BULLETIN OF

Annual Notices

From HMSA's Quality Management Department 2015

What's Inside

Utilization Management **2**

Members' Rights & Responsibilities **4**

HMSA's Clinical Practice Guidelines **6**

HMSA's Annual Quality Improvement Report **6**

Notification Requirements **7**

Access to Medical Care Standards **7**

After-Hours Care **7**

Advance Directives **7**

HMSA PHILOSOPHY OF CARE

At HMSA, we maintain the highest levels of quality health care for our members.

We maintain a mutually respectful relationship with our members and health care practitioners to promote effective, quality health care and service.

We value our members' health and well-being. Prevention is a key component of our comprehensive care programs, resulting in lower risks of illness and better management of problems.

We hold the credentialed health care practitioners in our network to high standards of quality in the health care and services that they provide and in the satisfaction of their patients.

We inform our members about how their health plan works, how network physicians are compensated, and how utilization monitoring supports the delivery of quality health care.

We encourage health care decision-making that's based on appropriate care and service and existence of coverage. We reward appropriate decisions on care through financial incentives. We don't reward practitioners or other individuals for denying payment or coverage and actively discourage barriers to care.

We don't encourage decisions that result in underutilization and we don't provide financial incentives to utilization management decision makers.

We afford our members and physicians the right to voice complaints, appeal decisions, and receive timely responses from us.

NOTICE OF PRIVACY PRACTICES

A copy of HMSA's Notice of Privacy Practices is available on hmsa.com.

For paper copies of this notice, contact:

HMSA Privacy Office
P.O. Box 860
Honolulu, HI 96808-0860

UTILIZATION MANAGEMENT

Utilization management (UM) is the evaluation of the appropriateness, medical necessity, and efficiency of health care services using established criteria and provisions of a patient's health plan. HMSA's UM program identifies opportunities to improve the quality and delivery of care. UM activities sometimes result in the implementation of new policies and procedures.

Our UM program doesn't offer financial incentives or have care management targets that promote or discourage the use of health care services. Clinical reviewers will immediately excuse themselves from UM cases when there are any real or perceived conflicts of interest.

Per your Participating Provider Agreement, you agree to comply with HMSA's UM requirements. We may reduce or deny payment to providers who don't meet UM requirements and whose services don't meet HMSA's medical policies and payment determination criteria.

Utilization Monitoring, Analysis, and Validation

We monitor practice patterns in billing and coding histories. Through data analysis, we look at the utilization, cost, and risk of services and identify opportunities to improve efficiency. When possible, we work to reduce your administrative activities and expenses.

We also provide feedback to promote evidence-based medicine. Nurse reviewers, medical directors, and certified coders conduct clinical and coding reviews when variances are found in our utilization data.

Clinical Criteria/Information Sources

To develop the medical policies we use in our UM decision making, we rely on scientific evidence and nationally recognized clinical criteria. Our medical policies draw on the medical necessity criteria (payment determination criteria) under Hawaii's Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4).

Our medical reviews are based on HMSA's medical policies, the Blue Cross and Blue Shield Association's policies, and Medicare coverage determination. Other sources of information include generally accepted standards of medical practice, review of medical literature, government approval status, and expert practitioners.

Precertification

Precertification is a process that reviews the appropriateness and medical necessity of a health care service with a member's health care benefits to determine if we'll pay for the service. Precertification evaluates claims that fall in the following categories:

- Services with aberrant or potentially inappropriate patterns of care.
- New technology and new uses of existing technology.
- Services with the potential for non-covered purposes (e.g., lifestyle enhancement).
- Transplants or other complex treatments that can be coordinated for quality to prevent unexpected out-of-pocket expenses for the member.
- Services with potential safety or efficacy issues.
- Appropriateness of location and level of care. Precertification decisions are based on scientific evidence and consider the patient's health coverage, individual circumstances, and the medical services that are available locally and how they're delivered. HMSA's list of services that require precertification is subject to change.

To ask about a UM issue or make a precertification request, please contact our precertification staff. Physician reviewers are also available to discuss or clarify a decision. All calls are returned within two business days during business hours.

UTILIZATION MANAGEMENT (CONTINUED)

Providers and Members in Hawaii

948-6464 on Oahu
1 (800) 344-6122 toll-free on the Neighbor Islands
Monday through Friday, 7:30 a.m. to 4:30 p.m.

Out-of-state Providers

1 (800) 877-5394 toll-free
Monday through Friday, 7:45 a.m. to 4:30 p.m., Hawaii Standard Time

Calls outside of business hours are received by a voicemail system and responded to by the following business day. Faxes can be received 24 hours a day at 944-5611 on Oahu.

