KAISER PERMANENTE®

Kaiser Permanente QUEST Provider Manual

*This Provider Manual is available to all **Kaiser Permanente** QUEST providers in electronic version unless the provider requests a hard copy. The Provider Manual is available online at no additional charge here: QUEST | Community Provider Portal | Kaiser Permanente. Requests for hard copies are provided at no charge to the provider within thirty (30) days.*

*The electronic version of the Provider Manual will be updated within five calendar days of any changes. **Kaiser Permanente** QUEST providers will be notified of changes made via email broadcast. Providers, and network providers making a request, will be notified in writing. Providers may also be notified of updates in the provider newsletter. All notifications will be available at no additional charge.*

Aloha & Welcome

As a Practitioner with **Kaiser Permanente** Hawaii, you are part of a unique organization within the community. Our size and experience enable **Kaiser Permanente** to attract outstanding physicians and professional staff who provide our members with quality and compassionate care.

Kaiser Permanente is committed to preventing disease, promoting health, and serving our members by Caring for Hawaii's People like Family. We take pride in the skills, experience and caring that our physicians and staff offer our members. Working as a team, our medical staff provides comprehensive, high-quality medical care to more than 253,000 members statewide.

Our relationship with you is very important to us. Our goal is to provide you with the best quality support and communication as we continue our partnership. To help the relationship run smoothly, we present this manual to provide information about **Kaiser Permanente**. This manual is designed as a reference guide for you and your staff. The contents will be periodically updated as we continue to move forward to improve best practices in alignment with the National Committee for Quality Assurance (NCQA), and Federal and State regulatory agencies. In addition, we welcome your suggestions to support your needs. Please share this manual with your Admissions, Quality Assurance, Business Offices and any other appropriate staff. Feel free to place this manual on your computer systems for access by your departments. However, because it is copyrighted, please do not reproduce it.

Kaiser Permanente appreciates your willingness to work with **Kaiser Permanente** and looks forward to a continued valuable relationship. Thank you for your participation and should you need additional information or have any questions, please do not hesitate to contact the Provider Contracting and Relations staff at **808-432-5429.**

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Chapter 1: About Kaiser Permanente

We hope the following overview of **Kaiser Permanente** organization will help you learn about Kaiser Foundation Health Plan, **Kaiser Permanente's** history, and the philosophy of **Kaiser Permanente.**

Who Are We?

Kaiser Permanente is one of the nation's largest not-for-profit health plans, serving 12.6 million members. At **Kaiser Permanente**, physicians are responsible for medical decisions. The Permanente Medical Groups, which provide care for **Kaiser Permanente** members, continuously develop and refine medical practices to help ensure that care is delivered in the most efficient and effective manner possible.

Founded in 1945, **Kaiser Permanente** headquartered in Oakland, California, comprises:

- **Kaiser Foundation Health Plan, Inc**.
- **Kaiser Foundation Hospitals** and its subsidiaries
- The Permanente Medical Groups

Mission

Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Our Service Areas

Kaiser Permanente evolved from private industrial medical care programs during the 1930s and 1940s and opened enrollment to the public on California's West Coast in 1945. Today, **Kaiser Permanente** serves the following local markets:

Northern and Southern California
Colorado
Georgia
Hawaii
Mid-Atlantic States (Maryland, Washington, D.C., Virginia)
Pacific Northwest (Oregon and parts of Washington)
Washington

Kaiser Permanente service areas are subject to change at any time. Learn more at **kp.org**

Our Medicaid Members

Beginning in 1971, with 500 public assistance families under a contract with the Hawaii Department of Human Services called X5, **Kaiser** continued to provide services to families with low-to-moderate income not eligible for public assistance through federal and state contracts. In August 1994, **Kaiser** was one of the first health plans to participate in the Hawaii QUEST program. Effective January 2015, Kaiser became one of five health plans participating in the

QUEST program, which integrates the aged, blind, and disabled population into the prior QUEST program. The goal of the QUEST program is to improve health outcomes by integrating programs and benefits, streamline care for members when health status changes, and to minimize the administrative burden on providers.

At **Kaiser Permanente**, we aim to not only increase access to care for the undeserved, but also to ensure these populations are afforded high-quality care. This is especially relevant for members whose multiple or high-risk conditions account for a larger share of medical services. We take pride in knowing that our members in these programs will have the same access and quality standards as all other members.

Our Structure

Kaiser Permanente is a collaborative organization of three contractually linked organizations briefly described below. Joint decision-making by the professions of medicine and business management, including all significant Program policy, planning, and resource allocation decisions, enables **Kaiser Permanente** to continue its pursuit of excellence in care and services for its members.

The **Kaiser Foundation Health Plan, Inc. (KFHP)** is a nonprofit corporation with the responsibilities of marketing, benefit plan design, computation of rate structures, data collection and enrollment. It contracts with the Hawaii Permanente Medical Group, Inc. and Kaiser Foundation Hospitals to provide health care services to members.

Hawaii Permanente Medical Group, Inc. (HPMG) is a for-profit corporation of board-eligible and board-certified physicians and other health care providers representing all major specialties and most subspecialties. It contracts with **Kaiser Foundation Health Plan, Inc**. to provide care to members at **Kaiser** Permanente's medical offices and hospital. The contract with **Kaiser Foundation Health Plan, Inc**. helps providers focus their attention on the practice of medicine rather than devoting energy to administrative tasks and the acquisition of facilities and equipment.

Kaiser Foundation Hospitals (KFH) is the third component of the **Kaiser Permanente** organization. It is a nonprofit corporation which provides hospital care, including room and board, nursing care and other standard services provided by a large community hospital.

Our Hawaii Service Area

The Hawaii Service Area of the **Kaiser Permanente** health care program began in 1958. It introduced the concept of a group practice prepayment plan to Hawaii's residents. Beginning with one medical center and 5,000 members, **Kaiser Permanente** now serves more than 260,000 members and features the Moanalua Medical Center in addition to more than 20 convenient locations on the islands of Oahu, Maui, Hawaii and Kauai. Services provided on the island of Kauai consist of contracts with independent primary and specialty practitioners including

specialty care at the Kauai Medical Clinic. **Kaiser Permanente** currently owns and operates a 275+ bed inpatient facility.

Kaiser Permanente only offers QUEST managed care membership to Medicaid beneficiaries who reside on the islands of Oahu and Maui.

Our Medical Group's Values Statement

The **Hawaii Permanente Medical Group** (**HPMG**) seeks associate physicians and other providers who support and promote **Kaiser Permanente's** mission of providing quality care and comprehensive medical services in an accessible, cost-effective manner for members. In addition, the **HPMG** Board of Directors has identified professional and personal values that enhance individual and collective medical practice. The following are our core values:

- The characteristics of professional competency, integrity, flexibility, reliability, compassionate caring, and a striving for excellence are core values necessary for our associates. Furthermore, we value good-natured team players who are approachable by colleagues and staff. We expect our associates to be hardworking professionals capable of an innovative approach to solving problems, who make efficient use of time and resources. And we expect a professionally appropriate attitude that embraces and accepts cultural diversity, excluding bigotry and prejudice.
- We value individuals who are responsive to constructive criticism and demonstrate courtesy and respect to fellow workers as well as patients. We place value on quality work with consistent standards. It is important for **Kaiser Permanente** to recognize professional limitations in forming the boundaries of work, matching confidence with competence.
- We seek associates who will actively assist the organization to function efficiently and effectively. Our strength comes from a shared sense of responsibility for the Medical Group and from our collective talents as medical professionals. Finally, we seek to achieve a balance between a satisfying career and a fulfilling personal life.

Chapter 2: Contact Information

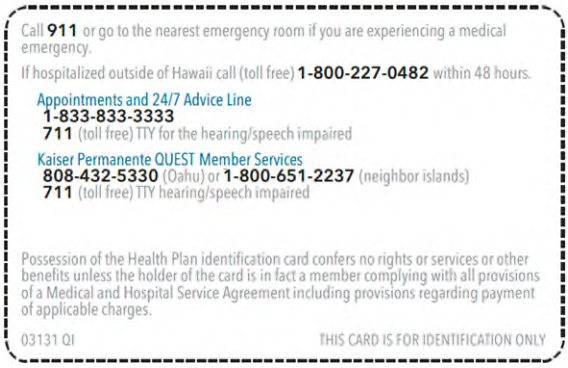
We appreciate your willingness to work with **Kaiser Permanente** in providing quality care to our Members. The Hawaii **Kaiser Permanente** Provider Contracting and Relations Department is committed to providing support to you and your staff which includes answering your contractual and operational questions.

Should you need additional information or have any questions, please do not hesitate to contact the Provider Contracting and Relations team or other departments as listed below:

Contact Numbers		
General information/assistance	Claims: **1-877-875-3805** Customer Service: 1-808-432-5955 (Oahu), 1-800-966-5955 (Toll Free)	Monday through Friday 8 a.m. to 4:30 p.m.
Assistance with QUEST Health Coordination	**Kaiser Permanente QUEST Provider Call Center** **808-432-5330 (Oahu)/** **1-800-651-2237 (toll-free) or by**	Monday through Friday except **Kaiser Permanente** - Observed Holidays 7:45a.m. to 4:30 p.m.
Questions regarding claims	**Claims Customer Service Department (877) 875-3805**	Monday through Friday except **Kaiser Permanente** - Observed Holidays 7:45 a.m. to 4:30 p.m.
Routine transfers	**Oahu Outside Care Coordinator** **808-432-7252** **808-432-7250** – after hours Fax: **808-432-7251**	Monday through Friday except **Kaiser Permanente** - Observed Holidays 8 a.m. to 4:30 p.m.
Emergency transfers to **Kaiser Permanente** Moanalua Medical Center & routine transfers after clinic	**Emergency Hotline** **808-432-7038**	24 hours
Questions regarding out of plan services and authorization	**Authorization and Referrals Management** **808**-432-5687 **808-432-5691** (facsimile)	Monday through Friday except **Kaiser Permanente** - Observed Holidays 8 a.m. to 4:30 p.m.
Questions regarding the QUEST program	**Kaiser Permanente QUEST Call Center** **808-432-5330** or toll-free at **1-800-651-2237**	Monday through Friday except State holidays 7:45 a.m. to 4:30 p.m.

Chapter 3: Membership Identification Card

When enrollment forms have been processed, the **Kaiser Foundation Health Plan** sends each new member a permanent membership card (example below). The card displays the member's medical record number which is used for identification.



The QUEST identification card has additional information required by DHS:

- Member's **Kaiser Permanente** Member Identification Number
- Member's name
- Effective date of member's **Kaiser Permanente** QUEST coverage
- Primary clinic name and telephone number
- Third Party Liability (TPL) information
- QUEST Call Center telephone number
- After Hours Advice Line telephone number

How to use the identification cards:
Members should show their **Kaiser Permanente** identification card and photo ID when they need medical care or services. Even if they do not have their card, we can still verify coverage in our membership system as long as they bring a photo ID. Members should only use their cards when they have maintained their **Kaiser Permanente** membership, and they should never let anyone else use their cards.

Chapter 4: Member Rights and Responsibilities

*All **Kaiser Permanente** QUEST members are sent a handbook with information about their rights and responsibilities.*

Member Rights and Responsibilities

Member Rights

As a person using our services, a member has specific rights regardless of age, cultural background, gender, gender identity, sexual orientation, financial status, national origin, race, religion, or disability.

For detailed information about member rights to privacy, please refer to Notice of Privacy Practices. A member can find the Notice of Privacy Practices on our website at **kaiserpermanente.org**, or contact our Customer Service Center at **808-432-5955** (Oahu) or **1-800-966-5955** (Neighbor Islands).

A member has the right to:

- Receive information about **Kaiser Permanente**, our services, our health care practitioners and providers, and his/her rights and responsibilities.
- Get information about the people who provide health care including their names, professional status, and board certification.
- Be treated with consideration, compassion, and respect taking into account his/her dignity and individuality, including privacy in treatment and care.
- Be free from neglect, exploitation, and verbal, mental, physical and sexual abuse.
- Make decisions about his/her medical care. This includes advance directives to have life-prolonging medical or surgical treatment given, ended, or stopped, withholding resuscitative services, and care at the end of life. The member has the right to assign another person to make health care decisions for him/her, to the extent allowed by law.
- Discuss all medically necessary treatment options, regardless of cost or benefit coverage.
- Voice his/her complaints freely without fear of discrimination or retaliation. If the member is not satisfied with how his/her complaint was handled, the member may have us reconsider his/her complaint.
- Make recommendations regarding **Kaiser Permanente's** Member Rights and Responsibilities statement.
- Be involved and include his/her family in the planning of his/her medical care. The member has the right to be informed of the risks, benefits, and consequences of his/her actions.
- The member may refuse to participate in research, investigation and clinical trials.
- Refuse care, treatment and services.
- Choose his/her primary care physician, change his/her primary care physician, or obtain a second opinion within **Kaiser Permanente**. The member also has the right to consult with a non-Plan doctor at his/her own expense.
- Have direct access to a practitioner of women's health services to ensure continuing care.
- Find out about his/her care. Have the right to talk it over with his/her doctor. Talk with the doctor about his/her medical condition. Discuss the diagnosis. Discuss what kind of treatment is available. The member may discuss alternatives to treatment. The member has a right to have these presented in a way that is appropriate to his/her condition and ability to understand.

- Have an interpreter for his/her language. The member has a right to have an interpreter when needed to understand his/her care and services.
- Be involved in considering ethical issues. The member has the right to contact our Bioethics Committee for help in resolving ethical, legal, and moral matters relating to his/her care
- Be informed of the relationship between **Kaiser Permanente** and other health care programs, providers, and schools.
- Be informed about how new technologies are evaluated in relation to benefit coverage.
- Receive the medical information and education he/she needs to participate in his/her health care.
- Give informed consent before the start of any procedure or treatment.
- Give or withhold informed consent to produce or use recordings, films, or other images of the patient for purposes other than his / her own care.
- Have access to medically necessary services and treatment, including emergency treatment, and covered benefits, in a timely and fair way. Services should not be arbitrarily denied or reduced in amount, duration or scope because of diagnosis, type of illness, or condition.
- Receive services in a coordinated manner. The PCP is in charge of the member's medical care. He or she treats the member, refers the member to specialists when needed, and connects the member to all of his/her services. The doctor will work with the member to help the member meet his/her health goals so that the member can live well.
- Have **Kaiser Permanente** consider and respect the member's needs. We respect the member's cultural and spiritual needs. We respect the member's psychological and social needs.
- Have privacy and confidentiality for all discussion and records of the member's care. We will protect the member's confidentiality. The member or a person the member choose can ask for the member's medical records. The member can see the records or get a copy. The member can ask to amend or correct them, within the limits of the law. In addition, the member has the right to limit, restrict or prevent disclosure of protected health information.
- Be treated in a safe, secure, and clean environment. Be free from physical and chemical restraints. Exception: these can only be used when ordered by a doctor, or in the case of an emergency. Even then, they can only be used when needed to protect the member or others from injury.
- Get appropriate and effective pain management. Get it as an important part of the member's care plan.
- Get an explanation of the member's bill and benefits. The member has this right regardless of how the member pay. The member has the right to know about our available services, referral procedures, and costs.
- Get other information and services. These are things required by various state or federal programs.
- When appropriate, be told about the outcomes of care. That includes outcomes that were not expected.

- Discuss “do not resuscitate” wishes or advance directive instructions for health care with the member’s surgeon and anesthesiologist prior to an operative procedure when the member wish to have the “do not resuscitate” honored in the event of a life-threatening emergency during an operative procedure.
- Medicaid patients receiving services, including in the Ambulatory Surgery Center, who wish to file a complaint or voice a concern may contact the Hawaii Medicaid Ombudsman, Koan Risk Solutions, Inc., email: hiombudsman@koanrisksolutions.com, 1-844-844-2430 (toll-free) or 808-488-7988 (Oahu). Medicare patients may contact the Medicare Beneficiary Ombudsman to get help with your Medicare-related questions or concerns, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If your inquiry requires a response from the Medicare Beneficiary Ombudsman, a 1-800-MEDICARE representative can direct your inquiry to the Medicare Beneficiary Ombudsman as needed.
- For more information visit www.cms.gov/Center/Special-Topic/Ombudsman/Medicare-Beneficiary-Ombudsman-Home. The patient receiving services in the Ambulatory Surgery Center may also contact Accreditation Association for Ambulatory Health Care; 5250 Old Orchard Road, Suite 200, Skokie, IL 60077. Tel: 847-853-6060, or by email: info@aaahc.org.
- Be informed about 432E HRS Patient’s Bill of Rights and Responsibilities.
- Be included in development of a service/treatment plan.
- Only be responsible for cost sharing in accordance with 42CFR Section 447.50.

Member Responsibilities

As a partner in his/her health care, the member has the following responsibilities:

- **Give Kaiser Permanente correct and complete information** about the member’s health. Tell **Kaiser Permanente** about the medical conditions the member have now. Tell **Kaiser Permanente** about the medical conditions the member had in the past.
- **Follow the treatment plan. The member** and the member’s health care practitioner agreed on the plan. Tell them if the member does not understand or cannot follow through with the member’s treatment.
- **Understand his/her health problems.** As much as possible, work with the practitioner to come up with treatment goals the member and they can agree on.
- **Tell Kaiser Permanente who the member is.** Use his/her **Kaiser Permanente** identification card the way it’s supposed to be used.
- **Cooperate with our staff.** Help **Kaiser Permanente** diagnose and treat his/her illness or condition properly.
- **Keep appointments.** If the member cannot keep them, cancel them in a timely manner.
- **Know the plan benefits.** Know the member’s plan. Know the member’s plan limits.
- **Sign a release form.** If the member chooses not to follow the recommended treatment or procedures, we will provide the member with adequate information to make an informed decision and will ask the member to sign a release form.
- **Realize the effects lifestyle has on health.** Understand that decisions the member make in his/her daily life, such as smoking, can affect his/her health.

- **Be considerate of others.** Respect the rights and feelings of the staff. Respect the privacy of other patients.
- **Don't make a disturbance.** Don't disrupt our operations and administration. Cooperate with staff. That way we can continue what we're doing for other patients.
- **Follow all hospital, clinic, and health plan rules and regulations.** Respect hospital visiting hours.
- **Cooperate** in the proper processing of third-party payments.
- **Tell Kaiser Permanente** when the member or his/her covered dependents change addresses.
- **Be responsible for his/her actions.** If the member refuse treatment, do not follow instructions, and if his/her actions or behavior interfere with facility and/or patient care, his/her care may be rescheduled. Should his/her medical condition change, the treatment plan may be modified.
- **For Ambulatory Surgery Center (ASC) patients:** Arrange for a responsible adult to take the member home and stay with the member for 24 hours, if required by his/her doctor.

Hospital patient rights and responsibilities

As a person using our services, the member has specific rights. These rights are the members', regardless of:

- age
- cultural background
- gender
- gender identity
- sexual orientation
- financial status
- national origin
- race
- religion
- disability

As a patient in the Moanalua Medical Center members have the right to:

- **Know his/her rights and responsibilities.** We'll give the member the information when the member become a hospital patient.
- **Have proper discharge from the hospital or transfer to another.** This may be for his/her welfare. It may be for another patients' welfare. It may be for other causes as determined by his/her doctor. The member has a right to have reasonable advance notice. The member has a right to have discharge planning. Qualified hospital staff will make sure the member get the right care in the right place when the member get out of the hospital.
- **Ask for a visit by clergy** at any time. The member has a right to take part in social and religious activities. The member may do this unless it harms the rights of other patients or would hurt his/her medical care.
- **Get and use his/her own clothes and things** as space permits. The member may do this unless it harms the rights of other patients, violates our safety practices, or would hurt his/her medical care.
- **Give informed consent** before the start of any recording, films, or other images for purposes of nonpatient care.

- **Access protective and advocacy services.**
- **Get appropriate educational services.** The member need these when a child or adolescent patient's treatment requires a significant absence from school.
- **Be protected from requests to perform services for Kaiser Foundation Hospital. The** member does not need to do things that are not included for therapeutic purposes in his/her plan of care.
- **Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation.** Federal regulations limit the use of restraints and seclusion.
- **Receive visitors of his/her choice** including a spouse, domestic partner, family member, or friend. All or certain visits may be excluded at his/her request or discretion of staff, physicians, or administration to allow for his/her and other's rights, safety or well-being.
- **File a complaint in the hospital**, either verbally or in writing with the department manager or supervisor. If the member is not satisfied with the response, please contact Hospital Administration. They are located on the first floor of the hospital. Or call the operator at **808-432-0000** and ask for them. If the concern cannot be resolved by the hospital, the member may contact The Joint Commission by phone, mail, fax, or email. Phone: Toll free U.S., weekdays 8:30 a.m.–5 p.m. Central time, 1-800-994-6610. Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. Fax: 630-792-5636. Email: complaint@jointcommission.org.

As a QUEST member, the member has the following additional rights and responsibilities.

Members have a right:

- Not to pay for our debts if we go broke.
- Not to pay for services if the state doesn't pay us.
- Not to pay for covered services if we or the state do not pay the doctor or the person who gave the member the service.
- To receive covered services outside of **Kaiser Permanente** (under a contract, referral or other arrangement) if we are unable to provide the service for the member and for as long as we are unable to provide it. The member will not have to pay more than if we provided the services directly.
- To get direct access to a specialist through a standing referral for the same condition if the specialist treated the member before and the member have special health care needs. Special health care needs are determined by an appropriate health care professional.
- To receive information on available treatment options and alternatives in a way that the member can easily understand and in a manner that takes into consideration his/her special needs.
- Freely exercise his/her rights, including those related to filing a grievance or appeal. Exercising those rights do not negatively affect the way we treat the member.
- To receive all written materials in an easily understood language and format.
- Receive services according to appointment waiting time standards.
- Receive services in a culturally competent manner.
- Receive services in a coordinated manner.

Members must tell DHS and **Kaiser Permanente** when there are any of these changes in his/her family:

- Death in the family (recipient, spouse, dependent)
- Birth
- Adoption
- Marriage
- Divorce
- Change in health condition (such as pregnancy or permanent disability)
- Change of address
- Institutionalization (such as nursing home, state mental health hospital or prison)

Also, the member must notify **Kaiser Permanente** if:

- Some other person, organization or program needs to pay for his/her care (such as no-fault insurance for a car accident, or workers' compensation for an injury on the job)
- He/she will need continuing medical care while visiting another island
- He/she is going to be away from home for more than 90 calendar days
- Please report the above information to **Kaiser Permanente** at **808-432-5330** or toll free at **1-800-651-2237** or **711** (TTY).

Member Inquiry and Grievances Process

Definitions

- **Action:**
  1. The denial or limited authorization of a requested service, including the type or level of service.
  2. The reduction, suspension, or termination of a previously authorized service.
  3. The denial, in whole or in part, of payment for a service.
  4. The failure to provide services in a timely manner as defined by the State of Hawaii.
  5. The failure of the health plan to act within prescribed timeframes
  6. For a rural area member or for islands with only one contractor or limited providers, the denial of a member's request to obtain services outside the network:
     a) From any other provider (in terms of training, experience, and specialization) not available within the network.
     b) From a provider not part of the 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; however, **Kaiser Permanente** is still responsible for reimbursement for the services the provider rendered.
     c) Because the only plan or provider available does not provide the service because of moral or religious objections.
     d) 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.
     e) The State determines that other circumstances warrant out-of-network treatment.

- **Authorized** Customer Feedback System (CFS) User: Staff members who are granted access to and authorized to use the CFS system.
- **Clinical Urgency**: A situation which could jeopardize the life or health of the member or the member's ability to regain maximum function.
- **Customer Feedback System**: The electronic database system used for the recording, documentation, and tracking of customer concerns and denials.
- **Grievance**: An expression of dissatisfaction from a member, member's representative, or a provider, with written consent, on behalf of member, about any matter other than an action, as "action" is defined above. Examples of issues that will be resolved through the grievance process include quality of care issues, waiting times in physician offices and rude or unresponsive physician or staff and failure to respect enrollee's rights. Standard disposition of a grievance and notice to the affected parties may not exceed 30 days from the date the grievance is received.
- **Inquiry**: A question regarding any aspect of the Health Plan's or Provider's operations, activities or behavior or to request disenrollment but does not express dissatisfaction.
- **Local Accountable Group**: The organizational entity responsible for the delivery of quality patient care and member service and response to any customer concerns with that care and service.
- **Organization determination**: an initial decision by Health Plan to pay or deny a request for payment or coverage of a service or item.
- **Sentinel Event:** an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. The terms sentinel event and medical error are not synonymous; not all sentinel events occur because of error and not all errors result in sentinel events. A distinction is made between an adverse outcome that is primarily related to the natural course of the patient's illness or underlying condition, and a death or major permanent loss of function that is associated with the treatment or lack of treatment of that condition, or otherwise not primarily related to the natural course of the patient's illness or underlying condition. **Kaiser Permanente** sentinel events are inclusive of all Joint Commission Sentinel Events.

General Requirements for Member Inquiries and Grievances

- Members may designate a representative or provider to make an inquiry or file a grievance on their behalf and may request a State administrative hearing
- Members may provide verbal consent for **Kaiser Permanente** staff to interact with the authorized representative or provider. The member's designation will be documented in the applicable **Kaiser Permanente** system when consent from the member is provided verbally.
- Members will be provided with any reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers with TTD and interpreter capability.
- The **Kaiser Permanente** systems used to record, and track inquiry and grievance information contain protected member demographic and medical care information. System users will handle this information in strictest confidentiality in accordance with Regional Policy 6226-06-01 "Regional Confidentiality and Security of Information" and MQD-RFP-2014-005.
- Members may submit an inquiry or file a grievance by calling **808-432-5955** or toll-free at **1-800-966-5955**, or by **711** (TTY). Members may also write to **Kaiser Permanente** at:

Kaiser Foundation Health Plan, Inc.
Customer Service Center
711 Kapiolani Blvd.,
Honolulu, HI 96813

Member Inquiry Process

All member oral or written inquiries will be addressed and provided a response in a timely manner.

- All member inquiries will be entered into the MACESS tracking system.
- If at any time during the inquiry process (written or telephone request), the member expresses a complaint of any kind, the inquiry then becomes a grievance or appeal and the member will be given his/her grievance and/or appeal rights, as applicable.

Member Grievance Process

If members are unhappy with Kaiser Permanente, they may file a grievance or have a representative or a provider file the grievance for them. They can ask anyone at **Kaiser Permanente** to send it to Member Services or mail it to: Member Services, **Kaiser Permanente**, 711 Kapiolani Boulevard, Honolulu, HI 96813. If they would like someone to help write the grievance, or they want to file their grievance by telephone, call the QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237**, or **711** (TTY).

A letter will be sent to the member within five business days to let them know that we have received the member's grievance. We will send it to the supervisor of the area they wrote or called about. That person will answer the grievance within 30 calendar days from when it was received.

If the member received Kaiser Permanente's answer, but they are still not satisfied, the member may ask for a state grievance review from the State of Hawaii's Department of Human Services Med-QUEST Division. The member must call or write to Med-QUEST within 30 days from the

date on the grievance resolution letter issued from the health plan. If the member does not do this, the member's complaint will be considered resolved.

