

2012 ALOHACARE MEDICARE PROVIDER MANUAL



AlohaCare
For a healthy Hawaii.

Welcome Physicians/Providers!

The AlohaCare Medicare Provider Manual offers you—our providers and your staff—with helpful information and details on our AlohaCare Advantage health plans. We recommend that you read this manual and keep it on hand for your staff to reference.

The Medicare Provider Manual is also available on our website, www.AlohaCare.org. If you have trouble accessing the information, please contact our Customer Service Department.

Table of Contents

Section 1:	INTRODUCTION TO ALOHACARE
Section 2:	IMPORTANT INFORMATION FOR PROVIDERS
Section 3:	PROVIDER ROLE
Section 4:	ALOHACARE ADVANTAGE AND ALOHACARE ADVANTAGE PLUS PROGRAM BENEFITS
Section 5:	MEMBER SERVICES
Section 6:	UTILIZATION MANAGEMENT/MEDICAL MANAGEMENT
Section 7:	PHARMACY SERVICES
Section 8:	BEHAVIORAL HEALTH
Section 9:	CARE MANAGEMENT AND DISEASE MANAGEMENT
Section 10:	BILLING AND REIMBURSEMENT
Section 11:	MEMBER APPEALS AND GRIEVANCES
Section 12:	PROVIDER COMPLAINTS, GRIEVANCES AND APPEALS
Section 13:	QUALITY IMPROVEMENT

SECTION 1: INTRODUCTION TO ALOHACARE

Aloha! Thank you for partnering with us to improve the health of our AlohaCare members and our community.

Our Story

AlohaCare is a local, non-profit health plan founded in 1994. We work with the most medically-fragile populations, including low-income seniors, to provide Medicaid and Medicare coverage to over 78,000 members.

AlohaCare started our Medicare plans in 2006 and provides care to Hawaii's Medicare population through a contract with the Centers for Medicare and Medicaid Services (CMS). We offer two Medicare Advantage Prescription Drug Plans (MA-PD), AlohaCare Advantage (HMO) and AlohaCare Advantage Plus (HMO SNP). Both plans offer comprehensive medical and prescription drug coverage. AlohaCare Advantage Plus is a Special Needs Plan (SNP) specifically designed for Medicare beneficiaries who also have full Medicaid coverage.

AlohaCare Mission

Our passion is to serve the people of Hawaii in the true spirit of aloha by providing a comprehensive continuum of quality health care to all, with special expertise in caring for those who are medically underserved and/or medically fragile.

This is accomplished by emphasizing prevention and primary care through community-governed health centers and in partnership with physicians and other healthcare providers that share our compassion and aloha for this population.

AlohaCare Vision

To be the world's most innovative health plan in solving the healthcare needs of special populations.

Core Values

We promise to demonstrate our core values each time we interact with you:

- Fairness
- Honesty
- Loyalty
- Respect/Dignity
- Trust

Contact Us

We are here to answer your questions and provide support to your office.

- Your telephone calls will be answered by a live Customer Service representative.
- We are available Monday through Friday, 8 a.m. to 8 p.m.
- Our after-hours answering service can provide member eligibility information. Calls made after-hours that need follow up are returned the next business day.

Important Phone Numbers

Department	Phone	Toll-free	Fax	Toll-free Fax
Customer Service/Provider Relations	973-6395	1-866-973-6395	973-0811	1-800-830-7222
Medical Management	973-1657	1-800-434-1002	973-0676	1-888-667-0680
Care Management	973-1650	1-800-434-1002	973-6392	1-808-973-6392
Pharmacy	973-7418	1-866-973-7418	973-6327	1-877-316-6376
Behavioral Health (Prior Auth Requests)	973-2475	1-888-875-4979	973-6324	1-800-293-4580

Mailing Address

AlohaCare
1357 Kapiolani Blvd, Suite 1250
Honolulu, HI 96814

SECTION 2: IMPORTANT INFORMATION FOR ALL PROVIDERS

AlohaCare Publications

AlohaCare is committed to providing clear, accurate and timely communications to our provider network. We publish the Medicare Provider Manual and a quarterly provider newsletter, *Kui Ka Lono*. Both publications are available online at www.AlohaCare.org.

Medicare Provider Manual

The Medicare Provider Manual is an extension of the AlohaCare Provider Agreement. Updates are made when the Center for Medicare and Medicaid Services (CMS) has updates to the Medicare Advantage Prescription Drug Plan (MA-PD) guidelines or when we update our own policies and procedures.

The Medicare Provider Manual helps you and your staff to understand the AlohaCare Advantage Program and AlohaCare policies and procedures. The online Medicare Provider Manual always represents the most current information. For an additional CD or printed copies of the Medicare Provider Manual, contact our Customer Service Department.

Provider Newsletter

Kui Ka Lono is designed to keep you informed of policy changes (such as changes to billing guidelines, referrals and authorizations), tips for claim submission, online tools and more. The newsletter serves as the primary vehicle for communicating any changes that may have a substantial impact on the rights or responsibilities of our network providers. It is mailed directly to your offices. Please notify your Provider Relations Representative of any changes in your address or contact information.

Quick Reference Guide

AlohaCare Quick Reference Guide is an easy, one page guide that contains information most useful to you in your day-to-day interactions with AlohaCare and our members. In the Quick Reference Guide, you will find information on the following:

- Important phone numbers
- Referral, notification and prior authorization process
- Pharmacy information
- Grievance and appeals process

You may find it helpful to keep this handy for answers to your most common questions.

Get On the Web with AC Online!

AC Online is a web portal designed just for you. At www.AlohaCare.org, you can log in and gain access to invaluable member information. The web portal allows you to view claims electronically, access member information and find the status of a referral or prior authorization.

Member Tab

- Find an AlohaCare member
- Check on a member's eligibility and PCP information

Claim Tab

- Look up a claim you billed and track their status

Prior Auth Tab

- Look up a referral, authorization or notification and track their status

Register for an AC Online Account

The AC Online Registration Form is available on our website or request the form by contacting our Customer Service Department.

Complete the form and fax to (808) 973-0811.

Use Electronic Claims for Faster Claim Payment

If you are interested in faster claims payment and reducing paperwork, consider submitting your claims electronically via our Electronic Data Interchange (EDI) program. This service is available to providers who meet the following requirements:

- You own your own billing software which is capable of submitting data files or use of a third-party billing service that can process and submit your claims for you.
- Have an AC Online account. See how you can register for an account in the section above.
- Complete a HIPAA Transaction Set Form. The HIPAA Transaction Set Form is available on our website or request the form by contacting our Customer Service Department. Complete the form and fax to (808) 973-0811.

Please allow 5 to 7 business days for us to set up your account. Our Provider Relations Department will contact you to discuss any details.

Electronic Fund Transfers

Electronic Fund Transfer (EFT) is available for those providers who choose to have payments automatically deposited into their bank account. A deposit slip or canceled check (which includes the bank routing number) is required to set up the process and verify account information.

To set up EFT payment, contact our Customer Service Department at 973-6395 or toll-free at 1-866-973-6395.

SECTION 3: PROVIDER ROLE

AlohaCare provides comprehensive medical and prescription drug coverage. We have a network of contracted physicians and providers to provide our members with the full range of Medicare Advantage covered services.

AlohaCare's provider network continues to grow to meet the diverse needs of our members. Our network includes a broad range of providers—PCPs, specialists, hospitals, facilities, pharmacies and ancillary services. This allows our network to meet the service delivery needs of our members.

Providers in our network must be Medicare-certified, maintain an active license and/or certification to practice in Hawaii and remain in good standing within their profession.

AlohaCare's Responsibility to Our Providers

A key component of AlohaCare's relationship with our providers is centered on the responsibility to be a good partner. We see ourselves as partners with providers in the delivery of timely and medically appropriate health care to our members.

AlohaCare has a responsibility to our network of providers to:

- Seek provider input to improve the quality of care for AlohaCare members
- Seek provider input to improve the quality of provider relations with AlohaCare
- Keep providers informed of any changes in AlohaCare's policies and procedures that may affect the provider network. AlohaCare gives 60-days advanced notice of modifications that may impact the provider's administrative office practices.
- Provide a dispute resolution/arbitration process for disagreements regarding contracts and a grievance/appeal process for other disagreements
- Not discriminate against the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification
- Not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment
- Not control, direct, supervise nor intervene in any way in the rendering of medical and other health services by the provider
- Process claims timely and accurately in accordance with contract requirements
- Provide access to accurate eligibility information telephonically or electronically to allow eligibility verification
- Provide training and education to providers regarding AlohaCare benefits and requirements, as well as ensure providers are trained on HIPAA, security and fraud and abuse

Provider Responsibilities

All AlohaCare network providers have responsibilities to:

- Successfully complete AlohaCare's initial credentialing process and subsequent re-credentialing processes
- Verify member eligibility, current PCP assignment and TPL coverage on the date of service (via AC Online or by calling our Customer Service Department)
- Maintain an accessible office environment conducive to the regulations and standards of the Americans with Disabilities Act (ADA), including the provision of assistance with interpreter (oral or sign), assistive listening devices or other acceptable means of alternate communication for language or hearing impaired individuals
- Provide services in a culturally competent manner based on an individual's background, ethnicity, cultural beliefs and language preference
- Schedule appointments in compliance with the AlohaCare appointment accessibility standards
- Maintain medical records that document all medical services provided to AlohaCare members in accordance with AlohaCare's medical record keeping policies
- Safeguard privacy and maintain confidentiality of member information in compliance with state and federal regulations
- Notify AlohaCare of potentially high-risk and complex cases. This allows for Care Coordination staff to assist with resources to ensure cost effective and appropriate care for our members
- Submit all claims/encounters to AlohaCare within required timely filing timeframes (within 1 year of date of service), with accurate and valid ICD-9 or DSM-4 diagnosis and CPT/HCPCS codes
- Look solely to the health plan, or in the instance of multiple payers, coordinate with payers for compensation for services rendered, with the exception of member cost sharing, as applicable for any covered services provided within the terms of the contract. Full-dual beneficiaries enrolled in AlohaCare Advantage Plus members shall not be billed for any cost sharing amount.
- Cooperate with all AlohaCare Quality Improvement initiatives, complaint or grievance inquiries, compliance investigations, fraud and abuse investigations and other federal or state reviews and requests, including providing copies of medical records when requested.
- Agree to allow access upon reasonable notice, during regular business hours, to members' records for the purposes of quality improvement, complaint/grievance/appeal investigations, compliance investigations, fraud and abuse investigations and other federal or state reviews
- Comply with all applicable federal and state laws prohibiting discrimination against any recipient or employee on the grounds of health status, race, color, sex, national origin, age, mental or physical handicap and not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin
- Participate in the AlohaCare Corporate Compliance Program, and report any potential compliance issues, including fraud and abuse
- Comply with AlohaCare's medical service guidelines, policies and procedures, contractual agreements and guidelines set forth in this manual
- Comply with the federal physician self-referral law, 42 C.F.R. Part 411, subpart J, as applicable, which generally prohibits a physician from making a referral for designated health services to an entity with

which the physician or a member of the physician's immediate family has a financial relationship unless statutory or regulatory exception applies

- In the event of termination of provider agreement, the provider shall continue to provide, coordinate or assist in the transition of care until AlohaCare makes reasonable and medically appropriate arrangements for the assumption of such covered services by another provider.
- In the event that provider refuses to provide any covered service based on moral or religious objections, the provider shall notify AlohaCare of covered member who requires such service(s) and make arrangements to refer the member to another participating provider who will provide the service.

Role of the Primary Care Provider (PCP)

At the core of AlohaCare's provider network is the Primary Care Provider (PCP). AlohaCare believes in fully supporting the PCP in his or her role as the central care coordinator for an AlohaCare member. As such, the PCP is responsible for assessing the member's health care needs and provides/directs the services to meet these needs in all aspects of care (care management, care coordination with specialists, delivery of primary care services, etc.).

AlohaCare's PCP panel includes Family Practice physicians, General Practice physicians, Internal Medicine physicians, Pediatricians, and Family or Pediatric Nurse Practitioners and Physician Assistants.

PCP Responsibilities

As the key provider for AlohaCare members, the PCP has the following additional responsibilities:

- Provide primary care services to AlohaCare members and coordinate all medically necessary care with other providers
- Complete an annual wellness exam to all assigned AlohaCare members each year
- Maintain continuity of care for members by coordinating all care, referrals and follow-up treatment of the member
- Honor member requests for second opinion, when reasonable, and coordinate referral and prior authorization requests that may be required
- Refer members to network providers and specialists and manage and coordinate the member's specialty care to avoid duplicated, unnecessary or fragmented care
- Maintain member referral information
- Provide preventive health services, ongoing health maintenance and disease prevention services according to established guidelines
- Assist to communicate AlohaCare's utilization review decision to the member
- Ensure that all chronic conditions and preventive services are addressed during a member office visit each year
- If applicable, and where contractually stated, maintain hospital admitting privileges at a licensed acute care hospital within the service area, have a written agreement on file with AlohaCare utilizing another AlohaCare provider for admission and treatment privileges, or have an arrangement with a hospital that uses hospitalists.
- Identify backup coverage when unavailable during regular office hours (i.e. out-of-town or on vacation) and provide written notice to AlohaCare of the coverage arrangements including the name of the covering

provider and the dates of coverage. The backup provider does not need to be an AlohaCare participating provider. The use of a covering provider who is not participating with AlohaCare is subject to approval, and at minimum the provider must be a Medicare participating provider.

- When making coverage arrangements, please ensure that the covering provider understands the payment arrangement under which he/she will be reimbursed for submitted claims while providing coverage.
- All covering providers who are not a part of AlohaCare's network of participating providers will be required to complete and submit a one-page profile to the Provider Relations Department.
- Provide telephone access 24 hours a day, 7 days a week. An answering machine or answering service must indicate how to contact you or an on-call provider in a medical emergency. It should not direct the member to go to the Emergency Room for non-emergent care.
- Follow AlohaCare's policies when referring members to specialists or other providers (refer to Section 6, under "Utilization Management: Medical Referrals, Prior Authorization and Notification").
- Comply with federal and state law regarding advance directives for adult members. At a minimum the provider shall:
 - Maintain written policies regarding a member's rights to make decisions about their medical care
 - Document in a prominent place in a member's medical record that the member has executed an advance directive
 - Document in member's medical record a copy of the advance directive or the member's refusal to execute such a document
 - Not discriminate against a member because of member's decision to execute or not execute an advance directive
 - Provide staff education on issue concerning advance directives
- Not collect a copay for influenza and pneumococcal vaccine administration (if other services are provided during an office visit, an office visit copay would apply)
- Adhere to CMS Marketing provisions
- Maintain procedures to inform members of follow-up care or provide training in self-care as necessary
- Provide services in a manner consistent with professionally recognized standards of care

PCP Patient Capacity

AlohaCare monitors capacity of its PCP network, to ensure that there is acceptable access to medical services for AlohaCare members. Such monitoring may include requesting information about:

- The total number of AlohaCare members assigned to the practice
- The total number of Medicare patients assigned to the practice

In addition to the overall volume of patients seen on an average weekly or monthly basis, AlohaCare may factor in the number of health care professionals (physicians and mid-level providers) utilized within the PCP office.

Requesting PCP Re-Assignment

At times, it may be necessary for a PCP to request a member re-assignment to another PCP. PCPs may request member re-assignment for a variety of reasons, including but not limited to: abusive, disruptive or dangerous behavior toward office personnel; noncompliance with treatment recommendations; repeated failure to keep or cancel scheduled appointments; or family continuity.

The PCP must send a certified letter to the member informing him or her of the intent to terminate the relationship and that care will be extended for 30 days. This will allow time to find another provider. The PCP is asked to provide urgent care during those 30 days or until a new provider is identified. A copy of the certified letter and any additional specific details of the problem must be mailed or faxed to the AlohaCare Provider Relations Department. In cases of extremely serious or dangerous situations, the PCP should call their assigned Provider Relations Representative and request expedited consideration.

AlohaCare's Customer Service Department will assist the member in selecting another PCP and will notify the member by phone or in writing of the new PCP assignment. A new member ID card will be sent to the member with the new PCP indicated.

The member's failure to exercise the option of choosing a new PCP shall result in the Customer Service Department automatically assigning the member to another PCP by the end of the 30-day period. The member will be notified by phone or in writing of the new PCP assignment and a new ID card will be sent to the member, with the new PCP indicated. Copies of all correspondence are retained by the Customer Service Department.

Specialist and Ancillary Provider

Specialist and Ancillary providers fill an integral role in our network. They ensure the timely provision of comprehensive and medically necessary specialty health care to our members.

In most situations, members access specialty care services by referral from their PCP, with the exception of direct access to women's specialists for routine and preventive services. To facilitate the provision of health care and promote timely processing of claims, specialty care and ancillary providers are asked to observe the following additional responsibilities:

- Comply with AlohaCare's prior authorization and referral policies for non-PCP services (refer to Section 6, under "Utilization Management: Medical Referrals, Prior Authorization and Notification").
- Coordinate the member's care with the PCP and provide the approved specialty or ancillary care. As a standard of care, AlohaCare expects the specialist to report in writing to the PCP the findings and recommendations for additional care after the visit. If additional visits, testing, or surgeries are recommended, the specialist will follow AlohaCare's Prior Authorization and Referral policies (refer to Section 6, under "Utilization Management: Medical Referrals, Prior Authorization and Notification").
- Identify backup coverage when unavailable during regular office hours (i.e. out-of-town or on vacation) and provide written notice to AlohaCare of the coverage arrangements including the name of the covering provider and the dates of coverage. The backup provider does not need to be an AlohaCare participating provider. The use of a covering provider who is not participating with AlohaCare is subject to approval, and at a minimum the provider must be a Medicare participating provider.
 - When making coverage arrangements, please ensure that the covering provider understands the payment arrangement under which he/she will be reimbursed for submitted claims while providing coverage.
 - All covering providers who are not a part of AlohaCare's network of participating providers will be required to complete and submit a one-page profile to the Provider Relations Department.

Credentialing/Recredentialing

The purpose of credentialing is to ensure that AlohaCare members receive care from qualified practitioners. Practitioner credentialing is a quality initiative that assures providers have met appropriate levels of education, training, certification and licensing and are qualified to deliver medical care to members.

AlohaCare has established procedures to credential health care practitioners interested in joining our network. The credentialing process is based on standards developed by the National Committee for Quality Assurance (NCQA) and URAC, both nationally recognized accreditation organizations.

All network practitioners must be credentialed by either AlohaCare or their parent facilities before providing services to AlohaCare members. Those practitioners completing credentialing through AlohaCare must submit a credentialing application that contains information pertinent to evaluating the practitioner's ability to provide care. Application information is verified by an independent agency. In addition, an office site review and medical record review will be conducted by AlohaCare for specific provider categories prior to the AlohaCare Credentials Committee rendering a credentialing decision.

AlohaCare Credentialing Policy

- AlohaCare ensures that practitioner credentialing/recredentialing is conducted in a non-discriminatory manner. AlohaCare will not discriminate against any provider requesting network participation on the basis of the applicant's race, ethnic/national identity, gender, age, sexual orientation or the type of diagnoses or procedures in which the practitioner specializes.
- AlohaCare has the sole right and responsibility to determine network need based on existing access and availability standards, participation criteria and other business and contractual requirements of AlohaCare subject to market or geographic needs. If a need does not exist, AlohaCare reserves the right not to accept the application. In the event that an applicant practitioner does not meet participation criteria, the application will not be considered.
- The credentialing process verifies that providers have the legal authority, training, experience and facilities required to provide appropriate care to AlohaCare members. The information obtained from the provider is verified through a primary source as recognized by accrediting bodies to ensure that the information is accurate and current.
- Explicit minimum criteria for provider participation with AlohaCare are delineated and each provider's file contains sufficient documentation that the criteria are evaluated in the credentialing process.
- AlohaCare will notify providers about information obtained during the credentialing process that varies substantially from the information provided to AlohaCare by the provider. Providers have the right to correct any erroneous credentialing information obtained.
- In accordance with AlohaCare policies concerning information practices and confidentiality, the information gathered will be treated in a confidential manner and the disclosure of such information will be limited to those parties mandated to receive such information by law.
- All providers must be credentialed within a 180-day time frame. This time frame begins with the date of signature of the credentialing application and/or the most recent attestation form and ends on the date of action by the AlohaCare Credentialing Committee.

