Administrative Manual for Participating Providers

January 2019

www.hwmg.org

737 Bishop Street, Suite 1200, Honolulu, HI 96813 • (808) 791-7557 • Toll-Free (800) 621-6998 x304

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Welcome

Hawaii-Western Management Group, Inc. (HWMG) owns and operates the provider network you are contracted with to provide health care services within the State of Hawaii. HWMG administers health plans for self-funded and fully insured clients including Hawaii Medical Assurance Association (HMAA), and provides their members with network access.

From time to time, HWMG may need to update the information in this manual. To obtain the most up-to-date version of this manual, visit the Provider Forms & Information section of our website at www.hwmg.org, or contact us to obtain a copy.

Thank you for your participation and support!

Contact Information

HWMG is located in Downtown Honolulu at Pacific Guardian Center, Mauka Tower. Should you have any questions or need assistance, please feel free to contact us as follows.

Mailing Address
HWMG
737 Bishop Street, Suite 1200
Honolulu, HI 96813

Mailing Paper Claims
HWMG - Claims Processing
P.O. Box 32580
Honolulu, HI 96803-2580

Submitting Electronic Claims
Payer ID 48330

Service or Department	Assists With	Contact Information	Hours of Operation (Hawaii Standard Time)
Online for Providers	• Forms & Information • Member Eligibility • Plan Benefits • Claims Status • Provider Directory • Precertification List	• www.hwmg.org • https://www.hmaaonline.com	24 hours a day, 7 days a week
IVR Phone System	• Member Eligibility	Phone (808) 791-7628 Toll-Free (866) 791-7628	24 hours a day, 7 days a week
Customer Service	• Member Eligibility • Plan Benefits • Claims Inquiries • Language Translation	Phone (808) 941-4622 Toll-Free (888) 941-4622 CustomerService@hwmg.org	Mon to Fri 8 am – 4 pm
Health Management	• Precertification • Utilization Review • Case Management	Phone (808) 791-7505 Toll-Free (888) 941-4622 x302 Fax (808) 535-8398 (precertification) (808) 791-7697 (other reviews) UM@hwmg.org	Mon to Thur 8 am – 5 pm; Fri 8 am – 4 pm
Provider Relations	• Provider Information Updates/Changes • Provider Contracts • Fee Schedules • Disputes/Appeals	Phone (808) 791-7557 Toll-Free (800) 621-6998 x304 Fax (808) 535-8314 ProviderRelations@hwmg.org	Mon to Fri 8 am – 4 pm
Credentialing	• Provider Credentials • Credentialing Review	Phone (808) 791-7518 Toll-Free (800) 621-6998 x518 Fax (808) 535-8318 Credentialing@hwmg.org	Mon to Thur 8 am – 5 pm; Fri 8 am – 4 pm

Guiding Principles for Patient Care

HWMG administers health plans for self-funded and fully insured clients, including Hawaii Medical Assurance Association (HMAA), and provides their members with network access. Plan members are encouraged to visit a participating provider for quality healthcare services to maximize their coverage and reduce their out-of-pocket expense.

We are committed to excellence in service; loyalty to providers and members; and pride in providing quality and affordable health insurance benefits.

Provider Access and Availability

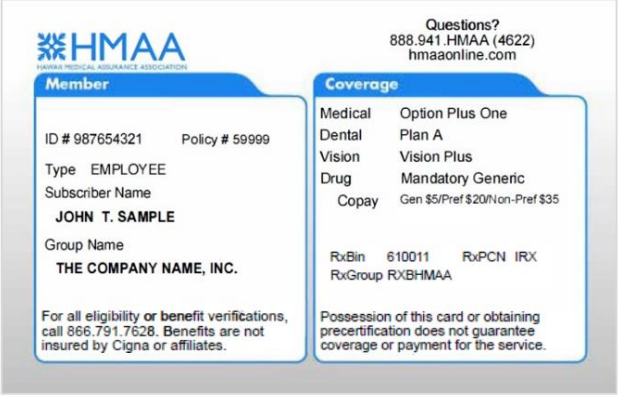
Providers must have their practice location(s) available during their specified office hours for patients to access care. Providers should also make reasonable efforts to provide care within the appropriate timeframe of the patient's request or need for an appointment. If you are unable to accept new patients, please inform Provider Relations so this can be noted in our Provider Directory.

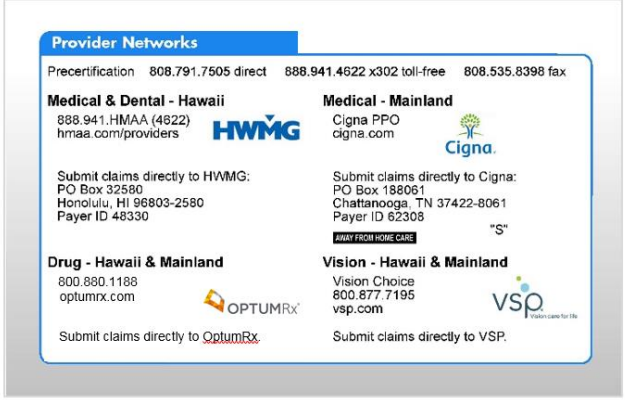
Appointment Type	Access and Availability Standard
Emergent	Immediately or directed to call 9-1-1 or go to nearest emergency room
Urgent	Within 24 hours
Non-Urgent/Non-Emergent	Within 1 week
Routine or Preventive	Within 30 days
Elective or Specialty Care	Within 60 days
Chronic Care	Within 6 months

Eligibility Verification

The member ID card reflects a patient's plan benefits, but does not guarantee coverage or eligibility. It is important for providers to have the most up-to-date information on file and to verify a patient's eligibility before rendering services. Therefore it is recommended that your office staff ask patients if any insurance information has changed since their last visit.