To ask for a State grievance review, call the Med-QUEST Division at 808-692-8094. Or mail a request to:

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

Med-QUEST will review the member's complaint. They will decide on it within 90 calendar days from getting the member's request. Their decision will be final.

Filing a claim

How to file a claim for payment

If the member receives medical care outside of **Kaiser Permanente**, the member may submit a claim with us. We review each claim to decide if we will pay. We look to see if the member's care was referred by us. We will see whether it was medically needed emergency care or urgent care. If we approve the member's claim, we will pay according to the member's plan benefits.

If the member has questions relating to filing a claim, please contact the QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237**. If the member has questions about a claim already submitted, please call Claims Administration toll free at **1-877-875-3805**.

The member may have someone file the claim on their behalf. If the member chooses to do this, the member must name this person in writing and state who is authorized to file the claim for the member. Both the member and the member's representative must sign this statement unless the person is the member's attorney. When necessary, the member's representative will have access to medical information about the member that relates to the request. If the member prefers, the member may call our QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237 or 711 (TTY)** to request a form.

Appeals

Did **Kaiser Permanente** health plan or the member's doctor refuse an item or service the member asked for? If the member does not agree with a decision that was made about the services the member is getting, or want to get, the member may ask for a review of an adverse benefit determination taken by **Kaiser Permanente** for the member's medical care. Some of the other reasons the member may want to file an appeal are if we stopped care that we already approved; if the member don't get care when the member need it; if we don't give the member an answer to a grievance or an appeal that the member already filed by the time we're supposed to; or if we can't provide the member with a medically necessary covered service within **Kaiser Permanente** and we don't authorize coverage for that service outside Kaiser Permanente. A

member, his or her authorized representative, or a provider acting on behalf of the member with the member's authorization may file an appeal if we deny coverage of a service.

After the member gets a denial notice or Notice of Adverse Benefit Determination, the member has 60 calendar days to make the member's appeal. The member may make an appeal orally or in writing. The member may ask **Kaiser Permanente** or someone else to help the member write the member's appeal. If the member would like help to write the member's appeal, call the QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237**, or **711** (TTY). The member may also request an interpreter to help the member through this process.

Only the member or someone with the member's permission may make an appeal. If the member gives someone else permission to make an appeal on their behalf, the member can let **Kaiser Permanente** know by sending **Kaiser Permanente** a letter or by calling **808-432-5330**, toll-free at **1-800-651-2237** or **711** (TTY). If the member lets **Kaiser Permanente** know by phone, the member must also send a letter confirming that the member is giving another person permission to make an appeal for them. The member's letter must have the name of the person authorization for that person to file an appeal for the member. The member and authorized person must both sign and date the letter. When necessary, the member's representative may have access to medical information about the member that relates to the request.

Send the member's appeal to:

Kaiser Foundation Health Plan Inc.
Attn: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813

You may fax the member's appeal to **808-432-5260** or send it by email at **KPHawaii.Appeals@kp.org**. The member may also contact the QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237** or **711** (TTY).

We will write to the member within five business days to say we got the member's appeal. The member will have a chance to present evidence and to argue facts or law if the member wants to. The member may do this in person or in writing. The member or the member's representative may examine the case file. The case file may have medical records and any other papers and records that we will look at during the appeals process. The member may give **Kaiser Permanente** written comments, papers, medical records, or other information to consider. We will review the case and give the member a written decision within 30 calendar days. We may take up to 14 more calendar days if the member asks **Kaiser Permanente** to or if we need more information and it would be in the member's best interest if we had more time before deciding. If the member didn't ask for the delay, we will make reasonable efforts to give the member prompt oral notice of the delay. We will also send the member a letter to explain why we need extra time within 2 calendar days. Then we will inform the member of the member's right to file a grievance if the member disagrees with our decision.

Expedited review

Sometimes we must review the member's appeal more quickly. When we receive the member's appeal, we will decide if taking the regular amount of time to review it could mean a danger to the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If we or the person who treats the member finds that it could, we will use a faster process. We call it an expedited review of the member's appeal. It's the same as the regular one except:

- If the member asks for it orally the member don't have to follow it up in writing
- We must ensure that the person who treats the member won't be punished for helping the member ask for the faster appeal
- We must make a decision on the appeal as fast as needed for the Member's health condition. We can't take more than 72 hours from when we receive the appeal. We may take up to 14 more calendar days if you or the Member requests an extension. If we need the extension, we will provide the reason to DHS and explain why the extension would is in the Member's best interest. If the Member didn't ask for the delay, we will make reasonable efforts to give prompt oral notice of the delay. If the request to extend the timeframe was made by you or us, we will also send the Member a letter explaining why the delay is needed within two calendar days and let the Member know that they have the right to file a grievance if they don't agree with the decision. We will issue and carry out the determination as quickly as needed based on the Member's health condition and no later than the date the extension expires. We will provide written notice and make reasonable efforts to provide oral notice to the Member, of the resolution of an expedited appeal.

We will notify DHS within 24 hours if an expedited appeal has been granted or if an expedited appeal time frame has been requested by the Member or by you. If we need an extension of 14 calendar days, we will provide the reason to DHS. We will notify DHS within 24 hours, or as soon as possible from the time the expedited appeal is upheld. We will also let DHS know how we notified you of the expedited appeal decision.

The written notice of the resolution will include:

- The results of the appeal process and the date it was completed
- For appeals not resolved wholly in favor of the Member:
    - The right to request a State administrative hearing as described in §9.5.J., and clear instructions about how to access this process
    - The right to request an expedited State administrative hearing
    - The right to request to receive benefits while the hearing is pending, and how to make the request
    - A statement that the Member may be held liable for the cost of those benefits if the hearing decision upholds the Health Plan's action.

If we say no to the member's request for an expedited review, here is what we must do:

- Transfer the member's appeal to the regular appeal process of no longer than 30 days from the day we received the appeal, with a possible 14 days extension.
- Make reasonable efforts to tell the member orally what we have done

- Tell the member in writing within two calendar days from when we received the member's appeal the reason the decision to extend the timeframe or deny a request for expedited resolution of an appeal
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
- If we said no to the member's request for an expedited appeal, and the member is unhappy about it, the member may file a grievance with us.

External review

DHS administrative hearing

If the member has gone through **Kaiser Permanente's** appeal process and is not happy with the decision we made about the member's appeal, the member, his or her authorized representative, or provider (if an authorized representative) can ask DHS for an administrative hearing. Write to the Administrative Appeals Office (AAO) of DHS. The AAO must receive the member's letter within 120 calendar days from when the member got **Kaiser Permanente's** notice of denial disposition about the member's appeal. Include information: any statements of fact or laws to support the member's request. Send the member's appeal to:

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

There is no cost to receive copies of the appeal file. The member has the right to name someone to file the appeal for the member. The member must name that person in writing when the member sends the member's appeal. The member may represent himself/herself at the hearing or the member may have a lawyer, a relative, a friend, or someone else there to speak on their behalf. The member will receive a decision within 90 calendar days from the date they received the member's request. We must follow the decision of the DHS administrative hearing. The member must go through Kaiser Permanente's appeal process first before asking for a DHS administrative hearing.

The member or the member's approved representative is considered to have used up Kaiser Permanente's grievance and appeal process if **Kaiser Permanente** does not follow the notice and timing requirements set by Med-QUEST Division of DHS. When this happens, the member has the right to file for a State administrative hearing. Members must exhaust **Kaiser Permanente's** internal grievance and appeals system before accessing the State's administrative hearing system.

Expedited DHS administrative hearing

If the member had an expedited review of the member's appeal with us, and it didn't go the way the member wanted it to, then the member may ask DHS for an expedited administrative hearing. The member must submit the member's letter to the AAO within 120 calendar days of getting the member's answer from **Kaiser Permanente** about the member's appeal. An expedited administrative hearing needs to be reviewed and decided upon within three business days from

when the member's request was filed. We will work with the State to ensure that the best results are provided for you and to ensure that the procedures comply with State and Federal regulations. When an expedited State administrative hearing is requested, we will submit information that was used to make the determination, for example, medical records, written documents to and from you, provider notes, etc. to DHS within 24 hours of the decision denying the expedited appeal.

Please send your request for an expedited State administrative hearing process to:

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

Receiving benefits during the appeals process or DHS administrative hearing
If we told the member that we are going to reduce, delay or stop anything that we already approved, the member has the right to still get those services during the appeals process or state administrative hearing process. For that to happen the member or authorized representative should request **Kaiser Permanente** to continue the member's benefits in a timely manner. This means within 10 calendar days of getting the denial notice or Notice of Adverse Benefit Determination, or before the date that the service is going to be reduced, delayed, or stopped. The services the member is asking to be continued must have been approved by an authorized provider within the time period covered by the original authorization.

If the member's benefits are continued during the appeal or administrative hearing process, it will be provided until one of the following happens:

- You withdraw the member's appeal
- You don't request a DHS administrative hearing within 10 calendar days of getting the denial notice or Notice of Adverse Benefit Determination from us
- The DHS administrative hearing does not decide in the member's favor

If **Kaiser Permanente** or DHS do not decide in the member's favor, the member will have to pay for the services that the member requested to be continued during the appeal process.
If you or your authorized representative requested to continue your benefits during an Appeal or a State Administrative Hearing process, we will continue your benefits if the following conditions are met:

- An appeal was requested within 60 calendar days following the date on the adverse benefit determination notice
- The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized services
- The services were ordered by an authorized provider
- The original authorization period has not expired
- You timely filed to request to continue your benefits on or before the later of the following:
    - Within 10 days of the Health Plan receiving the notice of adverse benefit determination; or

  - The intended effective date of the Health Plan's proposed adverse benefit determination.
- If the Health Plan continues or reinstates the Member's benefits while the appeal or State administrative hearing is pending, the Health Plan shall not discontinue the benefits until one of the following occurs:
  - The Member withdraws the appeal or request for a State administrative hearing;
  - The Member does not request a State administrative hearing within ten (10) days from when the Health Plan mails a notice of an adverse benefit determination; or
  - A State administrative hearing decision unfavorable to the Member is made.
- If the final resolution of the appeal or State administrative hearing is adverse to the Member, that is, upholds the Health Plan's adverse benefit determination, the Health Plan may, consistent with the State's usual policy on recoveries and as specified in the Health Plan's contract, recover the cost of services furnished to the Member while the appeal and State administrative hearing were pending, to the extent that they were furnished solely because of the requirements of this section.
- If the Health Plan or the State reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Health Plan shall authorize or provide these disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination.
- If the Health Plan or the State reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, the Health Plan shall pay for those services.

Medicaid ombudsman program

The State of Hawaii Department of Human Services (DHS) oversees the Medicaid ombudsman program. Koan Risk Solutions is contracted with DHS to independently review concerns and complaints against Medicaid Health Plans as another resource for members. Visit the ombudsman website: www.himedicaidombudsman.com. To contact the Medicaid ombudsman office:

- Hours of Operation: 7:45am-4:30pm Monday-Friday (Excluding Hawaii State Holidays)
- Office Address:

  Koan Risk Solutions, Inc.
  1580 Makaloa Street #550
  Honolulu, HI 96814

- Phone: 1-808-746-3324; Toll Free: 1-844-844-2430
- Fax: 1-808-356-1645
- Email: hiombudsman@koanrisksolutions.com
  Deaf or Hard of Hearing may access text-telephone (TTY) captioned telephone or Braille TTY by dialing **711**.

Access to Care Standards

Kaiser Permanente consistently maintains a sufficient number of providers to service our members. Our providers must adhere to the following QUEST program wait time standards and geo access standards to ensure timely access to care and services:

- Immediate care without prior approval for emergencies
- Within 24 hours for urgent care
- Within 24 hours for PCP pediatric sick visits
- Within 72 hours for PCP adult sick visits
- Within 21 days for PCP routine visits
- Within 21 days for routine behavioral health visits
- Within 4 weeks for visits with a specialist
- Within 4 weeks for non-emergency hospital stays

Interpreter/translation services

Kaiser Permanente offers interpreter services at no charge. If a member needs an interpreter during a doctor visit, let **Kaiser Permanente** know by calling our Customer Service Center at **808-432-5955** (Oahu) or (toll-free) **1-800-966-5955** (Neighbor Islands). A Customer Service representative may provide an interpreter over the phone or arrange for one in person. Members who are deaf, hard of hearing, or speech impaired may call toll free **711** (TTY).

If members need information in a different language or format (including large print or Braille), call the QUEST Call Center at **808-432-5330** or toll-free at **1-800-651-2237** for assistance.

Advance Directives for Health Care

Practitioners are encouraged to inform each adult member of his/her right to make advance medical decisions according to the Federal Patient Self-Determination Act of 1990, and Hawaii Revised Statutes, Section 327D. The purpose of the Act is to protect each adult patient's right to participate in health care decision-making to the maximum extent of his/her ability and to prevent discrimination based on whether the member has executed an advance directive for health care.

When a member provides an advance directive, an entry should be made in the medical record.

Cultural Competency Plan

Kaiser Permanente Hawaii Market's mission is to provide high quality affordable health care services and to improve the health of our members and the communities we serve. Delivering on this mission includes providing care in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Kaiser members have the right to receive information in a language and manner that can be easily understood. Communicating effectively with limited English-speaking patients or non-English speaking patients plays a large role in ensuring the quality of and compliance with care provided to members.

The **Kaiser Permanente** Hawaii Market 's Cultural Competency Plan is available to providers upon request at no charge. Link here: Cultural Competency Plan

Implementing Stepped approach to Behavioral Health

Kaiser Foundation Health Plan is collaborating with DHS and the other Health Plans to develop standardized protocols for Stepped Approach to delivering effective behavioral health services which include criteria describing how the Members should move up and down the continuum of care. **Kaiser Foundation Health Plan** will implement DHS-approved protocols.

Kaiser Foundation Health Plan also supports other integrated care including Medication-Assisted Treatment (MAT), and screening, brief intervention, and referral to treatment (SBIRT).

Please see our QUEST Medication-Assisted Treatment (MAT) policy found here: KP QUEST Hawaii Policy Medication-Assisted Treatment (MAT). This policy describes coverage of MAT for opioid use disorders (OUD) to meet the requirements for MAT within the QUEST RFP-MQD-2021-008 contract and federal rules. This policy does not address MAT for other SUDs.

Getting care for Medication-Assisted Treatment (MAT)

If members need Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD), providers can direct members to receive care in several ways.

- Members may self-refer to a primary care provider (PCP). PCPs are then able to refer members to the Integrated Behavioral Health department for Chemical Dependency Services.
- After referral, providers will assess members to identify the appropriate level of care needed and members will receive services from internal providers or through **Kaiser Permanente's** external contracted providers. Please see more information regarding Out-of-Plan/Network Referrals on page [32].
- Members may also receive additional therapy services based on their assessed medical needs to help with the treatment of OUD.

Referrals to external providers can also be made to Federal Opioid Treatment Programs that are certified by SAMHSA to provide Methadone treatment. A prior authorization is needed for out of network care.

To become a certified provider, please refer to Substance Abuse and Mental Health Services Administration (SAMHSA) website https://www.samhsa.gov/ for more information.

Accreditation of Opioid Treatment Programs – Substance abuse and Mental Health Services Administration (SAMHSA) is the authority – please visit SAMHSA website here:

https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program

Chapter 5: Availability of Providers

Kaiser Foundation Health Plan will monitor the number of Members cared for by its providers and will adjust PCP assignments as necessary to ensure timely access to medical care and to maintain quality of care. **Kaiser Foundation Health Plan** will have a sufficient network to ensure Members can obtain needed health services within the acceptable wait times as required in the QUEST RFP-MQD-2021-008 contract.

The acceptable wait times are:

- Emergency medical situations - Immediate care (twenty- four (24) hours a day, seven (7) days a week) and without prior authorization;
- Urgent care and PCP pediatric sick visits - Appointments within twenty-four (24) hours;
- PCP adult sick visits - Appointments within seventy-two (72) hours;
- Behavioral Health (routine visits for adults and children) - Appointments within twenty-one (21) days;
- PCP visits, routine visits for adults and children - Appointments within twenty-one (21) days; and
- Visits with a specialist or Non-emergency hospital stays - Appointments within four (4) weeks or of sufficient timeliness to meet Medical Necessity.

Chapter 6: Provider Rights and Responsibilities

Provider Requirements

Role and responsibility

- To be employed by **Kaiser Permanente**, these practitioners are required to have active licensure in the State of Hawaii. Licensure status is reviewed by the Credentials and Privileges committee. PCPs have the responsibility for supervising, coordinating, and providing initial and primary care to the member, initiating and coordinating both internal and outside referrals for specialty care and maintaining the continuity of the member's health care and medical record.

  Kaiser defines a PCP as a MD or DO who is a board certified/eligible internist, family practitioner, or pediatrician. The definition does not include the other providers (general practitioner, OB/Gyn, APRN, PA) in the QUEST RFP, in part because there are no access issues preventing each QUEST member from linking with an internist, family practitioner, geriatrician, or pediatrician. In addition, women (pregnant or non-pregnant) also have open access to an obstetrician/gynecologist and to see their OB/Gyn regularly. However, each member also has access to primary care services.

- Certain members may also have regular specialty care, linked to a specialist for a particular chronic condition. However, in addition, the member would also have a primary care physician who would work closely with the specialist. **Kaiser's** physician

assistants and nurse practitioners generally work in specialty areas, so do not provide primary care.

Reporting Overpayments and Refunding Kaiser Permanente

A QUEST (Medicaid) overpayment is a payment that exceeds the allowed payment for services specified in the QUEST contract.
Overpayments may occur when a service is submitted under an incorrect patient's name or member number, another insurance payor is identified, incorrect services are reported, or any payments received in error.
If you discover that you have received an overpayment, you must notify us in writing of the reason for the overpayment and return the overpaid amount to us within 60 calendar days after identifying the overpayment as follows:

- Include a copy of the Explanation of Payment (EOP) for each overpayment and highlight the overpaid amount.
- Enclose a check payable to **Kaiser Foundation Health Plan** in the amount of the overpayment.
- Provide the following information itemized for each member:
    - Reason for the overpayment refund
    - Date overpayment was identified
    - Patient name
    - QUEST member number and Medical Record Number (MRN)
    - Claim number
    - Date of service
    - Date of payment
    - Overpayment amount

Mail the EOP, check and itemized information to:

Kaiser Foundation Health Plan
Attention: Hawaii Regional Claims Recovery
P.O. Box 745820
Los Angeles, CA 90074-5820

PCP Selection and Change

- In the event that a member does not choose a PCP within 10 calendar days, or chooses to give up an existing assigned PCP, or chooses not to have a person as a PCP, they are linked to a clinic, which may then serve as a PCP for the patient. This is made possible by the group practice nature of Kaiser Permanente. Since staffing models at **Kaiser Permanente** are applied at a clinic and area level, adequate coverage for clinic assigned patients is assured. Primary care physicians in the particular clinic will serve the needs of the member and ensure individual treatment plans are developed and carried out.

- The member can select a PCP and change PCP at any time and for any reason. They may notify any staff member at any clinic in person for assistance. They may contact the QUEST office, notify **Kaiser Permanente** in person, by regular mail, by email, or may

also change their PCP online. A message is sent to the business office to initiate the change of PCP process. This may be done by email or directly through Health Connect. PCP changes become effective the following business day.

- Biography cards with information about PCPs accepting new patients help members make more informed PCP choices. These cards are available at all clinic check-in locations. These biographies are also available online.

- In the event that a PCP is unable to fulfill their responsibilities to the member, the physician, patient or QUEST staff member/manager will inform the QUEST Medical Director, who will assess the situation, and if necessary, develop an action plan to transition the member to another PCP. If the original PCP is unable to provide continued care to the member during the transition period, medical staff at the clinic of record will provide care for the member until the transition to the new PCP is complete. At any time, if the member's health or safety is in jeopardy, the member will be immediately transferred to another PCP, health plan, or provider.

- On Maui and Oahu, all PCPs are members of Hawaii Permanente Medical Group. When a PCP terminates from Kaiser, a letter is sent to the member and the member is assigned to another physician taking over the PCP's panel or to a new PCP of the member's choosing. However, during the interim, the member is automatically cared for by the other physicians in the health care team and/or the clinic to ensure of care.

PCP Monitoring

- PCP performance is monitored and supported at many levels: (1) QUEST reporting criteria, (2) teams of practitioners monitoring high risk or high volume concerns like abnormal mammograms, positive fecal occult blood, diabetic foot screening, etc., (3) periodic monitoring of patient and peer surveys, and (4) direct observation by the clinic and professional chiefs.

- Health Connect, our electronic medical record also supports PCPs and assists in monitoring their performance by: (1) the Panel Support Tool and "How Are We Doing" – data bases addressing issues of prevention , monitoring, and efficacy of care – that are directly accessible from the patients file, (2) the record itself is formatted to automatically document the necessary and appropriate medical information, assuring a complete, clear and compliant document that meets appropriate medical record standards, (3) internal and external referrals may be placed real time to minimize barriers to referral, and (4) allowing all providers access to the complete medical record, simplifying continuity of care.

- Aside from the routine monitoring of PCP performance through the professional chiefs and clinic chiefs, the QUEST program also monitors performance through regular reports on utilization, quality, and grievances/complaints, among others.

Provider Access

- As with any Kaiser member, QUEST female members have direct access to **Kaiser Permanente** gynecology services without the need for a referral.

- The QUEST Manager monitors the number of QUEST members assigned to each PCP through a regularly produced report to maintain an overall ratio of less than or equal to 1 PCP to 300 QUEST members. This information is also directly provided to DHS as described in QUEST RFP Section 51.520.3. If the average PCP to member ratio exceeds 1:300, the QUEST Manager will inform the QUEST Medical Director who will assess and, if necessary, develop corrective action which shall include discontinuation of auto assignment of new QUEST members who have exceeded the 1:300 ratio. Members, however, may continue to select PCPs who have exceeded the 1 to 300 ratio as long as their absolute panel size recommendations are not exceeded. No restrictions of auto-assignment are applied to clinics serving as PCPs.

Hospitalists

- Most **Kaiser Permanente** PCPs do not hospitalize their own patients. When admitted to the hospital, the member is automatically transferred to the care of an appropriate hospitalist or specialist that is with **Kaiser Permanente** at either Moanalua Medical Center on Oahu or Maui Memorial Hospital. The staff is hired specifically to provide these services. The PCP is notified of both the admission and the discharge and has immediate access to the information about the hospital stay through the Health Connect medical record. Members are scheduled for an outpatient follow-up with the PCP post hospital discharge within a week. Members at contracted hospitals are also managed by the facility's hospitalist.

In the event that a PCP is unable to fulfill their responsibilities to the member, the physician, patient or QUEST staff member/manger will inform the QUEST Medical Director, who will assess the situation, and if necessary, develop an action plan to transition the member to another PCP. If the original PCP is unable to provide continued care to the member during the transition period, medical staff at the clinic of record will provide care for the member until the transition to the new PCP is complete.

Provider Grievances & Appeals

Grievances and appeals filed by all providers will be proactively managed and resolved within 60 days of the day following the date of submission to the health plan. Providers are allowed 30 days from the decision of a grievance to file an appeal.

Providers may file a grievance to resolve issues and problems with the health plan (this includes problems regarding a member). This policy is not for filing a grievance or appeal on behalf of a member. Grievances and appeals filed on behalf of a member will be managed through the established regional member policies and procedures. Providers may ask for review of their grievance by the Provider Grievance/Appeals medical director.

Some examples of items that may be filed as a grievance are:

- 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, the PCP did not make a referral to a specialist; 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;
- 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.
- Benefits and limitations, for example, limits on behavioral health services or formulary;
- Enrollment and eligibility, 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.

An **appeal** is a request for review of an action. An action is defined as any one of the following:

- the denial or restriction of a requested service, including the type or level or service;
- 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 found in the access to care standards on pg. 25;
- the failure of the health plan to act within prescribed timeframes;
- 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
- the State determines that other circumstances warrant out-of-network treatment.

Providers may file an appeal for a payment dispute with the Claims Administration Department. Providers should submit the following information with the appeal:

- Name of provider and provider address
- Signed Waiver of Liability statement (sent with the EOP)
- Copy of original claim
- Remittance notification showing the denial
- Any clinical records or other information that explains the provider you should be reimbursed for the item or service
- Member name and date of birth
- **Kaiser Permanente** medical record number
- Date(s) of service
- **Kaiser Permanente** assigned claim number

Appeals should be submitted in writing to:

Kaiser Permanente Hawaii – Provider Appeals
Claims Administration Department
ATTN: Provider Appeals
PO Box 378021
Denver, CO 80237-9998

Providers may also file grievances and appeals on behalf of a member. Written consent from the member or the member's authorized representative is required. To file a grievance or appeal for a member, you may call **808-432-5330** or toll-free at **1-800-651-2237 or 711** (TTY). Members may also write to **Kaiser Permanente** at:

Kaiser Foundation Health Plan, Inc.
Appeals and Grievances
711 Kapiolani Blvd.
Honolulu, HI 96813

If a grievance is filed by a provider on behalf of a member or the member's authorized representative and there is no documentation of a written form of authorization, such as an appointment of representative form, then the provider will be advised about the written consent requirement in a manner to facilitate timely review of the concern.

Out-of-Plan/Network Referrals

All physicians have at times found the need to consult with another physician regarding their patient's care. At Kaiser Permanente, we value the services of our Network Practitioners who, in partnership with our own physicians, provide our members with the highest quality of care available. This section contains the policies and procedures regarding how to refer Kaiser Permanente members to another practitioner.

Kaiser Permanente provides most services through its own hospital and clinics; through physicians of **HPMG**; and to a much lesser extent, through providers contracted through Health Plan's Provider Contracting & Relations Department. The Health Plan has entered into an agreement with **HPMG** to provide or arrange for physician services for **Kaiser Permanente** members, including QUEST. Services provided through contracted providers account for only 2% of all services provided for **Kaiser Permanente** members.

When services or items from an outside provider are needed, an authorization request is submitted and processed through Kaiser Permanente's Authorization and Referral Management Department (ARM). Staff consults with the referring physician to ensure all prior authorization criteria are met. If the requested services meet benefit guidelines, the QUEST Member will be sent to the appropriate non-**Kaiser Permanente** medical provider. A relatively small volume of prior authorizations allows for manual tracking of performance from medical review, through the authorization decision, and ending with the notification to the member and provider. Each step of the prior authorization process is monitored to ensure compliance within the allowable timeframes as described in the QUEST contract. In the rare occasion that timeframes aren't met, counseling and education are provided to the staff.

For LTSS services, QUEST service coordinators will be reviewing and authorizing services. The authorization will be tracked electronically via our electronic claim system. Referrals for services provided by non-Plan/non-Network providers must be reviewed and authorized through the established Plan referral authorization process. This process assures that Members are:

- Referred to the appropriate specialty provider;
- Referred to the providers who have met our service, quality, and credentialing requirements;
- Eligible for the requested medical service.

The Kaiser Physician-in-Charge is responsible for the final review and authorization of out-of-plan/network requests, including Behavioral Health and Chemical Dependency requests.

