problems, referrals and results from diagnostic tests, including results from previous EPSDT visits*
- *Referring Members with an Autism Spectrum Disorder (ASD) diagnosis to behavior therapy, including intensive behavior therapy, for example, Applied Behavior Analysis (ABA)*
- *Requesting a prior authorization for Medically Necessary EPSDT special services in the event other healthcare, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Hawai'i Medicaid program*
- *Monitoring, tracking and following up with Members:*
    - *Who have not had a health assessment screening*

    - *Who miss appointments to assist them in obtaining an appointment*
- *Ensuring Members receive the proper referrals to treat any conditions or problems identified during the health assessment, including tracking, monitoring and following up with Members to ensure they receive the necessary medical services*
- *Assisting Members with transitioning to other appropriate care for children who age out of EPSDT services*

Providers will be sent a monthly membership list which specifies children eligible for a health assessment who have not had an encounter within 120 days of joining ʻOhana or are not in compliance with the EPSDT Program.

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

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

For more information on EPSDT Covered Services, refer to Section 1: Welcome to ʻOhana. For more information on the Hawaiʻi Medicaid EPSDT program forms, refer to the DHS website at ***https://medquest.hawaii.gov/en/plans-providers/managed-care-providers/provider-epsdt.html***.

For more information on the periodicity schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at ***https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx*****.**

Primary Care Offices

PCPs provide comprehensive primary care services to ʻOhana Members. Primary care offices participating in ʻOhana's Provider network have access to the following services:

- *Support of the Provider Relations, Customer Service, Population Health and Clinical Operations and Marketing and Sales departments, as well as the tools and resources at* ***www.ohanahealthplan.com/provider/default***
- *Information on ʻOhana network Providers for the purposes of referral management and discharge planning*

Federally Qualified Health Centers (FQHCS) and Rural Health Centers (RHCS) Required to Offer Urgent Care to Medicaid Patients

The QUEST Integration program requires that all Medicaid Members have access to Covered Services for urgent care at any FQHC or RHC without prior authorization. If urgent services are provided to any ʻOhana Member, the FQHC or RHC should refer the Member back to his or her assigned Primary Care Provider (PCP) to ensure continuity of care or assist the Member in selecting a new PCP if one is needed. The Member's PCP name and telephone number are listed on his or her ʻOhana Member ID card. If you have any questions about an ʻOhana Member who has received services at your center, please call

Customer Service at
1-888-846-4262.

Closing of Provider Panel

When requesting closure of a Provider panel to new and/or transferring ʻOhana Members, PCPs must:

- *Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel*
- *Maintain the panel to all ʻOhana 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 an ʻOhana Member, 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 ʻOhana Members. For more information, please refer to Section 6: Credentialing.

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

Termination of a Member

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

Reasonable efforts should always be made to establish a satisfactory Provider-Member relationship in accordance with practice standards. The Provider should provide adequate documentation on the Member's medical record to support his/her efforts to develop and maintain a satisfactory Provider-Member relationship. If a satisfactory relationship cannot be established or maintained, the Provider shall continue to provide medical care to the ʻOhana Member until such time written notification is received from ʻOhana stating the Member has been transferred from the Provider's practice, and such transfer has occurred.

Requests for transfer of Members should be submitted via ʻOhana's secure provider portal by users who have Administrator rights for their contract or subgroup. 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.

Smoking Cessation

PCPs should direct Members who smoke and wish to quit smoking to call 'Ohana's Customer Service department and ask to be directed to the Disease Management department. A Disease Management nurse educates the Member on national and community resources that offer assistance, as well as smoking cessation options available to the Member through 'Ohana.

Adult Health Screening

An adult health screening should be performed by a physician to assess the health status of all ʻOhana Members ages 21 and older. The adult Member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the adult preventive health guidelines and the Member physical screening tool, both on ʻOhana's corporate website at ***https://www.wellcare.com/Hawaii/Providers/Clinical-Guidelines****.*

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 within 10 days of receiving the notice of enrollment from DHS will be informed that the Member Handbook is available on the ʻOhana Health Plan website. Enrolled Members may request a paper copy of the Member Handbook without charge, which will be provided within 5 business days. Annually the Health Plan will provide a weblink to the online Member Handbook to all enrolled Members.

Enrollment

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

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

There may be exceptions to enrollment/eligibility per DHS. Please refer to the state website ***https://medquest.hawaii.gov****.*

Upon enrollment in ʻOhana, Members are provided with the following:

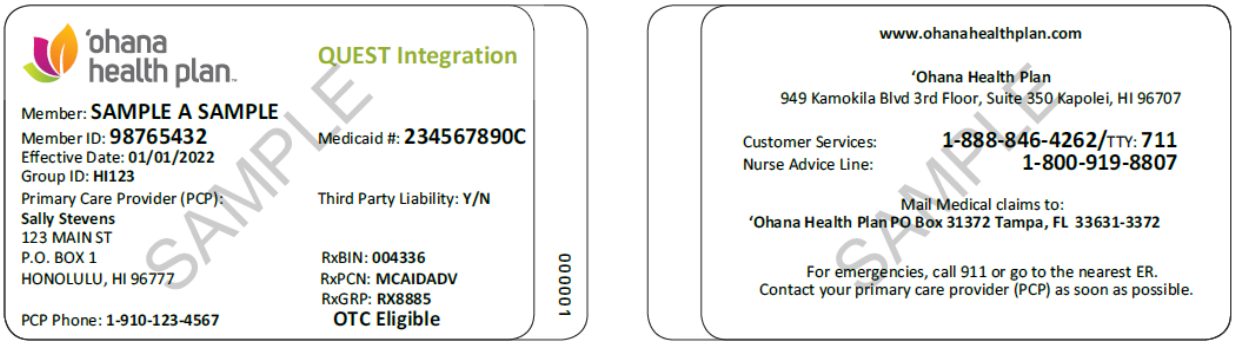
- *Terms and conditions of enrollment*
- *Description of Covered Services in-network and out-of-network (if applicable)*
- *Information about PCPs, such as location, telephone number and office hours*
- *Information regarding out-of-network emergency services*

- *Grievance and disenrollment procedures*
- *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 ʻOhana Members and the type of plan they have, and to facilitate their interactions with healthcare Providers. Information found on the Member ID card may include the Member's name, identification number, plan type, PCP's name and telephone number, effective date, Eligibility Renewal date (the Member's eligibility review date for the next calendar year), Third Party Liability (TPL) information, health plan contact information and claims filing address and 24-hour nurse call center phone number. Members enrolled in a Medicare Advantage plan as their primary insurance are not required to choose a PCP with ʻOhana; however, Members with fee-for-service Medicare shall choose a PCP even if not in ʻOhana's Provider network.

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



Eligibility Verification

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

Providers may do one of the following to verify eligibility:

- *Access the secure provider portal at **www.ohanahealthplan.com/provider/default***
- *Access ʻOhana's Interactive Voice Response (IVR) system*
- *Call Customer Service at **1-888-846-4262***

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 Agreement for additional details.

Member Rights and Responsibilities

'Ohana Members, both adults and children, have specific rights and responsibilities. These are included in the Member Handbook.

'Ohana Members have the right to:

- *Be treated with respect and with due consideration for their dignity and their right to privacy*
- *Receive information about 'Ohana, its services, its Practitioners and healthcare Providers and Member rights and responsibilities*
- *Receive information pursuant to 42 CFR §438.100(a)(1)(2) and §§9.4.C and 9.4.D of this RFP;*
- *Have the protections listed in the Patients' Bill of Rights and Responsibilities Act (HRS Chapter 432E)*
- *Have all records and medical and personal information remain confidential*
- *Participate with practitioners in making decisions regarding their healthcare, including the right to refuse treatment*
- *Be furnished healthcare services in accordance with 42 CFR sections 438.206 through 438.210*
- *Be free from any form of restraint or seclusion as a means of coercion, discipline, inconvenience or retaliation, as specified in federal regulations on the use of restraints and seclusion*
- *Request and receive a copy of their medical records, 45 CFR Parts 160 and 164, subparts A and E, and request that they be amended or corrected, 45 CFR §§164.524 and 164.526*
- *Freely exercise their rights, including those related to filing a grievance or appeal, without any adverse effects in the way 'Ohana or DHS treat the Member*
- *Have their privacy protected*
- *Know the names and titles of the Providers who take care of them*
- *Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand*
- *Know what to do for their health after they leave the hospital or office*
- *Refuse to take part in medical research*
- *Voice complaints or file an appeal about 'Ohana or the care provided by its network of Practitioners and Providers and know that if they do, it will not affect how they are treated*
- *Create an advance directive*
- *Have input in and make recommendations regarding 'Ohana's Member Rights and Responsibilities policy*
- *Have all 'Ohana staff members observe their rights;*
- *Have all these rights apply to the person who can legally make healthcare decisions for the Member*
- *Use these rights no matter what their sex, age, race, ethnic, economic, educational or religious background*
- *Receive healthcare services that are accessible, comparable in amount, duration and scope to those provided under Medicaid Fee-for-Service (FFS) and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished*
- *Receive appropriate services that are not denied or cut back just because of diagnosis, type of illness or medical condition*

- *Receive all information in a way the Member can easily understand, in alternative formats and in a manner that takes into consideration their special needs (such as reading level and translated materials)*
- *Have oral translation for all non-English languages (not just those that are most common) and sign language services at no cost to the Member*
- *Be informed that oral translation and sign language services are available, and how to access*
- *Receive information on:*
    - *The basic features of managed care*
    - *Who may or may not join the program*
    - *'Ohana's responsibilities for coordination of care in a timely manner in order to make an informed choice (potential Members)*
- *Receive a complete description of their right to leave the plan at least once a year*
- *Receive notice of any major change in benefits at least 30 days before the change is to go into effect*
- *Receive full information about emergency and after-hours services*
- *Receive 'Ohana's policy on referrals for specialty care and other benefits that are not provided by the Member's PCP*
- *Have direct access to a women's health specialist within 'Ohana's network of Providers*
- *Receive a second opinion at no cost to the Member*
- *Receive services in accordance with 42 CFR Sections 438.206 through 438.210:*
    - *Out-of-network if 'Ohana is unable to provide them in-network for as long as 'Ohana is unable to provide them in-network. In this case, the Member will not pay more than they would have paid if services were provided in-network.*
    - *According to the appointment waiting-time standards*
    - *In a culturally competent manner*
    - *In a coordinated manner*
- *Be included in service and care plan development*
- *Have direct access to specialists in the event the Member has a special healthcare need*
- *Choose between institutional care and Home- and Community-Based Services (HCBS), if determined cost-neutral by 'Ohana*
- *To not have services arbitrarily denied or reduced in amount duration or scope solely because of diagnosis, type of illness or condition.*
- *Not be held liable for:*
    - *'Ohana's debts in the event of insolvency*
    - *Covered Services provided to the Member:*
        - *By 'Ohana for which DHS does not pay 'Ohana*
        - *For which DHS or 'Ohana does not pay the Provider that furnished the services*
    - *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 'Ohana provided the services directly*
- *Provided with written notice of any significant change related to Member rights and responsibilities procedures at least 30 days before the intended effective date of change*
- *Have access to the Providers contracted with 'Ohana*
- *Informed regarding the restriction on freedom of choice among network Providers*
- *Only be responsible for cost sharing in accordance with 42 CFR §§447.50 through 447.57*

