Welcome Providers!
The AlohaCare QUEST Integration Provider Manual offers you—our contracted providers and your staff—with helpful information and details on our AlohaCare QUEST Integration health plan. We recommend that you read this manual and keep it on hand for your staff to reference.

The QUEST Integration Provider Manual is also available on our website: www.AlohaCare.org. If you have trouble accessing the information, please contact our Provider Services Department.

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SECTION 1 INTRODUCTION TO ALOHACARE QUEST INTEGRATION HEALTH PLAN

Welcome
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 Hawaii’s underserved populations, including low-income seniors, to provide Medicaid and Medicare coverage to over 62,000 members. We serve Hawaii’s Medicaid and Medicare populations through a QUEST Integration contract with the State of Hawaii.

Hawaii’s community health centers joined together to form AlohaCare when the State launched the Medicaid QUEST program for low-income families. We were one of the first QUEST health plans. Our service area is statewide, which includes the islands of Oahu, Kauai, Lanai, Maui, Molokai, Lanai and Hawaii Island. Approximately one out of every two of our health plan members are children. More than 44 percent of our health plan members live on a Neighbor Island.

AlohaCare Mission
Our mission is to serve individuals and communities in the true spirit of aloha by ensuring and advocating access to quality health care for all. This is accomplished with emphasis on prevention and primary care through community health centers that founded us and continue to guide us as well as with others that share our commitment.

Our Commitment

- By "empowered, healthy communities" and by "ensuring and advocating access to quality health care for all", we mean that:
  - AlohaCare’s core business will focus on being recognized as the best and most successful plan in serving the Medicaid and the dually-eligible Medicaid and Medicare populations of Hawaii; and,
  - AlohaCare’s core role will be that of a facilitator in helping communities to become more empowered to ensure access to quality health care for all.

- By "serve individuals and communities", we mean that we must constantly build and maintain special health plan expertise and capabilities that can successfully and effectively solve the most persistent challenges in meeting the health care needs of individuals within this population in the communities in which they live.

- By the "spirit of aloha", we mean that the principles of aloha by which we conduct our core business will result in the highest levels of member and provider satisfaction and of member retention among those organizations who serve these populations.

- By "with emphasis on prevention and primary care through community health centers", we mean that our main emphasis as a health plan in achieving our mission will come about largely through
our core partnership and collaboration with the community health centers and a focus on primary care and prevention.

- By "with others that share our commitment", we mean that, in addition to our emphasis in working with community health centers, we will also work in closer partnership and collaboration with physicians, other health care providers, social service organizations and communities that share our mission commitment.

Cultural Competency

Embracing cultural competency and diversity enables AlohaCare to meet the culturally and linguistically diverse needs of our members. In doing so, we direct the development of systems, policies and procedures to reflect the needs of our culturally diverse members, providers and employees. This philosophy ultimately improves member satisfaction and health outcomes. We are committed to building and maintaining a provider network as well as our employee workforce to reflect the diversity of Hawaii’s unique population.

AlohaCare’s Cultural Competency Plan identifies health practices and behaviors of members and designs programs and services to address cultural and language barriers to deliver appropriate and necessary care. All services are provided in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

AlohaCare providers are expected to provide health care services (including language assistance if requested) that respond effectively to the cultural and linguistic needs of our members. Annual and ongoing training is available.

The AlohaCare Cultural Competency Plan is available upon request, at no charge. Please contact us for more information.

AlohaCare Vision

We envision empowered healthy communities living in the spirit of Aloha.

Core Values

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

- Fairness
- Honesty
- Loyalty
- Respect/Dignity
- Trust
Organization and Administrative Structure

AlohaCare is an IRS 501(c)(4) non-profit corporation headquartered in Honolulu, Hawaii. We have offices on Oahu, Maui, Kauai, and Hawaii Island. We have over 270 employees, to assist our providers and partners with our members’ health care needs.

As a health plan founded and governed by Community Health Centers (CHCs), AlohaCare is deeply rooted in Hawaii’s diverse communities. The community-governed CHCs and their board members bring a great depth of experience and expertise serving populations challenged with financial, cultural, ethnic, linguistic, geographical and social barriers.

AlohaCare’s relationship with the CHCs provides a governance structure which has powerful ties to Hawaii’s underserved communities. The CHC CEOs and Executive Directors who serve on AlohaCare’s board are, in turn, under the direction of their own boards of directors, which are dominated by consumers, advocates and prominent members of their local communities. This brings into AlohaCare the unique voices of each of those communities, which represent the diverse population of our entire state, and particularly communities which have traditionally not been the focus of the mainstream health system.

What is QUEST Integration?

QUEST Integration (QI) is a Medicaid managed care program under the Hawaii Department of Human Services (DHS). Managed care means that the DHS has contracted AlohaCare to help members manage their health care needs. Our health plan assists members in receiving the highest quality of health care in the right care setting and at the time that they need the care.

AlohaCare QI provides coverage for those who qualify. We offer:

- Medical coverage
- Coverage for behavioral health and long-term services and supports
- Services to help in daily activities
- Independent living and input on a member’s health care decisions
- Care managers to help members get the care that they need

Provider Services Department

The Provider Services Department provides an active main interface between AlohaCare and the provider community. We strive to treat providers with respect and dignity as these are important values to AlohaCare. Our efforts will result in a network of providers that will provide a comprehensive continuum of quality health care and who will embrace the AlohaCare philosophy of delivering care to the underserved with ‘Aloha.’

The Provider Services Department’s focus is on recruiting, retaining and maintaining a viable provider network that meets the health care and service needs of our members. We provide support and assistance to providers to enable them to give efficient and effective care. We offer a variety of orientation and training opportunities to provide clarity on our processes and plan requirements.
Contact Us

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

- Your telephone calls will be answered by a live representative.
- Our offices are open Monday - Friday, 7:45 a.m. – 5:00 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.
- Answers and questions may also be accessed through our TDD/TTY system.
- Language assistance is also available upon request.

Important Phone Numbers

<table>
<thead>
<tr>
<th>Provider Services</th>
<th>Pharmacy Department</th>
<th>Care Navigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(808) 973-1650</td>
<td>(808) 973-7418</td>
<td>(808) 973-0712</td>
</tr>
<tr>
<td>Toll Free 800-434-1002</td>
<td>Toll Free 866-973-7418</td>
<td></td>
</tr>
<tr>
<td>TTY/TDD Users Toll Free</td>
<td>Fax (808) 973-6327</td>
<td></td>
</tr>
<tr>
<td>1-877-447-5990</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax (808) 973-0811</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Member Eligibility and Benefits
- Claims Inquiries
- Prior Authorization Inquires
- Discuss a Grievance or Appeal
- Contact Provider Services Representative

- Formulary Inquiries
- Prescription Prior Authorization Inquires
- Request for medication override

Select Option 1:
- Discuss Prior Authorization for Medical Services
- Refer a member for Service Coordination.
- Speak to a member’s Service Coordinator

Select Option 2:
- Coordinate or discuss travel services for members
<table>
<thead>
<tr>
<th>Our Locations</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oahu (Main Office)</td>
<td>1357 Kapiolani Blvd, Suite 1250</td>
</tr>
<tr>
<td></td>
<td>Honolulu, HI 96814</td>
</tr>
<tr>
<td>Maui</td>
<td>210 Imi Kala St, Suite 206</td>
</tr>
<tr>
<td></td>
<td>Wailuku, HI 96793</td>
</tr>
<tr>
<td>Kauai</td>
<td>4473 Pahee St, Suite N</td>
</tr>
<tr>
<td></td>
<td>Lihue, HI 96766</td>
</tr>
<tr>
<td>Hawaii Island</td>
<td>234 Waianuenue Ave., Suite 105</td>
</tr>
<tr>
<td></td>
<td>Hilo, HI 96720</td>
</tr>
</tbody>
</table>
SECTION 2 IMPORTANT INFORMATION FOR PROVIDERS

AlohaCare Publications

AlohaCare is committed to providing clear, accurate and timely communications to our provider network. We publish the QUEST Integration Provider Manual, a quarterly Provider Newsletter, *Kui Ka Lono* and periodic Provider Advisories. Our provider publications are available online at www.AlohaCare.org.

QUEST Integration Provider Manual

The QUEST Integration Provider Manual is an extension of the AlohaCare Provider Agreement. Updates are made when the Department of Human Services (DHS) updates the QUEST Integration Program or when AlohaCare updates our own policies and procedures.

The Provider Manual helps you and your staff to understand the QUEST Integration Program and AlohaCare policies and procedures. The online Provider Manual always represents the most current information. For additional printed copies of the QUEST Integration Provider Manual at no cost to you, contact our Provider Services Department at 973-1650 or toll free at 1-800-434-1002.

The Provider Manual will also be posted online at the AlohaCare website and will be updated not more than five (5) days following any change to the manual. Written notification to providers will come through the Provider Newsletter, provider advisories or direct mailing.

Provider Newsletters and Advisories

The Provider Newsletter and Provider Advisories are designed to keep you informed of policy changes (such as changes to billing guidelines and authorizations), program changes (such as QUEST Integration benefit changes), formulary updates, and 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 Provider Services 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:

- Office locations and addresses
- Important phone numbers
- Plan Operations Information for Providers
- AlohaCare’s Secure Provider Portal – AC Online
The Quick Reference Guide can be found on www.AlohaCare.org in the Plan Publications section within the Provider selection of the portal. The information reflected is periodically included in AlohaCare’s Provider Newsletter.

Provider Web Portal - AC Online

AC Online is a provider web portal designed just for you. It contains the most up to date information about your members and can be accessed 24 hours a day, 7 days a week at www.AlohaCare.org. You can log in and gain access to the following:

Member Information
- Find an assigned AlohaCare member
- Check on a member’s eligibility, TPL and Primary Care Provider information
- Find the Primary Care Provider Roster
- Receive Primary Care Provider Quality (HEDIS®) Reports
- Prescription Drug Utilization

Claim Information
- Look up a claim you billed and track its status

Access the Following Primary Care Provider Reports
- Primary Care Provider Roster
- Attribution Reports
- Quality (HEDIS®) Reports
- Gaps in Care Reports

Prior Authorization Information
- Submit a prior authorization or notification on line
- Look up authorization or notification and track its status

Administrative Access (Designated Administrator)

Administrative Access is given to a primary user authorized by a Provider, Group or Facility to perform the following functions:
- Add new user accounts
- Delete user accounts
- Change a user’s access in the portal
- Re-set and change user passwords

Administrative Access is automatically given to the requesting Provider, Administrator or Manager reflected on the form. If there is no Designated Administrator reflected in these field, administrative access will automatically default to the Provider.
Register for an AC Online Account
The AC Online Registration Form is available on our website or you can request the form by contacting Provider Services.

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

Electronic Data Interchange (EDI) Program
To begin set up for Electronic Data Interchange (EDI) submission, contact one of the following clearing houses and they will guide you through the process of submitting electronic claims to AlohaCare.

- Gateway also known as Trizetto
  Phone Number: 800-969-3666
  www.GatewayEdi.com

- Legacy also known as Hawaii X-Change & Administep
  Phone Number: 888-751-3271 ext. 3127
  www.LegacyConsulting.net
  *Note: Office Ally submits claims via this clearing house vendor.*

- Change Health
  Phone Number: 866-817-3813
  www.ChangeHealthcare.com

- ClaimRemedi also known as eSolutions
  Phone Number: 866-633-4726
  www.ClaimRemedi.com

- Nextgen
  Phone Number: 800-425-3385
  www.nextgen.com

**Providers, Practices and Facilities that have delegated their claims submissions for AlohaCare to a Physician Billing or Practice Management Services Company may work with our clearing house partners to establish EDI claims submissions capabilities for AlohaCare.**
Electronic Funds Transfers

AlohaCare has partnered with PaySpan to also provide electronic reimbursement payments for our providers. This free service will deposit AlohaCare reimbursement payments to the bank account(s) of your choice via electronic funds transfer (EFT), online access to Explanation of Payments (EOPs), and payment reconciliation reports. This service allows our providers to reduce costs, improve cash flow, and reduce paper usage.

If you have not previously used PaySpan, you may request your registration code(s) at https://www.payspanhealth.com/requestRegCode/ or contact PaySpan via e-mail at providersupport@payspanhealth.com. This registration code will allow you to register to receive payments via EFT. Please use subject line “Registration Code Request – AlohaCare” and include your name, the Tax Identification Number for your practice, and telephone number in the body of the e-mail.

Information with regard to registering for PaySpan may be located on www.alohacare.org in the Providers Resources section of our website or you may contact PaySpan directly via e-mail at providersupport@payspanhealth.com or by phone at 1-877-331-7154 Option 1 from 8am-8pm EST (3:00am –3:pm HST).

Access to Language Interpretation, Auxiliary Aids, Sign Language or Specialized Communication

If you need to access language interpretation, auxiliary aids (example: telephone handset amplifiers, assistive listening devices), sign language services, or specialized communication such as Braille or translation services to communicate with an AlohaCare member, please contact AlohaCare Member Services. These services are provided free to our members.

Oahu: (808) 973-0712
Toll Free: 1-877-973-0712
TTY/TTD users: 1-877-447-5990
SECTION 3 PROVIDER ROLE

AlohaCare has a network that includes a broad range of providers—PCPs, APRNs, specialists, hospitals, facilities, pharmacies, long-term service and support providers and ancillary services to provide our members with the full range of QUEST Integration covered services.

We appreciate the willingness of the provider community to partner with us to assure access to quality care for the disadvantaged members of our community.

This section addresses AlohaCare’s responsibilities to contracted providers as well as contracted providers’ roles and responsibilities.

AlohaCare’s Responsibility to Our Providers

AlohaCare recognizes that a successful partnership depends on acceptance of responsibility and a commitment to open, effective communication by both parties.

**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
- 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

Provider Responsibilities

**All AlohaCare network providers have responsibilities to:**

- Be contracted with Medicaid (DHS 1139 Form)
- Successfully complete AlohaCare’s initial credentialing process, as well as subsequent re-credentialing processes which occurs every three (3) years
- Verify member eligibility, current PCP assignment and third party liability (TPL) coverage on the date of service via AC Online or by calling our Member Services 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.
- Accept members for treatment unless the provider has requested a waiver from this provision from the health plan to close their panel.
- Provide culturally competent care based on an individual's background, ethnicity, cultural beliefs and language preference.
- Schedule appointments in compliance with the AlohaCare's appointment accessibility standards.
- Maintain health or medical records that document all medical or support services provided to AlohaCare members in accordance with AlohaCare's medical record keeping policies.
- Ensure confidentiality of member information in compliance with State and Federal regulations.
- Notify AlohaCare of potentially high-risk and complex cases or members with Special Health Care Needs, so our Service Coordination staff can assist with resources to ensure cost effective and appropriate care for the member.
- Notify AlohaCare if, in the opinion of the provider and as defined by the Plan or DHS, a covered member meets the criteria for the following designations:
  - Members Requiring Long-Term Services and Supports: The provider will assist in and support the Plan's effort to identify, coordinate, and manage members who are in need of long-term services and supports.
  - Members with Support for Emotional and Behavioral Development (SEBD) status: The provider will assist in and support the Plan's effort to identify, coordinate, manage and/or transition the care of members who meet criteria for this designation.
- Submit all claims/encounters to AlohaCare within required timeframes (within 365 days of date of service), with accurate and valid diagnosis and CPT/HCPCS/modifier code as appropriate, based on date of service.
- Look solely to the health plan for compensation for services rendered, with the exception of nominal cost sharing pursuant to the Hawaii Medicaid State plan (do not seek payment from the member for any covered services provided within the terms of the contract). Members may have to share in the cost of health care or support services. This is based on their Medicaid financial eligibility. Med-QUEST determines the cost sharing amount and informs AlohaCare of the monthly amount due from the member. If a member has a cost share, they must make payments to one of their providers every month. This is usually a long-term care facility or a home and community based provider.
- Cooperate with all AlohaCare Quality Improvement initiatives, complaint or grievance inquiries, compliance investigations, fraud and abuse investigations, and other state or
federal reviews, 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 state or federal reviews

- Comply with all applicable Federal and State laws prohibiting discrimination against any recipient or employee on the grounds of race, color, sex, sexual orientation, gender identity, national origin, age, mental and/or physical handicap or disability and not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. Participate in 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 CFR Part 411, subpart J, as applicable, which generally prohibits a physician from referring a member 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, treat, coordinate or assist in the transition of patient care until AlohaCare makes reasonable and 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 the 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)

In AlohaCare’s QUEST Integration Program, every member selects or is assigned to a primary care provider (PCP) appropriate to the member’s needs. The PCP is responsible for assessing the member’s health care needs and provides or directs the services to meet these needs in all aspects of care (care management, service coordination, delivery of primary care services, etc.).

<table>
<thead>
<tr>
<th>Department</th>
<th>Phone</th>
<th>Toll-free</th>
<th>Fax</th>
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<tbody>
<tr>
<td>QUEST Integration – Member Services</td>
<td>973-0712</td>
<td>1-877-973-0712</td>
<td>973-0726</td>
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</tr>
<tr>
<td>Medicare – Member Services</td>
<td>973-6395</td>
<td>1-866-973-6395</td>
<td>973-0726</td>
<td></td>
</tr>
<tr>
<td>Service</td>
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<tr>
<td>Provider Services</td>
<td>973-1650</td>
<td>1-800-434-1002</td>
<td>973-0811</td>
<td>1-866-973-0204</td>
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<td>Prior Authorization</td>
<td>973-1657</td>
<td>1-800-434-1002</td>
<td>973-0676</td>
<td>1-888-667-0680</td>
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<td>Service Coordination</td>
<td>973-0712</td>
<td>1-877-973-0712</td>
<td>973-6392</td>
<td></td>
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<tr>
<td>Pharmacy</td>
<td>973-7418</td>
<td>1-866-973-7418</td>
<td>973-6327</td>
<td>1-877-316-6376</td>
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<tr>
<td>Behavioral Health (Prior Authorization Requests)</td>
<td>973-1650</td>
<td>1-800-434-1002</td>
<td>973-6324</td>
<td>1-800-293-4580</td>
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<tr>
<td>Quality Improvement</td>
<td></td>
<td></td>
<td></td>
<td>973-2140</td>
</tr>
</tbody>
</table>

**Mailing Address:**
AlohaCare
1357 Kapiolani Blvd, Suite 1250
Honolulu, HI 96814
Who May Serve as a Primary Care Provider (PCP)

The following may serve as Primary Care Providers:

- Primary Care Providers who are licensed in the State of Hawaii as either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy) and be either a Family Practitioner, General Practitioner, General Internist, Pediatrician, Geriatrician or Obstetrician/Gynecologist.

- Advanced Practice Registered Nurses with prescriptive authority (APRN-Rx) who are licensed and registered by the state to practice as a nurse practitioner in accordance with State Law and section 16-89 subchapter 16, HAR, are certified as a nurse practitioner by a national certifying body that has established standards for a nurse practitioner, and possesses a master’s degree in nursing.

- Physician Assistants recognized by the State Board of Medical Examiners as a licensed physician assistant.

AlohaCare may allow specialists or other health care practitioners to serve as PCPs for members with chronic conditions provided that the member has selected a specialist with whom he or she has a historical relationship as his or her PCP. AlohaCare will confirm that the specialist agrees and understands the responsibilities of the PCP. Such confirmation may be in writing, electronically, or verbally. AlohaCare will monitor the performance of a specialist who is serving as a PCP to ensure that PCP responsibilities are met.

AlohaCare will allow a clinic to serve as a PCP as long as the clinic is appropriately staffed to carry out PCP functions.

PCP Responsibilities

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

- Serve as an ongoing source of primary care for the member, including supervising, coordinating, and providing all primary care services. The member’s medical record should include a treatment plan that documents the provider’s assessment and services to address and treat the member’s medical condition(s).

- Being primarily responsible for coordinating other healthcare services furnished to the member, including coordinating and initiating specialty care (including in and out of network), maintaining continuity of care; and maintaining the member's medical record (this includes documentation of services provided by the PCP as well as any specialty services).
  - Maintain continuity of care for members by coordinating all care, and follow-up treatment of the member.
  - Collaborate with AlohaCare to develop a care plan that facilitates integrated, coordinated, and continued care.

- Complete an initial history and physical assessment on all assigned members no later than the third office visit.
• Honor member requests for second opinion, when reasonable, and coordinate services performed by another specialist or ancillary provider and prior authorization requests that may be required.

• Refer members to a network specialist and manage and coordinate the member’s specialty care to avoid duplicated, unnecessary or fragmented care.

• Communicate AlohaCare’s utilization review decision to the member.

• Provide preventive health services, ongoing health maintenance and disease prevention services according to established clinical guidelines and best practices.

• Provide timely provision and documentation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) health care services, including screenings, preventive care and appropriate services provided by specialists and ancillary providers for members under the age of 21.

• If applicable, and where contractually stated, maintain hospital admitting privileges at a licensed acute care hospital within the service area, or in the absence of direct hospital privileges, have on file with AlohaCare, a written agreement utilizing another AlohaCare provider for admission and treatment privileges, or have an arrangement with a hospital that uses hospitalists to admit patients.

• Inform AlohaCare of locum tenens coverage when unavailable during regular office hours (i.e., out of town or on vacation). The provider is required to submit written notice of locum tenens coverage to AlohaCare reflecting 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 locum tenens coverage is on a temporary basis for a maximum of 60 days, when the regular physician is absent for reasons such as illness, pregnancy, vacation or medical education.
  
  o 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.

• 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: Prior Authorization and Notification”).

• Comply with Federal and State law regarding advance directives for adult members. At a minimum the provider shall:
  
  o Maintain written policies regarding a member’s rights to make decisions about their medical care.
  
  o Document in the medical record whether or not the member has executed an advance directive, and include a copy in record if the member has done so.
  
  o Not discriminate against a member because of member’s decision to execute or not execute an advance directive.
  
  o Provide staff education on issues concerning advance directives.
PCP Patient Capacity

Individual PCPs not practicing within a clinic are subject to a maximum AlohaCare QUEST Integration member panel size of 300 per DHS requirements. Once an individual PCP has met their maximum panel size of 300, members may continue to choose that PCP; however, AlohaCare will no longer include that PCP for auto-assignment. A waiver from this requirement may be granted based on geographic location, specialty and member needs. Please contact your Provider Services representative for more information regarding a waiver.

AlohaCare will monitor patient capacity of its PCP network, to ensure that there is acceptable access to medical services for AlohaCare members. Such monitoring may include:

- The total number of AlohaCare members assigned to the practice
- The total number of commercially-based patients assigned to the practice
- The total number of private-pay patients treated at 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.

Member Request to Change PCP

Members may request to have their PCP changed due to geographic restrictions (i.e. moving too far away to see their current PCP), wanting to see the same PCP as other family members, or other reasons. A member can call AlohaCare Member Services to change their PCP. The change will take place on the same day the member calls with the change request and the member will receive a new member ID card with the new PCP indicated. There are no limits to the number of times a member may change their PCP.

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; family continuity. Practice policies regarding patient termination cannot be different for Quest members than any other patient population. Appointment no-show fees per contract cannot be assessed to QUEST Integration members. However, consistent with the provider’s office policy, if an AlohaCare QUEST Integration member fails to show to repeat appointments they may be terminated as a patient and you can request they be re-assigned.

The PCP must send a letter to the member informing him or her of the intent to terminate the relationship and that care will be extended for 15 days. This will allow time to find another provider. The PCP is asked to provide urgent care during those 15 days or until a new provider is identified. A copy of
the letter and additional details of the problem must be mailed or faxed to the AlohaCare Member Services Department. In cases of extremely serious or dangerous situations, the PCP should call AlohaCare’s Provider Services number (808-973-1650) and request expedited consideration.

AlohaCare’s Member Services staff 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 automatic assignment of the member to another PCP by the end of the 15-day period following AlohaCare policy regarding automatic assignment of members to PCP providers. The member will attempt to be notified by phone and will be mailed a new ID card with their new PCP indicated. Copies of all correspondence are retained by the Member Services Department.

Immediate Transfer of Member
AlohaCare will immediately transfer a member to another PCP, health plan, or provider if the member’s health or safety is in jeopardy.

Specialist and Ancillary Provider Roles
In most situations, members’ access to specialty and ancillary care services are coordinated by their PCP. 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 processes and procedures.
- 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 policies and procedures as reflected within this manual. (see “Prior Authorizations and Notification” section of this manual)
- Identify backup coverage for AlohaCare members in active treatment when you are 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 eligible for participation in Medicaid programs.
- 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.
• If you are a capitated provider and the covering provider submits a claim for a capitated service, the claim will be processed and reimbursed as a capitated encounter and the covering provider will look to you for reimbursement; if you are a fee-for-service provider the covering provider will be paid fee-for-service.

**Credentialing/Re-credentialing**

The purpose of credentialing is to ensure that AlohaCare members receive medical, behavioral health care, and Long-Term Supports and Services (LTSS) from qualified providers. Provider credentialing is a quality initiative that assures providers have met appropriate levels of education, training, certification and licensing and are qualified to deliver care to members.

AlohaCare has established procedures to credential qualified providers interested in joining our network. The credentialing process is based on standards developed by the National Committee for Quality Assurance (NCQA).

All network providers must be credentialed by either AlohaCare or their parent facilities before providing services to AlohaCare members. Those providers completing credentialing through AlohaCare must submit a credentialing application that contains information pertinent to evaluating the provider’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:**

1. AlohaCare ensures that provider credentialing/re-credentialing 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 the provider specializes in.

2. 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.

3. 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.

4. 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.
5. AlohaCare will notify providers about information obtained during the credentialing process that varies substantially from the information provided to the Plan by the provider.

6. 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.

7. All credentialing verifications and the attestation signature must be current within 180 days at the time the Credentials Committee approves the credentialing application.

8. Re-credentialing 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. The re-credentialing process must be completed within 36 months of the date of the last credentialing approval.

9. AlohaCare is solely responsible for making initial credentialing and re-credentialing decisions based on the approval of the practitioner by the AlohaCare Credentials Committee.

10. Providers will be notified of the credentialing or re-credentialing 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, with a goal of completing the full credentialing process by the end of the 60th day.

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 to us so that we may ensure that its language complies with state and federal requirements. A provider remains fully responsible for all duties and obligations under the contract and must ensure that subcontractors perform according to appropriate standards, laws and regulations.

If you are considering entering into a subcontractor agreement, please contact our Provider Services Department 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 policy requires 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, OB/GYN specialist or high-volume Behavioral Health provider. 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 credentialing policy. An evaluation of a practitioner’s medical record keeping practices is necessary in rendering an initial credentialing decision.

Medical record reviews are also performed to evaluate AlohaCare quality initiatives to assess conformance and compliance with Preventive Health Care guidelines.

AlohaCare holds its contracted providers to medical record keeping standards in accordance with contractual obligations and any State and Federal 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:**

1. Medical records are maintained in a current, detailed, organized and comprehensive manner that conforms to good medical practice and permits effective professional medical review and compliance audit processes.

2. Medical records are systematically organized and legible to someone other than the writer, and reflect all aspects of patient care.

3. All medical records must be maintained and accessible to AlohaCare, our representatives, and the representatives of the Med-QUEST Division. Upon reasonable notice and during provider’s regular business hours, AlohaCare and the Med-QUEST Division have the right to prompt access 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 the provider’s agreement with AlohaCare.

4. AlohaCare, DHS and any applicable state or federal 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 patient consent.

5. 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 will be forwarded to the new PCP within 7 business days from receipt of a written request. Providers are required to make the medical records of AlohaCare patients available to requesting hospitals, specialists, long term service and support providers, and new PCPs at no charge to the member.