Following is a sample ID card distributed to members reflecting access to the HWMG participating provider network (subject to change). To verify eligibility, please utilize any of the services described in this manual's *Contact Information*.





It is a duty of Employer groups and clients to notify us of updates to member information on a timely basis. Sometimes, there are instances when these updates are not received timely or when an employer would like to discontinue a member's coverage retroactively. In these instances, we request that you understand that when information is given to you, it is correct on the date given but may change later, resulting in a non-covered claim.

Health Plan Benefits

There is a variety of coverage options available for medical, dental, prescription drug, and vision benefits which are subject to change upon an employer group's policy enrollment or renewal. To view plan documents and benefit information for a specific health plan administered by HWMG, please contact our Customer Service Center for assistance or visit https://www.hmaaonline.com.

Members have the right to dispute a decision made by their health plan related to coverage, reimbursement, or any other matter related to their health plan in accordance with the appeals procedure described in their plan documents.

Language Translation Services

We recognize the diverse cultures in Hawaii and the importance of communication in the language of our members. Feel free to utilize our language translation services by contacting our Customer Service Center at any time a language barrier should occur with a patient covered under a plan administered by HWMG.

Provider Information

All participating providers are listed in the Provider Directory. The directory is made available to customers online or, if requested, in paper or electronic format. To participate with HWMG, providers must meet the criteria outlined as part of their duties and obligations under the Participating Provider Agreement and this Administrative Manual.

Updating Your Provider Information

It is imperative to inform us of any changes regarding your practice information. This will ensure the accuracy of our records and the information given to our clients and members. All changes that affect your provider record must be submitted in writing to Provider Relations, preferably by using the **Provider Add, Delete or Change Form** available on our website under Forms & Information.

Information updates include, but are not limited to the following:

- Practice name or location
- Mailing, billing, or payments address
- Practitioners joining or leaving a facility or group practice
- Adding or closing practice locations
- Contact information such as name change, email, phone or fax numbers
- Practice office hours or access limitations
- SSN, Federal TIN, NPI, or CAQH ID number changes and additions (which serve as provider identifiers used by HWMG)
- Updated professional liability insurance, licensure or certifications
- Locum Tenens information for medical providers

If we do not have current information on file, there could be a delay in providing you with claims payments, network updates, and other important information.

Online for Providers

Our Online for Providers system offers 24/7 access to member eligibility, plan benefits and claims information to participating providers through a secure website. To ensure patient and provider information is kept confidential, a unique password is assigned for each provider taxpayer identification number. For access to this feature, please contact Provider Relations.

Forms & Information for Providers

There are a number of forms and information available online for your convenience. We may also communicate information to you through emails, letters, or faxes.

Confidentiality of Provider Information

Provider information obtained during the contracting and credentialing process is considered confidential and is handled and stored by HWMG in a confidential, secure manner as required by HWMG's Administrative Policies, URAC health network accreditation standards, and government regulations.

Network Participation

In order to participate in our provider network and be listed in our directory, providers are contracted with and credentialed by HWMG according to the terms outlined in the Participating Provider Agreement and the following guidelines.

Contracting Process

Individual, group, and facility providers will need to submit one contracting application and Form W-9 for their practice. Providers are contacted by Provider Relations upon review of the application to begin the contracting process.

- Contracting Application for Medical Providers
- Contracting Application for Dental Providers

Credentialing and Recredentialing Process

To ensure quality health care is provided to our members, providers are subject to a credentialing process in accordance with HWMG's Administrative Policies, URAC health network accreditation standards, and government regulations.

- **New Providers** (such as those joining a participating contracted practice) are subject to the initial credentialing process prior to joining the network or listed in the directory.
- **Participating Providers** who contracted with HWMG prior to February 2016 are subject to the initial credentialing process sometime during our phase-in period of 2016 through 2019.

Each practitioner, hospital, or facility will need to submit a credentialing application and supporting documentation to our Credentialing Department with a signed and dated Authorization, Attestation, and Release form that is less than 180 days old.

- Credentialing Application for Hospitals and Facilities
- Credentialing Application for Practitioners from HWMG, CAQH ProView, or another organization

Other application methods may be acceptable at the discretion of our Credentialing Committee. For more information, please contact our Credentialing Department.

HWMG will verify the information submitted, which includes contacting the primary source of particular credentials (e.g., state licensing boards or school programs). Providers are notified of any issues noted during this process.

Once we verify the information, it is presented for peer review. Credentialing applications that meet all of the acceptance criteria may be approved by the Chief Medical Officer. Applications that do not meet established criteria are presented to the Credentialing Committee (composed of network physicians) for review. All information considered in the credentialing and recredentialing process must be obtained and verified within 180 days prior to it being presented to the Chief Medical Officer or Credentialing Committee; otherwise the provider must re-sign the attestation declaring the information on the application and its supporting documentation are currently valid and accurate. Providers are notified within 10 business days of the Committee's decision.

Providers who were initially credentialed and approved to participate in the network are required to be recredentialed at least once every three years in order to maintain their participation status. Information obtained during the initial credentialing process is updated and re-verified by HWMG as required.

We understand that the contracting and credentialing process can be time-consuming, so please feel free to contact our Provider Relations or Credentialing Department for assistance or to inquire about the status of an application. For assistance from our credentialing database vendor CAQH, resources are available on their website at https://proview.caqh.org, or you may contact their Provider Help Desk toll-free at (888) 599-1771 or providerhelp@proview.caqh.org.

Health Management and Prior Authorization

We perform utilization management to ensure members receive appropriate levels of care and utilization of plan benefits. This includes prior authorizations, case management, and coordination of health care services that are clinically appropriate.