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

- *Know how ʻOhana works by reading the Member Handbook*
- *Carry their ʻOhana ID card and Medicaid ID card with them at all times and to present them prior to receiving healthcare services*
- *Notify ʻOhana if they lose their Member ID card*
- *Be on time for appointments*
- *Cancel or set a new time for appointments in advance*
- *Provide information that ʻOhana and its Practitioners and Providers need in order to provide care*
- *Ensure their Provider has their previous medical records*
- *Give information that ʻOhana and the Member's doctors and Providers need to provide care*
- *Understand their health problems and help set mutually agreed upon treatment goals with their Provider*
- *Follow the treatment plan and instructions for care they agree to with their Practitioners*
- *Know the medicine they take, what it is used for and how to take it*
- *Schedule appointments for all non-emergency care through their PCP*
- *Obtain a referral from their PCP for specialty care*
- *Cooperate with the Providers providing their healthcare*
- *Not be disruptive in any Provider's office*
- *Respect the:*
    - *Rights of all Providers*
    - *Property of all Providers*
    - *Rights of other patients*
- *Inform ʻOhana within 48 hours, or as soon as they can, if they are in a hospital or go to an emergency room*
- *Help his/her case manager/Agency or healthcare Provider obtain copies of all of his/her previous health records.*
- *Get information or get questions answered by calling Customer Service toll-free at* ***1-888-846-4262*** *(TTY* ***711****).*

Assignment of Primary Care Provider (PCP)

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

Changing Primary Care Providers

Members may change their PCP selection at any time by calling Customer Service. The requested change will be effective on the first day of the following month of the request if the request is received after the 10th day of the current month. Providers may change a Member's PCP via the PCP Change Form. A copy of

*the form is available at **www.ohanahealthplan.com/Providers/Medicaid/Forms** in the Resources area.*

Women's Health Specialists

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

Hearing-Impaired, Interpreter and Sign Language Services, and Specialized Communication for Members

Hearing-impaired, interpreter and sign language services and auxiliary aids are available to 'Ohana Members. This also includes specialized communication for Members (e.g., Braille, translation in a language other than English, etc.). Providers should coordinate these services for 'Ohana Members and call Customer Service at ***1-888-846-4262*** *if assistance is needed.*

Section 3: Quality Improvement

Overview

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

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

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in 'Ohana's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow 'Ohana the use of their performance data for quality improvement activities.

The QI program activities are written out in the Quality Assurance Performance Improvement (QAPI) work plan, which also includes the SDOH work plan. The activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS measures and/or medical record audits. The organization's Board of Directors has delegated authority to the QI committee to approve specific QI activities, including monitoring and evaluating outcomes, overall effectiveness of the QI program, and initiating corrective action plans when appropriate, when the results are less than desired or when areas needing improvement are identified.

Medical Records

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

To comply with regulatory and accreditation requirements, the QI department may conduct annual medical record audits in physician offices. A patient's record will be reviewed for content and evidence that care and screenings have been documented, as applicable. Physicians 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 'Ohana to assess the level of Provider compliance to documentation standards and clinical guidelines (disease and preventive), and to gauge quality of care and patient safety practices.

All medical records, including all entries in the medical record, for Hawai'i Medicaid 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 be maintained in a manner that permits effective professional medical review and medical audit processes*
- *Must be maintained in a manner that facilitates an adequate system for follow-up treatment*
- *Must be signed*
- *Must include the name and profession of the practitioner rendering services; for example, RN, MD, DO, including signature or initials of practitioner*
- *Must be legible to readers and reviewing parties and maintained in an orderly and detailed manner*
- *Must be dated and recorded in a timely manner. Late entries should include date and time of occurrence and date and time of documentation*
- *Should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed*
- *Should only include standard abbreviations and symbols*
- *Must include the patient's name or ID number on each page of the electronic or paper record*

- *Should include the following personal and biographical data in the record: (a) name; (b) Member ID; (c) age; (d) date of birth; (e) sex; (f) address; (g) home and work telephone numbers; (h) emergency contact; (i) legal guardianship; (j) marital status; (k) name of spouse; (l) next of kin or closest relative; (m) employer; (n) insurance information or family history as applicable*
- *Must reflect the primary language spoken by the Member and translation or communication needs of the Member. Translation or communication needs should address 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 the chart or prominent notation in a conspicuous place in the record.*
- *Must easily identify the past medical history including serious accidents, hospitalizations, operations, illness, prenatal care and birth, as appropriate. As appropriate, medical records from the previous Provider have been obtained and are easily accessible. Old records include past medical history, physical examinations, necessary tests and possible risk factors for the Member relevant to treatment and are used to assess the periodicity schedule and maintain continuity of care*
- *Must maintain a current immunization record in the chart*
- *Must provide a current medication list in the chart. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications*
- *Must provide a problem list, with past and current diagnoses and procedures used to provide continuity of care in the chart. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, health maintenance concerns, etc.*
- *Must contain information about consultations, referrals and specialist reports*
- *Must include notations on all forms or notes regarding follow-up care, calls or visits, when indicated*
- *Must include a screening for substance abuse of tobacco, alcohol and drugs with appropriate counseling/referrals if needed, and follow-up must be documented*
- *Must include documentation of screening for domestic violence with appropriate counseling/referrals if needed and follow-up*
- *For all Members older than 18, must provide evidence the Member was asked about or executed an advance directive, including a mental health directive, and there is documentation of acceptance or refusal.* ***Note:*** *The record must contain evidence that the Member was provided written information concerning the Member's rights regarding advance directives and whether or not the Member has executed an advance directive. The Member does not have to have an advance directive completed. A signed statement that the Member has been asked if they have a directive if not, offering one will suffice. A stamp may be utilized. The Provider shall not, as a condition of treatment, require the Member to execute or waive an advance directive*
- *Must detail informed consent discussions, where appropriate*
- *Must include, but not limited to, the following information:*
  - *HIPAA Protected Health Information release in chart*
  - *Age-appropriate lifestyle and risk counseling (including family planning)*
  - *Documentation of depression screening, with appropriate counseling/referrals, if needed*
  - *Chief complaint – subjective*
  - *Treatment plan is consistent with findings*
  - *Disposition, recommendations and/or instructions provided to the Member; including documentation on the Member's progress notes*
  - *Studies/tests ordered (for example, laboratory, X-ray, EKG) are reviewed*

- *Appropriate medically indicated follow-up after ER visits*
- *Appropriate medically indicated follow-up after hospital discharge*
- *Disposition, recommendations, and/or instructions provided to the Member, including documentation on the Member's progress notes – whether verbal, written or by telephone*
- *If surgery is proposed, is there documentation by the PCP that Member documentation of a consult with an appropriate surgeon?*
- *Documentation of current and past medical/behavioral history*
- *Hospital discharge summaries in chart*
- *Documentation of physician's follow-up plans for significant abnormal lab/x-ray/diagnostic test/consultation results*
- *Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits*
- *Assessment completed on risk of harming self or others or self-neglect for CCS Members*
- *Mental state exam completed for CCS Members*
- *Adult Health Screening include:*
    - *Nutritional Assessment documented*
    - *BP, Height, and BMI checked every 1 to 2 years or as determined by practitioner*
    - *Vision screening for adults ages 65+ years*
    - *Hearing screening for adults ages 65+ years*
    - *Pneumococcal vaccine – one dose for adults ages 65 + years*
    - *Influenza vaccine – All adults annually*
    - *Shingles vaccine (Zoster); age 60+*
    - *Tetanus-diphtheria boosters every 10 years*
    - *Screening for dyslipidemia every five years, more if indicated*
    - *Mammogram screening – Every 1 to 2 years for females ages 50-74*
    - *Colorectal cancer screening ages 50-75 years*
    - *Pap smear screening – every 1 to 3 years or per physician's recommendation, females only ages 21-64*
    - *Chlamydia screening – sexually active 16-24 ages or older (women only)*
    - *Osteoporosis screening (bone mass measurement) – every 2 years for those at risk or per physician's recommendations; women (only) ; ≥65 years old, or ≥ 50 years if at risk*
- *Child Health Screening include:*
    - *Developmental screening*
    - *Behavioral assessment*
    - *Depression screening for ages 11 and above*
    - *Height and weight measured **AND** plotted on a graph*
    - *Appropriate physical examination documented*
    - *Health education/anticipatory guidance noted*
    - *Nutritional Assessment, including counselling, annually up to age 5*
    - *Lead screening at 12 months*
    - *Lead screening by 24 months*
    - *Immunizations given and completed for age according to the recommended childhood immunization schedule recommended by the AAP*
    - *Dental assessment from age 6 months to 30 months*
    - *Vision assessment (subjective for children less than 3) and objective for children 4, 5, 6, 8, 10, 12, and 15*

- *Hearing assessment (subjective for children less than 2) and objective for children ages newborn, 4, 5, 6, 8 and 10. Audiometry screening once between 11 and 14 years; once between 15 and 17 years and once between 18 and 21 years.*
- *Body mass index (BMI) **OR** serum cholesterol for children older than 2 years of age if indicated*
- *Hemoglobin (Hgb) & hematocrit (Hct) at 12 months **AND** additional times if indicated*
- *Tuberculin (TB) risk assessment for children at 1, 6, 12, and 18 months, annually 2-21 years of age; when indicated a test is given for positive assessment*
- *Hereditary/Newborn metabolic screening*
- *Sexually transmitted disease screening as recommended by the American Academy of Pediatrics*
- *Pelvic exam/pap smear as recommended by the American Academy of Pediatrics*
- *Follow-up for abnormal values or findings*
- *Cholesterol screening once between 9 and 11 years of age and between 17 and 21 years of age*

- *OB Health Screening include:*
  - *OB physical assessment*
  - *Nutritional assessment and counseling*
  - *Blood type, D (Rh) and antibody screen*
  - *Rubella titer*
  - *Urinalysis*
  - *Pap smear test*
  - *STD testing*
  - *Syphilis (VDRL or RPR) testing*
  - *Hemoglobin (Hgb) assessment*
  - *HIV counseling and testing*
  - *Hepatitis B surface antigen (HBsAG) screening*
  - *Depression screening*
  - *Documentation of preterm Delivery Risk Assessment in the enrollee record by week 28 of pregnancy*
  - *Alpha fetoprotein screening*
  - *Diabetes screening/GTT*
  - *Group B strep screen*
  - *Postpartum visit six (6) weeks after delivery*

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 'Ohana 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 seven years after the date of the last professional service.

For minors, the health plan shall retain all medical records during the period of minority plus a minimum of ten years after the age of majority. Providers should have procedures in place to permit the

timely access and submission of medical records to ʻOhana, DHS, or to the new Primary Care Provider (PCP), upon request, within 60 days from receipt of the request. Information from the medical records review may be used in the recredentialing process, as well as quality activities.

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

EPSDT Screen Periodicity Schedule

The preventive pediatric healthcare guidelines for children are on WellCare's corporate website at ***https://www.wellcare.com/Hawaii/Providers/Clinical-Guidelines*****.**

The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5.

A Member should have an initial health check in the following situations:

- *Within 90 days of enrollment with ʻOhana or upon change to a new PCP, if prior medical records do not indicate current compliance with the periodicity schedule*
- *Within 24 hours of birth for newborns*

The medical record must contain documentation of a comprehensive health and developmental history in addition to an unclothed physical examination to determine if the child's development is within the normal range for the child's age, health history, appropriate immunizations according to age and health history, laboratory tests, health education, appropriate vision, hearing and speech testing.

