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DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
Quality and Member Relations Improvement Section
P.O. Box 700190
Kapolei, Hawaii 96709-0190

December 29, 2021

MEMORANDUM

MEMO NO.
QI-2145 [Replaces QI-1909]
CCS-21-12 [Replaces CCS-1902]

TO: QUEST Integration (QI) Health Plans
'Ohana Community Care Services (CCS)

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: REVISED GRIEVANCES AND APPEALS TEMPLATES

The purpose of this memorandum is to notify the health plans that this memo replaces QI-1909 and CCS-1902 which was previously issued on May 29, 2019. The following updated content will apply under the QI contract RFP-MQD-2021-008 and CCS Contract RFP-MQD-2021-010.

The Department of Human Services, Med-QUEST Division (MQD) is issuing this memorandum to provide QUEST Integration (QI) and Community Care Services (CCS) health plans with revised grievances and appeals templates.

The revisions include the following:
1) MQD discontinued the memo templates, previously 'B' templates.
2) Template 1A explains that an Appointment of Representative (AOR) form is required if another individual other than the member is able to receive the resolution of the grievance.
3) Template 2A explains that an Appointment of Representative (AOR) form is required if another individual verbally requests an appeal on behalf of the member and the health plan does not receive verbal or written consent from the member.
4) Template 4A is discontinued to align with 42 CFR §438.402(c)(3), that states members may request an appeal and grievance verbally.

5) MQD added a new template to align with 42 CFR §438.408(c)(1), that states members or health plans may extend a grievance resolution by an additional 14 calendar days. The new template is 5b – Extension of Grievance Resolution.

The attached templates are to be implemented effective immediately. Health plans must ensure that all MQD requirements are maintained if revising the templates.

Health plans shall perform the 6.9 or below readability check on only the sections of the template that require insertion of information to complete the section. The template wording issued from MQD should not be included in the readability check.

Please contact Jon Fujii via e-mail at jfujii@dhs.hawaii.gov. should you have any questions.

Attachments:
1A Acknowledgement of Appeal – Letter (rev 09/2021)
2A Acknowledgement of Grievance – Letter (rev 09/2021)
3 Appointment of Representative
4A Denial of Fast Appeal – Letter (rev 05/2019)
5A Extension of Appeal Resolution – Letter (rev 04/2019)
5B Extension of Grievance Resolution – Letter (rev 09/2021)
6A Notice of Adverse Benefit Determination – Denial of Payment Template – Letter (rev 05/2019)
7A Resolution of Appeal – Letter (rev 05/2019)
8A Resolution of Fast Appeal – Letter (rev 05/2019)
10A Resolution of Grievance – Letter (rev 05/2019)
11A Notice of Adverse Benefit Determination – Denial of Service Template – Letter (rev 05/2019)
12A Notice of Adverse Benefit Determination – Denial of Service Authorization – Letter (rev 05/2019)

ACKNOWLEDGEMENT OF APPEAL
[Health Plan Logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Acknowledgement of appeal

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] got your (insert appropriate term: letter, phone call) on (date received) telling us you want to file an appeal about (issue):

_____

_____

_____

_____

_____

What Happens Next?

[Choose one of the sentences below based upon if AOR is needed.
*Note AOR is only needed if the member is unable to give verbal consent. If member provides verbal consent, it should be documented.]

[If ***no*** AOR is needed:] We will review your case. We will give you a decision no later than 30 calendar days after we got your appeal request. If you do not get a decision within 30 calendar days, you have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a State administrative hearing.

[If AOR is needed:] We need the attached form(s) to notify anyone other than you of the resolution of your appeal.

☐ **Appointment of Representative** – Your (insert appropriate term: e.g. doctor, husband, daughter) asked to file an appeal for you and we need your okay to review the appeal. This form allows you to designate someone to act as your representative for this appeal. We need you to fill out and sign this form to notify anyone other than you of the resolution of the appeal. Send it back to us by (date) using the envelope we gave to you. We will give you a decision no later than 30 calendar days after we first received the appeal request.

You can send in any information to help you with your appeal. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address, this may be a Physical address or PO box)

Signature:
cc: Member (When applicable)

[Language Block]

ACKNOWLEDGEMENT OF GRIEVANCE
[Health Plan Logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Acknowledgement of grievance

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] got your (insert appropriate term: letter, phone call) on (date received) telling us you want to file a grievance about (issue):

_____
_____
_____
_____

If you do not agree with the grievance information stated above, please tell us below. Your response is due to us within 5 business days after you receive the acknowledgement letter.