Referrals are authorized for specific services, including frequency and duration of treatment. Services or care beyond the scope of the initial authorization need additional authorization.

For contracted and credentialed professional and facility information, please contact the Community Medical Services at **808-432-7529**.

Prior Authorizations

Prior authorization is required as indicated in the 'QUEST Covered Benefits and Services' starting on page 68. Most services within **Kaiser Permanente** require no prior authorizations. External referrals are generated in Kaiser's electronic medical record for the Authorizations and Referrals Department to review and make a determination. Prior authorization is required for LTSS/HCBS services and the "at-risk" population.

Call the Kaiser QUEST office at **808-432-5330** for:

- Ground transportation when medically necessary (see section below)
- Air and ground transportation, meals and lodgings for medically necessary care on another island or on the mainland
- Any member needing LTSS / HCBS
- Any member considered 'At Risk' (see page 82)

Follow **Kaiser's** Prior Authorization process:

- Prior authorization must be obtained before service is rendered
- No retroactive requests will be processed, except for newborns, state-generated retroactive enrollments, weekend/holiday/evening discharges, and when members transition to Kaiser from another QUEST health plan.

Prior Authorizations for Non-Emergency Transportation Services

The QUEST transportation benefit is for medically necessary appointments for members who have no other means of transportation, who reside in areas not served by public transportation, or cannot access public transportation due to their disability. The health plan may use whatever mode of transportation which can be safely utilized by the member.

The most cost-effective means of transportation that best meets the needs of the member's specific circumstances will be used when medically necessary as indicated by the Service Coordinator or PCP as documented in the care plan. Free transportation available to the member (e.g., friends, relatives, volunteer services, own vehicle, facility serving the member, consolidation of appointments, etc.) should be explored before other means of paid transportation are considered unless medically prohibited. Bus tickets may be provided for individual trips. Bus passes will be considered when the cost of multiple bus tickets exceeds or is expected to exceed the cost of a bus pass.

Taxi services shall be authorized when a recipient is unable to utilize public transportation or curb to curb services (Handi-Van) and only between the home of a recipient and to the nearest appropriate medical facility and back. Side trips are not allowed and will not be paid. In addition, payment will not be made for waiting time. Taxi services will only be provided after all other personal transportation options, such as family and friends, have been explored.

To be authorized, only licensed physicians are allowed to assess and justify the need for taxi services. Physical and/or mental impairment must be verified by a physician that travel by bus or Handi-Van would be either hazardous to the patient's health or would compromise his/her medical condition.

Contact the QUEST Call Center at **808-432-5330** or **1-800-651-2237** (toll-free) for more information.

How to Submit a Prior Authorization

Submit a prior authorization/referral form contact the following respective department listed below. You may also submit online via the following link:
http://providers.kaiserpermanente.org/html/cpp_hi/kponlineaffiliate.html

Examples of prior authorizations/referrals:
Prior Authorization: Call the **Kaiser** QUEST Health Coordinator at:
808-432-5330 or **1-800-651-2237** (toll-free). Fax: **808-432-5260**

- Adult Day Care Center (ADC)
- Adult Day Health Center (ADH)
- Assisted Living Facility (ALF) Community Care Management Agency (CCMA)
- Community Care Foster Family Home (CCFFH)
- Counseling and Training
- Environmental Accessibility Adaptations (EAA)
- Residential Care Services or Type 1 or Type II Expanded Adult Residential Care Home (E-ARCH)
- Home Delivered Meals
- Home Maintenance
- Moving Assistance
- Non-Emergent Only Transportation
- Personal Assistance Service Level I (PA1)
- Personal Assistance Service Level II (PA2)
- Personal Emergency Response Systems (PERS)
- Skilled (or Private Duty) Nursing
- Respite Care
- Specialized Medical Equipment and Supplies (SMES)
- Nursing facility
- Lactation counseling beyond six months

Kaiser Authorization Dept. for Plan Referral Phone at:
Phone: **808-432-5687**
Fax: **808-432-5691**
Alt Fax: **808-432-5667**

- Durable medical equipment (DME) and medical
- Hearing aid
- Breast pump (rental beyond six months and all purchases)
- Radiology/lab/other diagnostic services: Specialty procedures require prior authorization
- Dialysis

- Prior authorization is required for all rehabilitation services except for the initial evaluation
- Referral External Sleep Study
- Transplant
- Contact lenses
- Hospice

Transition of Care

Members transitioning to Kaiser Permanente:
If the member is receiving medically necessary covered services one day prior to enrollment to the health plan, **Kaiser Permanente** will be responsible for the cost of continuing these medically necessary services provided by contracted or non-contracted providers without prior approval. The period of coverage will include the prior period coverage (which is the period from the eligibility effective date to the data of enrollment into Kaiser QUEST), as well as any retroactive enrollment periods. **Kaiser Permanente** will provide 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. Claims submitted by non-**Kaiser Permanente** providers for medically necessary care during the 45-day transition period will be reviewed and authorized for payment. **Kaiser Permanente** will reimburse PCP services that a member may have accessed during a 45-day period prior to transitioning to a **Kaiser Permanente** PCP, even if the prior PCP is not in the Kaiser's network.

If the member transitioning into **Kaiser Permanente** is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal services the day before enrollment, Kaiser will be responsible for providing continued access to the prenatal provider, even if the provider is not part of Kaiser's network. Kaiser will continue covering prenatal services through the postpartum period.

Members transitioning from Kaiser Permanente:
Kaiser Permanente will assist the new health plan with obtaining the member's medical records and/or other vital information as requested. A release of protected health information form will be completed before information is sent to the new plan. **Kaiser Permanente** will cooperate with the member and the new health plan in transitioning the member into the new health plan.

The Primary Care Physician may be consulted for medical input and a collaborative decision by the interdisciplinary team will be made to initiate case coordination/management while assisting a member with the transition of care. Once transition of care is established with the new plan, no further case coordination will be necessary from the **Kaiser** QUEST plan.

Kaiser Permanente will be responsible for the care and cost of inpatient services for members who moves to a different service area in the middle of a month and enrolls in a different health plan. Responsibility will continue until discharge or level of care change, whichever is first. For non-hospitalized members, the new health plan is responsible from the date of enrollment. **Kaiser Permanente** will be responsible for the care and cost of services provided to members who move to a different service area and remain with **Kaiser** QUEST .

Pregnant members who are in their second or third trimester and are receiving medically necessary prenatal services the day before enrollment will be allowed to continue to receive care from their existing OB/GYN through the post-partum period, even if the provider is not in the new plan's network.

Newborns whose mother elects to change health plans after the first 30 days of the newborn's auto-assignment into the mother's health plan (at the time of delivery) will have care coordination and continuity of care until the newborn is transitioned into the new plan's network.

Members transitioning when provider terminates from Kaiser:
When a provider terminates from Kaiser, a letter is sent to the member who is assigned to another physician taking over the PCP's panel or to a new PCP of the member's choosing. However, during the interim, the member is automatically cared for by the other physicians in the health care team and/or the clinic to ensure continuity of care. The letter is sent to the member 30 days prior to the effective date of termination or relocation.

Chapter 7: Compliance and Fraud, Waste, and Abuse

Kaiser Permanente (KP) strives to demonstrate high ethical standards in its business practices. Because contracting providers are an integral part of KP's business, it's important that we communicate and obtain your support for these standards. The Provider Contract Agreement details specific laws, regulations, and contractual provisions with which you are expected to comply with.

Compliance with the Law

Providers are expected to comply with applicable State and Federal laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Title VI of the Civil Rights Act of 1964, and the American with Disabilities Act (ADA).

Kaiser Permanente Principles of Responsibility

The **Kaiser Permanente** Principles of Responsibility ("POR") is the code of conduct for Kaiser Permanente. Anyone who works for or on behalf of **Kaiser Permanente** is required to follow all applicable laws, policies, and this code of conduct. Please click on the attached link, **Code of Ethical Conduct - Kaiser Permanente's Principles of Responsibility.**

Kaiser Permanente Ethics and Compliance Program Description (Compliance Plan)

The **Kaiser Permanente** Ethics and Compliance Program includes a fraud, waste, and abuse plan and provides awareness to promote an ethical environment in compliances with laws and regulations.

Fraud, Waste, and Abuse (FWA)

Kaiser Permanente will investigate allegations of FWA related to goods and services provided to **Kaiser Permanente** or its members and will take corrective action, including, but not limited to, civil or criminal action where appropriate. The Federal False Claims Act and similar state laws make it a crime to present a false claim to the government for payment. These laws also protect "whistleblowers" (people who report noncompliance or FWA) from retaliation. **Kaiser Permanente** policy prohibits retaliation of any kind against individuals exercising their rights under the False Claims Act or similar state laws.

It is important to report FWA concerns in a timely manner.

The **Kaiser Permanente** Compliance Hotline is a convenient and anonymous way to report suspected wrongdoing without fear of retaliation. The **Kaiser Permanente** Compliance Hotline is available 24 hours a day, 7 days a week, at 1-888-774-9100.

Appropriate action is taken to investigate all allegations of noncompliance.

For prevention, detection, and reporting FWA - please click on the attached link, **Prevention Detection and Reporting Fraud, Waste, Abuse (FWA).**

Kaiser Permanente recognizes that acting responsibly with our resources is critical to our success. In addition, the Deficit Reduction Act of 2005 requires **Kaiser Permanente** to formally show our resolve in combating fraud, waste, and abuse, especially in the administration of Federal and State health care programs such as Medicare and Medicaid. The Deficit Reduction Act requires that we make these policies available for all physicians, employees and you, our outside network partners.

Compliance with Deficit Reduction Act Requirements: This policy serves as a compendium of the existing tools that we, along with federal and state agencies and individuals, use to fight fraud, waste, and abuse in the administration of federal and state health programs in our market. Examples of these tools include summaries of federal and state laws on false claims and protection of employees who report suspected violations. It also includes our own existing policies and procedures for detecting and preventing fraud. Please click on the attached link here, **Compliance with Deficit Reduction Act Requirements Policy.**

Fraud, Waste, and Abuse Control: This policy articulates our commitment to control fraud, waste, and abuse through prevention, detection, correction and reporting of any violation of a Federal or State law, regulatory requirement, contractual obligation or organizational policy or procedure. Please click on the attached link, **Fraud, Waste, and Abuse Control Policy**.

Chapter 8: Quality Management Program

Integrated Quality Program

The KP Quality Program includes many aspects of clinical and service quality, patient safety, behavioral health, accreditation and licensing, and other elements. The KP quality improvement program assures that quality improvement is an ongoing priority for the organization. Information about our quality program is available by visiting kp.org/quality, which includes our commitment to quality and patient safety, and our performance in quality measures.

To obtain a printed copy of this information, call Member Services at **1-800-966-5955** or TTY 711.

Additionally, we send an annual Quality Summary to provide you with the best quality support and communication. Topics covered in the summary include:

- Utilization Management
- Pharmaceutical Management
- Member Rights and Responsibilities
- Cultural Competency Plan
- Quality Program
- Clinical Practice Guidelines
- Special Needs Plan (SNP)

Patient safety is a central component of KP's care delivery model. We believe our distinctive structure as a fully integrated healthcare delivery system provides us with unique opportunities to design and implement effective, comprehensive safety strategies to protect our members. Providers play a key role in the implementation and oversight of patient safety efforts.

If you would like independent information about KP’s healthcare quality and safety, the following external organizations offer information online:

The National Committee for Quality Assurance (NCQA) works with consumers, purchasers of health care benefits, state regulators, and health plans to develop standards that evaluate health plan quality. KP is responsible to manage, measure, and assess patient care to achieve NCQA accreditation, which includes ensuring that all members are entitled to the same high level of care regardless of the site or provider of care. The focus of NCQA is on care provided in the ambulatory setting.

KP received accreditation from NCQA, and we periodically undergo re-accreditation. KP Hawaii Region provides the appropriate information related to quality and utilization upon request, so that KP may meet NCQA standards and requirements and maintain successful NCQA accreditation. You can review the report card for KFHP Hawaii at

Kaiser Foundation Health Plan, Inc. - Hawaii – NCQA Report Cards

The Leapfrog Group is a group of Fortune 500 companies, including nonprofit and large private companies, that encourages purchasers and consumers to use their healthcare buying power as leverage to create quality and safety standards in the U.S. The group gathers information about aspects of medical care and patient safety relevant to urban hospitals via an annual Leapfrog Survey. All KP hospitals in Hawaii, as well as most contracted hospitals, participated in the most recent survey. To review survey results, visit **www.leapfroggroup.org/cp**.

The Joint Commission is a healthcare accreditation organization recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain its accreditations, KP must undergo an on-site survey by The Joint Commission survey team at least every three years. KP has adopted a set of Joint Commission compliance expectations for contracted practitioners coming into our facilities. Learn more at **www.jointcommission.org**.

Utilization Management Program

For care delivered by **HPMG** and **Kaiser Foundation Hospital**-Moanalua staff, Utilization Management is based on an approach of advisory Utilization Management. **HPMG** physicians work collaboratively with their peers to ensure appropriate treatment plans and utilization of resources. In most cases, the final decision regarding a member's treatment plan rests with the **HPMG** attending physician. Utilization Management / Continuing Care staff is available to support physicians in the management of member's health care needs throughout the care continuum and provide a variety of services, such as discharge planning, utilization review, care management and ensuring compliance with internal and external regulatory requirements related to Utilization Management.

For care delivered by Contract Providers and Practitioners, the approach to Utilization Management includes an authorization process. For services not available within the **HPMG** / **KFH** system, procedures are developed for referrals to Contract Providers to ensure that referrals are appropriate. Contracted Providers are expected to comply with the Utilization Management procedures, to continue treatment plans, and to ensure appropriateness of care and resource management. In cases where Contracted Providers do not comply with **HPMG** / **KFH** procedures, reimbursement for services may be at risk.

Guidelines for Patient Medical Records

The medical record shall reflect an accurate, comprehensive record of care planned and/or provided to a patient. The medical record serves as primary documentation of the health care process for patients. Health care Providers document clinical data and observations, develop and communicate plans of care, and record patient and family responses to planned or provided care. Any Provider who documents health care information in the medical record shall adhere to the guidelines defined by scope of practice, security classification and job description in providing care for patients.

DHS personnel or personnel contracted by the DHS shall have access to all records, as long as access to the records is needed to perform the duties of the contract and to administer the QUEST program for information released or exchanged pursuant to 42 CFR Section 431.300. Practitioners shall provide DHS or its designee(s) with prompt access to members' medical records; provide members with the right to request and receive a copy of his or her medical records, and to request that they be amended, as specified in 45 CFR Part 164, and allow for paper and electronic record keeping.

All access use and disclosure of member protected health information must be in accordance with state and federal regulations regarding privacy and confidentiality. Without fail, physicians and employees are expected to follow the requirements of HIPAA, other laws and **Kaiser Permanente** policies on confidentiality, privacy and security.

Providers are required to adhere to the following requirements:

1. All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;
2. All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;
3. All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;
4. All medical records shall be legible, signed and dated;
5. Each page of the paper or electronic record includes the patient's name or ID number;
6. All medical records contain patient demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;
7. All medical records contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record;
8. All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;
9. All medical records contain the patient's past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history including prenatal care and birth;
10. All pediatric medical records include a completed immunization record or documentation that immunizations are up-to-date;
11. All medical records contain a history of screenings performed and the findings of those screenings, along with appropriate follow up actions, as needed, including counseling and interventions provided as well as referral actions taken;

12. All medical records include the provisional and confirmed diagnosis(es);
13. All medical records contain medication information;
14. All medical records contain information on the identification of current problems (i.e., significant illnesses, medical conditions and health maintenance concerns);
15. All medical records contain information about consultations, referrals, and specialist reports;
16. All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;
17. All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate;
18. All medical records for members eighteen (18) years of age or older include documentation as to whether or not the member has executed an advance directive, including an advance mental health care directive;
19. All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and
20. All medical records shall contain documented patient visits, which includes, but is not limited to:
    a. A history and physical exam;
    b. Treatment plan, progress and changes in treatment plan;
    c. Laboratory and other studies ordered, as appropriate;
    d. Working diagnosis(es) consistent with findings;
    e. Treatment, therapies, and other prescribed regimens;
    f. Documentation concerning follow-up care, telephone calls, emails, other electronic communication, or visits, when indicated;
    g. Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits;
    h. Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans;
    i. Hospitalizations and/or emergency department visits, if applicable; and
    j. All other aspects of patient care, including ancillary services.

See also, Hawaii Legal Guidance Matrix.doc, General Record Retention Requirements under Hawaii Law, Section II Provider Requirements, E. Ambulatory Surgical Centers (page 16) and Section IX. HIPAA Compliance (protected health information, page 48)

Chapter 9: Pharmaceutical Management Procedures and Drug Formulary

The **Kaiser** Hawaii Drug Formulary lists medications approved through a scientific review process by the Pharmacy and Therapeutics (P&T) Committee. Its intent is to enhance the quality of patient care by promoting safe, effective, and economical drug therapy. The **Kaiser** Hawaii Region's drug formulary is considered a closed formulary, in which listed medications are

usually covered under plan benefits. However, listing of a medication in our drug formulary does not necessarily mean it is covered under your patient's prescription drug benefit plan since prescription benefit coverage varies depending on your patient's plan.

Drugs covered by QUEST are those prescribed by a physician or other health care provider licensed for prescription privileges and is on the list of approved drugs and includes over-the-counter drugs. Drugs must be medically necessary to optimize the member's medical condition (including children receiving CAMHD services).

The QUEST benefit also includes:

- Medication management and patient counseling is also included.
- Drugs required to be covered by statute, including antipsychotic medication and continuation of antidepressant and anti-anxiety medications prescribed by a licensed psychiatrist or physician duly licensed in the State for a U. S. Food and Drug Administration (FDA) approved indication as treatment of a mental or emotional disorder,
- Drugs approved by the FDA that are eligible pursuant to the Omnibus Budget Reconciliation Rebates Act and necessary to treat members for human immunodeficiency virus, acquired immune deficiency syndrome, or Hepatitis C, or a member needing transplant immunosuppressive (without the need for a prior authorization).

Practitioners and providers who have questions regarding **Kaiser's Pharmaceutical Management** procedures may call the Pharmacy Administration Department at **808-**432-5549.

The formulary approval process ensures that available drugs meet established quality standards and that adequate information for their optimal use is provided, while limiting the availability of unsafe, "less than effective," or "ineffective" drugs, and drugs with a high potential for toxicity or abuse.

The drug formulary also supports cost management by promoting the use of effective but less costly therapeutic equivalents, reducing the number of therapeutically redundant drugs, optimizing pharmacy management or drug inventories, and maximizing leverage through the drug purchasing and bid process.

Non-formulary drugs are drugs not officially accepted for inclusion into our drug formulary. This includes new drugs not yet reviewed for addition, drugs that have been reviewed but denied admission to the formulary, or a brand, strength, or dosage form of a formulary drug not stocked in Kaiser pharmacies.

Non-formulary drugs are excluded from drug plan coverage unless your patient is allergic to a formulary drug, fails to respond to formulary drug therapy at maximum doses, or has special circumstances requiring the use of a non-formulary drug. If your patient meets any or all of these "medically necessary" conditions for use of a formulary drug, as documented in the patient's medical record, your patient may obtain his/her prescription at his/her usually supplemental charge or receive a refund on a prescription for which they initially paid full price. Non-

formulary drugs are not usually stocked in our pharmacies, therefore, there may be a delay before such a medication is dispensed or administered.

The formulary can be accessed via the kp.org website here: KPHI Quest Drug Formulary (kaiserpermanente.org). Formulary (list of covered drugs)

If you do not have access to the internet or have difficulties in accessing the formulary, you may call **Pharmacy Administration Department** at 808-432-5854 to request for a hardcopy to be sent to you.

Chapter 10: Credentialing

This section highlights procedures and policies, such as those regarding credentialing, bioethics, regulatory reporting, quality of care reporting, and other related information.

Credentialing

As an important part of **Kaiser Permanente's** Quality Management Program, all credentialing and recredentialing activities are structured to assure all practitioners are qualified to meet Kaiser Permanente's standards for the delivery of quality healthcare and service to its members.

As stated in the facility services agreements, all providers will remain in compliance with all applicable facility, local, State and Federal laws, rules and regulations including, but not limited to, those (a) regarding licensure, certification and accreditation of acute care hospitals; (b) necessary for participation in the Medicare and Medicaid programs; and (c) regulating the operations and safety of acute care hospitals (including all laws, rules and regulations regarding hazardous substances), and (2) accredited by The Joint Commission (TJC) or any successor and any other accreditation organization reasonably requested by Kaiser Foundation Hospitals.

The credentialing/recredentialing policies and procedures approved by **Kaiser Permanente** are intended to meet the standards outlined by NCQA.

All practitioners wishing to participate in **Kaiser Permanente** must successfully complete the credentialing process and must demonstrate their on-going ability to meet credentialing standards through a triennial recredentialing process. Practitioners are required to provide **Kaiser Permanente** with the information needed to review and verify their credentials.

The Professional Competency Department is responsible for collecting and verifying credentialing information while the Credentials and Privileges Committee reviews the completed credentialing or recredentialing files to determine if the practitioner will be approved for new or continuing participation in Kaiser Permanente.

Credentialing/Recredentialing Requirements (Practitioners)

These credentialing and re-credentialing requirements apply to all Licensed Independent Practitioners (LIPs) who provide health care services on behalf of Kaiser Permanente. These include, but are not limited to MDs, DOs, DPMs, DDSs, NPs, CNMs, PAs, PhDs, PSYs, CRNAs, LCSWs, ODs, and CNSs for Behavioral Health.
Each practitioner must provide/demonstrate that all the criteria noted below are met:

- A completed application which includes practitioner demographics, practice information, work history, educational background, and a personal attestation to the practitioner's physical and mental well-being and the accuracy of the information provided.
- A current valid license to practice.
- The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility, as applicable.
- A valid DEA or CDS certificate, as applicable to the specialty.
- Appropriate education and training for the practice specialty.
- Explanations for any gaps in work history (initial credentialing only).
- Evidence of current, adequate professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate with exceptions only granted upon complete review.
- Acceptable history of malpractice claims experience.
-
- Acceptable performance as recorded in all practice information related to **Kaiser Permanente** members.
- Full disclosure requirements as identified in accordance with 42 CFR Part 455, Subpart B.

Credentialing/Recredentialing Requirements (Organizational Providers)

These credentialing and re-credentialing requirements apply to organizational providers who provide health care services on behalf of Kaiser Permanente. Organizational providers are operations other than Licensed Independent Practitioners (LIPs). Organizational providers include but are not limited to: acute care hospitals, skilled nursing facilities, free standing surgical centers, home health/hospice agencies, transitional residential recovery services (TRRS), dialysis units, psychiatric centers (ambulatory, residential, and inpatient), providers of end-stage renal disease services, providers of outpatient diabetes self-management training, portable x-ray suppliers, rural health clinics, federally qualified health centers, designated urgent care clinics, and Long Term Care Services & Supports (LTSS) providers.

Each provider must provide/demonstrate that all the criteria noted below are met:

- A current valid license or certificate issued by the state and or local agency(s) with jurisdiction (as applicable).
- Evidence of current, adequate professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate with exceptions only granted upon complete review.
- Evidence of current automobile liability insurance (only applicable to Providers providing transportation services).

- Accreditation or site visit
    - Documentation of current accreditation issued by a Recognized Accrediting Body along with the most recent accreditation reports.
      -OR-
      Documentation of a site visit conducted by Centers for Medicare & Medicaid Services (CMS), Hawaii State Department of Health (DOH) or Community Ties of America (CTA) within the last three years that demonstrates a standard of quality acceptable to Kaiser Permanente.
      -OR-
      Undergo a site visit conducted by **Kaiser Permanente** staff that demonstrates a standard of quality acceptable to Kaiser Permanente.
- Hawaii's Online Kahu Utility (HOKU) registration

Credentials and Privileges Committee

When all credentialing or recredentialing requirements have been collected and verified, they are presented to the Credentials and Privileges Committee for review and approval of the practitioner's new or continued participation as a contracted practitioner.

Approvals
Practitioners who have been approved for new or continued participation in **Kaiser Permanente** are notified by electronic mail within one month of approval.

Denial as Termination of Participation
Practitioners are notified by electronic mail when they are denied participation with **Kaiser Permanente**. Depending on the reason for denial a practitioner may have the right to appeal the decision, please refer to the attached Notice and Fair Hearing Procedure.

Practitioner Rights to Review and Correct Erroneous Credentialing Information
Kaiser Permanente notifies a practitioner when a credentialing verification conflicts with information provided on the initial or recredentialing application. The practitioner then has the right to:

- review the conflicting verification documentation provided such disclosure is not prohibited by law, and
- submit documentation supporting or clarifying the information provided on the application.

The conflicting information and the practitioner's supporting documentation are included in the practitioner's credentials file for review by the Credentials and Privileges Committee.

Confidentiality of Credentialing Information

All information obtained during the credentialing and recredentialing process is considered to be confidential except as otherwise required by law.

Chapter 11: Claim and Invoice Submission

How to send Claims and Invoices to Kaiser Permanente
Send your completed claim, invoice or direct inquiries to the appropriate locations:

For Claim Submission:

Kaiser Foundation Health Plan, Inc.
Hawaii Claims Administration
PO Box 378021
Denver, Colorado 80237

Contact Numbers to Call for Billing Questions:
1-877-875-3805 (Toll-free) or
Kaiser Permanente Hawaii Customer Service for QUEST Claims 808-432-5330
or toll- free at 1-800-651-2237 or 711 (TTY) 7:45am – 4:30 Monday -Friday

For Invoice Submissions:

Kaiser Permanente Accounts Payable
QUEST
PO Box 178902
Honolulu, HI 96817
OR
Email: HI-AP@kp.org

It is your responsibility to submit itemized claims for services provided to QUEST Members in a complete and timely manner and based on chart documentation, in accordance with your Agreement, this Provider Manual and applicable law.

Methods of Claims Submission
Claims may be submitted by mail or electronically. Whether submitting claims on paper or electronically, only the UB-04 form will be accepted for facility services billing and only the CMS-1500 form, which will accommodate reporting of the individual (Type 1) NPI, will be accepted for professional services billing. Submitting claims that are handwritten, faxed or photocopied will be subject to processing delay and/or rejection.

When CMS-1500 or UB-04 forms are updated by NUCC/CMS, **Kaiser Permanente** will notify Provider when the **Kaiser Permanente** systems are ready to accept the updated form(s) and Provider must submit claims using the updated form(s).

Supporting Documentation for Paper Claims
In general, the Provider must submit, in addition to the applicable billing form, all supporting documentation and information that is reasonably relevant and necessary to determine payment. At a minimum, supporting documentation that may be reasonably relevant may include the following, to the extent applicable to the services provided:

- Authorization

- Admitting face sheet
- Discharge summary
- Operative report(s)
- Emergency room records with respect to all emergency services
- Treatment and visit notes as reasonably relevant and necessary to determine payment
- A physician report relating to any claim under which a physician is billing a CPT-4 code with a modifier, demonstrating the need for the modifier
- A physician report relating to any claim under which a physician is billing an "Unlisted Procedure", a procedure or service that is not listed in the current edition of the CPT codebook
- Physical status codes and anesthesia start and stop times whenever necessary for anesthesia services
- Therapy logs showing frequency and duration of therapies provided for SNF services

Electronic Data Interchange (EDI)
Kaiser Permanente encourages Providers to submit electronic claims (837I/P transaction). Electronic claim transactions eliminate the need for paper claims. Electronic Data Interchange (EDI) is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. **Kaiser Permanente** requires all EDI claims be HIPAA compliant.