6. 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.

7. Medical records are preserved and maintained for a minimum of 7 years from the last date of entry in the records. For minors, providers will preserve and maintain all medical records during the period of minority plus a minimum of 7 years after the age of majority.
Medical records should contain the following components:

- All entries are legible, signed and dated, and the provider is identified on each entry.
- Each page of the paper or electronic record includes the patient’s name or ID number.
- Demographic information including name, address, date of birth, sex, marital status, next of kin, home and work telephone numbers, and employment status, if applicable.
- Any adverse drug reaction and/or food or other allergies, or the absence of known allergies, are recorded in a prominent area of the medical record.
- Current medications are noted/listed and updated appropriately.
- There is an appropriate past medical history in the record that is easily identified including serious accidents, hospitalizations, operations and illnesses. For children less than three years old the medical record should also include a prenatal and birth history.
- All pediatric records include a completed immunization record or documentation that immunizations are up to date.
- For each patient encounter:
  - The chief complaint or purpose of the visit is documented.
  - Current problems, including health maintenance concerns are documented.
  - A physical examination appropriate to the patient’s condition is documented.
  - Laboratory or other studies ordered as appropriate.
  - Diagnoses or clinical impressions are documented consistent with findings.
  - There is a documented care plan.
  - There is documentation of treatments, procedures and tests with results.
  - Recommendations and instructions to patient are noted, including a date for return visit or other follow-up plan for each applicable encounter.
  - Reasons for and results of specialist and ancillary provider services are documented.
  - Consultant summaries, lab and other imaging study results reflect provider review.
  - Documentation of follow-up care including telephone calls.
  - Documentation that unresolved concerns from previous visits are addressed at subsequent visits.
  - Hospitalization if applicable to include discharge summaries for all hospital admissions.
  - Emergency care rendered to include records and discussion of requirements for physician follow-up.
  - Information on ancillary services.
- For patients 12 years and older, appropriate notations concerning the use of tobacco, alcohol, and other substances are to be documented.
- Appropriate health management and continuity of care are clearly reflected in the medical record. Where appropriate, evidence of follow-up to previous encounters, hospital discharge summaries, documented services and results provided by specialist, and documentation of...
emergency encounters and follow-up are recorded.

- For patients 18 years of age or older, documentation as to whether the patient has executed an advance directive, including an advance mental health care directive.

During 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 patient’s clinical information. The medical documentation should be organized, comprehensive and detailed. They should include patient identification, and 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 categories such as EPSDT and Maternity Care. 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 patients, a random selection of ten members is made from claims/encounter data. For a high-volume PCP, with more than 300 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 provides feedback to providers of our findings. Providers not in compliance at the time of review will be asked to submit a written action plan and are scheduled for a follow-up review within six months. Providers who do not submit a written action plan and/or are not in compliance on the second review will be presented to the Credentials Committee and/or Quality Improvement Advisory Committee for consideration of remedial actions.

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

For credentialing purposes, the policy requires 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, OB/GYN specialist or high-volume Behavioral Health provider. 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 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. For example, pediatric records are reviewed to assess conformance with EPSDT requirements and PCP records are reviewed to assess Preventive Health care guidelines.

AlohaCare holds its contracted providers to medical record keeping standards in accordance with contractual obligations and any State and Federal 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:

1. Medical records are maintained in a current, detailed, organized and comprehensive manner that conforms to good medical practice and permits effective professional medical review and compliance audit processes.

2. Medical records are systematically organized and legible to someone other than the writer, and reflect all aspects of patient care.

3. All medical records must be maintained and accessible to AlohaCare, our representatives, and the representatives of the Med-QUEST Division. Upon reasonable notice and during provider’s regular business hours, AlohaCare and the Med-QUEST Division have the right to prompt access 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 the provider’s agreement with AlohaCare.

4. AlohaCare, DHS and any applicable state or federal 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 patient consent.

5. 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 will be forwarded to the new PCP within 7 business days from receipt of a written request. Providers are required to make the medical records of AlohaCare patients available to requesting hospitals, specialists, long term service and support providers, and new PCPs at no charge to the member.

6. 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.

7. Medical records are preserved and maintained for a minimum of 7 years from the last date of entry in the records. For minors, providers will preserve and maintain all medical records during the period of minority plus a minimum of 7 years after the age of majority.

Medical records should contain the following components:

- All entries are legible, signed and dated, and the provider is identified on each entry
- Each page of the paper or electronic record includes the patient’s name or ID number
- Demographic information including name, address, date of birth, sex, marital status, next of kin, home and work telephone numbers, and employment status, if applicable
- Any adverse drug reaction and/or food or other allergies, or the absence of known allergies, are recorded in a prominent area of the medical record
- Current medications are noted/listed and updated appropriately
- There is an appropriate past medical history in the record that is easily identified including serious accidents, hospitalizations, operations and illnesses. For children less than three years old the medical record should also include a prenatal and birth history.
- All pediatric records include a completed immunization record or documentation that immunizations are up to date
- For each patient encounter:
  - The chief complaint or purpose of the visit is documented
  - Current problems, including health maintenance concerns are documented
  - A physical examination appropriate to the patient’s condition is documented
  - Laboratory or other studies ordered as appropriate
  - Diagnoses or clinical impressions are documented consistent with findings
  - There is a documented care plan
  - There is documentation of treatments, procedures and tests with results
  - Recommendations and instructions to patient are noted, including a date for return visit or other follow-up plan for each applicable encounter
  - Reasons for and results of specialist and ancillary provider services are documented
  - Consultant summaries, lab and other imaging study results reflect provider review
  - Documentation of follow-up care including telephone calls
o Documentation that unresolved concerns from previous visits are addressed at subsequent visits
o Hospitalization if applicable to include discharge summaries for all hospital admissions
o Emergency care rendered to include records and discussion of requirements for physician follow-up
o Information on ancillary services

- For patients 12 years and older, appropriate notations concerning the use of tobacco, alcohol, and other substances are to be documented.
- Appropriate health management and continuity of care are clearly reflected in the medical record. Where appropriate, evidence of follow-up to previous encounters, hospital discharge summaries, documented services and results provided by specialist, and documentation of emergency encounters and follow-up are recorded.
- For patients 18 years of age or older, documentation as to whether the patient has executed an advance directive, including an advance mental health care directive.

During 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 patient’s clinical information. The medical documentation should be organized, comprehensive and detailed. They should include patient identification, and 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 categories such as high volume adult primary care, pediatrician, OB-GYN and behavioral health. 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 those providers selected with current AlohaCare patients, a random selection of ten members is made from claims/encounter data. For a high-volume PCP, with more than 300 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 provides feedback to providers of our findings. Providers not in compliance at the time of review will be asked to submit a written action plan and are scheduled for a follow-up review within six months. Providers who do not submit a written
action plan and/or are not in compliance on the second review will be presented to the Credentials Committee and/or Quality Improvement Advisory Committee for consideration of remedial actions.

For serious deficiencies, 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.

Marketing Guidelines
AlohaCare is subject to QUEST Integration communication and marketing guidelines.

- All marketing material and member-related communications are reviewed and approved by Med-QUEST prior to distribution.

All member-related communications include a Language Block that informs the member that the document contains important information and directs the member to call AlohaCare to request the document in an alternative language or to have it orally translated. Providers are subject to compliance with the QUEST Integration marketing guidelines.

- Any marketing material developed and distributed by providers relating to the QUEST Integration Program must be submitted AlohaCare to submit to Med-QUEST for approval prior to distribution.

- Providers must allow equal access to all QUEST Integration plans to display plan-related marketing materials in their office (such as a sign indicating participation in the network of a specific QUEST Integration health plan).

Fraud, Waste and Abuse
As a Medicaid Managed Care Organization, AlohaCare is required by state and federal law to have a formal Fraud, Waste and Abuse (“FWA”) Program. Our program addresses prevention, detection, correction and reporting of incidents that can lead to fraud, waste and abuse, including but not limited to: the abuse, neglect, or exploitation of any individual receiving or providing QUEST Integration eligible services; and the loss, theft, misappropriation or overpayment of state and federal Medicaid funds. The FWA Program includes proactive data analysis and investigation of all suspected incidents of fraud, waste and abuse, recovery of inappropriate payments and training and education to mitigate future damage or loss. AlohaCare has deployed member and provider education initiatives in its efforts to support state and federal FWA cost saving initiatives.
**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.

**Waste** includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

**Abuse** means practices that are inconsistent with sound fiscal, business, or medical practices, and result directly or indirectly in an unnecessary cost to the Medicaid program, or in 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 Medicaid program.

**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**

- Providing less than the prescribed quantity but billing the health plan for the fully-prescribed amount
- Altering the prescription without the prescriber’s permission

**Common Types of Member Fraud and Abuse**

- Knowingly allowing an unauthorized person use a 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.

**Common Examples of Waste**

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory tests

Providers are required to participate in AlohaCare’s FWA Program, which includes providing training to your staff, and reporting instances of suspected fraud, waste and abuse committed by anyone receiving payment or services from the Medicaid program including a member, another provider or provider group, facility or supplier. 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, waste and abuse are confidential and should be sent to:

AlohaCare  
Attention: Corporate Compliance Officer  
1357 Kapiolani Blvd, 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. Current methods used to avoid fraudulent payments include, but are not limited to:

- Automated edits in the claim system to deny duplicate claims
- Member identity validation by matching the AlohaCare ID number and birth date as provided by Med-QUEST to what is submitted on the claim form
- Review of claims for unbundling of services
- Random verification with members as to whether billed services were furnished
- Retrospective anti-fraud and recovery services

Under our QUEST Integration contract with the State of Hawaii, AlohaCare is required to report all incidents of suspected fraud, waste and abuse to the state Medicaid agency within two (2) weeks or 14 calendar days of discovery.

Penalties for false claim submissions include liability to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus 3 times the amount of damages which the Government sustains because of the act of that person. Violators may also be held liable under applicable state of Hawaii laws and regulations.

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.

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 1996 HIPAA 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, Med-QUEST Division 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 State and Federal 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
- 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 State and Federal privacy regulations is part of this review.
SECTION 4 QUEST INTEGRATION PROGRAM AND BENEFITS

AlohaCare has a network that includes a broad range of providers—PCPs, APRNs, specialists, hospitals, facilities, pharmacies, long-term service and support providers and ancillary services to provide our members with the full range of QUEST Integration covered services.

We appreciate the willingness of the provider community to partner with us to assure access to quality care for the disadvantaged members of our community.

This section addresses AlohaCare’s responsibilities to contracted providers as well as contracted providers’ roles and responsibilities.

Program Introduction

The QUEST Integration Program is a statewide Medicaid demonstration project (Section 1115 waiver) that provides coverage for medical, behavioral health and long-term services and supports for eligible Hawaii residents through contracted health plans, such as AlohaCare.

QUEST Integration is administered by the Department of Human Services, Med-QUEST Division and is financed through the State of Hawaii and federal Centers for Medicare and Medicaid Services (CMS). For detailed information regarding Long-term Services and Supports benefits please see Section 10 Long Term Services and Supports later in this manual.

Administration of QUEST Integration Benefits

In the administration of QUEST Integration benefits, AlohaCare requires that certain services be prior authorized and/or undergo concurrent or retrospective review. The reviews ensure that the services are covered health interventions and meet the definition of medical necessity under § 432E-1.4 of the Hawaii Revised Statutes. See Appendix C for the text of HRS § 432E-1.4.

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. AlohaCare uses nationally developed clinical criteria (such as InterQual® Level of Care Criteria, InterQual® Imaging Criteria, InterQual® Procedures Criteria, InterQual® Level of Care Behavior Health Criteria, and American Society of Addiction Medicine for systematic medical necessity determinations.

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

AlohaCare’s decision is a determination of 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.

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

Some benefits have established limits for the benefit year(s). The benefit year runs January 1st through December 31st.

Non-Covered Services

Services not covered under QUEST Integration (QI)

Activities that are primarily custodial, or part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner, are not considered covered benefits. These services are typically excluded but in extenuating circumstances upon request we will review a treatment or service for medical necessity. Please review the exclusions list carefully for these and other types of exclusions:

- **Acupuncture**
- **Alternative Practices**
  - Biofeedback
  - Christian Science services
  - Faith healing
  - Naturopathic services
- **Beds**
  - Beds that do not meet the criteria as a hospital bed according to durable medical equipment guidelines
- **Certain Drugs**
  - Drugs not approved by the FDA
  - Brand name drugs (except single source drugs and name brand drugs when required by statute)
- **Chiropractic services**
- **Cosmetic surgery**
  - Cosmetic rhinoplasty (for example, nose surgery primarily to improve appearance)
  - Piercing of ears and/or other body parts
  - Electrolysis (hair removal)
  - Hair transplantation (for example, for baldness)
  - Reduction and augmentation mammoplasties (reducing or increasing breast size)
  - Panniculectomies (“tummy tuck”) and other body sculpturing
  - Acne treatment; excision or destruction of benign skin or subcutaneous lesions (without medical necessity)
- **Experimental or investigational services**
  - Procedures, drugs, devices and treatments
  - Treatment of complications caused by a previous experimental or investigational service
- **Fertilization treatments**
  - In vitro fertilization
- Reversal of sterilization
- Artificial insemination
- Sperm banking procedures
- Procedures and drugs to treat infertility or enhance fertilization

**Food including**
- Food supplements
- Health food

**Hansen’s disease treatment after diagnosis** (Except for surgical or rehab procedures to restore useful function)

**Hypnosis**

**Massage treatment** (From masseurs)

**Non-medical items**
- For example: books, television, computers, air conditioners, household items, motor vehicle, furnishings, or air purifiers and fans (unless medically necessary).

**Orthotic training** (unless medically necessary)

**Programs and memberships**
- Gym membership
- Summer camp
- Swimming lessons

**Penile and testicular prosthesis and related services**

**Psychiatric care and treatment for:**
- Sex problems
- Employment counseling
- Primal therapy
- Long-term character analysis
- Marathon group therapy

**Personal care items**
- For example: shampoos, toothpaste, toothbrushes, mouth washes, denture cleansers, shoes, slippers, clothing, laundry services, baby oil, sanitary napkins, diapers for babies, soaps, lip balm, Band-Aids, and contact lens solution.

**Physical exams, psychological evaluations, and/or immunizations**
- For employment (when the member is self-employed or as a requirement for continuing employment)
- For state driver’s license
- For securing life and other insurance policy/plans

**Pulmonary TB treatment** (When treatment is available at no cost to the general public)

**Routine foot care**
- Treatment of flat feet

**Sexual dysfunction treatment**
- Related services
- Supplies and drugs

**Shots and physical exams for travel**

**Stand-by services by physician**
- Telephone calls
- Writing of prescriptions
- Stat charges

**Treatment of persons confined to public institutions**
• **Topical application of oxygen**

• **Vision appliances**
  - Contact lenses for cosmetic purposes
  - Over-sized lenses (unless medically indicated)
  - Blended and progressive bifocal lenses (unless medically indicated)
  - Deluxe frames and lenses
  - Tinted or absorptive lenses
  - Trifocal lenses & variable
  - Spare glasses
  - Other vision aids (unless medically indicated)

• **Vision services**
  - Orth optic training
  - Prescription fee
  - Progress exams
  - Radial keratotomy
  - Visual training
  - Lasik procedure

**Services covered under the Medicaid fee-for-service program**

Some services are not covered by QUEST Integration, but are covered under the State Medicaid fee-for-service program. Prior authorization is not required for most services.

• **Routine dental care for children under the age of 21**
  Members must get dental care from a dentist who sees Medicaid patients. For more information, call Community Case Management Corporation (CCMC) at 792-1070 or call toll-free at 1-888-792-1070. Benefits include:
  - Diagnostic and preventive services once every six months
  - Emergency and palliative treatments
    - Eliminate acute infection
    - Relief of dental pain
    - Treat acute injuries to the teeth and supporting structures
  - Endodontic therapy
  - Oral surgery
  - Periodontics therapy
  - Prosthodontic services
  - Restorations

• **Emergency dental care for adults 21 years old and older**
  Members must get dental care from a dentist who sees Medicaid patients. For more information, call CCMC at 792-1070 or toll-free at 1-888-792-1070. Benefits include:
  - Acute injuries to the teeth and supporting structures
  - Treatment of elimination of acute dental infection
  - Relief of dental pain

• **Intentional termination of pregnancies (ITOP)**
Members must get ITOP services from a doctor who sees Medicaid patients and accepts Medicaid fee-for-service. Providers shall contact us or Medicaid fiscal agent for more information. In addition, Community Case Management Corp. (CCMC) may arrange transportation for ITOP services. CCMC may be reached at 792-1070 (on Oahu) or toll free at 1-888-792-1070.

- **State of Hawaii Organ and Tissue Transplant (SHOTT) Program**
The Department of Human Services provides transplants which are not experimental or investigational. The SHOTT program covers adults and children for liver, heart, heart-lung, lung, kidney, kidney-pancreas and bone marrow transplants. Children will be covered for transplants of the small bowel with or without liver. Children and adults must meet medical criteria as determined by the State and the SHOTT program. Providers shall contact us for more information.
Services from other agencies in the community

Some services are not covered under the QI program or the State Medicaid program. Members may be able to get them from other agencies or programs in the community.

- **For Adults with Serious and Persistent Mental Illness (SPMI)**
  If a member has been diagnosed with Serious and Persistent Mental Illness (SPMI), they may be eligible for additional behavioral health services from the Community Care Services (CCS) behavioral health program, which include:

  - Face-to-face care management and coordination services through contracted providers
  - Crisis services, including outreach
  - Integrated services for members who have co-occurring substance use and mental health problems
  - Psycho-social rehabilitation groups
  - Other specialized services

  Providers shall contact us for more information.

- **Child and Adolescent Mental Health Division (CAMHD) for Children Ages 3 through 20**
  CAMHD is part of the Department of Health and offers behavioral health services for children with emotional, mental health and behavioral disorders.

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- **Child and Adult Protective Services**
  Child and Adult Protective Services provide crisis intervention, including investigation and emergency services for children and adults who are reported to be abused, neglected or exploited by others.
  - Child Protective Services (CPS). For more information, call the CPS Hotline at 832-5300 or toll-free at 1-800-494-3991.
  - Child Welfare Services (CWS). For more information, call 586-4997.
  - Adult Protective Services (APS). For more information, call the APS Hotline at 832-5115.

- **Developmental Disability/Intellectual Disability (DD/ID) Services**
  The DD/ID program helps people with intellectual or developmental disabilities. These services include habilitation, behavioral assistance, housing, daily tasks and house chores. For more information, call DD/ID at (808) 586-5840.

- **Supplemental Nutrition Program For Women, Infants, and Children (WIC)**
  The WIC program helps individuals get free milk and other goods and services for themselves and their children. For more information on WIC services, call 586-8175 or toll-free at 1-888-820-6425.

- **Zero-To-Three Early Intervention Program**
  Zero-to-Three is for children between the ages of 0 and 3 years who need special health care and services. For more information, call the Hawaii Keiki Information Services System (H-KISS) at 594-0066 or toll-free at 1-800-235-5477.

- **Head Start Programs**
  Head Start Programs are for children between the ages of 3 and 5 years that provides education, health and family support services. For more information, call Honolulu Community Action Program Head Start at 847-2400 or Parent & Child Center Head Start at 842-5956.
SECTION 5 MEMBER SERVICES

AlohaCare has a network that includes a broad range of providers—PCPs, APRNs, specialists, hospitals, facilities, pharmacies, long-term service and support providers and ancillary services to provide our members with the full range of QUEST Integration covered services.

We appreciate the willingness of the provider community to partner with us to assure access to quality care for the disadvantaged members of our community.

This section addresses AlohaCare’s responsibilities to contracted providers as well as contracted providers’ roles and responsibilities.

Member Rights and Responsibilities

Members have the following rights:

Access to Care

- To receive services in a timely manner as specified in AlohaCare’s 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 and not pay more than he or she would have if services were provided 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. Choose a service provider of their choice among those organizations in AlohaCare’s provider network.
- 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.
- To be included in service plan development, if applicable.
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 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 or services, 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 patient’s condition and in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information is to be given to a legally authorized representative.
- To appoint a representative to act on his/her behalf.
- 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.

Communication

- To have access to interpreter services when the member does not speak or understand the major language of the community. To have access to sign language and TDD services for members with hearing impairments. Members also have the right to have an interpreter in the room during an exam. Interpreter, translation, sign language and TDD services are provided at no cost to the member.

- To have written materials made available to the member in the languages prevalent in the Hawaii, as determined by Med-QUEST. These languages include, but are not limited to English, Vietnamese, Korean, Ilocano and Chinese (Traditional).

- 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 requests.

File Grievances and Appeals

- 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.

- After exhausting AlohaCare’s appeal rights, the right to request a State administrative hearing and to request to receive benefits while the hearing is pending. The member may be held liable for the cost of those benefits if the hearing decision upholds the health plan’s action.

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, at no cost to the patient, 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.

Decision Making

- To participate in decisions regarding the member’s health care, including the right to refuse treatment.

Refusal of Treatment

- To refuse treatment to the extent permitted by law. An AlohaCare 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 unless copayment or deductibles are required by Med-QUEST rules.
- To be free from payment for covered services provided to the member in the event of AlohaCare’s insolvency.
- To be free from payment for covered services provided to the member in the event that the Department of Human Services (DHS) does not pay AlohaCare.
- To be free from payment for covered services provided to the member in the event that the DHS or AlohaCare does not pay the service provider.
- To be free from payment for covered services provided to the member under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if AlohaCare provided the services directly.
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 suggestions regarding our policies and procedures.

Members have the following responsibilities:

Information
- To provide information that is, to the best of the member’s knowledge, accurate and complete with regard to present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health. The member has the responsibility to make it known whether he/she clearly understands a contemplated course of action and what is expected of him/her. The member is also responsible for letting his/her physician know if he or she is taking part in any medical research tests.
- To notify Med-QUEST and AlohaCare of any change in status, such as marriage, divorce, birth or adoption of a child, death of a spouse or child or acceptance of a job. This also includes updated demographic information – primary and secondary telephone, physical (home) address and mailing address, emergency contact and email address.

Other Medical Insurance
- To provide all pertinent information related to the medical insurance coverage available at the time of a member’s eligibility determination and subsequent enrollment. If, at any time, the AlohaCare member receives medical coverage beyond his/her QUEST Integration coverage, the member is responsible for reporting this information to his/her QUEST Integration enrollment office and AlohaCare. Provider’s offices also are required to report knowledge of new third party payer information to AlohaCare.
- To provide information to AlohaCare and Med-QUEST pertaining to a worker’s compensation claim, personal injury or medical lawsuit or if the member has been involved in a car accident.

Compliance with Instructions
To follow the treatment plan recommended by his/her physician or other health care providers.

PCPs
- To know the name of his/her PCP. The member should call AlohaCare if he/she does not know this information.
- To call his/her PCP first before seeing other doctors. AlohaCare may not pay if a member receives medical services from a non-network provider without obtaining the appropriate authorizations.
Respect and Dignity

- To treat AlohaCare staff, providers and other members with respect and dignity and to cooperate with them.

Appointments

- To keep any appointments, the member has made. If a member is unable to keep an appointment, it is the member’s responsibility to notify the provider in advance.

Immunizations

- To provide immunization records to his/her PCP.

Be Responsible

- To use his/her AlohaCare ID card properly and responsibly. A member should identify himself/herself as an AlohaCare member to his/her doctors and have his/her membership card available when visiting his/her doctor. Members must not lend their membership card or allow other people to use the card.
- To stay healthy
- To contact his/her Med-QUEST eligibility worker if subject to an annual QUEST Integration eligibility review.
- Any cost-sharing requirements as required by State and Federal guidelines

Fraud and Abuse

- To report suspected member or provider fraud or abuse.

Make Medical Wishes Known

- To make his/her medical wishes known in the event that he/she is no longer able to make informed health care choices. This is known as an “Advance Directive,” which is defined as a set of written instructions about the member’s wishes regarding medical care. Examples of Advance Directives include Living Wills, Do Not Resuscitate Orders, Medical Durable Powers of Attorney, Appointment of Health Care Proxy, and Court-appointed Surrogates and Guardians. An Advance directive is used if the member is unable to make medical decisions for himself/herself and should be referred to by the member’s PCP or caregiver.

- The member’s doctor or caregiver will refer to these documents if necessary; the member does not need to carry it with him/her. When there are no written directives and the member is unable to make medical decisions, family members may be asked to make the decisions about the care and treatment the member receives.
Member’s Selection of Primary Care Provider (PCP)

To select a PCP within 10 days of receiving his/her QUEST Integration New Member Packet. PCP selection instructions are included in the new member packet.

If a member does not choose a PCP within 10 days of receiving his/her QUEST Integration New Member Packet, AlohaCare will assign the member to a PCP based on criteria such as geographic service area, PCP availability, member/PCP history, member’s medical needs, gender and age, family continuity and PCP panel restrictions.

Per RFP requirements, that auto assignment of a PCP will be made no sooner than the 25th day of enrollment. 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 Member Services Department to select another PCP. Members are not limited in the number of their PCP selections or changes.
Member ID Cards
AlohaCare members receive two identification cards, a temporary ID card followed by a permanent ID.

Temporary AlohaCare ID Card
Permanent AlohaCare ID Card

The QUEST Integration New Member Packet, which is sent to new enrollees shortly after enrollment into AlohaCare by Med-QUEST, contains a temporary ID card with the member’s name and QUEST Integration ID number. As a Primary Care Provider has not yet been selected, this card does not reflect this information. The temporary ID card allows a newly enrolled member the ability to obtain medical services in situations of immediate need.

If a new QUEST Integration member does not have an AlohaCare ID card, providers would request that the provider accept the State of Hawaii Department of Human Services letter of confirmation of enrollment into a QUEST Integration plan as a temporary ID card.

Possession of an AlohaCare ID card does not guarantee QUEST Integration eligibility.

Member Eligibility Verification
We recommend that providers verify a members’ eligibility and enrollment prior to rendering services. Providers may verify members’ eligibility via AlohaCare’s AC Online secure provider portal or by calling our Provider Services Department at 808-973-1650 or toll free at 1-800-434-1002. Failure to confirm members’ eligibility and enrollment 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.

Newborns
The birth of a child requires notification. Often, the mother’s hospital will fax AlohaCare a face sheet. AlohaCare uses the face sheet to alert Med-QUEST of the birth so that the newborn can be enrolled into the QUEST Integration Program, if appropriate.

According to Med-QUEST guidelines, a newborn is generally eligible under the mother’s QUEST Integration health plan from the date of birth for a minimum of 30 days thereafter.
If the newborn’s name was not included on the original notification, AlohaCare will follow up with the hospital to ensure enrollment of the newborn into the QUEST Integration Program and timely claims processing.

Provider Verification

When calling Provider Services to verify member information, please have the following available to assist call center staff in provider verification:

**Provider Information (Please identify by stating I am with “Dr. XYZ office Tax ID #123456789)**

- Provider’s name and Federal Tax Identification Number (FEIN)

**Member Information (Please identify the member you are calling to verify eligibility status, claims, authorization or payment status using the following identifiers)**

- Member’s name (required)
- Date of birth or AlohaCare ID #
- Date of service

To check on eligibility status, providers may call the Med-QUEST Customer Services Section at 524-3370 or toll free at 1-800-316-8005 or the Med-QUEST DHS Medicaid On-Line (DMO) service https://hiweb.statemedicaid.us

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 1996 HIPAA 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, Med-QUEST Division 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 State and Federal 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
- 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 State and Federal privacy regulations is part of this review.
SECTION 6 UTILIZATION MANAGEMENT/MEDICAL MANAGEMENT (UM/MM)

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. AlohaCare makes Utilization Management decisions based solely on appropriateness of care and service and member eligibility for plan benefits and coverage. AlohaCare does not specifically reward providers, staff, or any other individuals, for issuing denials of coverage, nor does it encourage or offer any financial incentives to individuals who are responsible for making UM decisions that result in underutilization.