- Recredentialing of providers occurs every 3 years (36 months from the date of the last credentialing approval) and will focus on verification of specific credentialing information, and additional components including member complaints and quality issues. The provider must continue to meet AlohaCare standards in all areas.
- AlohaCare is solely responsible for making initial credentialing and recredentialing decisions based on the approval of the practitioner by the AlohaCare Credentials Committee.
- Providers will be notified of the credentialing or recredentialing decision rendered by the AlohaCare Credentials Committee within 10 calendar days of the decision. In certain cases, provisional credentialing may be granted for a maximum of 60 days.

AlohaCare's Subcontracting Policy

The AlohaCare Provider Agreement specifies that a provider may not subcontract duties under the contract without AlohaCare's written consent. If permission is granted, the provider must submit a copy of the subcontract for AlohaCare to review to ensure that the subcontract language complies with state and federal requirements. A provider remains fully responsible for all duties and obligations under the contract and must ensure that subcontractor performs according to appropriate standards, laws and regulations.

If you are considering entering into a subcontractor agreement, please call the Contracts and Credentials Manager at (808) 973-0648 to discuss your obligations under the AlohaCare Provider Agreement.

Medical Records Requirements (for PCPs, Specialists and Ancillary Providers for Credentialing and Ongoing QI Reviews)

For credentialing purposes, the Medicare guidelines require an assessment of medical record-keeping practices and an onsite visit be performed for each of the provider's service locations that did not undergo such an evaluation in the past. This applies to each new PCP (defined as Family Practice physicians, General Practice physicians, Internal Medicine physicians, Pediatricians and Family or Pediatric Nurse Practitioners and Physician Assistants). For the purposes of credentialing reviews, AlohaCare considers high-volume Behavioral Health providers to be any provider who practices in a clinical setting that offers a continuum of care with an array of services (i.e. outpatient and inpatient services).

The value of organized, accurate, detailed and comprehensive patient medical records is a fundamental part of delivering and documenting quality, timely and medically necessary patient care. In accordance with NCQA guidelines and our URAC-based credentialing policy, an evaluation of a practitioner's medical record keeping practices is necessary in rendering an initial credentialing decision. Record reviews are also performed to evaluate AlohaCare quality initiatives.

AlohaCare holds its contracted providers to medical record keeping standards in accordance with contractual obligations and any federal and state laws. Below are standards for provider documentation and maintenance of members' medical records. These standards are monitored through the AlohaCare review process.

Medical Record Standards

- Medical records are maintained in a current, detailed, organized and comprehensive manner.
- Medical records are systematically organized and legible, and reflect all aspects of member care.

- Medical records conform to good professional medical practice and permit effective quality assurance review. For each member encounter, a complete, dated, signed progress note will be entered into the medical record. At a minimum, it should include the chief complaint or purpose of visit, objective findings, diagnosis or medical impression and therapeutic plan.
- Appropriate health management and continuity of care are clearly reflected in the medical records. Where appropriate, evidence of follow-up to previous encounters, hospital discharge summaries, referrals and referral results, and documentation of emergency encounters and follow-up are recorded.
- All medical records must be maintained and accessible to AlohaCare, our representatives and the representatives of CMS. Upon reasonable notice and during provider's regular business hours, they have the right to inspect, review and make copies of all records maintained by the provider with respect to all services rendered and payments received by the provider from all sources for covered services rendered to members during the term of their agreement with AlohaCare.
- AlohaCare, CMS and any applicable federal or state agencies or their designees shall have the right to conduct periodic audits of such records for quality reviews, fraud and abuse investigations or other purposes that may be delineated in state or federal regulations. In accordance with HIPAA requirements, the provider will make requested medical records available to the aforementioned without member consent.
- The medical record of a member is the property of the provider who generates the record. Members are entitled to a copy of their records. When members change PCPs, their medical records or copies of the medical records will be forwarded to the new PCP within 7 business days from receipt of a written request. Providers make the medical records of AlohaCare members available to requesting hospitals, specialists and new PCPs at no charge to the member.
- All medical records are maintained in a confidential manner. Access to a member's medical record must be restricted only to individuals directly involved in the member's treatment or monitoring of the quality of care, or by other individuals specifically authorized or permitted by law to have such access.
- Medical records are preserved and maintained for a minimum of 10 years from the last date of entry in the records.

Medical records should contain the following:

- All pages contain member ID
- Personal/biographical data (name, address, next of kin, date of birth and phone number)
- All entries are dated
- The provider is identified on each entry
- Allergies/adverse reactions/NKDA are adequately displayed and consistently recorded
- Current medications are noted/listed and updated appropriately
- Medical record is systematically organized and entries are legible to someone other than the writer
- Appropriate past medical history in the record
- Chief complaint or purpose of the visit is documented
- A physical examination, appropriate to the member's condition, is documented

- Diagnoses or clinical impressions are documented
- Plan of care as documented
- Documentation of treatments, procedures, and tests with results

- Recommendations and instructions to member have been noted, including a date for return visit or other follow-up plan for each applicable encounter
- Reasons for and results of referrals are documented
- Consultant summaries, lab and other imaging study results reflect the provider's review
- Advanced directive information/instructions given/offered to the member as documented

During the initial credentialing, the medical record review is not a review of actual clinical documentation. Rather, it is a review of the components and forms used to record a member's clinical information. The medical documentation should be organized, comprehensive and detailed. They should include member identification, demographics and clinical aspects of care. AlohaCare's benchmark for compliance with credentialing-related medical record reviews is 100%.

For quality review purposes not related to credentialing, AlohaCare is required to periodically review the medical charts for specific CMS requirements, such as HEDIS. Prior to a review, we will contact your office to let you know which charts will be reviewed and to establish a review date and time.

For the clinical review, if the provider doesn't have any current AlohaCare members, he/she will be asked to select five medical records of choice and "blind" the records for confidentiality purposes. For those providers with current AlohaCare members, a random selection of ten members is made from claims/encounter data. For a high-volume PCP, with more than 400 members, a minimum of 20 records will be reviewed.

AlohaCare's benchmark for compliance to clinical reviews is 80%. For providers who score 80% or better, we will send a letter indicating the results. All future reviews will be coordinated with any quality assurance/improvement needs or as quality of care issues arise.

AlohaCare will work with providers scoring below 80% and a follow-up review will be scheduled within eight months of notification of results. Providers not in compliance at the time of follow-up will be asked to submit a written action plan and are scheduled for a second follow-up review within six months. Providers who do not submit a written action plan and/or are not in compliance on the second follow-up review will be presented to the Credentials Committee and/or Quality Improvement Advisory Committee for consideration of remedial actions.

For serious deficiencies identified in the report, the time interval for follow-up review and/or the number of follow-up reviews prior to referral to the AlohaCare Credentials Committee or the Quality Improvement Advisory Committee may be reduced, at the Medical Director's discretion.

Appointment and Accessibility Standards

Ensuring that AlohaCare members have availability and access to timely medical care is a fundamental aspect of our plans. Adequate appointment availability ensures that PCPs are able to accommodate our members in a timely manner, based on the urgency of the member's medical condition or have an alternative provider who can render care in the event that you are unavailable. Appointment availability is also one of the dimensions

AlohaCare examines to determine network adequacy. AlohaCare will maintain accessibility to an adequate provider network, taking into account reasonable distance and travel times for members.

We monitor appointment and accessibility by reviewing complaints and conducting member satisfaction surveys. We also perform office site reviews, conduct clinical reviews for quality of care and review medical records.

When issues arise, AlohaCare contacts providers to determine if something is preventing timely access to medical appointments. If appointment standards are not being met, a corrective action is initiated. AlohaCare also evaluates whether accessibility barriers may be adversely affecting appointment availability. If it is determined that barriers exist, AlohaCare works collaboratively with the provider's office to correct the problem.

Primary Care Provider (PCP) and Specialist Appointment Standards

- Emergency care is available 24 hours a day, 7 days a week. Prior authorization is not required for emergent medical situations.
- Appointments within 24 hours for urgent care. Prior authorization is not required for urgent medical situations.
 - Urgent care is defined as services provided for the relief of acute pain, initial treatment of acute infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion and breathing difficulties, other than those of sudden onset and persistent severity.
- Appointments within 14 days for routine care
 - Routine care is defined as non-urgent symptomatic condition that is medically stable.
- Appointments within 30 days for preventive care
 - Preventive care is defined as a preventive health evaluation without medical symptoms for existing members such as a routine exam or annual physical.

Behavioral Health Appointment Standards

- Emergency care is available 24 hours a day, 7 days per week
- Appointments within 24 hours for urgent care
- Appointments within 6 weeks for routine care

Providers must assure that emergency services are available 24 hours a day, 7 days a week. This may be done through the use of recorded messages, an answering service or backup coverage. Backup coverage must be arranged when the provider is not available during regular office hours (i.e. out-of-town or on vacation). The backup provider does not have to be a participating AlohaCare provider. The use of a covering provider who is not participating with AlohaCare is subject to approval, and at minimum the provider must be a Medicare participating provider. To ensure timely claims processing and payment (if applicable), AlohaCare must be informed regarding alternative coverage.

Reporting Requirements

All providers are required to adhere to the following reporting requirements:

- Submit claims/encounters to AlohaCare in an accurate and timely manner.
- Claims (either hard-copy or electronic) are submitted within 1 year from the date of service.
- Claims with TPL involvement are submitted, with the primary carrier's Explanation of Benefits (EOB) within 1 year of the last date of service on the claim.

- Notify AlohaCare if you become aware that an AlohaCare member is in a long-term care or home and community based setting
- Notify AlohaCare when a member has other insurance or third party liability (TPL). As a Medicare Advantage plan, AlohaCare is usually primary, however there are circumstances where AlohaCare may be secondary or at a minimum need to coordinate services. AlohaCare is contractually bound to pursue other existing primary payers prior to paying a claim.
- Notify AlohaCare when you are going to be away and ensure that coverage arrangements have been made.
- Notify AlohaCare if you have objections to performing any health services that are within the scope of your responsibilities and make arrangements via the AlohaCare referral or prior authorization process for members to receive those services from another provider.
- Notify AlohaCare if you are involved in a malpractice or other action that has bearing on your ability to provide health services or impact the scope of your practice.
- Notify AlohaCare of other circumstances as stipulated in your AlohaCare Provider Agreement.

Marketing Guidelines

AlohaCare is subject to compliance with the Medicare Marketing Guidelines

- All member communications are reviewed and approved prior to distribution to members.
- Providers who develop their own comparative/descriptive marketing material for distribution to AlohaCare members must first receive approval from AlohaCare.

Providers are subject to compliance with the Medicare Marketing Guidelines

Providers performing marketing functions on behalf of AlohaCare, including all activities related to assisting in enrollment and education, must comply with the Medicare Marketing Guidelines.

Provider Do's

- Assist in objective assessment of their member's needs and potential plan options that may meet their needs
- Engage in discussions when members seek information or advice regarding Medicare options
- Provide names of health plans with which they contract and/or participate
- Provide information and assistance in applying for Low-Income Subsidy (LIS)
- Make available and/or distribute AlohaCare Advantage marketing materials as long as providers offer the option to all plans with which they participate. If the provider agrees to make available and/or distribute marketing materials for one of its contracted plans, it must accept future requests from other plans.
- Provide objective information on plan formularies, based on the member's medications and health care needs
- Provide objective information on plan information, such as covered benefits, cost sharing and utilization management tools
- Refer members to other sources of information, such as SHIP, an AlohaCare marketing representative, the State Medicaid Office, local Social Security Office, CMS' website or 1-800-MEDICARE
- Print out and share information with members from the CMS website
- Distribute the "Medicare and You" Handbook or "Medicare Options Compare"

Provider Don'ts

- Steer or attempt to steer a potential member toward a particular plan or provider
- Distribute plan information/applications within an exam room setting
- Health screening is a prohibited marketing activity
- Offer sales/appointment forms
- Accept enrollment applications on behalf of health plans
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests
- Mail marketing materials on behalf of health plans
- Offer anything of value to induce members to select you as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan
- Accept compensation directly or indirectly from the plan for beneficiary enrollment activities

Fraud and Abuse

As required by our contract with CMS, AlohaCare has established a formal Fraud and Abuse (also referred to as Fraud, Waste and Abuse) Program. This program addresses the prevention, detection and reporting of fraudulent and abusive situations. Such situations include, but are not limited to: the abuse, neglect or exploitation of any individual receiving or providing Medicare services; and the loss, theft, misappropriation or overpayment of Medicare funds.

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse means practices that are inconsistent with sound fiscal, business, or medical practices that result directly or indirectly in an unnecessary cost to the Medicare program or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicare program.

Waste is the use or expenditure of resources carelessly, extravagantly, or to no purpose.

AlohaCare's Fraud and Abuse Program is incorporated into our Corporate Compliance Program, and includes all of the elements, as laid out in the federal regulations.

The federal and state False Claims Acts prohibit knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. The False Claims Acts are enforceable against anyone that knowingly submits (or causes another individual/entity to submit) a false claim for payment by the federal government (or for Medicare, by an MA-PD plan using federal funds).

Common Types of Health Plan Fraud and Abuse

- Offering Medicare beneficiaries a cash payment, as an inducement to enroll
- Unsolicited door-to-door marketing
- Enrollment of beneficiaries without their knowledge or consent

Common Types of Provider Fraud and Abuse

- Accepting payments or other unlawful remuneration for ordering or prescribing certain supplies or drugs
- Billing for items or services not provided
- Billing for drug samples received for free
- Falsifying information to justify payment of a non-covered service
- Providing substandard or low quality care, or expired supplies or drugs
- Ordering and/or billing for medically unnecessary services
- Poor or incomplete documentation for services billed

Common Types Pharmacy Fraud and Abuse

- Bait and switch pricing (quoting one price for a drug, but at point of sale, charging a higher amount)
- Providing less than the prescribed quantity but billing for the fully-prescribed amount
- Altering the prescription without the prescriber's permission

Common Types of Member Fraud and Abuse

- Letting another person use the member's ID card
- Selling or giving someone else supplies, equipment or drugs paid for by AlohaCare
- Theft or alteration of prescriber's prescription pad
- Failure to report other medical or drug coverage
- Misrepresenting facts concerning a medical condition to obtain higher doses and or unnecessary drugs

Providers are required to participate in AlohaCare's Fraud and Abuse Program, which includes providing training to your staff and reporting instances of suspected fraud and abuse committed by anyone receiving payment or services from the Medicare program including a member, another provider or provider group, facility or supplier. You must provide proof to AlohaCare upon request of such training, including the list of attendees and credentials of the person conducting the training. Anonymous submissions can be accepted and ample detail should be provided to ensure that an appropriate and effective investigation can ensue. Reports of suspected fraud and abuse are confidential and should be sent to:

AlohaCare
Attention: Compliance Officer
1357 Kapiolani Boulevard, Suite 1250
Honolulu, HI 96814

AlohaCare takes many measures to detect false claim submissions and prevent incorrect payments, and initiates a full investigation if any irregularities are found.

Penalties for false claim submission may include fines of \$5,000 but not more than \$10,000 plus three times the amount of damages for all federal violations and state claims only if the claim amount is \$5,000 or more. For claims under \$5,000, violators will be required to pay interest at the maximum legal rate on the excess amounts and \$1,000 for each fraudulent claim.

Any person or entity with evidence of fraud may file a “qui tam” (whistleblower) lawsuit on behalf of the government. Under these provisions, this person, or persons, may be eligible to receive between 15 and 30 percent of Federal and State proceeds recovered. The federal and state law prohibits retaliation against anyone who in “good faith” reports and/or participates in an investigation of a false claim violation. Anyone who feels they have been unlawfully retaliated against should contact the state or federal government immediately.

SECTION 4: ALOHACARE ADVANTAGE AND ALOHACARE ADVANTAGE PLUS PROGRAM BENEFITS

Program Introduction

Medicare is government-issued health insurance for people 65 or older, under 65 with certain disabilities, or of any age with End-Stage Renal Disease. The four parts of Medicare are:

- **Part A – Hospital Insurance:** Helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home health care
- **Part B – Medical Insurance:** Helps cover hospital outpatient care, doctors' services, home health care and some preventive services to help maintain health
- **Part C – Medicare Advantage Plans:** Administration of Part A & Part B benefits by a Medicare Health Plan, such as AlohaCare
- **Part D – Medicare Prescription Drug Coverage:** Helps cover prescription drug costs

AlohaCare offers 2 Medicare Advantage Prescription Drug plans:

- **AlohaCare Advantage (HMO)** is a Medicare Advantage Prescription Drug Plan that offers our members additional benefits beyond Original Medicare with affordable cost sharing to the member.
- **AlohaCare Advantage Plus (HMO SNP)** is also Medicare Advantage Prescription Drug Plan that offers our members additional benefits beyond Original Medicare, but is available only to beneficiaries who have Medicare and full benefit Medicaid coverage. This is a type of Special Needs Plan (SNP), called a Dual Eligible Special Needs Plan.

AlohaCare Advantage Plus members are eligible for additional benefits through the Medicaid program, including assistance with paying for their Medicare premiums, deductibles and cost sharing, such as copayment and coinsurance. The Medicaid benefits available are managed under the QUEST Expanded Access (QExA) Program.

Providers should call the member's QExA health plan for any questions regarding the member's Medicaid benefits.

Administration of the AlohaCare Advantage and AlohaCare Advantage Plus Benefits

AlohaCare requires that certain services be prior authorized and/or undergo concurrent or retrospective review. During each review, a decision is made regarding the medical necessity of services being requested, prescribed or rendered. AlohaCare's determination is based on the medical information submitted by the provider, or

available in medical records/charts. AlohaCare uses nationally developed clinical criteria for medical necessity determinations to ensure consistent application to all members.

For prior authorization requests or concurrent review, AlohaCare requests that the treating physician or other licensed provider supply additional information to assist AlohaCare in the determination of medical necessity. For retrospective review, payment denials may be determined by the review of records received. In these cases, providers have the opportunity to submit additional information and request reconsideration through the grievance and appeals process.

Peer review is available if the provider and AlohaCare's Medical Director do not agree on whether a health intervention is medically necessary.

AlohaCare's decision is a determination of member eligibility at the time of service, benefit coverage and payment only, and not a determination of whether services should be rendered. The decision to provide medical services is made by the provider using his/her professional judgment. Because the member is responsible for payment of non-covered services, providers should explain that members will be responsible for the cost prior to rendering any non-covered services.

For a complete list of AlohaCare Advantage and AlohaCare Advantage Plus benefits, refer to Appendix A of the Medicare Provider Manual.