Each Provider office is required to have the following equipment to provide a complete health check:

- *Weight scale for infants*
- *Weight scale for children and adolescents*
- *Measuring board or device for measuring length or height in the recumbent position for infants and children up to age 2*
- *Measuring board or device for measuring height in the vertical position for children who are 2 years or older*
- *Blood pressure apparatus with infant, child and adult cuffs*
- *Screening audiometer*
- *Centrifuge or other device for measuring hematocrit or hemoglobin*
- *Eye charts appropriate to children by age*
- *Developmental and behavioral screening tools*
- *Ophthalmoscope and otoscope*

Additional points of emphasis regarding EPSDT screens include the following:

- ***Immunizations** are administered at required age parameters and intervals with dates documented. If the immunizations are not up to date according to age and health history, the Provider should document why immunizations were not given at the time of the EPSDT screen. For the immunization schedule, refer to the preventive pediatric healthcare guidelines for children on ʻOhana's corporate website at* ***www.wellcare.com/Hawaii/Providers/Clinical-***

Guidelines. *Note that certain immunizations may not be covered in the context of covered benefits.*

- *A PCP must perform all required components of an EPSDT health screen, as per the AAP and Advisory Committee on Immunization Practices (ACIP) periodicity schedules, and document appropriately in the Member's medical record. If a PCP chooses not to provide the immunization component of the screen, they have accountability to refer the Member to another network Provider such as a health department entity who can provide this service in a timely manner. 'Ohana will expect the PCP to follow up with the referred Provider to receive documentation regarding the provision of the immunization(s) to maintain an accurate and complete medical record.*
- *'Ohana will monitor for compliance to these requirements by:*
    - *Reviewing immunization rates by PCP, and*
    - *If the immunization rate of the PCP is less than the network average, 'Ohana will:*
        - *Assess for practice access and availability by:*
            - *Conducting an audit to verify compliance with access and availability*
            - *Requiring adoption of a corrective action plan (CAP) if access and availability standards are not met*
            - *Performing a focused medical record review*
        - *Based on negative findings, a CAP will be requested*
        - *If compliance to the CAP is not demonstrated, assess for a fee reduction*
        - *If lack of compliance continues, petition for removal from network participation*
- ***Lead Risk Assessment** is done at each screening at 6, 9, 12, 18, 24 months and 36 to 72 months of age. Any resulting risk identified through lead risk assessment should be documented both in the medical record and acted on by obtaining a blood lead level.*
- ***Annual Tuberculosis (TB) skin testing** is done if the Member is in a high-risk category. Only those children locally identified as high risk for TB disease should be tested. Results of TB risk assessment and testing as needed should be documented in the child's medical record.*
- ***Developmental Delay** is to be assessed by use of a formalized tool at 9, 18 and 30 months.*
- ***120-day Non-Compliant Report** – 'Ohana will send Providers a monthly membership list of EPSDT-eligible children who have not had a screen within 120 days of enrolling in 'Ohana or are not in compliance with the EPSDT periodicity schedule. The PCP shall contact these Members' parents or guardians to schedule an appointment. 'Ohana will also send letters to the parents and guardians of EPSDT-eligible children to remind them of preventive services needed based on the child's age.*

Practitioner and Provider Participation in the Quality Improvement Program

Network Practitioners and Providers will cooperate with QI activities. 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 'Ohana's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow 'Ohana the use of their performance data for quality improvement activities.

*Providers are invited to participate in the QI program. Avenues for participation include committee representation, quality/performance improvement projects, EPSDT assessments and feedback/input via satisfaction surveys, grievances, and calls to Customer Service at **1-888-846-4262**. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.*

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

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

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

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

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

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

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

Clinical Practice Guidelines (CPGs)

'Ohana adopts validated evidence-based CPGs and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede CPGs, the guidelines provide clinical staff and Providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations. The CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the UM Medical Advisory committee. CPGs, to include preventive health guidelines, may be found on 'Ohana's corporate website at ***https://www.wellcare.com/Hawaii/Providers/Clinical-Guidelines****.*

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. The tool comprises more than 90 measures across six domains of care, including:

- *Effectiveness of care*
- *Access and availability of care*
- *Experience of Care*
- *Utilization and risk adjusted utilization*
- *Health Plan Descriptive Information*
- *Measures Reported Using Electronic Clinical Data Systems*

HEDIS reporting is a mandatory process that occurs annually to provide an overview of the medical services received by Members. It is an opportunity for 'Ohana 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 'Ohana 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 'Ohana 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 'Ohana's website frequently for the latest news and updated documents at ***www.ohanahealthplan.com/provider/default****.*

Section 4: Utilization Management (UM) and Disease Management (DM)

Utilization Management

Overview

'Ohana's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and the Department while providing Members access to high-quality, cost-effective Medically Necessary care.

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 Providers are participating and contracted with 'Ohana*

'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 'Ohana 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 Providers or other individuals or entities performing UM activities for issuing denials of coverage, services or care. Financial incentives, if any, do not encourage or promote 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:

- *Milliman Care Guidelines (MCG)*
- *'Ohana Clinical Care Guidelines (CCG)*
- *State Medicaid contract*
- *State Provider Manuals, as appropriate*
- *Local and federal statutes and laws*
- *Medicaid and Medicare guidelines*
- *Hayes Health Technology Assessment*
- *American Society of Addiction Medicine Criteria for Substance Use Disorders (ASAM)*

The nurse reviewer and/or medical director involved in the UM process apply Medical Necessity criteria in context with the Member's individual circumstance and the capacity of the local Provider delivery system. When the above criteria do not address the individual Member's needs or unique circumstance, the medical director will use clinical judgment in making the determination.

The review criteria and guidelines are available to Providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by contacting the UM Department via Customer Service at ***1-888-846-4262****. The phone number is listed on the* ***Quick Reference Guide*** *on 'Ohana's website.*

UM Process

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

- *Notifications*
- *Referrals*
- *Prior authorizations*
- *Concurrent review*
- *Discharge planning*
- *ICN nurse review*
- *Retrospective review*

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

'Ohana forms for the submission of notifications and authorization requests are at ***www.ohanahealthplan.com/Provider/medicaid/forms*** *or by calling Customer Service at* ***1-888-846-4262****.*

Notifications

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

- *Prenatal services. OB Providers are required to notify 'Ohana of pregnancies via fax using the Prenatal Notification Form within 30 days of the initial visit. This process will expedite claims reimbursement.*
- *A Member's unplanned admission to a hospital. This allows 'Ohana 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 within 24 hours by secure electronic delivery, fax or telephone and include Member demographics, facility name and admitting diagnosis.

Referrals

For an initial referral to a Participating Provider, 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.

Services that require a referral:

- *Services that a Primary Care Provider (PCP) does not perform*
- *Specialist visits and specialty care at an office or free-standing clinic*

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

Services available without a referral:

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

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. Female Members have direct access to a women's health specialist within the network for Covered Services necessary to provide routine and preventive healthcare. This includes, but is not limited to, breast cancer screening (clinical breast exam), Pap smears and pelvic exams. Referrals by the PCP for these services are not required.

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

Prior Authorization

Prior authorization allows for efficient use of Covered Services and helps ensure 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*
- *Service coordination and disease management considerations*

*Prior authorization is **required** for elective or non-emergency services as designated by 'Ohana. Guidelines for prior authorization requirements by service type may be found:*

- *On the Quick Reference Guide on the website*
- *In the Authorization Lookup tool at **www.ohanahealthplan.com/auth_lookup***
- *By calling Customer Service at **1-888-846-4262***

Some prior authorization guidelines to note:

- *The prior authorization request should include the Member and Provider demographic information, the diagnosis to be treated, the CPT code describing the anticipated procedure, and any pertinent clinical information to support the request. If the procedure performed and billed is different from that on the request but within the same family of services, a revised request is not required.*

- *An authorization may be given for a series of visits or services related to an episode of care. The prior authorization request should outline the plan of care, including the frequency and total number of visits requested and the expected duration of care.*

- *The attending physician or designee is responsible for obtaining the prior authorization of an elective or non-urgent admission. Refer to the Authorization Lookup tool and/or the Quick Reference Guide on 'Ohana's website for a list of services requiring prior authorization.*

*Prior authorization requests may be submitted to 'Ohana via 'Ohana's secure provider portal at **https://provider.wellcare.com/ohanacare**, fax or mail. Fax numbers and mailing addresses are located on the prior authorization forms. Notification forms and authorization requests are on 'Ohana's website.*

Concurrent Review

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

Concurrent review is initiated as soon as '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 Milliman Care Guidelines (MCG) or 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 a lower level of care when clinically indicated and appropriate*
- *Complete timely and effective discharge planning*
- *Identify referrals appropriate for DM or quality-of-care review*
- *Identify cases appropriate for follow-up by the health coordinator*

The concurrent review process incorporates the use of Milliman Care Guidelines (MCG) or approved criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of 'Ohana's 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's review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

Discharge Planning

Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues that will need post-hospital intervention. The concurrent review or ICN works with the attending physician, hospital discharge planner, ancillary Providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the Member to the appropriate level of care. An ICN may refer an inpatient Member with identified complex discharge needs to service coordination for in-facility outreach for complex discharges.

Inpatient Care Nurse (ICN) Review

The UM department's role is designed to identify Members in the hospital who are at high risk for readmission to the hospital. The program is a two-fold process. It may begin with a pre-discharge screening to identify Members with complex discharge needs and will assist with the development of a safe and effective discharge plan.

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

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

Retrospective Review (Post-Service Review)

A retrospective review is any review of services that have already been provided. All requests for retrospective review can be requested up to 1 year from the date of service. There are two types of retrospective reviews that 'Ohana may perform:

- *Retrospective review initiated by 'Ohana*

  'Ohana requires periodic documentation including, but not limited to the medical record, Uniformed Billing form 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. In order to be eligible for the retrospective review, Providers must request a retrospective review within 60 days of the Member's insertion date into the plan. 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/pre-certification guidelines.

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

Members may request a copy of the criteria used for a specific determination of Medically Necessary Services by contacting the UM Department via Customer Service. Providers may call Customer Service at ***1-888-846-4262*** *or refer to the* ***Quick Reference Guide*** *on ʻOhana's website for contact information.*

Peer-to-Peer Request

At any time during the review process, the Provider or the ʻOhana medical director may initiate contact with each other to discuss the specific case being reviewed and to gather or offer information that may impact the determination. If Medical Necessity is not established with clinical information provided, a peer-to-peer discussion is offered to the treating and/or requesting Provider prior to rendering a Medical Necessity decision.

Services Requiring No Authorization

To facilitate timely and effective treatment of Members, ʻOhana has determined that many routine procedures and diagnostic tests are allowable without Medical Necessity review, including:

- *Certain diagnostic tests and procedures that are routinely part of an office visit, such as colonoscopies, hysteroscopies and plain film X-rays;*
- *Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a CLIA waiver. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:*
  - *Reproductive laboratory tests*
  - *Molecular laboratory tests*
  - *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 ʻOhana).*

All services performed without authorization are subject to retrospective review by ʻOhana.

For a listing by code of services that may or may not require a prior authorization, refer to the Authorization Lookup tool on ʻOhana's website. The list is subject to change without notice.

ʻOhana Proposed Actions/Notice of Adverse Benefit Determination (NOABD)

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

- *The action ʻOhana has taken or intends to take*
- *The reasons for the action include the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination. Such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;*
- *The Member's or Provider's right to appeal*
- *The Member's right to request a State Administrative Hearing*
- *The Member's right to representation*
- *Procedures for exercising Member's rights to appeal or file a grievance*
- *Member may represent himself or use legal counsel or an authorized representative*
- *Circumstances under which expedited resolution is available and how to request it*
- *Circumstances under which a State Administrative Hearing will be granted when action is based upon a change in federal and state law, as applicable*
- *The Member's rights to request and have services continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services*

Second Medical Opinion

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

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

Standard, Expedited and Extensions of Service Authorization Decisions

Decision Time Frames		
Type of Decision	***Time Frame***	***Extension***
Standard Pre-service	*14 calendar days*	*Additional 14 calendar days*
Expedited Pre-service	*72 hours*	*Additional 14 calendar days*
Post-service	*30 calendar days*	*14 calendar days*

Standard Service Authorization

'Ohana is committed to a 14-calendar-day turnaround time on prior authorization requests. 'Ohana will respond to the fax number(s) included on the prior authorization request form. An extension may be granted for an additional 14 calendar days if the Member or 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 no later than 72 hours of the request. ***Requests for expedited prior authorization decisions should be made by telephone, fax with a telephone call, or submission through the website with a telephone call.***

'Ohana may extend the 72-hour time frame by up to 14 additional calendar days, if the Member requests an extension, or if 'Ohana justifies to DHS a need for additional information and the extension is in the Member's best interest. If 'Ohana extends the time frame, it shall give the Member written notice of the reason for the decision to extend the time frame and inform the Member of the right to file a grievance if they disagree with that decision.