HIPAA Requirements

All electronic claim submissions must adhere to all HIPAA requirements. The following websites (listed in alphabetical order) include additional information on HIPAA and electronic loops and segments. HIPAA Implementation Guides can also be ordered by calling Washington Publishing Company (WPC) at 1-301-949-9740.

www.dhhs.gov
www.wedi.org
www.wpc-edi.com

Claims Submission Timeframes
Claims for services provided to Members should be submitted for payment within ninety (90) days of such service. However, all claims and encounter data must be sent to the appropriate address no later than 365 days (or any longer period specified in your Agreement or required by law) after the date of service or date of discharge, as applicable.

Member Cost Share
Please verify applicable Member Cost Share at the time of service by contacting Member Services. Members may be responsible to share some cost of the services provided. Member Cost Share are the fees a Member is responsible to pay a Provider for certain covered services.

CMS-1500 Field Descriptions
The fields identified in the table below as "Required" must be completed when submitting a CMS-1500 (02/12) claim form for processing:

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
1	MEDICARE/ MEDICAID/ TRICARE / CHAMPVA/ GROUP HEALTH PLAN/FECA BLK LUNG/OTHER	Not Required	Check the type of health insurance coverage applicable to this claim by checking the appropriate box.
1a	INSURED'S I.D. NUMBER	Required	Enter the patient's **Kaiser Permanente** Medical Record Number (MRN)
2	PATIENT'S NAME	Required	Enter the patient's name. When submitting newborn claims, enter the newborn's first and last name.
3	PATIENT'S BIRTH DATE AND SEX	Required	Enter the patient's date of birth and gender. The date of birth must include the month, day and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006
4	INSURED'S NAME	Required	Enter the name of the insured, i.e., policyholder (Last Name, First Name, and Middle Initial), unless the insured and the patient are the same—then the word "SAME" may be entered. If this field is completed with an identity different than that of the patient, also complete Field 11.
5	PATIENT'S ADDRESS	Required	Enter the patient's mailing address and telephone number. On the first line, enter the STREET ADDRESS; the second line is for the CITY and STATE; the third line is for the nine digits ZIP CODE and PHONE NUMBER.
6	PATIENT'S RELATIONSHIP TO INSURED	Required	Check the appropriate box for the patient's relationship to the insured.
7	INSURED'S ADDRESS	Required if Applicable	Enter the insured's address (STREET ADDRESS, CITY, STATE, and nine digits ZIP CODE) and telephone number. When the address is the same as the patient's—the word "SAME" may be entered.
8	RESERVED FOR NUCC USE	Not Required	Leave blank.
9	OTHER INSURED'S NAME	Required if Applicable	When additional insurance coverage exists, enter the last name, first name and middle initial of the insured.
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Required if Applicable	Enter the policy and/or group number of the insured individual named in Field 9 (Other Insured's Name) above. NOTE: For each entry in Field 9a, there must be a corresponding entry in Field 9d.
9b	RESERVED FOR NUCC USE	Not Required	Leave blank.
9c	RESERVED FOR NUCC USE	Not Required	Leave blank.
9d	INSURANCE PLAN NAME OR PROGRAM NAME	Required if Applicable	Enter the name of the "other" insured's INSURANCE PLAN or program.
10a-c	IS PATIENT'S CONDITION RELATED TO	Required	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. NOTE: If "yes" there must be a corresponding entry in Field 14 (Date of Current Illness/Injury). Place (State) - enter the State postal code.

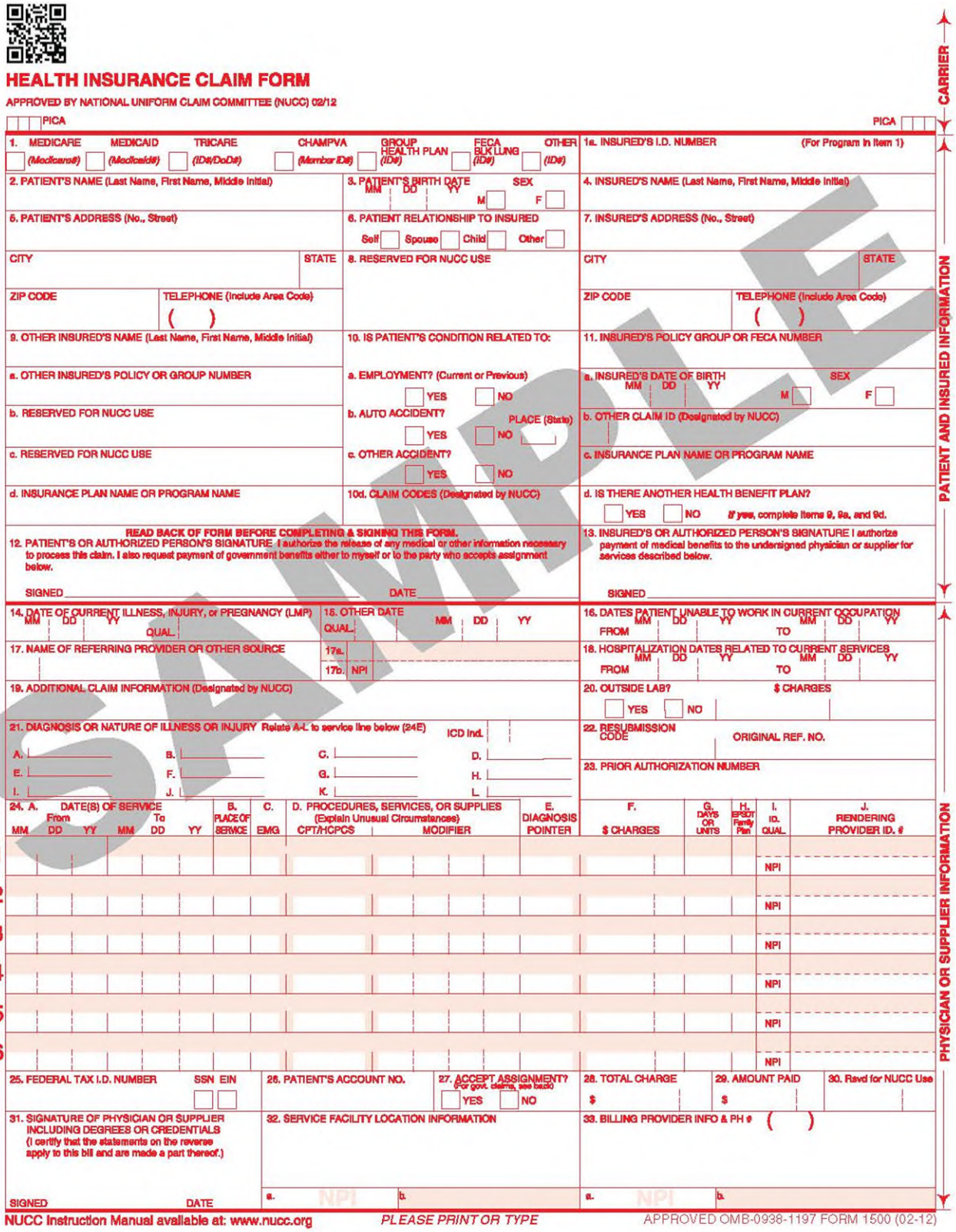
Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
10d	CLAIM CODES (Designated by NUCC)	Not Required	Leave blank.
11	INSURED'S POLICY NUMBER OR FECA NUMBER	Required if Applicable	Enter the insured's policy or group number.
11a	INSURED'S DATE OF BIRTH	Required if Applicable	Enter the insured's date of birth and sex, if different from Field 3. The date of birth must include the month, day, and FOUR digits for the year (MM/DD/YYYY). Example: 01/05/2006
11b	OTHER CLAIM ID (Designated by NUCC)	Not Required	Leave blank.
11c	INSURANCE PLAN OR PROGRAM NAME	Required if Applicable	Enter the insured's insurance plan or program name.
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Required	Check "yes" or "no" to indicate if there is another health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If "yes" then fields 9 and 9a-d must be completed.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Required if Applicable	Have the patient or an authorized representative SIGN and DATE this block unless the signature is on file. If the patient's representative signs, then the relationship to the patient must be indicated.
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Required	Have the patient or an authorized representative SIGN this block unless the signature is on file.
14	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY (LMP)	Required if Applicable	Enter the date of the current illness or injury. If pregnancy, enter the date of the patient's last menstrual period. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006
15	OTHER DATE	Not Required	Leave blank.
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not Required	Enter the "from" and "to" dates that the patient is unable to work. The dates must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2003
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Required if Applicable	Enter the FIRST and LAST NAME of the **Kaiser Permanente** referring or **Kaiser Permanente** ordering physician.
17a	OTHER ID #	Not Required	
17b	NPI NUMBER	Required	Enter the NPI number of the **Kaiser Permanente** referring provider
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Required if Applicable	Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Not Required	Leave blank.
20	OUTSIDE LAB CHARGES	Not Required	

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Required	Enter the diagnosis/condition of the patient, indicated by an ICD-9-CM (or its successor, ICD-10) code number. Enter up to 4 diagnostic codes, in PRIORITY order (primary, secondary condition).
22	RESUBMISSION	Not Required	
23	PRIOR AUTHORIZATION NUMBER	Required if Applicable	For ALL inpatient and outpatient claims, enter the **Kaiser Permanente** referral number, if applicable, for the episode of care being billed NOTE: this is a 10-digit alphanumeric identifier
24A-J	SUPPLEMENTAL INFORMATION	Required	Supplemental information can only be entered with a corresponding, completed service line. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. When reporting additional anesthesia services information (e.g., begin and end times), narrative description of an unspecified code, NDC, VP – HIBCC codes, OZ – GTIN codes or contract rate, enter the applicable qualifier and number/code/ information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/information. The following qualifiers are to be used when reporting these services. 7 – Anesthesia information ZZ – Narrative description of unspecified code N4 – National Drug Codes (NDC) VP – Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard OZ – Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) CTR – Contract rate
24A	DATE(S) OF SERVICE	Required	Enter the month, day, and year (MM/DD/YY) for each procedure, service, or supply. Services must be entered chronologically (starting with the oldest date first). For each service date listed/billed, the following fields must also be entered: Units, Charges/Amount/Fee, Place of Service, Procedure Code, and corresponding Diagnosis Code. IMPORTANT: Do not submit a claim with a future date of service. Claims can only be submitted once the service has been rendered (for example: durable medical equipment).
24B	PLACE OF SERVICE	Required	Enter the place of service code for each item used or service performed.
24C	EMG	Required if Applicable	Enter Y for "YES" or leave blank if "NO" to indicate an EMERGENCY as defined in the electronic 837 Professional 4010A1 implementation guide.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
24D	PROCEDURES, SERVICES, OR SUPPLIES: CPT/HCPCS, MODIFIER	Required	Enter the CPT/HCPCS codes and MODIFIERS (if applicable) reflecting the procedures performed, services rendered, or supplies used. IMPORTANT: Enter the anesthesia time, reported as the "beginning" and "end" times of anesthesia in military time above the appropriate procedure code
24E	DIAGNOSIS POINTER	Required	Enter the diagnosis code reference number (pointer) as it relates the date of service and the procedures shown in Field 21. When multiple services are performed, the primary reference number for each service should be listed first, and other applicable services should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4; or multiple numbers as explained. IMPORTANT: (ICD-9-CM, (or its successor, ICD-10) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.)
24F	$ CHARGES	Required	Enter the FULL CHARGE for each listed service. Any necessary payment reductions will be made during claims adjudication (for example, multiple surgery reductions, maximum allowable limitations, co-pays etc.). Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.
24G	DAYS OR UNITS	Required	Enter the number of days or units in this block. (For example: units of supplies, etc.) When entering the NDC units in addition to the HCPCS units, enter the applicable NDC 'units' qualifier and related units in the shaded line. The following qualifiers are to be used: F2 - International Unit ML - Milliliter GR - Gram UN Unit
24H	EPSDT FAMILY PLAN	Not Required	

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
24I	ID. QUAL	Required, if Applicable	Enter the qualifier of the non-NPI identifier. The Other ID# of the rendering provider is reported in 24j in the shaded area. The NUCC defines the following qualifiers: 0B - State License Number 1B - Blue Shield Provider Number 1C - Medicare Provider Number 1D - Medicaid Provider Number 1G - Provider UPIN Number 1H - CHAMPUS Identification Number EI - Employer's Identification Number G2 - Provider Commercial Number LU - Location Number N5 - Provider Plan Network Identification Number SY - Social Security Number (The social security number may not be used for Medicare.) X5 - State Industrial Accident Provider Number ZZ - Provider Taxonomy
24J	RENDERING PROVIDER ID #	Required if Applicable	Enter the non-NPI identifier in the shaded area of the field, if applicable. Enter the NPI number in the non-shaded area of the field, if applicable. Report the Identification Number in Items 24i and 24j only when different from data recorded in Fields 33a and 33b.
25	FEDERAL TAX ID NUMBER	Required	Enter the physician/supplier federal tax I.D. number or Social Security number of the billing provider identified in Field 33. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. IMPORTANT: The Federal Tax ID Number in this field must match the information on file with the IRS.
26	PATIENT'S ACCOUNT NO.	Required	Enter the patient's account number assigned by the Provider's accounting system, i.e., patient control number. IMPORTANT: This field aids in patient identification by the Provider.
27	ACCEPT ASSIGNMENT	Not Required	
28	TOTAL CHARGE	Required	Enter the total charges for the services rendered (total of all the charges listed in Field 24f).
29	AMOUNT PAID	Required if Applicable	Enter amount paid by other payer. Do not report collections of patient cost share
30	RESERVED FOR NUCC USE	Not Required	Leave blank.
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	Required	Enter the signature of the physician/supplier or his/her representative, and the date the form was signed. For claims submitted electronically, include a computer printed name as the signature of the health care Provider or person entitled to reimbursement.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
32	SERVICE FACILITY LOCATION INFORMATION	Required if Applicable	The name and address of the facility where services were rendered (if other than patient's home or physician's office). Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code Do not use commas, periods, or other punctuation in the address (e.g., "123 N Main Street 101" instead of "123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a 9-digit zip code, include the hyphen.
32a	NPI #	Required if Applicable	Enter the NPI number of the service facility if it is an entity external to the billing provider.
32b	OTHER ID #	Required if Applicable	Enter the two-digit qualifier identifying the non-NPI identifier followed by the ID number of the service facility. Do not enter a space, hyphen, or other separator between the qualifier and number.
33	BILLING PROVIDER INFO & PH #	Required	Enter the name, address and phone number of the billing entity.
33a	NPI #	Required if Applicable	Enter the NPI number of the billing provider.
33b	OTHER ID #	Required if Applicable	Enter the two-digit qualifier identifying the non-NPI number followed by the ID number of the billing provider. Do not enter a space, hyphen, or other separator between the qualifier and number. If available, please enter your unique provider or vendor number assigned by Kaiser Permanente.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

UB-04 (CMS-1450) Field Descriptions

The fields identified in the table below as "Required" must be completed when submitting a UB-04 claim form for processing:

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
1	PROVIDER NAME and ADDRESS	Required	Enter the name and address of the billing provider which rendered the services being billed.
2	PAY-TO NAME, ADDRESS, CITY/STATE, ID #	Required if Applicable	Enter the name and address of the billing provider's designated pay-to entity.
3a	PATIENT CONTROL NUMBER	Required	Enter the patient's account number assigned by the Provider's accounting system, i.e., patient control number. IMPORTANT: This field aids in patient identification by the Provider.
3b	MEDICAL / HEALTH RECORD NUMBER	Required if Applicable	Enter the number assigned to the patient's medical/health record by the Provider. Note: this is not the same as either Field 3a or Field 60.
4	TYPE OF BILL	Required	Enter the appropriate code to identify the specific type of bill being submitted. This code is required for the correct identification of inpatient vs. outpatient claims, voids, etc.
5	FEDERAL TAX NUMBER	Required	Enter the federal tax ID of the hospital or person entitled to reimbursement in NN-NNNNNNN format.
6	STATEMENT COVERS PERIOD	Required	Enter the beginning and ending date of service included in the claim.
7	BLANK	Not Required	Leave blank.
8	PATIENT NAME / ID	Required	Enter the patient's name, together with the patient ID (if different than the insured's ID).
9	PATIENT ADDRESS	Required	Enter the patient's mailing address.
10	PATIENT BIRTH DATE	Required	Enter the patient's birth date in MM/DD/YYYY format.
11	PATIENT SEX	Required	Enter the patient's gender.
12	ADMISSION DATE	Required if Applicable	For inpatient and Home Health claims only, enter the date of admission in MM/DD/YYYY format.
13	ADMISSION HOUR	Required	For either inpatient OR outpatient care, enter the 2-digit code for the hour during which the patient was admitted or seen.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
14	ADMISSION TYPE	Required	Indicate the type of admission (e.g. emergency, urgent, elective, and newborn).
15	ADMISSION SOURCE	Required	Enter the code for the point of origin of the admission or visit.
16	DISCHARGE HOUR (DHR)	Required if Applicable	Enter the two-digit code for the hour during which the patient was discharged.
17	PATIENT STATUS	Required	Enter the discharge status code as of the "Through" date of the billing period.
18-28	CONDITION CODES	Required if Applicable	Enter any applicable codes which identify conditions relating to the claim that may affect claims processing.
29	ACCIDENT (ACDT) STATE	Not Required	Enter the two-character code indicating the state in which the accident occurred which necessitated medical treatment.
30	BLANK	Not Required	Leave blank.
31-34	OCCURRENCE CODES AND DATES	Required if Applicable	Enter the code and the associated date (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.
35-36	OCCURRENCE SPAN CODES AND DATES	Required if Applicable	Enter the occurrence span code and associated dates (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.
37	BLANK	Not Required	Leave blank.
38	RESPONSIBLE PARTY	Not Required	Enter the name and address of the financially responsible party.
39-41	VALUE CODES and AMOUNT	Required if Applicable	Enter the code and related amount/value which is necessary to process the claim.
42	REVENUE CODE	Required	Identify the specific accommodation, ancillary service, or billing calculation, by assigning an appropriate revenue code to each charge.
43	REVENUE DESCRIPTION	Required if Applicable	Enter the narrative revenue description or standard abbreviation to assist clerical bill review.
44	PROCEDURE CODE AND MODIFIER	Required if Applicable	For ALL outpatient claims, enter BOTH a revenue code in Field 42 (Rev. CD.), and the corresponding CPT/HCPCS procedure code in this field.

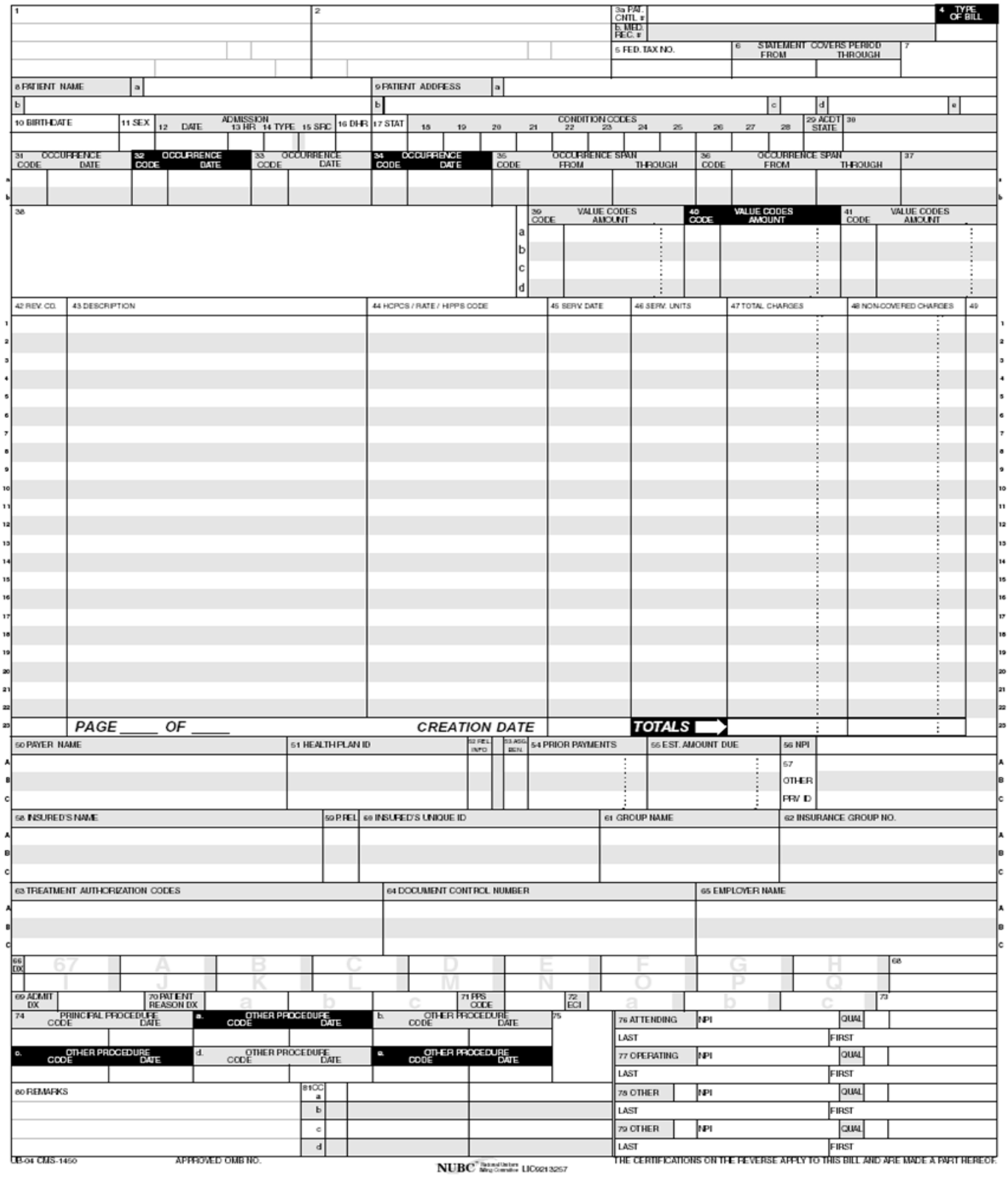
Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
45	SERVICE DATE	Required	Outpatient Series Bills: A service date must be entered for all outpatient series bills whenever the "from" and "through" dates in Field 6 (Statement Covers Period: From/Through) are not the same. Submissions that are received without the required service date(s) will be rejected with a request for itemization. Multiple/Different Dates of Service: Multiple/different dates of service can be listed on ONE claim form. List each date on a separate line on the form, along with the corresponding revenue code (Field 42), procedure code (Field 44), and total charges (Field 47).
46	UNITS OF SERVICE	Required	Enter the units of service to quantify each revenue code category.
47	TOTAL CHARGES	Required	Indicate the total charges pertaining to each related revenue code for the current billing period, as listed in Field 6.
48	NON-COVERED CHARGES	Required if Applicable	Enter any non-covered charges.
49	BLANK	Not Required	Leave blank.
50	PAYER NAME	Required	Enter (in appropriate ORDER on lines A, B, and C) the NAME and NUMBER of each payer organization from which you are expecting payment towards the claim.
51	HEALTH PLAN ID	Not Required	Enter the Plan Sponsor identification number.
52	RELEASE OF INFORMATION (RLS INFO)	Required if Applicable	Enter the release of information certification indicator(s).
53	ASSIGNMENT OF BENEFITS (ASG BEN)	Required	Enter the assignment of benefits certification indicator.
54A-C	PRIOR PAYMENTS	Required if Applicable	If payment has already been received toward the claim by one of the payers listed in Field 50 (Payer) prior to the billing date, enter the amounts here.
55	ESTIMATED AMOUNT DUE	Required if Applicable	Enter the estimated amount due from patient. Do not report collection of patient's cost share.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
56	NATIONAL PROVIDER IDENTIFIER (NPI)	Required	Enter the billing provider's NPI.
57	OTHER PROVIDER ID	Required	Enter the service Provider's Kaiser-assigned Provider ID if any
58	INSURED'S NAME	Required	Enter the insured's name, i.e. policyholder.
59	PATIENT'S RELATION TO INSURED	Required	Enter the patient's relationship to the insured.
60	INSURED'S UNIQUE ID	Required	Enter the patient's Kaiser Medical Record Number (MRN).
61	INSURED'S GROUP NAME	Required if Applicable	Enter the insured's group name.
62	INSURED'S GROUP NUMBER	Required if Applicable	Enter the insured's group number. For Prepaid Services claims enter "PPS".
63	TREATMENT AUTHORIZATION CODE	Required if Applicable	For ALL inpatient and outpatient claims, enter the **Kaiser Permanente** referral number, if applicable, for the episode of care being billed. NOTE: this is a 10-digit alphanumeric identifier
64	DOCUMENT CONTROL NUMBER	Not Required	Enter the document control number related to the patient or the claim as assigned by Kaiser Permanente.
65	EMPLOYER NAME	Required if Applicable	Enter the name of the insured's (Field 58) employer.
66	DX VERSION QUALIFIER	Not Required	Indicate the ICD version indicator of codes being reported. At the time of printing, Kaiser only accepts ICD-9-CM diagnosis codes on the UB-04. ICD-10 standards for paper and EDI claims will be implemented by **Kaiser Permanente** for outpatient dates of service and inpatient discharge dates on/after October 1, 2014.
67	PRINCIPAL DIAGNOSIS CODE	Required	Enter the principal diagnosis code, on all inpatient and outpatient claims.
67A-Q	OTHER DIAGNOSES CODES	Required if Applicable	Enter other diagnoses codes corresponding to additional conditions that coexist or develop subsequently during treatment. Diagnosis codes must be carried to their highest degree of detail.
68	BLANK	Not Required	Leave blank.
69	ADMITTING DIAGNOSIS	Required	Enter the admitting diagnosis code on all inpatient claims.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
70a-c	REASON FOR VISIT (PATIENT REASON DX)	Required if Applicable	Enter the diagnosis codes indicating the patient's reason for outpatient visit at the time of registration.
71	PPS CODE	Required if Applicable	Enter the DRG number to which the procedures group, even if you are being reimbursed under a different payment methodology.
72	EXTERNAL CAUSE OF INJURY CODE (ECI)	Required if Applicable	Enter an ICD-9-CM "E-code" (or its successor, ICD-10 code) in this field (if applicable).
73	BLANK	Not required	Leave blank.
74	PRINCIPAL PROCEDURE CODE AND DATE	Required if Applicable	Enter the ICD-9-CM (or its successor, ICD-10) procedure CODE and DATE on all inpatient AND outpatient claims for the principal surgical and/or obstetrical procedure which was performed (if applicable).
74a-e	OTHER PROCEDURE CODES AND DATES	Required if Applicable	Enter other ICD-9-CM (or its successor, ICD-10) procedure CODE(S) and DATE(S) on all inpatient AND outpatient claims (in fields "A" through "E) for any additional surgical and/or obstetrical procedures which were performed (if applicable).
75	BLANK	Not required	Leave blank.
76	ATTENDING PHYSICIAN / NPI / QUAL / ID	Required	Enter the NPI and the name of the attending physician for inpatient bills or the **Kaiser Permanente** physician that requested the outpatient services. Inpatient Claims—Attending Physician Enter the full name (first and last name) of the physician who is responsible for the care of the patient. Outpatient Claims—Referring Physician For ALL outpatient claims, enter the full name (first and last name) of the **Kaiser Permanente** physician who referred the Patient for the outpatient services billed on the claim.
77	OPERATING PHYSICIAN / NPI/ QUAL/ ID	Required If Applicable	Enter the NPI and the name of the lead surgeon who performed the surgical procedure.
78-79	OTHER PHYSICIAN/ NPI/ QUAL/ ID	Required if Applicable	Enter the NPI and name of any other physicians.
80	REMARKS	Not Required	Special annotations may be entered in this field.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
81	CODE-CODE	Required if Applicable	Enter the code qualifier and additional code, such as marital status, taxonomy, or ethnicity codes, as may be appropriate.

