HMSA QUEST Integration Plan

Par Provider Information Session/Webinar
December 2015
Agenda

- Introduction to QUEST Integration (QI)
- HMSA Responsibilities
- Provider Responsibilities
- Member Rights and Responsibilities
- Long Term Services and Supports (LTSS)
- Members “At Risk”
- Service Coordination
Agenda (cont.)

- Referrals and Pre-certifications
- Member Eligibility Verification
- Claims/Encounter Form Filing Information
- Electronic Transactions
- Reimbursements
- Cost Share
- Cultural Competency
- Enabling Services
- Administrative Information/Resources
- Questions/Survey
Introduction
What is QUEST Integration (QI)?

- QUEST eligible members
- QUEST Expanded Access (QExA) members
- Combined into QUEST Integration plan
- Covers all QUEST and QExA benefits
- Expanded benefits for some members
QUEST Integration members

HMSA’s QUEST Integration members

- **Non-ABD**
  - (Doesn't include Aged, Blind or members with disabilities)

- **ABD**
  - (Aged, Blind or members with disabilities)

- **ABD and LTSS**
  - (Aged, Blind or members with disabilities who have additional LTSS benefits)
HMSA Responsibilities

- Issue ID cards
- Process claims
- Case assistance/member education
- Medical reviews (pre- and post-payment)
- Home and community based services
- Service coordination
**HMSA Responsibilities**

**Our Partners**

- **Landmark**
  - Physical and occupational therapy utilization management

- **NIA**
  - Pre-certification of outpatient advanced imaging studies, selected spine procedures, selected cardiac services

- **Beacon Health Strategies**
  - Behavioral health utilization management
  - Service coordination

- **CVS**
  - Pharmacy benefits and Medical Specialty drug management services
HMSA Responsibilities
Beacon Health Strategies

- Case manager for standard behavioral health care of QUEST Integration members
- Links members to resources and services
- Educates member/family
- Maintains interaction with behavioral health providers
- Coordinates and assesses patient care
- Advocates for the patient’s needs
- Provides pre-certification of behavioral health services
HMSA Responsibilities

CVS Caremark

- Administrative support
- Benefit Plan Administration
- Medicaid Formulary Management
- Electronic Prior Authorizations
- Utilization Management
- Custom Network Design
- Medicaid Reporting
- Fraud and Abuse Management
- Specialty Drug Program
- Health Management
- Generic Dispensing
Provider Responsibilities

- Comply with Americans with Disabilities Act (ADA)
  - Physical accessibility
  - Interpreter services
- Comply with non-discriminatory requirements
- Certify the accuracy, completeness, and truthfulness of submitted data (claims, encounter data, medical records)
- Maintain confidentiality of such records
- Develop and fully and clearly discuss treatment options or service plans with members
- Meet QUEST Integration accessibility standards for urgent/emergent care, sick visits, and routine visits
Provider Responsibilities
Role of the Primary Care Provider (PCP)

- Ongoing source for primary care
- Coordinate health care with specialists
- Maintain continuity of care
- Maintain patient health records
- Maintain admitting privileges or a written agreement with a provider with admitting privileges
- Provide EPSDT exams to eligible members
- Responsible for patient’s health maintenance and disease prevention
- Work with Service Coordinator to coordinate care and create the member's service plan
Provider Responsibilities
Role of the Primary Care Provider (PCP) (cont.)

- Identify high-cost, high utilization, complex, or special needs cases for potential service coordination
- Attend or have representation at QUEST Integration informational sessions
- Fulfill PCP requirements for members transitioning to another PCP until accepted by new PCP
- Maintain accessibility standards
Provider Grievance and Appeals

- Grievance procedures
  - Dissatisfaction with our operations, activities, or behaviors
  - Verbally or in writing within 60 days of payment or episode
  - Resolution within 60 days of receiving grievance
  - Further recourse through appeal

- Appeal procedure
  - Submit written request for appeal within 30 days of grievance determination letter
  - Resolution within 60 days of receiving appeal
  - Further recourse through arbitration

- Arbitration submission within 60 days from appeal determination
Member Rights and Responsibilities

- Outlined for members in QUEST Integration Member Handbook
- Outlined for providers in QUEST Integration Provider Handbook
  - Member rights includes member grievance and appeals process
  - Providers may act on behalf of members filing grievances and appeals, with member written consent
Member Grievance and Appeals

- Right to file grievance
- Right to State administrative hearing
  - How to obtain hearing
  - Rules on representation
- Availability of HMSA assistance in filing grievance

- Right to have a provider/representative
  - Written consent
- Toll-free numbers
- Right to receive benefits during appeal/hearing
Member Grievance and Appeals (cont.)