New Technology

AlohaCare utilizes a systematic, scientifically-based assessment of new technologies and new applications of existing technologies to approve for coverage those which provide a demonstrable benefit for members.

Medical Request for 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. The medical request for prior authorization and notification are important processes in the coordination of care and further described in the following sections.

For standard service authorization decisions that deny or limit services: as expeditiously as the member’s health condition requires, but not more than fourteen (14) calendar days following receipt of request for service, with a possible extension of up to fourteen (14) additional calendar days (total time frame allowed with extension is twenty-eight (28) calendar days from the date of the request for services) if: (1) the member or provider requests an extension; or (2) the health plan justifies a need for additional information and how the extension is in the member’s best interest. If the health plan extends the time frame, it must: (1) give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision to extend the time frame; and (2) issue and carry out its determination as expeditiously as the member’s health condition requires but no later than the date the extension expires.

For expedited authorization decisions: as expeditiously as the member’s health condition requires but no later than seventy-two (72) hours after receipt of the request for service. The health plan may extend the seventy-two (72) hour timeframe by up to an additional fourteen (14) calendar days if the member
requests an extension, or if the health plan justifies to the DHS a need for additional information and how the extension is in the member’s best interest.

**The Request for Authorization and Notification (RAN) Form**

The Request for Authorization and Notification (RAN) form is used whenever a prior authorization or notification is needed.

**Specialty Care**

Specialty care services do not require a referral if the services are provided by an in-network/participating provider within the member’s home island. The appropriateness of referring an AlohaCare member for specialty care services is determined by the patient’s PCP or treating physician. Additionally, the PCP and/or treating physician must document the purpose and result of these services in the member’s medical records.

A PCP or treating physician determines that a medical condition requires the expertise of a specialist to diagnose and/or treat. The PCP/treating physician must refer the patient to an in-network/participating AlohaCare provider who, in the PCP’s opinion, is best able to determine the presence of a medical condition or the appropriate treatment.

AlohaCare provides female members with direct in-network access to a women’s health specialist for covered care necessary to provide routine and preventive healthcare services and management of obstetric and gynecological conditions. This is in addition to the member’s designated source of primary care if the PCP is not a women’s health specialist.

**Prior Authorization Process**

To ensure that only medically necessary and appropriate services are covered, prior authorization for specific services may be required. AlohaCare can accept both electronic and hard copy prior authorizations.

- Refer to the [Prior Authorization Look-up tool](www.AlohaCare.org) located on our website or you may contact our call center at 973-1650 or toll free at 800-434-1002. If a PA is required, complete the next steps.

- Complete a Request for Authorization and Notification (RAN) form to request authorization for the procedure
  - Fill in Member Information and PCP Information
  - Fill in the Prior Authorization Section including facility information, ICD-10 codes, diagnosis and requested service.
  - Attach current clinical notes pertinent to the request and documentation of medical necessity.

- Submit RAN form to AlohaCare
Submit electronically via our Provider Web Portal (AC Online) at www.alohacare.org (for information on how to sign up for AC Online. Please see Section 2 of this manual regarding the Provider Web Portal

You may also fax the RAN form to 973-0676 or toll-free at 1-888-667-0680

- **Confirmation of AlohaCare’s Receipt**
  - A submitter will receive a confirmation of submission for a RAN submitted via our Provider Portal (AC Online). These submissions be monitored by the provider.
  - It is recommended that the provider retain a copy of their fax confirmation when submitting a RAN via fax as it will provide the submitter proof of submission.

**Medical Review (status)**

A status of “medical review” indicates that a decision has not yet been rendered for a prior authorization request; AlohaCare is still reviewing the request and/or additional documentation or information is required to determine medical necessity.

We will notify the provider seeking authorization by telephone and/or by fax on AlohaCare’s Medical Information Request Form if additional documentation or information is required to determine whether the requested service meets InterQual® criteria, AlohaCare Medical Policy or American Society of Addiction Medicine (ASAM) criteria.

We will make two attempts to request additional documentation or information from the provider after the prior authorization is received.

When the first request for Medical Information Request form is issued, we request that the provider submit the additional documentation or information within 6 hours of request for an expedited request and 2 days for a standard request.

A second request will be sent within these timeframes requesting if the additional documentation or information is not received within the timeframes reflected within our first request. The timeframe for submission of information or documentation within 24 hours of the authorization’s due date for expedited requests and 7 days for standard request.

If the requested documentation or information is not received within a total of 72 hours for expedited request or 14 calendar days for standard requests, the prior authorization request will be denied due to insufficient documentation to determine medical necessity. Member/Provider may request an extension of up to 14 additional calendar days.
Adverse Benefit Determination (Denial)

An adverse benefit determination is any one of the following:

- The denial or restriction of a requested service, including the type or level or service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or part, of payment for a service;
- The failure to provide services in a timely manner, as defined in Section 40.230 (availability of providers);
- The failure of the health plan to act within prescribed timeframes and regarding the standard resolution of grievances and appeals;
- For a rural area member or for islands with only one health plan or limited providers, the denial of a member’s request to obtain services outside the network:
  - From any other provider (in terms of training, experience, and specialization) not available within the network;
  - From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;
  - If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days;
  - Because the only health plan or provider does not provide the service because of moral or religious objections;
  - Because the member’s provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; and

For any adverse benefit determination AlohaCare will give the member and the referring provider a written notice of adverse benefit determination within the following time frames:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days prior to the date the adverse benefit determination.
- For standard service authorization decisions that deny or limit service, as expeditiously as the member’s health condition requires, but not more than fourteen (14) calendar days following receipt of request for service, with a possible extension of up to fourteen (14) calendar additional days (total time frame allowed with extension is twenty-eight (28) calendar days from the date of the request for services) if: (1) the member or provider requests an extension; or (2) the health
plan justifies a need for additional information and how the extension is in the member’s best interest. If the health plan extends the time frame, it must: (1) give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision to extend the time frame; and (2) issue and carry out its determination as expeditiously as the member’s health condition requires but no later than the date the extension expires.

- For expedited authorization decisions: as expeditiously as the member’s health condition requires but no later than seventy-two (72) hours after receipt of the request for service. The health plan may extend the seventy-two (72) hour timeframe by up to an additional fourteen (14) calendar days if the member requests an extension, or if the health plan justifies to the DHS a need for additional information and how the extension is in the member’s best interest.

**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
- Pregnancy/Delivery
- Dialysis and Hospice
- Chemotherapy
- Radiation Therapy

**Notification Process**

- **May be submitted electronically via our Provider Web Portal (AC Online) or their Face Sheet or RAN form to AlohaCare.**
  - (808) 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, usually in the form of an admission face sheet from the hospital is required within 24 hours of an emergent or elective inpatient admission or observation stay. The notification initiates the AlohaCare inpatient concurrent review process.

- **The admission face sheet should contain the following information:**
  - Patient demographics
  - Medical Record Number
  - Name of admitting physician
Obstetrics
AlohaCare’s goal is to have healthy mothers and healthy babies. AlohaCare works with the PCP and the obstetrician to provide a variety of services, including the following:

- Prenatal testing
- Prenatal Care
- Transportation to access obstetrical care
- Delivery
- Postpartum care

Notification of diagnosis of pregnancy: Providers are asked to send AlohaCare notification within 24 hours of making a diagnosis of pregnancy for an AlohaCare member. The initial visit to determine pregnancy is payable separately, outside the Global Maternity package.

In the notification, please provide the following information:

- Expected date of confinement (EDC)
- Any high risk factors identified
- Name of health care provider who will be providing OB care

Notification Pregnancy Visit:

- May be submitted electronically via our Provider Web Portal (AC Online) or fax their Face Sheet or RAN form to AlohaCare
  - Fax to (808) 973-0676 or toll-free at 1-888-667-0680
- AlohaCare will send the submitter written confirmation (by fax or mail)

OB Services
Notification from OB physician for initial pregnant member visit: A notification is required when an OB physician is seeing a pregnant member for the first time. The notification is used by AlohaCare to inform Med-QUEST of the member’s pregnancy to help ensure the continuation of QUEST Integration benefits.

The notification to AlohaCare will result in an “authorization number” for the OB provider so that claims may be processed. If the OB provider participates only as a specialist, he/she will provide all pregnancy-related care. Coding of claims should reflect actual services provided by the OB.

NST/AFI’s and the first three OB ultra-sonograms do not require prior authorization and are included and payable under the global OB “notification number” issued upon pregnancy notification.
High Risk Pregnancy

AlohaCare utilizes a care management approach with its identified high risk pregnant members. When AlohaCare is notified that a member might be high risk, the member is followed by a service coordinator who works with the member, the PCP, obstetrician, and other providers to meet the medical needs of high-risk pregnant members.

Additional activities that your notification initiates include:

- AlohaCare sends a letter and educational brochures to the pregnant member.
- A more in-depth assessment is done of the member’s prenatal health for high risk pregnancies by the service coordinator, and reassessments are performed at later stages of gestation.
- Keiki Health Connection: AlohaCare asks that the provider encourage the mother, during pregnancy or as early as possible after delivery, to designate a PCP for her baby. Inform AlohaCare’s care manager if there are any suspected issues with your prenatal patient that may delay the newborn making a successful connection with a PCP. Our list of “Keiki Health Connection” risk factors includes:
  - Failure to select a PCP for the newborn as soon as possible
  - Late prenatal care
  - Young age (<16 years) of mother
  - Current alcohol or substance use
  - Methadone maintenance program
  - Social issues
  - Homelessness
  - Violence/abuse
  - Previous Child Protective Service (CPS) involvement
  - Other situations that may jeopardize the health of the mother or baby

If the OB provider is also the PCP, he/she provides all pregnancy-related care and any primary care services required. Notification to AlohaCare of the pregnancy and assignment of an “authorization number” is still required in this circumstance. Providers are required to use OB codes for billing, as described in the OB Coding Guidelines. For non-pregnancy related PCP services provided, separate additional reimbursement will be available. The OB will continue as the PCP after delivery unless the member contacts AlohaCare to request a change in PCP.

Notification Guidelines for Pregnant Members

While a pregnant member is under the care of an OB provider who is not her PCP, a prior authorization from the PCP is not required if rendering services outside of the OB authorization or for conditions unrelated to the pregnancy state of the member but can be easily treated by the OB provider. Examples include services for UTI, URI, most low back/pelvic pain complaints, vaginitis, hypertension and toxemia;
these services should be billed with the appropriate E&M code and will be paid outside of the Global OB inclusive payment structure.

Services for common pregnancy-related conditions occurring during pregnancy such as vaginal spotting, Braxton-Hicks contractions, gestational diabetes, hyper emesis, preterm labor and premature rupture of membranes are covered and reimbursed under the Global OB care.

Medical complications outside the scope of the OB practice, generally, are referred to specialists such as perinatology doctor. For conditions that require specialty care services, such as patients who have an unstable cardiac condition, brittle diabetes, or neurological disease, the PCP must refer the patient to a specialist.

Surgical complications during pregnancy will be eligible for fee-for-service payment if the operative report is attached to the claim.

When a member receives care from two different OB providers for ante partum care; the provider must bill for OB-related services rendered according to the guidelines in the CPT manual. AlohaCare may call the providers to determine or verify the number of times the member was seen at each office and which services were provided. Authorizations will be modified to reflect the actual care that was given to ensure accurate and appropriate claims payment.

Newborns

According to Med-QUEST guidelines, a newborn is generally the responsibility of the specific QUEST Integration health plan effective on the date of birth (and for a minimum of 30 days thereafter), only when the mother is a member of that health plan at the time of delivery. However, due to a new program that Med-QUEST is implementing, called Prior Period Coverage, eligibility in the health plan may be retroactive.

Once the notification is processed by AlohaCare, an authorization approval number is assigned and faxed to the provider. To expedite claims processing, this number should be entered in Box 23 of the CMS 1500 claim form, or Form Locator 63 on the UB04 claim form. If no notification is received, claims will be denied. All notifications received for medical/surgical admissions initiate concurrent review activities in which AlohaCare licensed RNs using InterQual® Level of Care Criteria guidelines assess the level of care and length of stay of the hospital stay for payment purposes.

AlohaCare will pend claims received for newborns until eligibility is verified and the QUEST Integration ID number is received from Med-QUEST Once the newborn eligibility and QUEST Integration ID number are established, AlohaCare will process the claim for the baby’s facility stay, provided a notification was received and authorization was entered. In cases where the newborn’s confinement exceeds that of the mother’s, a notification is required and AlohaCare will issue a separate inpatient authorization number for the newborn’s stay.
Prior Authorizations

AlohaCare’s prior authorization look-up tool is located on our website www.alohacare.org.

Providers have access to AlohaCare’s Prior Authorization look-up tool which provides timely and accurate information with regard to codes that do and do not require authorizations.

AlohaCare’s online look-up tool is also accessible to providers who submit electronic prior authorizations utilizing our secure provider portal, AC Online.

The online look-up tool will allow you and your staff to search for Prior Authorization requirements in several different ways:

- By Line of Business (LOB) – Medicare and Medicaid
- By Category (e.g. Durable Medical Equipment)
- By Code (e.g. particular CPT or HCPCS - complete code only)

Providers that do have internet access may contact AlohaCare Provider Services at 973-1650 or toll-free at 1-800-434-1002 to inquire whether services require prior authorization.

Note: For best results using the new website and the look-up tool, please make sure you have the latest version of your internet browser installed.

Services That Do Not Require a Prior Authorization or Notification

The following services may be performed without obtaining a 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).
- Services rendered as part of an inpatient hospitalization. AlohaCare will perform concurrent or retrospective 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 patient is admitted subsequent to presentation in the emergency room, a notification must be submitted to AlohaCare within 24 hours of admission.
- Well-woman Services such as gynecological health care services, including yearly exams, birth control, pap smears, breast exams, and family planning.
- Outpatient Behavioral Health
- services with the exception of services related to substance abuse disorders do not require a prior authorization. Members may self-refer to a Behavioral Health provider.

Emergency Services

Whenever possible, a QUEST Integration member should first contact his or her Primary Care Provider (PCP) for instructions regarding where to go for emergent/urgent care. For after-hours emergent/urgent care, the member can contact his or her PCP through a service such as Physicians Exchange. If the situation warrants, the member can be directed to the nearest emergency or urgent care facility for
services. If the member is unable to contact his or her PCP prior to seeking medical attention, the member should contact his or her PCP within 48 hours or as soon as reasonably possible. This allows the PCP to arrange for a transfer when the member’s condition is stable and provide follow-up care as necessary.

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 (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious harm to self or others due to an alcohol or drug abuse emergency
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions:
  - that there is not adequate time to effect a safe transfer to another hospital before delivery
  - that transfer may pose a threat to the health or safety or the woman or her unborn child

The AlohaCare Member Handbook lists examples of when a member should go to the emergency room including but not limited to active labor, seizures, broken bones, and head injury.

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.

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 improve or resolve the member’s condition.

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 or behavioral health
admission so that a review of the admission may occur, an estimated length of stay assigned, and
service 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 clinical care criteria not met and provide notification of any impending lowering of level of care
or denial based on review findings. 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.

Discharge Planning

Discharge planning is essential to the concurrent review process and will be initiated, upon admission,
by the hospital Utilization Management nurse. AlohaCare’s Service Coordinator, 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 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 service coordination.
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 is instituted.

Early discharge planning also allows initiation of service coordination services, particularly for special health care needs and/or complex cases. Please see Section 9 Service Coordination.

Three (3) specific services have additional requirements beyond the AlohaCare prior authorization request that entitle them to special mention. These include the following:

Specific Procedures for Sterilization

Federal regulations require us to ensure that very specific consent requirements are followed before we can pay for sterilizations. In conformance with federal law, AlohaCare requires the following:

- Sterilization (for male and female) requires prior authorization.
- Form DHS 1146 “Sterilization Required Consent Form” must be used to obtain consent or payment will be denied – no substitution of this form is allowed. This form must be signed by the patient at least 30 days and not more than 180 days prior to the sterilization procedure.
- Prior authorization request must be accompanied by a copy of DHS 1146 form with the following sections completed:
  - Consent to sterilization
  - Statement of Interpreter (if interpreter is used)
  - Statement of person obtaining consent
  - Mental competency must be determined
  - Voluntary consent must be obtained without duress
- Consent may not be obtained when:
  - Member is in labor or giving birth
  - Member is seeking to obtain or obtaining an abortion
  - Member is under the influence of alcohol or other substances that affect the individual’s state of awareness
  - Consent must be obtained at least 30 days, but not more than 180 days, before the scheduled date of the sterilization.
- Sterilization can be performed before the 30-day waiting period when it is performed at the time of premature delivery and consent was obtained at least 72 hours prior to the premature delivery and 30 days prior to the expected date of delivery. In cases of routine delivery, the consent must have been signed at least 30 days prior to the date of expected delivery.
- Sterilization can be performed before the 30-day waiting period when it is performed at the
time of emergency abdominal surgery, if at least 72 hours has passed since the consent for sterilization was obtained.

- The completed DHS form 1146 must be attached to the claim, with the remaining section (Statement of Physician) completed, in order for the claim to be payable.

**Specific Procedures for Hysterectomy**

Federal regulations require us to ensure that very specific consent requirements are followed before we can pay for hysterectomies. In conformance with federal law, AlohaCare requires:

- Hysterectomies must be prior authorized, and will be approved only in cases of medical necessity.
  - Form DHS 1145 “Hysterectomy Acknowledgement” must be completed and signed by the member to show that she specific information regarding the permanent incapability to reproduce after the procedure. No substitution of this form is allowed (see exception below for prior sterility) and must be submitted with the prior authorization request.
  - In instances where enrollee had prior sterilization procedure, is post-menopausal or has any other disease state that renders her sterile, documentation of the sterile state should be submitted with the prior authorization request in lieu of DHS Form 1145.
  - In cases where the hysterectomy is performed under an emergent or life-threatening condition, medical record documentation must be attached to the claim form to justify why the procedure was performed without prior consent or authorization in order for the claim to be payable.

Hysterectomies are not covered in the following circumstances:

- The hysterectomy is performed solely for the purpose of rendering a member permanently incapable of reproducing
- There is more than one purpose for performing the hysterectomy, but the primary purpose was to render the member permanently incapable of reproducing
- It is performed for the purpose of cancer prophylaxis

**Specific Procedures for Induced Termination of Pregnancy (ITOP) and Related Services**

ITOP and related services are not covered by the QUEST Integration health plans, but are covered by Medicaid FFS Program. Questions should be directed to the Medicaid FFS Program Affiliated Computer Systems (ACS), the FFS Program fiscal agent. ACS can be contacted at 952-5570 or toll-free at 1-800-235-4378. Questions related to the drug coverage should be directed to ACS PBM at 1-877-439-0803.

**Telemedicine**

AlohaCare covers telemedicine services as outlined below:
Technologies Involved

- An interactive telecommunications system must be used and the examination of the patient 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 patient (email).
- 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
- Nurse Midwife
- 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
- A hospital
- A critical access hospital
- A rural health clinic
- A federally qualified health center

Billing and Payment Issues

- Originating site: $20 facility fee
  - No prior authorization from AlohaCare is required
  - Type of service is “9 other items and services” (not a required field for AlohaCare for 1500 claim processing)
  - For UBs, appropriate bill types are: 12X, 13X, 71X, 73X, and 85X
For UBs, the appropriate revenue center should be billed: emergency room (450), operating room (360), clinic (510), etc.

If hospital outpatient department, $20 fee paid outside of other outpatient reimbursement methodology

If hospital inpatient, $20 paid in addition to regular per diems

If physician or practitioner office, paid lesser of actual charge or $20

- Practitioner at originating site
  - No “tele presenter” fee paid, and distant site practitioner cannot share any of his/her payment with the tele presenter (anti-kickback regulations)
  - Eligible to be paid for other distinct services provided that day that are reimbursable – if not the PCP, AlohaCare’s usual prior authorization/notification policies must be followed to receive payment

- Practitioner at distant site
  - A prior authorization is required from the PCP if the servicing provider is an out-of-network, out-of-state, non-participating specialist
  - Bill regular CPT code with “GT” modifier for interactive telecommunications
  - Bill regular CPT code with “GQ” modifier for asynchronous telecommunications
  - Reimbursement is at fee schedule amount for the CPT code used
  - No payment by health plan of a distant site “facility fee” for use of equipment by the distant site practitioner
  - No payment is made to the distant site practitioner for travel time or afterhours fees.

Clinical Decision Support Tools and Clinical Practice Guidelines

AlohaCare utilizes 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 definition of medical necessity found in Hawaii Revised Statutes (§423-1.4).

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

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

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

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

Reference criteria for Behavioral Health services use the most current version of:
• InterQual® Geriatric Psychiatry
• InterQual® Adult Psychiatry
• InterQual® Adolescent & Child Psychiatry
• InterQual® Chemical Dependency & Dual Diagnosis (Adult & Adolescent)
• InterQual® Residential & Community-Based Treatment-
• American Society of Addiction Medication (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 are reviewed at least annually by Quality Improvement Committee (CQIC).
In the absence of InterQual® criteria, other reference criteria, guidelines, and/or research tools are
used by AlohaCare to assist with medical determinations, such as medical policies, Hayes, and Clinical
Practice Guidelines.

AlohaCare’s medical policies are developed based on peer-reviewed scientific literatures, expert and
professional opinions, definitions and guidelines from national health care organizations, as well as
public health agencies and governments. AlohaCare review and revise medical policies every 12
months in a timely manner. The medical policies are posted on AlohaCare’s website at

Hayes is a nationally recognized clinical decision support tool. Hayes Rating system reflects the quality
and direction of the evidence regarding a test, technology, or care, including safety and efficacy,
impact on health outcomes, indications for use, and comparison with other technologies. Hayes is
subscribed annually.

AlohaCare publishes Clinical Practice Guidelines or links relevant to the QUEST Integration 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.

The Clinical Practice Guidelines are reviewed and updated annually. Provider input is obtained through
the AlohaCare Practitioners Advisory Committee (PAC). PAC reviews the existing guidelines to ensure
they remain current and in alignment with national and community standards of medical practice. PAC
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 QUEST
Integration 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 QUEST Integration 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 Patients with Major Depressive Disorder
- Routine Prenatal and Postpartum Care
- Chronic Heart Failure
- Coronary Artery Disease
- Child/Adolescent Immunizations
- Adult Immunizations

- Diagnosis and Treatment Management of Attention Deficit/Hyperactivity Disorder (ADHD) in School-Aged Children
- Diagnosis and Treatment of Chlamydia

Link to the most current medical policies and Clinical Practice Guidelines are available on our website at www.AlohaCare.org.
SECTION 7 PHARMACY SERVICES

Formulary

The AlohaCare QUEST Integration Formulary ("Formulary") is developed by AlohaCare’s Pharmacy and Therapeutics Committee whose members include participating network physicians and pharmacists. The Formulary, Formulary Updates, and Coverage Criteria are available to providers on our website at www.AlohaCare.org. Our Formulary is generic-based and includes select brand medications. Once a brand medication loses patent exclusivity, its generic counterpart is evaluated and may be added to the formulary. A non-formulary medication may be approved through our prior authorization process with clinical justification, which includes the rationale a member is unable to use a formulary medication.

Formulary Limitations

The Formulary lists all covered medications. Members are limited to a 30-day supply per prescription fill.

The following are additional requirements or limitations to the Formulary:

- **Prior Authorization:** Medications that require a Prior Authorization (PA) are noted on the formulary with a PA designation. PA requests undergo clinical review for appropriate utilization and approval.

- **Quantity Limits:** Medications with quantity limits (QL) are noted on the formulary with a QL designation. Established by the FDA dosing recommendations, quantity dispensing limits are implemented to minimize the potential for adverse drug reactions due to over utilization. If a higher dose is deemed medically necessary, requests will undergo clinical review for appropriateness and approval.

- **Step Therapy:** Medications with a step therapy edit are noted on the formulary with a ST designation. AlohaCare encourages the use of first line agents as much as possible. Certain medical conditions identified by AlohaCare require the use of a first line agent. Utilization of first line agents for these conditions is electronically identified; positive confirmation results in immediate approval at the pharmacy. Absence of a first line agent will prompt a request for prior approval. Approval is granted pending clinical review.

- **Age Limit:** Medications with an age limit (AL) are noted on the formulary with an AL designation. Requests that are outside of the covered age limit shall require a PA review.

- **Early Refills:** Early refills are limited to a maximum of a 30-day supply. An early refill may be required due to dosage changes, additional therapy, lost or stolen medication or vacation supply. When requesting an early refill for vacation supply, please provide the following:
  - Name of medication;
  - Quantity requested (30-day maximum); and
  - Vacation Itinerary (please note that travel to the Neighbor Islands is not eligible for a vacation supply). Vacation overrides are limited to a 30-day supply.
How to Request a Formulary Exception

As a provider you may request AlohaCare to make exceptions to our drug coverage rules as follows:

- Coverage for a drug that is not listed on the AlohaCare Formulary
- Reconsideration of coverage restrictions or limits placed on certain medications.

Requests for an exception to the formulary may be approved with documented treatment failure or adverse reactions to two formulary medications. To request a formulary exception, please follow the drug coverage determination or PA process outlined below:

- Fill out the Drug Coverage Request Form (found on the “Forms” tab on the AlohaCare website) and fax the completed form to AlohaCare Pharmacy Management at 973-6327 or toll-free at 1-877-316-6376. Failure to complete and provide all pertinent information may result in a denial and further delay the review process.

- A decision for all prior authorization requests will be made within 24 hours from the receipt of the request.

- For questions about medications, please email AlohaCare Pharmacy Management at pharmacy@alohacare.org or call 973-7418 or toll-free at 1-866-973-7418.

- AlohaCare will notify the prescribing provider’s office of the decision. If the request is denied, you may request a reconsideration or an appeal by contacting the Grievance and Appeals Department at:
  AlohaCare
  Attn: Grievance & Appeals Department
  1357 Kapiolani Blvd., Suite 1250
  Honolulu, HI 96814
  Phone: 973-0712 (toll free 877-973-0712)
  Fax: 973-2140 (toll free 877-973-2140)

AlohaCare members receiving a long-acting and/or multiple opioid drugs may be subject to a clinical drug use review to ensure appropriate drug usage specific to the member’s medical condition(s) and their individualized care plan.

AlohaCare can assist providers in limiting these types of drugs to a specific prescriber and/or a specified pharmacy upon the Provider’s approval.

After Hours Drug Access/Emergency Medication Supply Policy

After business hours, a retail pharmacist may dispense a 7-day emergency supply or smallest package size (i.e. one inhaler, or one vial of insulin) of non-formulary medications and advise the member to contact the prescribing provider on the next business day to request prior authorization for continuation of the non-formulary prescription. Alternatively, a retail pharmacist may inform the prescriber that a 7-day emergency supply has been dispensed and alert the prescriber that he/she must follow-up with AlohaCare to request a prior authorization for continuation of the non-formulary prescription. The 7-day emergency supply may be dispensed after-hours for formulary medications that do not process through the online system correctly, subject to verification of member’s eligibility and benefits. The pharmacist
should contact AlohaCare on the next business day to secure payment for the emergency supply (please see conditions below).