Form UB-04


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 ADMISSION DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
CONDITION CODES
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81CC
UB-04 CMS-1450
APPROVED OMB NO.
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Members with Other Insurance

When a member has other health care coverage that is primary to **Kaiser Permanente** Health Plan coverage, (such as No-Fault, Worker's Compensation, Medicare), the Practitioner needs to bill that primary insurance carrier directly.
Kaiser Permanente will review for payment consideration any remaining balance and may reimburse applicable co-payments and deductibles, if any, of the contractually eligible charges for the member's covered benefits.

Remittance Advice
The Remittance Advice Details (RAD) is designed for line-by-line reconciliation of transactions. Reconciliation of the RAD to providers' records will help determine which claims are paid or denied.

Refer to the Remittance Advice Details (RAD) example form for a completed sample of RA. (See legend below)

1.1 Remittance Advice Details

A. Patient Name
B. Line of Business (LOB)
C. Service Dates
D. Claim Number (Claims System Number)
E. Code
F. Description
G. Billed
H. Contract (Amount Paid)
I. Adjust (Adjustment Amount)
J. Pt share
K. Provider Name (Vendor#)
L. Provider Address
M. Check#
N. Check Amount
O. Total for Provider
P. Interest Owed

Remittance Advice Report

Remittance Advice

Remittance Detail Report

Vendor: K

L Provider Address

City, State Zip code

Vendor: **K** Provider ID#: 12724188

Vendor ID: **K** Provider Name:

Check #: **M** Check Date: 07/01/2015 Check Amount: **N**

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Ins. Co. Name: KAISER FOUNDATION HEALTH PLAN [1] Check #: **M** Claim #: **D**

Patient Name: Last name, First Name - **A** Date of Birth: Month/Day/Year

Patient Acct#:

Member ID: xxxxxx Group:

Service Date	Procedure /DRG	**G** Billed	Before Ben Disallow	Not Penalty	Net Allowed	Primary Covered	Copay/ **J** Deduct	Exc Ben **J** Coins	Patient Amt	Adj After Ben Total	**I** Adjust	RSN	Penalty Withhold	Ben Discount	Paymnt	Codes	Ins
C Service Dates	90999	5885.00	0.00	0.00	4708.12	0.00	0.00	15.00	0.00	15.00	0.00		0.00	0.00	1176.88	4693.12	3,23,45,
C 05/18/15	90999	5885.00	0.00	0.00	4707.76	0.00	0.00	15.00	0.00	15.00	0.00		0.00	0.00	1177.24	4692.76	3,23,45,
C 05/20/15	90999	5885.00	0.00	0.00	4708.12	0.00	0.00	15.00	0.00	15.00	0.00		0.00	0.00	1176.88	4693.12	3,23,45,
Claim Totals:		17655.00	0.00	0.00	14124.00	0.00	0.00	45.00	0.00	45.00	0.00		0.00	0.00	3531.00	**O** 14079.00	0.00

CLAIM EOB SUMMARY

Claim Level Code: [23] Payment adjusted, due to impact of prior payor adjudication (Use only with Group Code OA): Generated by adjudicator Added by retro adjudication process.
P Interest Amount: 17.36
Penalty Amount: 0.00

Total for Processed Claims:
---------- --------- --------- --------- --------- -------- -------- -------- -------- --------- --- ----
---- -------- ---------- --------- -------- ---------
17655.00 0.00 0.00 14124.00 0.00 0.00 45.00 0.00 45.00 0.00
0.00 0.00 3531.00 14079.00 0.00

Total for HMO B -*:
---------- --------- --------- --------- --------- -------- -------- -------- -------- --------- --- ----
---- -------- ---------- --------- -------- ---------
17655.00 0.00 0.00 14124.00 0.00 0.00 45.00 0.00 45.00 0.00
0.00 0.00 3531.00 14079.00 0.00

Remittance Advice

Remittance Detail Report
Vendor: Vendor Name
Address
City, State Zip Code

Service Procedure Before Ben Not Copay/ Exc Ben Patient
Adj After Ben Net Primary
Date /DRG Billed Disallow Penalty Allowed Covered Deduct Coins Amt
Total Adjust RSN Penalty Withhold Discount **H** Paymnt Codes Ins
======== ========= ========== ========= ========= ========= =========
======== ======== ======== ======== ========= === ======== ========
========== ========= ======== =========

Total for **Vendor Name** *:
---------- --------- --------- --------- --------- -------- -------- -------- -------- --------- --- ----
---- -------- ---------- --------- -------- ---------
17655.00 0.00 0.00 14124.00 0.00 0.00 45.00 0.00 45.00 0.00
0.00 0.00 3531.00 14079.00 0.00

Remittance Advice

Remittance Detail Report

Vendor: Name
Address
City, State Zip Code

Service Date | Procedure /DRG | Before Ben Billed | Not Disallow | Copay/ Penalty | Exc Ben Allowed | Patient Covered | Adj Deduct | After Ben Coins | Net Amt | Primary Total | Adjust RSN | Penalty Withhold | Discount Paymnt | Codes | Ins

17655.00 0.00 0.00 14124.00 0.00 0.00 45.00 0.00 45.00 0.00 0.00 0.00 3531.00 14079.00 0.00

Total for payee **Vendor Name** - [Check # **M**]

Total Interest Amount: 298.75

Total Penalty Amount: 0.00

CODES SUMMARY

E Reason Code: [3] **F** Co-payment Amount

Reason Code: [C] Contracted Rate Payment

Reason Code: [45] Chg exceeds fee sched/max allowbl or contrctd/legisltd fee,use only with Group Codes PR/CO

*** End of Report ***

Claims Adjudication Overview

This topic provides a high-level description of the first-pass adjudication business process. Details of how to perform individual tasks are found in the desk level procedures (DLPs) in this repository.

Most first pass adjudication for KPClaimsConnect is auto-adjudicated, meaning that the claim is reviewed and priced by the system without manual claim adjudicator intervention.

Once the claim comes into the system either electronically, through Electronic Data Interchange (EDI), or manually, through mail room receipts of paper claims, a series of data checks are performed on the claim to determine whether to pay or deny the claim. See Paper Intake.

The system looks at many different elements of the claim during auto-adjudication: authorization exclusions, matching referrals, membership coverage/eligibility, provider selection, contract pricing, CPT/HCPCS/revenue codes, modifier placement, service dates, claim billed/allowed/insurance/net amounts.

- If there are no questions about these claim elements, the claim will automatically pay or deny and be released to AP.
- If there are questions about one or more of these elements, the system applies a code to hold or pend the claim for manual review. There could be specific claim types that will always require review, for example high dollar claims, or there can be combinations of factors that cause the claim to hold/pend for review.

If the system cannot automatically determine whether to pay or deny the claim based on the data available, or if there are Federal, State, or regional policy rules that require the claim is reviewed before it is paid or denied, then the system applies a claim code on the claim to stop the claim from auto-adjudicating, and routes it to a person to perform an action.

Claim Codes

There are four types of claim codes that are applied to a claim or a line on a claim: pend, hold, denial, and/or informational. More than one claim code can be applied to a claim or claim service line. The following table gives a description of the claim code types and their effects on the claim depending on whether the claim code is applied at the claim level or service line level.

For specific claim codes and applicable DLPs, refer to the Pend/Hold Code Matrix.

Claim Code	Applied to Claim	Applied to Service Line
Pend/Hold	Pends/holds the claim for manual review. **Note:** The difference between a pend code and a hold code is on whether they hold a claim when there is a denial code on the claim. If a denial code is on the claim with a pend code, the claim will deny. If a denial code is on the claim with a hold, the claim will hold for review.	Pends/holds the claim for manual review.

Deny	Denies the claim. **Note:** If the claim has a hold code, it will not auto-deny. Instead, the claim will hold for review to determine if the denial stays or will be overwritten.	Denies the service. **Note:** A service line may be denied, but the claim is still payable with a status of Clean. These are sometimes referred to as Clean Denials.
Informational	No effect. Claim code and description may be set up to print on RA and/or EOB to provide payment explanation.	No effect. Claim code and description may be set up to print on RA and/or EOB to provide payment explanation.

Note: A claim can have a combination of pend/hold and denial codes applied at the service line level.

Claim Code Distribution

The claim is assigned to the applicable In Basket pool based on the claim code(s) and will be reviewed and cleared by users assigned to that pool. The following documents lists provide reference to how pools are mapped for distribution for each region.

- Hawaii Distribution Scheme
- Northwest Distribution Scheme
- See Resolving Claim Codes.

CRM Process

The person or department receiving the claim may require additional information or may need to assign a task to a different person or department before they can finalize claims processing. CRMs can be sent to request action and/or additional information. See Completing Tasks and Resolving CRM Records.

When Can Members be Billed?

Members do not have any co-payments for covered services.

You cannot bill a member in the following situations:

- **You** fail to follow Kaiser Permanente's procedures which results in our non-payment to you
- Member is a no-show for a scheduled appointment for covered services.

You may bill a member in the following situations:

- **Member** self-refers to a specialist or other provider within our network without following Kaiser Permanente's procedures which results in our non-payment to you.

- When the member requests and agrees to pay for a non-covered service or self-referrals, and you obtain prior agreement from the member regarding the cost of the services and payment terms at the time of service.

Reporting Requirements
As a Medicaid Health Plan, **Kaiser** QUEST is required to submit a variety of reports to the State on a schedule.

Some examples include:

- Timely access
- Over and under utilization
- Quality and satisfaction, e.g. HEDIS, CAHPS
- Drug utilization
- Interpretative services
- Member and provider grievances
- Suspected fraud and abuse, including child abuse and adult abuse

As a provider, you are required to comply with all requests for information necessary for **Kaiser** QUEST that do meet state reporting requirements. This information will also provide **Kaiser Permanente** with information about your practice and patients gathered from claims for process improvement and quality and performance improvement initiatives.

Chapter 12: Kaiser Permanente QUEST Program Covered Benefits

For more than 35 years, **Kaiser Permanente** Hawaii Market has had a program of medical care and outreach service for persons with low income. The program began in 1971 with the enrollment of 500 public assistance families under a contract with the Hawaii Department of Human Services (DHS). It continued with federal and state contracts for medical care for families with low-to-moderate income who were not eligible for public assistance.

In 1994, in an effort to increase access to health care and control the rate of health care expenditures, the State of Hawaii implemented the Hawaii QUEST program. QUEST is a statewide program that provides medical and behavioral health services using capitated managed care delivery systems.

QUEST stands for:

Quality Care
Universal Access
Efficient Utilization
Stabilizing Cost
Transforming provision of health benefits to public clients

Kaiser Permanente has participated in the QUEST program since its inception.

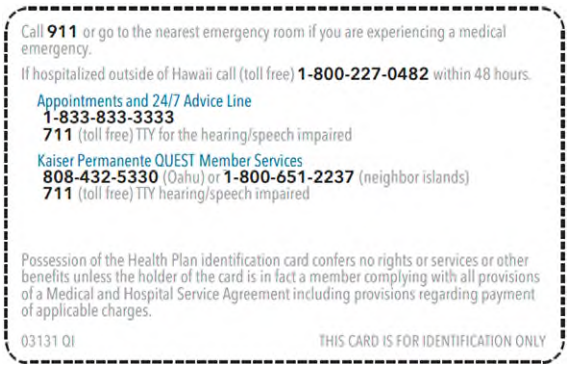
Kaiser Permanente is proud to be a participating health plan in the new QUEST program serving member starting January 1, 2015. We provide services to **Kaiser Permanente** QUEST members on the islands of Oahu and Maui.

How to reach us

The **Kaiser Permanente** QUEST Call Center assists members and providers. Call **Kaiser Permanente** at **808-432-5330** or toll-free at **1-800-651-2237**. We're here from 7:45 a.m. to 4:30 p.m., Monday through Friday, except holidays. After normal business hours, you may leave a message on the voice mailbox and someone will call you back as soon as possible, but no later than 4:30pm the following business day. Members who are deaf, hard of hearing, or speech impaired may call toll free **711 (TTY).** .

Kaiser Permanente identification cards

Kaiser Permanente QUEST members have a **Kaiser Permanente Identification Card**



The QUEST identification card has additional information required by DHS:

- Member's **Kaiser Permanente** Member Identification Number
- Member's name
- Effective date of member's **Kaiser Permanente** QUEST coverage
- Primary clinic name and telephone number
- Third-party liability (TPL) information (not **Kaiser Permanente** insurance)
- QUEST Call Center telephone number
- After-hours advice line telephone number

QUEST Covered Benefits and Services

Service	Description
Primary and Acute Care Services (in alphabetical order)	
Community Palliative Care	Community Palliative Care is a special kind of medical help for people who are very sick. It is given outside of hospitals, like in homes or community centers. A serious illness is one that can be life-threatening and makes it hard to do everyday things, affects how good life feels, or makes it hard for people taking care of the sick person. Palliative care tries to make people feel better by reducing symptoms and stress. It can be given at any time during the illness, even if the person is still getting treatment to try to cure the illness.
Cornea Transplants and Bone Graft Services	Cornea transplants and bone graft services are covered when medically necessary.
Cognitive Rehabilitation Services	Services provided to cognitively impaired persons, most commonly those with traumatic brain injury, that assess and treat communication skills, cognitive and behavioral ability, and cognitive skills related to performing ADLs. Five cognitive skills areas: • Attention Skills - sustained, selective, alternating, and divided • Visual Processing Skills - acuity, oculomotor control, fields, visual attention, scanning, pattern recognition, visual memory, or perception • Information Processing Skills - auditory or other sensory processing skills, organizational skills, speed, and capacity of processing • Memory Skills - orientation, episodic, prospective, encoding, storage, consolidation, and recall • Executive Function Skills - self-awareness, goal setting, self-initiation, self-inhibition, planning and organization, self-monitoring, self-evaluation, flexible problem solving, and metacognition Approaches include: • Education • Process training • Strategy development and implementation • Functional application • Selected approaches should match the appropriate level of awareness of cognitive skills • Some techniques/strategies include: o Speech/language/communication o Neuropsychological assessment

Service	Description
	○ Compensatory memory techniques ○ Executive functions strategies ○ Reading/writing skills retraining
Diagnostic Testing	Include, but is not limited to: • Screening and diagnostic radiology and imaging • Screening and diagnostic laboratory tests • Other screening or diagnostic radiology or laboratory services When Medically Necessary Prior approval is not required for laboratory, imaging, or diagnostic services. Prior approval is required for: • Magnetic resonance imaging • Magnetic resonance angiogram • Positron emission tomography • Reference lab tests that cannot be done in Hawaii and not specifically billable by clinical laboratories in Hawaii • Disease-specific new technology lab tests • Genetic tests • Psychological testing • Neuropsychological testing • Cognitive testing • Computerized tomography
Dialysis	Provided by: • Medicare-certified hospitals • Medicare-certified end stage renal disease (ESRD) providers Settings where you can receive dialysis include: • Hospital inpatient • Hospital outpatient • Non-hospital renal dialysis facility • Member's home Dialysis services include: • Equipment • Supplies • Diagnostic testing (including laboratory tests)

Service	Description

	• Drugs for dialysis treatment approved by Medicare when Medically Necessary
	• Hepatitis B surface antigen
	• Anti-HB testing for patients on hemodialysis
	• Intermittent peritoneal dialysis
	• Continuous ambulatory peritoneal dialysis (CAPD)
	• Alfa-Epoetin (EPO) provided during dialysis
	• Other drugs related to ESRD
	• Home dialysis equipment and supplies prescribed by physician
	• Physician services
	• Hospital stays for
	  • acute medical conditions requiring dialysis treatments
	  • a patient receiving chronic outpatient dialysis for an unrelated medical condition
	  • placement, replacement, or repair of the chronic dialysis route.

Durable Medical Equipment (DME) and Medical Supplies	Durable medical equipment needed to: • Reduce a medical disability • Restore or improve function Supplies for rent or purchase include: • Oxygen tanks and concentrators • Ventilators • Wheelchairs • Crutches and canes • Eyeglasses • Orthotic devices • Prosthetic devices • Hearing aids • Pacemakers • Medical supplies (surgical dressings, continence, and ostomy supplies) • Foot appliances (orthoses, prostheses) • Orthopedic shoes and casts • Ortho digital prostheses and casts • Other medically necessary durable medical equipment covered by the Hawaii Medicaid program Prior approval is required.
Emergency and Post-Stabilization Services	Services in an emergency room for emergent conditions. If the condition is considered non-emergent, you may have to pay for charges related to the visit. Kaiser Permanente will not deny payment for emergency services sought by a prudent layperson, even if emergency services are determined not needed and regardless if the provider is in- or out-of-network.

Service	Description
	You are also covered for care that keeps your condition stable after an emergency. Post-stabilization services include follow-up outpatient specialist care. If you receive post-stabilization services from a provider outside of Kaiser Permanente's network, we will not charge you more than if services were obtained through an in-network provider.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Routine checkups for children and youth under the age of 21 included (but are not limited to): • Medical and behavioral health screening • Dental screening and referral to dentist • Diagnostic tests • Immunizations • Preventive care, etc. • Additional services to correct or amend defects of physical, mental/emotional, and conditions discovered as a result of EPSDT screens when Medically necessary.
Family Planning Services	Services for members who are sexually active and of childbearing age: • Education and counseling to make informed choices and understand contraceptive methods • Emergency contraception and counseling, as indicated • Follow up care and office visits (to help prevent unwanted pregnancies; to help plan the number of pregnancies; to help plan the time between pregnancies; or to confirm if you are pregnant) • Pregnancy testing • Family planning drugs, supplies, and devices to prevent unwanted pregnancy (to include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all individuals with reproductive capacity) • Diagnosis and treatment of sexually transmitted diseases You have the choice to get the above family planning services from Kaiser Permanente or from an out-of-network provider without a referral from us. Other family planning services available to you: • Office visits and diagnostic tests to diagnosis infertility • Sterilization. Services are voluntary and confidential to Members.
Fluoride Varnish	Application by a qualified primary care provider is covered for children between one and six years of age who have not received topical fluoride treatment by a dentist or qualified PCP within the past six months.

Service	Description
	Qualified PCPs include physicians and nurse practitioners. These qualified PCPs may delegate under direct supervision to a PA, RN, LPN, or certified medical assistant.
Habilitation Services	Habilitative services and devices develop, improve, or maintain skills and functioning for daily living to developmentally appropriate levels when medically necessary. Habilitative services and devices include: • Audiology services • Occupational therapy • Physical therapy • Speech-language therapy • Vision services • Augmentative communication devices • Reading devices • Visual aids Devices used as school-based services or used only for activities at school are not covered when not medically necessary. Does not include routine services listed in Vision Services on page 33.

<table>
<tr><th>Service</th><th>Description</th></tr>
<tr><td>Hearing Services</td><td>Services include:
Diagnostic services
Screening
Preventive care
Corrective services/equipment/supplies
<table>
<tr><th>Service</th><th>Age 3 years or younger</th><th>Age 4 years or older</th><th>Under age 21</th><th>Age 21 and older</th><th>Prior approv require</th></tr>
<tr><td>Initial Exam</td><td></td><td></td><td>One time a year</td><td>One time a year</td><td>No</td></tr>
<tr><td>Electroacoustic Exam</td><td>4 times per year</td><td>2 times per year</td><td></td><td></td><td></td></tr>
<tr><td>Fitting/ Orientation/ Hearing Aid Check</td><td></td><td></td><td>Two times every three years</td><td>One time every three years</td><td>Yes</td></tr>
<tr><td>Hearing aid devices (includes service/loss/ damage warranty, a trial or rental period</td><td></td><td></td><td>One hearing aid per ear every 24 months</td><td>One hearing aid per ear every 24 months</td><td>Yes</td></tr>
</table>
Services provided by or under the direction of an otorhinolaryngologist or an audiologist when medically necessary.</td></tr>
<tr><td>Home Health Services</td><td>Home health services are part-time or intermittent care for the Members who do not require hospital care provided under the direction of a physician in order to prevent re-hospitalization or institutionalization.

Services provided at your home by qualified home health agencies include by not limited to:
Skilled nursing
Home health aides
Medical supplies and DME
Therapeutic services (physical and occupational therapy)
Audiology and speech pathology</td></tr>
<tr><td>Immunizations</td><td>Receive the following immunizations approved by CDC’s Advisory Committee including but not limited to type of language:
Influenza
Diphtheria usually combined with Tetanus</td></tr>
</table>

Service	Description
	• Pneumococcal vaccine • Other vaccines as needed
Inpatient Hospital Services for Medical, Surgical, Maternity/Newborn Care, and Rehabilitation	Includes the cost of room and board for inpatient stays. The services include: • Nursing care • Medical supplies, equipment, and drugs • Diagnostic services, physical therapy, occupational therapy, audiology and • Speech-language pathology services • Other services in this category When Medically Necessary.
Inpatient Hospital Maternity/Newborn Care Services	Women in good health with deliveries that are not complex may stay in the hospital for up to: • 48 hours after a natural birth • 96 hours after a cesarean section The patient and physician may agree to an early discharge.
Medical Services Related to Dental Needs	Kaiser Permanente covers dental services to treat medical conditions done in a medical facility like a hospital when medically necessary. Also includes: • Referrals • Follow-ups • Coordination • Provision of appropriate medical services related to dental needs (including but not limited to: • Emergency room treatment • Hospital stays • Ancillary inpatient services • Operating room services • Excision of tumors • Removal of cysts and neoplasms • Excision of bone tissue surgical incisions • Treatment of fractures (simple and compound) • Oral surgery to repair traumatic wounds surgical supplies • Blood transfusion services ambulatory surgical center services • X-rays • Laboratory services • Drugs • Physician examinations • Consultations • Second opinions • Sedation by physician anesthesiologist • Dental or medical services resulting from a dental condition that are provided in a medical facility (e.g., inpatient hospital and ambulatory surgical center).

Service	Description
	Includes: • Medical services for adults and children required as part of a dental treatment • Dental procedures by oral surgeons and physicians (primarily plastic surgeons, otolaryngologists, and general surgeons) • Services by a dentist or physician due to a medical emergency (for example, car accident, where the services are primarily medical) • Services in relation to oral or facial trauma, oral pathology. Includes, but not limited to infections of oral origin, cyst and tumor management, and craniofacial reconstructive surgery, as inpatient basis in an acute care hospital setting. Services in a private office or hospital-based outpatient clinic for services not medically necessary or provided by government-sponsored or subsidized dental clinics, and hospital-based outpatient dental clinics are not covered by Kaiser. Also see "Covered by Med-QUEST but not by Kaiser Permanente" at the end of this section.
Nutrition Counseling	Types of services for members include: • Diabetes Self-Management Education • Nutrition counseling for obesity • Nutrition counseling for other metabolic conditions (if medically necessary)
Other Practitioner Services	Other practitioner services by: • Certified nurse midwife services • Licensed APRN services • Family, pediatric, and psychiatric health specialists • Paraprofessionals including peer support specialists • Licensed or certified healthcare provider including: o Behavioral health providers (psychologists, marriage and family therapists, mental health counselors, and CSACs) When services are Medically Necessary
Outpatient Hospital Services	Outpatient hospital services to prevent, diagnose, or manage the pain of an illness or injury such as: • Family planning • Medical services related to dental needs • Imaging services • Laboratory studies • Oncology services • Diagnostic testing

Service	Description
	• Ambulatory surgery services • Physical therapy • Occupational therapy • Speech therapy • Blood storage and processing • Respiratory services • Audiology services • Cardiology services • Chemotherapy services • Radiation services • Surgeries performed in a freestanding ambulatory surgery center (ASC) or hospital ASC • Twenty-four (24) hours a day, seven (7) days per week, emergency services • Urgent care services • Medical supplies, equipment, and drugs Services when Medically Necessary.
Physician Services	Services provided by or under the direct supervision of physicians include: • Physical examinations • Screening examinations • EPSDT screenings for children and youth under age 21 Services when Medically Necessary and provided at locations including, but not limited to: • Physician's office • Clinic • Private home • Licensed hospital • Licensed skilled nursing or intermediate care facility or • Licensed or certified residential setting
Podiatry (foot and ankle) Services	Treatment of conditions of the foot and ankle such as: • Professional services, not involving surgery provided in an office or clinic • Diabetic foot care (inpatient and outpatient) not involving surgery • Diagnostic radiology procedures limited to ankle and below • Surgical procedures limited to ankle and below • Foot and ankle care for infection or injury in an office or outpatient clinic • Bunionectomies when the bunion is present with overlying skin ulceration or neuroma secondary to the bunion.
Pregnancy-Related Services for Pregnant	Services for the health of the woman and her fetus during the woman's pregnancy and up to sixty (60) days post-partum when Medically Necessary.