Members and health care providers who have questions about UM processes may also write to the following address:

HMSA — Medical Management Department
P.O. Box 2001
Honolulu, HI 96805

For services relating to behavioral health, providers or members may call HMSA's behavioral health services at 1 (855) 856-0578 toll-free.

Interrater Reliability

We conduct interrater reliability assessments at least annually to see if HMSA reviewers are consistently applying UM criteria and identifying opportunities for improvement.

Variable Intensity Review (VIR)

Variable intensity reviews look at selected providers and their compliance with HMSA policies. If the provider is consistently compliant, HMSA may decrease or waive precertification and claims documentation requirements for the provider and/or exempt the provider from periodic UM reviews. However, if the provider is not compliant with HMSA's policies, the provider may see certain requirements intensify.

Appeals

Our members and/or their representatives have the right to appeal an HMSA decision. When a precertification request is denied, we give members and/or their representatives information on how to file an appeal, the types of appeals that are available, who can request an appeal, when to file an appeal, what information to include, and what to do if they disagree with an appeal decision.

Case Management

Case management helps members and their families who are experiencing multiple or complex conditions to access care, services, and coordination of care.

The goal of case management is to help members reach optimum health or improved capabilities. Through a collaborative process, a case manager works with providers, hospitals, and family members to help coordinate health care services and health plan benefits. Coordinating services and providing individualized case management ensures that members understand their options and have access to the best possible care.

To refer a patient or receive additional information about the case management program, call 1 (855) 765-7264 toll-free, Monday through Friday, 8 a.m. - 7 p.m., or Saturday, 8 a.m. - 5 p.m. Faxes can be received 24 hours a day at 748-0662 on Oahu.

MEMBERS' RIGHTS AND RESPONSIBILITIES

HMSA respects members and their rights. Our policies uphold our members' rights and support their responsibilities to work with their health care providers to advance their health.

Members' Rights

- Members have the right to make recommendations regarding their health plans' Members' Rights and Responsibilities policies.

Information Disclosure

- Members have the right to information about HMSA, covered services, the names and qualifications of physicians and other providers involved in their medical treatment, and Members' Rights and Responsibilities.
- Members have the right to information about how HMSA participating providers and HMSA make medical treatment decisions, including information about how payment is determined and made.
- Members have the right to information about their medications — what the medications are, how to take them, and what the possible side effects are.
- To make an informed decision about, consent to, or refuse a course of treatment, members have the right to receive as much information about a proposed medical treatment or procedure as they may need. Except in cases of emergency services, this information includes:
  - A description of the proposed treatment or procedure.
  - Any medically significant risks.
  - The risks of any alternate courses of treatment or nontreatment.
  - The name of the person who will perform the treatment or procedure.
- Members have the right to be informed of continuing health care needs after being discharged from an inpatient or outpatient facility.
- Members have the right to examine and receive an explanation of any bills for non-covered services, regardless of payment source.

Accessibility of Services and Providers

- Members have the right to receive emergency services when they, acting reasonably, believe they have an emergency medical condition. In these situations, we won't deny payment.
- Members have the right to receive urgently needed services when traveling within or outside of the service area or in the service area when unusual or extenuating circumstances prevent them from getting care from their primary care provider.
- Members have the right to a choice of health care providers to receive appropriate, high-quality care and services. (Note: Some health care providers may not be accepting new patients because they are at capacity.)
- Members have the right to reasonable continuity of care and to know in advance the time and location of an appointment, as well as the name of the provider who will provide the care.
- Members have the right to timely access to their primary care provider or physician and referrals to specialists when medically appropriate.

MEMBERS' RIGHTS AND RESPONSIBILITIES (CONTINUED)

Participation in Treatment Decisions

- Members have the right to an honest discussion about appropriate or medically necessary treatment options available for their conditions regardless of cost or benefit coverage.
- Members have the right to actively participate in all decisions regarding their health and treatment options.
- Members have the right to refuse treatment or leave a medical facility even if it's against the advice of the provider (as long as the member accepts responsibility for the consequences of the decision to leave).
- Members have the right to know if a provider proposes experimental or investigative treatment. Members have the right to refuse to participate in such treatment.
- Members have the right to complete an advance directive, living will, or other directive and to have that directive placed in their medical records.
- Members have the right to assign their rights to any person who may have the legal responsibility to make decisions about their medical care on their behalf.