**QUEST Integration**

- After AlohaCare’s normal business hours and/or in emergent circumstances (i.e., a natural disaster\(^1\) or a true emergency\(^2\)), pharmacy providers are authorized to dispense a seven (7) day emergency supply of medication to AlohaCare’s QUEST Integrated members without Prior Authorization until AlohaCare can make a medically necessary determination regarding new drugs.\(^3\)
- A Hawaii Standardized Prescription Drug Prior Authorization Form (“Form”) must be completed by the pharmacy and submitted to Aloha Care. In lieu of the prescriber’s signature, the words “Emergency Dispensing” must be written in the signature space of the Form. In addition, the date, time, and justification for dispensing the drug must be entered on the Form and documented on the prescription.\(^4\)
- The dispensing of the seven (7) day emergency supply of medication applies only to outpatient prescription drugs from manufacturers that participate in the Drug Rebate Program and for drugs that are not determined to be less than effective (LTE)(DESI 5 and 6).\(^5\)
- AlohaCare shall reimburse all “Emergency Dispensing” prescriptions if the above criteria are met. AlohaCare shall contact the pharmacy via the phone number provided on the Form the next business day. Once AlohaCare issues a verbal approval, the claim may be processed at the point of sale (POS).
- Pharmacy providers are instructed to call the AlohaCare Pharmacy Department at 808-973-7418 (Oahu) or 1-866-973-7418 (Neighbor Island) on the next business day to request a Form for the emergency medication supply if needed.

**MEDICARE**

Pharmacy providers are connected to AlohaCare’s Medicare after hours call center provider if calling outside of the following hours and have access to AlohaCare’s Clinical Reviewer (pharmacist or physician) for emergency/urgent questions and/or issues:

- 7:45 a.m. to 5:00 p.m. Monday through Friday
- AlohaCare business holidays

\(^1\) Natural disaster means any disaster such as a tsunami, hurricane, volcanic eruption, typhoon, earthquake, or flood. Hawaii Administrative Rules §11-50-2 (Feb 24, 2014).
\(^2\) True emergency means the consequence of delaying the dispensing of the drug by 24 to 72 hours results in a high probability of serious adverse effects on the person’s health. Serious adverse effects are hospitalization, medically necessary emergency room care, and loss of bodily function or life. Medicaid Provider Manual 19.1.6.2 (Jan 2011).
\(^3\) RFP-MQD-2014-005 Sec. 40.740.1.s
\(^4\) Medicaid Provider Manual 19.1.6.2.c.1 (Jan 2011).
\(^5\) Medicaid Provider Manual 19.1.6.2.a.1 (Jan 2011).
Excluded Drugs
The following are exclusions and are not covered by the QUEST Integration pharmacy benefit:

- Drugs not approved by the U.S. Food and Drug Administration or deemed “less than effective” (DESI 5 and 6) by the Centers for Medicare and Medicaid Services (CMS)
- Brand medications when there is an equivalent generic medication
- Drugs prescribed by a dentist that are not primarily medical in nature (dental coverage is provided by Medicaid fee-for-service program)
- Experimental and investigational drugs that are generally an unproven benefit
- Hansen’s Disease drug treatment
- Drugs related to in-vitro fertilization, reversal of sterilization, artificial insemination and to test fertility
- Drugs related to food supplements and prepared formulas for weight loss
- Immunizations for travel (domestic or foreign)
- Pulmonary tuberculosis treatment, if treatment is available at no charge to the general public
- Drugs excluded by the Hawaii Medicaid Program
- Sexual dysfunction drug treatments
- Drugs used for cosmetic purposes

How to Request a Copy of the AlohaCare QUEST Integration Formulary

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

A drug reference database, Drug Finder, is also 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 AlohaCare Pharmacy and Therapeutics Committee.

When AlohaCare updates the QUEST Integration Formulary we send notifications to providers via our Provider Advisories or Newsletters.
SECTION 8 BEHAVIORAL HEALTH

Mental Health and Substance Use Disorders

AlohaCare provides comprehensive health benefits to all AlohaCare members. Behavioral health services may be needed for mental health conditions that are acute, episodic or short term in nature to more chronic conditions that may require longer term treatment. The behavioral health operations are integrated as part of our comprehensive approach to clinical management, ensuring the highest quality of services. Our staff work to establish continuity of care for members with psychiatric, substance use, and/or medical co-morbidity. Our Service Coordinators assess every member for all needs, including behavioral, medical, physical, psychosocial, and long term service and supports using a comprehensive assessment tool.

Behavioral Health services are provided to:

- Improve the level of functioning in order to relieve or reduce the level of impairment and disability,
- Prevent deterioration in functioning, where possible,
- Maintain the level of functioning for conditions that have reached a plateau of improvement and would deteriorate without supportive treatment, and
- Increase coping skills and level of functioning for those suffering from mental illnesses and/or substance use disorders.

Self-Referral to BH Services

Members who have behavioral health or substance use needs can self-refer by making an appointment to see an AlohaCare participating provider. The member may also call an AlohaCare Care Manager or Service Coordinator to assist in finding a provider. If the requested service requires a prior authorization, the provider/facility staff will call/fax their request for authorization to AlohaCare’s Behavioral Health fax line at 808-973-6324. The PCP is notified by AlohaCare of authorized services that their patient has been approved to receive.

AlohaCare providers have barrier-free access to emergency behavioral health services. Although visits to the emergency room do not require prior authorization, the facilities have the option to notify AlohaCare of a member’s emergency psychiatric admission. A Clinician is available after hours and can be reached by calling 1-800-973-0712.

If requested, a telephonic review of the clinical issue is completed by the clinician and the provider to determine if acute care is the most appropriate level of care for the member.

Service Coordination

AlohaCare employs licensed Behavioral Health Clinicians, Licensed Social Workers, Licensed Practical Nurses, or Registered Nurses to assist providers and members with the prior authorization process and coordination of member care by:
Assessing the initial level of care required and monitoring the ongoing level of care,

Assisting the provider in identifying the benefits available to the member,

Facilitating cost effective, quality services targeted toward the unique needs of each member receiving care,

Facilitating the delivery of crisis intervention services,

Facilitating and coordinating consultations with PCPs and other providers, and

Coordinating referrals to CCS for adult members diagnosed with a Serious and Persistent Mental Illness (SPMI) or to CAMHD for children in need of Support for Emotional and Behavioral Development (SEBD) services.

The Behavioral Health Medical Director is a board certified psychiatrist and is available to providers for case consultation. The BH Clinician will refer a case to the Behavioral Health Medical Director if:

- The services requested do not meet medical necessity criteria.
- The services requested require a psychiatrist’s knowledge.
- There is a quality of care concern.

**Covered and Non-Covered Services**

The behavioral health services that are covered under the QUEST Integration Program are detailed in the QUEST Integration Benefits listings. Outpatient behavioral health services are not subject to plan benefit limits. All are subject to medical necessity. Non-covered services are detailed in the QUEST Integration Exclusions listings.

Some behavioral health services require prior authorization. Emergency services including ambulance transportation, post-stabilization services and urgent care services do not require prior authorization.

Members who have behavioral health special needs and meet the clinical criteria for the SEBD or CCS programs have access to additional and intensive services that are not routinely available to non-SPMI members.

An explanation of the services covered by the QUEST Integration Program are provided below:

**Covered Services That Do Not Require Prior Authorization**

**Emergency services**

Emergency services are not subject to prior authorization and include ambulance service when medically necessary, use of the emergency room, post stabilization services, and urgent care services.

**Crisis Services**

Crisis services and shelters are available to AlohaCare members and may be accessed directly according to patient 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.

Contact AlohaCare for member assistance with crisis services during regular office hours. For after-hours, weekend or holiday crisis services, providers can call:

- **Crisis LINE** of Hawaii at 832-3100 or toll-free at 1-800-753-6879:
  - Telephonic supportive counseling and information,
  - Crisis Mobile Outreach services for individuals in crisis or at risk for harm,
  - Access to licensed crisis shelters for stabilization,

**Outpatient Professional and Facility-Based**

Individual, family, and group psychotherapy services provided by Psychiatrists, Advanced Practice Registered Nurses (APRNs) with prescriptive authority, Psychologists, Advanced Practice Registered Nurses (APRNs), Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Licensed Mental Health Counselors are common covered treatment modalities and not subject to prior authorization.

- There are no benefit limits for outpatient psychotherapy treatment services.
- **No** prior authorization is required for outpatient psychotherapy services or medication management therapy services.
- Group therapy is an acceptable means of psychotherapy and AlohaCare encourages its use when clinically appropriate.

**Outpatient Professional Services that always require prior authorization:**

- **Psychological Testing**: Psychological testing for the purpose of clarifying the diagnosis, differential diagnosis or course of care is subject to a prior authorization. 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 must:
  - Complete the Outpatient Psychological Testing Request form and fax the form to the BH fax line at 808-973-6324, or mail the form to AlohaCare, prior to administering the services.
  - AlohaCare may authorize psychological testing based on InterQual® Criteria and the evaluation of the BH Medical Director.

- **Neuropsychological Testing**: AlohaCare will review requests based on InterQual® Criteria.

- **Prior authorization is always required for the following facility-based services:**
  - Partial hospitalization - A partial hospitalization program may be hospital-based or non-hospital based (free-standing) and provide structured treatment services for behavioral
health, substance use or both conditions concurrently. Regardless of the setting, this level of care includes the following characteristics:

- May be a step-down from inpatient setting or residential level of care,
- Intensive non-residential level of service where multi-disciplinary medical, and nursing services are provided,
- More than 4 hours of treatment per day,
- Usually a 5 day a week program,
- Offers medication management, psycho-educational and skill building groups, relapse prevention, group therapy,
- Inclusive of diagnostic assessment, registration, intake, orientation, treatment planning, disposition planning, aftercare, and client advocacy services, and
- Urine Drug Screens for substance use programs.

 o Residential

This level of care is reserved for members who are in need of continuous 24 hour structured or monitored milieu environment with both professional and paraprofessional staff available. Members needing this intense level of care receive up to 25 hours per week of professionally driven substance use and behavioral health services which are comprised of: group therapy, psychoeducational groups, skill building, relapse prevention and development of coping skills.

Residential treatment for substance use and/or behavioral health conditions is provided in a licensed facility:

- Milieu-based and individualized treatment planning,
- Staff on-site 24 hours a day, 7 days a week,
- At least 4 hours daily of on-site treatment consisting of counseling/education, psycho-social rehabilitation or vocational skill building activities
- At least one (1) hour of individual counseling per week
- Inclusive of diagnostic assessment, treatment planning, disposition planning, aftercare, and client advocacy services, and
- Urine Drug Screens for substance use disorder programs.

 o Intensive outpatient services (IOP)

Intensive outpatient services are structured programs that provide treatment services for behavioral health, substance use, or both conditions simultaneously. This level of care includes the following characteristics:

- Treatment provided up to four (4) hours daily
- Usually a three (3) days a week program
- Services provided are of greater intensity than outpatient (OP) services
- Services provided in a structured setting by a multi-disciplinary team
- Inclusive of diagnostic assessment, treatment disposition planning, aftercare, and client advocacy services, and
- Urine Drug Screens for substance use disorder programs.
o Low intensity outpatient (LIOP)

Lower intensity outpatient services are structured programs that provide treatment services for behavioral health, substance use, or both conditions simultaneously. Treatment provided at a minimum of 4-8 hours a week:

- Usually a 2 day a week program,
- Services comprised of psychoeducational classes, skill building, relapse prevention, and group therapy,
- Provides one (1) hour of individual counseling per week,
- Services provided in a structured setting by a multi-disciplinary team,
- Inclusive of diagnostic assessment, treatment, disposition planning, aftercare, and client advocacy services, and
- Urine Drug Screens for substance use disorder programs.

o Outpatient services (OPS) – Substance Use Disorders

- This level of care is reserved for members who are in the contemplation stage or relapse prevention phase of treatment:
- Treatment provided at a minimum of 1-3 hours per week
- Usually once a week
- Individual/group counseling, psychoeducational and skill building groups, relapse prevention, group therapy
- Inclusive of diagnostic assessment, treatment, disposition planning, aftercare, and client advocacy services, and
- Urine Drug Screens.

o Substance Use Withdrawal Management Services

A wide range of Substance Use Disorder (SUD) services are available, including methadone maintenance and withdrawal management (“Detox”) 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 SUD modalities. Treatment decisions are based in part on the American Society of Addiction Medicine (ASAM) criteria and InterQual® guidelines, which assist in determining the most appropriate level of care for a given member’s needs. Service criteria for various types of SUD services are explained below. 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 request for the planned treatments/interventions will be based on medical necessity.
The withdrawal management services available are:

- Ambulatory medical outpatient withdrawal management,
- Social withdrawal management – residential, for members without serious medical problems,
- Inpatient withdrawal management, for those members who have potentially serious, life-threatening medical problems as a result of their drug or alcohol use. Inpatient withdrawal management should be performed in a licensed general medical care facility, and
- Methadone/LAAM withdrawal management.

- **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 clinician will review all requests using ECT guidelines. The 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.

We encourage PCP’s who are managing patients with behavioral health conditions to contact AlohaCare to arrange a psychiatrist for medication evaluation and follow-up medication management. Non-physician behavioral health providers are also encouraged to contact us to arrange services provided by a psychiatrist.

**Acute BH Inpatient Services that Require a Notification**

**Acute Inpatient Admissions**

Acute care is available to patients who are eligible for benefits and meet admission criteria. For all members who are admitted for emergency psychiatric care, the facilities are required to fax the admission face sheet to the Behavioral Health fax line (808-973-6324) within 24 hours of admission. Upon receipt of the admission face sheet, an AlohaCare BH Clinician will contact the inpatient facility to perform a review to determine medical necessity, screen for any special health care needs, and review the member’s discharge plans for a smooth transition of care. Emergency, post-stabilization days, and urgent care services are not subject to prior authorization. “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 improve or resolve the member’s condition. A Clinician is on-call after hours, on weekends and holidays to provide assistance for emergency situations. Call 808-973-0712 to reach the after-hours clinician.

Generally, admissions are based on the presence of DSM V 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/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.
• Medical illness and psychiatric illness which, in combination, require initial inpatient care.
• If appropriate, short admission 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 mental status.

Other General Information related to Inpatient Admissions

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 behavioral health or SUD diagnosis, no additional 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.

Retrospective/Concurrent Review and Continued Stay
Continued hospitalization is determined through the application of 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, transition to 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 Director. 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 V diagnosis and severity of symptoms,
• Clinical rationale for admission/continued inpatient stay,
• Treatment plan,
• Estimated length of stay, and
• Proposed discharge plan.

An authorization may be pended if a medical record review is needed or more clinical information needs to be obtained. In those cases, the facility must provide access for AlohaCare Behavioral Health clinical staff to conduct on-site reviews during normal weekday business hours or provide copies of the medical
Discharge Planning

Discharge planning is essential to the concurrent review process and should be 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 UM staff and ancillary department personnel. AlohaCare’s Senior Clinical Management 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:

- Evaluation for appropriate setting to deliver continued care,
- Coordination of follow-up services, including medications,
- Assessment of the family or other community-based support network,
- Coordination with other state agencies/programs: Child and Adolescent Mental Health Division (CAMHD) and Alcohol and Drug Abuse Division (ADAD), as necessary,
- Evaluation for discharge medications,
- Medication reconciliation,
- Notification/Collaboration with PCP and other relevant specialists, and
- Evaluation of Special Health Care Needs (SHCN), Serious and Persistent Mental Illness (SPMI), and Support for Emotional and Behavioral Development (SEBD) status.

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 as soon as possible as well as a copy of the discharge instructions. When a transfer to another program is part of the discharge plan, the program must contact AlohaCare before rendering services if prior authorization is required.

Termination of Treatment

Providers must notify AlohaCare when a member is discharged from treatment. For outpatient discharges from services that require prior authorization 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 course of treatment has been completed or is being discontinued due to lack of compliance (e.g., member consistently missing appointments, member not following through with reasonable treatment recommendations).

If the member is being released from care in order to transfer care to another provider, the releasing provider must notify AlohaCare by phone, fax or mail with the date the member was released from the
Behavioral Health Special Needs Populations

AlohaCare staff work with members and providers to identify and coordinate care for members who meet the clinical criteria for two Behavioral Health Special Needs programs - the Support for Emotional and Behavioral Development (SEBD) program for children, and the Community Care Services (CCS) program for adults with Serious and Persistent Mental Illness (SPMI). Members who meet the criteria for these programs as defined by the CAMHD and MQD are eligible to receive additional, more intensive services. The programs are explained in greater detail below.

Support for Emotional and Behavioral Development (SEBD) Program

A child eligible for the SEBD Program is defined as a child (ages 3 through 20 years) who exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with his or her capacity to remain in the community without significant and intense care management. For these children, the disability is so severe and persistent that it results in a long term limitation of functional capacities for primary activities of daily living, such as maintenance of interpersonal relationships, self-care, and participation in educational and recreational activities. Such an individual needs supportive treatment or services for a long term or indefinite period of time. Behavioral health benefits for this program are authorized and provided through the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health (DOH).

Eligibility Criteria for SEBD Program

An AlohaCare member may be eligible for the SEBD Program, if he or she meets the following criteria:

- Age 3 through 20,
- Has a Child and Adolescent Functional Assessment Scale (CAFAS) score of 80 or higher, and
- Has had, at any time during the previous six (6) months, a qualifying primary DSM V diagnosis.

In the absence of a qualifying diagnosis from the DSM V the following conditions will not qualify a member for inclusion in the SEBD program:

- Mental Retardation
  - Mild Mental Retardation (317)
  - Moderate Mental Retardation (318.0)
  - Severe Mental Retardation (318.1)
  - Profound Mental Retardation (318.2)
  - Mental Retardation, Severity Unspecified (319)

- Learning Disorders
  - Reading Disorder (315.0)
• Mathematics Disorder (315.1)  
• Disorder of Written Expression (315.2)  
• Learning Disorder NOS (315.9)  
  o Motor Skills Disorder  
    • Developmental coordination Disorder (315.4)  
  o Communication Disorders  
    • Expressive Language Disorder (315.31)  
    • Mixed Receptive-Expressive Language Disorder (315.32)  
    • Phonological Disorder (315.39)  
    • Stuttering (307.0)  
    • Communication Disorder NOS (307.9)  
  o Pervasive Developmental Disorders  
    • Autistic Disorder (299.00)  
    • Rett Disorder (299.80)  
    • Childhood Disintegrative Disorder (299.10)  
    • Asperser’s Disorder (299.80)  
    • Pervasive Developmental Disorder NOS (299.80)  
  o Substance Abuse Disorders  
  o Mental Disorder Due to a General Medical Condition

If you are providing care for an AlohaCare member with these illnesses, please refer the member’s parent/guardian to the CAMHD Family Guidance Center (FGC) for evaluation. The SEBD Coordinator at the FGC will screen the member and schedule an appointment for an assessment.

**Community Care Services (CCS) Program for Adults with a Serious and Persistent Mental Illness (SPMI)**

Adult members who meet the criteria for additional intensive behavioral health services and have been determined to have a Serious and Persistent Mental Illness (SPMI), may be enrolled in the State’s Behavioral Health Managed Care (BHMC) program, called “Community Care Services” (CCS).

For these adult members, their disability is so severe and persistent that it results in a long term limitation of their functional capacities of daily living, such as interpersonal relationships, inability to maintain housing, self-care, participation in educational or vocational activities, and employment.
Eligibility Criteria for the CCS program:

To be eligible for the CCS program, the member must meet the SPMI eligibility criteria listed below as determined by the Med-QUEST Division (MQD):

- The member must have QUEST Integration coverage,
- The member must be 18 years of age or older,
- The member must demonstrate the presence of a qualifying diagnosis (see next section below) for at least 12 months or is expected to demonstrate the qualifying diagnosis for the next 12 months,
- The member must meet at least one of the criteria below, demonstrating instability and/or functional impairment:
  - Global assessment of functioning (GAF) <50; OR
  - Clinical records demonstrate that the member is currently unstable under current treatment or plan of care:
    - Multiple hospitalizations in the last year, and currently unstable,
    - Substantial history of crisis and currently unstable to include but not limited to consistently non-compliant with meds and follow-up,
    - Unengaged with providers,
    - Significant and consistent isolation,
    - Resource deficit causing instability,
    - Significant co-occurring medical illness causing instability,
    - Poor coping/independent living/problem solving skills causing instability, or
    - At risk for hospitalization, OR
  - Member requires protective services or requires intervention by housing or law enforcement officials.

Qualifying Diagnoses for the CCS program:

- Schizophrenic Disorders: (F20.0, F20.1, F20.2, F20.5, F20.9)
- Schizoaffective Disorders (F25.x)
- Schizophreniform Disorder (F20.81)
- Delusional Disorders (F22)
- Mood Disorders – Depressions (F32.3, F33.2, F33.3)
- Post-Traumatic Stress Disorder (F43.10, F43.12)
- Substance Induced Psychosis (F10.15x, F10.25x, F10.95x, F11.15x, F11.25x, F11.95x, F12.15x, F12.25x, F12.95x, F13.15x, F13.25x, F13.95x, F14.15x, F14.25x, F14.95x, F15.15x, F15.25x, F15.95x, F16.15x, F16.25x, F16.95x, F18.15x, F18.25x, F18.95x, F19.15x, F19.25x, F19.95x)
Provisional eligibility

Members who do not meet the requirements listed above, but are assessed by AlohaCare’s Behavioral Health Medical Director as clinically appropriate to receive additional services provided only by the CCS program to help safeguard the member’s health and safety, shall be referred to the DHS - Med-Quest Division (MQD) for an evaluation and possible provisional eligibility into the CCS program.

Excluded Diagnoses for the CCS program:

Unless one of the disorders listed above is also present, the conditions listed below do not qualify a member for inclusion in the CCS program:

- Delirium, dementia and amnesic and other cognitive disorders
- Disorders usually diagnosed in infancy, childhood or adolescence (i.e. mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders, communication disorders)
- Substance induced disorders except as described in a “Qualifying Condition” category
- Substance dependence disorders
- Psychotic disorders not otherwise classified – Brief Psychotic Disorder (298.8)
- Sexual and gender identity disorders
- Factitious disorders
- Impulse control disorders not elsewhere classified
- Adjustment disorders
- Psychological factors affecting medical conditions
- V codes
- Anxiety disorders
- Personality disorders
- Mental disorder due to a general medical condition
- Substance-related disorders persisting less than three months after detoxification and stabilization.

Once a member has been identified as possibly meeting the SPMI criteria, the behavioral health provider must complete the DHS 1157 form (Referral for Serious Mental Illness (SMI) Community Care (CCS) Program), and submit it to AlohaCare’s Behavioral Health fax line (808-973-6324), along with the member’s behavioral health evaluation and/or clinical records that support the presence of the qualifying diagnosis. AlohaCare reviews the referral for completeness and determines if the member is likely to meet eligibility criteria. If the referral is complete and the member appears to meet eligibility criteria the referral and supporting documentation is forwarded to MQD for final determination of eligibility. It is important that all documentation be made available and complete to facilitate timely submission and review by MQD. If a member’s referral is incomplete AlohaCare will work with the referring provider in order to get any remaining information necessary for the referral. If a member does not appear to meet eligibility criteria a final review of the referral will take place with the Behavioral Health Medical Director before a denial is made. If it is determined by the BH Medical Director that the member is not eligible for CCS AlohaCare will communicate that information to the referring provider. An updated or revised referral
can be sent if additional information is available that would appear to make the member eligible.

When an AlohaCare member is enrolled into the CCS program, AlohaCare transitions the member’s behavioral health care to CCS, which is administratively and financially responsibility for all behavioral health and SUD services, including medications prescribed to treat these conditions. AlohaCare remains responsible for providing medical services and for coordinating services with the member, the PCP, and with the CCS case manager to facilitate comprehensive care based on the member’s needs.

If a member is determined to not meet the CCS eligibility criteria, AlohaCare remains responsible for providing medically necessary standard behavioral health and medical benefits that the member may require.

**Additional Intensive Behavioral Health Services for Members enrolled in the CCS program:**

Members enrolled in the CCS program receive additional and intensive services that are not routinely available to non-SPMI members. Several of these services are listed and briefly explained below:

- **Specialized Residential Services** – Are provided in a licensed residential facility for members with co-occurring behavioral health and substance use disorders. The facility provides 24/7 staff coverage which includes nursing services (at least 10 hours daily) as well as a Qualified Mental Health Professional (e.g., LMFT, LCSW, etc.) who are able to provide psychiatric and treatment services, including medication and medication management, counseling and therapy, and group and individual psychoeducation. Services also include diagnostic assessment, treatment, disposition planning, and referral linkage and client advocacy services. Length of stay is usually no longer than 90 days.

- **Licensed Crisis Residential Services (LCRS)** – A 24 hour specialized residential crisis shelter with a full array of services, including nursing services, medication management, and psychiatric consultation, provided under the supervision of a licensed mental health clinician and a psychiatrist.

- **Case Management** – A CCS RN or licensed behavioral health clinician who is assigned to the member who performs face-to-face assessments, care and service planning, outreach and ongoing monitoring of the patient and coordinates care with appropriate individuals who are members of the care team supporting the member.

- **Psycho-Social Rehabilitation (PSR)** – Include services conducted as either group or individual sessions that promote social skills building, supervised social and recreation group activities, and pre-vocation preparation activities.
• **Other Enabling Services** - CCS members who require additional enabling services that support and promote member stability may receive:
  - Supportive Housing
  - Financial Management/Representative Payee
  - Supportive Employment
  - Clubhouse

For questions regarding the CCS Program, please call AlohaCare Customer Service Department and ask to speak with the member’s Lead Care Manager.
SECTION 9 SERVICE COORDINATION

Program Introduction

The AlohaCare Service Coordination Department includes the following programs: Population Health, Service Coordination, Population Health, Medication Therapy Management, Long Term Services and Supports, EPSDT and Transition of Care.

Population Health Program

AlohaCare’s Population Health activities range from outreach calls to members, outreach calls to parents, educational and informative mail-outs, educational text messages, calls to PCPs and specialists to coordinate care. Members are reminded of the importance of preventive screenings, pregnant women are reminded of the importance of maintaining their OB/GYN appointments and new mothers are reminded of the importance of continuing their own care and their baby’s care. In some cases, AlohaCare staff can schedule appointments for members to help foster their compliance with best practices and help member access care. Providers are provided with a copy of the member signed service plan and invited to an inter-disciplinary care team meeting to discuss the member’s goals and service plan.

Service Coordination

Service Coordination Programs are available to members who are identified as being high risk for hospitalization or emergency room usage, needing long term services and supports, diagnosed with serious persistent mental illness or for members who may have complex psychosocial needs. Physicians and other providers are integral, active participants in our members’ care and important partners to the Service Coordination Team.

- AlohaCare has several service coordination programs to address the needs of our members which include:
  - Complex Care Management for members with complex care needs needing intensive care management
  - Population Health Management – general preventive health member outreach and education services and for members with one or more chronic diseases and do not meet the criteria for catastrophic/intensive care management

AlohaCare uses a variety of information to identify members who may benefit from service coordination. Service coordination activities are conducted over the phone, through written correspondence, and through face-to-face contact in the field. Potential trigger indicators that alert AlohaCare staff and the PCP that the member may benefit from some level of service coordination include, but are not limited to:

- Medical Triggers, such as but not limited to multiple chronic conditions, neonatal high risk
infants, frequent ER utilization, frequent inpatient hospitalizations

- Behavioral Health Triggers such as but not limited to non-compliance with treatment plan or service plan, deteriorated level of functioning (GAF 30 and above), serious mental illness including major depression, suicide ideation/attemp, counseling for child/adolescent ongoing for 12 or more months, high risk pregnancies, frequent inpatient psychiatric admissions.