- Dissatisfaction with our operations, activities, or behavior
- Expressed verbally or in writing
  - Member
  - Member’s authorized representative
  - Provider acting on behalf of member with member’s written consent or written consent of member’s authorized representative
- Grievance determination letter sent within 30 days of receiving the grievance
- Further recourse through State Grievance Review
Member Grievance and Appeals (cont.)

- State Grievance Review
  - Call 1(808)692-8094 or write
  - Med-QUEST Division, Health Care Services Branch, P.O.Box 700190, Kapolei, HI 96709-0190

- Request grievance review within 30 days of HMSA’s grievance determination

- State determination made within 90 calendar days from request for review.
Member Grievance and Appeals (cont.)

- **Standard Appeal**
- **Verbally or in writing**
  - Member
  - Member’s authorized representative
  - A provider on behalf of a member with the member’s written consent
  - Legal representative of a deceased member’s estate
- **Requested within 30 days from any adverse action**
- **HMSA resolves within 30 days.**
Long Term Services and Supports
Institutional Setting

- Skilled nursing facility
- Intermediate care facility
- SNF or ICF waitlisted on an acute floor
Long Term Services and Supports
Home and Community Based Services

- Adult day care
- Adult day health
- Assisted living services
- Community care management agency services (CCMA)
- Community care foster family home (CCFFH)
- Counseling and training
- Environmental accessibility adaptations
- Expanded-adult residential care home (E-ARCH)
- Home delivered meals
- Home maintenance
Long Term Services and Supports
Home and Community Based Services (cont.)

- Moving assistance
- Non-medical transportation
- Personal assistance services (Level I and Level II)
- Personal emergency response system (PERS)
- Respite care
- Skilled or private duty nursing
Long Term Services and Supports
Self-Direction Option

- Members assessed to need Personal Assistance (PA) Level I or Level II, and/or Respite Care
- Services cannot be activities that the family would ordinarily perform, or is responsible to perform
- Member becomes employer of personal assistant (PA) and Respite provider and must be able to perform employer duties
- Service Coordinator team assists member by creating the self-direction plan and training/validating/monitoring
Members “At Risk”

- Don’t meet criteria for nursing facility care but are ‘at risk’ of deteriorating to institutional LOC
- Reside at home or with family/friends, or a community shelter (i.e. YMCA, YWCA, IHS, etc.,)
- Not residing in a care home, foster home, hospital, nursing facility, hospice, or ICF/ID
- Eligible for services such as
  - Home delivered meals
  - Personal emergency response system
  - Personal assistance
  - Adult day care
  - Adult day health
  - Skilled or private duty nursing services
Service Coordination

- A person-centered service delivery system
- Ensures the needs of those with special health care needs and those receiving long term services and supports are met
- Service coordinators assist in coordinating services with other agencies, programs, and community services
- Call QUEST Integration Provider Service for Service Coordination referral:
  - 948-6486 (Oahu)
  - 1 (800) 440-0640 (toll free)
Service Coordination

Who is eligible?

- Children with Special Health Care Needs (SHCN)
- Adults with SHCN
- Members at risk
- Institutionalized members
- Members receiving home and community-based services
- Members opting for self-direction
Service Coordination
Responsibilities of Coordinators

- Support the PCP
- Coordinate a team of decision-makers
- Conduct member assessments
- Develop and monitor a service plan in conjunction with the care team, including member, member's family, PCP, specialists, community agencies, service coordinator etc.
- Coordinate and facilitate access to services with providers, programs, and community agencies
Referrals

- **Self referrals**
  - Behavioral health (OP)
  - Refractive vision services
  - Family Planning
  - Well-woman exam and mammogram

- **All other specialty care requires PCP referral**

- **Register** these referrals with HMSA
  - Referral to a provider not in HMSA’s QUEST Integration provider network
  - Plastic surgery services
  - Off-island specialist services
Referrals (cont.)

- Methods of registering a referral with HMSA
  - Fax the referral form
    - 948-5648 (Oahu)
    - 1 (800) 960-4672 (toll-free)
  - Register the referral online via HHIN
    - Select “Submit Referrals” tab, then click on “iExchange”
  - Call QUEST Integration Provider Service
    - 948-6486 (Oahu)
    - 1 (800) 440-0640 (toll-free)

- HMSA approval is needed for referrals outside HMSA QUEST Integration provider network
Pre-certifications (Prior Authorizations)

- Refer to QUEST Provider Handbook for list of services requiring pre-certification
- Submit for approval before services are rendered to appropriate reviewer based on category of service
  - PT/OT – Landmark
  - ST – HMSA Medical Management
  - Drugs – CVS Caremark
  - Behavioral health – Beacon Health Strategies
Pre-certifications (cont.)