Precertification of Medical Services, Drugs, and DME

The list of medical services, drugs, and DME requiring precertification may vary for each health plan administered by HWMG and is subject to change at any time without prior notice. Contact us or visit our website to view the current precertification program list and requirements.

Precertification requests are approved for medical necessity only. Approval is not a guarantee of benefits or payment and is contingent on standard eligibility verification. Failure to obtain precertification may result in a reduction of benefits or payment.

Predetermination of Dental Services

Predeterminations of dental benefits are not mandatory although highly recommended for services over $300. Predetermination provides an estimate of payment for the proposed treatment. Monies are not held in reserve.

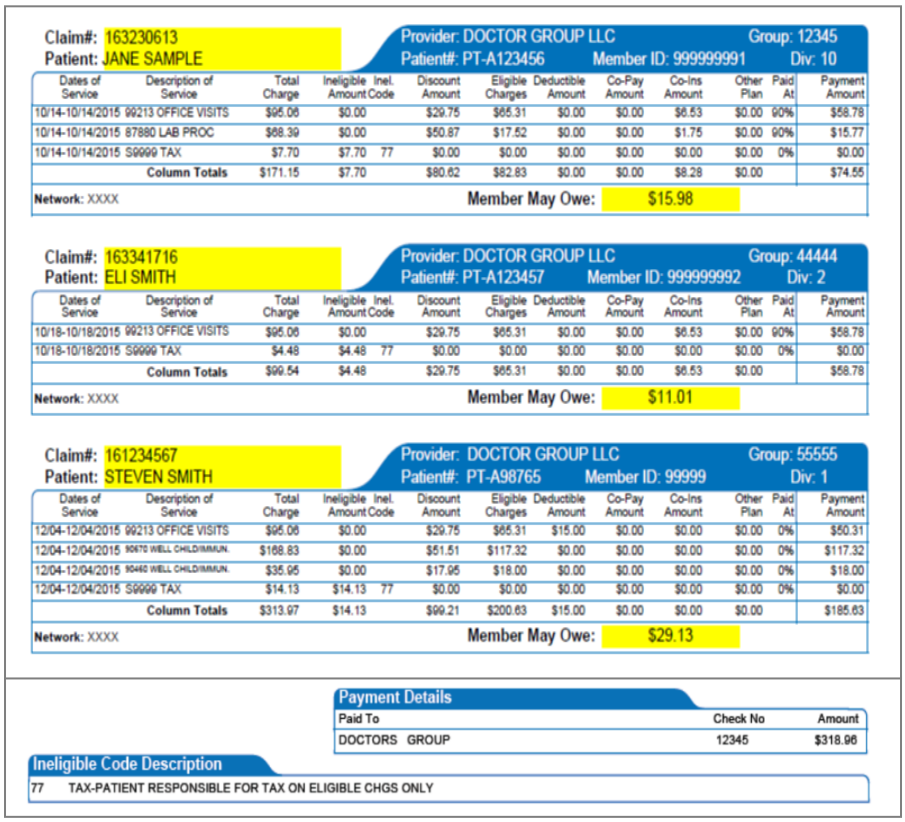
HWMG will respond to predetermination requests within 30 calendar days of receipt. Predeterminations are valid for up to 3 months from the date of issue. After services have been rendered, you may return the predetermination document reflecting the exact dates of service.

Predeterminations do not serve as authorizations or guarantees of benefits. The patient's eligibility and coverage are evaluated as of the actual dates services are rendered.

Provider Payment Reports

As a participating provider, payments will be sent directly to you. You will receive a Provider Payment Report (PPR) with each payment. Following are a sample and description of the information that can be found on the Provider Payment Report.

- Name and address of the provider receiving the payment
- Patient information including name, insured ID number, and policy (group) number
- Claim information including the service date(s) and brief description of service
- Total charges presented
- Provider discount or reduction in charges negotiated
- Deductible amounts applied to the patient
- Copayment and coinsurance amounts charged to the patient
- Payment amount to provider including the check date and number, if applicable
- Non-covered services and ineligible codes (if any)
- Additional comments (if any)



Claim#: 163230613
Patient: JANE SAMPLE
Provider: DOCTOR GROUP LLC Group: 12345
Patient#: PT-A123456 Member ID: 999999991 Div: 10

Dates of Service	Description of Service	Total Charge	Ineligible Amount	Inel. Code	Discount Amount	Eligible Charges	Deductible Amount	Co-Pay Amount	Co-Ins Amount	Other Plan	Paid At	Payment Amount
10/14-10/14/2015	99213 OFFICE VISITS	$95.06	$0.00		$29.75	$65.31	$0.00	$0.00	$6.53	$0.00	90%	$58.78
10/14-10/14/2015	87880 LAB PROC	$68.39	$0.00		$50.87	$17.52	$0.00	$0.00	$1.75	$0.00	90%	$15.77
10/14-10/14/2015	S9999 TAX	$7.70	$7.70	77	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
	Column Totals	$171.15	$7.70		$80.62	$82.83	$0.00	$0.00	$8.28	$0.00		$74.55

Network: XXXX Member May Owe: $15.98

Claim#: 163341716
Patient: ELI SMITH
Provider: DOCTOR GROUP LLC Group: 44444
Patient#: PT-A123457 Member ID: 999999992 Div: 2

Dates of Service	Description of Service	Total Charge	Ineligible Amount	Inel. Code	Discount Amount	Eligible Charges	Deductible Amount	Co-Pay Amount	Co-Ins Amount	Other Plan	Paid At	Payment Amount
10/18-10/18/2015	99213 OFFICE VISITS	$95.06	$0.00		$29.75	$65.31	$0.00	$0.00	$6.53	$0.00	90%	$58.78
10/18-10/18/2015	S9999 TAX	$4.48	$4.48	77	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
	Column Totals	$99.54	$4.48		$29.75	$65.31	$0.00	$0.00	$6.53	$0.00		$58.78