Please refer to the Quick Reference Guide on 'Ohana's website for the appropriate contact information.

Emergency/Urgent Care and Post-Stabilization Services

Emergency medical services are covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard that are not subject to prior authorization requirements and are available 24 hours per day, 7 days per week to 'Ohana Members manifesting an emergency medical condition. Urgent Care Services should be provided within 24 hours. See Section 13 Definitions for definitions of "Emergency Medical Services" and "Urgent Care Services."

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

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

Examples of non-emergencies include:

- *A cold or the flu*
- *Earache*
- *Sore throat.*
- *Using the emergency room for your convenience.*
- *Using the emergency room during normal physician office hours for medical conditions treatable in a physician's office.*

Urgent Care means the diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life or health, but which require medical attention 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, as prescribed in 42 CFR § 438.114, to improve or resolve the Member's condition. 'Ohana is responsible for providing post-stabilization care services 24 hours a day, 7 days a week, both inpatient and outpatient.

Once the Member's condition is stabilized, 'Ohana may require pre-certification for hospital admission or prior authorization for follow-up care. 'Ohana is financially responsible for post-stabilization services that are not pre-authorized or precertified by an in-network Provider or 'Ohana representative, regardless of whether the services are provided in or out of network and are rendered to maintain, improve or resolve the Members' stabilized condition if:

- *'Ohana does not respond to the Provider's request for pre-certification or prior authorization within one hour*
- *'Ohana cannot be contacted*
- *'Ohana's representative and the attending Provider cannot reach an agreement concerning the Member's care and an 'Ohana Provider is not available for consultation. In this situation, 'Ohana shall give the treating Provider the opportunity to consult with an in-network Provider, and the treating Provider may continue with care of the Member until an 'Ohana Provider is reached or one of the criteria outlined below is met*

'Ohana's responsibility for post-stabilization services that it has not approved will end when:

- *An in-network Provider with privileges at the treating hospital assumes responsibility for the Member's care*
- *An in-network Provider assumes responsibility for the Member's care through transfer*
- *'Ohana's representative and the treating physician reach an agreement concerning the Member's care*
- *The Member is discharged*

In the event the Member receives post-stabilization services from a Provider outside of 'Ohana's network, 'Ohana is prohibited from charging the Member more than they would be charged if they had obtained the services through an in-network Provider.

Transition of Care

Transition to 'Ohana for New Members

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

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

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

For Members with services for SHCN and LTSS, services will continue for at least ninety (90) days, or until the Member has received an assessment.

After the initial TOC requirements are completed, Providers are required to follow ʻOhana's prior authorization or concurrent review requirements.

Transition from ʻOhana

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

Pregnant Women

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

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

When ʻOhana becomes aware that a covered Member will be disenrolled from ʻOhana and will transition to a Medicaid fee-for-service (FFS) program or another managed care plan, a review nurse who is

familiar with that Member will provide a TOC report to the receiving plan, or appropriate contact person for the designated FFS program.

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

Authorization Request Forms

Providers should use 'Ohana's standard authorization request forms to ensure receipt of all pertinent information and enable a timely response to a Provider's request, including:

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

To ensure timely and appropriate claims payment, the form must:

- *Have all required fields completed*
- *Be typed or printed in black ink for ease of review*
- *Contain a clinical summary or have supporting clinical information attached*

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

A Prenatal Notification Form should be completed by the OB/GYN Provider during the first visit and faxed to 'Ohana within 30 days of initial visit. Notification of OB services enable 'Ohana to identify a Member who might benefit from the Prenatal Program and/or High-Risk Pregnancy Program.

*All forms are on 'Ohana's website at **www.ohanahealthplan.com/Provider/medicaid/forms** in the Resources area. All forms should be submitted via fax to the number listed on the form.*

Hawai'i Delegated Entities

'Ohana does not delegate any UM activities to external entities.

Health Coordination Services Program for Hawai'i Medicaid Members

Overview

'Ohana offers comprehensive Health Coordination Services (HCS) to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. 'Ohana trusts Providers will help coordinate the placement and cost-effective treatment of patients who are eligible for 'Ohana's HCS

Programs. The HCS program at 'Ohana is called Health Coordination Services and Disease Management Services. (See ***Disease Management*** *section for more information about that program).*

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

HCS emphasizes continuity of care for a Member through the coordination of care among physicians and other Providers. Proper care coordination addresses the ongoing needs of a Member rather than being restricted to a single practice setting.

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

'Ohana's HCS teams are led by healthcare professionals, such as specially trained Nurses, Social Workers and Behavioral Health Specialists who assess the Member's risk factors, develop a Health Action Plan (HAP), establish treatment goals, monitor outcomes and evaluate the outcomes for possible revisions to the service plan. Non-clinical associates serve as ancillary support, freeing licensed clinical staff to perform functions that call for a licensed personnel to perform. Collaboration within the team allows Members to be assigned to a Primary Health Coordinator who best meets Members' primary needs

The Health Coordination team works with PCPs to coordinate care for the Member and expedite access to care and needed services.

'Ohana's HCS teams also serve in a support capacity to the PCP and help to link the Member to Providers, medical services, residential, social and other support services, as needed. The Provider may request Health Coordination services for any 'Ohana Member.

The Health Coordination begins with Member identification and follows the Member until discharge from the Program. Members may be identified for Health Coordination through numerous ways, including: (a) a referral from a Member's PCP; (b) self-referral; (c) referral from a family member; (d) after completing a Health Risk Assessment (HRA); and (e) data mining for Members with moderate or high health risks.

'Ohana's philosophy is that the HCS program is an integral management tool in providing care for 'Ohana Members. Once a Member is enrolled in HCS, key elements of the process include:

- ***Clinical Assessment and Evaluation*** *– A comprehensive assessment of the Member is completed to determine where they are in the health continuum. This assessment gauges the Member's support systems and resources and seeks to align them with appropriate clinical needs.*
- ***Health Action Planning*** *– Collaboration with the Member and/or caregiver to identify the best way to fill any identified gaps or barriers to improve access and adherence to the Provider's plan of care*

- ***Service Facilitation and Coordination*** *– Working with community resources to facilitate Member adherence with the plan of care. Activities may be as simple as reviewing the plan with the Member and/or caregiver or as complex as arranging services, transportation and follow-up.*
- ***Member Advocacy*** *– Advocating on behalf of the Member within the healthcare system. The HCS team helps the Member find services that optimize their health emphasizing continuity of care for the Member by coordinating care among physicians and other Providers.*

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 the 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 at* ***1-888-846-4262***
- *Online:* ***www.ohanahealthplan.com***

Individuals with Special Health Care Needs

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

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

- *Allow Members who need a course of treatment or regular care monitoring to have direct access through a standing authorization or approved visits, as appropriate for the Member's condition or needs:*
    - *Obtain a standing authorization, complete the Outpatient Authorization Request Form and document the need for a standing authorization under the pertinent clinical summary area of the form*
    - *Outline in the authorization the plan of care, including the frequency, total number of visits and the expected duration of care.*

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

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

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

Other Member needs commonly identified for ʻOhana's SC program include:

- ***Catastrophic** – Head injury, near drowning, burns*
- ***Multiple Chronic Conditions** – Multiple co-morbidities such as diabetes, COPD, and hypertension, or multiple intricate barriers to quality healthcare (i.e., AIDS)*
- ***At-Risk Screening** – Potential for hospitalization or institutionalization if certain additional services are not provided*
- ***Complex Discharge Needs** – Member discharged home from acute inpatient or SNF with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated, non-healing wounds, advanced illness, etc.*

Health Coordinators work closely with the Provider on when to discharge the Member from the HCS program. Reasons for discharge from Health Coordination Services include the Member: (a) is meeting primary service plan goals; (b) has declined additional services; (c) has disenrolled from health plan; and (d) is unable to be contacted by ʻOhana.

In addition to the above, HCS responsibilities for nursing facility level of care (NF LOC) Member include:

- *Completing NF LOC assessments (Hawaiʻi DHS Form 1147) and submitting to PCP for signature and review*
- *Sending the completed NF LOC assessments to DHS or its designee for a functional eligibility determination*
- *Providing options for counseling regarding institutional placement and HCBS alternatives*
- *Assisting Members in transitioning to and from nursing facilities/residential care facilities*

Hawaiʻi DHS Form 1147 – At Risk or Nursing Facility Level of Care

If a Member is awaiting placement in a facility, is at a potential NF LOC or "At-Risk" for institutionalization or hospitalization (see definition), the Health Coordinator will complete the DHS Form 1147 (if they are a registered nurse), coordinate the completion of the 1147 with the PCP or hospital,

or make a referral for a LOC assessment to be performed. The completed form will be forwarded to the Member's PCP for signature and submitted in accordance with DHS policies and procedures.

Health Action Plan Development

The Health Coordinator will develop a Health Action Plan (HAP) for each member in Health Coordination Services. The HAP will be developed in collaboration with the Member, Member's PCP, and other individuals involved in the care of the Member. The Health Acton planning process will begin at the time of the initial assessment. Based on the results of the initial assessment and subsequent consultation and Interdisciplinary Team meetings with the Member's Providers, Specialists, and existing case managers, if applicable, a comprehensive HAP will be developed.

Health Action Plan Components

At a minimum, all HAP will include information regarding:

- *Member measurable goals and desired outcomes*
- *Current medical conditions and associated Medically Necessary services*
- *Other service needs and authorized service units/budgets*
- *Medications and medication management*

Interdisciplinary Care Team (ICT)

A Member with complex needs and multiple Service Plan goals may benefit from an Interdisciplinary Care Team (ICT). A Health Coordinator focuses on the creation of the ICT. The ICT may include a PCP, other Providers such as Specialists, family members, caregivers, cultural leaders and others that a Member designates. If a team is assembled, the Member or designee may attend any team meetings. Homebound Members can have the meetings in their homes. The PCP and other members of the ICT may be asked to participate in the ICT either in person, via telephone, or through participation in the service planning process.

Reviewing Health Action Plans

Upon completion, the HAP will be signed and dated by the Health Coordinator and the Member, and his or her representative or surrogate. HAP will be sent to Primary Care Provider and other members of ICT as necessary.

Updating Health Action Plans

HAPs will be reviewed and updated by the HCS team:

- *When significant events occur in the life of a Member, including (a) the death of a caregiver; (b) change in health status; (c) change in living arrangement; (d) institutionalization; and/or (e) change in Provider, i.e., if the Provider change affects the HAP*
- *When the next due date of the goal is to be reviewed*
- *When closing Health Coordination services*

The HCS team will communicate Service Plan updates to the PCP by sending the updated HAP via fax or mail.

Provider Access to Health Coordination Services

Refer to Access to Health Coordination Services and Disease Management Programs in the Disease Management section.

Disease Management Program

Overview

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

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

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

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

The DM program covers some of the most commonly managed disease states that are prevalent in Hawaiʻi today as required by the state:

- *Diabetes*
- *Smoking cessation*
- *Asthma*

Candidates for Disease Management

ʻOhana encourages referrals from Providers, Members, hospital discharge planners and others in the healthcare community.

