July 1, 2020  Prior Authorizations

AlohaCare believes in and supports the roles of our providers. Our providers’ responsibilities are to provide and coordinate care to ensure that members receive medically appropriate services. The medical request for prior authorization and notification are important processes in the coordination of care.

The information shared within this Advisory is to remind providers of the tools available to assist with AlohaCare’s Prior Authorization process and to emphasize the importance of following our plan’s policies and procedure to avoid delays in care for our members, processes and providers’ payments for services rendered that may or may not require a pre-service prior authorization.

Thank you for the services you provide to our members. Please contact AlohaCare’s Provider Services Department at (808) 973-1650 or toll free at 1-800-434-1002 with questions.

Topics covered in this advisory include:
- AlohaCare’s Prior Authorization Look-up Tool
- Online Electronic Prior Authorization (EPA) Tool
- Requirements for Non-Participating, Out-of-Network, and Out of State Providers
- Direct or Balance Billing Members
- Retro Authorization Request

AlohaCare’s Prior Authorization Look-up Tool

The prior authorization look up tool can be easily accessed on AlohaCare’s home page, https://www.alohacare.org/PriorAuth/, allowing users to:

- Verify services that require a prior authorization
  - Search by Line of Business (LOB) and CPT/HCPCS Code
  - Search by LOB, Type and Category
- Downloadable into Excel (XLSX) or Comma Delimited (CCV) formats for integration with billing or medical records system

Prior authorization requirements are reviewed quarterly and notifications regarding changes are announced through AlohaCare fax blast, provider newsletters, and by provider relations staff.

Providers should utilize the look-up tool prior to rendering services to avoid claim denials due to lack of authorizations. If Prior Authorization Tool access issues arise, it is best to contact our Provider Services Department at (808) 973-1650 or toll free at 1-800-434-1002 with inquiries related to our prior authorization process. Or you may refer to our Provider Manuals published on www.alohacare.org.

**AlohaCare does not issue letters to providers for services that do not require prior authorization or notification submission to the Plan.**
AC Online Electronic Prior Authorization (EPA) Submission Capability

Participating providers can verify authorization requirements, submit and track electronic prior authorizations through AC Online, AlohaCare’s Secure Provider Portal. The following types of prior authorizations may be submitted through the online EPA Program:

- Medical and Surgical Service Authorizations – Both Physician and Facility
- Durable Medical Equipment and Medical Supply Authorizations
- Medically Necessary Non-Emergency Medical Transportation Service Authorizations (Ground, Air and Lodging)
- Facility Admission Notification (Face Sheet)
- Pregnancy Notification

AlohaCare’s EPA system will not produce or accept any submission for services that do not require a prior authorization, nor will AlohaCare issue letters for services that do not require a prior authorization.

Providers may register for access to AC Online by completing the AC Online Registration Form located on www.alohacare.org/Providers/Forms.

Nonparticipating, Out of Network & Out of State Providers and Facilities

All medical services rendered by a non-participating, out-of-network or out-of-state provider or facility require prior authorization.

In most situations, members’ access to specialty and ancillary care services are coordinated by or with their PCP. To facilitate the provision of health care, promote timely access to specialty care and processing of claims, providers are asked to observe the following:

- Coordinate the member’s care with member’s PCP, an in-network/ in-state participating specialist and/or facility.

- When services are coordinated by a member’s PCP, treating specialists should provide written reports to the member’s PCP that includes findings and recommendations for additional care. If additional visits, testing, or surgeries are recommended, the specialist will inform the member’s PCP and follow AlohaCare’s Prior Authorization processes, policies and procedures.

- A member may not self-refer to out-of-network specialists without following plan procedure. All out-of-network specialist visits and services require prior authorization. It is recommended that members work with their PCP or participating treating physician to acquire access to medically necessary services to ensure AlohaCare’s Prior Authorization processes, policies and procedures are followed.