SECTION 5: MEMBER SERVICES

Member Rights and Responsibilities

Members Have The Following Rights:

Access to Care

- To receive services in a timely manner as specified in appointment standards
- To receive services out-of-network if AlohaCare is unable to provide services in-network, for as long as AlohaCare is unable to provide them in-network
- To receive services in a culturally competent manner based on an individual's background, ethnicity, cultural beliefs and language preference
- To receive services in a coordinated manner
- To receive direct access to specialists for special health care needs
- To not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness or condition
- To receive medical care and services regardless of member age, race, creed, sex, sexual preference, national origin or religion. AlohaCare will not deny or allow fewer services solely based on the member's diagnosis, type of illness or health condition.
- To have an adequate provider network within a member's geographic service area that is available and accessible with regard to distance and travel time
- To have direct access to a women's health specialist within AlohaCare's provider network

Respect and Dignity

- To be treated with respect and with due consideration for the member's dignity and privacy at all times and under all circumstances

Identity

- To know the identity and professional status of individuals providing service, and to know which physician is primarily responsible for a member's care

Privacy and Confidentiality

Members have the right to have all records and medical and personal informational remain confidential and protected, including,

- Being interviewed and examined in surroundings designed to assure reasonable audio/visual privacy
- Having any discussion or consultation involving care conducted in a discreet manner. Individuals not directly involved with the member's care will not be present unless permission has been given by the member.
- Having the member's medical record read only by individuals directly involved in his/her care, individuals ensuring the quality of their medical care, or other individuals to whom the member gives such permission.

- Expecting all communications and other records pertaining to care, including the source of payment for treatment, to be treated as confidential
- Limiting, restricting or preventing disclosure of his/her personal health information

Information

- To obtain complete and accurate information concerning diagnosis (to the degree known), available treatment options and alternatives and any known prognosis from the member's physician, other health care practitioners, or clinics. This information is to be communicated in a manner appropriate to the member's condition and in terms the member can reasonably be expected to understand. When it is not medically advisable to give such information to the member, the information is to be given to a legally authorized representative.
- To appoint a representative to act on his/her behalf
- To participate in decisions regarding the member's health care, including the right to refuse treatment
- To receive copies of his/her medical records and Protected Health Information (PHI), unless the member's physician or AlohaCare believes something in the records would jeopardize the member's health, safety or security or that of someone else
- To request that AlohaCare or an AlohaCare provider amend or correct the member's medical records. If a member's request is denied, the member has the right to obtain the reason for denial in writing.
- To know who sees their medical records and Protected Health Information, unless the review is conducted for treatment, payment, health care operations, or some other reason written in the law
- The right to request quality of care grievance data from AlohaCare.

Communication

- To have access to interpreter services when the member does not speak or understand the major language of the community. The member also has the right to an interpreter in the room during an exam. Interpreter or translation services are provided at no cost to the member.
- To have written materials made available in another language or alternate format upon request
- To ask AlohaCare to send mail and call the member at the address and telephone number of his/her preference, to protect his/her privacy. If AlohaCare cannot honor the request, the member will be informed of the reason.
- To receive a timely response for prior authorization and referral requests, including the organization determination
- To request an expedited organization determination, or an extension, and if the request is denied, the right to receive a written notice that explains the member's right to file an expedited grievance.
- To a written notice from AlohaCare of its own decision to take an extension on a request for an organization determination that explains the reasons for the delay and explains the member's right to file an expedited grievance if he or she disagrees with the extension.
- To receive information from AlohaCare regarding the member's ability to obtain a detailed written notice regarding the member's services.
- To a detailed written notice of a decision to deny, terminate or reduce a payment or service in whole or in part, or to reduce the level of care in an ongoing course of treatment which includes the enrollee's appeal rights

File Grievances and Appeals

- To have grievances heard and resolved in accordance with CMS guidelines
- To freely exercise his/her rights, including those related to filing a grievance or appeal; the exercise of these rights will not adversely affect the way the member is treated. This includes the right to have a provider or authorized representative file a grievance or appeal on the member's behalf when authorized in writing to do so.
- To receive benefits while an appeal or hearing is pending. The member may be held liable for the costs of those benefits if the health plan's adverse action is upheld.
- To request an expedited reconsideration
- To request and receive appeal data from AlohaCare
- To receive notice when an appeal is forwarded to the Independent Review Entity (IRE).
- To automatic reconsideration by an IRE contracted by CMS, when AlohaCare upholds its original adverse determination in whole or in part.
- To an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy meets the appropriate threshold requirement.
- To request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the member in whole or in part.
- To judicial review of the hearing decision if the ALJ hearing and/or MAC review is unfavorable to the member, in whole or in part, and the amount remaining in controversy meets the appropriate threshold requirement.
- To file a quality of care grievance with a Quality Improvement Organization (QIO)
- To request a QIO review of a termination of coverage of inpatient hospital care. If a member receives immediate QIO review of a determination of non-coverage of inpatient hospital care, the above rights are limited. In this case, the enrollee is not entitled to the additional review of the issue. The QIO review decision is subject to an ALJ hearing if the amount in controversy meets the appropriate threshold, and review of an ALJ hearing decision or dismissal by the MAC. Members may submit requests for QIO review of determinations of non-coverage of inpatient hospital care.
- To request a QIO review of a termination of services in skilled nursing facilities (SNF), home health agencies (HHA) and comprehensive outpatient rehabilitation facilities (CORF). If a member receives QIO review of a SNF, HHA or CORF service termination, the member is not entitled to the additional review of the issue by AlohaCare. Members may submit requests for QIO review of provider settings.
- To request and be given timely access to the member's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information. AlohaCare shall have the right to charge the member a reasonable amount, for example, the costs of mailing and/or an amount comparable to the charges established by a QIO for duplicating the case file material. At the time the request for case file material is made, AlohaCare should inform the member of the per page duplicating cost. Based on the extent of the case file material requested, AlohaCare will provide an estimate of the total duplicating cost for which the member will be responsible. AlohaCare may also charge the member the cost of mailing the material to the address specified. If member case files are stored off-site, then AlohaCare may not charge the member an additional cost for courier delivery to a plan location that would be over and above the cost of mailing the material to the enrollee.

- To challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals (“aggrieved parties”) may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the Department of Appeals Board (DAB) of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The new coverage challenge process is available to both beneficiaries with original Medicare and those enrolled in Medicare health plans.

Consent

- To have reasonable information and participation involving his/her health care. In cases where a minor is being treated, the parent(s) or legal guardian(s) are afforded the same information and participation rights regarding the minor’s care, condition and/or treatment plan (except where, by law, a minor is emancipated and has the right to make his or her own treatment decisions). To the degree possible, this information is based on a clear, concise explanation of the condition and all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and the probability of success.
- To not be subjected to any procedure without voluntary, competent, and understanding consent, or the consent of a legally authorized representative. To be informed of medically significant alternatives for care or treatment when they exist. The member also has the right to know who is responsible for authorizing and performing the procedures or treatment.

Second Opinion

- To receive a second medical opinion, when deciding on medical treatment

Be Informed

- To know about any experimental, research or educational activities having to do with his/her care. After a member is given this information, the member can choose to participate or not.

Refusal of Treatment

- To refuse treatment to the extent permitted by law. The member is responsible for his/her actions if treatment is refused or if the instructions of the physician, other health care practitioner(s), or clinic are not followed.

Freedom from Restraint or Seclusion

- To be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, unless it is necessary for treatment or the safety of others as specified in federal regulations on the use of restraints and seclusion.

Payment

- To be free from payment for covered services provided to the member except any applicable copayment or deductibles
- To be free from payment for covered services provided to the member in the event of AlohaCare’s insolvency

Advance Directives

- To execute an advance directive and to give instructions about his/her health
- To name someone to make health treatment decisions on his/her behalf
- To express member's wishes regarding the designation of his/her health care providers

Suggestions and Comments

- To make comments or suggestions about AlohaCare including suggestion regarding our policies and procedures

Members Have The Following Responsibilities:

Get familiar with their covered services and rules to follow for these covered services

- Members should use their Evidence of Coverage booklet to learn what is covered and rules that need to be followed to get their covered services.

If the member has other health insurance coverage or prescription drug coverage in addition to our plan, the member is required to tell us

- AlohaCare is required to follow rules set by Medicare to make sure that our members are using all of their coverage in combination when they get covered services under our plan. This is called 'coordination of benefits' because it involves coordinating the health and drug benefits the member gets from our plan with any other health and drug benefits available to the member.

Tell the doctor or other health care providers that the member is enrolled in AlohaCare

- Show their plan membership card whenever the member receives medical care or Part D prescription drugs

Help doctors and other providers by giving information, asking questions and following through on care

- To help the member's doctors and other health care providers give the best care, the member should learn as much as possible about their health problems and give information the doctor needs about the member's health. Follow the treatment plans and instructions that the member and doctors agree upon
- Make sure their doctors know all of the drugs the member is taking, including over-the-counter drugs, vitamins and supplements.
- Ask questions. The doctors and other health care providers are supposed to explain things in a way the member can understand.

Be considerate

- AlohaCare expects all of our members to respect the rights of other patients. We also expect the member to act in a way that helps the smooth running of the doctor's office, hospital and other offices.

Pay what they owe

AlohaCare expects our members to be responsible for these payments:

- In order to be eligible for our plans, members must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some members must pay a premium for Medicare Part A and most members must pay a premium for Medicare Part B to remain a member of the plan.

- For most of the medical services or drugs covered by the plan, members must pay their share of the cost when getting the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost).
- If the member gets any medical services or drugs that are not covered by the plan or by other insurance they may have, the member must pay the full cost.
- If the member disagrees with our decision to deny coverage for a service or drug, they can make an appeal.
- If the member is required to pay a late enrollment penalty, they must pay the penalty to remain a member of the plan.

Tell us if they move

- If the member is going to move, it is important that we are notified right away.
- If the member moves outside of our service area, they cannot remain a member of our plan.
- If the member moves within our service area, we still need to know so we can keep the member's membership record up to date and know how to contact the member.

Call Customer Service for help if they have questions or concerns

- AlohaCare also welcomes suggestions for improving our plan.

Selection of Primary Care Provider (PCP)

Members shall select a PCP at the time of enrollment. Enrollment applications do not require a PCP selection and will be accepted and processed. Applications received without a PCP selection will receive a follow-up phone call from the Customer Service Department.

If a member does not have a PCP after enrollment, the Customer Service Department will call the member, for up to 30 days, to identify a PCP selection. After 30 days, AlohaCare will assign the member to a PCP based on criteria such as geographic service area, PCP availability, member/PCP history, gender and age, family continuity and PCP panel restrictions. Members assigned a PCP through this process are informed of their PCP assignment upon receipt of his/her permanent AlohaCare ID card that identifies the PCP. Members can contact our Customer Service Department to select another PCP. Members are not limited in the number of their PCP selections or changes.

Member Eligibility Verification

Always verify eligibility and PCP assignment before rendering services. Providers can check eligibility with AC Online or by calling our Customer Service Department. Failure to confirm eligibility and PCP assignment may result in denial of payment for services provided to ineligible members.

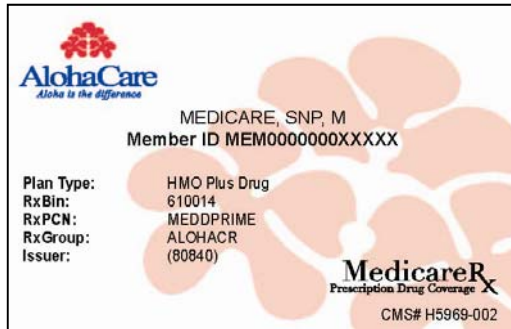
A member's AlohaCare eligibility status, PCP assignment and third party liability (TPL) coverage may change at any time.

Prior to rendering each service, the provider must verify:

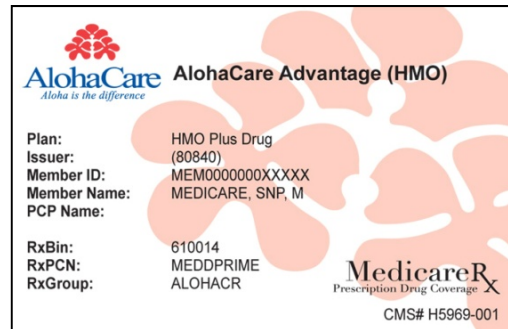
- Current member eligibility
- Current PCP assignment
- TPL/other coverage availability

Member ID Cards

AlohaCare members receive two identification cards, a temporary ID card followed by a permanent ID.



Temporary ID Card



Permanent ID card

The New Member Packet, which is sent to new enrollees after enrollment, contains a temporary ID card with the member's name and ID number. As a PCP has not yet been selected, this card does not contain PCP information. The temporary ID card is used by new members to obtain medical services in situations of immediate need.

If a new member does not have an AlohaCare ID card, providers should contact the plan to confirm eligibility. Possession of an AlohaCare ID card does not guarantee eligibility.

Provider Verification

When calling Customer Service to verify member information, please have available at least one of the following pieces provider and member information:

Provider Information

- Provider's name *and* Federal Tax Identification Number (TIN)

Member Information

- Member's name (required)
- Date of birth or AlohaCare ID #
- Date of service
- Procedure or diagnosis code

Confidentiality and Privacy of Protected Health Information

Maintaining the confidentiality of our members' health information has always been a high priority at AlohaCare. Health Insurance Portability and Accountability Act (HIPAA) Privacy added provisions to further secure protected health information from unwanted disclosure.

AlohaCare has implemented policies and procedures to comply with the HIPAA of 1996 Standards and Regulations as stated in 45 Code of Federal Regulations (CFR) parts 160 and 164 – Privacy and Security. The HIPAA regulations safeguard our members' information concerning the collection, use and release of written, verbal and electronic protected health information (PHI).

“Confidential Information” is a collective term for information, data, documents, records or materials related to AlohaCare's business. Confidential information is only made available to authorized AlohaCare staff and business associates, CMS and applicable State or Federal agencies or their designees. Member medical information and records are not released to other third parties, for reasons other than for activities supporting treatment, payment or health plan operations without consent of the member unless the disclosure is ordered by a court of competent jurisdiction.

AlohaCare expects our providers to adhere to federal and state regulations regarding confidentiality involving, but not limited to:

- Confidentiality of member identifiable medical or claim information and records for any purpose
- Confidentiality of provider credentialing/re-credentialing files and other peer review materials
- Confidentiality of AlohaCare reports, minutes, or other documents containing sensitive information. Release of confidential information to third parties is only upon written consent, except as and to the extent authorized by law.

Providers shall develop and implement privacy policies and procedures in accordance with the HIPAA Privacy Standard and Federal confidentiality regulations (42 CFR Part 2). Special care, ensuring compliance with State and Federal laws, should be applied to the handling of HIV, substance abuse, alcohol abuse, mental health and minors' treatment records. Providers shall confidentially maintain all the following information, including but not limited to:

- Eligibility information and any other information containing the names, addresses, identification numbers and telephone numbers of members which have been provided by AlohaCare
- All member identifiable claims information

In addition, AlohaCare requires confidentiality of proprietary information including:

- Financial arrangements between AlohaCare and any contracted provider or hospital
- Any AlohaCare compensation rate schedules

As part of the credentialing process, AlohaCare performs a site review of specific provider office sites. The review of an office confidentiality policy and adherence to federal and state privacy regulations is part of this review.

SECTION 6: UTILIZATION MANAGEMENT/MEDICAL MANAGEMENT

Utilization management (UM) is an important component of evaluating the necessity, appropriateness and efficiency of health care services in accordance with established guidelines and criteria. Medical Management (MM) strengthens the partnership between AlohaCare and our providers by establishing medical protocols that ensure the delivery of high quality health care with the goal of optimizing health outcomes for our members. Through UM and MM activities, AlohaCare works with our network providers to advocate, develop and implement quality initiatives and interventions to improve the health and well-being of our members.

Utilization Management: Medical Referrals, Prior Authorization and Notification

AlohaCare believes in and supports the role of the PCP. The PCP's responsibility is to both provide and coordinate care to ensure that members receive medically appropriate services. Referral, prior authorization and notification are important procedures for coordination of care. In the following sections, the procedures for medical referral, prior authorization and notification are described.

Please note that even under the unlikely occurrence that a payer is primary to AlohaCare, we require that our referral and prior authorization processes be followed in the event that either the primary payer information is not valid or that a balance remains for which AlohaCare may be responsible.

The Referral, Authorization and Notification (RAN) Form

The Referral, Authorization and Notification (RAN) form is used whenever a referral, prior authorization or notification is needed.

Specialty Care Referral

Referrals for specialty care services do not require authorization. However, AlohaCare needs to be notified of these referrals according to the procedure presented here so that the specialists will be paid. The appropriateness of referring an AlohaCare member for specialty care services is determined by the member's PCP.

Referrals are used when the PCP determines that a medical condition requires the expertise of a specialist to diagnose and/or treat. The PCP must refer the member to an AlohaCare network provider who, in the PCP's opinion, is best able to determine the presence of a medical condition or the appropriate treatment.

Behavioral Health and Chemical Dependency treatment episodes do not require a PCP referral. Members may self-refer to a Behavioral Health provider, although PCPs are notified by AlohaCare of authorized services that their member receives.

Referral Process

PCP referring member to a Specialist

1. PCP completes the Referral, Authorization and Notification (RAN) form
 - o Provide information about specialist: name, specialty and contact information
 - o Provide clinical information about the member: ICD-9 codes and diagnosis
 - o Define the scope of the referral by checking one of the following boxes: “Consult,” “Consult and Treat,” or “Consult, Treat and Follow-up”
 - o Provide a date range during which the referral is valid in the box denoted as “DOS From: To:” Unless the PCP specifies an effective date range for the referral, AlohaCare will approve the referral at the scope specified for a maximum period of one (1) year.
2. Fax RAN form to AlohaCare at 973-0676 or toll-free at 1-888-667-0680
3. Wait for written confirmation from AlohaCare
 - o AlohaCare will fax the PCP and Specialist a confirmation that we received the referral
4. For urgent phone referrals and inquiries during business hours, call 973-1657 or toll-free at 1-800-434-1002

Specialists’ Responsibilities Regarding a Referred Member

The specialist must verify a member’s eligibility prior to each appointment. Eligibility can be verified with AlohaCare’s provider web portal, AC Online, or by calling our Customer Service Department. The specialist will see the member and provide the PCP with a written consultation report that will assist the PCP in the management of the member.

- **Consultation-Only Referral but Treatment Recommended:** If the referral specifies consultation only, and the specialist determines that the member needs services, an additional referral and/or prior authorization must be generated by the PCP.
- **Specialist Recommends Procedure Requiring Prior Authorization:** If the specialist determines that it is necessary to do a procedure that falls into a category on AlohaCare’s Prior Authorization List, the specialist will fax the request for prior authorization to AlohaCare. AlohaCare will notify both the PCP and the specialist, via faxed authorization, of any prior authorization that is processed. If a procedure/service does not require Prior Authorization and you are not the member’s Primary Care Provider (PCP), then you must verify that a referral is on file with AlohaCare or obtain a signed Referral Form from the member’s PCP.
- **Specialist Recommends Referral to Another Specialist:** If a specialist wants to send a member to another specialist for care, the PCP is required to generate the referral.
- **Post-Surgical Physical Therapy:** The specialist may request physical therapy services as follow-up for surgical procedures.

Special Situations

- **Standing Referral:** In certain situations, AlohaCare will allow members to have a standing referral to a specialist. In this situation, the PCP needs to provide supporting medical information to AlohaCare at the time of the initial referral to ensure that it is processed appropriately.

- **Specialist as PCP:** In some cases, AlohaCare will allow a specialist to act as a PCP for members with special health care needs. In this situation, the PCP needs to provide supporting medical information to AlohaCare at the time of the initial referral to ensure that it is processed appropriately.

The Director of Provider Relations and the Medical Director will assess whether the Specialist has the clinical focus and expertise to treat the condition as a PCP. If the assessment is approved, the Director of Provider Relations will contact the Specialist to explain the responsibilities of a PCP and confirm that the Specialist has agreed to serve as the PCP.