Service	Description
Women and Expectant Parents	Services provided for pregnancy and maternity care such as: • Prenatal care • Diagnostic tests (Radiology, laboratory, and other diagnostic tests) • Treatment of missed, threatened, incomplete abortions • Health education and screening for conditions that could make a pregnancy "high risk" • Fetal development • Labor and delivery of infant and post-partum care • Diagnostic ultrasound • Fetal stress and non-stress testing • Prenatal vitamins • Screening, diagnosis, and treatment for pregnancy-related conditions, to include SBIRT, screening for maternal depression, and access to necessary behavioral and substance use treatment or supports • Lactation counseling – up to six months* • Breast pump rental – up to six months* • Breast pump purchase – requires prior approval • Educational classes on childbirth, breastfeeding, and infant care • Counseling on healthy behaviors, to include prevention and harm reduction • Inpatient hospital services, physician services, other practitioner services, and any other services that impact pregnancy outcomes. • Inpatient and outpatient substance use treatment for pregnant and parenting women and their children. *May be extended with prior approval.
Prescription Drugs	Medications when Medically Necessary to optimize the Member's medical condition, including behavioral health prescription drugs for children receiving services from CAMHD. Includes: • Prescription drugs and certain over-the-counter drugs which are on the list of approved drugs and prescribed by your doctor who is licensed to prescribe • Medication management and counseling • Medications of non-pulmonary and latent tuberculosis not covered by DOH.
Preventive Services – Adult (21 years or older)	Includes: • AAA (abdominal aortic aneurysm) screening for those that meet criteria

Service	Description
	• Blood pressure • Breast cancer screening • Cervical cancer screening • Chemoprophylaxis • Colorectal cancer screening • Diabetes screening for those that meet criteria • Health education and counseling • Hepatitis C screening for those that meet criteria • Immunizations • Prostate cancer screening • Rubella serology or vaccine history • Total cholesterol measurements • Tuberculin skin testing • Weight/height measurements
Preventive Services – Children (Less than 21 years of age)	Includes: • Age-appropriate dental checkup and oral fluoride • Age-appropriate health education • EPSDT services • Hospital stay for normal, term, and healthy newborn • Immunizations • Newborn screening • Other age-appropriate laboratory screening tests • Screening to assess health status • Tuberculin skin testing For help finding a dentist, call Community Case Management Corporation (CCMC) at 808-792-1070 or toll-free at l-888-792-1070. CCMC can explain the covered dental benefits and help you find a dentist near you.
Preventive Services – Pregnant Women	Includes: • Diagnostic amniocentesis, diagnostic ultrasound, fetal stress, and non-stress • Diagnosis of premature labor • Health education and screening • Hospital stays • Prenatal laboratory screening tests • Prenatal visits • Prenatal vitamins, including folic acid
Radiology/Laboratory/ Other Diagnostic Services	Includes: • Diagnostic and therapeutic radiology and imaging • Screening and diagnostic laboratory test

Service	Description
	• Other medically necessary diagnostic or therapeutic service Services may require a prior approval.
Rehabilitation Services	Provided to patients who are expected to improve in a reasonable period of time with therapy provided by licensed physical therapist (PT), licensed occupational therapist registered (OTR), licensed audiologist, and licensed speech pathologist respectively. A PT assistant or a certified occupational therapy assistant may be utilized as long as they are working under the direct supervision of either a PT or OTR, respectively. Services include: • Physical therapy • Occupational therapy • Audiology • Speech-language pathology Services are limited to those who expect to improve in a reasonable period of time. Services for children under EPSDT have different requirements Prior approval is required for all rehabilitation services except for the initial evaluation.
Sleep Laboratory Services	Diagnosis and treatment of sleep disorders performed by sleep laboratories or sleep disorder centers. Sleep laboratory service providers accredited by the American Academy of Sleep Medicine.
Smoking Cessation Services	Services include: • At least four in-person sessions of at least ten (10) minutes each per quit attempt, including individual, group, or phone counseling. • Two (2) effective components of counseling, practical counseling (problem-solving/skills training), and social support delivered as part of the treatment, shall be emphasized. • Counseling services by licensed providers trained on this service. Including: physician, psychologist, clinical social worker in behavioral health, APRNs, Mental Health Counselors and Certified tobacco treatment specialists under supervision of a licensed provider. • Medications approved by the U.S. Food and Drug Administration (FDA) • No out-of-pocket cost or co-payment required for these services or medication No prior approval or step therapy is needed for treatment
Sterilizations and Hysterectomies	Sterilizations and Hysterectomies for both men and women when the following are met: • Age 21 years or older at time of consent

Service	Description
	• Mentally competent • Requires Sterilization Required Consent Form at least 30 calendar days before the procedure but not more than 180 days between the date of consent and date of sterilization (except for premature delivery or emergency abdominal surgery) • A Member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since consent for sterilization was signed • For premature delivery, the informed consent shall be at least 30 days before the expected date of delivery. The expected date of delivery shall be provided on the consent form • An interpreter is provided when needed and arrangements for Members who are visually impaired, hearing impaired, or disabled made to communicate the required information. • Member is not institutionalized (in a prison, mental hospital, or other rehabilitative facility) • If the Member is incapacitated, then a court order is required, and the required amount of time shall pass pursuant to HRS §560:5-609. Hysterectomies not covered under the following: • For the purpose of making the Member permanently incapable of reproducing • There is more than one purpose for the hysterectomy, but the primary purpose is to make the Member permanently incapable of reproducing • It is performed for the purpose of cancer prophylaxis when not medically needed
Telehealth Services	Services include live consultations through video or web calls. These services are covered if referred by an in-network provider and if you have trouble getting to the provider. Telehealth services are not available from providers outside the USA.
Transportation Services	Services include emergency and non-emergency ground and air transportation. Transportation to and from medically necessary covered medical appointments for: • Members who have no means of transportation • Members who reside in areas not served by public transportation or who cannot access public transportation

Service	Description
	Transportation is also covered when your medical condition requires treatment that is not available in the area where you are. Travel services include: • Ground and air transportation • Lodging • Meals Prior approval is required. Includes travel services when medically necessary for the member and (if needed) one attendant. Also covered if you do not have access to specialty providers (including but not limited to psychiatrists and specialty physicians)
Urgent Care Services	Care for a medical condition that is serious but not life threatening and needs to be treated within 24 hours. Call any Kaiser Permanente clinic for an appointment. If the clinic is closed, call the after-hours advice line at **1-833-833-3333**, toll free at 1-800-467-3011, or **711** (TTY). Urgent care out of area is only covered for members under age 21.

<table>
<tr>
<td>Vision Services</td>
<td>Routine eye exams and glasses:

<table>
<tr><th>Service</th><th>Under age 21</th><th>Age 21 and older</th></tr>
<tr><td>Eye exam*</td><td>Once in 12 months</td><td>Once in 24 months</td></tr>
<tr><td>Visual aids** (Eyeglasses***, contact lens****, frames, other parts of glasses, fittings and adjustments)</td><td>One every 24 months</td><td>One every 24 months</td></tr>
</table>

*Additional visits may be allowed with prior approval when Medically Necessary.

**Visual aids must be prescribed by ophthalmologists or optometrists and covered when Medically Necessary. Individuals under forty (40) years of age require medical justification for bifocals.

***Replacement and new glasses with significant changes in prescription are covered within the benefit periods for both adults and children with prior approval.

****Contact lenses are only covered when Medical Necessity is established.

Dispensing of the visual aids begins anew after each twenty-four (24)-month period since the prior dispensing.

Also covered for all Members:
• Prescription lenses
• Cataract removal
• Prosthetic eyes
• Cornea (keratoplasty) transplants provided in accordance with the Hawaii Administrative Rules

Emergency eye medical-condition care covered for all members without prior approval.

Vision services not included:
• Orthoptic training
• Prescription fee
• Progress exams
• Radial keratotomy
• Visual training</td>
</tr>
</table>

Service	Description
	• Lasik procedure
Other Facility Services	
Hospice Care	Provides care to terminally ill patients who are not expected to live more than six months. Hospice services will be covered in the home, nursing facility or inpatient settings. Children under the age of 21 can receive treatment to manage or cure disease while in hospice care.
Nursing Facility	Includes: • Skilled Nursing Facility (SNF) • Intermediate Care Facility (ICF) • Subacute level of care in a hospital
Behavioral Health Services	
Standard Behavioral Health Services (includes psychiatric services and substance abuse treatment services)	Includes: • Room and board • Nursing care • Medical supplies • Equipment • Medications • Medication management • Diagnostic services • Professional services • Medically necessary services • Substance abuse treatment services Use of triage lines or screening systems, telemedicine, e-visits, and/or other technological solutions covered when applicable. Covered for the involuntarily committed for evaluation and treatment when Medically Necessary. Not covered for Members receiving behavioral health services from the CCS program.
Ambulatory Mental Health Services	Includes: • 24-hour access line • Mobile crisis response • Crisis stabilization • Crisis management • Crisis residential services

Service	Description
	The psychiatric evaluation and treatment of Members criminally committed to ambulatory mental healthcare settings are covered by the state. Medical and standard behavioral health services for Members criminally committed to ambulatory mental healthcare settings may be billed to Kaiser.
Collaborative Care Model	Services provided by a primary care team consisting of a primary care provider and a care manager who works in collaboration with a psychiatric consultant, such as a psychiatrist.
Psychotropic Medications and Medication Management	Medications and medication management includes: • Evaluation, prescription maintenance of psychotropic medications • Medication management • Counseling • Education • Promotion of algorithms and guidelines
Inpatient Psychiatric Hospitalizations	Includes • Room/board • Nursing care • Medical supplies • Equipment • Medications and medication management • Diagnostic services • Psychiatric and other behavioral health practitioner services • Ancillary services • Other services When Medically Necessary.
Psychiatric or Psychological Evaluation and Treatment	Services to evaluate and provide treatment of behavioral health include: • Individual and group counseling and monitoring
Medically Necessary Alcohol and Chemical Dependency Services	Inpatient and outpatient substance abuse services. Provided in a setting accredited according to standards set by the Alcohol and Drug Abuse Division (ADAD) of the Hawaii State Department of Health.
Medication-Assisted Treatment (MAT)	Medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUDs. Medications approved by the FDA and are clinically driven and tailored to meet each patient's needs.
Parity in Mental Health and SUD	Services necessary for compliance with the requirement for parity in mental health and SUD benefits in 42 CFR Part 438, Subpart K.

Service	Description
SBIRT	Early intervention treatment services for persons with SUDs, and those at risk for developing a SUD.
Substance Use Disorder (SUD) Treatment	Inpatient and outpatient treatment when Medically Necessary. SUD treatment in a treatment setting accredited by the ADAD. Includes: • Medication approved by FDA for SUDs. • Methadone/Levomethadyl acetate services for acute opiate detoxification as well as maintenance.

Long-Term Services and Supports (LTSS)

Members who are aged and disabled can receive care in an institution like a nursing facility or in community settings like Care Homes, Foster Homes, or a member's own home through Home and Community Based Services (HCBS). A special form called DHS 1147 - Level of Care (LOC) and At-Risk Evaluation Form is done to find out what kind of help they need. The form is completed at least once a year to see if their needs have changed.

Members who live in their own home and are At-Risk can receive limited services that may include:

- Meals delivered to their home
- Personal Emergency Response System (PERS)
- Help with personal care
- Adult day care
- Adult day health services
- Private duty nursing

To receive more LTSS services, a member must meet the Intermediate Care Facility (ICF) level of care and be approved by the State to receive long-term care benefits.

Acute Waitlisted SNF/ICF	Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF) level of care services provided in an acute care hospital in an acute care hospital bed.
Adult Day Care Center (ADC)	Supportive care for four or more disabled adults. Including: • Observation/supervision by center staff • Coordination and use of behavioral, medical, and social care plans, and implementation of instructions listed in Health Action Plan. Also includes therapeutic, social, educational, and recreational activities. Performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency. Does not include medication administration, tube feedings, and other activities which require healthcare-related training.

Service	Description
Adult Day Health Center (ADH)	Organized day program with nursing oversight. Provided to adults with physical and/or mental conditions. The purpose is to help members to stay in the community as much as possible. Provided under supervision of RN. Members who require skilled nursing services, will have services provided by an RN or under the direct supervision of an RN. Services 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 • Transportation services.
Assisted Living Facility (ALF)	Services include: • Personal care • Supportive care (homemaker, chore, PCS, and meal preparation) • Nursing • Help with medication Payment for room and board is not allowed. Members receiving ALF services shall be receiving ongoing CCMA services.
Attendant Care	Hands-on care, both supportive and health-related in nature, provided to children. The service includes the Member supervision specific to the needs of a medically stable, physically disabled child. Includes: • Skilled or nursing care • Housekeeping activities • Supportive services for the absence, loss, diminution, or impairment of a physical or cognitive function. May be self-directed as personal assistant delegated services.

Service	Description
Community Care Management Agency (CCMA)	For members living in Community Care Foster Family Homes and other community settings, services by a CCMA include: • Nurse delegation to the caregiver • Identifying needed services, supplies, and equipment • Face-to-face monitoring • Use of the health action plan • Assisting the caregiver with undesired effects and/or changes in condition of members
Community Care Foster Family Home (CCFFH)	Services provided in a State-certified private home by a principal care provider who lives in the home. CCFFH may accept up to three adults each. Services include: • Personal and supportive care • Homemaker • Chores • Companion services • Nursing • Medication oversight (as permitted under state law)

Service	Description
Counseling and Training	Counseling and training serviced provided to the Members, families/caregivers, and professional and paraprofessional caregivers on behalf of the Member. Provided individually or in groups. Provided at the Member's home or an alternative site. Counseling and training activities include: • Member care training for members, families, 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 HAP • Employer skills updates as needed to safely maintain the individual and home • Crisis intervention • Supportive counseling • Family therapy • Suicide risk assessments and intervention • Death and Dying counseling • Anticipatory grief counseling • Substance Abuse Disorder counseling • Nutrition assessment and counseling on coping skills to deal with stress caused by member's deteriorating functional, medical, mental status
Companion Services	Non-medical care, supervision, and socialization prior approved by a service coordinator and documented in the health action plan.
Environmental Accessibility Adaptations (EAA)	Physical changes to the member's home required by the HAP, Medically Necessary to ensure the health, welfare, and safety of the member, allowing the member to stay at home as much as possible. Without these adaptations, the member would require institutionalization. Includes: • Installation of ramps and grab-bars • Widening of doorways • Modification of bathroom facilities • Installation of specialized electric and plumbing systems Window air conditioners may be installed when it is necessary for the health and safety of the Member.

Service	Description
	Not covered: Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual. Examples include carpeting, roof repair, central air conditioning, etc. Adaptations 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.
Home Delivered Meals	Home-delivered meals are provided to individuals who cannot prepare nutritionally-sound meals without help and need meal services to stay independent in the community and to prevent institutionalization. Home-delivered meals are nutritional and delivered to a member's home. Excludes residential or institutional settings. Two meals a day.
Home Maintenance	Services to maintain a safe, clean, and sanitary environment. Services not included as a part of personal assistance. Including: • Heavy-duty cleaning • Minor repairs to essential appliances (to stoves, refrigerators, and water heaters) • Fumigation or extermination services For individuals who cannot perform cleaning and minor repairs without assistance and are assessed, to need the services in order to prevent institutionalization.
Moving Assistance	May be provided in rare cases for members assessed by Heath Coordination team and found that the Member needs to move to a new home. For example: • Unsafe deteriorating home • Member is evicted from current home • Member is not able to afford home due to a rent increase • Wheelchair bound member living above the first floor of a multi-story building without elevator • Home is unable to support the Member's additional needs for equipment • Moving expenses include packing and moving of belongings
Non-Medical Transportation	Offered to enable individuals to gain access to community services, activities, and resources, specified by the HAP. Only when not included in the HCBS service being accessed. Members living in a residential care setting or a CCFFH are not eligible for this service. This does not replace medical transportation.

Service	Description
Nursing Facility (NF), Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF)	Services provided in a nursing facility licensed and certified to provide skilled nursing and rehabilitative services on a regular basis. Nursing facility members require assistance 24 hours a day with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) and need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis. Services include skilled nursing, health-related care, and rehabilitative services on a regular basis in an inpatient facility. Services in a nursing facility include 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.

Personal Assistance Service Level I (PA1)	For members who are not living with their family and may need help with their daily activities.
	May be self-directed by the member and include:
	• Companion services (meal prep, laundry, errands) – prior approval needed.
	• Homemaker/chore services including:
	  • Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish
	  • Care of clothing and linen by washing, drying, ironing, mending
	  • Shopping for household supplies and personal essentials (not including cost of supplies)
	  • Light yard work, such as mowing the lawn
	  • Simple home repairs, such as replacing light bulbs
	  • Preparing meals
	  • Escorting the member to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the health action plan, when no other resource is available
	  • Providing standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer
	  • Reporting and/or documenting observations and services provided, including observation of member self- administered medications and treatments, as appropriate
	  • Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate a change in service provided

Service	Description
Personal Assistance Service Level II (PA2)	For members needing: • Moderate to total assistance with activities of daily living and health maintenance activities May be self-directed and consist of the following • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing • Assistance with bowel and bladder care • Assistance with ambulation and mobility • Assistance with transfers • Assistance with medications, which are ordinarily self-administered when ordered by member's physician • Assistance with feeding, nutrition, meal preparation and other dietary activities • Assistance with exercise, positioning, and range of motion • Taking and recording vital signs, including blood pressure • Measuring and recording intake and output, when ordered • Collecting and testing specimens as directed • 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 • 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 • Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service • 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 health action 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. Provided by Home Health Aide, Personal Care Aide, Certified Nurse Aide or Nurse Aide.
Personal Emergency Response Systems (PERS)	Electronic device with a 24-hour emergency assistance service that helps members get secure immediate help in an emotional, physical, or environmental emergency. Individually designed to meet the needs and capabilities of the Member and includes training, installation, repair, maintenance, and response needs. Access to PERS may be through an electronic device for Members at high risk of institutionalization to secure help in an emergency. Or the Member

Service	Description
	may wear a portable "help" button to allow for mobility. The response center is staffed by trained professionals. Allowable types of PERS items include: • 24-hour answering or 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 (e.g., blinking lights, etc.) • Telephone adaptive devices not available from the telephone company • Other electronic devices or services designed for emergency assistance Limited to those individuals: • Living alone • Alone for significant parts of the day • Have no regular caregiver for extended periods of time • Who would otherwise require extensive routine supervision Only provided to Members residing in a non-licensed setting except for an ALF.
Residential Care Services or Type I or Type II Expanded Adult Residential Care Home (E-ARCH)	Services provided in a licensed private home by a principle care provider who lives in the home. Includes: • Personal care • Nursing • Homemaker • Chores • Companion services • Medication oversight (provided by a principle care provider who lives in the home) Residential care is furnished: • In a Type I E-ARCH, five or fewer residents provided that up to six residents may be allowed at the discretion of DHS to live in a Type I home with no more than three residents of whom may be NF LOC

Service	Description
	• In a Type II E-ARCH, six or more residents, where no more than 20 percent 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 shall be receiving ongoing CCMA services.
Respite Care	May be provided on a short-term basis to individuals unable to care for themselves. Respite may be provided hourly, daily, or overnight in the following locations: individual's home or place of residence; CCFFH; E-ARCH; Medicaid-certified NF; licensed respite day care facility; or other community care residential facility approved by the State.
Skilled (or Private Duty) Nursing	For members requiring ongoing nursing care at home or in the community, provided by licensed nurses. Services may be self-directed under personal assistance level II/delegated using nurse delegation procedures as outlined in HRS §457-7.5 and the Health Plan Manual.
Specialized Medical Equipment and Supplies (SMES)	Refers to the purchase, rental, lease, warranty costs, assessment costs, installation, repairs, and removal of devices, controls, or appliances, as specified in the health action plan that enable individuals to increase and/or maintain their abilities to perform ADL, or to perceive, control, participate in, or communicate in the environment in which they live. Services include but are not limited to: • Items necessary for life support • Specialized infant car seats • Modification of parent-owned motor vehicle to accommodate the child, e.g. wheelchair lifts • Intercoms for monitoring the child's room • Shower seat • Portable humidifiers • Electric utility bills specific to electrical life support devices (e.g., 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

Service	Description
	• Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month. Items reimbursed shall be in addition to any medical equipment and supplies furnished under the MSP 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.
Subacute Facility Services	Members do not require acute care but need more intensive skilled nursing. Services provided in: • A licensed nursing facility • A licensed and certified hospital
Community Integrattion Services (CIS)	
To be eligible, you need to be eighteen (18) years of age or older to be eligible. Also, you must meet the following to qualify for CIS: 1. Be chronically homeless, or 2. Currently homeless and have one of the qualifying health conditions listed below, or 3. Living in an institution and cannot leave without stable housing and have one of the qualifying health conditions listed below, or 4. Living in public housing and at risk of being kicked out and have one of these qualifying health conditions: • A mental health disorder affecting one or more major life activities, or • Diagnosed with substance use disorder, or • Have a chronic physical or complex health needs, or • Go to the emergency department or inpatient hospital often. CIS is divided into three categories: (1) pre-tenancy services, (2) tenancy services, and (3) other housing and tenancy support services.	
Pre-tenancy services	Include: • Screening and assessments • Developing housing support assistance plan • Searching for housing • Preparing and submitting applications • Identifying needs for start-up • Identifying equipment, technology, and other changes needed • Reviewing safety of housing • Moving assistance • Housing crisis plan
Tenancy services	Include: • Identifying and assisting with behavioral management

Service	Description
	• Educating you about roles and responsibilities of tenant/landlord • Coaching you how to develop and maintain relationships with landlords/property managers • Teaching you how to resolve disagreement with your landlords/neighbors • Connecting you with supportive groups to help prevent you from being kicked out of your home • Housing recertification process • Updating/maintaining housing assistance and crisis plans • Developing skills for daily living and maintaining your home • Coordinating Service care • Managing housing crisis
Community Transition Services	Include: • Case Management Services: o Moving into stable housing o Assessing the unit's and Member's readiness for move-in o Assisting the Member in obtaining furniture and commodities • Housing Quality and Safety Improvement Services. o Repairs or remediation for issues such as mold or pest infestation if cost effective method of addressing occupant's health condition, as documented by a health care professional, and not covered under any other program. • Legal Assistance. o Connecting to expert community resources to address legal issues impacting housing and health, such as assistance with breaking a lease due to unhealthy living conditions. • Securing House Payments. o Provide a one-time payment for security deposit and/or first month's rent provided that such funding is not available through any other program. Once for each Member, except for State determined extraordinary circumstances such as a natural disaster.
Other Services	
Certification of Physical/Mental Impairment	Coverage for evaluations and re-evaluations of disabilities.
Advance Care Planning	Voluntary advance care planning services between a provider and the Member with or without completing relevant legal forms as described in 42 CFR §438.3.(j).
Hospice Care	A program that provides care to terminally ill patients who are not expected to live more than six months. A participating hospice provider shall meet Medicare requirements.

Service	Description
	Children under the age of twenty-one years may receive treatment to manage or cure their disease while concurrently receiving hospice services.

Value-Added Services

Service	Description	Eligibility
Inpatient Palliative Care	Palliative care focuses on providing total care to our members with chronic, potentially life limiting illness. The care focuses on the physical, spiritual, emotional, and social needs of the member and family. Our goal is to relieve suffering in all its manifestations. We provide this care through an interdisciplinary team including physician, nurse, social worker, and chaplain. Palliative care focuses on symptoms management and alleviating the stress and suffering of a chronic illness.	Members with life limiting illness in hospital setting Prior Authorization required.
Medical Respite	When a member is discharging from the hospital and has lingering medical needs but does not have stable housing, **Kaiser Permanente** contracts with providers for medical respite housing which includes case management services.	Members with medical need for follow-up care and unstable housing Prior Authorization required
Aqua Therapy	We offer aqua or hydrotherapy to members in need of physical therapy during recovery from injury or to manage chronic pain when they cannot tolerate land-based physical therapy (PT) and meet medical necessity criteria. Aqua therapy takes place in a salt-water based, heated pool with expert physical therapists.	At physician discretion for members who cannot tolerate land-based PT Prior Authorization required
Remote Monitoring Technology	**Kaiser Permanente** provides blood pressure cuffs, pulse oximeters, and glucose monitors to some members with chronic conditions. In some cases, the devices are integrated with KPHC and automatically feed readings into the member's health record.	At physician discretion Prior Authorization required
Behavioral Health Self-care Apps	**Kaiser Permanente** offers members free access to: Calm and Headspace online behavioral health applications to help with mild-to-moderate depression, anxiety, and sleep issues. They are also high quality, secure, and confidential.	All **Kaiser Permanente** members https://healthy.kaiserpermanente.org/hawaii/health-wellness/mental-health/tools-resources/digital
Lifestyle Medicine Program	**Kaiser Permanente's** Lifestyle Medicine Program offers a wide variety of classes, coachinq, and other resources to improve members' health and wellbeing. Classes range from weight loss,	All **Kaiser Permanente** members

	nutrition, and exercise to sleep, hygiene, and unlimited attempts at smoking cessation. It also includes individual health coaching for all members.	https://kpinhawaii.org/our-services **https://kpinhawaii.org/our-services**

Covered by DHS Med-QUEST but not by Kaiser Permanente

Some services are not covered by your medical plan. Members can get these services in other ways.

- **Dental care:** The DHS, not Kaiser Permanente, covers dental services. Some limitations and prior authorization may apply.

Dental Services are now available to eligible members over the age of 21. **Some limitations and prior authorization may apply.** Effective January 1, 2023, covered services include the following:

Services	Description and Limitation
Preventative Services	• **Comprehensive Oral Evaluation – Once every 5 years** • **Periodic screening examinations - 2 per year** • **Prophylaxis - 2 per year** • **Topical fluoride or fluoride varnish - 2 per year**
Diagnostic and Radiology Services	• **Bitewing x-rays - 2 per year** • **Full series x-rays – 1 every 5 years** • **Periapical x-rays** • **Biopsies of oral tissue**
Endodontic Therapy Services	• **Root canal therapy on permanent molars**
Restorative Services	• **Amalgams on primary and permanent posterior teeth** • **Composites on anterior and posterior teeth** • **Pin and/or post reinforcement** • **Cast cores** • **Recement inlays and crowns** • **Stainless steel crowns**
Oral Surgery	
Periodontal Therapy Services	• **Scaling and root planning – one every 24 months**
Prosthodontic Service	• **Complete Upper and Lower Dentures – one every 5 years** • **Partial Dentures – one every 5 years** • **Denture relines -- one every 2 years** • **Repairs**
Emergency and Palliative Treatment	• **Gingivectomy, for gingival hyperplasia** • **Other medically necessary emergency dental services**

For help finding a dentist, call Community Case Management Corporation (CCMC) at 808-792-1070 or toll-free at 1-888-792-1070. CCMC can explain the covered dental benefits and help you find a dentist near you..

- **Elective abortions or intentional termination of pregnancy (ITOP):** Intentional terminations of pregnancy (ITOP) are not covered by Kaiser Permanente. They are covered by the Med-QUEST Division (MQD). You will need authorization. Your provider shall contact MQD's Clinical Standards Office (CSO), on ITOP requests. MQD can also arrange transportation.

- **State of Hawaii Organ and Tissue Transplant (SHOTT) Program:** DHS provides transplants through the SHOTT program. Covered transplants must be non-experimental, non-investigational for the specific organ/tissue and specific medical condition being treated. These transplants may include liver, heart, heart-lung, lung, kidney, kidney-pancreas, and allogenic and autologous bone marrow transplants. In addition, children may be covered for transplants of the small bowel with or without liver. Children and adults must meet specific medical criteria as determined by the State and the SHOTT program contractor. We can help with a referral to the SHOTT Program when it is medically appropriate.