Respect and Nondiscrimination

- Members have the right to be treated with respect and with recognition of their dignity and right to privacy.
- Members have the right to exercise these rights regardless of their race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care. Both HMSA and HMSA participating providers will uphold these rights.

Confidentiality of Health Information

- HMSA has always safeguarded and handled members' information with the utmost confidentiality. Members have the right to request access to the records that HMSA has about them.
- Members have the right to request amendments to and restrictions on the use of their records, to have their communications sent to an alternative address (to avoid putting their life in danger), and to receive an accounting of disclosures that HMSA made about them.
- HMSA requires verbal or written permission from members or members' personal representatives before their information may be released to persons other than the member for purposes that aren't required by law or aren't permitted by HMSA policies.

Complaints

- Members have the right to voice complaints and appeal decisions about their health plan, providers, or the care they received.
- Members have the right to expect that HMSA will look at problems fairly and address them appropriately.
- Members have the right to a response from HMSA or from an HMSA participating provider for reasonable requests made for services.

MEMBERS' RIGHTS AND RESPONSIBILITIES (CONTINUED)

Members' Responsibilities

Plan Information and Benefits

- Members are responsible for reviewing information about services their plan pays for, policies, and procedures as stated in their *Guide to Benefits* or *Evidence of Coverage* and other member materials.
- Members are responsible for complying with all the terms of their membership with HMSA.
- Members are responsible for reporting any changes that may affect their membership.
- Members are responsible for asking questions of their health care providers and HMSA.
- Members are responsible for providing HMSA and providers with the information they need to provide care to the extent possible.

Self-management

- Members are responsible for understanding their health conditions and for participating in the development of mutually agreed on treatment plans to the extent possible.
- Members are responsible for following treatment plans and instructions for care that they've agreed on with their providers.
- Members are responsible for behaving in a manner that supports the care provided to other patients and the general operations of the facility where they're receiving care.

Reporting Fraud

- Members are responsible for reporting wrongdoing and fraud to the appropriate resources or legal authorities.

HMSA'S CLINICAL PRACTICE GUIDELINES

We review HMSA's Clinical Practice Guidelines (CPGs) annually in collaboration with physician reviewers who practice locally. We adopt guidelines that reflect current, evidence-based practices from national sources. CPGs serve as an educational reference and don't supersede your clinical judgment of the appropriate and necessary care for your patients.

To view the CPGs, refer to the Provider E-Library at hmsa.com/portal/provider/zav_PH.CPG.00.01.htm. To request a paper copy, call Ramona Ung at 948-6661 on Oahu.

HMSA'S ANNUAL QUALITY IMPROVEMENT REPORT

HMSA's 2014 Quality Improvement Program Evaluation Report summary is available to all HMSA health care providers and members. This report highlights clinical and service accomplishments for the year and provides an assessment of the overall effectiveness of HMSA's Quality Improvement Program.

To view the report, go to hmsa.com/about/quality. To request a paper copy, call Ramona Ung at 948-6661 on Oahu.

NOTIFICATION REQUIREMENTS

Participating providers (including specialists and specialty group practices) who terminate their participation with HMSA must notify their affected HMSA members at least 30 days before the termination date. Timely notification prevents confusion and helps members transition smoothly to another HMSA participating provider for their care.

To view details about this notification requirement, see the Termination of a Participating Physician Agreement in the Provider E-Library.

ACCESS TO MEDICAL CARE STANDARDS

HMSA has established the following standards to ensure that members have timely access to the medical care they need:

- A member should be seen within 21 days for regular or routine care (e.g., non-urgent, non-symptomatic conditions such as well-baby checks, preventive care, and physical exams).
- A member should be seen within 24 hours for an urgent, symptomatic condition (e.g., high fever, ear pain/infection).

AFTER-HOURS CARE

In addition to normal office hours, primary care providers must make services accessible to their patients 24 hours a day, seven days a week. You can arrange for your patients to receive after-hours care with another HMSA participating provider or you can offer your patients access through the Physicians' Exchange or an answering service. A member should receive a response to an after-hours call within three hours.

ADVANCE DIRECTIVES

Advancements in medical technology have given patients new, life-sustaining options, making it important for you to discuss with your patients the kind of care they'd want to receive in the event of a serious illness or accident. You can lead the discussion about the importance of advance directives with your patients.

If you're a primary care provider with patients 18 years and older who have Medicare or QUEST Integration plans, you're required to document in a prominent part of their medical records if they have advance directives.

For more information and tools on advance directives, see the website for Kokua Mau, Hawaii's Hospice and Palliative Care Organization, at kokuamau.org.