- Medical/surgical – HMSA Medical Management
- LTSS services – HMSA Medical Management
- Clearly identify urgent/emergent cases for expedited review
Pre-certifications (Prior Authorizations)

- HMSA pre-certification forms available online

Mail to: HMSA – Medical Management
        P. O. Box 2001
        Honolulu, HI 96805-2001

Fax: 1 (800) 944-5611

Phone: (808) 948-6464 (Oahu)
       1 (800) 344-6122 (Neighbor Islands)

Monday-Friday: 7:45 a.m. - 4:30 p.m.

Online: https://hhin.hmsa.com/HHIN
Pre-certifications (Prior Authorizations)

- Electronic submissions accepted through HHIN
Pre-certifications (Prior Authorizations)

- Electronic submissions accepted through Cozeva
Pre-certifications (Prior Authorizations)

- Timeliness guidelines
  - Routine requests within 14 days
  - Urgent requests within 3 business days
- If pre-certification is not obtained before the service is provided, submit a paper claim attaching documentation for the medical necessity
  - Claim will undergo medical review
  - Claim without documentation will be denied for no authorization
Verifying Member Eligibility

- Check membership ID card at each visit or encounter
- Access HMSA’s Hawaii Healthcare Information Network (HHIN)
  - Available 24 hours, 7 days/week
  - Free access and support
- Call QUEST Integration Provider Service
  - 948-6486 (Oahu)
  - 1 (800) 440-0640 (Neighbor Islands)
  - Monday – Friday, 7:45 a.m. to 4:30 p.m.
Verifying Member Eligibility
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Verifying Member Eligibility

![Health Plan Card]

- **Member Name**: KEIKI K QUEST
- **Member ID**: XLQ1234567890
- **Effective Date**: 11/05/14
- **Benefit**: NON-ABD
- **RXBIN**: 004336
- **RXPCN**: ADV
- **RXGRP**: RX3987

**Quest Integration**
- **Birth Date**: 08/05/07
- **Sex**: M
- **PCP**: KIMO U. MAHALO MD
- **Network**: BIG ISLAND FAMILY PRACTICE
- **PCP Phone**: (808) 123-4567
- **PCP Effective Date**: 09/16/14
- **TPL1**: HMSA HEALTH PLAN HI
- **TPL2**:
Verifying Member Eligibility

[Image of a member ID card showing the effective date as 11/05/14 and the benefit as NON-ABD.]
Verifying Member Eligibility

- Regular QUEST Member
Verifying Member Eligibility

- Aged, Blind or Disabled Member (previous QExA member)
Verifying Member Eligibility

ABD member eligible for Long Term Service and Supports (LTSS)
Verifying Member Eligibility

- Back of QUEST Integration ID card
Claims/Encounter Form Processing

- Issues affecting claims processing
  - Patient eligibility
  - Prior authorization
  - Benefit status
  - Missing claim info

- Circumstances when member can be billed
  - Requested non-covered services
  - Requested “deluxe” services
  - Primary insurance benefit amounts
  - Cost share (if applicable)
Claims Filing Information

- Professional services billed on CMS 1500 claim form
- Facility services billed on UB-04 claim form
- Obtain forms from form vendor
- Filing deadline is 365 days from date of service
- Use ICD-10 diagnosis codes for services rendered 10/1/15 and after
- Other insurance is always primary to QUEST Integration
  - Bill other insurance before QUEST Integration
  - Submit QUEST Integration claim with amount of other insurance payment or copy of insurance denial notice
- Paper or electronic submissions accepted
Claims Filing Information (cont.)