Interventions for identified Members vary depending on their level of need and stratification level. Interventions are based on industry-recognized Clinical Practice Guidelines (CPGs). Members identified

at the highest stratification levels receive a comprehensive assessment by a DM nurse, disease-specific educational materials, identification of a service plan and goals, and follow-up assessments to monitor adherence to the plan and attain goals.

Disease-specific CPGs adopted by ʻOhana may be found on the corporate website at ***www.ohanahealthplan.com/providers/clinical-guidelines/CPGs****.*

Access to Health Coordination Services and Disease Management Programs

If a Provider would like to refer an ʻOhana Member as a potential candidate to the DM program or HCS program, or would like more information about one of the programs, they may call Customer Service at ***1-888-846-4262*** *or complete and fax the Referral for Service Coordination Disease Management form on ʻOhana's website at* ***www.ohanahealthplan.com/provider*** *in the Resources area.*

Section 5: Claims

Overview

*The focus of ʻOhana's Claims Department is to process claims in a timely manner. ʻOhana has a toll-free phone number for Providers to call the Customer Service department (**1-888-846-4262**). For more information, refer to the Quick Reference Guide on ʻOhana's website.*

Updated 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 systems, 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 will no longer 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 webinar occurs several times. Providers can register for the date and time that works best for them by contacting PaySpan directly.*

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

Timely Claims Submission

Unless otherwise stated in the Agreement, Providers must submit claims (initial, corrected and voided) within 12 months of 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) is primary, Providers must submit claims within 6 months of the date of the Explanation of Payment (EOP) or 12 months of 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 Agreement for filing Clean Claims.

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

- *A clearinghouse electronic acknowledgement indicating the claim was electronically accepted by ʻOhana*
- *A Provider's electronic submission sheet with all the following identifiers – patient name, Provider name, date of service to match EOP/claim(s) in question, prior submission bill dates and 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 ID and 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 on the CMS website at ***www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index.html.***

Taxonomy

Providers are to submit claims with the correct taxonomy code consistent with Provider demographic information for the Covered Services being rendered 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 (NDC)

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

Strategic National Implementation Process (SNIP)

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

If a claim is rejected for lack of compliance with '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 section below.

Claims Submission Requirements

Providers using electronic submission shall submit all claims to 'Ohana, or its designee, as applicable, using HIPAA compliant 837 electronic format, or a CMS-1500 and/or UB-04, or their successors. Claims shall include the Provider's NPI (exceptions are made for atypical Providers), Tax ID and the valid

taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a Covered Service and/or no claim is complete for a Covered Service unless performance of that Covered Service is fully and accurately documented in the Member's medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider, with the exception of Member expenses and/or non-Covered Services. For more information on paper submission of claims, refer to the Quick Reference Guide on 'Ohana's website. For more information on Covered Services under 'Ohana's Medicaid plan, go to ***www.ohanahealthplan.com****.*

Electronic Claims Submissions

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

Clearinghouses can exchange data with one another; Providers should work with their existing clearinghouse, or an 'Ohana-contracted clearinghouse, to establish EDI with 'Ohana. For a list of 'Ohana-contracted clearinghouse(s), information on the unique 'Ohana payer identification (Payer ID) numbers used to identify 'Ohana on electronic claims submissions, or to contact 'Ohana's EDI team, refer to the Provider Resource Guide on 'Ohana's website at ***www.ohanahealthplan.com/provider/medicaid/resources****.*

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 'Ohana, 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.

For more information on EDI implementation with ʻOhana, refer to the ʻOhana Companion Guides at ***www.ohanahealthplan.com/provider/claims_updates****.*

Paper Claims Submissions

ʻOhana accepts paper claims if permitted in the Agreement; however, for timelier processing of claims, Providers are encouraged to submit electronically. For assistance 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 Agreement and until the Provider has the ability to submit electronically, ʻOhana will accept paper claims (UB-04 and CMS-1500 or their successors) if they contain the required elements and formatting described below:

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

Other Claims Submissions

Providers who render non-traditional Home and Community Based Services or related services (i.e., home modification) to ʻOhana Members may submit their claims to ʻOhana by invoice. Invoices must be mailed, faxed or emailed to ʻOhana's Provider Relations Department. For more information on submitting claims via methods other than electronic or CMS-1500 or UB-04 forms, contact a local Provider Relations representative or call Customer Service at ***1-888-846-4262****. Please refer to the Quick Reference Guide for contact information.*

Claims Processing

Readmission

ʻOhana may choose to review claims if data analysis deems it appropriate. ʻOhana 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), ʻOhana will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Providers who do not submit the requested medical records or who do not remit the overpayment amount identified by ʻOhana may be subject to a recoupment.

Disclosure of Coding Edits

ʻOhana 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 claim payment or a request for review of medical records, prior to or subsequent to payment, which 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 ʻOhana. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a Non-Covered Service, and thus Providers must not bill or collect payment from Members for such reductions in payment.

Prompt Payment

Health Plan shall reimburse a Clean Claim that is not contested or denied not more than 30 days calendar days after receiving the claim filed in writing, or 15 days calendar days after receiving the Clean Claim filed electronically, unless a shorter payment time frame is specified in the Agreement.

Coordination of Benefits (COB)

ʻOhana shall coordinate payment for Covered Services in accordance with the terms of a Member's benefit plan, applicable state and federal laws, and CMS guidance. Providers (contracted and non-contracted) shall bill primary insurers (i.e., Medicare) for items and services they provide to a Member before they submit claims for the same items or services to ʻOhana. Any balance due after receipt of payment from the primary payer should be submitted to ʻOhana for consideration, and the claim must include information verifying the payment amount received from the primary plan, as well as a copy of the EOP. ʻOhana 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 ʻOhana policies and procedures regarding subrogation activity.

Encounters Data

Overview

This section is intended to provide Providers with the necessary information to allow them to submit encounter data to ʻOhana. If encounter data does not meet the service level agreements (SLAs) for timeliness of submission, completeness or accuracy, DHS has the ability to impose significant financial sanctions on 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 Agreement, vendors and Providers should submit complete and accurate encounter files to ʻOhana as follows:

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

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

Accurate Encounters Submission

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

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

For more information on submitting encounters electronically, refer to ʻOhana's Companion Guides on ʻOhana's website.

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

Encounters Submission Methods

Delegated entities and Providers may submit encounters using several methods: electronically, through the ʻOhana's contracted clearinghouse(s), via DDE or using WellCare's Secure File Transfer Protocol (SFTP) process.

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

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/provider/claims_updates****.*

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse or an ʻOhana-contracted clearinghouse, to establish EDI with ʻOhana. For a list of ʻOhana-contracted clearinghouses, refer to Job Aids and Resource Guides on ʻOhana's website.

A unique ʻOhana payer ID was included in the welcome letter from ʻOhana. This payer ID must be used to identify ʻOhana on electronic claims submissions. For more information on ʻOhana payer IDs or to contact the EDI team, refer to the Quick Reference Guide on ʻOhana's website.

Submitting Encounters Using Direct Data Entry (DDE)

Delegated entities and Providers may submit their encounter information directly to ʻOhana using ʻOhana's DDE portal. The DDE tool is on the provider portal at ***https://provider.wellcare.com/ohanacare****. For more information on free DDE options, refer to the Hawai'i Medicaid Provider Resource Guide on ʻOhana's website.*

Encounters Data Types

There are four encounter types for which delegated vendors and Providers are required to submit encounter records to ʻOhana. 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 ʻOhana's ANSI ASC X12 837I, 837P and, 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides.

Encounters submitted to ʻOhana 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 – An encounter that has never been submitted to ʻOhana previously*
- *Voided Encounter – An encounter that ʻOhana deletes from the encounter file and is not submitted to the State*
- *Replaced or Overlaid Encounter – An encounter that is updated or corrected within ʻOhana system*

Balance Billing

Providers shall accept payment from ʻOhana for Covered Services provided to ʻOhana Members in accordance with the reimbursement terms outlined in the Agreement. Payment made to Providers constitutes payment in full by ʻOhana for covered benefits, with the exception of Member expenses. For Covered Services, Providers shall not balance-bill Members any amount in excess of the contracted reimbursement amount in the Agreement. An adjustment in payment as a result of ʻOhana'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 ʻOhana 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 ʻOhana procedures*
- *Covered Services for which a claim has been returned and denied for lack of information*

- *Remaining or denied charges for those services where a contracted Provider fails to notify the plan of a service that required prior authorization. Payment for that service will be denied*
- *Sales tax or GET on services rendered*

Providers may bill ʻOhana 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, the Provider may bill the Member if the Provider provided the Member with an Advance Beneficiary Notice of non-coverage; and*
- *If the Provider and Member agree in advance to a Non-Covered Service or self-referral and the Member is given information about the cost of the procedure and the payment terms at the time of service*

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 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:*

ʻOhana Health Plan, Inc.
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:*

ʻOhana Health Plans, Inc.
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 ʻOhana within the time frame as indicated in the ʻOhana Provider Manual or as specified in your Participating Provider Agreement. 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:

ʻOhana Health Plan, Inc.
Attn: Payment Policy Disputes Department
PO Box 31426
Tampa, FL 33631-3426

Hold Harmless Dual Eligibles

Those dual eligible Members whose Medicare Part A and B Member expenses are identified and paid for at the amounts provided for by Hawaiʻi 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 Hawaiʻi Medicaid. Providers shall accept ʻOhana's payment as payment in full.

Cost Share

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

A Member's cost share is available on the DHS eligibility site or by contacting 'Ohana's Customer Service department at ***1-888-846-4262.*** *The Provider will collect the amount from the Member and remit the full amount due to 'Ohana. The remittance is due to 'Ohana by the end of the statement month. The standard process is through inclusion of cost share on the claim (FL 29 for Professional (CMS 1500) claim forms and value code 23 in FL 39-41 for Institutional (UB-04) claim forms).*

Non-Covered Services

'Ohana Members may be billed for non-Covered Services like cosmetic procedures and items of convenience (i.e., televisions) only if the Provider bills a Member for non-Covered Services, the Provider shall inform the Member and obtain prior written agreement from the Member regarding the cost of the procedure and the payment terms at the time of service.

Corrected or Voided Claims

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

To submit a corrected or voided claim electronically:

- *Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8' – indicating 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~*

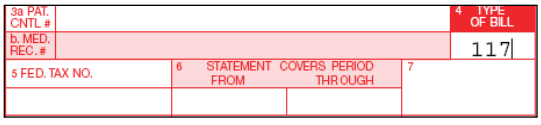
These codes are not intended for use for original claim submission or rejected claims.

To Submit a Corrected or Voided Claim Via Paper

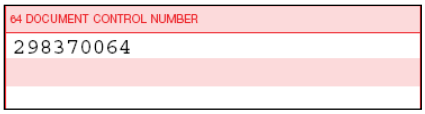
- *For institutional claims, the Provider must include the original 'Ohana claim number and bill frequency code per industry standards.*

Example:

Box 4 – Type of Bill: the third character represents the "Frequency Code"

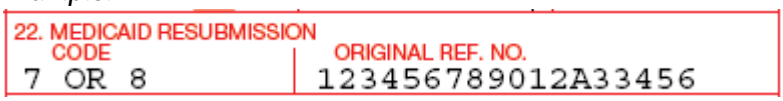


Box 64 – Place the Claim number of the Prior Claim in Box 64



- *For professional claims, the 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 appear on an EOP after the EOP that is sent out for the newly submitted corrected claim.