- Child/Adolescent Triggers such as but not limited to office visits for recurrent diagnosis, child under Child Welfare Services jurisdiction, foster care placement, delayed EPSDT visits

- Pharmacy Triggers such as but not limited to Polypharmacy – chronic opioid use and potential member mismanagement of controlled medications.

- Activities of Daily Living/Social Triggers such as but not limited to long term service and support needs after hospitalization, homelessness, potential care giver needs, etc.

Service Coordination begins with an evaluation of our members using claims data and other available information such as the Health Risk Assessment. AlohaCare utilizes the Guiding Care system, a state-of-the-art, web-based care management system that allows the member’s service coordination team (which includes AlohaCare service coordinators, utilization management staff, program leadership, and the member’s treating providers/clinics and Community Care Management Agencies, if any) to deliver coordinated, timely and clinically appropriate care, health education, and support services to our members with chronic healthcare needs using sophisticated clinical and risk analytics and automated decision support tools. The system is designed to identify, help, manage and address health concerns among individuals either at risk for or who have a broad range of physical health, behavioral health and social support needs.

AlohaCare’s Service Coordination staff work in collaboration with providers, members, caregivers, and any others who may be involved in the care of the member to ensure that medically necessary health care and support services is being provided. This includes collaboration in the service planning process, identifying areas of opportunities, setting goals and interventions which will assist members in meeting their individual needs and coordinating cost effective quality services. Services plans are member-centric and the member is the key decision maker and is encouraged to be actively involved in the development of their individual service plan.

To support the provider in the service coordination process, AlohaCare’s Service Coordination system helps to guide the member through the health care continuum by:

- Educating and encouraging members to engage in healthy behaviors,
- Assisting members in accessing appropriate health services based on their needs,
• Reminding members about preventative services,
• Helping members to schedule appointments and medically necessary transportation as needed,
• Referring members for appropriate medical, behavioral, and community resources., and
• Helping members live as well, and as independently as possible in their preferred setting.

Members may be referred into Service Coordination programs through a variety of ways including the following:

• Identification through a Health Risk Assessment performed on all newly enrolled members for any special health care needs,
• Direct member referral,
• Referral by the member’s family or representative,
• Referral by the member’s Primary Care Provider (PCP) or other involved health care providers,
• Internal referrals from non-clinical AlohaCare Departments such as Medical Management, Member Services or other Care Managers, or
• Referral from other sources.

If you would like to refer a member to the Service Coordination Program, please call 1-808-973-0712 Option 1.

Service Coordination for members with Special Health Care Needs (SHCN’s)

Special Health Care Needs (SHCNs) are chronic physical, developmental, behavioral or emotional conditions that require additional services beyond what is generally needed. AlohaCare provides a higher level of intensive coordination to help members with special health care needs.

Upon enrollment, AlohaCare screens all newly enrolled plan members or previous AlohaCare members returning to the plan after disenrollment for 6 months or more, to identify those with Special Health Care Needs (SHCN), as defined by Med-QUEST and AlohaCare Criteria. Members are mailed a Health Risk Assessment and also called to complete a Health Risk Assessment. Members who do not complete the Health Risk Assessment receive follow-up calls in an attempt to complete the Health Risk Assessment telephonically.

If AlohaCare determines that the member has Special Health Care Needs, the following shall apply:
• Individuals with SHCNs must have access to providers who are experienced in delivering the appropriate care and are available and physically accessible. If AlohaCare network provider is not available, AlohaCare allows the member to see an out-of-network provider. In addition, AlohaCare permits either a standing authorization or an adequate number of direct access visits to a specialist(s) as determined by the member’s PCP, and considers the use of specialists as a primary care provider in certain circumstances.

• AlohaCare will assign a service coordinator to coordinate care with provider organizations, other Medicaid agencies, and community organizations in order to effectively deliver the supports a member needs and to prevent duplication of benefits and services (e.g., Early Intervention Program, Department of Health-Child and Adolescent Mental Health Division, Community Care Services, etc.)

Members identified as having Special Health Care Needs will have an initial assessment conducted with the member in their home or community. This assessment utilizes the Med-QUEST standardized Health and Functional Assessment (HFA), and is conducted within the following timeframes:

• Seven (7) calendar days of initial enrollment for members whose eligibility is based upon receipt of HCBS.

• Fifteen (15) calendar days of identification that the member needs service coordination.

• On an expedited basis upon request.

Specific Special Health Care Needs factors that will be utilized to identify a member’s need for service coordination include:

For Adults

• Adults with high risk pregnancies, chronic medical conditions (i.e., asthma, diabetes, hypertension, and chronic obstructive pulmonary disease), cancer, multiple chronic conditions; behavioral health conditions, including substance use disorders, who are not receiving services through CCS; and social conditions such as homelessness and limited English proficiency;

• Adults whose use of prescription medication includes the use of atypical antipsychotics, the chronic use of opioids, the chronic use of polypharmacy, and other chronic use of specific drugs that exceed the use by other adults in the health plan as identified by the health plan (e.g. on ten (10) or more prescription medications);

• Adults with hepatitis B, C or HIV/AIDS;

• Adults whose utilization of emergency department services is beyond that generally used by other adults in the health plan;

• Adults being discharged from an acute care setting;
• Adults with a hospital readmission within the previous thirty (30) days;

• Adults whose utilization causes the member to be in the top five percent (5%) by utilization frequency and/or expenditures for any of the following:
  - Outpatient medical visits;
  - Outpatient behavioral health visits;
  - Emergency department visits;
  - Inpatient days;
  - Prescription drugs;
  - Overall.

• Adults who have a chronic physical, behavioral, or social condition that requires health related services of a type or amount beyond that required by adults generally (RFP Section 40.910.2).

For Children:

• Children with conditions such as asthma, diabetes, hypertension, cancer, chronic obstructive pulmonary disease, and children who become pregnant;

• Children with Hepatitis B, C or HIV/AIDS;

• Children who take medication for any behavioral/medical condition that has lasted, or is expected to last, at least twelve (12) months (excludes vitamins and fluoride);

• Children who are limited in their ability to do things that most children of the same age can do because of a serious medical/behavioral health condition that has lasted or is expected to last at least twelve (12) months;

• Children who need or receive speech therapy, occupational therapy, and/or physical therapy for a medical condition that has lasted or is expected to last at least twelve (12) months;

• Children who are outliers for emergency room utilization;

• Children being discharged from an acute care setting when LOS is greater than ten (10) days, and children with multiple admissions during a six (6) month period;

• Children who have a hospital readmission within the previous thirty (30) days;

• Children who need or receive treatment or counseling for an emotional, developmental, or behavioral problem that has lasted or is expected to last at least twelve (12) months; and

• Children who have a chronic physical, behavioral, or emotional condition that requires health related services of a type or amount beyond that required by adults generally (RFP Section 40.910.1).

In coordinating care, AlohaCare is responsible to ensure that the member’s privacy is protected in accordance with the privacy requirement of applicable State and Federal law, to the extent that these laws are applicable.

Providers may also identify AlohaCare members with SHCNs, and can call the Provider Services
Department and ask for the Service Coordination Department.

Role of Service Coordinator

AlohaCare members identified as having SHCN (including LTSS) will receive field Service Coordination activities performed in the community. Members in this category will have a dedicated nurse or social worker assigned as their single point of contact with AlohaCare. When assigned, the field Service Coordinator will become the primary coordinator for all activities being performed to meet the member’s needs, ensuring services are delivered effectively, monitoring goals and following-up on urgent problems.
Medication Therapy Management

Medication Therapy Management (MTM) Services are available to assist members to ensure that their medications are working to improve their health. A pharmacist or other health professional is available to provide consultation on obtaining the most benefit from the prescribed medications. Each member will get an action plan and medication list after the consultation, which can be shared with health care providers at the member’s request.

A potential member for this program must have at least three or more multiple chronic diseases. Core chronic conditions include:

- Chronic Heart Failure (CHF);
- Diabetes;
- Dyslipidemia;
- End-Stage Renal Disease (ESRD);
- Hypertension;
- Respiratory Disease-Asthma;
- Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD)
- Bone Disease-Arthritis-Osteoporosis;
- Mental Health-Depression.
Population Health (PHM) Program

AlohaCare has a cohesive plan of action for addressing Member needs across the continuum of care through its Comprehensive PHM Strategy. This strategy was developed with both the NCQA PHM Standards and the NCQA PHM Model as a guide for developing activities in which the primary focus is the Member/Population at the center. Because the center “Population” is interchangeable (specific populations and/or disease state), it allows flexibility in determining where to focus interventions. Detailing AlohaCare’s PHM strategy with specific, measurable, achievable, relevant and time-framed goals helps to structure and focus efforts on providing services to Members across the Continuum of Care.

All PHM programs include the Identification, Assessment and Risk Stratification of Members into (1) of four (4) Areas of Focus:

- Keeping Members Healthy
  Preventive Service Programs, such as Promoting Keiki Wellness and Promoting Women’s Health against Cervical Cancer;
- Managing Members with Emerging Risks
  Diabetes Management and Asthma Management Programs for Members with these primary condition diagnoses;
- Patient Safety or Outcomes across Settings
  Transition of Care (TOC) Programs for Members Post-hospitalization;
- Managing Multiple Chronic Illnesses
  Complex Case Management Programs (CCMP) and Geriatric Resources for Assessment and Care of Elders (GRACE).

Providers play a vital role in our Population Health Management efforts. For members who have not established care with a PCP, or are not self-managing their Health and Wellness as evidenced by: 1) frequent ER visits; 2) Hospitalizations; 3) Non-Compliance with office visits; and/or 4) filling medication prescriptions, the PCP and Specialists (as appropriate) will be asked to work collaboratively with AlohaCare’s staff to develop a coordinated plan of care. This plan of care will include interventions that are specific to the severity of the Member’s condition and individualized to meet member needs. AlohaCare’s Pharmacy staff may also consult with the member’s PCP/Specialists, as well as Community pharmacists, to address any medication issues that may arise. In addition, Providers will periodically receive educational materials based on the most current Evidence-based Clinical Best-Practices.

One of the most important elements in each Population Health Management Program is the member’s willingness to engage and participate in his or her health care. The member’s care team, led by the PCP and supported by AlohaCare Lead Care Managers (LCMs), PHM Care Coordinators, and TOC Care Coordinators, help the member to address barriers to care, educate the member regarding his or her disease or condition and to adhere to the member’s Individualize Treatment and Care Plan.
AlohaCare identifies members for a specific Population Health Management Program (or Programs) based on Utilization data and Prior Authorization, as well as other review activities specific to the member. Once identified, assessed and determined to meet eligibility criteria for a specific Population Health Management Program/Programs, the member is automatically enrolled. The member has the option to “opt out” of the Program at any time. The PCP may make a referral on the member’s behalf, or the member may self-refer, into any of the Population Health Management Programs, at which time enrollment eligibility will be determined.

In order to refer a member to an AlohaCare Population Health Management Program, or to ask questions, please call our Member Services Department. For more information on how AlohaCare can be of further assistance regarding Population Health Management needs for AlohaCare Members, please call our Provider Services Department.

Transition of Care

Transition to new provider:

If a member changes their PCP, AlohaCare staff will facilitate a smooth transition by informing the new PCP of current authorizations, current medications and current status of service coordination, if applicable. For members dis-enrolled from AlohaCare and transferring to a new plan, AlohaCare will respond to a request to release information if appropriately signed by the member or the member’s legal representative/guardian.

Transition to AlohaCare:

AlohaCare provides continuation of services for individuals with SHCN and LTSS for at least ninety (90) days or until the member has received a health and functional assessment (HFA) by their service coordinator. AlohaCare provides continuation of other services for all other members for at least forty-five (45) days or until the member’s medical needs have been assessed or reassessed by the PCP who has authorized a course of treatment. AlohaCare reimburses PCP services that the member may access during the forty-five (45) days prior to transition to their new PCP even if the former PCP is not in the network of the new health plan.

Transition to another health plan:

If the member moves to a different service area in the middle of the month and enrolls in a different health plan, AlohaCare shall remain responsible for the care and the cost of the inpatient services (as provided in Section 50.210) provided to the member, if hospitalized at the time of transition, until discharge or level of care changes, whichever occurs first. Otherwise, the new health plan shall be responsible for all services to the member as of member’s date of enrollment. If the member moves to a different service area and remains with AlohaCare, AlohaCare shall remain responsible for the care and
cost of the services provided to the member.

AlohaCare will cooperate with the member and the new health plan when notified in transitioning the care of a member who is enrolling in a new health plan. AlohaCare shall submit transition of care information to DHS utilizing a format specified by DHS for transition to the new health plan within five (5) business days of the former health plan being notified of the transition. AlohaCare will assure that the DHS or the new health plan has access to the member’s medical records and any other vital information that the AlohaCare has to facilitate transition of care.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program

The health and well-being of our keiki is of utmost importance. To help them on the road to good health, the federally defined EPSDT program has specific requirements of the health plan and its PCPs.

The AlohaCare EPSDT program facilitates the provision of comprehensive health services for members under age 21 years old that includes primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems identified through the EPSDT screening process.

EPSDT Provides:

- Preventative care for members from newborn through age 20.
- Complete medical, mental and behavioral health, and dental care.
- Services and Medicines.
- Treatment for problems that are identified.
  - Intensive Behavioral Therapies (e.g. Applied Behavioral Analysis (ABA) services for members with an Autism Spectrum Disorder (ASD) Diagnosis.

EPSDT checkups include:

- Complete physical exam
- Lab Tests (as needed)
- Immunizations
- Vision and Hearing screening
- Developmental/Behavioral and Mental Health screening (as needed)
- Referrals to specialists (as needed)
- Oral (mouth) check
- Prescription medications (as needed)
Parents, legal guardians and the child’s PCP are the key to the success of the EPSDT program. AlohaCare EPSDT RN Coordinator and other designated staff work with these individuals to ensure the timely provision of routine well child and preventive health services.

If you need assistance with EPSDT–related services, we encourage you to contact AlohaCare’s EPSDT staff by calling our Provider Services Department.
EPSDT Screening Examinations

**Interperiodic screens**: Interperiodic screens are medically necessary screens which occur between the complete periodic screens. A definition of an interperiodic screen is a physical examination which is done more than 3 months after a complete examination has already been completed. This interperiodic screen may be required for school sports participation or as a complete new patient exam by a new PCP.

**Partial Screens**: Partial screens occur when a screen for one or more specific conditions is needed such as a vision or hearing screen.

Problems identified through the EPSDT screening are followed by diagnosis and medically necessary treatment or referral to an appropriate community resource. This includes diagnosis and treatment of acute and chronic medical and behavioral health conditions as well as the provision of certain medical services associated with dental needs. AlohaCare will cover all medically necessary medical and behavioral health services allowable by Medicaid and included in the child's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP). Even if the child is determined to potentially benefit from the Support for Emotional and Behavioral Development (SEBD) Program, AlohaCare will be responsible for necessary medical services under the IEP or IFSP.

Additional benefits that may normally not be covered by QUEST Integration are extended to children under EPSDT if medically necessary and appropriate. Prescription drugs not on the formulary and durable medical equipment typically not covered are examples of these services. Chiropractic, personal care, private duty nursing services and certain non-experimental medical and surgical procedures will also be provided if medically necessary.

Reproductive health services for both males and females who are sexually active and/or of childbearing age are included. These include family planning, STD and pregnancy-related services.

AlohaCare is responsible for covering the cost of pre-placement physical examination as well as the comprehensive physical (performed within 45 days of a pre-placement examination) for foster children. The EPSDT RN Service Coordinator assists CPS workers with identifying the child’s PCP and helps to arrange these services, as needed, to assure that children receive the care they need in order to have a safe environment.

**Childhood Immunizations**

Immunizations are a very important part of EPSDT covered services. It is expected that the immunization status of the child will be assessed at each office visit whether it is for EPSDT, chronic, or acute care. When a child's immunization status is not up to date, appropriate immunizations should be administered.
AlohaCare has implemented a proactive EPSDT plan, in compliance with Federal and State immunization regulations. PCPs are required to follow the **Recommended Childhood and Adolescent Immunization Periodicity Schedule** for immunizations that must be administered at recommended ages and specific time frames. The Schedule can be found on the American Academy of Pediatrics website at [http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx](http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx)

Immunizations to be administered are outlined below:

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>diphtheria, tetanus, and pertussis</td>
</tr>
<tr>
<td>Tdap</td>
<td>tetanus, diphtheria toxoid, and acellular pertussis (adolescent vaccine)</td>
</tr>
<tr>
<td>Td</td>
<td>tetanus and diphtheria toxoid (booster dose)</td>
</tr>
<tr>
<td>HepB</td>
<td>hepatitis B vaccine</td>
</tr>
<tr>
<td>HepA</td>
<td>hepatitis A vaccine</td>
</tr>
<tr>
<td>IPV</td>
<td>inactivated polio virus vaccine</td>
</tr>
<tr>
<td>MMR</td>
<td>measles, mumps, and rubella</td>
</tr>
<tr>
<td>HIB</td>
<td><em>haemophilus influenza</em> type b vaccine</td>
</tr>
<tr>
<td>Varicella</td>
<td>varicella (&quot;chicken pox&quot;)</td>
</tr>
<tr>
<td>PCV/PPV</td>
<td>pneumococcal conjugate vaccine/pneumococcal polysaccharide vaccine</td>
</tr>
<tr>
<td>MCV4/PSV4</td>
<td>meningococcal conjugate vaccine/meningococcal polysaccharide vaccine</td>
</tr>
<tr>
<td>Influenza/LAIV</td>
<td>influenza inactivated vaccine (&quot;flu&quot;)/Live attenuated influenza vaccine (&quot;flu&quot;)</td>
</tr>
<tr>
<td>HPV</td>
<td>human papillomavirus vaccine</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>rotavirus vaccine</td>
</tr>
</tbody>
</table>

* Acellular Pertussis vaccine (DTaP) is recommended for the fourth and fifth doses of the DTP series among children ages 15 months through six years of age.

The PCP should administer simultaneously all vaccine doses needed according to this schedule. PCPs are required to record:

- Vaccine and dosage given
- Date the vaccine was given (month/day/year)
• Name of the manufacturer of the vaccine, and lot number
• Signature of the person administering the vaccine.

Providers are required to submit a completed DHS Form 8015 “Hawaii Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) form” or DHS Form 8016 “EPSDT Immunization Catch-Up and Follow-Up Form” with the claim and maintain a copy in the child member’s medical record.

PCP office staff should educate parents and guardians about immunizations at each EPSDT visit; explain to them the importance of immunizations and the need to comply with the Periodicity Schedule, as well as the true contraindications of vaccines and the risks and benefits of the immunization.

PCP office staff should also encourage parents and/or guardians to maintain a copy of their child’s personal immunization record card and the provider’s office should update this record at each visit during which immunizations are administered. The documentation should include: what vaccine was given; the date (month/day/year) of the vaccine, and; who administered the vaccine.

**AlohaCare Monitoring of Childhood Immunizations**

The immunization-deficient member under the age of 21 years old will be monitored by referral of the PCP and through other means of identification such as medical record audits or reports generated from the DHS form 8015 and 8016 submissions. When deficiencies are noted, AlohaCare directs Interactive Voice Response (IVR) calls to notify parents or guardians that the child is missing important Well Child Visits.

AlohaCare also monitors PCPs for the preceding immunizations, doses required, and percentage of compliance for children per HEDIS® standards using medical record reviews, which date back in accordance to the age of the child. The EPSDT Coordinator will present a correction plan to AlohaCare’s Quality Improvement Advisory Committee if immunization rates fall below the standards set by MedQUEST and CMS. The EPSDT Coordinator will work collaboratively with the Department of Health Immunization Program to provide training on immunizations and technical support to AlohaCare providers and their staff.

**Immunization Contact Information**

Please contact the Hawaii Immunization Program at (808) 586-8300 or see the CDC website (www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html) for recommended vaccine schedules. You may also contact AlohaCare’s EPSDT staff by calling Provider Services at 973-1650 or toll-free at 1-
Childhood Lead Testing

Federal law requires that all children enrolled in Medicaid be screened for lead poisoning, and the QUEST Integration Program requires screening for lead exposure as part of the EPSDT program.

The State requirements for lead screening within the EPSDT program for children enrolled in QUEST Integration are:

- **ALL** children, around the ages of 12 and 24 months (or 25 – 72 months if not previously done) should be screened using the Lead Risk Assessment. The Lead Risk Assessment can be verbal but the fact that a risk assessment was done should always be documented in the medical record and on DHS forms 8015 and 8016. The question should be taken from the Child Lead Risk Questionnaires provided by the State. Your office may also get copies by contacting the Hawaii State Maternal & Child Health Branch Childhood Lead Poisoning Program at (808) 733-9044.

- **ALL** children covered by QUEST Integration should have their blood lead level screened at 12 and 24 months of age or between 25 and 72 months of age if the child has not been previously tested. Blood lead screening is also suggested when any risk factor is present or any signs/symptoms consistent with lead poisoning are present. Blood tests are always required if any questions on the Lead Risk Assessment are positive. For the specific blood testing guidelines for QUEST Integration children, refer to Hawaii State Maternal & Child Health Branch Childhood Lead Poisoning Program at (808) 733-9044.

EPSDT Education and Outreach

In conjunction with the PCP, the EPSDT staff and other AlohaCare staff will carry out the responsibilities of the EPSDT Education and Outreach program for eligible enrolled members under 21 years of age through mailings, analysis of administrative claims data, and follow-up phone calls. Additional outreach activities as listed below will also target EPSDT recipients.

Provider Education and Outreach

All EPSDT providers will receive ongoing education and training on current immunization recommendations or changes in the federal and state regulations for the EPSDT program through meetings, telephone calls or correspondence letters from AlohaCare EPSDT staff. EPSDT PCPs will receive direct contact from our Medical Director about changes to EPSDT policy, when appropriate.

Member Education and Outreach

Within 30 days of enrollment, each new AlohaCare member will receive an information packet which includes an AlohaCare’s EPSDT pamphlet and a letter regarding information on the EPSDT program. The following information is included in these documents:

800-434-1002 for questions regarding childhood vaccines.
• The benefits of preventive health care.
• A description of the complete services covered under EPSDT.
• How and where to obtain these services and assistance with scheduling appointments.
• There is no charge for EPSDT screening and services.
• Transportation to necessary medical visits is available in accordance with AlohaCare policies.

Targeted Mailings and Other Interventions

AlohaCare’s EPSDT staff uses data from claims and DHS 8015 and 8016 forms received for all members less than 21 years old, to assess access to services such as EPSDT. If after six months of enrollment, the data indicates that a child has not accessed EPSDT services, the EPSDT staff will follow-up with a reminder IVR call. If after 12 months, the data indicates the same information, the member’s parents (or legal guardians) will receive another follow-up reminder IVR call. A telephone call by the EPSDT Care Coordinator is made to the parents of the EPSDT-deficient members younger than the age of 2.

AlohaCare provides more specific information to the PCP/EPSDT providers of any enrolled child who has not had an EPSDT visit in the previous 6 and 12 months’ time frame, as indicated by the AlohaCare EPSDT Utilization Reports. The PCP will be responsible for outreach to patients and scheduling of appointments.

The EPSDT staff monitors PCP referrals for children requiring specialized care in order to facilitate compliance. The staff will follow-up through claims data or through individual contact with the child’s parents, specialist or other provider referred to in order to determine if the visit was completed.

EPSDT Claims Processing

DHS requires that all claims for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services must include the appropriate completed EPSDT form.

These new forms are universal among all QUEST Integration health plans and MUST be attached to any claim for EPSDT services.

EPSDT Forms:

• DHS 8015 (Exam Form)
• DHS 8015A (Additional Information Form)
• DHS 8016 (Catch-up/Follow-up Form)
For additional EPSDT forms and/or questions regarding the forms, please contact our Provider Services Department.

**Claims Processing Requirements:**

**EPSDT**

- If a claim is submitted without both an EP modifier and EPSDT form, the claim will be paid at the regular non-EPSDT fee schedule rate.
- A claim submitted without an EP modifier but with an EPSDT form attached will be returned to provider to verify if EPSDT services were done and to add the modifier as appropriate.
- A claim submitted with an EP modifier but no EPSDT form attached will be denied as “missing form.”
- Providers must resubmit any returned claims with the appropriate information and EPSDT form for reimbursement.

**How to Bill for Comprehensive EPSDT Services (DHS 8015 Form)**

When providing a comprehensive EPSDT service (which must include all of the age-appropriate elements of an EPSDT visit), you must bill using a CPT-4 preventive medicine procedure code range with an ‘EP’ modifier in order to receive the enhanced global payment for EPSDT.

AlohaCare follows Correct Coding Initiative (CCI) guidelines. Therefore, when billing EPSDT preventative medicine services on the same day of immunization administration code the modifier 25 should be appended to the EPSDT E/M along with the EP modifier.

When a separately identifiable E/M service is performed on the same day as an EPSDT visit, a modifier -25 should be appended and line diagnosis pointer should support the condition for which the patient is being treated.

**How to Bill for Immunization Services**

- Itemize all immunization services performed as part of EPSDT visit.
- Appended SL modifier to indicate to all state supplied vaccines.
- Indicate a zero-line charge.

Please note, accurate billing of all services performed as part of the EPSDT visit will reduce the delay of claims processing and/or denial of claims. Furthermore, this will also reduce AlohaCare’s requirement to request medical records to support HEDIS measurements.
How to Bill for Catch-up Immunization Services (DHS 8016 Form)

Immunization Requirements

No more than two (2) follow-up visits for screening attempts will be allowed. For example, if on the dates of the first and second follow-visit for an audiogram, the child was unable to comply, the provider should not schedule a third follow-up visit for the audiogram. Instead, the audiogram should be attempted at the next EPSDT comprehensive visit.

On field 21 of the 1500 claim form, diagnosis or nature of illness or injury, use the appropriate ‘Z’ code to represent a wellness visit, routine infant or child health check. Also use any ICD-10 codes relevant to any abnormal screenings detected during the visit.
# Vaccine Matrix

<table>
<thead>
<tr>
<th>Member Age</th>
<th>Which Vaccines are Covered Benefits?</th>
<th>Vaccines Provided Free From the State (VFC Program)</th>
<th>Does AlohaCare Reimburse for the Cost of the Vaccine</th>
<th>How does AlohaCare Reimburse for Vaccine Administration?</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 18 Years</td>
<td>All vaccines recommended by the ACIP and CDC Immunization Schedule</td>
<td>Yes</td>
<td>No, the provider obtains the vaccines from the VFC Program</td>
<td>Vaccine administration is included in the global EPSDT reimbursement</td>
<td>All EPSDT benefits including the administration of immunizations, Snellen vision tests, hearing tests, etc., are included in the global EPSDT payment.</td>
</tr>
<tr>
<td>19 to 20 Years</td>
<td>All vaccines recommended by the CDC Recommended Adolescent/Adult Immunization Schedule</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>The global EPSDT fee is paid which includes administration of immunizations and routine screenings.</td>
</tr>
<tr>
<td>21+ Years</td>
<td>All vaccines listed in the QUEST Integration benefit matrix and/or as recommended by the physician based on medical necessity, provided the service is not a QUEST Integration excluded service.</td>
<td>No</td>
<td>Yes</td>
<td>Yes, see Notes</td>
<td>When billing an office visit at the same time as the vaccine administration, please use the appropriate office-based E&amp;M code with distinct ICD-10 diagnoses or appropriate modifiers, to indicate it as a separately identifiable service.</td>
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</tbody>
</table>

## Dental EPSDT Services to be performed by the PCP

Generally, dental services for QUEST Integration members are the responsibility of the State of Hawaii Medicaid Fee-For-Service program. There are, however, services that the medical PCP is expected to provide.