Network: XXXX Member May Owe: $11.01

Claim#: 161234567
Patient: STEVEN SMITH
Provider: DOCTOR GROUP LLC Group: 55555
Patient#: PT-A98765 Member ID: 99999 Div: 1

Dates of Service	Description of Service	Total Charge	Ineligible Amount	Inel. Code	Discount Amount	Eligible Charges	Deductible Amount	Co-Pay Amount	Co-Ins Amount	Other Plan	Paid At	Payment Amount
12/04-12/04/2015	99213 OFFICE VISITS	$95.06	$0.00		$29.75	$65.31	$15.00	$0.00	$0.00	$0.00	0%	$50.31
12/04-12/04/2015	90670 WELL CHILD/IMMUN.	$168.83	$0.00		$51.51	$117.32	$0.00	$0.00	$0.00	$0.00	0%	$117.32
12/04-12/04/2015	90460 WELL CHILD/IMMUN.	$35.95	$0.00		$17.95	$18.00	$0.00	$0.00	$0.00	$0.00	0%	$18.00
12/04-12/04/2015	S9999 TAX	$14.13	$14.13	77	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
	Column Totals	$313.97	$14.13		$99.21	$200.63	$15.00	$0.00	$0.00	$0.00		$185.63

Network: XXXX Member May Owe: $29.13

Payment Details

Paid To	Check No	Amount
DOCTORS GROUP	12345	$318.96

Ineligible Code Description

77 TAX-PATIENT RESPONSIBLE FOR TAX ON ELIGIBLE CHGS ONLY

EFT and ERA Services

Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) services are available to help save time and administrative costs. HWMG uses Zelis Payments (formerly Pay-Plus Solutions) to provide a secure and efficient way to receive ePayments and remittance data. If you are interested in these services, you may visit our website for more information, or contact Zelis Member Services at (877) 828-8834 or www.zelispayments.com to register or inquire about ePayment services.

Overpayments and Adjustments

HWMG utilizes a process whereby overpayments and adjustments are withheld from future claim payments after a 30-day notice has been provided. This process, in most cases, eliminates the need for you to issue refund checks to us. When it is necessary for HWMG to withhold funds from a payment to you, the overpayment or adjustment will appear as a negative amount on your provider payment report, and detailed information including the patient name, date of service, account number and overpayment reason is shown at the bottom of the report.

If we are unable to withhold an overpayment or adjustment from your claim payments within a 90-day period, we will request a refund from you in writing. The refund is due 30 days thereafter, unless you dispute it in writing.

Calculating a Patient's Out-of-Pocket Expense

To assist you with determining a patient's portion when a copayment or coinsurance is involved, following is a sample calculation for an office visit.

Office Visit	
Network Eligible Charge	$ 40.00
Patient Copayment	$ 5.00
Patient Plan Benefit	90% of eligible charge
Patient Coinsurance	10%
State Tax %	4.712% of eligible charge
Coinsurance & Tax	
Eligible Charge	$ 40.00
Minus Patient Copayment	- $ 5.00
= Difference	= $ 35.00
Patient Coinsurance %	10%
Multiply by Difference	x $ 35.00
= Patient Coinsurance	= $ 3.50
State Tax %	4.712%
Multiply by Eligible Charge	x $ 40.00
= Tax	= $ 1.89
Patient's Out-of-Pocket	
Copayment	$ 5.00
Plus Coinsurance	+ $ 3.50
Plus Tax	+ $ 1.89
= Patient Out-of-Pocket Expense	**= $10.39**

Claims Filing

Please file claims on a timely basis. Payment will not be made on any claim received by HWMG more than one year after the date of service. The standard claim forms accepted are as follows:

- **UB-04 Claim Form** for medical inpatient and outpatient facilities
- **CMS 1500 Claim Form** for medical professional and other services
- **ADA Dental Claim Form** for dental services

HWMG accepts claims in paper or electronic format. Please submit claims to:

HWMG Claims Processing
P.O. Box 32580
Honolulu, HI 96803-2580

Electronic Payer ID 48330
through Smart Data Solutions

Electronic Data Interface (EDI) Claims Submission

You are not required to submit claims electronically for payment. HWMG accepts electronic claims using Smart Data Solutions as its EDI clearinghouse. We do not assess providers with charges to file electronic claims, although fees may be assessed by your EDI clearinghouse.

Providers interested in submitting electronic claims may visit our website for details or contact Provider Relations. Please have the following information available:

- Name of billing company or software package you are using
- Estimated claims volume that would be submitted electronically
- Whether your office is presently submitting electronic claims to other companies

You may also contact Smart Data Solutions' Toll-Free Support at (855) 297-4436 or stream.support@sdata.us to register, set up a direct connection, or inquire about EDI services.

Claims Filing Instructions

Providers must complete and file the appropriate claim form on behalf of the patient. A separate claim must be filed for each covered patient and each provider. Please notify us of any updates to your information prior to submitting claims affected by the change. All information submitted on the claim forms must be accurate and supported by the underlying health records (medical or dental). Records need not be provided to HWMG unless required by our administrative policies or requested by HWMG.

Claims Processing Timeliness Standards

All claims must be filed within one year from the date of service. HWMG will make its best effort to complete benefit determinations and process claims timely in accordance to these standards.

If the claim is not correctly completed, this may result in a delay of your claims processing or the denial and return of your claim.

- **Contested Claim:** If a claim requires additional information or more time for review by HWMG, we will notify you within the specified timeliness standard.
- **Uncontested Claim:** If payment is not made within the specified timeliness standard, HWMG will calculate interest beginning the next calendar day.