Services from other agencies in the community:

- **Early Intervention Program (EIP)** provides services for children 0 – 3 years of age with special needs. Services are provided in places where a child lives, learns, and grows. Parents and/or caregivers are coached on how to help their child succeed in their environment. Services covered include: Assistive Technology, occupational therapy, physical therapy, psychology services, special instruction, speech-language pathology, and vision services. For more information, call 808-594-0066.
- **Honolulu Community Action Program (HCAP) – Head Start**
  This is a federal program to help prepare children ages 3 – 5 years old for school. Some of the programs offered are part-day or full-day centers, home-based, Head Start DOE combined classrooms, and family activities. To apply, or for more information, call 808-847-2400.
- **Women, Infant and Children (WIC)** - This program helps low-income, nutritionally at-risk pregnant women, new moms, and children under age 5 with healthy foods, nutrition education, screening and referrals to other health, welfare, and social programs. Some of the healthy foods are milk, eggs, cheese, cereal, peanut butter, fruits, vegetables, and infant food. For more information, call 808-586-8175 on Oahu or 1-888-820-6425.
- **Tuberculosis Control Program:** This program is for the diagnosis, treatment, identification, prevention, and appropriate therapy of tuberculosis. For more information, call the Tuberculosis Control Branch at 808-832-5731.
- **Hansen's Disease Community Program:** This program is for patients with Hansen's Disease. The program provides treatment, education, assistance to family members and health care providers, and helps patients obtain services. For more information, call the

Hansen's Disease Branch at 808-733-9831.

- **Community Care Services (CCS) Behavioral Health Program (provided by Ohana Health Plan)**: Adult Members eighteen (18) years or older with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) may be eligible for additional behavioral health service from the CCS program. Specialized behavioral health services include inpatient and outpatient therapy, tests to monitor the member's response to therapy, and intensive case management. For more information, call 1-888-846-4262.
- **Services for Individuals with Developmental Disabilities/Intellectual Disabilities (DD/ID):** The DOH Developmental Disability Division (DOH/DDD) provides intermediate care facility/ID services to some individuals. Kaiser Permanente and DOH/DDD coordinate activities for people with DD/ID. For more information, call 808-586-5840.
- **Support for Emotional and Behavioral Development (SEBD) for children:** Behavioral health services are available for children/youth less than twenty-one (21) with diagnosis of emotional and behavioral development disorders. The Department of Health, through its Child and Adolescent Mental Health Division (CAMHD) SEBD program provides behavioral health services, including transportation, to children and adolescents ages 3 through 20 who need intensive behavioral health services. To find out more, call one of the Family Guidance Centers listed below.

Family Guidance Center	Address	Phone Number	Fax Number
Pearl City Office	Central Oahu Family Guidance Center (COFGC) 860 Fourth Street, 2nd Floor Pearl City, Hawaii 96782	808-453-5900	808-453-5940
Family Court Liaison Branch (FCLB)	Hawaii Youth Correctional Facility 42-470 Kalanianaole Hwy. Building 03 Kailua, Hawaii 96734	808-266-9922	808-266-9933
Honolulu	Honolulu Oahu Family Guidance Center (HOFGC) 3627 Kilauea Avenue, Room 401 Honolulu, Hawaii 96816	808-733-9393	808-733-9377
Leeward Oahu	Leeward Oahu Family Guidance Center (LOFGC) 601 Kamokila Blvd., Room 355 Kapolei, Hawaii 96707	808-692-7700	808-692-7712
Kaneohe Office	Central Oahu Family Guidance Center (COFGC) 45-691 Keaahala Road Kaneohe, Hawaii 96744	808-233-3770	808-233-5659
Maui	Maui Family Guidance Centers (MFGC) 270 Waiehu Beach Road, Suite 213 Wailuku, Hawaii 96793	808-243-1252	808-243-1254

Services that are typically NOT covered under the QUEST Program

- Personal care items such as shampoos, toothpaste, toothbrushes, mouth washes, denture cleansers, shoes, slippers, clothing, laundry services, baby oil, sanitary napkins, diapers for babies, soaps, lip balm, bandages, and contact lens solution
- Non-medical items such as books, telephones, beepers, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items, motor vehicles or furnishings
- Experimental and/or investigative services, procedures, drugs, devices, and treatments; drugs not approved by the Federal Drug Administration (FDA)
- Treatment of complications resulting from previous cosmetic, experimental or investigative services, or other services that are not covered
- Treatment of baldness, including hair transplants and topical medications, wigs, and hairpieces
- Treatment of persons confined to public institutions
- All medical and surgical procedures, therapies, supplies, drugs, and equipment for the treatment of sexual dysfunction or inadequacies
- Penile or testicular prostheses and related services
- Reversal of sterilization, in vitro fertilization, artificial insemination, sperm banking procedures, fertilization by artificial means, and all procedures and drugs to treat infertility or enhance fertilization
- Bereavement counseling, employment counseling, primal therapy, long-term character analysis, marathon group therapy, and/or consortium
- Routine foot care, treatment of flat feet
- Swimming lessons, summer camp, gym membership, and weight control classes
- Beds – lounge beds, bead beds, water beds, day beds, overbed tables, bed lifters, bed boards, bed side rails if not an integral part of a hospital bed
- Contact lenses for cosmetic purposes, bifocal contact lenses
- Oversized lenses, blended or progressive bifocal lenses, tinted or absorptive lenses (except for aphakia, albinism, glaucoma, medical photophobia) trifocal lenses (except as a specific job requirement), spare glasses
- Refractive eye surgery
- Physical exams and/or psychological evaluations as a requirement for employment or as a requirement for continuing employment (e.g., truck and taxi drivers' licensing)
- Physical exams and/or psychological evaluations as a requirement for drivers' licenses or for the purpose of securing life and other insurance policies or plans
- Organ transplants not meeting the guidelines established by the Medicaid program and organ transplants not specifically identified as benefits
- Biofeedback, acupuncture, chiropractic services, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment (by masseurs), and any other form of self-care or self-help training and any related diagnostic testing
- Ambulance wait time, physician wait time, standby services, telephone consultations, telephone calls, writing of prescriptions, stat charges
- Treatment of pulmonary tuberculosis that is covered by DOH

- Treatment of Hansen's Disease that is covered by DOH
- Topical application of oxygen
- Orthoptic training
- Travel medicine
- OPTIFAST programs and supplements, bariatric classes, and supplies

Emergency Services

Definitions:
Emergency Medical Condition – 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 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 impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition shall not be defined based on lists of diagnoses or symptoms.

Emergency Services – Any covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish services and that are needed to evaluate or stabilize an emergency medical condition.

Emergency services from non-**Kaiser Permanente** practitioners are covered **ONLY** if the services meet the prudent layperson standard and the services were immediately required because it was an unforeseen illness or injury and the delay caused by coming to a **Kaiser Permanente** facility would have resulted in death, serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or placed the health of the individual in serious jeopardy. Continuing or follow up care from non-**Kaiser Permanente** providers is not covered, except for post-stabilization care while waiting to transfer care to Kaiser Permanente.

If a member is admitted to a non-**Kaiser Permanente** facility, the member or a family member must notify **Kaiser Permanente** within 48 hours after care begins (or as soon as reasonably possible) by calling the phone number on the back of their **Kaiser Permanente** identification card.

Urgent Care: Urgent care is defined as care for a sudden and unforeseen illness or injury which is required to prevent serious deterioration of the member's health and which cannot be delayed until the member is medically able to safely return to the Hawaii Service Area to receive care from a **Kaiser Permanente** practitioner (if outside the Hawaii Service Area), or to travel to a **Kaiser Permanente** facility.

When members are in need of urgent care, please contact the nearest clinic. After hours, call the **Kaiser Permanente** After Hours Advice Nurse (1-800-467-3011 from Neighbor Islands or **808-432-7700** from Oahu).

QUEST Health Coordination

Kaiser Permanente will identify those members who may be candidates for health coordination. For members new to **Kaiser Permanente** and subject to initial assessment requirements and timeframes, the determination of need for LTSS will be included in that assessment. Health coordination assignments will be determined by the LTSS Manager or someone on his/her behalf when the cases are received. Specifically, those who qualify for Health Coordination fall into seven (7) categories:

1. Adults with SHCN and EHCN
2. Children with SHCN and EHCN
3. Members receiving HCBS
4. Members choosing Self-Direction
5. Institutional LOC members residing in an institutional setting
6. Dual eligible
7. Community Integration Services (CIS)

While Medical Group physicians have ultimate responsibility as the manager of his or her panel of patients, an additional health coordination support system is available for eligible QUEST members. This system focuses on the use of licensed social workers, registered nurses, and para-professional staff to:

- Coordinate the timely access and use of medically necessary services.
- Direct and, as needed, assist QUEST enrollees in their use of the **Kaiser Permanente** system to obtain services
- Outreach to QUEST new member enrollees to familiarize them with the **Kaiser Permanente** health plan, link them to a Primary provider, and inform them of their benefits (preventative care, EPSDT, SHCN, EHCN, Chronic disease management, community resources, etc.).
- Assist with discharge planning for hospital patients.
- Track QUEST enrollees' compliance with prescribed treatment and assist their compliance by coordinating necessary patient education.
- Assist the provider to outreach to the QUEST enrollee for urgent matters in the clinic or at the enrollee's home.
- Refer members to other programs or agencies when care coordination services are not available at Kaiser

The PCP in conjunction with his or her support staff will be responsible for ensuring that recipients receive adequate information to permit them to make medically informed decisions about their health care needs.

QUEST service coordinators and support staff are located in the “hub” **Kaiser Permanente** clinics on the islands of Oahu and Maui. Communication through the electronic medical record allows all providers and support staff to have immediate access to pertinent medical and social information. Physicians, QUEST service coordinators and support staff are supported by

established systems within **Kaiser Permanente** to direct the QUEST member toward selected preventive services, track patients' scheduled appointments and, when necessary, remind them about the need to fulfill the visit.

Referrals to QUEST staff may be made by calling **808-432-5330** or **1-800-651-2237** (toll-free).

Services for children
Regular medical visits are very important to keep children as healthy as possible and reduce the spread of disease. Children's regular visits, examinations, immunizations (shots), and screening tests are included in well-child care at no cost.

For members under age 21, the QUEST program provides these preventative services in a program called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Children will be examined periodically to check for any illness. Checkups are needed more often in the child's first years and less often as he or she grows older (see examination and vaccine schedule on page 16). Some children look healthy but have hidden health problems. Screening tests, such as blood tests, give the doctor information about the child's health. If any health problems are found, the doctor looks for the cause, makes a diagnosis, and orders treatment.

These medically necessary services, including behavioral therapy for children, are provided at no cost to you. The behavioral therapies include intensive behavioral therapy for children with autism spectrum disorder (ASD), including applied behavioral analysis (ABA) for the treatment of children with an ASD diagnosis.

Reminders of the next EPSDT appointment will be made by phone and email through kp.org. Here is what to expect at the child's EPSDT checkups:

- Height, weight, and blood pressure checks
- Eye exams
- Hearing tests
- Lab tests
- Immunizations
- Screening for lead, tuberculosis (TB) and other conditions
- Mental and physical assessment
- Screening for behavioral health issues or substance abuse
- Review of medications (including fluoride and multivitamins)
- Referrals to specialist or dentist, if needed
- Health education and guidance about the child's health care
- Education and guidance for the child's growth and development
- Information regarding accessing care, such as appointments, advice nurse, or after-hours care

The schedule on the next page may be used to remind parents when to make appointments for their child. Parents should let the child's health care provider know if the child is ill or taking

medicines (such as steroids) that may suppress their immunity. This schedule may change based on the child's health care needs. Please check with the child's health care provider.

Physical exams are advised once yearly from age 2 – 6 years, then once every other year. More exams may be needed depending on the child's health care needs. Rotavirus vaccine for 2 and 4 months of ages only. TB risk assessment will be done with each physical exam starting from 2 years of age and annually up to 17 years of age. The TB skin test will only be done if the risk assessment is positive.

YOUR HEALTHY CHILD'S EXAMINATION AND VACCINE SCHEDULE

AGE	APPOINTMENT TYPE	VACCINE TYPE
2-3 days	Physical exam	Hepatitis B (HepB) administered at birth
2–3 weeks	Physical exam	Catch up immunizations if needed
2 months	Physical exam with shots	Diphtheria-Tetanus-acellular Pertussis (DTaP), Haemophilus Influenza B (Hib), Polio, Pneumococcal Conjugate Vaccine (PCV), HepB, Rotavirus
4 months	Physical exam with shots	DTaP, Hib, Polio, PCV, Rotavirus, Hep B if part of combo vaccination
6 months	Physical exam with shots	DTaP, Hib, Polio, PCV, HepB
9 months	Physical exam	Catch up immunizations if needed
12–13 months	Physical exam with shots	TB risk assessment if indicated at 12 months of age (TB skin test done if risk assessment positive), Hepatitis A, Measles-Mumps-Rubella (MMR), Varicella
15 months	Physical exam with shots	DTaP, Hib, PCV
18 months	Physical exam with shots	Hepatitis A
23–24 months	Physical exam	Catch up immunizations if needed
3 years	Physical exam with shots	MMR, Varicella
4 years	Physical exam with shots	DTaP, Polio
5 years	Physical exam with shots	DTaP, Polio (if not done at age 4 years)
6 years	Physical exam	Catch up immunizations if needed
7–13 years	Physical exam with shots	Physical done yearly. 9 years: Human Papillomavirus (HPV) series of two doses for both girls and boys; 11- 12 years: Tetanus-Diphtheria-acellular Pertussis (Tdap); Meningococcal
14–20 years	Physical exam with shots	Physical done yearly. Meningococcal booster. Catch up vaccines if needed

All persons ages 6 months and older should receive annual flu vaccination

Definitions

Abuse -– Any of the following:

- Practices (fiscal, business, or medical) that are not sound and cost more;
- Payments to providers for services not medically necessary;
- Payments to providers for services that do not meet professional standards for health care in a managed care setting;
- Payments to providers for services not in the contract for duties for health care in a setting;
- Events or medical practices of providers that are not sound.

Activities of Daily Living (ADLs) – Activities a person performs on a daily basis, for self-care, such as:

- feeding,
- grooming,
- bathing,
- dressing and
- toileting.

Acute Care – Medical care provided under the direction of a physician at a hospital for a condition requiring inpatient care and having a relatively short duration.

Adult - All members age of twenty-one (21) years or older for coverage benefit purposes only.

Adult Day Care Center – A licensed facility that is maintained and operated by an individual, organization, or agency for the purpose of providing regular care which includes supportive care to four (4) or more disabled adults.

Adult Day Health Center – A licensed facility that provides organized day programs of therapeutic, social, and health services for adults with physical or mental impairments, or both. Members requiring nursing oversight or care. For the purpose of restoring or maintaining, to the fullest extent possible, their ability for remaining in the community.

Adult group - Individuals who obtain Medicaid eligibility in accordance with Hawaii Administrative Rules, 17-1718.

Advance Directive - A written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to provision of health care when the individual is incapacitated.

Adverse Benefit Determination - 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 regarding the standard resolution of grievances and appeals;
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

  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
  - The State determines that other circumstances warrant out-of-network treatment.

Aged, Blind, or Disabled (ABD) – A category of eligibility under the State Plan for persons who are aged (sixty-five [65] years of age or older), legally blind, and/or disabled.

Ambulatory Care - Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other PCPs.

Appeal - A review by the health plan and State Administrative Appeal of an adverse benefit determination.

Appointment – A face-to-face interaction between a provider and a member. This does include interactions made possible using telemedicine but does not include telephone or e-mail interaction.

Assisted Living Facility – A licensed facility that consists of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.

Attending Physician – A medical doctor (MD) or a doctor of osteopathy (DO), authorized to practice medicine and surgery by the State, who orders and directs the services required to meet the care needs of a Medicaid Member. The attending physician may be a physician from a group practice who is designated as the primary physician or an alternate physician that has been delegated the role of the attending physician by the Member's initial attending physician during the physician's absence. At the time he or she elects to receive hospice care, the attending physician has the most significant role in the determination and delivery of the individual's medical care**.**

Authorized Representative – A person who can make care- related decisions for a member who is not able to make such decisions alone. A representative may, in the following order of priority, be a person who is:

- A court-appointed guardian of the person;
- A spouse or other family member (parent) as designated by the member or the State according to HRS 327 E-5; or
- Any other person who is not court-appointed, not a spouse or other family member who is designated as the member's healthcare representative according to HRS 327 E-5.

Auto-Assignment – The process utilized by DHS to enroll Members into a Health Plan, using predetermined algorithms, who (1) are not excluded from Health Plan participation and (2) do not proactively select a Health Plan within the DHS-specified timeframe. Also, the process of assigning a new Member to a primary care physician chosen by the Health Plan, pursuant to the provisions of this Contract.

Behavioral Health Services – The full continuum of services from screening to specialty treatment services to support individuals who have mental health and substance use needs, including those with mild to moderate conditions, emotional disturbance, mental illness, or substance use conditions**.**

Benchmark – A target, standard, or measurable goal based on historical data or an objective/goal.

Beneficiary – An individual who has been determined eligible and is currently receiving Medicaid.

Benefit Year – A continuous twelve (12)-month period generally following an open enrollment period. In the event the contract is not in effect for the full benefit year, any benefit limits shall be pro-rated.

Benefits - Those health services that the member is entitled to under the QUEST program and that the health plan arranges to provide to its members.

Breast and Cervical Cancer Program – A program implemented by the State of Hawaii, Department of Health (DOH) to detect breast and cervical cancer or pre-cancerous conditions of the breast or cervix. Enrolled individuals receive treatment in the QUEST program when referred by DOH.

Care Team – A team of healthcare professionals from different professional disciplines who work together to manage the physical, behavioral health, and social needs of the Member.

Centers for Medicare & Medicaid Services (CMS) – The United States federal agency which administers the Medicare program and, working jointly with state governments, the Medicaid program, and the SCHIP.

Child and Adolescent Mental Health Division (CAMHD) - A division of the State of Hawaii Department of Health that provides behavioral health services to children ages three (3) through twenty (20) who require support for emotional or behavioral development.

Children - All members under the age of twenty-one (21) years of age for coverage benefit purposes only.

Children's Health Insurance Program (CHIP) or State Children's Health Insurance Program (SCHIP) – A joint federal-state healthcare program for uninsured, targeted, low-income children, established pursuant to Title XXI of the Social Security Act that is implemented as a Medicaid expansion program in Hawaii.

Chronic Condition – Any on-going physical, behavioral , or cognitive disorder. Including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms and service use or needs beyond what is normally considered routine.

Claim - A bill for services, a line item of services, or all services for one member within a bill.

Code of Federal Regulations (CFR) – The codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.

Cold-Call Marketing – Any unsolicited personal contact, whether by phone, mail, or any other method, by the Health Plan with a potential Member, Member, or any other individual for marketing.

Community Care Foster Family Home (CCFFH) - A home that is certified by the State DOH to provide an individual with twenty-four (24) hour a day living accommodations and home and community-based services (HCBS).

Community Care Management Agency (CCMA) - An agency that is involved with

- locating,
- coordinating and
- monitoring services to residents in community care family homes or members in E-ARCHs and assisted living facilities.

A health plan may be the owner of a community care management agency.

Community Care Services (CCS) – A behavioral health program administered by DHS. CCS provides eligible adult Members specialized behavioral health services to severe mental illness (SMI) and severe and persistent mental illness (SPMI).

Community Health Worker (CHW) – A frontline public health worker who is a trusted Member of and/or has a close understanding of the community served to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW serves as an integral Member of the care team, providing in-home visits, accompanying Members to provider visits as needed, and assisting Members with healthcare needs.

Community Integration Services (CIS) – Pre-tenancy supports and tenancy sustaining services that support individuals to be ready and successful tenants in housing that is owned, rented or leased to the individual.

- Pre-Tenancy services help to identify the individual's needs and preferences. Also, assists in the housing search process, and provides help to arrange details of the move.
- Tenancy services help with independent living maintaining. Includes:
    - tenant/landlord education,
    - tenant coaching and
    - assistance with community integration and inclusion to help develop natural support networks.

Community Paramedic (CP) – An advanced paramedic that works to increase access to primary and preventive care and decrease use of emergency departments, which in turn decreases healthcare costs. Among other things, CPs may play a key role in providing follow–up services after a hospital discharge to prevent hospital readmission. CPs can provide health assessments, chronic disease monitoring and education, medication management, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow–up care, and minor medical procedures. CPs work under the direction of an Ambulance Medical Director.

Community Transition Services (CTS) – A pilot program within the CIS benefit. This program is designed to address eligible beneficiaries' specific health determinants to improve health outcomes and lower healthcare costs. CTS program benefits include transitional case management services, securing house payments, housing quality, safety improvement services, and legal assistance. CTS program benefits are authorized by CMS and shall be provided to all beneficiaries who meet CIS eligibility criteria on a voluntary basis.

Comprehensive Risk Contract – A risk contract that covers comprehensive services including, but not limited to inpatient hospital services, outpatient hospital services, rural health clinic services, federally qualified health center (FQHC) services, laboratory and x-ray services, early and periodic screening, diagnostic, and treatment (EPSDT) services, LTSS, and family planning services.

Conspicuously Visible – Individuals seeking services from, or participating in, the health program or activity could reasonably be expected to see and be able to read the information that is sufficiently conspicuous and visible as defined by HHS Office of Civil Rights at 45 CFR §92.8(f)(1).

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – A comprehensive set of surveys that ask consumers and patients to report on and evaluate various aspects of quality of their healthcare. The acronym CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Contract – The contract between the Health Plan and DHS to provide medical services. The written agreement between DHS and the contractor that includes the Competitive Purchase of Service (AG Form 103F1 [10/08]), General Conditions for Health and Human Services Contracts (AG Form 103F [10/08]), any special conditions and/or appendices, this RFP, including all attachments and addenda, and the Health Plan's proposal.

Contract Services – The services to be delivered by the contractor that are designated by DHS.

Contractor – Successful applicant that has executed a contract with DHS.

Co-Payment – The amount that a Member shall pay, usually a fixed amount of the cost of a service.

Cost-Neutral – When the aggregate cost of serving people in the community is not more than the aggregate cost of serving the same (or comparable) population in an institutional setting.

Covered Services - Those services and benefits to which the member has a right to under Hawaii's Medicaid programs.

Critical Access Hospital (CAH) – A hospital designated and certified as a CAH under the Medicare Rural Hospital Flexibility Program.

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members. This requires a willingness and ability to draw on community- based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications and other supports.

Days - Unless otherwise specified, the term "days" refers to calendar days .

Dental Emergency - An oral condition that does not include services aimed at restoring or replacing teeth and shall include services for relief of dental pain, remove serious infection, treat serious injuries to teeth or supportive structures of the oral-facial complex.

Department of Health, Developmental Disabilities Division (DOH-DDD) – The DOH-DDD provides services for persons with intellectual and/or developmental disabilities (I/DD). Most services provided are through the Medicaid 1915(c) HCBS Waiver for individuals with I/DD to support these participants to live in their homes and communities through services that promote each person's self-determination, health, community integration, and safety (Section 1915(c) of the Social Security Act).

Department of Human Services (DHS) – Department of Human Services, State of Hawaii.

Department of Health and Human Services (DHHS) – United States Department of Health and Human Services.

Director – The administrative head of the department of human services unless otherwise specifically noted.

Dual Eligible – Member eligible for both Medicare and Medicaid.

Dual Eligible Special Needs Plan (D-SNP) – A dual eligible special needs plan that enrolls beneficiaries who are entitled to both Medicare (Title XVIII) and Medicaid (Title XIX Medical Assistance from a State Plan). D-SNPs are defined in the federal regulations at 42 CFR §422.2 and authorized at Section 1859 of the Social Security Act.

Durable Medical Equipment (DME) – Medical equipment that is ordered by a doctor for use in the home. These items shall be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – EPSDT services aim to identify physical or mental defects in individuals and provide healthcare, treatment, and other measures to correct or ameliorate any defects and chronic condition discovered in accordance with Section 1905r of the Social Security Act. EPSDT includes services to:

- Seek out individuals and their families and inform them of the benefits of prevention and the health services available;
- Help the individual or family use health resources, including their own talents, effectively, and efficiently; and
- Ensure the problems identified are diagnosed and treated early before they become more complex and their treatment more costly.

Effective Date of Enrollment – The date as of which a participating health plan is required to provide benefits to an Member.

Eligibility Determination - An approval or denial of eligibility for medical assistance, as well as a redetermination or termination of eligibility for medical assistance. .

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

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman, or her unborn child) in serious jeopardy;
- Serious impairment of body functions,
- Serious dysfunction of any bodily functions;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman who is having contractions:
    - That there is inadequate time to affect a safe transfer to another hospital before delivery; or
    - That transfer may pose a threat to the health or safety of the woman or her unborn child.

Emergency Medical Transportation – Ambulance services for an emergency medical condition.

Emergency Room Services – Emergency services provided in an emergency room.

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

Encounter – A record of medical services rendered by a provider to a Member enrolled in the Health Plan on the date of service.

Encounter Data – A compilation of encounters.

Enrollment - The process by which an individual, who has been determined eligible, becomes a member in a health plan, subject to the limitations specified in the DHS Rules.

Enrollment fee - The amount a Member is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long-term care services. A resident of an intermediate care facility for I/DD or a participant in the

Medicaid waiver program for individuals with developmental disabilities or intellectual disabilities are exempt from the enrollment fee.

Excluded Services – Healthcare services that health plan does not pay for or cover.

Expanded Adult Residential Care Home (E-ARCH) – A licensed facility that provides twenty-four (24) hour living accommodations. There is a fee. For adults unrelated to the family. The member requires at least minimal assistance in the: activities of daily living, personal care services, protection, and healthcare services. And who may need the professional health services provided in an intermediate care or skilled nursing facility . There are two types of expanded care ARCHs in accordance with Section 321-15.62, HRS:

- Type I – home allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the department to live in a type I home, with no more than three (3) nursing facility level residents; and
- Type II – home allowing six (6) or more residents with no more than twenty percent (20%) of the home's licensed capacity as nursing facility level residents.

Expanded Health Care Needs (EHCN) – A Member that has complex, costly health care needs and conditions, or who is at risk of developing these conditions is imminent. The Members that meet EHCN criteria are considered to be highly impactable and likely to benefit from health coordination services (HCS).

Federal Financial Participation (FFP) – The contribution that the federal government makes to State Medicaid programs.

Federal Poverty Level (FPL) – The federal poverty level (FPL) updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 USC §9902(2), as in effect for the applicable budget period used to determine an individual's eligibility in the medical assistance programs.

Federally Qualified Health Center (FQHC) – An entity that has been determined by the Secretary of the DHHS to meet the qualifications for an FQHC, as defined in Section 1861(aa)(4) of the Social Security Act.

Federally Qualified Health Maintenance Organization (HMO) – An HMO that CMS has determined is a qualified HMO under Section 1310(d) of the Public Health Service Act.

Fee-for-Service (FFS) – A method of reimbursement based on payment for specific services rendered to an individual eligible for coverage under Med-QUEST.

Financial Relationship – A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes an indirect ownership or investment interest no matter how many levels removed from a direct interest or a compensation management with an entity.

Fraud - An intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to the individual or some other individual. It includes any act that constitutes fraud under applicable federal or state laws.

Grievance - An expression of dissatisfaction from a Member, Member's representative, or provider on behalf of a Member about any matter other than an adverse benefit determination.

Grievance Review - A State process for the review of a denied or unresolved grievance by a Health Plan, including instances where the aggrieved party is dissatisfied by the proposed resolution.