- DHS Form 1147 required for LTC confinement
- Only original forms (red “fade-away” ink) accepted for submission
- Font size 10 through 12
- Black ink (no dot matrix)
- No highlighter marks
- Do not try to squeeze in more info than field can hold
- Billed service(s) must be documented in patient records
Rejected claims

- All claims undergo validation edits
- Claims that fail an edit are rejected from entering the processing system
- Rejection letter (Form 97) is sent to the provider identifying the rejected claim and the reason(s) why it rejected
- Submit a new claim with the correction(s) as noted on the rejection letter (Do not label as Resubmission)
Claims denied for additional information

- Claims denied on a Report to Provider (RTP)
- Reason for denial/requested additional information is noted on the RTP
- See instructions for Resubmitting Claims
Resubmitting Claims

- Resubmitted CMS 1500 (paper) claims require the following:

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<th>CMS-1500</th>
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<tr>
<td>Indication of replacement claim</td>
<td>Block 22 – Resubmission code “7” – (Replacement)</td>
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<tr>
<td>Original HMSA Claim ID</td>
<td>Block 22 – Original Ref. No. must contain Original HMSA Claim ID</td>
</tr>
<tr>
<td>Reason for correction</td>
<td>Block 19 – Reserved For Local Use Include text explaining reason for attachments (e.g. op notes, EOB)</td>
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- Claims without this information will deny as a duplicate claim
- Remember to include any necessary attachments with the resubmitted claim
Resubmitting Claims (cont.)

- Resubmitted 837P (electronic) claims require the following:

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<td>Indication of replacement claim</td>
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<tr>
<td>Original HMSA Claim ID</td>
<td>Loop 2300 REF - Payer Claim Control Number REF01 = &quot;F8&quot; (Original Reference Number) REF02 = Original HMSA Claim ID</td>
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<tr>
<td>Reason for correction</td>
<td>Loop 2300 NTE - Claim Note Segment NTE01 = &quot;ADD&quot; NTE02 = text explaining reason for correction Optional - NTE segment at Loop 2400 line level if more space is needed.</td>
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HMSA’S Electronic Transaction Services
Electronic Transactions

EDI (Electronic Data Interchange). A communication system that allows the electronic exchange of data between business partners.

HMSA supports the following EDI transactions:

- Electronic Claims Submission
- Electronic Eligibility Verification
- Electronic Claim status
- Electronic Funds Transfer
- Electronic Remittance Advice
- Electronic Report to Provider
Electronic Transactions
HHIN (Hawaii Healthcare Information Network)

HHIN. HMSA’s website for participating providers to access member plan and benefit information at any time. Some of the transactions available on HHIN include:

- Eligibility Verification
- Plan Benefits
- Claim Status
- Report to Provider
- Pre-Authorization Requests
- Fee Schedules
Electronic Transactions
Electronic Claims Submission

Electronic claims can be submitted 2 ways:

- Batch
  - Multiple claims sent in a file
  - Requires an electronic billing system or clearinghouse
- DDE (Direct Data Entry)
  - Single claim entered & sent per file
  - Submitted online

Benefits of submitting an electronic claim:

- Paperless
- Cost & Time Savings
- Quicker turn-around
- Improved/more stable cash flow
Electronic Transactions
Electronic Claims Submission

Who can submit claims electronically?
- Participating providers
- Non-Participating providers
- Certain restrictions will apply

System requirements:
- Batch
  - Qualified electronic billing system
  - Authorized Clearinghouse
- Direct Data Entry (DDE)
  - Internet access
  - Current web browser - Internet Explorer (v7 or higher)
Electronic Transactions
Contact Us – Outreach

For more information about HMSA’s electronic products, requesting a new set-up, or to request HHIN training, please contact the Electronic Transaction Services Outreach team at:

**By Phone**
- (808) 948-6255

**By Email**
- ETSOutreach@hmsa.com
Electronic Transactions
Contact Us – Technical Support

For technical related questions and issues, please contact the ETS Help Desks at:

**Electronic Data Interchange (EDI) Help Desk**
- (808) 948-6355 or toll free at (800) 377-4672
- edisupport@hmsa.com

**HHIN Help Desk**
- (808) 948-6446 or toll free at (800) 760-4672
- hhinhelpdesk@hmsa.com
Special Claim Submission Procedures

LTSS Providers

- Bill only for contracted services

- Adult day care
- Assisted living
- Community care management
- Environmental accessibility adaptations
- Home delivered meals
- Moving assistance
- Personal assistance (Levels I & II)
- Private Duty Nursing
- Specialized medical equipment and supplies
- Adult day health
- Community care foster family home
- Counseling and Training
- Expanded-adult-residential care home
- Home maintenance
- Non-medical transportation
- Personal emergency response system
- Respite care
Special Claim Submission Procedures

LTSS Providers

- Bill only for services actually rendered
  - Do not bill for services during a period of hospitalization or confinement in a long term care facility

- Use appropriate codes and units
  - E.g., a code described as ‘per day’ must be billed by number of days, not minutes
Special Claim Submission Procedures