AlohaCare has contracted with specialty providers to care for our members. We ask that PCPs support AlohaCare by referring to a participating specialist. If you need assistance in locating a participating specialist, contact our Customer Service Department.

Prior Authorization Process

To ensure that only medically necessary and appropriate medical services are covered, prior authorization for specific services is required. For the behavioral health prior authorization process, refer to “Section 8 Behavioral Health Care”. For the Pharmacy prior authorization process, refer to “Section 7 Pharmacy Management – Part D Coverage”.

The most current listing of our prior authorizations can be found online at www.AlohaCare.org.

Refer to the Prior Authorization List to determine if the service requires a prior authorization (PA)

If a PA is required, complete the next steps.

1. If there is a referral on file from the PCP, the specialist completes a new (RAN) form to request authorization for the procedure
 - Fill in Member Information and PCP Information.
 - Fill in the Prior Authorization Section with pertinent clinical information including facility information, ICD-9 codes, diagnosis and requested service.
 - Attach appropriate clinical notes and documentation of medical necessity.
2. Fax RAN form to AlohaCare at 973-0676 or toll-free at 1-866-667-0680
3. Wait for written confirmation from AlohaCare
 - AlohaCare will fax the Specialist and PCP a confirmation of receipt with further instructions.

Medical Necessity Review (status)

In situations where a decision has not yet been rendered for a prior authorization request; AlohaCare is still reviewing the request and/or additional information to establish medical necessity.

AlohaCare will notify the provider seeking authorization by telephone or fax if additional information is needed to determine if the requested procedure meets InterQual® criteria. A follow-up fax is also sent to the provider on AlohaCare’s Medical Information Request Form if the requested information has not been received within 7 days. If the medical information has not been received on the 7th day, a second request is sent asking for the information to be sent within 7 days.

If the requested information is not received within a total of 14 days, the prior authorization request will be denied due to insufficient documentation to determine medical necessity, unless the member or provider requests an extension of up to 14 additional calendar days to provide the requested information.

Notification Procedure

A notification serves to inform AlohaCare of the initiation of specific events that trigger other activities. Notifications are required within 24 hours after presentation for facilities and professional care services via a face sheet or the RAN form.

Services requiring notification via Face Sheet or RAN form:

- Hospital Admissions
- Observation Stays
- Dialysis
- Chemotherapy
- Radiation Therapy

Notification Process

- Fax the Face Sheet or RAN form to AlohaCare 973-0676 or toll-free at 1-888-667-0680
- AlohaCare will fax the facility written confirmation (by fax or mail) with further instructions

Hospital Admissions and Observation Stays

A notification is required within 24 hours of an emergent or elective inpatient admission, usually in the form of an admission face sheet. The notification initiates the AlohaCare inpatient concurrent review process.

The admission face sheet should contain the following information:

- Member demographics
- Medical Record Number
- Name of admitting physician
- Diagnosis/es
- Date of admission

For a complete listing of services that require prior authorization or notification, see Appendix B.

Services That Do Not Require Referral, Prior Authorization or Notification

The following services may be performed without obtaining a referral or prior authorization, or sending a notification:

- Professional services provided in the medical inpatient setting (an exception: a surgeon requires a prior authorization for elective surgeries or surgeries)
- Services rendered as part of an inpatient hospitalization. AlohaCare will perform concurrent or retroactive review of the inpatient admission and stay
- Services provided by a member's PCP in the PCP's office, provided that the service was not specifically noted on the "AlohaCare Prior Authorization List"

- Laboratory, radiology and other services/procedures that are not specifically noted on the “AlohaCare Prior Authorization List”
- Emergency room services. However, if the member is admitted subsequent to presentation in the emergency room, a notification must be submitted to AlohaCare within 24 hours of admission.

Definitions Related to Emergency Services

An Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual 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

Prior authorization is not required for urgent care, emergency services and/or post-stabilization care and services.

AlohaCare members are encouraged to communicate with their PCP prior to the development of an emergency situation. Members are informed that they may seek emergency services at the nearest hospital’s Emergency Room. If an emergency situation occurs, members are advised to seek emergency services through the EMS 911 system or through the local emergency system. The PCP is encouraged to coordinate appropriate follow-up care with the attending physician and the member.

Hospitals must notify AlohaCare within 24 hours after an emergency admission. Prior authorization for Behavioral Health hospital admission and follow up care is required once an emergent condition is considered stabilized (refer to Behavioral Health Section). Concurrent review of all hospital admissions, including emergent admissions, is performed using InterQual® Level of Care Criteria guidelines.

An emergency medical condition is not defined or limited by AlohaCare based on a pre-established list of diagnoses or symptoms. Emergency services may be retrospectively reviewed for medical necessity and appropriateness of care using the “prudent layperson” standard. Post-stabilization Care Services are covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or to improved or resolve the member’s condition.

For professional services provided as an emergency in a location other than the emergency room, you must enter “Y” in box 24I of the 1500 claim form to avoid denials for lack of prior authorization or referral form attachment. Documentation may be requested, on a case-by-case basis, to substantiate the emergency nature of the service.

Retroactive Authorization or Notification Approvals

Requests for retroactive authorizations or notification approvals are considered only where there are unusual and extenuating circumstances. Requests for retroactive authorizations should be presented to the AlohaCare Customer Service Department and should include details of the circumstances regarding the failure to obtain prior

authorization or provide notification in a timely manner and any pertinent information to assess medical necessity. These requests will be reviewed on a case-by-case basis.

Inpatient Concurrent Review and Continued Stay

Prior authorization is required for elective admissions to a hospital whether they are initiated by the PCP or by a specialist that the member has been referred to by the PCP. Emergent admissions may be initiated by the PCP, on-call physician or the Emergency Department physician. Emergent admissions do not require prior authorization.

The hospital is required to notify AlohaCare within 24 hours after a medical/surgical admission so that a review of the admission may occur, an estimated length of stay assigned, and care coordination may commence. Notification to AlohaCare may be given by means of fax or a telephone call.

Upon receipt of the inpatient admission notification, AlohaCare verifies the member's PCP and attending physician information in our system to facilitate discharge planning and coordination of care.

The member's facility medical record will be reviewed on-site or by telephone by an AlohaCare Medical Management nurse or Behavioral Health Clinician to determine necessity of admission. InterQual® Criteria is used to determine the severity of illness and intensity of service for continued stay. Special attention will be given to whether or not the services could have been administered in a setting other than an inpatient setting.

Necessity of continued medical/surgical or psychiatric hospitalization will be determined using InterQual® Criteria. When the member no longer meets these criteria, a discharge review will occur and a secondary review by AlohaCare's Medical Director/BH Medical Director will also be performed. Continued stay, care at a lower level of care, or denial of payment for these cases is determined by the Medical Directors. AlohaCare will communicate with facility UM staff or with the attending physician, to discuss discrepancies in care and notify of any impending lowering of level of care or denial. The facility will be given the opportunity to present further documentation for reevaluation of the need for continued stay.

Inpatient Stays of Less than 24 Hours

For an inpatient stay that is less than 24 hours, an AlohaCare Utilization Management Nurse or BH Clinician will evaluate the admission. If the member is receiving care per the inpatient criteria, an authorization for payment of one day will be made at the appropriate inpatient service level of care. If the inpatient admission criteria are not met, authorization for payment will be denied. Since these reviews and discharges usually occur quickly, it can be expected that nearly all these reviews will be retrospective in nature; the Utilization Management Nurse or BH Clinician will arrange to either review the medical records on site or request a copy of the records be sent to AlohaCare.

Notification of the payment authorization decisions will be faxed to the provider and facility. In the cases of lowering level of care or denials, the Utilization Management nurse or BH Clinician will notify the facility.

Some hospitals have indicated to AlohaCare that they do their own internal review of "less than 24-hour" admissions. If upon internal review the facility determines that the stay did not warrant inpatient status, the facility

will notify AlohaCare of the request to change the initial notification to outpatient status, and AlohaCare will process authorization according to outpatient policies and procedures. This situation will occur only upon request from the facility. Otherwise, any notifications of inpatient admission will continue to be evaluated by AlohaCare per the inpatient criteria.

Discharge Planning

Discharge planning for inpatient stays is essential to the concurrent review process and will be initiated, upon admission, by the hospital Utilization Management nurse. AlohaCare's UM nurse or BH Clinician will assist with required authorizations for discharge. Early discharge planning enables the UM Nurse to case manage the member, avoid unnecessary inpatient days, prepare members for appropriate discharge from the facility and ensures services have been established to facilitate a safe transition to the outpatient setting and timely, efficient and effective outpatient follow-up. Discharge planning will occur in conjunction with the attending physicians; appropriate facility personnel, including social workers; hospital UM staff; and ancillary department personnel. Special attention is given to members with special health care needs. Although this is assessed by the UM nurse and BH Clinicians, providers are urged to inform us if you believe that the member has a special health care need and may benefit from more intensive care management services and intervention.

AlohaCare's Senior Clinical Staff or a Medical Director may be involved when there are complicated critical diagnoses to ensure that coordination of the most medically appropriate, cost-effective health care options are instituted.

Early discharge planning also allows initiation of care coordination services, particularly for special health care needs and/or complex cases. Care Coordinators conduct a post discharge follow-up questionnaire with members which include questions related to medication reconciliation, post discharge follow-up appointments with providers and or specialists and interventions that may be required to prevent further inpatient admissions. The Care Coordination team collaborates with providers and their staff to improve health outcomes and prevent future inpatient admissions. Members are assessed and offered Care Management services at the conclusion of the questionnaire.

Telemedicine

AlohaCare covers telemedicine services, which require prior authorization for providers at both the originating site and the distant site.

Technologies Involved

- An interactive telecommunications system must be used and the examination of the member must be at the control of the practitioner at the distant site.
- Asynchronous store and forward technologies are permitted as substitute for interactive telecommunication system at Federal Telemedicine Demonstration Program sites in Alaska and Hawaii. An asynchronous telecommunications system does not include telephone calls, images transmitted via facsimile machines, or text messages without visualization of the member (e-mail).
- A medical professional is not required to present the beneficiary to the practitioner at the distant site unless medically necessary.

Eligible Practitioners

- Physician
- Nurse Practitioner
- Advanced Practitioner Registered Nurse
- Physician Assistant
- Clinical Nurse Specialist
- Clinical Psychologist
- Clinical Social Worker

Eligible Geographic Areas

- Beneficiary must be presented from an originating site located in either a rural health professional shortage area (HPSA) or a county outside of a Metropolitan Statistical Area (MSA).
- Entities participating in a Federal Telemedicine Demonstration Project qualify as eligible originating sites, regardless of their geographic location.

Authorized Originating Sites

- The office of a physician or practitioner
- Hospital
- Critical access hospital
- Rural health clinic
- Federally qualified health center

Billing and Payment Issues

- Prevailing Medicare fee

Clinical Decision Support Tools and Clinical Practice Guidelines

AlohaCare utilizes evidence based, nationally-recognized and accepted criteria and guidelines to assist with determinations related to medically necessary services. Medical necessity and level of care appropriateness criteria are consistent with the appropriate National Coverage Determination (NCD) per the Medicare guidelines. In the absence of a NCD, Local Coverage Determination (LCD) is used. In the absence of any Medicare coverage determination guidance, InterQual® criteria are used.

Reference criteria utilized for medical services use the most current version of:

- InterQual® Care Planning
- InterQual® Procedures Criteria
- InterQual® Imaging Criteria

Reference criteria utilized by AlohaCare for inpatient length of stay use the most current version of:

- InterQual® Acute Care Criteria
- Length of Stay Guidelines by Diagnosis and Operation

Reference criteria for Behavioral Health services use the most current version of:

- InterQual® Behavioral Health Criteria

- InterQual® Geriatric Psychiatry
- InterQual® Adult Psychiatry
- InterQual® Adolescent Psychiatry
- InterQual® Chemical Dependency & Dual Diagnosis
- InterQual® Residential (Adolescent Psychiatry)
- ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (Second Edition Revised PPC-2)

InterQual®, Length of Stay Guidelines, and ASAM-PPC are published and updated annually and these criteria and the disease-specific clinical practice guidelines adopted by AlohaCare are reviewed at least annually by the AlohaCare Quality Improvement Advisory Committee (QIAC).

AlohaCare has developed clinical practice guidelines that are relevant to the Medicare population, based on (but not limited to) the following: age groups, disease categories, and special risk status. Practice guidelines are based on valid and reliable clinical evidence and/or consensus of health care professionals in relevant field.

On an annual basis, provider input is obtained through the QIAC. The QIAC reviews the existing guidelines to ensure they remain current and in alignment with national and community standards of medical practice. The QIAC also makes recommendations on additional guidelines to be adopted, based on scientific evidence, best practices, the populations served by AlohaCare and any identified recipient needs of the Medicare population.

The following criteria are used in the development and adoption of Clinical Practice Guidelines:

- The guidelines are directed at improving outcomes for a clinical issue of importance to AlohaCare's Medicare members.
- The guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a relevant field. Sources of information for supportive decision-making include, but are not limited to, the findings, guidelines and recommendations set forth in peer-reviewed medical journals; those advised by recognized authoritative agencies (i.e. Centers for Disease Control, etc.); those set forth by accrediting agencies; and known community standards of care.
- Practice guidelines are reviewed to ensure that there is conformance between the guidelines adopted and AlohaCare's utilization management decision tools, lists of non-covered services and any enrollee educational materials currently in use.

AlohaCare has adopted Clinical Practice Guidelines for the following:

- Adult Preventive Health
- Management of Asthma
- Diabetes Mellitus
- Treatment for Members with Major Depressive Disorder
- Chronic Heart Failure

Updates to the Clinical Practice Guidelines are available on our website at www.AlohaCare.org.

SECTION 7: PHARMACY MANAGEMENT – PART D COVERAGE

Overview

The AlohaCare Advantage and AlohaCare Advantage Plus Formularies (“Formulary”) provide you with a list of medications that AlohaCare will cover within various therapeutic classes. Effective use of these formularies is based on the support we receive from you, our valued provider. To assist and ensure that AlohaCare members receive high quality medical care that maximizes their drug benefit while reducing their out-of-pocket prescription drug expenses, we ask for your cooperation in following these guidelines when prescribing medications for our members:

- Prescribe Formulary generic drugs first
- Prescribe a brand Formulary drug when a generic equivalent is not available
- Evaluate medication profiles for appropriateness and duplication of therapy

For assistance, contact the AlohaCare Pharmacy Department at 973-7418 or toll-free at 1-866-973-7418.

AlohaCare Advantage and AlohaCare Advantage Plus Formularies

The Formularies for our Medicare Advantage Prescription Drug plans were developed by the AlohaCare Pharmacy and Therapeutics (P&T) Committee following CMS guidance for Part D drug coverage. The P&T Committee is comprised of practicing, credentialed physicians, pharmacists and nurses representing a wide range of specialties with various expertise in caring for the Medicare population and meets quarterly to review and evaluate new drugs in order to keep pace with the continuous advances in pharmacotherapy. The P&T Committee’s selection of drugs is based on an objective evaluation of the drug’s efficacy, safety, side effects, pharmacokinetics and published clinical literature, as well as its cost effectiveness profile.

The medications listed on the Formulary are organized by therapeutic category and therapeutic class. The drug names under each category are listed in alphabetical order, including the drug’s generic name, brand name (if any), member copayment tier level and any associated utilization management parameters.

How to Request a Copy of the Formularies

The Formularies are available on our website at www.AlohaCare.org. To request a hard copy of the formularies, please contact our Customer Service Department.

A searchable drug look-up function, Drug Finder, is available on our website. Look for the green Drug Finder button on the left side of each webpage. It is updated with the most recent Formulary approved by the Centers for Medicare and Medicaid Services (CMS) and the AlohaCare P&T Committee.

Amending the Formulary

As a provider, you may ask AlohaCare to consider adding to or deleting a drug from the Formulary by completing the AlohaCare “Request for Addition/Deletion of Medication to Formulary” form. This form can be found on our website, in the Provider section, under Forms.

Requests should be addressed to:

AlohaCare
Attn: Pharmacy Management Department
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

In your request, specify the name of the drug and provide copies of relevant published clinical studies/literature, along with your rationale which may include the unique characteristics of the local population, regional standards of medical care for the disease category and other pertinent information to support the addition or deletion of a formulary drug(s). AlohaCare will send you a letter confirming the receipt of your request. Once AlohaCare P&T Committee reviews your request, we will let you know their decision.

Formulary Changes

To ensure that AlohaCare’s Formulary is updated, comprehensive and meets the needs of members, changes, additions, and deletions to the formulary will occur. In those events, AlohaCare will notify all affected members of the change at least 60 days prior to the change taking effect. Changes are updated in our Drug Finder and also posted to our website. Formulary changes include the following:

- AlohaCare removes a drug from the Formulary;
- AlohaCare adds prior authorization requirements to a drug;
- AlohaCare institutes quantity limits;
- AlohaCare implements step therapy utilization limitations on a drug; or
- AlohaCare moves a drug to a higher cost-sharing tier.

If affected by a formulary change, AlohaCare will continue to cover the drugs in question for members taking the drug at the time of the change for the remainder of the plan year as long as the drug continues to be medically necessary and prescribe to the member and not removed for safety reasons.

If the FDA deems a drug on the Formulary to be unsafe or the drug’s manufacturer removes the drug from the market, AlohaCare will immediately remove the drug from our Formulary and provide notification to members who are taking the drug thereafter.

Generic Drugs

AlohaCare endorses the use of the Food and Drug Administration’s (FDA) approved bioequivalent generics and encourages the prescribing/dispensing of these medications. In general, generic drugs are as clinically effective and in many cases, less costly than their counterpart brand medications. Generic drugs are generally included on our Formulary unless they are explicitly excluded by CMS for Medicare Part D coverage.

Medicare Excluded Drugs

AlohaCare covers at least two (2), and in many cases several chemical agents available in each therapeutic category/class. However, there are certain drugs that are excluded from coverage under the Medicare Part D Program regulations. The Formulary does not include, and AlohaCare does not pay for or cover the following drugs and/or categories or medications:

- Barbiturates
- Benzodiazepines
- Drugs used for anorexia, weight loss, or weight gain
- Drugs used to promote fertility
- Drugs for the symptomatic relief of cough and colds
- Drugs used for the treatment of sexual or erectile dysfunction (ED)
- Drugs used for cosmetic purpose or hair growth
- Non-prescription or Over-the-Counter (OTC) drugs (except under step-therapy rules)
- Prescription vitamins, which the manufacturer seeks to require as a condition of sale that associated test or monitoring services be purchased exclusively from the manufacturer or its designee
- Less than effective DESI drugs (and those drugs identical, related or similar) such as Librax and Midrin

Step-Therapy Utilization

The AlohaCare P&T Committee has approved step-therapy edits as a means to ensure cost effective drugs are used prior to a more costly alternative drug. These step-therapy edits are built into the pharmacy claims system and are applied to the member's prescription, if applicable, at the time of dispensing. Thus, a prescription for a Formulary brand drug may need a prior authorization if the pharmacy claims system does not see an OTC or generic drug within the same therapeutic category/class as the brand drug in the member's medication profile.

Drugs on the Formulary affected by step-therapy are noted with a "ST" designation next to the drug name.

Quantity Limits

The AlohaCare P&T Committee has approved quantity limits on the amount of certain drugs that AlohaCare will cover for safety and effectiveness reasons. These quantity limits are based on several factors including the FDA-approved dosing guidelines, medical literature and other treatment guidelines.

Drugs with quantity limits are noted on the Formulary with a "QL" designation next to the drug name.

Prior Authorization or Drug Coverage Determination Process

Certain drugs require prior authorization. Drugs that require prior authorization are noted on the Formulary with a "PA" designation next to the drug name.