Habilitation Devices – Devices that support the provision of Habilitation Services in inpatient and/or outpatient settings. Habilitation devices include but are not limited to:

- Mobility devices, such as wheelchairs, motorized scooters, walkers, crutches, canes, prosthetic devices, orthotic braces, and other orthotic devices.
- Devices that aid hearing loss, including hearing aids, cochlear implants (pediatric and adult), and hearing assistive technology.
- Devices that aid speech include DME, and augmentative and alternative communication devices, such as voice amplification systems.
- Prosthetic eyeglasses and prosthetic contact lenses for the management of a congenital anomaly of the eye.
- Dental devices (not for cosmetic purposes).

Habilitative/Habilitation Services – Healthcare services that help to keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Action Plan (HAP) – A person-centered individualized plan that is developed with the Member and/or authorized representative based on the SHCN, expanded health care needs (EHCN), or LTSS assessment conducted by the Health Coordinator. A HAP includes, but is not limited to, the following: LTSS assessment conducted by the Health Coordinator. A HAP includes, but is not limited to, the following:

- Person-centered goals, objectives, or desired outcomes;
- A list of all services and interventions required (Medicaid and non-Medicaid), the amount, the frequency and duration of each service, and the type of provider to furnish each service.
- A description how all clinical and non-clinical healthcare-related needs and services will be coordinated, including coordination with outside entities providing supports for the Member.
- For Members receiving HCBS, the HAP shall be developed consistent with 42 CFR §441.301(c).
- The HAP is regularly reviewed, updated, and agreed upon by the Member or authorized representative with the entity providing health coordination.

Healthcare Professional – A physician, podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse, licensed clinical social worker, nurse practitioner, or any other licensed or certified professional who meets the State requirements of a health care professional.

Healthcare Provider – Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State.

Health Information Exchange (HIE) – HIE allows doctors, nurses, pharmacists, other Healthcare Providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

Health Insurance – A contract that requires the health insurer to pay some or all of healthcare costs in exchange for a premium.

Health Maintenance Organization (HMO) – See Managed Care Organizations.

Health Plan - Any health care organization, insurance company, accountable care organization, health maintenance organization, or managed care organization that provides covered services on a risk basis to enrollees in exchange for capitated payments.

Health Plan Manual – DHS manual contains operational guidance, policies, and procedures required of the Health Plan participating in QUEST. It will clarify reporting requirements and metrics used by DHS to oversee and monitor the Health Plan's performance. The Health Plan Manual, as amended or modified, is incorporated by reference into the Contract.

Health Professional Shortage Area (HPSA) – An area designated by the United States DHHS' Health Resources and Services Administration (HRSA) as being underserved in primary medical care, dental, or mental health providers. These areas can be geographic, demographic, or institutional in nature.

Health Insurance Portability and Accountability Act (HIPAA) – The Health Insurance Portability and Accountability Act that was enacted in 1996.

Home and Community Based Services (HCBS)- Long-term care services provided to an individual residing in a community setting who is certified by DHS to be at the nursing facility level of care (LOC) and would be eligible for care provided to an individual in a nursing facility or a medical facility receiving nursing facility LOC.

Hospital - Any licensed acute care facility in the service area to which a member is admitted receiving inpatient services pursuant to arrangements made by a physician. Acute care hospitals may additionally be designated as CAHs, as defined by the Medicare Rural Hospital Flexibility Program.

Hospital Outpatient Care – Care in a hospital that usually does not require an overnight stay.

Hospital Services - Except as expressly limited or excluded by this agreement, those medically necessary services for registered bed patients that are generally and customarily provided by licensed acute care general hospitals in the service area and prescribed, directed, or authorized by the attending physician or other provider.
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Hospitalization – Care in a hospital that requires admission as an inpatient for an overnight stay. An overnight stay for observation could be outpatient care.

In Lieu of Service (ILS) – Under the federal Medicaid managed care rules (42 CFR 438.3[e][2]), ILS substitute for services or settings covered in a state plan because they are a cost-effective alternative. The actual costs of providing the ILS are included when setting capitation rates, and they also count in the numerator of the medical loss ratio. ILS, however, can only be covered if the State determines the service or alternative setting is a medically appropriate and cost-effective substitute or setting for the State Plan service; if beneficiaries are not required to use the ILS; and if the ILS is authorized and identified in the contract with Medicaid managed care plans.

Incentive Arrangement – Any payment mechanism under which a Health Plan may receive funds for meeting targets specified in the contract; or any payment mechanism under which a provider may receive additional funds from the Health Plan for meeting targets specified in the contract.

Indian – The term "Indians" or "Indian", unless otherwise designated, means any person who is a Member of an Indian tribe, as defined in this §2.6, except that, for the purpose of 25 USC §§1612 and 1613, such terms shall mean any individual who:

- irrespective of whether he or she lives on or near a reservation, is a Member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such Member; or
- is an Eskimo or Aleut or other Alaska Native; or
- is considered by the Secretary of the Interior to be an Indian for any purpose; or
- is determined to be an Indian under regulations promulgated by the Secretary of Health and Human Services.

Indian Health Care Provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian tribe, tribal organization, or urban Indian organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC §1603).

Indian Tribe – The term "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85

Stat. 688) (43 USC §1601 et. seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Inquiry – A contact from a Member that questions any aspect of a Health Plan, subcontractor, or provider's operations, activities, or behavior, or requests disenrollment, but does not express dissatisfaction.

Institutional or nursing facility level of care (NF LOC)-The decision that a member needs the services of nurses in an setting to deliver the 's planned treatment for total care. These services can be provided in the home or in programs. And is cost-neutral. Also, it is the least limiting option to care in a hospital or nursing home.

Instrumental Activities of Daily Living (IADLs) – Activities related to independent living. Includes:

- preparing meals,
- running errands to pay bills or
- pick up medication,
- shopping for groceries or personal items, and
- performing light or heavy housework.

Kauhale Online Eligibility Assistance (KOLEA) System – The State of Hawaii certified system that maintains eligibility information for Medicaid and other medical assistance beneficiaries. Kauhale means community in Hawaiian.

Long-Term Services and Supports (LTSS) –
Services provided to a Member in an inpatient medical facility receiving NF LOC or to a resident of a NF LOC. These facilities include assisted living facilities, expanded adult care homes, community care foster family homes, nursing facilities, and sub-acute units.

Managed Care – A comprehensive approach to the provision of healthcare that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost-effective manner.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under the final rule of the BBA and that is: (1) a federally qualified HMO that meets the requirements under Section 1310(d) of the Public Health Service Act; (2) any public or private entity that meets the advance directives requirements and meets the following conditions: (a) makes the service it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services that are available to other non-Medicaid members within the area served by the entity and (b) meets the solvency standards of 42 CFR Section 438.116 and Section 432-D-8, HRS.

Marketing – Any communication from a Health Plan to a Member or any other individual that can reasonably be interpreted as intending to influence the individual to enroll in the particular Health Plan, or dissuade them from enrolling into, or dis-enrolling from, another Health Plan.

Marketing Materials – Materials that are produced in any medium by or on behalf of a Health Plan and can reasonably be interpreted as intending to market to potential Members.

Medicaid - A federal/state program authorized by Title XIX of the Social Security Act, as amended, which provides federal matching funds for a Medicaid program for members of federally aided public assistance and Supplemental Security Income (SSI) benefits and other specified groups. Certain minimal populations and services must be included to receive FFP; however, states may choose to include certain additional populations and services at State expense or if CMS approved receive FFP.

Medical Expenses – The costs, excluding administrative costs, associated with the provision of covered medical services under a Health Plan.

Medical Facility – A means a facility which:

- Is organized to provide medical care, including nursing and convalescent care;
- Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of the individuals on a continuing basis in accordance with accepted standards;
- Is authorized under state law to provide medical care;

Is staffed by professional personnel who have clear and definite responsibility to the institution in the provision of professional medical and nursing services including adequate and continual medical care and supervision by a physician, sufficient RN, or licensed practical nurse (LPN) supervision and services and nurse aid services to meet nursing care needs, and appropriate guidance by a physician on the professional aspects of operating the facility.

Medical Necessity – Procedures and services, as determined by DHS, which are considered to be necessary and for which payment will be made. Medically-necessary health interventions (services, procedures, drugs, supplies, and equipment) shall be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Medical Office – Any outpatient treatment facility staffed by a physician or other healthcare professional licensed to provide medical services.

Medical Services - Except as expressly limited or excluded by the contract, those medical and behavioral health professional services of physicians, other health professionals and paramedical

personnel that are generally and customarily provided in the service area and performed, prescribed, or directed by the attending physician or other provider.

Medical Specialist – A physician, surgeon, or osteopath who is board certified or board eligible in a specialty listed by the American Medical Association, or who is recognized as a specialist by the participating healthcare plan or managed care health system.

Medicare - Means the healthcare insurance program for the aged and disabled administered by the Social Security Administration under title XVIII of the Social Security Act.

Medicare Special Savings Program Members – Qualified severely impaired individuals, medical payments to pensioners, qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, qualifying individuals and QDWIs who may be eligible to receive assistance with some Medicare cost sharing.

Medication-Assisted Treatment (MAT) - Treatment for opioid use disorder combining the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

Medication-Assisted Treatment (MAT) Medications – The FDA has approved several different medications to treat alcohol and opioid use disorders. MAT medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. Medications used for MAT are evidence-based treatment options and do not just substitute one drug for another.

- Opioid Dependency Medications - Buprenorphine, methadone, and naltrexone are used to treat opioid use disorders to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. These MAT medications are safe to use for months, years, or even a lifetime. As with any medication, consult your doctor before discontinuing use. Source: Medication-Assisted Treatment (MAT) | SAMHSA
- Opioid Overdose Prevention Medication - Naloxone is used to prevent opioid overdose by reversing the toxic effects of the overdose. According to the World Health Organization (WHO), naloxone is one of a number of medications considered essential to a functioning health care system.

Source: Medication-Assisted Treatment (MAT) | SAMHSA

Medication-Assisted Treatment (MAT) Providers – For more information on how to become a MAT Provider, please visit SAMHSA - Substance Abuse and Mental Health Services Administration website here https://www.samhsa.gov/.

Contracted Federal Opioid Treatment Programs (OTP) are licensed by Department of Health.

Med-QUEST Division (MQD) – The offices of the State of Hawaii, Department of Human Services, which oversees, administers, determines eligibility, and provides medical assistance and services for state residents.

Member – An individual who has been designated by the Med- QUEST Division to receive medical services through the QUEST program as defined in Section 30.300 and is currently enrolled in a QUEST health plan. See also Enrollee.

Model of Care (MOC) – A quality improvement tool used to ensure the unique needs of each Member enrolled in a special needs plan (SNP) are identified and addressed. In 2010, the ACA designated the NCQA to execute the review and approval of SNPs' MOC based on standards and scoring criteria established by CMS. NCQA assess MOC from SNPs according to detailed CMS scoring guidelines.

National Committee for Quality Assurance (NCQA) – An organization that sets standards, develops HEDIS measures, and evaluates and accredits Health Plans and other MCOs.

Native Hawaiian – Refers specifically to people of native Hawaiian descent**.**

Neighbor Islands (neighbor islands) – Islands in the State of Hawaii other than Oahu – Hawaii Island, Maui, Lanai, Molokai, Kauai, and Niihau.

Network – A group of doctors, hospitals, pharmacies, and other healthcare experts hired by a health plan to take care of its Members.

New Member - A member (as defined in this section) who has not been enrolled in a health plan during the prior six (6) month period.

Non-Participating Provider – A provider who does not have a contract with any health insurers or plans to provide services to Members.

Nurse Delegation – In accordance with the current HAR §16-89-100, the ability of a RN to delegate the special task for nursing care to an unlicensed assistive person.

Nursing Facility (NF) – A freestanding or a distinct part of a facility that is licensed and certified to provide appropriate care to individuals referred by a physician. Such individuals are those who need twenty-four hour a day assistance with the normal ADL, need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis, and may have a primary need for twenty-four hours per day of skilled nursing care on an extended basis and regular rehabilitation services.

Operational Effectiveness Program - A quality assurance program for Health Plan operations.

Overpayment - A QUEST (Medicaid) overpayment is a payment that exceeds the allowed payment for services specified in the QUEST contract.

Paraprofessional – An unlicensed, licensed, or certified healthcare team Member that provides person centered care, patient engagement, community resources, and culturally-competent care. A paraprofessional may include a medical assistant, community health worker, a peer support specialist or other specific titles, and provides basic healthcare services in settings such as hospitals, health clinics, physical offices, nursing care facilities and patient homes.

Participating -
When referring to a Health Plan it means a Health Plan that has entered into a contract with DHS to provide Covered Services to Members. When referring to a Healthcare Provider it means a Provider who is employed by or who has entered into a contract with a Health Plan to provide Covered Services to Members. When referring to a facility it means a facility that has entered into a contract with a Health Plan for the provision of Covered Services to Members.

Participating Provider – A provider who has a contract with health plans to provide services.

Patient-Centered Medical Home (PCMH) – A system of care designed to meet the needs of the whole patient. The model utilizes a team-based approach, but the PCP is responsible for the continuity and coordination of a patient's care.

Patient Protection and Affordable Care Act of 2010 (ACA) – Federal legislation that, among other things, puts in place comprehensive health insurance reforms.

Peer Support Services – Peer support services are provided by a Peer Support Specialist certified by Adult Mental Health Division of the DOH. Peer support services are coordinated within the needs and preferences of the Member in achieving the specific, individualized goals that have measurable results and are specified in the care, service, or treatment plan.

Peer Support Specialist – An individual who uses their lived experience of recovery from mental illness, addiction, and/or chronic disease management, plus skills learned in formal training, to deliver services that promote recovery, health, and resiliency. Peer support specialists are certified by Adult Mental Health Division (AMHD) as a part of the Hawaii certified peer specialist program or a program that meets the criteria established by AMHD and shall complete ongoing continuing education requirements. Additionally, they shall be supervised by a mental health professional, as defined by the State.

Performance Improvement Project (PIP) – Quality improvement initiatives undertaken by Health Plans in accordance with 42 CFR §438.240(d) that are designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

Person-Centered Planning – As defined in 42 CFR §441.301(c)(1)-(3).

Personal Assistance – Care provided when a member, member's parent, guardian or legal

employs hires and oversees a personal assistant. The health plan will this person. This is based on watching of the member and the personal assistant during the actual delivery of care. The Documentation of this certification will be kept in the member's individual plan of care.

Physician – A licensed Doctor of Medicine or Doctor of Osteopathy.

Physician – A licensed Doctor of Medicine or Doctor of Osteopathy.

Physician Services – Services provided by an individual licensed under state law to practice medicine.

Plan – A benefit provided by employers, unions, or other group sponsors to pay for healthcare services.

Post-Stabilization Services – 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.

Preauthorization – A decision by a Health Plan that a healthcare service, treatment plan, prescription drug, or DME is medically necessary. Sometimes called prior authorization, prior approval or precertification. A Health Plan may require preauthorization for certain services prior to Members receiving them, except in an emergency. Preauthorization does not guarantee the Health Plan will cover the cost.

Prepaid Plan – A Health Plan for which premiums are paid on a prospective basis, irrespective of the use of services.

Prescription Drug – Drugs and medications that, by law, require a prescription.

Prescription Drug Coverage – Health plan that helps pay for prescription drugs and medications.

Prescription Monitoring Program (PMP) – The purpose of the program is to improve patient care and stop controlled substance misuse. PMPs use formulary controls, provider-directed interventions such as education, screening, and intervention programs to decrease inappropriate utilization. Additionally, PMPs include a patient review and restriction program that can limit use by Members who are seeking multiple controlled substance prescriptions from different providers, often from multiple pharmacies, within a short period of time.

Presumptive Eligibility – Initial Medicaid eligibility given to a potential Member for a specified period of time prior to the final determination of their eligibility.

Preventive Services (Adult Health) – Services that can prevent or detect illnesses and disease in earlier, more treatable stages, thereby significantly reducing the risk of illness, disability, early death, and medical costs. Examples include screening and preventive services identified in

recognized clinical practice guidelines such as those published by the United States Preventive Services Task Force, the Centers for Disease Control and Prevention (CDC), HRSA's women's preventive services guidelines, and DOH's guidelines on screening for tuberculosis. Additional examples of adult preventive services include:

- Immunizations;
- Screening for common chronic and infectious diseases and cancers;
- Clinical, non-clinical, and behavioral interventions to manage chronic disease and reduce associated risks and complications;
- Support for self-management of chronic disease;
- Support for self-management for individuals at risk of developing a chronic disease;
- Screening for pregnancy intention as appropriate;
- Counseling to support healthy living;
- Support for lifestyle change when needed; and
- Screening for behavioral health conditions

Preventive Services (Pediatrics and Adolescent Health) – Services that can prevent or detect illnesses and disease in earlier, more treatable stages, thereby significantly reducing the risk of illness, disability, early death, and medical costs. This includes evidence-based screening and preventive interventions such as those recognized in Bright Futures guidelines issued by HRSA and the CDC, all screening, assessment, and preventive services covered by EPSDT, and DOH screening guidelines for tuberculosis. Additional examples of preventive services include:

- Immunizations;
- Screening for common chronic and infectious diseases and cancers;
- Clinical, non-clinical, and behavioral interventions to manage chronic disease and reduce associated risks and complications;
- Support for self-management of chronic disease;
- Support for self-management for individuals at risk of developing a chronic disease;
- Screening for pregnancy intention as appropriate;
- Counseling to support healthy living;
- Support for lifestyle change when needed; and
- Screening for behavioral health and developmental conditions.

Primary Care – Outpatient care to include: prevention, treatment of acute conditions, and management of chronic conditions. Primary care is often first contact care of the same complaint. May result in diagnostic testing and treatment, appropriate consultation or referral and includes coordination and continuity of care.

Primary Care Provider (PCP) - A practitioner selected by the Member to manage the Member's utilization of health care services who is licensed in Hawaii and is:

- A physician, either an MD or a DO, and shall generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician-gynecologist (for women, especially pregnant women) or geriatrician;
- An APRN-Rx. PCPs have the responsibility for supervising, coordinating, and providing initial and primary care to enrolled individuals and for initiating referrals and maintaining the continuity of their care; or
- A physician's assistant recognized by the State Board of Medical Examiners as a licensed physician assistant.

Prior Period Coverage – The period from the eligibility effective date as determined by DHS up to the date of enrollment in a Health Plan.

Prior Period Performance Rate – The actual score on a specific performance measure for the prior reporting period.

Private Duty Nursing (PDN) – PDN is a service provided to individuals requiring ongoing, long-term maintenance nursing care at home or in the community (in contrast to home health or part time, intermittent skilled nursing services under the Medicaid State Plan [MSP]). The service is provided by licensed nurses (as defined in HRS, Chapter 457) within the scope of state law, consistent with physician's orders, and in accordance with the Member's HAP. PDN services may be self-directed under personal assistance level II/delegated using nurse delegation procedures as outlined in HRS §457-7.5.

Private Health Insurance Policy – Any health insurance program, other than a disease-specific or accident-only policy, for which a person pays for insurance benefits directly to the carrier rather than through participation in an employer or union sponsored program.

Protected Health Information (PHI) – As defined in the HIPAA Privacy Rule, 45 CFR Section 160.103.

Provider - Any licensed or certified person or public or private institution, agency, or business concern authorized by DHS to provide healthcare, services, or supplies to individuals receiving medical assistance.

Provider Grievance – An expression of dissatisfaction made by a provider as described in §8.4.B.

Provider Preventable Conditions (PPC) – Provider-preventable conditions are conditions that meet the definition of a healthcare-acquired condition or other provider-preventable conditions. A healthcare-acquired condition (HAC) means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under Section 1886(d)(4)(D)(iv) of the Act; other provider-preventable condition may include conditions that have been found based upon a review of medical literature by qualified professionals to be reasonably preventable through the application of procedures supported by evidence-based guidelines, and have a negative

consequence for the Member. At a minimum, other provider-preventable conditions include wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; or surgical or other invasive procedure performed on the wrong patient.

QUEST - QUEST is the managed care program that provides healthcare benefits, including long-term services and supports, to individuals, families, and children; the program serves both non-aged, blind, or disabled (non-ABD) individuals and ABD individuals, with household income up to a specified federal poverty level (FPL). This is the demonstration project developed by DHS.

Rehabilitative/Rehabilitation Services – Healthcare services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because Members were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rehabilitation Devices – Devices that support the provision of rehabilitation services in inpatient and/or outpatient settings. Rehabilitation devices include but are not limited to:

- Mobility devices, such as wheelchairs, motorized scooters, walkers, crutches, canes, prosthetic devices, orthotic braces, and other orthotic devices.
- Devices that aid hearing loss, balance or tinnitus disorders, including hearing aids, aural rehabilitation with cochlear implants for both pediatric and adult, and hearing assistive technology.
- Devices that aid speech include DME, speech-generating equipment, and augmentative and alternative communication devices, such as voice amplification systems.
- Cognitive aids to assist with memory, attention, and other challenges with cognition.
- Prosthetic eyeglasses and prosthetic contact lenses for the management of trauma to the eye or ophthalmologic disease.
- Dental devices, excluding devices for cosmetic purposes).

Resident of Hawaii – A person who resides in the State of Hawaii or establishes his or her intent to reside in the State of Hawaii.

Risk Share – The losses or gains associated with Health Plan costs or savings related to expected healthcare expenditures that are shared between the Health Plan and DHS. A Health Plan may separately enter into risk share arrangements with providers.

Rolling Plan Change – All QUEST members can change their Health Plan after being in a plan for 12 straight months. This is known as a Rolling Plan Change (RPC) period. When a QUEST member changes their Health Plan, the new plan starts the first day of the second month after the change. For example, if a member asks to change their Health Plan in November, the new plan starts January 1st of the next year.

Rural Health Center (RHC) – An entity that meets the qualifications for an RHC, as defined in Section 1861(aa)(2) of the Social Security Act.

Rural Providers – Primary medical care, dental, or mental health Providers who serve in a HRSA-designated HPSA. HRSA-designated HPSA can be found using the following website: http://hpsafind.hrsa.gov/.

Self-Direction – A service delivery option under LTSS HCBS. Personal assistance services provided for an LTSS Member when the Member, Member's parent, guardian, or legal representative employs and supervises a personal assistant. The personal assistant is certified by the Health Plan as able to provide assistance with ADL and/or IADL provided as an alternative to nursing facility placement to persons with a physical disability. Documentation of this certification will be maintained in the Member's individual plan of care.

Service Area – The geographical area defined by zip codes, census tracts, or other geographic subdivisions, i.e., island that is served by a participating Health Plan as defined in its contract with DHS.

Severe Mental Illness (SMI) – A mental disorder which exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with a person's capacity to remain in the community without treatment or services of a long-term or indefinite duration. This mental disability is severe and persistent, encompassing individuals with SMI, SPMI, or requiring support for emotional and behavioral development (SEBD), resulting in a long-term limitation of a person's functional capacities for primary ADL such as interpersonal relationships, homemaking, self-care, employment, and recreation.

Significant Change – A change that may affect access, timeliness, or quality of care for a Member (i.e., loss of a large provider group, change in benefits, change in Health Plan operations, etc.) or that would affect the Member's understanding and procedures for receiving care.

Skilled Nursing (SN) – Skilled nursing is a service provided to individuals requiring home health or part time, intermittent skilled nursing services under the MSP (in contrast to ongoing, long-term nursing care) at home or in the community. The service is provided by licensed nurses (as defined in HRS Chapter 457) within the scope of state law, consistent with physician's orders and in accordance with the Member's HAP.

Skilled Nursing Care – A LOC that includes services that can only be performed safely and correctly by a licensed nurse (either a RN, a LPN, or APRN).

Social Determinants of Health (SDOH) – Conditions in which people are born, grow, live, work, and age that shape health. Socio-economic status, discrimination, education, neighborhood and physical environment, employment, housing, food security and access to healthy food choices, access to transportation, social support networks and connection to culture, as well as access to healthcare are all determinants of health. Hawaii state law recognizes that all state

agency planning should prioritize addressing these determinants to improve health and wellbeing for all, including Native Hawaiians.

Special Health Care Needs (SHCN) – A Member that has chronic physical, behavioral, developmental, or emotional conditions that require health-related services of a type or amount that is beyond what is required of someone of their general age.

Special Treatment Facility – A licensed facility that provides a therapeutic residential program for care, diagnoses, treatment, or rehabilitation services for individuals who are socially or emotionally distressed, have a diagnosis of mental illness or substance abuse, or who have a developmental disability or intellectual disability (DD/ID).

Specialist – A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

State - The State of Hawaii.

State Fiscal Year (SFY) – The period July 1 through the following June 30 of consecutive calendar years.

State Plan – The document approved by DHHS that defines how Hawaii operates its Medicaid program. The State Plan addresses areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.

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

Sub-Acute Care – A LOC that is needed by an individual not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of patients in a SNF.

Substance Abuse and Mental Health Services Administration (SAMHSA) – The agency within DHHS that leads public heath efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Substance Use Disorder (SUD) – SUDs occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Support for Emotional and Behavioral Development (SEBD) – A program for behavioral health services for children and adolescents administered by CAMHD.

Telehealth – As defined by HRS §346-59.1, the use of telecommunications services to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced healthcare services and information while a patient is at an originating site and the Healthcare Provider is at a distant site. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself, does not constitute a telehealth service for the purposes of this definition.

Temporary Assistance to Needy Families – Time-limited public financial assistance program that replaced Aid to Families with Dependent Children that provides a cash grant to qualified adults and children.

Third Party Liability (TPL) – Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of a member or to Medicaid.

Transitions of Care – The movement of Members between healthcare practitioners, settings, and home as their conditions and care needs change. For example, a Member might receive care from a PCP or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving to another care team at a SNF.

Urgent Care - The diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life or health. Requires medical attention within 24 hours.

Utilization Management Program (UMP) - The requirements and processes established by a health plan to ensure members have equitable access to care, and to manage the use of limited resources for maximum effectiveness of care provided to members.

Value-Added Services – Under the federal Medicaid managed care rules (42 CFR §438.3[e][1][i]), services that are not covered under the State Plan, but that a Health Plan chooses to spend capitation dollars on to improve quality of care and/or reduce costs. Value-added services seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care. The cost of value-added services cannot be included in the capitation rates; it can, however, be included in the numerator of the MLR if it is part of a quality initiative.

Value-Based Payment (VBP) – An approach to payment reform that links provider reimbursement to improved performance or that aligns payment with quality and efficiency. This form of payment holds Healthcare Providers accountable for both the cost and quality of care they provide. VBP strives to reduce inappropriate care and to identify and reward the highest

performing providers. VBP may include but not be limited to different reimbursement strategies such as FFS with incentives for performance, capitation payment to providers with assigned responsibility for Member care, or a hybrid model.

Waste – Overutilization of services or other practices that do not improve health outcomes and result in unnecessary costs. Generally not caused by criminally negligent actions but rather the misuse of resources.

Whole-Person Care – Whole-person care addresses the health, behavioral health, psycho-social, and social services needs of a Member in a person-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.