Reimbursement

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

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

- ***Incidental Surgeries/Complications** – A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by an 'Ohana medical director on whether the proposed complication merits additional compensation above the usual allowable amount.*
- ***Admission Examination** – One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.*
- ***Follow-up Surgery Charges** – Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.*

- ***Multiple Procedures*** *– Payment for multiple procedures is based on current CMS percentages methodologies. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service or when multiple surgical procedures are performed on the same day and by the same surgeon.*
- ***Assistant Surgeon*** *– If there are no reimbursement guidelines on the Hawai'i Medicaid website for payment of assistant-at-surgery services, payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies. 'Ohana uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as "sometimes," CMS is used as the secondary source.*
- ***Co-Surgeon*** *– If there are no reimbursement guidelines on the Hawai'i Medicaid website for payment of co-surgery procedures, payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his/her distinct, operative work by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure, as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier '62' added.*

Modifier

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

Allied Providers

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

Value-Based Payments (VBP)

Value-Based Payments (VBP) are incentive-based payments, typically with some element of risk to the provider, which may be in addition to Fee for Service (FFS) claim payments or may replace them entirely. In a VBP model the provider's interests are better aligned with the health plan's since they share a desire to improve cost efficiencies and proactively manage utilization to avoid waste while enhancing the overall patient experience and quality of life. While the provider will typically receive less from claims, they may have the opportunity to earn significantly more overall based on agreed-upon utilization, quality or cost measures. This evolution to "gain share" models based on a panel loss ratio below a target level, or impactable utilization decreasing from a baseline target level, or some other savings-based measure, should result over time in significantly decreased cost of care and better patient health outcomes. These models often have a quality threshold, for instance, a provider's panel must exceed the 50th percentile for HEDIS measures or 3 Medicare Stars to qualify for a bonus payment, regardless of cost or utilization improvements.

Overpayment Recovery

ʻOhana strives for 100% payment quality but recognizes that a small percentage of financial overpayments will occur while processing claims. Reasons for overpayment include retroactive Member disenrollment, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement.

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 after the initial claim payment was received by the Provider, or as otherwise set forth in the Hawaiʻi statute. No such time limit shall apply to overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing, required by, or initiated at the request of, a self-insured plan, or required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or Members.

In all cases, 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 ʻOhana recognizes that the Provider may use the carrier address it has on file. The standard request notification provides 30 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 frame will constitute acceptance of the terms in the letter and will result in offsets to future payments. The Provider will receive an EOP indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months and no refund has been received, the Provider may be contacted to arrange payment.

If the 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, Inc.
Recovery Department
P.O. Box 31584
Tampa, FL 33631-3584

Providers with any questions about this can call Customer Service toll-free at ***1-888-846-4262****. For more information on contacting ʼthe Customer Service department, refer to the Quick Reference Guide on ʻOhana's website at* ***www.ohanahealthplan.com/provider/medicaid/resources****.*

Section 6: Credentialing

Overview

Credentialing is the process by which the appropriate peer review bodies of ʻOhana evaluate the credentials and qualifications of practitioners, including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations. For purposes of this Credentialing section, all references to "practitioners" shall include Providers of health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/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)*
- *Ownership Disclosure & Control*

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

The Credentialing Department 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 ʻOhana Members.

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

After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider.

Credentialing may be done directly by ʻOhana or by an entity approved by ʻOhana for delegated credentialing. In the event 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/re-application 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 written 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 of 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 him/her 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 ʻOhana 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.

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 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.

'Ohana'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 MD/DO/DPM/DDS/DMD).*

***Work History** – Practitioners must provide a minimum of five years' relevant work history as a health professional.*

***Ownership & Control Disclosure** – Practitioners must provide a current Ownership & Control Disclosure document*

***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). Primary Care Providers (PCPs) may have hospital-admitting privileges or may enter into a formal agreement with another 'Ohana-participating Provider who has admitting privileges at an 'Ohana-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 policies and procedures.*

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

Site Inspection Evaluation (SIE)

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

- *Office-site criteria*
  - *Physical accessibility*
  - *Physical appearance*
  - *Adequacy of waiting room and examination room space*
- *Medical/treatment record keeping criteria*

SIEs are conducted for:

- *Unaccredited facilities that do not have a current CMS or State site survey to provide*
- *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, ʻOhana.

Allied Health Professionals

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

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

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

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

- *Advanced practice registered nurse with prescriptive authority (APRN-Rx)*
- *Licensed clinical social worker*
- *Licensed mental health counselor*
- *Licensed marriage and family therapist*
- *Physical therapist*
- *Occupational therapist*
- *Audiologist*
- *Speech/language therapist/pathologist*

Ancillary Health Care Delivery Organizations

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

'Ohana has a Participating Provider dispute resolution peer review panel process if 'Ohana 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 whom 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 'Ohana 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 panel processes, are provided to the practitioner. Notification to the practitioner will be mailed by overnight, recorded or certified return receipt mail.

The practitioner has up to 30 days to file a written request via recorded or certified return receipt mail to access the dispute resolution peer review panel process.

Upon timely receipt of the request, the medical director or his/her designee shall notify the practitioner of the date, time and telephone access number for the panel hearing. 'Ohana then notifies the practitioner of the schedule for the review panel hearing.

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

The dispute resolution peer review panel shall consider and decide the case objectively and in good faith. The medical director, within 5 business days after final adjournment of the dispute resolution peer review panel hearing, shall notify the practitioner of the results of the first-level panel hearing. 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 5 business days of 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 frame and manner specified waives any right to such review to which they might otherwise have been entitled. 'Ohana 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 action.

*A Member or Provider may file a grievance either verbally by calling **1-888-846-4262**, or in writing, about any matter related to their coverage or care, without concern of reprisal from the Company, its employees or Providers. A Member, Member's representative, or Provider acting on behalf of the Member with the consent of the Member, may file a grievance or complaint, either verbally or in writing. A Member may, in person or by telephone, verbally identify another person who may communicate with the health plan on the Member's behalf to file a grievance. 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., 3rd Floor, Suite 350
Kapolei, HI 96707

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

Grievances include but are not limited to:

- *The quality of care or quality of service given by a Provider*
- *Rudeness of a Provider or a Provider's employee*
- *Failure to respect the Member's rights regardless of whether remedial action is requested*

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 in writing at any time. Refer to the Quick Reference Guide on 'Ohana's website for contact information.

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 which includes the acknowledgement and the decision letter. The resolution letter will include the*

results/finding of the resolution, all information considered in the investigation of the grievance, and the date of the grievance resolution.

- *Include clear instructions in the resolution letter as to how to access the State's grievance review process on the written disposition of the grievance.*

- *Ensure that individuals who make decisions on grievances are not involved in any previous level of review or decision-making, nor is a subordinate of any such individual.*

- *Ensure that decision makers on grievances of Adverse Benefit Determinations take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.*

The Member is made aware of their rights to have an authorized representative and appropriate toll-free numbers, as well as TTY numbers in the Member Handbook. Customer Service will serve as the intake point of grievance submission and provide appropriate assistance to include auxiliary aids and services upon request, such as providing interpreter services, in accordance with all Customer Service policies.

The time frame for standard grievances may be extended up to 14 days if:

- *The Member asks for an extension or the plan documents that additional information is needed, and the delay is in the Member's interest.*
- *The time frame is extended for any reason other than at the Member's request; the plan must notify the Member verbally/orally of the reason for the delay by close of business of the day the determination to extend is made, and within two calendar days of the determination, in writing, of the reason for the delay.*
- *Resolve the grievance as expeditiously as the Member's health condition requires and no later than the date the extension expires.*

The Member may request a State grievance review from MQD within 30 calendar days of the grievance decision from 'Ohana. A request for a State grievance review may be made by contacting the MQD office at or mailing a request to:

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

'Ohana will in no way discriminate against either Members or Providers for filing or supporting a grievance or appeal. 'Ohana (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 to file a grievance.

The State 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, 'Ohana 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 5 business days to respond.

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

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

For quality-of-care issues, the case is then referred to a QI nurse who reviews the medical records to determine if a quality issue exists. If the nurse feels a quality issue exists, the case is referred to 'Ohana's Medical Director for review. If the medical director determines a quality issue exists, the case is referred to the Utilization Management Committee (UMC) which serves as the peer review committee for further investigation. If no quality issue is identified, the case is entered into 'Ohana'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 decision or action. 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*
- *Failure to authorize services in the required time frames*
- *Failure to render a decision on an appeal in the required time frame*
- *Failure to provide a resolution on a grievance in the required time frame*
- *Failure to let a Member see a non-participating provider if Member lives in rural area or in an area with limited Providers who cannot meet Member's medical needs*

'Ohana established and maintains a separate 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/provider** in the Resources area. The Member and the person who will be representing the Member must sign the statement.*

An appeal may be filed when 'Ohana issues a Notice of Adverse Benefit Determination to an 'Ohana 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 in order to establish the appeal submission date. 'Ohana will assist the Member, Provider or authorized representative in this process.

Appeals may be verbal or written to:
'Ohana Health Plan
P.O. Box 31368
Tampa, FL 33631-3368
Toll Free: ***1-888-846-4262***

Written Pharmacy Appeals can be sent to:
'Ohana Health Plan
Attn: Pharmacy Appeals
P.O Box 31398
Tampa, FL 33631-3398

Upon the receipt of an appeal, 'Ohana will issue an acknowledgment letter within five business days notifying the Member that the Plan received the request for appeal. 'Ohana 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 for standard appeals.

'Ohana shall ensure that decision makes on appeal take into account all comments, documents, records and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

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

'Ohana may extend the resolution time frame by up to 14 calendar days if the Member requests the extension, or 'Ohana 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, 'Ohana will give the Member written notice of the reason for the delay in two calendar days.

'Ohana 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 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 'Ohana's action.*

'Ohana 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 Member and/or Provider on behalf of Member may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

Expedited Appeal Process

'Ohana 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 by calling ***1-888-846-4262*** *or in writing. No additional written follow-up will be required. An expedited appeal is only appropriate when 'Ohana determines or the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental 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.

If ʻOhana denies the request to process an expedited appeal, then ʻOhana will automatically transfer and process the request using the 30-calendar-day time frame for standard appeals beginning on the date ʻOhana received the original request. The Member will also receive prompt oral notification within 24 hours regarding the denial of an expedited request and will follow up with written notification to the Member within two calendar days.

Additional information may be submitted during an appeal; however, the time frame to submit additional information on an expedited appeal is limited.

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

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

ʻOhana will provide the reason it is requesting a 14 additional day extension to the MQD. ʻOhana 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, or if ʻOhana 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 delay or denial*
- *Within two days give the Member written notice of the reason for the decision to extend the time frame or deny a request for expedited resolution of an appeal;*
- *Inform the Member verbally and in writing that they may file a grievance with ʻOhana for the delay or denial of the expedited process, if they disagree with that decision; and*
- *Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.*

Reversal of Denial of an Expedited Appeal Decision

If ʻOhana overturns its initial action and/or the denial, it will issue authorization to cover the requested service and notify the Member verbally within 72 hours of receipt of the expedited appeal request, followed with written notification of the appeal decision within two calendar days.

Affirmation of Denial as an Expedited Appeal Decision

If ʻOhana 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 understood 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, in person and in writing, to present evidence and testimony and make legal and factual arguments. 'Ohana will inform the Member of the limited time available for this sufficiently in advance of the resolution time frame for appeals for expedited appeals.

DHS Administrative Hearing for Regular Appeals

If the Member is not satisfied with 'Ohana's written Notice of Disposition of the appeal, they may file for a DHS administrative hearing up to 120 calendar days from the receipt 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 they may request information on exhausting the health plan's one level of appeal and the right to a state hearing after receiving notice that the Adverse Benefit Determination is upheld. The Member has a right to representation at the DHS administrative hearing to include, at a minimum, the Member or they may use legal counsel, a relative, 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 30 calendar days of receipt of the Member's appeal determination to the following address:

State of Hawai'i Department of Human Services
Administrative Appeals Office
P.O. 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 they must submit a letter to the AAO within 120 calendar days of receipt of the Member's appeal determination.