The Drug Coverage Determination or Prior Authorization process is to ensure that drugs are covered within the FDA-approved indication(s) and the coverage use criteria defined by the American Hospital Formulary Service Drug Information, DRUGDEX Information System and United States Pharmacopeia – Drug Information (or its successor publications). Providers must obtain prior approval by requesting a drug coverage determination before AlohaCare will cover any of these drugs.

Drug Coverage Determination: Formulary Exception, Utilization Exception and Tiering Exception

Another aspect of the drug coverage determination process is the formulary exception. Providers may ask AlohaCare to make an exception to our coverage rules. There are several types of exceptions that providers can ask us to make:

- To cover a drug that is not on our Formulary (i.e. formulary exception). AlohaCare will only approve your request for a formulary exception if your requested drug is medically required and all other formulary drugs and dosage forms will not be as effective. If approved, the member's copayment will be at the non-preferred brand tier copayment.
- To waive coverage restrictions or limits on drugs (i.e. utilization exception). If a drug has a quantity limit, you can ask us to waive the limit and cover more.
- To provide a higher level of coverage for a drug (i.e. tiering exception). If the member's drug is contained in one of our non-preferred tiers, providers may ask us to cover it at the copayment associated with the preferred tier. Generally, AlohaCare will only approve a request for a tiering exception if there is no alternative in the preferred tier that will be as effective in treating the member's condition and/or would cause the member to have adverse medical effects. A tiering exception request cannot be requested for drugs that are in the Specialty Tier/Tier 5.

When requesting a formulary utilization or tiering exception, providers must submit a statement supporting your request. Generally, AlohaCare will make a decision within 72 hours of receiving the supporting statement. You can request an expedited exception if you believe that member's health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, AlohaCare will make a decision no later than 24 hours after we receive your supporting statement.

How to Request a Prior Authorization or a Drug Coverage Determination

1. Complete a "Drug Coverage Request Form" request. A copy is available on our website or by calling Customer Service.
2. Include the member's clinical history and/or other pertinent medical and drug history information when submitting the request form.
3. Fax the completed form to AlohaCare Pharmacy Management Department at 973-6327 or toll-free at 1-877-316-6376.

Coverage Determination Review Timeframes

- **Standard Request** – AlohaCare may take up to 72 hours to render a decision for a Formulary prior authorization request.
- **Expedited Request** – A request that requires a decision within 24 hours, because a member's health would be seriously harmed by waiting the standard 72 hours for a decision. All faxed requests should be marked as "Expedited" and followed up with a telephone call to the Pharmacy Management Department at 973-7418 or toll-free at 1-866-973-7418.

Drug Coverage Determination Notification Letter

If the drug coverage request meets applicable Plan rules and coverage criteria, the provider and member will be notified of the approval. If the drug coverage request does not meet applicable Plan rules, the request is forwarded to an AlohaCare Medical Director for a determination.

For those initial coverage determination requests that are not approved, a denial notice is faxed to the provider and a hard copy mailed to the member stating the clinical rationale for non-approval of the request. If the determination involves a denial, suspension or termination of services, the notification letter will conform to all CMS requirements and timelines which include providing the specific detailed reason for the determination and the member's appeal rights.

Drug Coverage Redetermination Request

In the event of a denial of an initial drug coverage determination request, the provider may request a drug redetermination on behalf of the member as long as you provide notice to your member. Under Medicare rules, "an enrollee's appointed representative, or an enrollee's prescribing physician may request that a Part D sponsor (AlohaCare) expedite a redetermination in situation where applying the standard time frame could seriously jeopardize the enrollee's life, health, or ability to regain maximum function."

A member or provider may request a drug redetermination in writing to:

AlohaCare
Attn: Grievance & Appeals Department
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Vaccines

Both Influenza and Pneumococcal vaccines have no copayments for members and are covered under Part B along with the Hepatitis B vaccine (for high risk individuals). Generally, all other vaccines are covered under Part D.

Pharmacy Providers

AlohaCare has delegated certain pharmacy operation functions, including the pharmacy network, to our Pharmacy Benefits Manager, Medco Health Solutions Inc. (Medco).

All Pharmacies within the pharmacy network must comply with the minimum standards of pharmacy practice within the State of Hawaii. As stated in the Medco Pharmacy Services manual, which is part of the Medco network pharmacy agreement, a pharmacy is required to operate a computer system that allows for recording of member drug and medical history. This computer system must be compatible with the Drug Utilization Review (DUR) messaging received via the Medco TelePAID® system when a prescription claim is being adjudicated. The prescription claim transmission also must be compliant with the most currently recognized version of the National Council for Prescription Drug Programs (NCPDP).

Pharmacy providers may access Medco's Pharmacy Services Help Desk 24 hours a day, including holidays, at 1-800-922-1557.

Limited Access Medications

Limited access medications are Part D drugs are designated by the FDA to only be available at certain pharmacies within the pharmacy network and require enrollment in a Risk Evaluation and Mitigation Study (REMS) program. Limited Access drugs are noted on the Formulary with an "LA" designation next to the drug name.

MTM Program (Medication Therapy Management Program)

Medication Therapy Management is a program that the Centers for Medicare and Medicaid Services (CMS) requires Part D plan sponsors to offer to our members. CMS provides guidelines for members' inclusion in MTM program.

AlohaCare has delegated the MTM program to Medco. Medco's program is designed to ensure that covered Part D medications prescribed to targeted beneficiaries are appropriately utilized to optimize therapeutic outcomes. The program's goals are to increase the value of the drug benefit through member education about the medication they are taking, to minimize adverse events and to help identify and cost-saving opportunities. The program is focused on the needs of the individual member.

If you have an AlohaCare member enrolled in the MTM program you may periodically be contacted by a Medco pharmacist or representative in regards to the care of the member.

Transition of Care

New members of AlohaCare Advantage may be taking drugs that are not on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Providers should speak with their member to decide if the member should switch to a different drug that we cover or request an exception in order to get coverage for the drug. AlohaCare will provide a temporary supply of the non-formulary drug during the first 90-days of membership.

For new members who are a resident of a long-term-care facility (like a nursing home), we will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days.

SECTION 8: BEHAVIORAL HEALTH CARE

Behavioral Health and Chemical Dependency

AlohaCare's goal is to provide optimal comprehensive health benefits to all AlohaCare members. AlohaCare's behavioral health operations are incorporated into our comprehensive approach to clinical management to ensure the highest quality of services. Both medical management and behavioral health staff work together to establish continuity of care for members with psychiatric, chemical dependency, and/or medical co-morbidity.

AlohaCare expects that our Behavioral Health (BH) providers can achieve clinical progress and outcomes for our members. AlohaCare carefully reviews requests for additional services and monitors BH utilization data. Our BH clinicians and Medical Directors will be actively involved in clarifying treatment goals and/or discussing care options with requesting providers, when appropriate. Care management and coordination services are available for members who require additional support due to complex behavioral health care needs. We look forward to working with you to help achieve improved clinical outcomes for our members.

Behavioral Health services are provided:

- To improve the level of functioning in order to relieve or reduce the level of impairment and disability
- To prevent deterioration in functioning, where possible
- To maintain the level of functioning for those conditions that have reached a plateau of improvement and would deteriorate without supportive treatment
- To increase coping skills and level of functioning for those who have behavioral health issues and/or chemical dependency

To ensure the prudent use of medically necessary behavioral health services and optimizing coordination of care, AlohaCare will closely evaluate requests for services from multiple clinicians providing treatment services to the same member at the same time for the same condition. This evaluation will address potential duplication of services and promote collaboration of care.

Behavioral Health Care Coordination

AlohaCare Clinician/Care Coordinators are licensed Behavioral Health Clinicians and/or Registered Nurses. The clinicians and nurses assist the provider and member by:

- Assessing the initial level of care required, and monitoring the ongoing level of care
- Facilitating cost effective, quality services targeted toward the unique needs of each AlohaCare member receiving care
- Facilitating the delivery of crisis intervention services
- Facilitating and coordinating consultations with Primary Care Providers (PCPs), and other providers

AlohaCare's Behavioral Health Medical Directors are board certified psychiatrists and are available to AlohaCare staff and providers for case consultation. The BH Clinician/Care Coordinator will refer a case to the Behavioral Health Medical Directors if:

- The services requested do not meet medical necessity criteria.
- The services requested require a psychiatrist's review to determine medical necessity.
- There is a quality of care concern.

Members who have behavioral health issues or chemical dependency needs can access care in the following ways:

- A member can self-refer by making an appointment to see an AlohaCare participating provider or by calling the AlohaCare Behavioral Health Department for assistance.
- No PCP referral is required for Behavioral Health Services.

Behavioral Health Department

Contact the Behavioral Health Department at 973-2475 or toll-free at 1-888-875-4979. Fax to 973-6324 or toll-free at 1-800-293-4580.

An on-call Behavioral Health Clinician may be reached after business hours, on weekends or holidays, for emergency inpatient admissions assistance by calling the numbers given above and following the given instructions.

Should an emergency inpatient admission be necessary, the inpatient facility is asked to notify AlohaCare by submitting a face sheet within 24 hours of the admission.

Outpatient Behavioral Health and or Chemical Dependency

Licensed certified social workers, Advanced Practice Behavioral Health nurses, Advanced Practice Registered Nurses, Licensed Masters level Clinicians, Psychologists and Psychiatrists provide care for our members.

Individual, family, and group therapy are common treatment modalities.

- No prior authorization is required for outpatient mental health psychotherapy services and or medication management services rendered by in-network Psychiatrists and Advance Practice Registered Nurses (APRNs) with prescriptive authority.
- No prior authorization is required for the first fifteen (15) hours of outpatient MH psychotherapy and/or medication management services. This change is applicable to AlohaCare members who are new to your practice, or for members who are returning to you with a new spell of illness (typically described as a new treatment episode following a break in care of 60 days or longer after a previous treatment episode). Prior authorization will commence if you determine that your AlohaCare member requires medically necessary outpatient services that exceed the initial 15 hours.
- The Outpatient Mental Health and or Chemical Dependency Form and required supporting documentation must be submitted via fax to: 973-6324 or toll-free at 1-800-293-4580 before the 16th service hour of treatment is initiated.

Prior Authorization is required for:

Psychological and Neurological Testing:

- Psychological testing for the purpose of assisting in clarifying the diagnosis, differential diagnosis or course of care is a covered behavioral health benefit.

- Generally six (6) hours of psychological testing may be authorized within a twelve month period
- Psychological testing must be administered, monitored and evaluated by a qualified provider.
- Providers requesting psychological testing:
 - 96101 – Provider administers testing, interprets results and writes report
 - 96102 – Member tests on a computer, and the provider interprets results and writes report
 - 96103 – Technician administers the testing, and the provider interprets results and writes report
- AlohaCare’s BH Clinicians may authorize an initial three (3) hours of psychological testing and the BH Medical Director will evaluate requests for an additional three (3) hours of testing, based on Inter-Qual Criteria.

Providers must complete the Outpatient Psychological Testing Request form and fax or mail the form to AlohaCare prior to administering the services.

Substance Abuse Treatment and Facility-based services (e.g., IOP, LIOP, day treatment):

To request prior authorization for services such as Partial Hospitalization, Day treatment, Residential, Chemical Dependency Intensive outpatient services (IOP), Chemical Dependency Low Intensity outpatient services (LIOP) and Chemical Dependency outpatient service (OP):

- The provider is first encouraged to check AC Online or contact the AlohaCare Behavioral Health Department to verify the member’s eligibility. If requested services are medically appropriate, an initial authorization will be given telephonically.
- For continued care, the provider must mail or fax the Mental Health Outpatient and/or Chemical Dependency Treatment Plan prior to the 16th service being provided.

Partial Hospitalization/Day Treatment Services

- This level of care is reserved for members who are in need of a structured day treatment program to prevent relapse or continued use.
- The service criteria for partial hospitalization are a minimum of 15 to 20 hours of professionally structured and delivered treatment services per week.
- This service is comprised of: psycho educational groups and classes, skill building, relapse prevention, and group therapy.
- This level of care requires the member to have one (1) hour of individual counseling per week.
- This service is inclusive of diagnostic assessment, registration, intake, orientation, treatment planning, and disposition planning, aftercare, and referral linkage and client advocacy service.
- A partial hospital/day treatment program may be used as a step up from a less intensive level of care, or as a step down form a more intensive level of care. Dual diagnosis partial hospital/day treatment programs specialize in the concurrent treatment of co-occurring mental health and substance use disorders.

Residential CD Services

- This level of care is reserved for members who are in need of 24 hour per day structured or monitored milieu environment with both professional and paraprofessional staff available.
- Members needing this intense level of care require 25 hours per week of professionally driven chemical dependency services which are comprised of: group therapy, psycho educational group, skill building, relapse prevention and coping skills.

- This level of care requires the member to have one (1) hour of individual counseling per week. This service is inclusive of diagnostic assessment, registration, intake, orientation, treatment planning, and disposition planning, aftercare, and referral linkage and client advocacy service.

Chemical Dependency

- A wide range of CD services are available which includes detoxification services, both medical (for those with a history of acute withdrawal) and social (for those with no known history of severe withdrawal, residential treatment facilities and intensive outpatient treatment options).
- Also available is the option for specialized outpatient visits with individual providers concurrently trained and experienced in therapeutic and chemical dependency modalities.
- Treatment decisions are based in part on the ASAM criteria and InterQual® guidelines, which assist in determining the most appropriate level of care for a given member's needs.
- The criteria for each imply that the specified services are available to members who are being treated at that level of care.
- Individualized treatment plans are required, and must specify the level of care and the number of sessions requested for each individual member.
- Treatment plans will be reviewed by an AlohaCare clinician.
- Approval of prior authorization requests for the planned treatments/interventions will be based on medical necessity.

The types of detoxification services that are available are:

- Ambulatory medical outpatient detoxification
- Social detoxification – residential, for members without serious medical problems
- Inpatient medical detoxification, only for those members who have potentially serious, life-threatening medical problems as a result of their drug or alcohol use

IOP, LIOP, and OPS authorizations

- An initial request for six flex sessions will generally be approved, provided the member is eligible for benefits, and is not currently being seen by another behavioral health provider for the same requested services
- By authorizing a specific number of flex sessions, the provider is able to customize treatment based on the member's care needs. These flex sessions are authorized as procedure codes 90807 or 90806.
- Authorizations for procedure code 90807 are limited to psychiatrists and advanced practice nurses with prescriptive authority.
- Authorizations for other non-physician providers will show the 90806 code, or other codes as requested.
- When submitting claims, provider must bill with the specific services rendered.
- Group therapy is an acceptable means of psychotherapy and AlohaCare encourages its use when clinically appropriate.

Intensive Outpatient CD Services (IOP)

- This level of care is reserved for members who are in need of regular contact with the treatment program to prevent relapse or continued use.

- The service criteria for IOP are a minimum of 9 to 14 hours of professionally structured and delivered treatment per week.
- The service is comprised of psycho educational groups and classes, skill building, relapse prevention, and group therapy.
- This level of care requires the member to have one (1) hour of individual counseling per week.
- This service is inclusive of client registration, intake, orientation, treatment planning, disposition planning, aftercare, referral linkage and client advocacy service.

Low Intensive Outpatient CD Services (LIOP)

- This level of care is reserved for members who require less frequent contact with the treatment program to prevent relapse.
- The service criteria for LIOP is a minimum of 4 to 8 hours of professionally structured and delivered treatment services per week.
- The service is comprised of: psycho-educational groups and classes, skill building, relapse prevention, and group therapy.
- This level of care requires the member to have one (1) hour of individual counseling per month.
- This service is inclusive of client registration, intake, orientation, treatment planning, disposition planning, aftercare, referral linkage, and client advocacy service.

Outpatient CD Services (OPS)

- This level of care is reserved for members who may be in the contemplation stage of their substance use, or it may be used as for the relapse prevention phase of treatment
- The service requires a minimum of 1 to 3 hours of professionally driven care per week, comprised of individual and/or group counseling, psycho-educational groups and classes, skill building, relapse prevention, and group therapy components
- This service is inclusive of client registration, intake, orientation, treatment planning, and disposition planning, aftercare, and referral linkage and client advocacy service.

Electroconvulsive therapy (ECT)

- Electroconvulsive therapy (ECT) is considered an invasive procedure. Every effort should be made to determine whether more conservative treatment techniques would produce a satisfactory outcome for the member.
 - The AlohaCare BH Clinician will review all requests using ECT guidelines. The BH Clinician will also document the member's current clinical and medical condition, as well as attempts at more conservative treatment.
 - This information is forwarded to the Behavioral Health Medical Director, who renders the approval or denial decision for all ECT requests.

Individual Therapy in excess of one hour per day:

- CPT codes: 90808, 90809, 90814 and 90815
- These services will be evaluated on a case-by-case basis, taking into consideration various factors that may necessitate the need for individual therapy services that exceed one hour of service, including the lack of or inability to use public transportation, an acute exacerbation, etc. Providers should provide a detailed explanation for this requirements.

Medication Management

We encourage PCP's who are managing members with behavioral health conditions to contact the BH Department in finding an in-network Psychiatrist or APRN with prescriptive authority for medication evaluation and follow-up medication management. Non-physician behavioral health providers are also encouraged to call us to arrange appropriate referrals to psychiatrists.

Medication management (90862) for behavioral health diagnoses is considered a general medical visit.

Termination of Treatment

Providers must notify AlohaCare when a member is discharged from treatment. For outpatient discharges, providers should fax or mail the "Notification of Termination of Treatment" form to AlohaCare within one week of termination.

This notification form should be used to inform AlohaCare when a member's treatment has been completed or is being discontinued due to lack of compliance (member consistently missing appointments, member not following through with reasonable treatment recommendations).

Inpatient Services

Acute Inpatient Admissions for Mental Health – Acute care is available to members who meet admission criteria and have inpatient benefits remaining. All inpatient hospital admissions require a notification from the facility within 24 hours of the member's admission.

The notification serves to initiate the concurrent review process in which AlohaCare clinicians will concurrently review the care provided in the facility which includes any quality of care or delay in care issues, length of stay, level of care and discharge planning. If any issues are identified, the AlohaCare Concurrent Reviewer will discuss the issue with the facility UM and/or QI staff, and/or the attending physician, as needed. An AlohaCare BH Clinician will contact the inpatient facility by phone within 24 hours of receiving admission notification to conduct an initial review for medical necessity.

Please note that the availability of inpatient benefits is based on plan guidelines, which has a lifetime limit of 190 days if the member is confined in a free-standing psychiatric facility. The 190 day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.

Generally, acute psychiatric admissions are based on the presence of DSM-IV Axis I diagnosis and the presence of one or more of the following:

- Potentially homicidal/suicidal individual who presents a danger to self or others. This threat must be related to a behavioral health diagnosis.
- A major psychiatric condition where the individual is unable to function in the outpatient setting to the extent that he or she cannot provide basic self-care, and is at risk for serious life-threatening problems. Dementia and other organic neurological impairing conditions do not apply.

- Diagnostic testing and/or treatment is required that is only available on an inpatient basis (such as ECT -- Electroconvulsive Therapy).
- Medical illness and psychiatric illness which, in combination, require initial inpatient care.
- Short admission, if appropriate, for 24 hour monitoring for a toxic reaction or illicit substances, to ensure proper dosage, dose titrations or conversions to other medications, or to ensure compliance to medication therapy needed to maintain and prevent further deterioration of a member's condition

Emergency, Post-stabilization days ("Post-stabilization Care Services" are covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the member's condition), and urgent care services are **not subject to prior authorization** and are subject to retrospective medical necessity review.