- Submit detailed claims to:

  HMSA QUEST Integration
  P.O. Box 3520
  Honolulu, HI 96811-3520
Reimbursements

- Professional
- Acute care facility
- Long term care facility
- LTSS providers
Report to Provider (RTP)

- Daily claims processing, with payments run on Tuesdays
- Checks mailed every Thursday
- Electronic deposits may be arranged
- Promptly reconcile RTP with accounts receivables
- Monitor outstanding claims for follow-up if needed
### Report to Provider (RTP)

**Carrier:** HAWAII MEDICAL SERVICE ASSOCIATION  
**Program:** HMSA QUEST Integration

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Cost Share

- Amount determined by Med-QUEST
- Member responsible for payment of cost share to cost share provider or to HMSA
- Collected by cost share provider for institutionalized members and for non-institutionalized members receiving specific LTSS services
  - Providers should submit collected amounts on field #29 of the CMS 1500, or in FL 39 using value code 23 on the UB-04 claim form
- Collected by HMSA for non-institutionalized members not receiving LTSS services
Member Billings

- No balance billing of QUEST Integration members
- Providers accept QUEST Integration payments as payments in full
- Members can be billed for
  - Noncovered services or upgraded services (member-signed Financial Agreement Statement required)
  - Services rendered before/after eligibility
  - Primary insurance payments sent to the member or plan subscriber by the other insurance
  - Cost shares
- No-show fees cannot be charged to QUEST Integration members.
Cultural Competency

- Cultural background and values shape member views
- Key cultural messages
  - Members are multicultural
  - Members have a right to be treated with courtesy, consideration, and respect
  - Respect diversity and eliminate biases and preconceptions that can be barriers to successful delivery of health services
- QUEST Integration member communications
  - Easy to understand English reading level
  - Available in locally spoken foreign languages
- Provider foreign language capabilities
Cultural Competency (cont.)

- Outreach and care assistance to members is sensitive to their beliefs but is aimed at improving their health outcomes.

- Myths about public assistance members:
  - They’re noncompliant
  - Providers have to make all the healthcare decisions
  - Those with disabilities are incapable of discussing their health
  - Their superstitions and beliefs are incomprehensible
  - They don’t want to talk about their culture, they want to be treated like everyone else
Cultural Competency (cont.)

- HMSA identifies cross-cultural conflicts or complaints
  - Annual Cultural Competency staff training
  - Complaints and grievances are trended, analyzed and acted upon in a timely manner
  - Annual announcement to members to contact HMSA to report situations of lack of cultural adherence
- HMSA does not assume that lack of complaints or grievances indicates that incidents are not occurring
- Avenues to identify areas for improvement
  - Member communication
  - CAHPS survey
  - Member Service contacts
  - Provider communication
Enabling Services

- Interpreter
- Transportation
- Auxiliary aids for members with disabilities
- Contact QUEST Integration Provider Services for arrangements
  - 948-6486 (Oahu)
  - 1-800-440-0640 (toll free from Neighbor Islands)
- 24-hour Nurse Advice Line
  - Free service for HMSA QUEST members
  - Medical questions answered
  - Advice on treatment options (home, office, ER)
  - Phone number on back of member ID card
Administrative Information/Resources
Medical Records Documentation

- Maintained a minimum of 7 years from last entry date
- For minors, maintained while a minor plus a minimum of 7 years after age of maturity
- If PCP changes, transfer records to new PCP within 7 business days from receipt of records request
- Records must support submitted claims
  - Must be legible
  - Must accurately document services provided and billed for
  - Must be made available to DHS, HMSA and others as specified by DHS for audit and review purposes
- Members have a right to receive copies of their medical records and request corrections
Administrative Information/Resources

Reporting Requirements

- Member information
  - Report all cases of suspected child abuse to DHS Child Welfare Services Section
  - Report all suspected dependent adult abuse to the DHS Adult Protection Services Section

- Claims/encounter data
  - Submit claims/encounters to document patient services
  - Services billed/reported must be supported by patient records

- Suspected fraud and abuse by members or other providers
Administrative Information/Resources
Provider Communications

- HMSA website: hmsa.com
- Provider Resource Center
  - QUEST Provider Handbook
  - QUEST Bulletins
  - HMSA Provider Updates
  - Other HMSA communications
Thank you!

- Please complete the **Webinar Evaluation form**, and fax it to 948-6887 (Oahu) or 1-800-540-1668 (Neighbor Islands)
- Questions?