Receipt of “clean claims” will result in a faster turnaround time. A claim is considered clean if the applicable billing claim form is properly completed in accordance with the instructions described on the form and directions set forth by HWMG or regulatory mandates.

FUNCTION	STANDARD
Benefits Determination	
Non-urgent	
- Pre-service	15 days
- Post-service	30 days
Urgent	72 hours
Extension of Time to Make Decision	
Non-urgent	
- Other than for missing claim information	15 days
- For information missing from claim	45 days
- Deadline to make decision	45 days from our request
- Claimant time to respond	72 hours
Urgent	
- For information missing from claim	48 hours
- Deadline to make decision	48 hours
- Claimant time to respond	48 hours
Duty to notify claim is not clean	
- Obligation not required	None, if reported monthly
- Pre-service, non-urgent	5 days
- Pre-service, urgent	24 hours
- Post-service, paper	15 days
- Post-service, electronic	7 days
Timeframe to Pay Claims	
If not denied or contested	
- Paper	30 days
- Electronic	15 days
After missing information is received	
- Paper	30 days
- Electronic	15 days
Note: Late Payment Interest = 15% per annum (paid with claim if more than $2)	

Common Reasons for Returned Claims

Following is a list of common errors on claim forms that may cause a delay in processing. It is important to review these areas before submitting claims to avoid any unnecessary delays.

- Patient’s name and member ID
- Patient’s name and date of birth
- Date of service
- Date, place, and cause of injury
- Descriptive diagnosis, procedure, or service codes
- Total charges
- Services not being appropriate for diagnosis submitted
- Provider’s TIN, billing name and address
- Provider’s or agent’s signature
- Supportive data for modifiers

Resubmission of Claims

Claims that are resubmitted due to changes in diagnosis, procedure or service codes (e.g., office notes or operative reports) require documentation to substantiate the change. You must clearly indicate that it is a resubmission to avoid unnecessary delays in processing.

Claim Filing Tips

Filing your claims carefully and concisely will help ensure they are processed accurately and in a timely manner. Following are helpful claim filing tips.

All applicable sections of the claim form should be completed. For further assistance with **UB-04 or CMS-1500 Claim Forms**, instructions are available on the CMS website at www.cms.gov. For further assistance with the **ADA Claim Form**, instructions are available on the ADA's website at www.ada.org.

Acupuncture, Chiropractic, and Naturopathic Care

To assist in determining which CPT code to file, following are the most commonly used codes for these services (subject to change). Please refer to the most current CPT codes published by the American Medical Association (AMA) before submitting your claim.

SERVICE	VALID CPT CODE
Acupuncture	
Acupuncture, one or more needles;	
- without electrical stimulation, initial 15 minutes	97810
- without electrical stimulation, each add'l 15 minutes	97811
- with electrical stimulation, initial 15 minutes	97813
- without electrical stimulation, each add'l 15 minutes	97814
Chiropractic Care	
Chiropractic manipulative treatment (CMT)	
- for spinal, one to two regions	98940
- for spinal, three to four regions	98941
- for spinal, five regions	98942
- for extraspinal, one or more regions	98943
Naturopathic Care	
Unlisted special service, procedure or report	99199

Claims for new patients should include the corresponding CPT code within range 99201 to 99205 in order to bill for evaluation and management (E&M) services. E&M codes for established patients are **not** eligible for payment.

Ambulatory Surgical Center (ASC) for Facility or Professional Services

ASC Facility claims should include the corresponding surgery CPT code followed by the modifier. ASC Professional Service claims should include the corresponding surgery CPT code only.

Anesthesia for OB/GYN Services, Pregnancy Labor, and Delivery

When filing claims with anesthesia for OB/GYN services, submit with modifier –47 only if there is no other CPT code available for the procedure (e.g., a paracervical block should be billed with CPT code 64435 rather than with modifier –47).

For pregnancy labor and delivery, payment is processed according to the global unit values shown below. The global unit values represent a combination of the base units for anesthesia rendered during long labor and time units. After 3 hours, increasing the unit value by one for each additional hour is allowed. Thus, 4 hours are valued at 14 units; 5 hours at 15 units; and so on. A maximum number of units will not be imposed as long as service is being rendered.

Time in Minutes	Converted to Hours	Unit Value
Up to 30 minutes	up to ½ hour	7
45 minutes	¾ hour	8
60 minutes	1 hour	9
90 minutes	1 ½ hours	10
120 minutes	2 hours	11
150 minutes	2 ½ hours	12
180 minutes	3 hours	13
240 minutes	4 hours	14

Coordination of Benefits (COB)

For patients entitled to the same or similar benefits under multiple plan coverage, coordination of benefits is determined using the National Association of Insurance Commissioners (NAIC) rules. When a patient is covered by Medicare and a plan administered by HWMG, the Medicare Secondary Payer (MSP) rules apply.

- The Primary Carrier is responsible for costs of services provided up to the benefit limit for the coverage or as if no other coverage exists. The primary coverage is determined by which plan covered the patient the longest and has the earliest effective date.
- The Secondary Carrier is responsible for the total allowable charges, up to the benefit limit for the coverage less the primary payment not to exceed the total amount billed. The secondary coverage will not exceed the amount the carrier would have paid if it had been the only coverage.

The “Birthday Rule” applies to dependents who are natural born and adopted children. Primary coverage is determined by the subscriber’s birthday that falls earliest in the year, if both parents are employed and have coverage. If both parents have the same date of birth, the plan which covered the patient the longest is considered primary.