For complicated emergency situations you may reach a Behavioral Health Clinician who is on-call 24 hours a day, seven days a week by calling the Behavioral Health Department at 973-2475 or toll-free at 1-808-875-4979.

Inpatient Medical Consultations for Behavioral Health Admissions

In the event that a medical consultation is requested for a member who has been admitted for a mental health or chemical dependency diagnosis, no prior authorization is required for these consultation services. These services are payable under the facility's authorization number and the appropriateness of any medical consultations will be evaluated during the concurrent review process.

Discharge Planning

Discharge planning is essential to the concurrent review process and is initiated upon the member's admission to the facility. Early discharge planning enables the facility and AlohaCare staff to coordinate care for the member, avoid unnecessary inpatient days and prepare members for appropriate discharge from the facility. Discharge planning will occur in conjunction with the attending physicians and appropriate facility personnel, including social workers, hospital utilization management staff and ancillary department personnel. AlohaCare's Senior Clinical Administrator or Behavioral Health Medical Director may intervene when there are complicated critical diagnoses to ensure that coordination of the most medically appropriate, cost effective health care options are instituted.

Discharge planning includes:

- The evaluation for appropriate setting to deliver continued care
- The coordination of follow-up services, including reconciliation of preadmission and post discharge medications, and post discharge provider appointments
- The assessment of the family or other community-based support network
- Notification/Collaboration with PCP and other relevant specialists

An after-care plan must be in place prior to discharge from any facility and a copy of the discharge plan given to the member. To ensure continuity and coordination of care, AlohaCare requests notification of the member's discharge status within 24-48 hours of discharge. When a transfer to another program is part of the discharge plan, the program must contact AlohaCare for prior authorization before rendering services.

Retrospective/Concurrent Review and Continued Stay

Concurrent review occurs 24 hours prior to the notification end date. Continued acute hospitalization stays are determined by following InterQual criteria, and is based on the information received from the inpatient facility. The Behavioral Health Medical Director reviews the case to determine the need for continued stay, a lower level of care, or denial of authorization for additional days (once the emergent crisis is stabilized).

All denials for admission, continued stay and lowered levels of care, are issued by the AlohaCare Behavioral Health Medical Directors. The inpatient facility and attending physician will be notified of denials for continued stay 24 hours prior to the authorized end date. The inpatient facility and attending physician are given the opportunity to present further documentation for reconsideration of the decision.

Information required for the retrospective/concurrent review notification process includes:

- Level of care
- Date of admission
- DSM-IV-Axes I-IV and Severity of Symptoms
- Clinical rationale for admission/continued inpatient stay
- Treatment plan
- Estimated length of stay
- Proposed discharge plan

An authorization may be placed in a pended status if a medical record review is needed, or more clinical information needs to be obtained. The facility must provide access for AlohaCare BH clinical staff to conduct on-site reviews during normal weekday business hours or provide copies of the medical records at no cost to the Plan when requested.

Crisis Services

Crisis services and shelters are available to AlohaCare members according to member needs. This service is meant to be used to stabilize a member until definitive treatment can be arranged, or to bridge a gap for a member who does not meet inpatient criteria but is not stable enough to return to the community.

ACCESS LINE: 832-3100 or for Neighbor Islands: (808) 753-6879

SECTION 9: CARE MANAGEMENT AND DISEASE MANAGEMENT

Program Introduction

The primary function of the Care Management team is to collaboratively assess, plan, implement, coordinate, monitor, and evaluate the services and resources available to meet our member's health care needs and to promote quality and cost effective health outcomes. The Care Management team is comprised of RN Care Coordinators, Disease Management Nurses, Licensed Behavioral Health Clinician/Care Coordinators and Member Service Navigators (MSNs).

The MSNs are a key part of the Care Management team. They provide personal face-to-face services to our members. This enhanced benefit provides assistance in the following areas:

- Health plan education
- Schedule appointments with PCP and or Specialists
- Attend scheduled provider or social service appointments with members
- Assistance with care coordination activities under the direction and supervision of the Medicare RN Care Coordinators to assist the member in understanding the interventions and goals developed within the Individual Care Plan (ICP)
- Assist in obtaining necessary referrals and or prior authorizations for services
- Assist family members and caregivers involved in the member's care
- Refer members to the Disease Management Program and other plan service programs
- Provide resources and assist in obtaining needed social services and community resources
- Assist with maintaining eligibility with AlohaCare and other entitlement programs

Providers are encouraged to request the assistance of the MSNs. Call Customer Service at 973-6395 or toll-free at 1-866-973-6395 and ask for Care Management.

Goals of the Care Management Program

- Ensuring that services are provided in a timely and cost effective manner through early assessment of needs, and development of an Individual Care Plan (ICP)
- Coordination of care in conjunction with PCPs, Specialists, family members and or care givers (if needed), community based agencies, facility care managers and social workers, QExA plans (Medicaid Plan for dual eligible SNP members) to ensure members are reaching optimal health outcomes.
- Empowering members to be active decision makers in their own care
- Providing optimal Care Coordination activities that encourage and allow our members to achieve their maximum level of independence, health and functionality

Referral to Care Management Program

- Identification of high risk members with Special Health Care Needs, through the completion of the Health Screening Survey
- By the member's Primary Care Provider (PCP) or other health care provider
- Direct member referral
- By the member's family or representative
- Internal referrals from clinical AlohaCare areas such as Utilization Management (UM), Pharmacy Drug Utilization Review, Behavioral Health, Clinical Operations, Disease Management and Care Management team
- Internal referrals from non-clinical AlohaCare areas as the Customer Service Department or Enrollment Department
- Referral from other external sources

Providers who have identified AlohaCare members who are high-risk and in need of Care Coordination, call Customer Service at 973-6395 or toll-free at 1-866-973-6395 and ask for Care Management.

AlohaCare Referral Forms can be fax to 973-6382 or toll-free at 1-808-973-6392.

Health Screening Survey

Upon enrollment, AlohaCare members are sent a Health Screening Survey. The Health Screening Survey is a self-assessment, based on a weighted scoring mechanism for each question which identifies members for the program. AlohaCare will screen all newly enrolled members to identify any special health care needs and high risk members through the completed screening tool. We encourage providers to assist in filling out the Health Screening Survey to help us identify members for the Care Management Program.

Regardless of scoring methodology used within the Health Screening Survey, all AlohaCare Advantage Plus members are automatically enrolled into the Care Management Program and assigned a Member Service Navigator. Members may opt-out of the Care Management Program at anytime.

Individual Care Plan (ICP)

AlohaCare utilizes a multidisciplinary team approach in coordinating care among providers, practitioners, ancillary services, community services and other needed resources. The member's PCP should direct all care for the member. The AlohaCare Care Coordinator is responsible for ensuring that the member receives the care directed by the PCP. The Care Coordinator, in consultation with the member (and family/representative, if appropriate and/or as the member wishes), the member's PCP, specialists and other parties involved in the member's care, facilitates the ICP activities and interventions and works as an advocate for the member.

The Member's Individual Care Plan (ICP) is developed in coordination with the member and the member's PCP and other providers of care. Re-evaluation of the ICP will occur according to the level of care to which a member is assigned. All individualized care plans are mailed to the member's PCP and/or Specialist, which includes the contact information of the assigned Care Coordinator. PCPs and/or Specialists should review and make any changes or recommendations necessary.

Providers who wish to discuss a member's Individual Care Plan, call Customer Service at 973-6395 or toll-free at 1-866-973-6395 and ask for Care Management.

Enrollment in Care Management

All newly enrolled members are screened to identify any special health care needs and enrollment into Care Management. As a full-dual eligible beneficiary, all AlohaCare Advantage Plus members are enrolled in Care Management due to the complexity of the care coordination for Medicare and Medicaid benefits.

Medical indicators include but are not limited to:

- Alzheimer's, Dementia
- Asthma
- Hypertension
- Cancer
- Diabetes with complications, newly diagnosed for stabilization
- Leukemia
- Renal failure
- Cerebral vascular diseases, cerebral hemorrhage, stroke
- Chronic Heart Failure
- CNS disorders: MS, CP, quadriplegic, paraplegic, anoxic brain damage, spinal cord injuries
- Coagulation defects
- COPD
- Frequent ED utilization
- Frequent Inpatient admissions and or readmissions
- Post Discharge follow-up
- HIV infection, AIDS
- Multiple trauma victims, multiple fractures, amputations, head injuries
- Chronic neuromuscular diseases
- High utilization of Speech, Occupational, or Physical Therapy
- Terminal illness
- Ventilator dependent

Behavioral Health indicators include but are not limited to:

- 2 or more failed chemical dependency (CD) episodes within 1 month
- 2 or more failed psychiatric hospitalizations in 6 months
- History of violence or abuse
- Non-compliant with treatment plan or service plan
- Deteriorated level of functioning (GAF 30 or under)
- Left inpatient stay against medical advice (AMA)
- Pervasive development disorder (autism, etc.)
- Substance Abuse
- Major depression
- Suicide ideation/attempt

Pharmacy indicators include but are not limited to:

- Atypical psychotics
- Clozaril use
- Opioid chronic use
- History of or current member mismanagement and over utilization of controlled substances
- Polypharmacy – chronic

Activities of daily living/social indicators include but are not limited to:

- Non Compliance
- Frequent Falls
- Transition of Care needs
- Home health needs
- Durable Medical Equipment needs
- Substance Abuse
- Homeless
- Transportation Needs
- Lives alone with no family or caregiver assistance
- No social supports in place
- Translation barriers

Disease Management

AlohaCare has developed a Disease Management (DM) program to address the following chronic diseases and conditions:

- Asthma/COPD
- Diabetes
- Chronic heart failure
- Depression
- High-risk pregnancy

AlohaCare's DM Program is based on the premise that effective disease management:

- Educates members on self-management of their illness
- Supports provider/member relationship and plan of care
- Prevents acute disease exacerbations/episodes and reduce long-term complications of chronic diseases
- Reviews appropriate laboratory testing, physician checks, lifestyle modifications, dietary planning and physical fitness as these are just as important as medication management to the overall well-being of the member with a chronic disease state
- Follows identified best practices, as stated in AlohaCare's Clinical Practice Guidelines for Major Depression, Diabetes, Asthma and Chronic Heart Failure
- Directs the member towards health plan resources in order to maximize access, quality and cost effectiveness of care and minimize the member's potential out of pocket expenses

The main goal of the disease management programs is to assist the member to be able to self-manage his/her disease, thus enhancing healthy living and lowering the use of inpatient and emergency services.

Providers play an important role in our disease management efforts. For members who are not self-managing their chronic disease as evidenced by ER visits, hospitalizations and/or non-compliance with office visits and/or filling medication prescriptions, the PCP and specialist will be asked to work collaboratively with AlohaCare's staff to develop a DM plan. AlohaCare's pharmacist may also consult with the PCP, specialists, and community pharmacist when medications appear to be a problem for the member. In addition, providers will periodically receive educational materials to remind them of clinical best practices.

The PCP, Case Manager or member may make a referral into the Disease Management program whenever there is evidence of a lack of the member's ability to manage the underlying disease.

If you would like to refer a member to the AlohaCare Disease Management Program, you can fax in a referral form to 973-6392 or toll-free at 1-808-973-6392 or call in a referral to AlohaCare.

For more information on how we can assist you with your disease management needs for AlohaCare members, call our Customer Service Department.

SECTION 10: BILLING AND REIMBURSEMENT

Claim Submission

All encounters for AlohaCare members must be submitted as a claim, regardless of whether the services are covered under a capitation or fee-for-service payment arrangement.

Paper claims should be typed or printed legibly. Initial submissions must be on original claim forms; no copied forms are accepted for initial claim submission. Electronic submission of claims can be arranged by contacting AlohaCare's Provider Relations Department.

Mail claims to:

AlohaCare
Claims Department
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

All claims must contain required information and all data must be consistent and valid. Omission of required information will result in a denied claim. Missing information should be provided via claim resubmission.

Filing Deadlines

All claims must be submitted within the AlohaCare filing deadlines, which are set based on Medicare regulations within specific time limits:

- Effective January 1, 2011, claims where AlohaCare is the primary payer must be received within 1 year of the date of service. Claim resubmissions must be received within one year of date of service.
- Third Party Liability (TPL) claims must be received within 1 year from the date of service, with the Explanation of Benefits (EOB) from other insurance carriers attached.
- For facilities billing for inpatient stays, the filing deadline is from date of discharge.
- Exceptions to the filing deadlines will be granted only for unusual circumstances. Requests for waiver of the deadline should be sent with details regarding the circumstances for the filing delay. These requests will be reviewed on a case-by-case basis. These requests should be sent to:

AlohaCare
Attention: Claims Department – Timely Filing
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Resubmissions

If a claim is being resubmitted, it must be clearly marked "RESUBMISSION" and must be received by AlohaCare within one year from the date of service (or date of discharge for facilities resubmitting inpatient claims). Claims resubmitted after one year will generally not be considered for payment. All resubmissions must be submitted on

paper with any corrections or additional information required to reprocess the claim. Any attachments required on the original submission should be sent with the resubmitted claim. To help expedite research and reprocessing, give an explanation regarding the reason for resubmission and attach a copy of the remittance advice with the original claim payment information, mail resubmissions to the AlohaCare Claims Department.

Proper Billing

Claims submitted on the incorrect claim form will not be accepted for processing.

- The CMS 1500 is the standard claim form used to bill professional services, including those of individual practitioner and non-hospital outpatient clinics, and suppliers of medical equipment.
- The UB04 is the standard claim form used to bill institutional or facility claims such as inpatient, outpatient hospital, residential/outpatient treatment centers and skilled nursing facility.

CMS encounter reporting guidelines require reporting of a CPT, HCPCS or modifier code when billing for outpatient services. When there are multiple CPT/HCPCS/modifier codes for the same revenue code, the revenue code must be repeated as a separate line item for each CPT/HCPCS/modifier code, when appropriate. Absence of a valid CPT/HCPCS/modifier code with these revenue codes will result in denial of the line item.

Note: If billing electronically, effective January 1, 2012 you will be required to submit using the 5010 format. If you need information, please go the Medicare site for this project at:
https://www.cms.gov/ICD10/11a_Version_5010.asp.

Procedure and Diagnosis Codes

Current, valid ICD-9, CPT and HCPCS codes and modifiers must be used. A detailed description of the service provided must be included when using “unclassified or unspecified” codes. Prior to using HCPCS temporary (C,Q or S) codes, check with AlohaCare as to our ability to accept these codes and/or discuss alternative coding.

AlohaCare will require the use of ICD-10 codes once the federally mandated implementation date is reached on October 1, 2013. Providers must ensure they are able to bill with these codes at that time. If you need information, please go to the Medicare site for this project at: <https://www.cms.gov/icd10/>.

Coding to the appropriate specificity (using the CPT 4th or 5th digits, depending on the diagnosis) is required, and incomplete codes will not be accepted.

Prior Authorization/Referral Information

When billing for services, the prior authorization/notification or referral number assigned by AlohaCare should be entered on the claim form in order to expedite payment. On the CMS 1500 form, the number should be entered in box 23; on the UB04 form, the number should be entered in box 63.

Claims Review

AlohaCare refers to Medicare guidelines. AlohaCare claims examiners also reference CPT and “National Correct Coding Initiative” guidelines and handbooks and the “Medicare Billing Guide” with regard to bundling/unbundling, global surgical packages and correct modifier use. AlohaCare will deny service lines that are coded inappropriately (example: one of the submitted codes is defined in such as way as it should not be separately reported when submitted with another code on the claim). Such denials are not a determination that the

procedure/service was not medically necessary; it means that according to generally accepted coding practices, the procedure/service should not be coded separately under this circumstance.

Additional types of claims review may be performed for purposes including, but not limited to:

- Determination and verification of medical necessity and appropriateness of billed services
- Confirmation of appropriateness of the place of service and level of care
- Accuracy of coding
- Compliance with Medicare guidelines
- Preparation and analysis of grievance, appeal, and reconsideration cases
- Utilization trending
- Quality Improvement review for data collection
- Review of services performed on emergent or urgent basis without prior authorization
- Investigation of complaints or reports of potential fraud and abuse

Reimbursement

Reimbursement for covered services is determined according to the provider contract. Non-contracted providers are reimbursed at least at a level that the provider would have been entitled to under original Medicare.

Appropriate billing and reimbursement methodology, including but not limited to:

- **Bilateral Surgical Procedures:** When a CPT/HCPCS code describes a unilateral procedure, and the provider performs the service on both sides of the body in the same session, the provider should bill the appropriate unilateral code with modifier “50” for both procedures performed. This should be billed on a single claims line. Payment is made at 150 percent of the applicable fee schedule amount for the unilateral procedure. CPT/HCPCS codes defined as bilateral should not be billed with modifier “50.”
- **Assistant Surgeon Claims:** The assistant surgeon should bill the appropriate procedure code, appending modifier “80.” Payment is made at 20% of the applicable fee scheduled amount for the procedure. AlohaCare follows Medicare guidelines for which procedures are eligible for assistant surgeon reimbursement. The assistant surgeon claims will be denied if the procedure code billed does not match that billed by the primary surgeon, or if there is no primary surgeon’s bill on file. Assistant surgeon’s claims for services provided at a teaching hospital must be submitted with documentation verifying the non availability of a qualified resident. Correct use of modifier “82” is acceptable.
- **Anesthesia:** ASA codes must be used, followed by any applicable anesthesia modifier. All anesthesia claims must be billed with anesthesia time. Reimbursement is calculated on base ASA units plus time units. Indicate anesthesia start and finish time in Box 19.
- **Facility Inpatient Late Charges:** Claims for late charges (bill type 115) will be processed but will not affect payment on claims paid on DRGs or on a per diem basis. Late charges may affect reimbursement of an outlier claim, but in order to be considered the charge must be filed within the claims filing deadline, and the entire claim must be resubmitted for the full service period.
 - If the type of bill is not changed to identify a replacement claim (field 3 digit 7) or void/cancel claim (field 3 digit 8) it is considered a duplicate of the original.

Member Direct Billing

In accordance with the Medicare guidelines, providers cannot bill or make any attempt to collect payment, directly or through a collection agency, from a person claiming to be eligible except in the following circumstances:

- Deductible, copayment and coinsurance.
- Individual was not eligible on date of service.
- No-show fees. Provider shall inform the member in advance of imposing the fee, or the intent to impose such a fee and what the member must do to avoid such assessment.
- Non-covered services were performed. The provider must inform the member of the non-covered status of the service and that the member is responsible for the cost prior to rendering services. Documentation of the member's signed acceptance of payment responsibility should be placed in the member's medical record.
- Member self-referral to a specialist or other provider without following plan procedure. The specialist must inform the member that specialist visits require a referral and that the member is responsible to pay for any services rendered without a referral. Documentation of the member's signed acceptance of payment responsibility should be placed in the member's medical record.

Third Party Liability (TPL)/Coordination of Benefits

After the primary carrier has processed a claim and if AlohaCare is responsible for payment of a portion of health services rendered to the member, the servicing provider must submit the claim to AlohaCare to process. The provider must submit the following information to ensure accurate and timely processing:

- A completed claim form.
- If a facility is billing or where applicable, an itemized bill.
- The matching explanation of benefits (EOB) statement from the insurance carrier who processed the claim as primary carrier.

AlohaCare follows Medicare's Secondary Payer Guidelines:

- St. Anthony's Medicare Secondary Payer: Billing and Reimbursement Guide
- Full text of the National Association of Insurance Commissioners (NAIC) guidelines for Coordination of Benefits and determination of primary/secondary status, Model Regulation 120

AlohaCare will coordinate payment based on Medicare Secondary Payer Guidelines.

Claims denied by the primary carrier, with the exception of claims rejected for eligibility or non-covered services, will require the provider to appeal the primary carrier's initial decision. Documentation of the original denial and results of the appeal will be required before AlohaCare can review for payment.