### Birth to 11 months old
- Oral Evaluation
• Check for presence of baby bottle tooth decay - brown and/or white spots, or obvious destruction, on the maxillary anterior teeth and back molars, as well as mandibular teeth.

• Check for proper growth and development of the teeth and jaw.

• Check for healthy gums.

• Check for adequate oral hygiene

• Recommendation of systemic fluoride or vitamins with fluoride for all children six months through three years of age is 0.25 mg daily. This reflects the general experience in Hawaii. If the child’s drinking water is fluoridated, this guidance does not apply.

• Anticipatory Guidance

  • Teething
  • Oral Habits - thumb sucking, pacifiers
  • Injury prevention - use of walkers
  • Oral Hygiene - wiping the teeth and gums with gauze or a wash cloth
  • Nutrition - avoid fruit juices, formulas and soda in infant’s naptime and night time bottle; decrease foods high in refined sugar content

• Dental Referral: Refer the child for a dental visit if either of the following is present:

  • Signs of baby bottle tooth decay
  • Any evidence of problems with teeth, gums, or jaw structure

• Discourage:

  • Night ad lib breast feeding after the first primary teeth have erupted
  • Being put to bed with a bottle. If unable, use plain water only.

12 months and Thereafter

• Oral Evaluation

  • Check for obvious tooth decay, including baby bottle tooth decay
  • Check for proper growth and development of teeth and jaw
  • Check for healthy gums
  • Check for adequate oral hygiene

• Recommendation of systemic fluoride or vitamins with fluoride:

  • six months - three years of age: 0.25 mg daily*
  • three - six years of age: 0.5 mg daily*
  • six - 16 years of age: 1.0 mg daily*

  *This reflects the general experience in Hawaii. If the child’s drinking water is fluoridated, this guidance does not apply.

• Dental Referral
Refer all children to the dentist at one-year-old, especially if no teeth are present

If no dental visit in the past six months (be sure to ask)

If any problems are found

If the child has been seen by a dentist remind parent to keep appointment for their child’s six-month check-up.

QUEST Integration Dental services are provided by the Medicaid Fee-For-Service Program. If parent is not sure who the child’s dentist is, refer parent to Community Case Management Corp. who provides outreach for dental services at 792-1070 or toll-free at 1-888-792-1070.

- Encourage elimination of bottle feeding by 12-14 months of age.
- Anticipatory Guidance - Adapt to the child’s age
  - Oral Habits - thumb sucking, nail biting, chewing ice
  - Injury Prevention - learning to walk, sport activities (mouth guards)
  - Oral Hygiene - tooth brushing and flossing
  - Nutrition - decrease of foods high in refined sugar content
  - Substance Abuse (drugs, smoking, and smokeless tobacco) - from ages 10 to 20 years old
  - Pregnancy - importance of oral hygiene to prevent gum problems

Contact dentist if problems occur - broken tooth, swelling, bleeding

Coordination with Other Services

The AlohaCare Service Coordination Department coordinates with community-based resources/services for services not covered by the QUEST Integration Program. These community resources include (but are not limited to) the following:

- Alcohol and Drug Abuse Division
- Adult Mental Health Division
- CCS for Behavioral Health
- Developmental Disability/Intellectual Disability Division of the Department of Health
- Child and Adolescent Mental Health Division
- Child Protective Services/Child Welfare Services
- 0-3 program (Early Intervention Services)
- Healthy Moms, Healthy Babies
- Head Start Programs
- Community Care Services (CCS)
- WIC (Women, Infant and Children Program)
- Adult Protection
- Department of Justice
• Other community-based organizations such as the Life Foundation, American Cancer Society, American Lung Association, etc.

Generally, coordination with these programs is for services not covered by the QUEST Integration Program, to provide member support. Referrals to these programs are communicated to the member, the member’s PCP and other providers involved in the member’s care and indicate the contact information of programs involved to ensure smooth connection.

WIC Program

The Women, Infant and Children (WIC) Program is a special supplement nutrition program. In addition to providing healthful foods, WIC also provides nutrition education, breastfeeding promotion, substance abuse prevention, immunization coordination, and health and social services referrals. The federal WIC program is available statewide. The program is funded entirely by the federal government and is administered by the state DOH.

QUEST Integration members are entitled to these free health promotion services. AlohaCare may refer members and asks for your assistance to ensure that our members who qualify for WIC are referred to the program.

The following people are entitled to receive WIC assistance:

• Pregnant women
• Post-partum women
• Breastfeeding women (up to 1 year after birth)
• Non-breastfeeding postpartum women (up to six months after the birth of an infant or after pregnancy ends)
• Infants and children up to their 5th birthday

WIC provides:

• Nutritious food
• Nutrition education
• Breastfeeding support
• Health care and social service referral

Participating in WIC is linked with:

• Improved birth outcomes
• Improved diet and diet related outcomes
- Improved infant feeding practices
- Higher immunizations rates and regular source of medical care
- Improved cognitive development

You may call the WIC office at 586-8175 or toll-free at 1-888-820-6245 to request copies of brochures or to determine where the nearest WIC clinic is located to share with your patients. You may access their website at http://health.hawaii.gov/wic/.
Long-term Services and Supports (LTSS)

Long-term services and supports (LTSS) are provided if a member meets the appropriate level of care. There are different types of LTSS:

- Home and Community Based Services (HCBS) provided in an individual’s home or other community residential setting.
- “At-risk” services are certain HCBS services that are provided to an individual if an assessment indicates that the individual is “at-risk” of deteriorating to the institutional level of care. This individual does not meet the criteria to receive all HCBS services.
- Services provided in an institutional setting such as a nursing facility.

How does a member qualify for LTSS?

The member must meet certain level of care requirements and have a face-to-face assessment performed with a Service Coordinator. The Service Coordinator will determine what services are necessary based on the assessment.

At-risk services

At-risk services are certain HCBS services that are provided when the assessment indicates the member is “at-risk” for worsening and going into a nursing home or other type of care outside of the home. At-risk services include:

- Adult day care and health
- Home-delivered meals
- Personal care assistance
- Personal emergency response system
- Skilled nursing services

Home and Community Based Services (HCBS)

AlohaCare will provide HCBS services to members as part of their benefit package when the level of care requirements is met as part of the assessment process. HCBS include the following:

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<tr>
<th>NAME OF SERVICE</th>
<th>DESCRIPTION/COVERAGE</th>
<th>COVERAGE LIMITS</th>
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<tr>
<td>Adult day care</td>
<td>Adult day care is defined as a licensed facility that provides regular supportive care provided to four (4) or more disabled adult participants. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant’s</td>
<td>Based on health and functional assessment of the member</td>
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| Adult day health               | Adult day health refers to a licensed facility that provides an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care. The purpose is to restore or maintain, to the fullest extent possible, an individual’s capacity for remaining in the community.  
In addition to nursing services, other components of adult day health may include: emergency care, dietetic services, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services. | Based on health and functional assessment of the member                                                                                                                                                                          |
| Assisted living facility services | Assisted living facility services include personal care and supportive care services (homemaker, chore, personal care services, and meal preparation) that are furnished to members who reside in an assisted living facility. Members receiving Assisted Living Services must be receiving ongoing Community Care Management Agency Services. | Based on health and functional assessment of the member  
Does not include room and board in an assisted living facility for adults                                                                                                                                                       |
| Community Care Management Agency (CCMA) services | CCMA services are provided to members living in Community Care Foster Family Homes (CFFH), Expanded Adult Residential Care Homes (E-ARCHs), Assisted living facilities and other community settings, as required.  
The following activities are provided by a CCMA:  
- continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89 Subchapter 15;  
- initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of members; | Based on health and functional assessment of the member                                                                                                                                                                          |
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<td>• service plan...</td>
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<td>Community Care Foster Family Home Services (CCFH)</td>
<td>CCFFH services are personal care, nursing, homemaker, chore, and companion services and medication oversight (to the extent permitted under State law) provided in a certified private home by a principal care provider who lives in the home.</td>
<td>Based on health and functional assessment of the member</td>
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<tr>
<td>Counseling and training</td>
<td>Counseling and training activities include the following: member care training for members, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling on coping skills to deal with the stress caused by member’s deteriorating functional, medical or mental status. Counseling and training is a service provided to members, families/caregivers, and professional</td>
<td>Based on health and functional assessment of the member</td>
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<td>NAME OF SERVICE</td>
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<td>and paraprofessional caregivers on behalf of the member. Counseling and training services may be provided individually or in groups. This service may be provided at the member’s residence or an alternative site.</td>
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<td>Based on health and functional assessment of the member</td>
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<tr>
<td>Environmental accessibility adaptations</td>
<td>Environmental accessibility adaptations are those physical adaptations to the member’s home, required by the individual’s service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member.</td>
<td>Excluded are those adaptations or improvements to the home that are of greater utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.</td>
</tr>
<tr>
<td>Home delivered meals</td>
<td>Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day’s nutritional regimen. Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization.</td>
<td>Based on health and functional assessment of the member</td>
</tr>
<tr>
<td>Home maintenance</td>
<td>Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to</td>
<td>Based on health and functional assessment of the member</td>
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<td>NAME OF SERVICE</td>
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<td>acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.</td>
<td>Based on health and functional assessment of the member</td>
</tr>
<tr>
<td>Moving assistance</td>
<td>Moving assistance is provided in rare instances when it is determined through an assessment by the service coordinator that an individual need to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; home unable to support the member’s additional needs for equipment; member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.</td>
<td>Based on health and functional assessment of the member</td>
</tr>
<tr>
<td>Non-medical transportation</td>
<td>Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the service plan. This service is to be used only when transportation is not included in the HCBS service being accessed. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.</td>
<td>Based on health and functional assessment of the member</td>
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<tr>
<td>NAME OF SERVICE</td>
<td>DESCRIPTION/COVERAGE</td>
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| Personal assistance services –Level I and Level II | Personal assistance, sometimes called attendant care for children, are services provided in an individual’s home to help them with their IADLs and ADLs. Personal assistance services Level I are provided to individuals, requiring assistance with IADLs in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I is for individuals who are not living with their family who perform these duties as part of a natural support. Personal assistance services Level I may be self-directed and consist of the following:  
I. Companion Services  
Companion services, pre-authorized by the service coordinator in the member’s service plan, means non-medical care, supervision and socialization provided to a member who is assessed to need these services. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping/errands, but do not perform these activities as discrete services. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual.  
ii. Homemaker/Chore Services  
Homemaker/Chore services means any of the activities listed below, when the individual that is regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others. Homemaker/chore services, pre-authorized by the service coordinator | Based on health and functional assessment of the member |
<table>
<thead>
<tr>
<th>NAME OF SERVICE</th>
<th>DESCRIPTION/COVERAGE</th>
<th>COVERAGE LIMITS</th>
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<tr>
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<td>in the member’s service plan, are of a routine nature and shall not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker/chore services specified in this section shall cover only the activities that need to be provided for the member, and not for other members of the household.</td>
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<td></td>
<td>• Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish;</td>
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<td></td>
<td>• Care of clothing and linen by washing, drying, ironing, mending;</td>
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<td></td>
<td>• Marketing and shopping for household supplies and personal essentials (not including cost of supplies);</td>
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<td>• Light yard work, such as mowing the lawn;</td>
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<td>• Simple home repairs, such as replacing light bulbs;</td>
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<td></td>
<td>• Preparing meals;</td>
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<td>• Running errands, such as paying bills, picking up medication;</td>
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<td>• Escort to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available;</td>
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<td></td>
<td>• Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer;</td>
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<td>• Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments, as appropriate; and</td>
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<td>• Reporting to the assigned provider, supervisor or designee, observations about changes in the member’s behavior, functioning, condition, or self-care/home</td>
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<tr>
<td>NAME OF SERVICE</td>
<td>DESCRIPTION/COVERAGE</td>
<td>COVERAGE LIMITS</td>
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<td>management abilities that necessitate more or less service.</td>
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<td>Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform ADLs and health maintenance activities. Personal assistance services Level II shall be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. Personal assistance services Level II may be self-directed and consist of the following:</td>
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<tr>
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<td>• Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing;</td>
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<td></td>
<td>• Assistance with bowel and bladder care;</td>
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<td>• Assistance with ambulation and mobility;</td>
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<td>• Assistance with transfers;</td>
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<td></td>
<td>• Assistance with medications, which are ordinarily self-administered when ordered by member’s physician;</td>
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<td></td>
<td>• Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member’s physician;</td>
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<td>• Assistance with feeding, nutrition, meal preparation and other dietary activities;</td>
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<td>• Assistance with exercise, positioning, and range of motion;</td>
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<td>• Taking and recording vital signs, including blood pressure;</td>
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<td></td>
<td>• Measuring and recording intake and output, when ordered;</td>
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<td>• Collecting and testing specimens as directed;</td>
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<td>• Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, HAR;</td>
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<td>• Proper utilization and maintenance of member’s medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished;</td>
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<tr>
<td>NAME OF SERVICE</td>
<td>DESCRIPTION/COVERAGE</td>
<td>COVERAGE LIMITS</td>
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<td>Reporting changes in the member’s behavior, functioning, condition, or self-care abilities which necessitate more or less service; and Maintaining documentation of observations and services provided. When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the service plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member’s family, may also be provided.</td>
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<tr>
<td>Personal Emergency Response Systems (PERS)</td>
<td>PERS is a twenty-four (24) hour emergency assistance service which enables the member to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the member and includes training, installation, repair, maintenance, and response needs. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in cases of emergency. The individual may also acquire a portable assistance device to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals. The following are allowable types of PERS items: 24-hour answering/paging; beepers; med-alert bracelets; medication reminder services; intercoms; life-lines; fire/safety devices, such as fire extinguishers and rope ladders; monitoring services; light fixture adaptations (blinking lights, etc.); telephone adaptive devices not available from the telephone company; and other electronic devices/services designed for emergency assistance.</td>
<td>Based on health and functional assessment of the member</td>
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<tr>
<td>NAME OF SERVICE</td>
<td>DESCRIPTION/OVERAGE</td>
<td>COVERAGE LIMITS</td>
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<td>All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer’s authorized dealers whenever possible. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting except for an ALF.</td>
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<tr>
<td>Residential care services are personal care services, nursing, homemaker, chore, companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principle care provider who lives in the home. Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (EARCH), allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the DHS to live in a Type I home with no more than three (3) residents of whom may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, no more than twenty percent (20%) of the home’s licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home. Members receiving residential care services must be receiving ongoing CCMA services.</td>
<td>Based on health and functional assessment of the member</td>
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<tr>
<td>Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual’s home or place of residence; CCFFH;</td>
<td>Based on health and functional assessment of the member</td>
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<tr>
<td>NAME OF SERVICE</td>
<td>DESCRIPTION/COVERAGE</td>
<td>COVERAGE LIMITS</td>
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<td>E-ARCH; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the State. Respite care services are authorized by the member’s PCP as part of the member’s service plan. Respite services may be self-directed.</td>
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<td>Skilled (or private duty) nursing</td>
<td>Skilled nursing is a service provided to individuals requiring ongoing nursing care (in contrast to Home Health or part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the service plan. The service is provided by licensed nurses within the scope of State law and authorized in the member’s service plan. Skilled nursing services may be self-directed under Personal Assistance Level II/Delegated using registered nurse delegation procedures outlined in Chapter 16-89, Subchapter 15, HAR.</td>
<td>Based on health and functional assessment of the member</td>
</tr>
<tr>
<td>Specialized medical equipment and supplies</td>
<td>Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, assessment costs, installation, repairs and removal of devices, controls, or appliances, specified in the service plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate in the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation and may include: Specialized infant car seats; Modification of parent-owned motor vehicle to accommodate the child, i.e. wheelchair lifts; Intercoms for monitoring the child's room; Shower seat; Portable humidifiers;</td>
<td>Based on health and functional assessment of the member</td>
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<tr>
<td>NAME OF SERVICE</td>
<td>DESCRIPTION/COVERAGE</td>
<td>COVERAGE LIMITS</td>
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<td>Electric utility bills specific to electrical life support devices (ventilator, oxygen concentrator); Medical supplies; Heavy duty items including but not limited to patient lifts or beds that exceed $1,000 per month; Rental of equipment that exceeds $1,000 per month such as ventilators; Emergency back-up generators specific to electrical life support devices (ventilator, oxygen concentrator); and Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month.</td>
<td>Items reimbursed shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. Specialized medical equipment and supplies shall be recommended by the member’s PCP.</td>
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<tr>
<td>Subacute Facility Services</td>
<td>Subacute facility services are provided in either a licensed nursing facility or a licensed and certified hospital in accordance with Hawaii Administrative Rules. Subacute facility services provide the member with services that meet a level of care that is needed by the member not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of members in a skilled nursing facility. The subacute services shall be provided in accordance with the Hawaii Administrative Rules.</td>
<td>Based on health and functional assessment of the member</td>
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</table>

At-risk services

At-risk services are certain HCBS services that are provided to members who do not meet the criteria for all HCBS services, but whose assessment indicates that they are “at-risk” of deteriorating to the institutional level of care. Certain services may include:

- Home-delivered meals
- Personal emergency response system
- Personal assistance (limited to 10 hours per week)
- Adult day care and health
- Skilled nursing services
If you think an individual may qualify as being at-risk, call us and our service coordinators will perform a Health and Functional Assessment to determine eligibility for services.

Self-Direction

Members approved for HCBS services may also choose to receive services in a program that provides the opportunity to have choice and control over their providers. This is referred to as Self-Direction.

In the self-direction program, members will be responsible for fulfilling the following functions:

- Recruiting and selecting providers;
- Determining provider duties;
- Determining a rate of pay that is at least the Federal or State minimum wage, whichever is higher;
- Scheduling providers;
- Instructing and training providers in preferred duties;
- Supervising providers;
- Evaluating providers;
- Verifying the time worked by providers and approving time sheets; and
- Discharging Providers.

Service Coordinators assist the member in facilitating self-direction and accessing available resources and supports and with all of the necessary paperwork.

Self-Direction Providers for members eighteen years of age or older who meet the State prescribed provider qualifications and training standards may include:

- Parents
- Spouse
- Family member
- Health care providers

Self-directed services may not be an activity that the family would ordinarily perform or is responsible to perform. AlohaCare will consider the extent to which an individual who is the same age without disability would need the requested service or assistance as the member with a disability.

AlohaCare’s Service Coordinators will provide you with information about the self-direction program.

AlohaCare may terminate provision of self-direction services on behalf of a member for health and welfare issues.

Institutional Services

There are many different types of LTSS institutional service settings, as described below.
<table>
<thead>
<tr>
<th>NAME OF SERVICE</th>
<th>DESCRIPTION/COVERAGE</th>
<th>COVERAGE LIMITS</th>
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<tr>
<td>Acute Waitlisted ICF/SNF</td>
<td>Acute waitlisted ICF/SNF is either ICF or SNF level of care services provided in an acute care hospital in an acute care hospital bed. Health plans shall identify individuals who are acute waitlisted for discharge to a more appropriate location for treatment.</td>
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<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>Nursing facility services are provided to members who need twenty-four (24) hours a day assistance with ADLs and IADLs and need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis. Nursing facility services are provided in a free-standing or a distinct part of a facility that is licensed and certified as meeting the requirements of participation to provide skilled nursing, health-related care and rehabilitative services on a regular basis in an inpatient facility. The care that is provided in a nursing facility includes independent and group activities, meals and snacks, housekeeping and laundry services, nursing and social work services, nutritional monitoring and counseling, pharmaceutical services, and rehabilitative services. Services are provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis for members who need twenty-four (24) hours a day assistance with ADLs and IADLs.</td>
<td>Based on health and functional assessment of the member</td>
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<tr>
<td>Intermediate Care Facility (ICF)</td>
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<tr>
<td>Nursing Facility (NF) Services</td>
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<tr>
<td>Sub-acute facility services</td>
<td>Sub-acute facility services are provided in either a licensed nursing facility or a licensed and certified hospital in accordance with Hawaii Administrative Rules. Sub-acute facility services provide the member with services that meet a level of care that is needed by the member not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of</td>
<td>No limit</td>
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</table>
members in a skilled nursing facility. The sub-acute services shall be provided in accordance with the Hawaii Administrative Rules.
SECTION 11 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 must be printed with a font size between 10 and 12. All submissions must be on original claim forms; no copied forms are accepted for claim submission. Please see Appendix A of this provider manual for additional information regarding requirements and helpful tips on the CMS 1500 claim and the CMS 1450 (UB-04) forms. Electronic submission of claims can be arranged by calling AlohaCare.

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 our requirements to submit encounter data to the State of Hawaii Med-QUEST Division within specific time limits:

- Claims where AlohaCare is the primary payer must be received within 365 days of date of service. Claim resubmissions must also be received within 365 days of date of service.
- Third Party Liability (TPL) claims must be received with the Explanation of Benefits (EOB) from other insurance carriers attached.
- For facilities billing for inpatient stays, the filing deadlines are from date of admission. Interim billings, using appropriate bill types, are encouraged for lengthy confinements.
- Exceptions to the filing deadlines will be granted only for unusual and extenuating circumstances. Please resubmit the claim with a letter attached detailing the reasons for the filing delay and follow the resubmission policy below.

Resubmissions

AlohaCare will accepts both EDI and Hardcopy Resubmission claims. If a claim is being resubmitted via Hardcopy, it must be clearly marked “RESUBMISSION”. Resubmissions must be received by AlohaCare within one year from the date of service (or date of admission for facilities resubmitting inpatient claims). Claims resubmitted after one year will generally not be considered for payment. 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.

To submit Corrected or Voided Claims via EDI:
Please work directly with your clearing house.

To submit Corrected Claims via Hardcopy:

**UB-04**
- Clearly mark Resubmission on the Claim Form
- Indicate the appropriate frequency code in form locator 4 – Type of Bill (Claim Frequency Code 7 for replacement)
- Indicate if available, the AlohaCare original Claim ID in form locator 64 – Document Control Number
- Indicate the reason for correction in form locator 18-28 - Condition Code
  - D0 – Changes to Service Dates
  - D1 – Changes to Charges
  - D2 – Changes to Revenue Codes, HCPCS, or HIPPS
  - D3 – Second or Subsequent Interim Billing
  - D4 – Changes to Diagnosis or Procedure Codes
  - D8 – Changes to Make Medicare the Primary Payer
  - D9 – Other Changes – Please add explanation to form locator 80 – Remarks
  - E0 – Patient Status
- Mail resubmissions to the AlohaCare Claims Department.

**1500**
- Clearly mark Resubmission on the Claim Form
- Indicate the appropriate resubmission code in Item Number 22 (Code 7 for replacement)
- Indicate if available, the AlohaCare original Claim ID in Item Number 22
- Indicate the reason for correction in Item Number 19 – Reserved for Local Use
- Mail resubmissions to the AlohaCare Claims Department.

To submit Voided Claims via Hardcopy:

**UB-04**
- Indicate the appropriate frequency code in form locator 4 – Type of Bill (Claim Frequency Code 8 for replacement)
- Indicate if available, the AlohaCare original Claim ID in form locator 64 – Document Control Number
Indicate the appropriate resubmission code in Item Number 22 (Code 8 for replacement)
Indicate if available, the AlohaCare original Claim ID in Item Number 22
Indicate the reason for correction in Item Number 19 – Reserved for Local Use

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.

Med-QUEST 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.

Procedure and Diagnosis Codes

Current, valid ICD-10, 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 Provider Services Department or your Provider Network Representative as to our ability to accept these codes and/or discuss alternative coding.

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/Notification Information

When billing for services, the prior authorization/notification 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 claims review guidelines are based on but not limited to Current Procedural Terminology (CPT), Hawaii Med-QUEST policies or guidelines, industry standard National Correct Code Initiative (NCCI) policy and guidelines, industry payment rules and guidelines that are specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB), coding conventions defined by the American Medical Association, Medicare National Coverage Determinations (NCD), and Medicare Local Coverage Determinations (LCD). AlohaCare will deny service lines that are coded inappropriately (example: one of the submitted codes is defined in such a 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 billed separately under this circumstance.
Additional types of claims review may be performed for purposes including, but not limited to:

- Determination and verification of medical or functional necessity and appropriateness of billed services
- Bundling and unbundling
- Confirmation of appropriateness of the place of service and level of care
- Accuracy of coding
- Services included in global care
- Duplicate claims
- Compliance with the QUEST Integration Program and AlohaCare plan benefits
- 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

**Newborn Claims**

AlohaCare will pend claims received for newborns until eligibility verification and the QUEST Integration ID number is received from Med-QUEST. Generally, but not always, Med-QUEST will assign the newborn to AlohaCare when the mother is eligible with AlohaCare on either the date of birth or retroactively. Once the newborn’s eligibility and QUEST Integration ID number is established, AlohaCare will process the claim provided that all other claim processing requirements are fulfilled. Newborn claims must contain the full name of the child.

**Member Direct Billing**

In accordance with the Hawaii QUEST Integration Program guidelines, providers cannot bill or 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 should be placed in the member’s medical record.
- QUEST Integration Adult members can be billed for services exceeding benefit limitations.
- Member self-referral to an out-of-network specialist or other provider without following Plan procedure. Out-of-network specialist visits require an authorization and the member is responsible to pay for any services rendered without an authorization. Documentation of the
member’s signed acceptance of payment responsibility should be placed in the member’s medical record.

- AlohaCare does not pay for services if the patient had primary coverage through a prepaid benefits plan (examples include: HMSA Health Plan Hawaii, Kaiser Health Plan) but did not go to a primary payer’s designated facility for treatment. The provider is responsible for checking for eligibility and TPL coverage in advance of providing services. AlohaCare may pay for QUEST Integration covered services if the service is excluded from coverage under the prepaid benefits plan.

- Members may have to share in the cost of health care or support services. This is based on their Medicaid financial eligibility. Med-QUEST determines the cost sharing amount and informs AlohaCare of the amount. If a member has a cost share, they must make payments to one of their providers every month. This is usually a long-term care facility or a home and community based provider.

- In cases where a member is retro-enrolled and made payment directly to a provider, AlohaCare will work with the member and provider to ensure that the member is reimbursed. Participating providers should bill AlohaCare and reimburse the member for any payment that they made.

**Note: If plan procedures are not followed resulting in nonpayment, the provider may not bill the member.**

**Third Party Liability (TPL) / Coordination of Benefits**

As a Medicaid Managed Care health plan, AlohaCare is always considered the payer of last resort when a member has other insurance coverage. If any other insurance carrier is liable for incurred charges, that carrier must reimburse the provider to the limits of its coverage before AlohaCare will be responsible for its share of the payment.

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 first

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. If the primary carrier denied a service which is a covered benefit under AlohaCare, the service may be payable. Payment will be determined based on AlohaCare benefits, administrative requirements and the clinical appropriateness of the service according to the claim diagnosis.
Professional: For all covered professional services, AlohaCare will coordinate up to our reimbursement allowance for the billed procedure. Provided that all claim submission requirements have been met, AlohaCare will calculate payment using our reimbursement allowance for the billed procedure less the primary carrier’s payment as shown on the explanation of benefits. Provider adjustment amounts made by the primary carrier will not be factored into coordination of benefit payments. No additional payment will be made if the primary carrier’s payment is greater than AlohaCare’s standard reimbursement allowance for the billed procedure.