If the patient’s secondary carrier is a plan administered by HWMG, include a copy of the primary carrier’s Explanation of Benefits (EOB) or Report to Member (RTM) with your claim submission to help expedite processing. We will coordinate benefits up to the amount of the patient’s responsibility.

Dental Services

Prior to filing a claim, please review our **Dental Claim Submission Requirements** and **Processing Guidelines** (subject to change at any time) available on our website. Special limits and restrictions may apply to certain basic, preventive, restorative, or major services.

Injectable Medications

Claims for injectable medications should indicate the HCPC code, NDC number, and medication name in the appropriate boxes of the claim form.

Locum Tenens for Medical Services

Locum tenens are substitute physicians who cover for a regular physician when they are absent due to illness, pregnancy, vacation or continuing medical education. The regular physician has a *financial agreement* to pay the locum tenen a per diem or similar fee for time basis.

To file a medical claim for a locum tenen, include all of the regular physician's information on the CMS-1500 Claim Form and indicate the locum tenen's name in box 19. Do not file claims with the locum tenen's TIN on the form.

If there is no financial agreement between the two physicians, this is not considered a locum tenen. Therefore, claims should be billed with the treating physician's information. In this case, do not indicate on the claim that you are covering for a physician.

Medicare Coverage

For patients who qualify for Medicare coverage due to end-stage renal disease (ESRD), special Medicare rules apply for calculating payments.

Physical Exams

Claims for physical exams should be submitted with the proper preventive medicine CPT codes and corresponding diagnosis codes.

Physical Therapy and Occupational Therapy

Services must be ordered by a physician, physician's assistant, or advanced practice registered nurse under an individual treatment plan; document the need for skilled physical and/or occupational therapy in the medical records; be medically necessary and reasonably expected to significantly improve the patient's condition as defined in the member's plan documents. Other limitations may apply.

Special Limitations on Covered Services

Certain services covered by a patient's health plan may be subject to special limitations. A special limit is a restriction on a covered service such as the dollar amount, how often a patient can receive the service, an age restriction, exclusion, or some other limitation. Please view these limitations by referring to the patient's health plan documents and benefit information.

State Vaccination Programs for Children

If you are a provider participating with a State vaccination program for children and using vaccines federally purchased by the State, please provide us with a copy of the program's confirmation letter verifying your participation. We will process the claims for administrative charges only.

Third-Party Liability or Subrogation

Third-party liability (TPL) or subrogation situations occur when:

- A patient has an injury or illness caused, or is alleged to have been caused, by another individual and the patient has, or may have, the right to recover damages or obtain payment for that injury or illness; or
- A patient has, or may have, the right to recover damages or receive payment from another individual for that injury or illness without consideration to liability.

Do not submit claims if the patient has coverage under workers' compensation insurance. Any expenses under workers' compensation will not be covered.

If the injury or illness involves a motor vehicle accident, auto insurance personal injury protection assistance must be used in its totality before health plan benefits can be used. Before determination of plan benefits is made, we may request for the patient to complete and sign documents to secure our rights to reimbursement in a third-party liability situation. If the patient does not comply with this request, a postponement of payment or denial of claims may occur. Having your patient complete a **TPL Questionnaire** at the time of service and including it with your claim submission will help expedite the processing of claims that could potentially be a third-party liability.

Unlisted Procedures

When submitting a claim with unlisted procedures, please attach the operative report and/or clinical notes for that visit. Claims submitted without supporting documentation may be denied.

Requests for Reconsideration

Claim Payment

If you disagree with a claim payment decision that we make, you may contact our Customer Service Center to request a reconsideration of the claim payment. Requests for reconsideration must be made within one year of the date the claim was paid or denied. When calling, be sure to provide us with the following information so we can promptly review your request.

- Patient's name
- Patient's member ID #
- Date of service
- Amount billed
- Issue to be resolved
- Information to support the request

All reconsideration requests should contain additional information for our review and decision-making. Please be sure to provide this information in a timely manner. Otherwise, the request may take longer to process.

After speaking to a representative, he/she will review the file, obtain your reason for reconsideration, and forward your claim to the appropriate department for review. These requests are handled in accordance with our *Claims Processing Timeliness Standards*.

The reconsideration process is intended to provide a quick, easy and informal means to address and resolve payment issues, but is not intended to supplant the formal appeal process provided in your Participating Provider Agreement and this Administrative Manual. In order to assure time to pursue the formal appeal process if you are not satisfied with our reconsideration decision, please request your reconsideration early enough to still have time to file a formal dispute for administrative matters.

Utilization Review Denial

If you disagree with a denial which was based in whole or in part on a clinical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate, you may contact our Health Management Department to request reconsideration.

All reconsideration requests should contain additional information for our review and decision-making. Otherwise, the request may take longer to process. The reconsideration process is intended to provide a quick, easy and informal means to address any additional clinical information, but is not intended to supplant the formal appeal process provided in your Participating Provider Agreement and this Administrative Manual.

Eligible Charge

If you disagree with a specific eligible charge, you may request an increase by contacting Provider Relations, preferably via email. We will analyze your request and communicate our decision in a timely manner.

Dispute Resolution

HWMG strives to informally resolve any issues you may have as soon as possible. If issues cannot be resolved informally through reconsiderations, participating providers have the right to dispute the following types of determination made by HWMG in accordance with the terms outlined in the Participating Provider Agreement and this Administrative Manual.

- Administrative matters including claims payment disputes;
- Termination from the provider network or any action such as suspension by HWMG related to a provider's professional competency (e.g., conduct, quality of care, or credentialing review).

Your request must be in writing and include all relevant documentation to:

HWMG, Attn: Provider Relations
737 Bishop Street, Suite 1200
Honolulu, HI 96813

Disputes Involving Administrative Matters

If you wish to dispute a determination made by HWMG for administrative matters (e.g., administrative procedures or claims payment), you must request an appeal. We must receive your appeal within 180 days from the date we first informed you of the action in dispute.