Provider Request for Retro Authorization

Effective August 1, 2020, a provider may submit a Request for Retro Authorization due to extenuating circumstances.

Retro authorization request for reconsideration should be submitted utilizing the attached form. The most current version of this form is located within the Prior Authorization section of our website www.alohacare.org.
Requests for Retro Authorization should be submitted prior to a claim submission. Failure to follow this process will result in a denied claim.

Claims that have been denied specifically for no prior authorization or prior authorization absent and do not meet any of the criteria reflected below will need to be submitted as a formal written request to AlohaCare’s Grievance and Appeals department for review and consideration.

These requests will be considered if the following criteria has been met:

- Member enrollment issues.
- Member did not notify provider of change in medical plan.
- Prior authorization was obtained but unforeseen circumstances required additional services to be performed.
- Environmental factors that precluded the provider from obtaining the prior authorization or submitting notification (e.g. natural disaster, fire, health pandemic, etc.)
- Member not established with assigned Primary Care Provider (PCP) and PCP will not provide referral.
- Service rendered by non-participating provider under the referral of a participating provider who is acting as the Plan’s agent.

All pertinent documentation that will assist in determining the medical necessity or appropriateness of the level of care and length of stay being requested that was available at the time of service must be submitted along with this request. Retro authorization requests may be faxed to (808) 973-0676 or toll Free 1-888-667-0680 or via mail to:

AlohaCare
Attn: TCSS Department
1357 Kapiolani Blvd, Suite 1250
Honolulu, HI  96814

A response to the dispute will be issued no later than 30 days from the date of receipt.
# AlohaCare Request for Retro Authorization

Line of Business:
- [ ] AlohaCare SNP Medicare
- [ ] AlohaCare QUEST / QUEST ABD

Please select one of the following

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<th>Retro Authorization related to:</th>
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<tr>
<td>Enrollment Issues</td>
<td>Plan Change</td>
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</table>

## PROVIDER INFORMATION

Provider Name:  
Provider Tax ID: Provider NPI:  
Provider Phone: Provider Fax:  
Provider Address:  
Contact Name:  
Signature: Date:  

## MEMBER INFORMATION

Member Name: Member ID: Date of Birth:  

## PRIOR AUTHORIZATION INFORMATION

<table>
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<tr>
<th>Service Date(s):</th>
<th>Codes</th>
<th>Modifiers</th>
<th>Units</th>
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Details of Extenuating Circumstance:
Direct or Balance Billing Members

In accordance with the Hawaii QUEST Integration Program guidelines, providers cannot make any attempt to collect payment for covered services or no-show fees, directly or through a collection agency, from a person claiming to be a QUEST Integration eligible member except in the following circumstances:

- The individual was not eligible for QUEST Integration Program on date of service.

- 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 must be placed in the member’s medical record.

- QUEST Integration Adult members can be billed for services exceeding benefit limitations.

- Member had self-referred to an out-of-network (“non-par”) provider without prior authorization. Documentation of the member’s signed acceptance of payment responsibility must be placed in the member’s medical record.

- Member had primary insurance coverage through a prepaid benefits plan but did not receive treatment at one of the primary insurance plan’s approved facilities (examples include: HMSA Health Plan Hawaii, Kaiser Health Plan). The provider is required to acquire a denial from a member’s primary plan in order for AlohaCare to review and process a prior authorization. The provider is responsible for checking for eligibility and Third Party Liability coverage prior to rendering services. AlohaCare may pay for QUEST Integration covered services if the service is not-covered or excluded from coverage under member’s primary plan.

- Member’s cost share has been determined by Med-QUEST, particularly, for LTSS and HCBS providers.

- When a member makes a direct payment to a provider for a service, but is subsequently retro enrolled in AlohaCare, the provider should bill AlohaCare and reimburse the member for the payment(s) made.

Providers may not bill members if plan procedures are not followed resulting in non-payment or non-coverage of services.