Services covered under a capitated agreement must also be submitted to the primary carrier and billed to AlohaCare with an EOB from the primary carrier. AlohaCare will process the claim as a capitated service and report any COB information as part of Medicaid encounter reporting requirements.

The Department of Human Services has set reimbursements for the following types of providers: Critical Access Hospitals, Federally Qualified Health Centers, Hospices, and Rural Health Centers. These provider types are excluded from the lessor of logic. Their total reimbursement must equal the published rates applicable to the date of service/admission date.

AlohaCare will apply our internal policies for “global” procedure codes, and will combine component code payments and coordinate up to the AlohaCare eligible reimbursement, which may not necessarily cover 100 percent of any co-pay, deductible, or other patient responsibility amount indicated by the primary payer. Our payment, in this regard, must be considered payment in full, and the member cannot be balance billed.

**Coordination with Coverage other than Medicare UB-04 claims for Skilled Nursing Facility, Inpatient Rehabilitation, and Home Health Agency:** AlohaCare will reimburse the sum of member’s coinsurance, copayment and deductible.

**COORDINATION OF COVERAGE UB-04 claims**

UB-04 Acute Inpatient claims: Other carrier’s payment will be applied at the claim level. AlohaCare will reimburse up to AlohaCare’s allowed amount for the claim or the sum of member’s coinsurance, copayment and deductible, whichever is less. If the carrier’s payment for the claim exceeds AlohaCare’s allowed amount for the claim no payment will be made for the claim.

UB-04 Outpatient claims: Other carrier’s payment will be applied at the claim level. AlohaCare will reimburse up to AlohaCare’s allowed amount for the claim or the sum of member’s coinsurance, copayment and deductible, whichever is less. If the carrier’s payment for the claim exceeds AlohaCare’s allowed amount for the claim no payment will be made for the claim.

Example 1 (UB-04 Acute Inpatient and Outpatient):

A. Claim Total: $1,000  
B. Other Carrier’s Payment: $250  
C. AlohaCare’s Allowed Amount: $400  
D. Variance between AlohaCare’s Allowed Amount ($400) and Other Carrier’s Payment ($250) = $150  
E. Other Carrier’s Coinsurance + Deductible: $100

From the example above, AlohaCare’s payment would be $100 since E is less than D.
Example 2 (UB-04 Acute Inpatient and Outpatient)

A. Claim Total: $1,000
B. Other Carrier’s Payment: $250
C. AlohaCare’s Allowed Amount: $300
D. Variance between AlohaCare’s Allowed Amount ($300) and Other Carrier’s Payment ($250) = $50
E. Other Carrier’s Coinsurance + Deductible: $100

From the example above, AlohaCare’s payment would be $50 since D is less than E.

COORDINATION OF COVERAGE CMS HCFA 1500 claim

CMS 1500 claims: Other carrier’s payments will be applied by service line for covered services, except for claims involving global reimbursements (e.g. EPSDT, global OB, etc.). AlohaCare will reimburse up to AlohaCare’s allowed amount. If the carrier’s payment exceeds AlohaCare’s allowed amount no payment will be made for that service line. For services involving a global reimbursement all carrier payments for service lines included in the global reimbursement will be consolidated and subtracted from the AlohaCare allowed amount for the global service. If the carrier’s payment exceeds AlohaCare’s allowed amount, no payment will be made.

Example 1 (CMS 1500 claims):

A. Claim Total: $330
B. Other Carrier’s Payment: $156
C. AlohaCare’s Allowed Amount: $247
D. Variance between AlohaCare’s Allowed Amount ($247) and Other Carrier’s Payment ($156) = $91
E. Other Carrier’s Coinsurance + Deductible: $0

From the example above, AlohaCare’s payment would be $91 (D).

When the Other Carrier’s Payment exceeds AlohaCare’s Allowed Amount, no additional payment will be made by AlohaCare.

Example 2 (CMS 1500 claims):

A. Claim Total: $330
B. Other Carrier’s Payment: $250
C. AlohaCare’s Allowed Amount: $247
D. Variance between AlohaCare’s Allowed Amount ($247) and Other Carrier’s Payment ($250) = ($3)
E. Other Carrier’s Coinsurance + Deductible: $0
From the example above, B is greater than C, no payment is made.

Coordination with Medicare coverage (Including Medicare Advantage plans)

UB-04 claims (Skilled Nursing Facility, Inpatient Rehabilitation, Hospice, and Home Health Agency): AlohaCare will reimburse the sum of member’s coinsurance, copayment and deductible.

UB-04 Acute Inpatient claims (Part A): Medicare payments will be applied at the claim level. AlohaCare will reimburse the difference between AlohaCare’s allowed amount less the Medicare paid amount for the claim, or the sum of member’s coinsurance, copayment and deductible, whichever is less. If the Medicare payment for the claim exceeds AlohaCare’s allowed amount for the claim no payment will be made for the claim.

UB-04 claims (Part B): Medicare payments will be applied at the claim level. AlohaCare will reimburse up to AlohaCare’s allowed amount for the claim or the sum of member’s coinsurance, copayment and deductible, whichever is less. If the Medicare payment for the claim exceeds AlohaCare’s allowed amount for the claim no payment will be made for the claim.

Example 1 (UB-04 Acute Inpatient and Outpatient):

A. Claim Total: $1,000
B. Other Carrier’s Payment: $250
C. AlohaCare’s Allowed Amount: $400
D. Variance between AlohaCare’s Allowed Amount ($400) and Other Carrier’s Payment ($250) = $150
E. Other Carrier’s Coinsurance + Deductible: $100

From the example above, AlohaCare’s payment would be $100 since E is less than D.

Example 2 (UB-04 Acute Inpatient and Outpatient):

A. Claim Total: $1,000
B. Other Carrier’s Payment: $250
C. AlohaCare’s Allowed Amount: $300
D. Variance between AlohaCare’s Allowed Amount ($300) and Other Carrier’s Payment ($250) = $50
E. Other Carrier’s Coinsurance + Deductible: $100

From the example above, AlohaCare’s payment would be $50 since D is less than E.

CMS 1500 claims: AlohaCare will reimburse the sum of member’s coinsurance, copayment, and deductible. Federally Qualified Health Centers and Rural Health Centers will be reimbursed up to the Department of Human Services published rates.
AlohaCare will also reimburse for services covered under QUEST Integration but not covered under Medicare.

AlohaCare will automatically process the secondary claim using the primary claim for AlohaCare’s dual eligible members without the provider having to submit a new claim for secondary processing.

**Cost Share Collection**

When AlohaCare designates a provider to be responsible for cost share collection, the provider shall collect the applicable monthly cost share from the member in an amount determined by Med-QUEST. AlohaCare’s compensation to provider will be reduced by the member’s monthly cost share.

**Benefits Coordination for Motor Vehicle Incidents**

These provisions apply to claims for services in connection with an illness or injury caused by the use, maintenance or operation of a motor vehicle. It is required that claims are to be submitted to the motor vehicle insurance carrier in accordance with Hawaii state law regardless of fault.

If the member is involved in a motor vehicle-related accident, claims must be submitted to the motor vehicle insurance carrier first.

The order of coverage is as follows:

1. The Personal Injury Protection coverage of the motor vehicle involved.
2. If the vehicle involved is uninsured, the injured person’s own motor vehicle insurance Personal Injury Protection applies.
3. If the injured person is not the owner of the vehicle involved, and a relative living within the injured person’s household has motor vehicle coverage, the Personal Injury Protection in that policy applies.

**Required Information for AlohaCare Consideration:**

If the member has exhausted the available motor insurance Personal Injury Protection benefits AlohaCare requires the following information before remaining claims related to the accident can be processed:

- A letter from the motor vehicle insurer reflecting that Personal Injury Protection benefits have exhausted.
- A recap or summary for the motor insurance carrier detailing which claims related to the incident were covered including dates if service, the provider’s name and payment for service performed.
- Completed AlohaCare Injury/Illness Report form signed by the injured party or by the parents or legal guardian if the injured party is a minor.

Note: A completed AlohaCare Injury and Illness form along with all necessary documentation should be submitted only after motor vehicle benefits have exhausted. AlohaCare’s Injury/Illness form can be located in the Member Documents section of our website [www.Alohacare.org](http://www.Alohacare.org)
**Benefits Coordination for Worker’s Compensation**

These provisions apply to claims for services provided in connection with an illness or injury that may be work related. Claims for these services must be submitted to the Workers’ Compensation carrier of the member’s employer.

If the member’s Worker’s Compensation carrier denies payment. Either the member, Provider or facility may notify AlohaCare of the denial. AlohaCare requires the member to provide additional information regarding their case and a copy of the denial of claims or coverage correspondence issued by the members’ employer’s Worker’s Compensation carrier.

AlohaCare will not provide benefit coverage for services unless it is determined by the Department of Labor that the injury or illness is not work related or until written proof is provided that Worker’s Compensation benefits have exhausted. In these instances, AlohaCare’s required the following documentation:

- A completed AlohaCare Injury/Illness Report form signed by the injured party or by the parents or legal guardian if the injured party is a minor.
- A copy of the Worker’s Compensation or Department of Labor denial letter indicating that the member’s illness or injury is not work related.
- Or, a copy of the Worker’s Compensation exhaustion of benefit letter along with detailing which claims related to the incident were covered including dates if service, the provider’s name and payment for service performed.

Note: A completed AlohaCare Injury and Illness form along with all necessary documentation should be submitted only after Worker’s Compensation benefits have exhausted or been denied by the member’s employer’s Worker’s Compensation carrier or the Department of Labor. AlohaCare’s Injury/Illness form can be located in the Member Documents section of our website [www.alohacare.org](http://www.alohacare.org)

We ask that providers to encourage our members to contact Med-QUEST to update third party liability in instances where the member may be covered by another insurance carrier or when an injury or illness is caused by motor – vehicle accident or worker’s compensation incident. Encouraging members to report third party liability coverage of services will assist with AlohaCare’s processing of claims and reduce the delay of payments for covered services to the submitting provider.

**Pharmacy Claim Submission Standard**

The Tele PAID 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 Payer Sheet. The most current Payer Sheet can be obtained through AlohaCare’s website at [www.alohacare.org](http://www.alohacare.org)

Pharmacies must submit all claims through the Tele PAID System and will comply with all information communicated via the Tele PAID 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:
- Patient’s date of birth does not match the information we have on record, provided to AlohaCare by Med-QUEST

How to prevent errors:
- When possible, request additional ID to verify patient identity
- Call AlohaCare for assistance in correcting any inaccurate information

**Use valid ICD-10 diagnosis codes, revenue codes, CPT and HCPCS procedure codes, and NDC.**

Errors seen:
- Missing or incomplete procedure, revenue, or diagnosis codes (i.e. 4th or 5th digit, when required)
- 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
- Not supplying NDC when needed

How to prevent errors:
- Include diagnosis, procedure, and revenue codes where required
- Use current ICD-10 diagnosis codes, CPT and HCPCS procedure codes and revenue codes
- Do not submit CMS-1500 Claims with duplicate diagnosis codes

**Submit claims only for eligible patients**

Errors seen:
- Services rendered after member’s disenrollment date
- Services rendered during break in member’s coverage
• Claims submitted for patients that are not enrolled in AlohaCare

How to prevent errors:
• Ask member for the AlohaCare ID card
• Check eligibility on AC Online or Call the AlohaCare Provider Services Department
• Call Med-QUEST Enrollment Call Center to determine QUEST Integration plan and eligibility

Submit original claims within the filing deadline (365 days from the date of service including resubmissions).

Errors seen:
• Claims that appear to be original submissions are submitted past the filing deadline

How to prevent claims 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 and box 14 of the CMS 1500 claim form

Errors seen:
• Claims related to pregnancy or accidents, with box 10 and/or box 14 left blank on the CMS 1500 claim form

How to prevent errors:
• Always complete box 10 and box 14 on the CMS 1500 claim form when billing for pregnancy or accident-related services
Provide complete information on a UB04 form

Errors seen:

- Missing Value Code 80 data
- Missing or invalid Attending Physician data
- 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 (e.g., occurrence code for work-related injury used on claims for children and infants)

How to prevent errors:

- Provide the appropriate Value Code 80 data when billing accommodation revenue codes
- Provide accurate Attending Physician data, Physician Name should match the NPI provided
- Use appropriate External Cause Diagnosis Codes whenever an accident occurrence code is used (01-05)
- Review UB04 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 TPL

How to prevent errors:

- Attach Explanation of Benefits to TPL claims or submit Other Carrier Payment information via electronic claim submission.

Anesthesia

Errors seen:

- Total number of minutes not reported
- Missing or invalid ASA codes

How to prevent errors:

- Always report the total number of minutes in box 24G
- Report start and end time
- 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

**Attending Provider Information**

Errors seen:

- Facility claim is submitted without an attending physician or the attending physician name does not match the submitted NPI.

How to prevent errors:

- Submit the attending provider name and corresponding NPI. The provider should be the individual that has overall responsibility for the patient’s medical care and treatment reported on the claim
- Do not submit a clinic’s or facility’s NPI as the attending provider since value must be an individual

**Unspecified Diagnosis Codes**

Errors seen:

- Claim is submitted using an unspecified or nonspecific diagnosis code

How to prevent errors:

- Diagnosis codes must be coded to the highest level of specificity

**Value Code 80**

Errors seen:

- Facility claim is submitted without Value Code 80 data

How to prevent errors:

- Claims that are submitted with accommodation revenue codes should be submitted with the appropriate units in the Value Code 80 field

**Other Claims Tips**

Avoid duplicate claim submissions. We encourage providers and their staff members to utilize AC Online to check on the status your claim or to contact our Provider Services Department. Duplicate claim submissions slow down claims processing by adding unnecessary volume.
If you do not understand a claims denial, or have received multiple denials, contact our Provider Services Department for assistance. Continuing to resubmit a claim without correcting the specific error causing the denial may cause further delay in processing the claim.

Reimbursement

Reimbursement for covered services is determined according to the provider’s agreement with AlohaCare. Out-of-network providers are reimbursed based on a non-contracted fee schedule. Under federal law, emergency services provided by non-contracted providers, are paid standard Medicaid rates. Because AlohaCare is a Medicaid Managed Care plan, payments made must be considered payment in full, and members cannot be balance billed.

Appropriate Billing and Reimbursement Methodology

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. Time units are calculated as one (1) unit for each 15-minute period. Any minutes beyond a whole unit will be rounded up or down to the nearest whole unit. Indicate total number of minutes in Box 24G. Our systems will calculate it to the nearest whole unit.
Facility Inpatient Late Charges

Claims for late charges (bill type 115) will be processed but will not affect payment on claims paid 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.

Remittance Advice

AlohaCare has partnered with PaySpan to provide remittance advice for our providers. Remittance advice is a report mailed to providers with their checks. The remittance advice summarizes claims status and is useful in posting payments. Please find an explanation of remittance advice in Appendix B of this provider manual.

Electronic Funds Transfers

AlohaCare has partnered with PaySpan to also provide electronic reimbursement payments for our providers. This free service will deposit AlohaCare reimbursement payments to the bank account(s) of your choice via electronic funds transfer (EFT), online access to Explanation of Payments (EOPs), and payment reconciliation reports. This service allows our providers to reduce costs, improve cash flow, and reduce paper usage.

If you have not previously used PaySpan, you may request your registration code(s) at https://www.payspanhealth.com/requestRegCode/ or contact PaySpan via e-mail at providersupport@payspanhealth.com. This registration code will allow you to register to receive payments via EFT. Please use subject line “Registration Code Request – AlohaCare” and include your name, the Tax Identification Number for your practice, and telephone number in the body of the e-mail.

Information with regard to registering for PaySpan may be located on www.alohacare.org in the Providers Resources section of our website or you may contact PaySpan directly via e-mail at providersupport@payspanhealth.com or by phone at 1-877-331-7154 Option 1 from 8am-8pm EST (3:00am –3:pm HST).

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.

AlohaCare may recover any payments for services made to the Provider due to member eligibility, TPL
adjustments, audit findings that show such payments to be inappropriate, or were inadvertently paid for non-covered services. Payment recoveries based on audit findings may be recovered from a future payments. AlohaCare will issue a 60-day notification of our findings to the Provider prior to performing these recoveries. A provider may request other repayment arrangements when the notification of recovery is received.

Provider Initiated Recoveries

Professional Services:

If you require that a complete recovery needs to be performed because all services on a claim were inappropriately billed, we require a letter with the following information. Please send your request to AlohaCare, Attn: Claims Correspondence at 1357 Kapio

lani Blvd., Suite 1250, Honolulu, HI 96814.

a. Member Name
b. Member QUEST Integration ID
c. AlohaCare Claim Number
d. Reason for Recovery
e. Total payment to be recovered

If you require a recovery for a single line item or service billed on a claim with multiple service lines, submit a corrected CMS 1500 (clearly marked “Resubmission”) with a cover letter reflecting the following information to our claims department.

a. Member Name
b. Member QUEST Integration ID
c. AlohaCare Claim Number
d. CPT code related to the recovery
e. Reason for Recovery
f. Total amount to be recovered

TPL (i.e., Other Carrier payment, No Fault & Work Comp) recovery requests would need to be submitted with a cover letter, primary payer EOB and a corrected claim (clearly marked “Resubmission”) supporting primary payer payment and balance forwarded for appropriate coordination if one is allowed. The cover letter should include the following information:

a. Member Name
b. Member QUEST Integration ID
c. AlohaCare Claim Number
d. Total amount to be recovered

Facility Services:
If you require that a complete or partial recovery needs to be performed because services on the claim were inappropriately billed, please submit a corrected UB to our claims department. Please note the Type of Bill (Field 4) will need to be corrected in order for the adjustment to be processed appropriately. Please clearly indicate at the top of the claim “resubmission” or “corrected claim”.

TPL (i.e., Other Carrier payment, No Fault & Work Comp) recovery requests need to be submitted with a primary payer EOB, a corrected UB reflecting primary plan payment, and balance forwarded for appropriate coordination. Please note the UB Type of Bill (Field 4) will need be corrected in order for the adjustment to be processed accordingly. Please clearly indicate at the top of the claim “resubmission” or “corrected claim”.

SECTION 12 VISION SERVICES

AlohaCare provides vision benefits for QUEST Integration members. As with other professional services, vision claims should be submitted to AlohaCare on the CMS-1500 claim form.

Prior authorization is not required for members seeing participating providers for routine vision services (eye exam, refraction, glasses) that are within the QUEST Integration Plan guidelines and limits.

AlohaCare Vision Guidelines

The following guidelines are based on Medicaid guidelines and criteria for vision benefits and vision-related medical conditions (version dated 10/18/02) with a few AlohaCare modifications.

Description

Program covers eye and vision services provided by qualified optometry/ophthalmology professionals within certain criteria based on the member’s age. For information on glasses and contact lenses, see the section about Vision Eyewear later in this chapter.

Amount, Duration, and Scope

1) Emergency eye care, which meets the definition of an emergency medical condition, is covered for all AlohaCare members. Vision examination and the provision of prescription lenses are covered. Cataract removal is covered for all eligible members.

2) An ophthalmologic exam with refraction includes:
   - Determination of visual acuity
   - Tonometry (routine and serial)
   - Gross visual fields
   - Muscle balance
   - Slit lamp microscopy

3) Ophthalmoscope is payable as a separate procedure. If done within a pre-op period, it is considered a pre-operative examination.

4) Eye examinations are considered bilateral and should be coded as a single procedure code. Right and left or bilateral modifiers will not be paid.
Exclusions
Excluded vision services include:

- Orth optic training
- Prescription fee
- Progress exams
- Radial keratotomy
- Visual training
- Lasik procedures
- All charges for drugs and supplies used in the office for testing are included in the fee for the specific procedure; no additional allowance for the drugs will be made.

Limitations
Screening Limited to:

- Once in a 12-month period for the QUEST Integration Keiki members
- Once in a 24-month period for the QUEST Integration Adult members

Visits done more frequently are payable when indicated by symptoms or medical condition, but are subject to prior authorization.

Cataracts
Cataract removal is a covered service (under Medical) when the cataract is visible by exam, ophthalmoscope or slit lamp, and any of the following apply:

- Visual acuity that cannot be corrected by lenses better than 20/70 and is reasonably attributable to the cataract; or
- In the process of complete inability to see the posterior chamber, vision is confirmed by potential acuity meter (PAM) reading, or
- For eligible members who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist is obtained.

Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the recipient will achieve visual functional ability when visual rehabilitation is complete.

Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures and the member’s medical status.

The global period covers 45-days post-operative follow-up and one pre-operative day on the day of surgery. A separate professional fee will be allowed for evaluation prior to the procedure.
Corneal Transplants

Indications for penetrating keratoplasty are:

Corneal opacification that sufficiently obscures vision through the anterior segment of the eye with at least light perception present. Causes for this problem include:

- Corneal injury and scarring;
- Corneal degeneration (from Fuch’s or other dystrophy or from previous cataract and/or intraocular lens implantation);
- Corneal degeneration from keratoconus or familial causes;
- Corneal infection (e.g., herpes)
- Therapeutic graft for relief of pain is needed and the patient has at least light perception vision present or the patient has corneal degeneration due to an eye inflammation resulting in pain, however useful vision is still present.

Indications for lamellar keratoplasty include:

- Superficial layer corneal scarring and deformity due to trauma, degeneration, infection, or congenital deformity (anterior)
- Aphakia
- High myopia
- High refractive error
- Keratoconus
- Recurrent pterygium

Additional conditions and limitations for corneal transplants are as follows:

- There is no intractable glaucoma in the eye under consideration
- There is no active eye infection at the time of surgery
- There are no general medical contraindications to surgery or anesthesia
- There is an informed consent obtained from the patient or patient’s representative
- There is no age restriction

Prior Authorization

Prior authorization is required by AlohaCare for the performance of corneal transplants as per our policy and procedure on elective surgery performed in the non-office setting.

Vision Eyewear

Description

The charges incurred in dispensing visual aids prescribed by ophthalmologists or optometrists are
covered by the AlohaCare. These include costs for the lens, frames, or other parts of the glasses, as well as fittings and adjustments.

**Amount, Duration, and Scope**

The following are covered:

**Eyeglasses**

- Refractive corrections criteria for an original prescription is (+) or (-) 0.50 diopter, sphere or cylinder, or 1 vertical or 5 horizontal prism diopters for each eye.
- Refractive correction of a change in prescription is (+) or (-) 0.50 diopter, sphere or cylinder, or 6 degrees in cylinder axis for both eyes.
- Glass or plastic lenses may be used. Glass must conform to standard Z-80 (National Bureau of Standards) as it existed on September 15, 1983. **Polycarbonate lenses must be prior authorized.**
- Nose pads and rocking pads are considered as part of the technical servicing for the complete glasses. Replacement of the pads is considered a repair and is payable. Frame adjustment, verification or prescription and dispensing of eyeglasses and technical servicing are included in the servicing of the entire glasses.
- Frames: please refer to limitations later in this chapter.
- Frames: **covered at a capped amount of $30.** The provider must provide a selection of frames from which the member may choose. This selection will be reimbursed by AlohaCare at the fee amount stated above and there should be no co-payment or balance billing to the AlohaCare member.

AlohaCare members are allowed to pick frames outside of the AlohaCare selection. However, the provider must inform the member that AlohaCare will only pay the fee schedule amount and the member will be responsible for the balance up to the actual cost of the frames. The provider should obtain the member’s agreement to be balance billed in writing to protect the provider.

PLEASE NOTE that this differs from the Medicaid requirement that there be no balance billing to members. In the Medicaid program, a member who chooses to select frames outside of the selection that is paid in full by Medicaid results in NO BENEFIT for the frames from the Medicaid program. The Medicaid member is then required to pay in full for the more expensive frames, as well as the cost of the technical servicing of the frames.

Providers may only bill Medicaid for the charges pertaining to the lenses. It is for this reason that we advise providers to show the AlohaCare frame selection and obtain written agreement from the member with regards to balance billing in the event that frames outside of the AlohaCare set are selected.

**Contact Lenses**

Contact lenses are only covered in the following conditions:

- Keratoconus in one or both eyes where corrected vision by glasses is less than 20/40 and the vision is further improved by contact lenses.
• Corneal astigmatism in one or both eyes greater than 4.00 diopter is correctable by contact lenses.
• Irregular astigmatism due to corneal imperfection where corrected vision by glasses is less than 20/40 and vision is further improved by contact lenses.
• Anisometropia due to aphakia or other causes where the vision corrected by glasses in the non-affected eye is less than 20/50, the problem either will last for at least 6 months or is permanent, and the person requires binocular vision for educational or job purposes.
• Bilateral aphakia when a person becomes ill using spectacle glasses or when the person’s occupation makes the wearing of glasses hazardous.
• Certain inflammatory conditions of the cornea for which therapeutic contact lenses are indicated with the recommendation of an ophthalmologist.

Miscellaneous Vision Supplies
• Prosthetic eyes are covered. A global fee includes payment for all visits, materials, costs, modifications or replacement because of poor fitting or unacceptable defect within 90 days from the initial visits for fitting. Members on the Neighbor islands requiring prosthesis should be referred to a provider who can complete the prosthesis in one series of daily visits.
• Subnormal visual aids are covered.

Repairs
• Minor repairs are covered.

Exclusions
• Blended bifocals
• Bifocal contact lenses
• Spare pair of glasses or contacts
• Repairs on glasses that no longer meet the member’s needs are not payable
• Tinted lenses for cosmetic reasons. Members must pay for all expenses, both technical and material.
• Oversized lenses unless authorized
• Contact lenses solely for cosmetic purposes such as obscuring an opaque pupil
• Contact lens care kit and accessories
• All services or material not in compliance with the restrictions in these guidelines

Limitations
Eyeglasses are limited to:
• Once every 12 months for the QUEST Integration Keiki members under the age of 21.
• Once in a 24-month period for the QUEST Integration Adult members
A new pair within the 24-month period for adults or the 12-month period for under 21 year old members is payable if the change in prescription meets the guidelines described above under “Eyeglasses.” The 24-month period (or 12 months for under 21) will begin again from the date of the most recently dispensed glasses. The claim for the new glasses, however, must have both the old and new prescriptions to confirm the prescription change and avoid processing delays.

Exams or visual aids (glasses) that exceed the limitation require Prior Authorization.

Tinted or color-coated corrective lenses or “clip-ons” are payable for persons with aphakia, albinism, glaucoma, or other medical conditions excluding photophobia not associated with such conditions. The tint or coat should allow use of the lenses indoors and at night. These lenses must be prior authorized.

Bilateral Plano glasses are payable as safety glasses for persons with one remaining functioning eye. Balance lenses are payable if the other eye has a prescription that meets the criteria for lenses.

Persons with presbyopia who require minimal or no distance correction are to be fitted with ready-made half-glasses.

When unusual complications affect normal recovery, ready-made temporary glasses should be rented or purchased following cataract extraction (with or without insertion of an intra-ocular prosthetic lens) until the eyes have healed and refractive error has stabilized. Prior authorization is required except when prescribed by an ophthalmologist who must be identified on the claim. No additional allowance is payable for plastic cataract lenses. Payment will be made at the level of standard cataract lenses. Repairs are payable for the current eyewear only.