Send written appeals to the address above or fax to (808) 535-8314.

HWMG will consider the appeal and respond within 60 calendar days of receipt. Determination is made by an Appeals Committee. Members on this committee will not have been involved in the initial decision-making which is the subject of the dispute.

If you disagree with HWMG's appeal decision, you may request Binding Arbitration in accordance with the terms of your Participating Provider Agreement.

Disputes Involving Network Termination or Action by HWMG Related to Professional Competency

If you wish to dispute a determination made by HWMG related to network termination or action related to professional competency (e.g., conduct, quality of care or credentialing review), you must request an appeal. Your request must be in writing and enclose all relevant documentation available. We must receive your appeal within 60 days from the date we first informed you of the termination or action by HWMG in dispute.

Send written appeals to the address above or fax to (808) 535-8318.

First-Level Appeal and Decision: The first-level appeal is reviewed by a peer review Appeals Committee comprised of at least one practicing clinical peer physician and two qualified members who were not involved in the initial decision-making that is the subject of the dispute. The Appeals Committee will convene within 20 calendar days of appeal receipt. You may appear to present

evidence or testimony. We will notify you of the committee's decision in writing within 10 business days following the completion of the hearing. If you disagree with the decision or if you have additional information supporting your appeal that may not have been available at the time the initial appeal was filed, you may file a second written appeal within 30 days of receiving HWMG's initial decision.

Second-Level Appeal and Decision: The second-level appeal is reviewed by a peer review Appeals Committee comprised of at least three (3) qualified committee members who did not serve on the first-level Appeals Committee and who were not involved in the initial decision-making that is the subject of the dispute. The Appeals Committee will convene within 20 calendar days of appeal receipt. You may appear to present evidence or testimony. We will notify you of the committee's decision in writing within ten (10) business days following the completion of the hearing. If you disagree with the Second Appeals Committee's decision, you may request Binding Arbitration in accordance with the terms of your Participating Provider Agreement.

Expedited Review

You may request an expedited review of any HWMG's decision to deny payment in any matter where a quicker response time is required by law. HWMG will provide a decision in accordance with federal or state timeliness standards.

Binding Arbitration

Any and all claims, disputes, or causes of action between HWMG and Provider, including but not limited to any and all claims, disputes or causes of action based upon contract, tort, statutory or administrative law, or actions in equity ("Dispute"), shall be resolved by binding arbitration as set forth below.

The arbitration shall be initiated by any party by serving Notice on the other party demanding arbitration and stating the substance of the controversy and contention of the party requesting arbitration. Any dispute must be timely submitted and arbitration pursuant to the time frame and procedures in section above.

The arbitration shall be conducted by a single arbitrator in Honolulu, Hawaii, pursuant to the Federal Arbitration Act and the arbitration rules of Dispute Prevention and Resolution, Inc., applicable to the Federal Arbitration Act. Consolidation of parties shall not be permitted in arbitration. Each party will bear its own costs, expenses and attorney's fees associated with the arbitration. The fees and costs of the arbitrator and the arbitration service shall be borne by the party to the arbitration that does not prevail. The decision of the arbitrator shall be final and binding on the parties. The parties waive their respective rights to jury trial. No action may be brought in any court in connection with any Dispute or any arbitration decision, except as provided under the Federal Arbitration Act. The arbitration award and the matter in dispute between the parties shall be kept in strict confidence. The parties shall preserve the confidentiality of Member Personal Health Information, Peer Review and Quality Assurance information which may be entailed in such Dispute, except insofar as state or federal laws require reporting to governmental authorities or national data banks.

Definitions

The following terms are defined as follows. Refer to HWMG's Participating Provider Agreement and our clients' health plan documents for additional terms and definitions.

Agreement. HWMG's Participating Provider Agreement, including its Exhibits, Administrative Manual, and clients' health plans that may be amended from time to time.

Claim. A complete billing for covered services from Provider on a healthcare claim form or other form approved by HWMG or required by federal or state law, or by electronic transmission accepted by HWMG.

Covered Benefits. A service or supply that qualifies for payment under the terms and conditions of the Member's Plan Document and meets the Eligible Claim criteria set forth below.

Eligible Charge. The lower of the Provider's actual charge or the amount HWMG establishes as the maximum eligible fee.

Eligible Claims. All Claims submitted for payment must be:

(1) for Services constituting Covered Benefits under the particular Member's Plan;
(2) for Services that were necessary and appropriate for the symptoms, diagnosis, and direct care or treatment of the Member's illness or injury, or for preventive services specifically covered by the particular Member's Plan Document;
(3) not primarily for the convenience of the Member or Provider;
(4) in compliance with all Professional Standards of care and the terms of this Agreement, as may be amended from time to time;
(5) complete and accurate in regards to all information required by the Claim form and include any additional information required by HWMG's Administrative Policies; and
(6) submitted within one year after the date on which the Service was rendered.

Member. An individual who meets the eligibility requirements and is enrolled in a plan offered by HWMG's clients.

Notice. All Notices which are required to be given, served or sent by any party to any other party pursuant to this Agreement shall be in writing, via certified mail, return receipt requested.

Our. Reference to Hawaii-Western Management Group, Inc. (HWMG).

Plan. Any health plan administered by HWMG that provide benefits for services performed by the Provider.

Plan Document. The plan description or other evidence of healthcare coverage issued by HWMG's clients or other Plan that describes Member's plan and Covered Benefits.

Professional Standards. Generally recognized professional standards relating to clinical care, billing, professional ethics, record-keeping, confidentiality, and related matters regarding rendering of medical services, prevailing in the applicable professional community at the time Services are rendered, for the medical specialty involved.