Benefits Coordination for Motor Vehicle Incidents and Workers Compensation

AlohaCare will recover reimbursements when it is discovered that payment was made for services that should have been billed to another payer.

- Where AlohaCare members have purchased their own motor vehicle insurance, claims should be submitted to the member's motor vehicle insurance carrier. If the member is injured while in a vehicle belonging to another person and that person is insured by a standard motor vehicle insurance policy, bill the vehicle owner's insurance carrier.
- When motor vehicle insurance benefits have been exhausted, a letter from the no-fault carrier indicating that benefits have been exhausted must be attached to the claim. This letter must reference the specific services being billed as non-payable.
- When AlohaCare members are injured while working, claims should be filed with the employer.

Claim Adjustments and Recoveries

When AlohaCare makes an adjustment on a previously paid claim, or recoups a claim that was paid inappropriately, the recovery will appear on the next remittance advice as a negative payment amount. When posting payment of the other claims on the remittance advice, you will need to also post any recoveries as payment reversals in your accounting systems in order for your totals to match the check amount. Also, any cost sharing amount paid by the member that require adjustment, the provider must refund the member of the overpaid cost share.

AlohaCare may recoup any payments for services made to the provider due to member eligibility or TPL adjustments, audit findings that show such payments to be inappropriate or non-covered services. Recoupments based on audit findings may be recovered from a future payment.

Recoupments based on audit findings may be recovered from a future payment after giving the provider a 30-day written notice of the findings or through other repayment arrangements made with the provider.

Pharmacy Claim Submission Standard

The TelePAID System sets pricing, eligibility and other information that must be used by AlohaCare's Participating Pharmacy Network. AlohaCare's participating providers will transmit drug claims with all required fields using the most current NCPDP standards, which are incorporated in Medco Health's Version 5.1 Payer Sheet.

Pharmacies must submit all claims through the TelePAID System and will comply with all information communicated via the TelePAID System or otherwise by AlohaCare and/or Medco. Refer to your Medco Pharmacy Services Manual for further details.

Improving Claim Submissions/Correcting Common Errors

Use the correct ID number

Errors seen:

- Using the ID number of another family member
- Member ID number with additional or missing numerals

How to prevent errors:

- Copy the number carefully from the member ID card

Validate date of birth

Errors seen:

- Member's date of birth does not match the information we have on record, provided to AlohaCare by the member

How to prevent errors:

- When possible, request additional ID to verify member identity
- Call AlohaCare for assistance in correcting any inaccurate information

Use valid and current ICD-9 diagnosis codes, revenue codes, CPT and HCPCS procedure codes

Errors seen:

- Missing or incomplete procedure, revenue, or diagnosis (i.e. 4th or 5th digit, when required) codes
- Using deleted/expired or invalid codes for date of service
- Using temporary codes not accepted by AlohaCare
- Using NDC codes without current CPT or HCPCS code

How to prevent errors:

- Include diagnosis, procedure, and revenue codes where required
- Use current ICD-9 diagnosis codes, CPT and HCPCS procedure codes and revenue codes

Submit claims only for eligible members

Errors seen:

- Services rendered after member's disenrollment date
- Services rendered during break in member's coverage
- Claims submitted for members that are not enrolled in AlohaCare

How to prevent errors:

- Ask member for the AlohaCare ID card
- Call the AlohaCare Customer Service Department or check eligibility on AC Online.

Submit original claims within the filing deadline (one year from the date of service)

Errors seen:

- Claims that appear to be original submissions are submitted past the filing deadline

How to prevent claim denials:

- Submit claims within the filing deadline.
- If submitting a follow-up or corrected claim, include documentation of previous submissions and indicate "RESUBMISSION" on claim form

Provide applicable CPT or HCPCS codes for selected revenue codes

Errors seen:

- Revenue codes are submitted without applicable CPT, HCPCS or modifier code describing the service or item provided

- Revenue codes are submitted with a procedure code that does not match the revenue code category (e.g. CPT procedure code billed with Supplies revenue code)

How to prevent errors:

- Review list of revenue codes that require CPT/HCPCS codes
- Match up CPT/HCPCS codes with the applicable revenue code
- Use current, valid CPT, HCPCS and revenue codes

Incomplete box 10, box 11 and box 14 of the CMS 1500 claim form

Errors seen:

- Claims related to accidents, with box 10, box 11 and/or box 14 left blank on the CMS 1500 claim form

How to prevent errors:

- Always complete box 10, box 11 and box 14 on the CMS 1500 claim form when billing for accident-related services. If the box does not apply, indicate 'none'.

Provide complete accident information for accident claims when billing accident-related services on a UB04 form

Errors seen:

- Accident occurrence codes are used but no accident diagnosis code given
- Accident diagnosis code used but no accident occurrence code given
- Wrong accident occurrence codes are used to describe accident

How to prevent errors:

- Use appropriate E codes whenever an accident occurrence code is used (01-05)
- Review UB-04 processing manual to be sure the correct definitions are associated with usage of the occurrence codes

Attachments missing

Errors seen:

- Explanation of Benefits missing on claims where there is primary payor

How to prevent errors:

- Attach Explanation of Benefits to TPL claims

Anesthesia

Errors seen:

- Start and end time not reported
- Missing or invalid ASA codes

How to prevent errors:

- Report start and end time
- Always report the total number of minutes in box 24G
- Bill with valid ASA codes

Charge amount discrepancies

Errors seen:

- Service line charges do not match total charge

How to prevent errors:

- Carefully check that the total amount showing on the claim matches the total of the service line charges
- When billing multi-page claims, indicate 'continue' in box 28 and indicate the total amount on the last page

Other claims tips

Avoid duplicate claim submissions. Contact our Customer Service Department or use AC Online to check on the status of your claim. Duplicate claim submissions slow down claims processing by adding unnecessary volume. Additionally, state and federal auditors have identified duplicate claims submission as a trigger for fraud and abuse investigations (see Fraud and Abuse section of this manual for further details).

If you do not understand a claims denial, or have received multiple denials, contact our Customer Service Department for assistance. Continuing to resubmit a claim without correcting the specific error causing the denial may cause further delay in processing the claim.

SECTION 11: MEMBER APPEALS AND GRIEVANCES

In the Evidence of Coverage (EOC) booklet issued to our members, details are provided about their grievance and appeal rights along with the corresponding processes. A link to the EOC documents can be found in the member section of AlohaCare's website. Additionally copies of AlohaCare's member grievance and appeal policies and procedures are available upon request. AlohaCare provides assistance to members in filing appeals or grievances, including interpreter services, alternate formats and access for TTY users.

Member Appeals

What is an appeal?

If a health care service or a prescription drug is denied, a claim for a service or drug is denied or if AlohaCare fails to provide members with a timely decision about covering a service or a prescription drug, members have the right to file an appeal in writing. If the denial could jeopardize their health status, they may request an expedited appeal by phone or fax.

The first level of an appeal is conducted by the plan's health care professionals and physicians. AlohaCare must gather information and make a determination within a 30-day time period, or within 72 hours for expedited appeals. Time extensions are possible. Claim payments are decided within 60 days.

If AlohaCare upholds its initial denial, we send the appeal automatically to Medicare's independent review contractor. If the independent reviewer agrees with AlohaCare's denial, members have the same rights to all federal levels of appeals and judicial review as do beneficiaries in Original Medicare.

How a member appeal is filed

Members, their doctor or an appointed representative may request an appeal, standard or expedited, by contacting AlohaCare verbally or in writing. Requests may be made by a family member, friend or other party, on the members' behalf, if the individual demonstrates legal authority to do so. As an example, a medical power of attorney will be accepted or other similar document. Another way for the member to delegate this authority is by submitting a signed Appointment of Representative form to us.

Written appeals are sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Members, personal representatives or other authorized representatives may call the Customer Service Department and we will assist the member in filing the written appeal.

Grievances

What is a grievance?

A grievance is any dispute (other than one that involves an organization or coverage determination or payment) that expresses dissatisfaction with the operations, activities or behavior of AlohaCare. This could include complaints about our customer service hours, about a network provider (including a pharmacy provider), having to wait too long for medical or prescription drug services or quality of care. For quality of care complaints, in addition to using the grievance process, members can contact an independent review organization called a Quality Improvement Organization (QIO).

A member or the member's representative ("legally authorized representative" or "appointed representative") has the option to file a grievance either orally or in writing when expressing dissatisfaction about AlohaCare, delegated entity or provider no later than sixty (60) calendar days after the event or incident that initiated the grievance.

Expedited grievances can be filed if AlohaCare refused to expedite an organization or coverage determination or appeal, or invoked an extension to an organization or coverage determination or appeal time frame.

How a member grievance is filed

Written grievances are sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Members, personal representatives or other authorized representatives may call the Customer Service Department and we will assist the member in filing the grievance. A provider or other individual calling to file an oral grievance on behalf of the member must provide written or verbal authorization from the member. Member's written authorization should be faxed or mailed to the Grievance Coordinator. Staff receiving the grievance will document the issue and forward it to the grievance coordinator on the member's behalf.

How a member grievance is resolved

AlohaCare renders a resolution of the grievance within thirty (30) calendar days of the receipt date. AlohaCare takes into account all documents, records or other information submitted by the provider rendering the service relating to the case. A letter of resolution is mailed by the Grievance Coordinator to the grievant and copies are sent to all parties whose interest has been affected by the decision. If the grievance was concerning a quality of care issue, the resolution letter explains the member's right to file a written quality of care grievance with the Quality Improvement Organization (QIO):

Mountain-Pacific Quality Health Foundation
1360 S Beretania St., Suite 501
Honolulu, HI 96814
(808) 545-2550

AlohaCare renders a resolution of an expedited grievance within twenty-four (24) hours of receipt. AlohaCare takes into account all documents, records or other information submitted by the provider rendering the service relating to the case. A verbal resolution is given to the member and provider the twenty-four (24) hours resolution timeframe. Within seventy-two (72) hours of the verbal resolution a letter of resolution is mailed by the Grievance Coordinator to the grievant and copies are sent to all parties whose interest has been affected by the decision.

SECTION 12: PROVIDER COMPLAINTS, GRIEVANCES AND APPEALS

AlohaCare's complete policies and procedures for Provider Complaints, Grievances and Appeals are available upon request.

Inquiries

Providers are encouraged to call the Customer Service Department at 973-6395 or toll-free at 1-866-973-6395 for any inquiry, question or request for assistance regarding any aspect of AlohaCare's operations. If during the contact the provider expresses dissatisfaction of any kind, the inquiry becomes an expression of dissatisfaction and becomes a complaint or grievance.

Complaints

A provider, either contracted or non-contracted, has the right to file a complaint if they are dissatisfied with any aspect of AlohaCare's operations or staff behavior. Examples might include,

- Benefits and limits, for example, limits on behavioral health services or formulary
- Eligibility and enrollment, for example, inability to confirm enrollment or identify the PCP
- Member issues, including members who fail to meet appointments or do not call for cancellations; instances in which the interaction with the member is not satisfactory; instances in which the member is rude or unfriendly; or other member-related concerns
- Health plan issues, including difficulty contacting the health plan or its subcontractors due to long wait times or busy lines; problems with AlohaCare's staff behavior; delays in claims payments; denial of claims; claims not paid correctly; or other health plan issues

Written complaints can be sent to:

AlohaCare
Attention: Customer Service Department
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Verbal complaints may be made by calling the Customer Service Department to explain the problem or concern. Complaints are usually addressed by the staff member who receives them within 24 hours. If the complaint cannot be resolved in 24 hours, or if the provider is not satisfied with the resolution of the complaint, it is escalated to a grievance.

Grievances

Providers may file a grievance with AlohaCare if they are unhappy with any aspect of AlohaCare's operations activities, or behavior pertaining to issues such as:

- Availability of service

- Delivery of service
- Quality of service
- Any issue not resolved to the provider's satisfaction at the complaint level
- Provider requests complaint of any type to be dealt with at the grievance level

All grievances must be filed no later than sixty (60) calendar days after the event or incident that initiated the grievance.

How to file a grievance

Written grievances should be sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Verbal grievances may be made by calling the Customer Service Department to explain the problem or concern. Staff receiving the grievance will document the issue and forward it to the grievance coordinator on the provider's behalf.

How the grievance is resolved

Within ten (10) calendar days of the receipt date, the grievant is informed by letter that the grievance has been received. The acknowledgment letter includes any action taken and the due date of the resolution. A copy of the acknowledgment is mailed by the Grievance Coordinator to all parties whose interest has been affected by the grievance.

AlohaCare renders a resolution of the grievance within thirty (30) calendar days of the receipt date. AlohaCare takes into account all documents, records, or other information submitted by the provider rendering the service relating to the case. A letter of resolution is mailed by the Grievance Coordinator to the grievant and copies are sent to all parties whose interest has been affected by the decision.

Appeals

If a provider disagrees with AlohaCare's denial of health care service or a prescription drug, denial of a claim for a service or drug or if AlohaCare fails to provide a member with a timely decision about whether we will cover a service or a prescription drug, the provider may file an appeal on behalf of the member. If the denial could jeopardize the member's health status, they may request an expedited appeal by phone or fax.

AlohaCare will handle provider appeals of denial or delays in service as member appeals (refer to Section 11: Member Appeals and Grievances).

All appeals must be filed in writing within sixty (60) calendar days after receipt of AlohaCare's decision.

How to file an appeal

Written appeals should be sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Verbal appeals may be made by calling the Customer Service Department to explain the problem or concern. Staff receiving the appeal will document the issue and forward it to the grievance coordinator on the provider's behalf.

Disagreement with the denial of a claim, in whole or in part

AlohaCare renders a decision of the appeal within sixty (60) calendar days of the receipt date. AlohaCare takes into account all documents, records or other information submitted by the provider rendering the service relating to the case. A letter of resolution is mailed by the Grievance Coordinator to the appellant and copies are sent to all parties whose interest has been affected by the decision.

Non-contracted provider appeal

The non-contracted provider appeal process is different from the contracted provider appeal process. If AlohaCare denies a request for payment from a non-contracted provider, the provider has the right to appeal. If he/she is appealing on his or her behalf, the Grievance Coordinator notifies the non-contracted provider of the specific reason for the denial and provides a description of the appeals process. The Grievance Coordinator also explains that in the event that the non-contracted provider wishes to appeal, the non-contracted provider is required to sign a waiver of liability statement.

Expedited Appeals

An expedited appeal shall be authorized if the application of the standard review time frame may:

- Seriously jeopardize the life or health of the member;
- Seriously jeopardize the member's ability to attain, maintain or regain maximum functioning; or
- Subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the expedited appeal.

The appropriate review will be completed within seventy-two (72) hours of receipt of the request.

Please do not indicate "expedited" on a request that does not meet the criteria stated above. Other types of "rush" requests will be accommodated by AlohaCare when possible.

How to file an expedited grievance or appeal

Written expedited grievances or appeals should be mailed or faxed to:

AlohaCare
Attention: Expedited Appeal Request
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814
Fax: 973-2140

Providers may also call the Customer Service Department to assist in filing the expedited appeal. Specifically indicate that you are requesting an expedited appeal and provide details regarding the criteria above.

No punitive action is taken against any provider who file grievances, appeals, expedited grievances or who supports a member's appeal or expedited appeal.

A provider has the right to appeal an action taken by AlohaCare related to his or her status in the provider network or an action related to the provider's professional competency or conduct. The issues involved in the dispute may include, but are not limited to:

- Failure to adhere to AlohaCare's policies and procedures
- Providing and ordering health care services not in compliance with generally accepted standards of practice
- Practice patterns falling outside of accepted norms
- Professional conduct or competence which may be detrimental to a member's health and safety or to AlohaCare's reputation

AlohaCare sends the provider a letter via certified mail which states,

- That a professional review action has been proposed to be taken against the provider and the reasons for the action
- That the provider has the right to file a grievance and request a timely hearing regarding the proposed action, and that the provider must request the hearing within thirty (30) days of receipt of the notice of the action

If the provider does request a hearing in a timely manner, AlohaCare's Medical Director will convene a peer review panel to review the appeal. Each panel consists of three qualified individuals of which one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider who has filed the dispute. A hearing is scheduled and notice is given, stating:

- The place, time, and date of the hearing, which is not less than thirty (30) days after the hearing notice, unless AlohaCare and the provider agree that an extension is warranted
- A list of witnesses, if any, expected to testify to the peer review panel

The right to the peer review hearing may be forfeited if the provider fails, without good cause, to appear.

At the hearing, the provider has the right to:

- Be represented by an attorney or any other person the provider chooses
- Have a record made of the proceedings and receive copies of the record upon payment of any reasonable charges associated with their preparation
- Call, examine and cross-examine witnesses
- Present evidence determined to be relevant by the hearing officer, arbitrator or panel, regardless of its admissibility in a court of law
- Submit a written statement at the close of the hearing

Upon completion of the peer review panel's hearing, the provider has the right to receive, via certified mail:

- The written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations
- A written decision from AlohaCare, including a statement of the basis for the decision

SECTION 13: QUALITY IMPROVEMENT

AlohaCare's Quality and Performance Improvement Program (QPIP) supports the mission, vision, values and corporate culture of AlohaCare by promoting the systematic measurement, monitoring and improvement of aspects of clinical care and services that are important to the members we serve and to the provider community that partners with us in serving these members.

Goals

AlohaCare's overall strategic direction is established by the Board of Directors. The key Board strategic goals of the QPIP are,

- Improve clinical quality outcomes in partnership with AlohaCare's provider network
- Assure a service-oriented health care system that is provider and member-sensitive

Objectives

The objectives of the QPIP are to:

1. Establish and maintain standards for quality of care and service
2. Monitor the performance of network providers in providing quality and access to care through the use of clinical indicators, member satisfaction and complaint data, utilization data and other sources to identify and respond to opportunities for improvement, to assure that:
 - Appropriately needed care is available
 - Medically necessary services are provided in the most appropriate setting and in accordance with recognized standards of care
 - Services are provided in a timely manner with reasonable waiting times for office visits and the scheduling of appointments
 - Services comply with standards of cultural and linguistic competency and that language assistance is available as needed
 - Members are made aware of the availability of transportation and translation services and are assisted when such services are needed
3. Identify, review and investigate potential clinical quality issues and take corrective action where appropriate
4. Monitor and address potential over- and under-utilization of services
5. Assure that members and providers have a means by which they may seek resolution of perceived failure by providers or AlohaCare personnel to provide appropriate health care services, access to care or quality of care
6. Achieve high provider and member satisfaction regarding quality of service, clinical quality, utilization management and disease management

7. Coordinate quality improvement activities with utilization review, disease management, care management, preventive services, pharmacy, behavioral health, health education, provider relations, credentialing and information systems and other relevant activities to involve all functional areas of the company in the quality improvement process (see also the AlohaCare Utilization Management and Disease Management Program Description)
8. Collaborate with community and network providers including Community Health Centers, medical groups, public health organizations, health educators and others to provide systematized, planned processes to improve the health of our members

QPIP Activities

The key activities conducted by AlohaCare in support of the QPIP include,

1. Monitoring and analyzing key indicators of performance to identify opportunities for improvement, including but not limited to:
 - Access and Availability: Provider availability (access to appointments and after-hours care), network adequacy and AlohaCare telephone accessibility
 - Provision of medically necessary and appropriate services, including under- and over-utilization: HEDIS® measures, utilization management reports, pharmacy utilization reports
 - Member Satisfaction, Rights and Responsibilities: inquiries, complaints, grievances and appeals; member satisfaction surveys (e.g. CAHPS)
 - Provider Feedback: provider complaints, grievances and appeals; provider satisfaction surveys, provider relations reports, advisory committee feedback
 - Organizational Performance: Claims processing timeliness and accuracy, enrollment timeliness and accuracy, credentialing timeliness
2. Conducting Performance Improvement Projects (PIPs) as identified in the annual Workplan (refer to Quality Improvement Study Development Policy)
3. Developing and maintaining standards of clinical practice, including clinical practice guidelines (refer to Clinical Practice Guideline Development Policy)
4. Investigating and resolving potential quality of care issues identified from any source (refer to Clinical Quality Issues Referral Process Policy)
5. Receiving, investigating, and resolving member or provider complaints, grievances and appeals (refer to policies on member and provider grievances and appeals)
6. Conducting medical record reviews to assure appropriate record keeping and delivery of key services (refer to Medical Record Keeping Policy)
7. Assuring the competency and performance of AlohaCare's provider network (refer to Provider Credentialing and Recredentialing Policy)

8. Coordinating with utilization management and disease management activities to assure that members receive coordinated care in the most appropriate setting (Refer to AlohaCare's Utilization Management and Disease Management Program Description)
9. Reviewing reports and recommendations from the Quality Improvement Organization (QIO) for Medicare
10. Monitoring AlohaCare employee satisfaction and engagement through employee forums, satisfaction surveys, and exit interview evaluations

Quality Improvement Oversight

The Board of Directors of AlohaCare approves the Quality and Performance Improvement Program and also monitors the programs' effectiveness. The Board of Directors delegates the authority for the operational implementation and accountability for these programs to the AlohaCare CEO, Medical Director and the Quality Improvement Advisory Committee (QIAC) which is comprised of AlohaCare network health care providers including PCPs, Specialists and Behavioral Health practitioners and AlohaCare senior staff.