An expedited DHS administrative hearing must be heard and determined within three business days of 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 an expedited DHS administrative hearing, 'Ohana will submit information that was used to make the determination, for example, medical records, written documents to and from the Member, Provider notes, etc. 'Ohana 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

'Ohana 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 'Ohana mailing the Notice of Adverse Benefit Determination; or*
    - *The intended effective date of 'Ohana's proposed Adverse Benefit Determination*
- *The appeal or request for state administrative hearing involves the termination, suspension or reduction of previously authorized services*
- *The services were ordered by an authorized Provider*
- *The original authorization period has not expired*

If 'Ohana continues or reinstates the Member's services while the appeal or DHS administrative hearing is pending, 'Ohana 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 of when 'Ohana mails a Notice of Adverse Benefit Determination*
- *A state administrative hearing decision adverse to the Member is made*

If the final resolution of the appeal or state administrative hearing is adverse to the Member, that is, upholds 'Ohana's Adverse Benefit Determination, then 'Ohana 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 'Ohana or the State reverses a decision to deny, limit or terminate services that were not furnished while the appeal was pending, 'Ohana will authorize or provide these disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it received notice reversing the determination.

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

Provider Grievance

'Ohana 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 'Ohana 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.

The Grievance Department will send an acknowledgement letter within five (5) business days to the Provider confirming receipt and details of the dissatisfaction. Provider grievances shall be resolved within 60 calendar days of the day 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., 3rd Floor, 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 at ***1-888-846-4262****, where Customer Service representatives are available to answer questions, help file a Provider grievance and resolve issues. The appropriate Customer Service department contact information is in the Quick Reference Guide on ʻOhana's website.*

Provider Payment Dispute/Administrative Appeals

Although it is ʻOhana's intent to satisfy Providers, ʻOhana recognizes that there may be instances where a Provider needs to file a grievance or appeal a decision. ʻOhana's 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 calling Customer Service at ***1-888-846-4262*** *during normal business hours. Please refer to the Quick Reference Guide on ʼOhana's website for contact information.*

Electronic Inquiries

'Ohana can 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 call the EDI Assistance line, which is listed in the Quick Reference Guide on 'Ohana's website.

Informal Claim Payment Resolution Procedure – Adjustment Requests

An informal claim resolution procedure precedes the formal claim resolution procedure. The informal claim resolution procedure 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 'Ohana 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*

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

'Ohana 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 call Customer Service at ***1-888-846-4262*** *or contact them in writing. The appropriate contact information is in the Quick Reference Guide on 'Ohana's website.*

Provider Appeals

An administrative appeal is a payment dispute between Provider and 'Ohana for services already provided, where the Provider does not agree with the results of 'Ohana'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 'Ohana's Appeals Department. The letter must detail the reason for the appeal and be accompanied by any and all supporting documentation, such as the EOP and/or medical records. The Appeals Department will receive, distribute and coordinate all administrative appeals. Appeals may be mailed to:

'Ohana Health Plan

P.O. 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 send an acknowledgement letter to the Provider confirming receipt of the appeal within ten (10) calendar days, then will research and determine the current status of a payment dispute. If more 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 'Ohana'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.*
- *The Appeals Department will render a written determination within two (2) calendar days, but no more than sixty (60) calendar days of 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 about the Provider payment dispute process should be directed to a Provider Relations representative or call Customer Service at ***1-888-846-4262****. Refer to the Quick Reference Guide for contact information.*

Submission of Provider Termination Appeal Request

If a Provider termination is initiated by 'Ohana, regardless of whether the termination is for cause or not, 'Ohana will notify the Provider of the termination decision in writing via certified mail of the reason. When applicable, 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 'Ohana's termination notice. 'Ohana will send an acknowledgement letter to the Provider within five business days of receipt of the appeal request. 'Ohana may request additional information from the Provider 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, 'Ohana 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 'Ohana overturns the termination of the Provider, 'Ohana will ensure that there is no lapse in the period of the Provider's participation with 'Ohana.

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 Primary Care Provider (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

‘Ohana Health Plan’s Compliance Program

Overview

‘Ohana maintains a Corporate 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 ‘Ohana, ‘Ohana employees, contractors (including delegated entities), and business partners in an ethical and legal manner. All Providers, including Provider employees and Provider subcontractors and their employees, are required to comply with ‘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 the Health Insurance Portability and Accountability Act of 1996 (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 fraud, waste and abuse (for example, 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 fraud, waste, and abuse*
    - *Process for reporting suspected fraud, waste and abuse*
    - *Protections for employees and subcontractors who report suspected fraud, waste and abuse*
    - *Types of fraud, waste, and abuse that can occur*
- *Cultural Competency training*
  - *Programs to educate and identify the diverse cultural and linguistic needs of the Members Providers serve*
- *Disaster Recovery and Business Continuity*
  - *Development of a Business Continuity plan that includes the documented process of continued operations of the delegated functions in the event of a short-term or long-term interruption of services*

Providers, including Provider employees and/or Provider subcontractors, must report to ‘Ohana any suspected fraud, waste or abuse (FWA), misconduct or criminal acts by ‘Ohana, or any Provider, including Provider employees and/or Provider subcontractors, or by ‘Ohana 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 Medicaid 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). WellCare utilizes 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 has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. 'Ohana's Code of Conduct and Business Ethics policy are found 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 ʻOhana 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. Report suspected fraud, waste and abuse by calling ʻOhana's FWA hotline at* ***1-866-685-8664****.*

Fraud, Waste and Abuse (FWA)

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

Federal and state regulatory agencies, law enforcement and ʻOhana vigorously investigate incidents of suspected fraud, waste and abuse. Providers are cautioned that unbundling, fragmenting, upcoding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians' CPT, the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

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

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

To report suspected FWA, call ʻOhana's confidential and toll-free FWA hotline at ***1-866-685-8664*** *or send a report in writing to:*

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

Details of the corporate ethics and compliance program and ʻOhana's FWA hotline contact information 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 in HIPAA privacy and security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of Members' medical records and other PHI; and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

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

Examples of confidential information include, but are not limited to the following:

- *Medical records*
- *Communication between a Member and a Provider regarding the Member's medical care and treatment*
- *All personal and/or protected health information as defined under the federal HIPAA privacy regulations, and/or other state or federal laws*
- *Any communication with other clinical persons involved in the Member's health, medical and mental care for example, diagnosis, treatment and any identifying information such as name, address, Social Security Number, etc.)*
- *Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem*
- *Any testing for a communicable disease, such as acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV) 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, Members may call 'Ohana's Customer Service using the toll-free number on their Member ID card. Providers may contact 'Ohana's Customer Service department at ***1-888-846-4262*** *or 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 associates of ʻOhana value diversity within the organization and to see that Members in need of linguistic services have adequate communication support. In addition, ʻOhana is committed to having Providers fully recognize and care for the culturally diverse needs of the Member they serve.

The objectives of the Cultural Competency program are to:

- *Identify Members that have potential cultural or linguistic barriers for which alternative communication methods are needed*
- *Utilize culturally sensitive and appropriate educational materials based on the Member's race, ethnicity and primary language spoken*
- *Make resources available to meet the unique language barriers and communication barriers that exist in the population*
- *Help Providers care for and recognize the culturally diverse needs of the population*
- *Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served*
- *Decrease healthcare disparities in the minority populations we serve*

Culturally and linguistically appropriate services (CLAS) are healthcare services that respect and respond to cultural and linguistic needs. The delivery of culturally competent healthcare and services requires healthcare Providers and/or their staff to 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***
  - *Analysis of claims and encounter data to identify the healthcare needs of the population*
  - *Collection of Member data on race, ethnicity and language spoken*
- ***Community-Based Support***
  - *Outreach to community-based organizations which support minorities and people with disabilities to help ensure that the existing resources for Member are being used to their full potential.*
- ***Diversity and Language Abilities of ʻOhana Staff***
  - *Non-Discriminating – ʻOhana may not discriminate with regard to race, religion or ethnic background when hiring associates*
  - *Recruiting – ʻOhana recruits diverse talented associates in all levels of management*
  - *Multilingual – ʻOhana recruits bilingual associates for areas that have direct contact with Members to meet the needs identified, and encourages Providers to do the same*
- ***Diversity of Provider Network***
  - *Providers language abilities are captured upon credentialing and this information is made available in the Provider Directory so that Member can choose a Provider that speaks their primary language*
  - *Providers are recruited to help ensure a diverse selection of Providers to care for the population served*
- ***Linguistic Services***
  - *Providers will identify Members that have potential linguistic barriers for which alternative communication methods are needed and will contact ʻOhana to arrange appropriate assistance*

- *Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer Service department*
- *Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by ʻOhana's Customer Service department*
- *Written materials are available for Members in large print format, and certain non-English languages, prevalent in ʻOhana's service areas*

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

- ***Provider Education***
  - *ʻOhana's Cultural Competency program provides a cultural competency checklist to assess the Provider office's cultural competency*
  - *For more information on the Cultural Competency program, registered provider portal users may access the cultural competency training on ʻOhana's website*
  - *A paper copy, at no charge, may be obtained upon request by contacting Customer Service at **1-888-846-4262** or a Provider Relations representative*
  - *Providers must adhere to the Cultural Competency program as set forth above*

Cultural Competency Survey

*Providers may access the Cultural Competency Survey at **www.ohanahealthplan.com/provider** in the Resources area.*

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 defines a "delegated entity" as a subcontractor that performs a core function under one of 'Ohana's government contracts.

'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's Delegation Oversight Committee (DOC) is the governing body for the delegation oversight process and provides oversight of subcontracted vendors where specific services are delegated. The DOC 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 management procedures are an integral part of the pharmacy program that ensure and promote the utilization of the most clinically appropriate agent(s) to improve the health and well-being of 'Ohana Members. The utilization management tools that 'Ohana uses to optimize the pharmacy program include:

- *Preferred Drug List (PDL)*
- *Mandatory Generic policy*
- *Step therapy (ST)*
- *Quantity limit (QL)*
- *Age limit (AL)*
- *Coverage Determination Review process*
- *Pharmacy Lock-In program*
- *Provider Education Program (PEP)*
- *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, e.g., National Institutes of Health (NIH) Asthma guideline, Joint National Committee (JNC) VIII Hypertension guidelines*
- *Prescribe drugs listed on the PDL*
- *Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class*
- *Evaluate medication profiles for appropriateness and duplication of therapy*

To contact 'Ohana's Pharmacy Department, please refer to the Quick Reference Guide on 'Ohana's website.

Preferred Drug List

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

- *A list of covered pharmaceuticals, including restrictions and preferences, and co-payment information, if applicable.*
- *How to use the pharmaceutical management 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 interchange and step-therapy protocols.*

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

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

*The PDL is at **www.ohanahealthplan.com/provider/pharmacy**. Practitioners may call **1-888-846-4262** to receive a copy of the pharmaceutical management procedures and updates by mail, fax or email. Changes to the PDL and applicable pharmaceutical management procedures are communicated in advance to Providers as the following:*

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

Additions and Exceptions to the Preferred Drug List

Providers may request consideration for addition of a drug to 'Ohana's PDL by writing to 'Ohana and explaining the medical justification. For contact information, refer to the Quick Reference Guide on 'Ohana's website.

For more information on requesting exceptions, refer to the Coverage Determination Review Process in Section 4: Utilization Management (UM) and Disease Management (DM).

State Exceptions

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

Generic Medications

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

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

For more information on the Coverage Determination Review process, including how to access the form, see Coverage Determination Review Process in *Section 4: Utilization Management (UM) and Disease Management (DM).*

Step Therapy

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

Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven, safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on 'Ohana's PDL have been evaluated through the use of clinical literature and are approved by 'Ohana's P&T Committee. Please refer to the PDL to view drugs requiring step therapy.