Protected Health Information. Individually identifiable health information that is transmitted by electronic media, or transmitted or maintained in any other form or medium. Protected health information excludes individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; records described in 20 U.S.C. 1232g(a)(4)(B)(iv); and employment records held by a covered entity in its role as employer.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, or health care clearinghouse; (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) Identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Services. Eligible healthcare services and/or supplies that qualify for payment according to the Member's Plan Documents, as further described in the Participating Provider Agreement.

We. Reference to Hawaii-Western Management Group, Inc. (HWMG).

Appendix

Other Rules and Regulations for Dental Providers

Dental Claims Submission. Provider shall only submit Claims for Services personally provided by Provider or by an employee of the Provider incident to Provider's professional Services and under Provider's direct supervision. Services are "incident to" if furnished as an integral part of Provider's personal professional Services in the course of diagnosis or treatment. "Direct supervision" requires that the Provider must be physically present in the office suite and immediately available to provide assistance and direction throughout the time the employee is performing Services.

Provider shall furnish to HWMG all additional information (including medical records) required by HWMG to verify and substantiate Provider's Claims for Services, within five business days of HWMG's request, or immediately upon HWMG's request if pertaining to preauthorization of urgently needed Services.

No payment shall be made by HWMG for any Eligible Claim submitted to HWMG more than one year after the date of Service related to the Eligible Claim, and Provider shall not attempt to collect payment from HWMG or Member for Claims for Services for which Provider failed to submit a Claim to HWMG within one year of the date of Service to the Member.

HWMG does not govern Provider's charges to a Member for any service or supply that is not a Covered Benefit under the Member's Plan. However, prior to providing such service or supply, Provider agrees to obtain Member's signed statement informing Member that the service or supply is not expected to be covered by the Member's Plan, and acknowledging the Member's personal financial responsibility for the service or supply unless such actions would be prohibited by EMTALA or other applicable law under the circumstances existing at the time of the Member's treatment.

Provider shall cooperate with coordination of benefits procedures in HWMG's Administrative Policies, including identification of third party payment sources and documentation of Services as may be needed for such third party coverage, such as auto insurance, workers' compensation, disability insurance, other health insurance, or other third party claims.

Dental Records. Provider shall ensure that a dental record is established and maintained for each Member, that fully and accurately documents Services provided and billed, and that complies with generally recognized medical practices and all applicable federal and state laws, rules and regulations.

Dental information, records, charts, and files regarding Members shall be kept, maintained, used, disclosed, and accessed in accordance with all applicable federal and state laws, rules and regulations pertaining to records management, privacy and confidentiality.

Subject to applicable federal and state laws, Provider shall allow HWMG or its designees access to medical and business records for purposes of utilization review, quality assurance, peer review activities, claims processing, dispute resolution, fraud and abuse inquiries, and other operational needs of HWMG. Access to records shall occur at Provider's premises in a reasonable manner and at a mutually agreeable time within ten (10) calendar days following HWMG's request. Copies of records requested by HWMG shall be provided by Provider to HWMG, at Provider's own cost, within five business days following HWMG's request.

Failure of Provider to provide prompt access to records for the purposes stated in this section shall constitute a material breach of Contract that may result in termination of Participating Provider Agreement.

Provider shall protect the confidentiality of Members' Protected Health Information in accordance with HIPAA and all other applicable laws, rules and regulations, and to execute a Business Associate Agreement on a form approved by HWMG when determined necessary by HWMG for privacy protection. Provider shall use its best efforts to obtain a Member's written authorization on a form approved by HWMG for access to records when required by law, the records holder, or HWMG.

Miscellaneous. The Rules and Regulations may be amended only by mutual written agreement of HWMG and Provider, except that HWMG:

(a) may amend as necessary to comply with federal or state laws or regulations, with thirty calendar days written Notice to Provider;

(b) may amend HWMG's Administrative Policies to address its operational needs, to the extent the amended Administrative Policies are not inconsistent with the terms of HWMG Participating Provider Agreement, by providing copies of any amended Administrative Policy to Provider at least thirty days before its effective date;

(c) may amend Members' Plan Documents to address Covered Benefits and any other aspects of operation of Member Plans, within the same time frame that state and federal law require notice to Members of material changes in Plan Documents; and

HWMG and Provider agree to meet and confer in good faith regarding issues or problems arising out of the performance of this Agreement including, but not limited to, those pertaining to Member complaints, customer service, utilization of services, credentialing, authorization, claims processing, and disputes.

Participate and cooperate in any utilization management, quality assurance, peer review, and regulatory compliance activities as may be required by HWMG for accreditation or regulatory purposes, as long as it does not unreasonably interfere with members' medical care;

Participate and cooperate with HWMG's claims review and appeal processes, and with HWMG's investigation of any complaints, appeals or other concerns relative to the Provider and/or Services provided.

HWMG and Provider shall comply with all state and federal laws, rules and regulations in performance of this Agreement, including but not limited to all laws prohibiting discrimination against any person on the grounds of race, color, national origin, religion, creed, sex, sexual orientation, age, disability or other protected class in regards to employment or in participation in the benefits of the Services provided under this Agreement, and all applicable privacy laws, including the Health Insurance Portability and Accountability Act ("HIPAA") and its Code Sets and Transaction Standards, Security Standards, and Privacy Rule.

Nothing contained in the Rules and Regulations is intended or shall be interpreted:

(a) to interfere with the Provider-Patient relationship;

(b) to discourage or prohibit Provider from discussing preventive or treatment options with Members, or

(c) to discourage or prohibit Provider from providing other medical advice or treatment deemed appropriate by the Provider, even though it may not be covered under the Member's Plan.

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