The structure of the Quality and Performance Improvement Program is designed to promote organizational accountability, responsibility, and authority in the identification, evaluation and correction of quality of care problems and organizational areas needing improvement. This involves extensive participation of advisory committees, AlohaCare staff and network providers.

The Committees that participate in implementing and conducting AlohaCare's QAPI Program are:

- **Corporate Quality Improvement Committee (CQIC)** Comprised of AlohaCare's CEO and Senior Staff, this committee approves policy and procedures and process coordination of the QAPI Program.
- **Quality Improvement Advisory Committee (QIAC)** Responsible for assessing the status and progress of all QAPI Program efforts. The QIAC is responsible for recommending and/or monitoring of information and trends for conformance with standards and criteria for delivering of care and service. The QIAC reviews outcome studies and recommends action based upon results.
- **Pharmacy and Therapeutics Subcommittee (P&T)** Provides a forum for provider input on the cost effectiveness, medical efficacy and therapeutic benefit of drug therapies, diagnostic technologies and other treatment interventions. The committee makes recommendations regarding the AlohaCare Formulary and use of diagnostic and treatment technologies.
- **Grievance Committee** AlohaCare staff-only committee, responsible for reviewing member and provider complaints and making reports and recommendations to the QIAC.
- **Credentials Committee** Responsible for the review and assessment of provider applications to join AlohaCare's network, and establishes that each network provider is qualified by training, experience, and performance consistent with the standards established by the AlohaCare Provider Credentials Policy.

Appendix A

2012 AlohaCare Advantage and AlohaCare Advantage Plus Benefits

Benefits change on January 1 of each year. The information below is taken from the Summary of Benefits. All covered benefits listed are for in-network providers. Authorization rules may apply.

The current Summary of Benefits document is available on our website at www.AlohaCare.org.

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
Premium and Other Important Information	\$0 monthly plan premium in addition to the Medicare Part B premium. \$3,400 out-of-pocket limit.	\$0 monthly plan premium in addition to the monthly Medicare Part B premium.* \$6,700 out-of-pocket limit.
Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	For Medicare-covered hospital stays: Days 1 - 10: \$220 copay per day Days 11 - 90: \$0 copay per day Cost per lifetime reserve day: Days 1 - 60: \$0 copay per day Except in an emergency, providers must tell the plan that the member is going to be admitted to the hospital.	The amounts for each benefit period are \$0 or: Days 1 – 60: \$1156 deductible* Days 61 – 90: \$289 per day* Days 91 – 150: \$578 per lifetime reserve day* Except in an emergency, providers must tell the plan that the member is going to be admitted to the hospital.
Inpatient Mental Health Care	For Medicare-covered hospital stays: Days 1 – 10: \$118 copay per day Days 11 – 90: \$0 copay per day Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days 1 – 60: \$0 copay per day Except in an emergency, providers must tell the plan that the member is going to be admitted to the hospital.	The amounts for each benefit period are \$0 or: Days 1 – 60: \$1156 deductible* Days 61 – 90: \$289 per day* Days 91 – 150: \$578 per lifetime reserve day* Except in an emergency, providers must tell the plan that the member is going to be admitted to the hospital.

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
Skilled Nursing Facility (SNF) (In a Medicare-certified skilled nursing facility)	No prior hospital stay is required. For SNF stays: Days 1 – 10: \$90 copay per day Days 11 – 100: \$0 copay per day	No prior hospital stay is required. The amounts for each benefit period are: \$0 or Days 1 – 20: \$0 per day* Days 21 – 100: \$144.50 per day*
Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay for Medicare-covered home health visits.	\$0 copay for Medicare-covered home health visits.*
Hospice	Members must get care from a Medicare-certified hospice.	Members must get care from a Medicare-certified hospice.
Doctor Office Visits	\$2 copay for each primary care doctor visit for Medicare-covered benefits. \$20 copay for each specialist visit for Medicare-covered benefits.	0% or 20% of the cost for each primary care doctor visit for Medicare-covered benefits.* 0% or 20% of the cost for each specialist visit for Medicare-covered benefits.*
Chiropractic Services	\$20 copay for each Medicare-covered visit.	0% or 20% of the cost for each Medicare-covered visit.
Podiatry Services	\$30 copay [or 25% of the cost] for each Medicare-covered visit.	0% or 20% of the cost for each Medicare-covered visit.* 0% of the cost for up to 8 supplemental routine visit(s) every year.

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
Outpatient Mental Health Care	<p>\$35 copay for each Medicare-covered individual therapy visit.</p> <p>\$35 copay for each Medicare-covered group therapy visit.</p> <p>\$35 copay for each Medicare-covered individual therapy visit with a psychiatrist.</p> <p>\$35 copay for each Medicare-covered group therapy visit with a psychiatrist.</p> <p>25% of the cost for Medicare-covered partial hospitalization program services.</p>	<p>0% or 40% of the cost for each Medicare-covered individual therapy visit.*</p> <p>0% or 40% of the cost for each Medicare-covered group therapy visit*</p> <p>0% or 40% of the cost for each Medicare-covered individual therapy visit with a psychiatrist*</p> <p>0% or 40% of the cost for each Medicare-covered group therapy visit with a psychiatrist*</p> <p>0% or 40% of the cost for Medicare-covered partial hospitalization program services*</p>
Outpatient Substance Abuse Care	<p>\$35 copay for Medicare-covered individual visits.</p> <p>\$35 copay for Medicare-covered group visits.</p>	<p>0% or 20% of the cost for Medicare-covered individual therapy visits.*</p> <p>0% or 20% of the cost for Medicare-covered group visits.*</p>
Outpatient Services/Surgery	<p>25% of the cost for each Medicare-covered ambulatory surgical center visit.</p> <p>25% of the cost for each Medicare-covered outpatient hospital facility visit.</p>	<p>0% or 20% of the cost for each Medicare-covered ambulatory surgical center visit.*</p> <p>0% or 20% of the cost for each Medicare-covered outpatient hospital facility visit.*</p>
Ambulance Services (Medically necessary ambulance services)	<p>25% of the cost for Medicare-covered ambulance benefits.</p>	<p>0% or 20% of the cost for Medicare-covered ambulance benefits.*</p>

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
<p>Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>\$0 to \$50 copay for Medicare-covered emergency room visits.</p> <p>\$1,000 limit for emergency services outside the U.S. every year.</p> <p>If the member is admitted to the hospital within 3-day(s) for the same condition, the member pays \$0 for the emergency visit.</p>	<p>0% or 20% of the cost (up to \$65) for Medicare-covered emergency room visits.*</p> <p>\$1,000 limit for emergency services outside the U.S. every year.</p> <p>If the member is admitted to the hospital within 3-day(s) for the same condition, the member pays \$0 for the emergency visit.</p>
<p>Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>\$30 copay for Medicare-covered urgently needed care visits.</p>	<p>0% or 20% of the cost for Medicare-covered urgently needed care visits.*</p>
<p>Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/Psychological Services, and more)</p>	<p>\$30 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p>	<p>0% or 20% of the cost for Medicare-covered Occupational Therapy visits.*</p> <p>0% or 20% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits.*</p>
<p>Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)</p>	<p>20% of the cost for Medicare-covered items.</p>	<p>0% or 20% of the cost for Medicare-covered items.*</p>
<p>Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)</p>	<p>25% of the cost for Medicare-covered items.</p>	<p>0% or 20% of the cost for Medicare-covered items.*</p>

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
<p>Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)</p>	<p>\$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>25% of the cost for Diabetes supplies.</p>	<p>\$0 copay for Diabetes self-management training.*</p> <p>0% or 20% of the cost for Diabetes monitoring supplies*</p> <p>0% or 20% of the cost for Therapeutic shoes or inserts*</p>
<p>Diagnostic Tests, X-Rays, and Lab Services, and Radiology Services</p>	<p>0% of the cost for Medicare-covered lab services.</p> <p>0% to 25% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>25% of the cost for Medicare-covered X-rays.</p> <p>25% of the cost for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>If the doctor provides services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$2 to \$20 may apply.</p> <p>If the doctor provides services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$2 to \$20 may apply.</p>	<p>0% of the cost for Medicare-covered lab services.*</p> <p>0% or 0% to 20% of the cost for Medicare-covered diagnostic procedures and tests.*</p> <p>0% or 20% of the cost for Medicare-covered X-rays.*</p> <p>0% or 20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays).*</p> <p>0% or 20% of the cost for Medicare-covered therapeutic radiology services.*</p> <p>If the doctor provides services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of 0% or 20% of the cost may apply*</p> <p>If the doctor provides services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of 0% or 20% of the cost may apply*</p>
<p>Cardiac and Pulmonary</p>	<p>25% of the cost for Medicare-</p>	<p>0% or 20% of the cost for</p>

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
Rehabilitation Services	covered Cardiac Rehabilitation Services 25% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services 25% of the cost for Medicare-covered Pulmonary Rehabilitation Services	Medicare-covered Cardiac Rehabilitation Services* 0% or 20% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services* 0% or 20% of the cost for Medicare-covered Pulmonary Rehabilitation Services*
Preventive Services and Wellness/Education Programs	\$0 copay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test • Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual • Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) 	\$0 copay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test • Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual • Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
	<p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>The plan covers the following supplemental education/ wellness programs:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters 	<p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>The plan covers the following supplemental education/ wellness programs:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Health Club Membership/ Fitness Classes
Kidney Disease and Conditions	<p>20% of the cost for renal dialysis.</p> <p>\$0 copay for kidney disease education services.</p>	<p>0% or 20% of the cost for renal dialysis*</p> <p>\$0 copay for kidney disease education services*</p>
Prescription Drugs	<p>Drugs covered under Medicare Part B 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs covered under Medicare Part D \$0 deductible</p> <p>Initial Coverage Members pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$4 copay for a one-month (30- 	<p>Drugs covered under Medicare Part B \$0 yearly deductible for Part B-covered drugs.*</p> <p>0% or 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.*</p> <p>Drugs covered under Medicare Part D \$0 deductible</p> <p>Initial Coverage Depending on the member's income and institutional status, the member pays the following:</p> <p>For generic drugs (including brand</p>

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
	<p>day) supply of drugs in this tier</p> <ul style="list-style-type: none"> • \$12 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$7 copay for a one-month (30-day) supply of drugs in this tier • \$21 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$40 copay for a one-month (30-day) supply of drugs in this tier • \$120 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$80 copay for a one-month (30-day) supply of drugs in this tier • \$240 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 5: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier <p>Long Term Care Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$4 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$7 copay for a one-month (31-day) supply of drugs in this tier 	<p>drugs treated as generic), either:</p> <ul style="list-style-type: none"> • A \$0 copay or • A \$1.10 copay or • A \$2.60 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> • A \$0 copay or • A \$3.30 copay or • A \$6.50 copay <p>Retail Pharmacy</p> <p>Members can get drugs the following way(s):</p> <ul style="list-style-type: none"> • one-month (30-day) supply • three-month (90-day) supply <p>Long Term Care Pharmacy</p> <p>Members can get drugs the following way(s):</p> <ul style="list-style-type: none"> • one-month (31-day) supply <p>Catastrophic Coverage</p> <p>After the member's yearly out-of-pocket drug costs reach \$4,700, they pay a \$0 copay.</p>

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
	<p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$40 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$80 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 5: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Coverage Gap After the member's total yearly drug costs reach \$2,930, the member receives a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs, until the yearly out-of-pocket drug costs reach \$4,700.</p> <p>Catastrophic Coverage After the member's yearly out-of-pocket drug costs reach \$4,700, the pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance • A \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs 	
Dental Services	<p>In general, preventive dental benefits (such as cleaning) not covered.</p> <p>25% of the cost for Medicare-</p>	<p>In general, preventive dental benefits (such as cleaning) not covered.</p> <p>0% or 20% of the cost for</p>

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
Hearing Services	<p>covered dental benefits.</p> <p>\$0 copay for up to 1 hearing aid(s) every year.</p> <p>\$30 copay for Medicare-covered diagnostic hearing exams.</p> <p>\$30 copay for up to 1 supplemental routine hearing exam(s) every year.</p> <p>\$30 copay for up to 1 hearing aid fitting-evaluation(s) every year.</p> <p>\$500 plan coverage limit for hearing aids every year</p>	<p>Medicare-covered dental benefits.*</p> <p>In general, supplemental routine hearing exams and hearing aids not covered.</p> <p>0% or 20% of the cost for Medicare-covered diagnostic hearing exams.*</p>
Vision Services	<p>\$0 copay for</p> <ul style="list-style-type: none"> • one pair of eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of glasses every year 	<p>Non-Medicare-covered eye exams and glasses not covered.</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.*</p>

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Benefit Description	AlohaCare Advantage	AlohaCare Advantage Plus
	<ul style="list-style-type: none"> • up to 12 pair(s) of contacts every year • up to 1 pair(s) of lenses every year <p>0% to 25% of the cost for exams to diagnose and treat diseases and conditions of the eye</p> <p>\$25 copay for up to 1 supplemental routine eye exam(s) every year</p> <p>\$100 plan coverage limit for eye wear every year</p>	<p>0% or 0% to 20% of the cost for exams to diagnose and treat diseases and conditions of the eye.*</p>
Over-the-counter items	The plan does not cover Over-the-Counter items.	The plan does not cover Over-the-Counter items.
Transportation (Routine)	This plan does not cover supplemental routine transportation.	This plan does not cover routine transportation.
Acupuncture	\$25 copay per visit up to 3 visit(s) every year.	\$0 copay per visit up to 12 visit(s) every year.

*As a full benefit Medicaid beneficiary, medical cost sharing is covered by the QExA program

Appendix B

Prior Authorization, Notification and Registration Matrix

Procedure	
PA = Prior Authorization N = Notification R = Registration	
Ambulatory/Outpatient Surgical Procedures (billing location other than "office") Except for Services Listed on the PA Fact Sheet Below.	PA
Chemotherapy	N
Dialysis	N
DME Rentals	PA
Emergency Inpatient Stay	N
Home Health Services	PA
Home IV Therapy and Injectibles	PA
Hospice	N
Hyperbaric Oxygen Therapy	PA
Hysterectomy with DHS 1145 Form	PA
Lodging	PA
Meals	PA
MRI & MRA	PA
Non-Emergent Inpatient Stays including Elective Surgeries and Inpatient Rehabilitation	PA (prior) and N (at admission)
Non-Formulary Medications	PA
Observation Stays	N
Occupational Therapy	PA
Out-of-State Referrals	PA
PET Scans (Brain Only)	PA
Physical Therapy (Aqua Therapy)	PA
Purchased DME, Prosthetic and Orthotics items if on the list	PA
PUVA Therapy	PA
Radiation Therapy	N
Sleep Studies	PA
Speech Therapy	PA
Sterilizations with DHS 1146 Form	PA
Telemedicine Services	PA
Translation Services	N
Transportation, Air and Ground (non-emergent)	PA

Behavior Health Services	
Acute Inpatient Admissions	PA
Behavior Health Inpatient & Chemical Dependency Treatment	PA
Behavior Health Outpatient Therapy No prior authorization is required for outpatient psychotherapy services rendered by in-network Psychiatrists and Advance Practice Registered Nurses (APRNs) with prescriptive authority after the initial 15 hours of service are rendered.) Prior Authorization will commence if medically necessary services that exceed the initial 15 hours are required by submitting the Mental Health (MH) Outpatient and/or Chemical Dependency (CD) Treatment Plan prior to the 16 th hour of service.	No PA for initial 15 hours of service
Electroconvulsive therapy (ECT)	PA
Facility Based Services (e.g., IOP, LIOP, day treatment)	PA
Individual psychotherapy sessions in excess of 1 hour per day (CPT codes: 90808, 90809, 90814, and 90815)	PA
Initial Diagnostic Assessment/Evaluation The initial diagnostic assessment /evaluation is counted in the initial 15 hours with no PA.	No PA for initial 15 hours of service
Medical Management Services	N
Neuropsychological Testing	PA
Psychological Testing	PA
Substance Abuse Treatment	PA

Prior Authorization Fact Sheet

<p>Amputations</p> <p>No prior authorization required. AlohaCare encourages providers to contact the Care Management Department to assist with transitioning the member smoothly back to the home setting.</p>
<p>Breast Excision, Biopsies and Mastectomies</p> <p>No prior authorization required. Please note that all prophylactic mastectomies and mastectomies for gynecomastia require a prior authorization.</p>
<p>Cervical Cerclage</p> <p>No prior authorization required.</p>
<p>Colonoscopy and Sigmoidoscopy</p> <p>No prior authorization required. AlohaCare encourages providers to contact the Care Management department with any abnormal findings so that the Case Manager can assist you in care managing the member.</p>

<p>Diagnostic D&C</p> <p>No prior authorization required.</p>
<p>Eye surgeries</p> <p>No prior authorization required. Please note that ptosis of the eyelids; pterygium and adult strabismus will continue to require a prior authorization.</p>
<p>Fractures and Removal of Hardware</p> <p>No prior authorization required.</p>
<p>Heart surgery</p> <p>Heart surgeries (including vessels) do not require a prior authorization. Please note that any procedure coded as “unlisted” need a prior authorization. Inpatient procedures continue to require notification via the hospital inpatient face sheet.</p>
<p>Hernias</p> <p>No prior authorization required.</p>
<p>Imaging Services (MRI’s and MRA’s of the Brain, Head, and Neck)</p> <p>Code range 70540-70553 do not require prior authorization; all other MRI’s and MRA’s need prior authorization.</p>
<p>LEEPs and Colposcopies</p> <p>No prior authorization required.</p>
<p>Removal of Stents</p> <p>No prior authorization required.</p>
<p>Behavioral Health Services</p> <p>Prior authorization will commence if determined that an AlohaCare patient requires medically necessary outpatient services that exceed the initial 15 hours of service (without PA).</p> <p>Diagnostic Interview (90801): Always counted as one hour of service and counted within the first fifteen (15) hours for new members, members who are returning with a new spell of illness (a new treatment episode following a break in care of 60 days or longer after a previous treatment episode), and substance abuse assessments.</p>