Quantity Limits

Quantity limits are used to ensure that pharmaceuticals are supplied in a quantity consistent with the Food and Drug Administration (FDA) approved dosing guidelines. Quantity limits can also be used to help prevent billing errors. Please refer to the PDL to view drugs with quantity limits.

Age Limits

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

Over the Counter (OTC) Medications

'Ohana will only pay for over the counter (OTC) items listed on the PDL that are prescribed to the Member. Examples of OTC items listed on the PDL include:

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

- *Proton pump inhibitors*

For a complete list of OTC medications covered with a prescription, please refer to the PDL on ʻOhana's website.

Injectable and Infusion Services

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

Approved self-injectable and infusion drugs are covered when supplied by retail pharmacies and infusion vendors contracted with ʻOhana. Please contact the Pharmacy Department regarding criteria related to specific drugs.

Coverage Limitations

The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

- *Agents used for anorexia, weight gain or weight loss*
- *Agents used to promote fertility*
- *Agents used for cosmetic purposes or hair growth*
- *Drugs for the treatment of erectile dysfunction*
- *DESI drugs or drugs that may have been determined to be identical, similar or related*
- *Treatment for active tuberculosis (these are covered by the Hawaiʻi State Department of Health (DOH) Tuberculosis Control program)*
- *Medications used for Hansen's Disease (these are covered by the Hawaiʻi State DOH)*
- *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.

Member Co-Payments

There are no co-payments when medications are covered by ʻOhana for Members with Medicaid-only coverage. Please note: Many ʻOhana Members will be dually enrolled in Medicare and have pharmacy coverage via their Part D plan. Co-pays under Part D Medicare plans will vary by carrier.

Coverage Determination Review Process (Requesting Exceptions to the PDL)

The goal of the Coverage Determination Review process (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 FDA-approved indications. The Coverage Determination Review process is required for:

- *Duplication of therapy*
- *Prescriptions that exceed the FDA indicated daily or monthly quantity limit*

- *Drugs not listed on the PDL*
- *Drugs that have an age limitations*
- *Drugs listed on the PDL but still require prior authorization (PA)*
- *Brand name drugs when a generic exists*
- *Drugs that have a step therapy edit (ST), and the first-line therapy is inappropriate*

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 may be accessed on 'Ohana's website.

'Ohana may require a prescriber's office to request a Prior Approval (PA) as a condition of coverage or pharmacy payment if the PA request is approved or denied within 24 hours of receipt. If a prescription cannot be filled when presented to the pharmacist due to a PA requirement and the prescriber's office cannot be reached, then 'Ohana must instruct the pharmacy to dispense a 72-hour emergency supply of the prescription. The pharmacy is not required to dispense a 72-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the Member's health or safety, and they have made good faith efforts to contact the prescriber. 'Ohana must reimburse the pharmacy for dispensing the emergency supply of medication.

If authorization cannot be approved or denied, and the drug is Medically Necessary, a seven-day emergency supply of the non-preferred drug may be supplied to the Member.

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

Medication Appeals

To request an appeal of a Coverage Determination request decision, Providers may request an exception to 'Ohana's PDL orally or in writing. Refer to 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 'Ohana, the request will follow the appeals process described in Section VIII Appeals and Grievances.

Pharmacy Management – Provider Education Program (PEP)

The Pharmacy Provider Education Program (PEP) is designed to provide physicians with utilization reports to identify overutilization and underutilization of pharmaceutical products. The reports will also identify medication related care gaps, opportunities for optimizing best practices guidelines and cost-effective therapeutic options. These reports are delivered by the state pharmacy director and/or clinical pharmacy manager to physicians identified for the program.

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 Road
Tampa, FL 33634
Phone: ***1-866-458-9246*** *(TTY* ***1-855-516-5636****)*
Fax: ***1-866-458-9245***
www.acariahealth.com

Section 11: Behavioral Health

Overview

'Ohana provides behavioral health benefits for Medicaid Members. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Some specialty behavioral health services may be provided outside of the health plan benefit through the 'Ohana Community Care Services (CCS) Program. 'Ohana can assist with coordination and/or referral to these services.

'Ohana supports the concept of Stepped Care is that individuals can move up or down a continuum of services as needed and that treatment level and intervention will be paired with the individual's level of acuity to provide effective care without overutilization of resources. The goal is to meet individual needs at the lowest level possible while ensuring high-quality results which allows the system to use limited resources to their greatest effect on a population basis.

Some behavioral health services may require prior authorization, including all services provided by non-participating providers. WellCare uses Milliman Care Guidelines (MCG) for all behavioral health services, and American Society for Addiction Medicine (ASAM) criteria for substance use disorder, among other clinical criteria used by WellCare. These criteria are well-known and nationally accepted guidelines for assessing level of care criteria for behavioral health.

Behavioral Health Program

Behavioral health services requiring timely notification or prior authorization include:

- *Acute inpatient*
- *Residential Substance Abuse Treatment*
- *Partial hospitalization program*
- *Intensive outpatient program*
- *Behavioral Health Day Treatment*
- *ABA Services*
- *ECT treatment*
- *TMS treatment*
- *Psychological testing*

Behavioral health services that do not require prior authorization:

- *Psychiatric or psychological evaluation*
- *Physician services including medication management*
- *Routine outpatient counseling and therapy*
- *Methadone treatment services*

*If the Member needs a referral to a behavioral health Provider, call Customer Service at **1-888-846-4262**.*

Specialized Behavioral Health Services for Hawai'i Medicaid Adult Members

Adult Medicaid Members 18 years or older with a diagnosis of serious mental illness (SMI) or a severe and persistent mental illness (SPMI) may be eligible for additional behavioral health services from the Department of Human Services' Community Care Services (CCS) program offered by ʻOhana Health Plan.

In addition, the full array of QUEST Integration behavioral health benefits, the CCS program offers intensive behavioral health case management services to eligible adults. Every CCS Member is assigned to a community-based case manager. CCS case managers meet frequently in the community with beneficiaries to assist them with the following, including but not limited to:

- *Food and Housing*
- *Securing and maintaining eligibility for general assistance or Social Security benefits*
- *Medication management and monitoring*
- *Hospital discharge planning*
- *Crisis Services*
- *Alcohol and/or drug treatment*

Members who choose not to be in the CCS Program can still obtain standard behavioral health services through 'Ohana QUEST Integration.

Members and Providers can contact ʻOhana Customer Service, to inquire about referring a Member to CCS. CCS referral packets are completed by a licensed behavioral health clinician, reviewed by 'Ohana for completeness and forwarded to MQD for eligibility review. MQD makes the final determination about whether a Member is approved for CCS. Once approved, 'Ohana will notify the Member and referring Provider.

Continuity and Coordination of Care Between Medical Care and Behavioral Health Care

Primary Care Providers (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 health Providers must use the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) when assessing the Member for behavioral health services and document the DSM-5 diagnosis and assessment/outcome information in the Member's medical record.

Communication with the PCP should occur more frequently if clinically indicated. 'Ohana encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization ('Ohana recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to the PCP). Please send this communication, with the properly signed consent, to the Member's identified PCP noting any changes in the treatment plan on the day of discharge.

We strongly encourage open communication between PCPs and behavioral health Providers. If a Member's medical or behavioral condition changes, '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 the PCP obtain this ROI as soon as possible.

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

Responsibilities of Behavioral Health Providers

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

Section 12: ʻOhana Resources

Medicaid Forms and Documents
www.ohanahealthplan.com/Provider/medicaid/forms *(under Overview)*

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

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

Clinical Coverage Guidelines (links to WellCare's corporate website)
www.wellcare.com/Hawaii/Providers/Clinical-Guidelines/CCGs

Behavioral Health
www.ohanahealthplan.com/providers/medicaid/behavioral-health.html

Pharmacy
www.ohanahealthplan.com/provider/pharmacy

Section 13: Definitions

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

***Abuse** Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or contractual obligations for healthcare in the managed care setting. Incidents or practices of providers that are inconsistent with sound medical practices.*

***Adverse Benefit Determination (may also be referred to as an adverse action)** Any one of the following:*

A. *Denial or restriction of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness or a covered benefit;*
B. *Reduction, suspension or termination of a service previously authorized service*
C. *Denial, in whole or in part, of payment for a service*
D. *Failure to provide services in a timely manner, as defined by the Department;*
E. *Failure of a health plan to act within prescribed time frames regarding the standard resolution of grievances and appeals;*
F. *For a rural area Member or for islands with only one health plan or limited providers, the denial of a Member's request to obtain services outside the network:*
    - *From a provider not part of a network that is the main source of a service to the Member, provided that the provider is given the same opportunity to become a participating Provider as other similar providers;*
    - *From a provider not part of a network that is the main source of a service to the Member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;*
    - *If the provider does not choose to join the network or does not meet the qualifications, the Member is given a choice of participating Providers and is transitioned to a participating Provider within 60 days;*
    - *Because the only health plan or provider does not provide the service because of moral or religious objections;*
    - *Because the Member's provider determines that the Member needs related services that would subject the Member to unnecessary risk if received separately and not all related services are available within the network; and*
    - *The State determines that other circumstances warrant out-of-network treatment.*

***Appeal** means a request from a Member or Provider to review an Adverse Benefit Determination made by ʻOhana.*

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

A. *A court-appointed legal guardian*
B. *A person who has a durable power of attorney for healthcare*
C. *A person who is designated in a written advance directive*

Authorization *means an approval of a prior authorization request for payment of services and is provided only after 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 as defined in the Agreement.*

Centers for Medicare & Medicaid Services ("CMS") *means the United States federal agency which administers Medicare, Medicaid and the Children's Health Insurance Program.*

Clean Claim *means as defined in the Agreement*

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

Companion Guide *means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and encounter data submitted to 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 there is no other available intervention that offers a clinically appropriate benefit at a lower cost.*

Covered Services *means as defined in the Agreement.*

DHS *means the State of Hawaiʻi, Department of Human Services.*

EPSDT *means the Early and Periodic Screening, Diagnostic 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 younger than the age of 21.*

Emergency Medical Condition *means as defined in the Agreement. See Section 4 Emergency/Urgent Care and Post-Stabilization Services for definition.*

Emergency Medical Services *or* ***Emergency Care*** *are Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.*

Encounter *means a record of medical services rendered by a Provider to a Member enrolled in the health plan on the date of service.*

Encounter Data *means a compilation of encounters.*

Excluded Person *means an individual or entity who:*

(a) Is currently excluded, debarred, suspended or otherwise ineligible to participate in:

(i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG

(ii) Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration

(b) Has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs

(c) Is currently excluded, debarred, suspended or otherwise ineligible to participate in state medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a state governmental authority

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 of 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 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. 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*

Internal review *means the review of a Member's complaint or grievance by 'Ohana.*

LTAC *means a Long-Term Acute Care hospital.*

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

Medically Necessary *means as defined in the Agreement.*

Member *means an individual properly enrolled in a benefit plan and eligible to receive Covered Services at the time such services are rendered.*

Member Expenses *means co-payments, coinsurance, deductibles or other cost-share amounts, if any, that a Member is required to pay for Covered Services under a benefit plan.*

Members with Special Health Care Needs *means Members with special needs and are defined as adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.*

MQD *means the Med-QUEST Division of DHS.*

Notification *means a communication to 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 which defines age-appropriate services and time frames for screenings within the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.*

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

Practitioner *means a licensed or certified professional who provides medical care or behavioral healthcare services.*

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 *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.*

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.*

Stepped Care *means individuals can move up or down a continuum of services as needed and that treatment level and intervention will be paired with the individual's level of acuity to provide effective care without overutilization of resources. The goal is to meet individual needs at the lowest level possible while ensuring high-quality results which allows the system to use limited resources to their greatest effect on a population basis.*

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 the diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life or health, but which require medical attention 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-conference 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 – 99537	*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*

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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