Contact lenses See section above

Prior Authorization

Eyeglasses

- Polycarbonate lenses must be prior authorized for QUEST Integration Adult members.
- Bifocal lenses for AlohaCare members under 40 years of age must have medical justification. No additional payment is made for blended bifocals.
- Trifocals are payable only for members currently wearing them for specific job requirements.
- Replacement of children’s glasses that are lost, stolen or severely damaged within 12 months of the last pair must be approved before being dispensed.
- Replacement of an adult’s glasses within 2 years must be pre-approved before being dispensed. The information should include one or more of the following information:
  a) The date and circumstances of loss
  b) The date the previous glasses were made
  c) The refractive prescription and the previous prescription, if a change is being requested
- Replacement of lens or frames or any part of the glasses does not require authorization.
However, replacement of the entire glasses within the time limits requires prior authorization.

- Tinted, absorptive or color-coated corrective lenses or clip-ons must be prior authorized.
- Ready-made glasses not prescribed by an ophthalmologist after cataract extraction requires prior authorization.

Contact Lenses

- A sterilization unit for soft contact lenses must be medically justifiable.
- All contact lenses must be prior authorized including those with a change of prescription during the 24-month period in which the last pair was received for members over 20 or within 12 months for members under 21. Dispensing of the lenses from the new prescription begins a new 12/24-month period.

Miscellaneous vision supplies

- Initial and replacement prosthetic eyes must be prior authorized.
SECTION 13 PROVIDER GRIEVANCES AND APPEALS

Definitions:

**Grievance** – A written communication made by a provider expressing dissatisfaction pertaining to the following:

- Benefits and limits, for example, limits on behavioral health services or formulary;
- Eligibility and enrollment, for example long wait times or 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; and
- Health plan issues, including difficulty contacting the health plan or its subcontractors due to long wait times, busy lines, etc.; problems with the health plan’s staff behavior; delays in claims payments; denial of claims; claims not paid correctly; or other health plan issues.
- Issues related to availability of health services from the health plan to a member, for example delays in obtaining or inability to obtain emergent/urgent services, medications, specialty care, ancillary services such as transportation, medical supplies, etc.;
- Issues related to the delivery of health services, for example, medication was not provided by a pharmacy, the member did not receive services the provider believed were needed, provider is unable to treat member appropriately because the member is verbally abusive or threatens physical behavior; and
- Issues related to the quality of service, for example, the provider reports that another provider did not appropriately evaluate, diagnose, prescribe or treat the member, the provider reports that another provider has issues with cleanliness of office, instruments, or other aseptic technique was used, the provider reports that another provider did not render services or items which the member needed, or the provider reports that the plan’s specialty network cannot provide adequate care for a member.

**Appeal** – A written request made by a provider for review of an adverse decision of a grievance.

How to File a Grievance or Appeal

Written grievances or appeals should be sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814
Fax: (808) 973-2140

Grievances or appeals must be filed within one year from the date of the occurrence generating the grievance or appeal.
Upon receipt of the grievance or appeal, written notification of receipt will be sent to the provider within ten (10) calendar days.

AlohaCare will render a decision and notify the provider in writing within sixty (60) days of receipt of the grievance or appeal.

Filing a Grievance or Appeal on Behalf of a Member

AlohaCare members or their representatives have the right to file a grievance or appeal if they are dissatisfied with anything related to the care they are receiving or the actions or activities of the health plan. Providers may file a grievance or appeal on behalf of a member with the written authorization from the member or member’s representative. See Section 14 Member Appeals and Grievances for additional information on the requirements and timelines for member grievances and appeals.

Peer Review Process

Peer reviewers are available to participate on a first-level or second-level review hearing panel to review disputes related to a provider’s status in the network, or any action taken by AlohaCare related to a provider’s professional competency or conduct. The peer review panels are convened by the Medical Director. Members of a second-level panel are selected keeping in mind the requirement to not have been involved in either the initial decision or the first-level panel’s decision-making process.

- 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 regarding a potential breach of performance issues, which 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 Credentialing Staff sends the provider a letter via certified mail which states
  - A professional review action has been proposed to be taken against the provider and the reasons for the action
  - The provider has the right to file an appeal and request a timely hearing regarding the proposed action, and that the provider must request the hearing within thirty (30) days

- If the provider does request a hearing in a timely manner, 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
- A list of witnesses, if any, expected to testify to the peer review panel

- For the peer review hearing, the provider has the right to:

  - An arbitrator mutually acceptable to the provider and AlohaCare or
  - A hearing officer who is appointed by AlohaCare who is not in direct economic competition with the provider involved or
  - A panel of at least three individuals appointed by AlohaCare who are not in direct economic competition with the provider involved and at least one individual is not involved in the provider network management, and who is a clinical peer of the participating provider that filed the dispute
  - 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
- If the decision of the first-level panel’s hearing is adverse to the provider, information on the provider’s right to appeal to a second-level panel. Processes for the second-level panel follow those for the first level panel.

Peer reviewers are not made available if:

- No adverse professional review action taken
- If the suspension or restriction of clinical privileges is fourteen (14) days or less and an investigation is being conducted to determine the need for a professional review action
- If an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, is necessary because failure to suspend or terminate the provider may result in an imminent danger to the health of any individual

No punitive action is taken against any provider who files a grievance or appeal, or who supports a member’s appeal or expedited appeal.

AlohaCare’s complete policies and procedures for Provider Grievances and Appeals are available upon request.
SECTION 14 MEMBER GRIEVANCES AND APPEALS

AlohaCare provides assistance to members in filing grievances or appeals, including interpreter services and access for TTY/TTD users.

Member Grievance
A member or a member’s authorized representative may file a grievance orally or in writing with the health plan at any time. The health plan shall accept any grievance filed on the member’s behalf from a member’s representative even without verbal or written consent of the member. This could include the following:

- Health Plan’s or provider’s operations
- Health Plan’s or provider’s activities
- Health Plan’s denial of an expedited appeal request
- Health Plan’s or provider’s failure to respect the recipient’s rights
- Health Plan’s or provider’s or staff behavior
- Provider quality of care
- Health Plan’s privacy practices – copies of these grievances are also forwarded to the AlohaCare Privacy Officer

Written Grievance
Written grievances should be sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814
Fax: 1-808-973-2140

Oral Grievance
Members or their representatives may call the Member Services Department and we will assist in filing the grievance. A provider calling to file an oral grievance on behalf of the member must provide written authorization from the member. Member’s written authorization should be faxed or mailed to the Grievance Coordinator.

Member Services Department
Tel: (808) 973-0712
Toll Free: 1-877-973-0712
TTY/TDD Users Toll Free 1-877-447-5990

Process
Each grievance will be thoroughly investigated by gathering all documentation, records, or any other...
information submitted by all relevant parties and using the applicable statutory, regulatory and contractual provisions, as well as AlohaCare’s policies and procedures.

AlohaCare will send a written acknowledgement of the grievance within five (5) business days of receipt of the grievance. AlohaCare will render a resolution of the grievance and send a written disposition of the grievance resolution as expeditiously as the member’s health requires but no longer than thirty (30) calendar days from the receipt date. AlohaCare will take into account all documents, records, or other information submitted by the grievant, provider or facility rendering the service relating to the case. A letter of resolution will be mailed to the grievant and copies are sent to all parties whose interest has been affected by the decision. The date of the letter is considered the decision date.

If the disposition of the grievance does not meet the satisfaction or expectations of the member, the member has the right to request a Grievance Review from the MQD within thirty (30) calendar days of receipt of the grievance disposition. Members must exhaust AlohaCare’s internal grievance system prior to requesting a Grievance Review. To request a Grievance Review by Med-QUEST, the member may call (808) 692-8094, or the member may submit the request in writing to:

Med-QUEST Division
Health Care Services Branch
PO Box 700190
Kapolei, HI  96709-0190

The Med-QUEST Division (MQD) will review the grievance and contact the member with a determination within ninety (90) calendar days from the day the request for a grievance review is received. The grievance review determination made by the MQD is final.

Member Appeals

Members, or a member’s authorized representative or a provider with the members written consent, may file an appeal within sixty (60) calendar days of the notice of an adverse benefit determination made by AlohaCare. An adverse benefit determination is defined as any of the following:

- The denial, or limited authorization, of a requested service including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in a whole or in part, of payment for a service
- The failure to provide services in a timely manner, according to the appointment and availability standards established by Med-QUEST.
- Unreasonable delays in service
- Appeals or grievances not resolved within prescribed timeframes
- For a rural area recipient, the denial of a recipient’s request to obtain services outside the network for certain circumstances, including the following:
  - The denial of member’s request to obtain services outside the network if there is no other suitable provider (in terms of training, experience, and specialization) in the network
  - If the provider has been a primary source of service to the recipient and the provider does
not choose to join the network or the provider does not meet the qualifications to join the network

- If the network providers will not perform a covered service due to moral or religious objections
- If the recipient needs related services unavailable within the network to avoid risk of further harm
- If the state determines that other circumstances warrant out-of-network treatment

Written Appeals

Written appeals should be sent to:

AlohaCare
Attention: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814
Or faxed to: 1-808-973-2140

A provider or other individual filing a written appeal on behalf of the member must obtain and include a written authorization from the member with the appeal submission. If someone other than the member or legally authorized representative files a written appeal without the member’s written authorization, the Grievance Coordinator will contact the person filing the grievance and inform him/her of the need for member authorization.

Oral Appeals

Members or their authorized representatives may call the Member Services Department and we will assist the member in filing the appeal. The member will be informed that all appeals must be in writing and that we will send the completed form for review and signature. The form is forwarded to the Grievance Coordinator to be sent with the acknowledgment letter. The oral request will establish the receipt date; however, if the member’s written authorization is not received within thirty (30) calendar days of original contact, the appeal will be denied as invalid. A notification will be sent to the member in writing.

Process

All appeals will be thoroughly investigated by gathering all documentation, records, or any other information submitted by all relevant parties, without regard to whether such information was submitted or considered in the initial consideration of the case, and using the applicable statutory, regulatory and contractual provisions, as well as AlohaCare’s policies and procedures.

AlohaCare will render a resolution of the appeal as expeditiously as the member’s health requires, but
no longer than thirty (30) calendar days from the receipt date of the appeal except in the case of expedited appeal. AlohaCare will take into account all documents, records, or other information submitted relating to the case. A letter of resolution will be mailed to the member and copies are sent to all parties whose interest has been affected by the decision. The recipients will include any provider that may be affected by the decision. The effective date of the decision will be the postmarked date of the mailing.

AlohaCare may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the member requests the extension or if additional information is needed. If AlohaCare determines that additional information is needed, a letter will be sent to the member and other affected parties including the provider. The content of the notification will include the following details:

- Nature of the appeal
- Reason for the extension of the decision and how the extension is in the member’s best interest

If the appeal relates to an action that reduced, stopped or delayed care that had previously been approved, the member has the right to receive benefits while the appeal is pending if:

- The member requests that AlohaCare continues the benefits;
- The member files the request for an appeal in a timely manner. This means:
  - Within ten (10) calendar days of the date AlohaCare mailed the notice of the unfavorable action, or
  - On or before the effective date of the unfavorable action (whichever is later);
  - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services we approved were ordered by an authorized provider; and
- The amount of time covered by our original approval has not expired.

The member may have to pay for the services if AlohaCare’s final decision is to deny the appeal.

If the appeal is not resolved wholly in favor of the member, the member may access the DHS Administrative Hearing process by submitting a letter to the Administrative Appeal Office within one-hundred and twenty (120) calendar days (or an expedited review if applicable) from the receipt of the member’s appeal determination. Members must exhaust AlohaCare’s internal appeal system prior to requesting an administrative hearing. The member has the right to representation during such hearing. Members are permitted to speak for themselves, or have a lawyer, friend, relative or someone else speak for them to say why they are not satisfied with the resolution.

The address for the Administrative Appeals Office is:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

The member has the right to continue to receive benefits from AlohaCare while waiting for the hearing if:

- The member requests that we continue the benefits;
- The member files the request for a hearing in a timely manner. This means:
Within ten (10) calendar days of the date AlohaCare mailed the notice of the unfavorable action, or

- On or before the effective date of the unfavorable action (whichever is later);

- The request for a hearing involves stopping, delaying or reducing a course of treatment that we had authorized;
- The services were ordered by an authorized provider; and
- The amount of time covered by our original approval has not expired.

The member may have to pay for services that AlohaCare denied if the State administrative hearing or external review denies the appeal.

The State shall reach its decision within ninety (90) days of the date the member filed the request for an administrative hearing with the State.

**Expedited Member Appeal**

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
- Subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the expedited appeal

**Written Filing**

Written expedited member appeals should be mailed or faxed to:

AlohaCare  
Attention: Expedited Appeal Request  
1357 Kapiolani Blvd., Suite 1250  
Honolulu, HI 96814  
Fax: 808-973-2140

**Oral Filing**

Members or their authorized representatives may call the Member Services Department and we will assist the member in filing the expedited appeal. The caller should specifically state that he/she is requesting an expedited appeal.

**Process**

Upon receipt, the request will be forwarded immediately to a Senior Clinical staff member or a Medical Director, as appropriate.

If the request does not meet the criteria for an expedited appeal resolution, AlohaCare will transfer the request to the timeframe for a standard appeal resolution. The member will be notified of the denial of expedited appeal request verbally. AlohaCare will also send out a written notice within two calendar days and in that notice explain how to file a grievance if the member disagrees with the decision to deny the expedited appeal request.
If the request meets the criteria for an expedited appeal resolution, an appropriate review will be completed by the clinical staff as expeditiously as the member’s health condition requires within seventy-two (72) hours of receipt. AlohaCare shall make reasonable efforts to provide oral notice to the member and provide written notice with the appeal determination.

AlohaCare may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the member or provider appealing on behalf of the member requests the extension or if additional information is needed, and the delay will not adversely affect the member. If AlohaCare determines that additional information is needed, a letter will be sent to the member and other affected parties including the provider. The content of the notification will include the following details:

- Nature of the appeal
- Reason for the extension of the decision

If the appeal is not resolved wholly in favor of the member, the member has the right to request an Expedited DHS Administrative Hearing within 120 calendar days of notification of denial. The member may file for an expedited State Administrative Hearing only when AlohaCare has provided an expedited appeal and the action of the appeal was determined to be adverse to the member (action denied in whole or part). To request an Expedited State Administrative Hearing the member should send a letter to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

An expedited State administrative hearing will be heard and determined within three (3) business days with no opportunity for extension on behalf of the State. The member has the right to representation during such hearing. Members are permitted to speak for themselves, or have a lawyer, friend, relative or someone else speak for them to say why they are not satisfied with the resolution.

The member has the right to receive benefits while the hearing is pending. See specific requirements above.

Copies of AlohaCare’s member grievance and appeal policies and procedures are available upon request.
SECTION 15 QUALITY IMPROVEMENT

AlohaCare’s Quality Assessment and Performance Improvement Program (QAPI) 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

The goals of the QAPI are aligned with the “Triple Aim”:

a. To improve the health care provided to AlohaCare’s members;

b. To improve the health of the populations we serve; and

c. To reduce the costs of health care.

QAPI Activities

The key activities conducted by AlohaCare in support of the QAPI include:

1. Monitoring and analyzing key indicators of performance to identify opportunities for improvement, including but not limited to:

   a. Access and Availability: provider availability (access to appointments and after-hours care), network adequacy, AlohaCare telephone accessibility;

   b. Provision of medically necessary and appropriate services, including under- and over-utilization, HEDIS® measures, and medical and pharmacy utilization;

   c. Member Satisfaction and Rights and Responsibilities: inquiries, grievances and appeals, member satisfaction surveys (e.g., CAHPS);

   d. Provider Feedback: provider grievances and appeals; provider satisfaction surveys, provider relations reports, advisory committee feedback;

   e. Organizational Performance: Claims processing timeliness and accuracy, enrollment timeliness and accuracy, credentialing timeliness, etc.

2. Conducting Performance Improvement Projects (PIPs) as identified in the annual Work Plan;
3. Developing and maintaining standards of clinical practice, including clinical practice guidelines;

4. Investigating and resolving potential quality of care issues identified from any source;

5. Receiving, investigating, and resolving member or provider grievances and appeals;

6. Conducting medical record reviews to assure appropriate record keeping and delivery of key services;

7. Assuring the competency and performance of AlohaCare’s provider network;

8. Coordinating with utilization management and disease management activities to assure that members receive coordinated care in the most appropriate setting; and

9. Monitoring AlohaCare employee satisfaction and engagement through employee forums, satisfaction surveys, and exit interview evaluations.

Providers agree to cooperate with AlohaCare’s Quality and Performance Improvement Program and to allow AlohaCare to use provider performance data to support quality improvement activities.

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 and Medical Director.

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:

- The Corporate Quality Improvement Committee (CQIC) which is comprised of AlohaCare’s CEO and Senior Staff. CQIC is responsible for overall direction and coordination of the QAPI Program.
- The Practitioner Advisory Committee (PAC) which includes practitioners representing a variety of specialties reflective of the AlohaCare network. PAC is responsible for reviewing provider and member experience survey results, reviewing medical necessity criteria, informing AlohaCare about issues within the provider community and recommending and/or monitoring of information and trends for conformance with standards and criteria for delivering of care and
service.

- The Pharmacy and Therapeutics Subcommittee (P&T) includes practicing physicians and advanced practice nurses (APRNs) from the AlohaCare network, AlohaCare pharmacist(s), and AlohaCare staff. This committee provides a forum for provider input on the cost effectiveness, medical efficacy and therapeutic benefit of drug therapies, diagnostic technologies and other treatment interventions, and makes recommendations regarding the AlohaCare Formulary and use of diagnostic and treatment technologies.

- The Credentials Committee is 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 Credentialing policies to participate as an AlohaCare Provider. The Committee is also responsible for re-credentialing participating practitioners and providers in accordance with AlohaCare policies. Members include practitioners representing primary care and specialties in AlohaCare’s network.

Providers who are interested in serving on any of AlohaCare’s advisory committees are urged to contact AlohaCare’s Medical Director.

More detailed information about AlohaCare’s Quality and Performance Improvement Program, the annual QAPI Work plan, or the annual evaluation of the program is available by calling Provider Services.

**Value-Based Healthcare**

AlohaCare has begun a process of making payments to providers based on value, not volume, of services provided.

For primary care physicians, AlohaCare implements an annual quality incentive program where PCPs can earn additional payments for improving performance levels on key quality metrics. This program is consistent with the MQD Pay-For-Performance (P4P) program and includes, but may not be limited to the following quality measures:

<table>
<thead>
<tr>
<th>1. Childhood Immunization Status (CIS-CH)</th>
<th>2. Well-Child Visits in the First 15 Months of Life (W15)</th>
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<tr>
<td>3. Well-Child Visits in the 3rd, 4th, 5th &amp; 6th Years of Life (W34)</td>
<td>4. Comprehensive Diabetes Care (CDC): HbA1c Control (&lt;8%)</td>
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<tr>
<td>5. Comprehensive Diabetes Care (CDC): HbA1c Testing</td>
<td>6. Adolescent Well-Care Visits (AWC)</td>
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<tr>
<td>7. Cervical Cancer Screening (CCS)</td>
<td>8. Screening, Brief Intervention &amp; Referral to Treatment (SBIRT) Training</td>
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<tr>
<td>9. Prenatal and Postpartum Care-Timeliness of Prenatal Care (PPC-AD)</td>
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These quality incentive programs are evaluated and revised as appropriate each year and will be communicated by letter and other forms of communication to all PCPs. Information about the programs will be available on AlohaCare’s website.

Gaps In Care reports are currently available in our Provider Portal. Providers are able to log in directly to our Provider Portal and view Gaps in Care reports for members. These reports will tell you whether your patient has met or not met the measure up to the most recent claim synchronization which could have a 3-month lag. Some contributing factors involving reporting lag time range from the time of service to the time of claim submission to AlohaCare, and data reconciliation once the claim has been received.

For hospitals, this change involves changing payment methods from per diems for inpatient services and fee-for-service for outpatient services to acuity-based reimbursement models where available and appropriate.

AlohaCare is committed to supporting our provider network in providing measureable improvements in the quality of care our members receive.

APPENDIX A

CMS-1500 Claim Form:

The CMS-1500 claim form answers the needs of many insurers. It is the basic form prescribed by the Centers of AlohaCare and Medicaid Services (CMS) for the AlohaCare program for claims from physicians and suppliers. All claims must be submitted using the form CMS-1500.

Preparing the CMS-1500 Claim Form:

Successful scanning begins with the proper submission of claim data. It is important that claims be submitted with proper and legible coding. Claims that are not legible or properly coded will be returned or rejected. Please follow these helpful hints when completing your CMS-1500 forms:
The font should be:

- Legible (computerized or typed claims, laser printers are recommended)
- In black ink
- Courier or Arial in 10, 11 or 12-point font
- Capital letters

The font must not have:

- Dot matrix print
- Bold, script, italic or stylized font
- Broken characters
- Red ink
- Mini-font

Do not submit paper claims with:

- Liquid correction fluid changes
- Data touching box edges or data running outside of the numbered boxes
- More than six service lines per CMS-1500 claim form. Do not compress two lines of information on one line. If more than six service lines are required, see instructions listed below under 'Claims Submitted with Multiple Pages.
- Information in the shaded area in 24a through 24h. These fields are used by AlohaCare and would be populated with National Drug Code (“NDC”) for physician-administered drugs.
- Narrative descriptions of procedure codes, modifiers or diagnosis codes
- Stickers or rubber stamps
- Data, mailing address or labels on the top portion of the CMS-1500 claim form
- Special characters (e.g., hyphens, periods, parentheses, dollar signs and ditto marks)
- Handwritten descriptions
- Super bills

The claim form must be:

- An original CMS-1500 printed in red 'drop out' ink with the printed information on back. Photocopies are not acceptable.
- Size: 8 ½ x 11 with the printer pin-feed edges removed at the perforations
- Free from excessive creases or tears (do not fold or staple)
- Clean and free from stains, notations, strike-overs, crossed-out or highlighted information, liquid correction fluid, glue, or tape

Attachment Reminders:

- All attachments must identify the patient’s name, Health Insurance Claim number (HICN), date of service and other pertinent information
- Attachments must be a full page (8 ½ x 11)
Operative reports, radiology reports, etc., should be submitted with paper claims only when either the coding guidelines indicate these reports are needed to process the service(s) or when an AlohaCare representative requests this additional information.

Secondary Paper claims: Only attach the summary notice (i.e., EOB or Remittance Advice) from the primary insurer that specifically corresponds to the claim you are submitting.

Preparing the CMS-1450 (UB04 Claim Form):

The CMS-1450 claim form, also known as the UB04, is a uniform institutional provider claim. Successful scanning begins with the proper submission of claim data. It is important that claims be submitted with proper and legible coding. Claims that are not legible or properly coded will be returned or rejected.

The font should be:
- Legible (computerized or typed claims, laser printers are recommended)
- In black ink
- Courier or Arial in 10, 11 or 12-point font
- Capital letters

The font must not have:
- Dot matrix print
- Bold, script, italic or stylized font
- Broken characters
- Red ink
- Mini-font

Do not submit paper claims with:
- Liquid correction fluid changes
- Data touching box edges or data running outside of the numbered boxes
- Narrative descriptions of procedure codes, modifiers or diagnosis codes
- Stickers or rubber stamps
- Data, mailing address or labels on the top portion of the CMS-1450 claim form
- Special characters (e.g., hyphens, periods, parentheses, dollar signs and ditto marks)
- Handwritten claims
- Super bills
- Photocopies of claim

The claim form must be:
- An original CMS-1450 printed in red 'drop out' ink with the printed information on back.
- Size: 8 ½ x 11 with the printer pin-feed edges removed at the perforations
- Free from excessive creases or tears (do not fold or staple)
- Clean and free from stains, notations, strike-overs, crossed-out or highlighted information, liquid correction fluid, glue, or tape and staples
Attachment Reminders:

- All attachments must identify the patient’s name, Health Insurance Claim number (HICN), date of service and other pertinent information
- Attachments must be a full page (8 ½ x 11)
- Operative reports, radiology reports, etc., should be submitted with paper claims only when either the coding guidelines indicate these reports are needed to process the service(s) or when an AlohaCare representative requests this additional information.
- Secondary Paper claims: Only attach the summary notice (i.e., EOB or Remittance Advice) from the primary insurer that specifically corresponds to the claim you are submitting (do not staple to claim form)
As we welcome our collaboration with Payspan we have made some changes to the appearance of the Provider Explanation of Payments (EOP). These changes are reflected within the diagram below:

1/3/2019

AlohaCare
Remittance Advice for January 03, 2019

AlohaCare
1357 Kapilani Blvd, Suite 1250
Honolulu, HI 96814

Service Provider: Dr. Aloha

Patient Name: HEALTHY MEMBER

Primary Care Physician on Date of Service: Dr. Aloha

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<tr>
<th>Line</th>
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<th>Billed Amount</th>
<th>Provider Adjustment</th>
<th>Allowed Amount</th>
<th>Deduct Amount</th>
<th>Copay</th>
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Claim Explanation:

This remittance advice is sent by AlohaCare Payor. If you have any questions, please contact AlohaCare Customer Service at 1-800-973-1680.

Page 1 of 1
AlohaCare, 1357 Kapilani Blvd, Suite 1250, Honolulu, HI 96814
Corporate Website: www.alohacare.org
Online: (800) 973-1680 Fax: (800) 973-1318 Toll Free: 1-800-434-1082
Medical Necessity Definition
Hawaii Revised Statutes §432E-1.4

§432E-1.4 Medical necessity.

(a) For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan’s medical director to be medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.

(b) A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan’s medical director or physician designee, and is:

(1) For the purpose of treating a medical condition;
(2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;
(3) Known to be effective in improving health outcomes; provided that:
   (A) Effectiveness is determined first by scientific evidence;
   (B) If no scientific evidence exists, then by professional standards of care; and
   (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
(4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

(c) When the treating licensed health care provider and the health plan’s medical director or physician designee do not agree on whether a health intervention is medically necessary, a reviewing body, whether internal to the plan or external, shall give consideration to, but shall not be bound by, the recommendations of the treating licensed health care provider and the health plan’s medical director or physician designee.

(d) For the purposes of this section:

"Cost-effective" means a health intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health intervention; provided that the characteristics of the individual patient shall be determinative when applying this criterion to an individual case.

"Effective" means a health intervention that may reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

"Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. New interventions for which clinical trials have not been conducted and effectiveness has not been scientifically established shall be evaluated on the basis of professional standards of care or expert opinion. For existing interventions, scientific evidence shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional
standards of care shall be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Giving priority to scientific evidence shall not mean that coverage of existing interventions shall be denied in the absence of conclusive scientific evidence. Existing interventions may meet the definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.

"Health outcomes" mean outcomes that affect health status as measured by the length or quality of a patient's life, primarily as perceived by the patient.

"Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

"Physician designee" means a physician or other health care practitioner designated to assist in the decision-making process who has training and credentials at least equal to the treating licensed health care provider.

"Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and the health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. Scientific evidence may be found in the following and similar sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);

(3) Medical journals recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act, as amended;

(4) Standard reference compendia including the American Hospital Formulary Service-Drug Information, American Medical Association Drug Evaluation, American Dental Association Accepted Dental Therapeutics, and United States Pharmacopoeia-Drug Information;

(5) Findings, studies, or research conducted by or under the auspices of federal agencies and nationally recognized federal research institutes including but not limited to the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
(6) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

"Treat" means to prevent, diagnose, detect, provide medical care, or palliate.

"Treating licensed health care provider" means a licensed health care provider who has personally evaluated the patient.

[L 2000, c 250, §8; am L 2011, c 43, §18]