_____
_____
_____
_____

What Happens Next?

[Choose one of the sentences below based upon if AOR is needed
*Note AOR is only needed if the member is unable to give verbal consent. If member provides verbal consent, it should be documented.]

[If ***no*** AOR is needed:] We will review your case. We will give you a decision no later than 30 calendar days after we got your grievance request. If you do not get a decision within 30 calendar days or receive a request to extend the grievance for an additional 14 calendar days, you have the right to ask the State of Hawaii Department of Human Services, for a State grievance review.

[If AOR is needed:] We need the attached form(s) to notify anyone other than you of the resolution of your grievance.

You can send in any information to help you with your grievance. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address this may be a Physical address or PO box)

Signature:
cc: Member (When applicable)

[Language Block]

APPOINTMENT OF REPRESENTATIVE
[Health Plan Logo]

Date: **Member number:**

Name: **Reference/Case number:**

PART 1 --- APPOINTMENT OF REPRESENTATIVE (to be filled out by Member)

I allow _____ to act for me when filing a
(Name of person you want as your representative)
grievance, claim or appeal.

The person I have named can act for me when giving or receiving any information about my grievance, claim or appeal. This includes personal medical information.

Member:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

PART 2 --- ACCEPTANCE OF APPOINTMENT (to be filled out by Representative)

_____ , accept the appointment. I will
(Name of person who will be member's representative)
act on behalf of the member to file a grievance, claim or appeal.

Relationship to Member: (Must be age 18 or older)	
Representative Signature:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

This authorization is good for one year from the date you sign this form unless you tell us the following:

Date: _____/_____/_____Or Event: _____
Month Day Year

Part 3 ---YOUR INDIVIDUAL RIGHTS (Please read):

I understand that:

- I do not have to sign this form.
- I can cancel this form by writing to [Health Plan] at the address below except for the information that was already disclosed.
- Once my protected health information is disclosed to the person or organization I specified in **Part 1** of this form, the information in their possession may no longer be protected by privacy laws.

Please complete this form. Mail, fax, or deliver this form to the address below:

[Health Plan name]

[Address – Physical address or PO box]

[Fax number]

Member Signature: _____ Date: _____

[Language Block]

DENIAL OF FAST APPEAL
[Health Plan Logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Denial of fast appeal

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] got your request for a fast appeal on (Date received) about (issue):

_____

_____

_____

_____

We will not do a fast review of your appeal because:

_____

_____

_____

What Happens Next?

We will review your case as a standard appeal. We will decide your appeal within 30 calendar days after we got your appeal request. We will give you a decision by (Insert date).

If you do not agree with our decision to review your case as a standard appeal, you have the right to file a grievance with (health plan name). You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health plan name]
[Address – Physical address or PO box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

[If AOR is needed:] We need the attached form to start your appeal.

☐ **Appointment of Representative** – Your (insert appropriate term: e.g. doctor, husband, daughter) asked us for an appeal for you and we need your okay to review the appeal. This form lets you choose someone to act as your Representative for this appeal. We need you to fill out and sign this form. Send it back to us by (Date) using the envelope we gave to you. When we receive this form, we will review your case. We will give you a decision no later than 30 calendar days after we receive your completed form.

You can send in any information to help you with your appeal. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file.

Contact Information:
If you need information or help, or to give us more information about your appeal, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)

Signature:
cc: Member (When applicable)

[Language Block]

EXTENSION OF APPEAL RESOLUTION
[Health Plan Logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Extension of appeal resolution

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] got your appeal on (Date received) about (issue):

_____

_____

_____

_____

_____

We need more time to look at your case. We have not made a decision yet because (Insert reason for delay). Taking more time is in your best interest. We may take up to 14 more calendar days. We will give you a decision by (Insert date).

If you do not agree with the 14 calendar day extension, you have the right to file a grievance with (health plan name). You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health plan name]
[Address – Physical address or PO box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

Signature:
cc: Member (When applicable)

[Language Block]

EXTENSION OF GRIEVANCE RESOLUTION
[Health Plan Logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Extension of grievance resolution

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] got your grievance on (Date received) about (issue):

_____

_____

_____

_____

_____

We need more time to look at your case. We have not made a decision yet because (Insert reason for delay). Taking more time is in your best interest. We may take up to 14 more calendar days. We will give you a decision by (Insert date).

If you do not agree with the 14 calendar day extension, you have the right to file a grievance with (health plan name). You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health plan name]
[Address – Physical address or PO box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

Signature:
cc: Member (When applicable)

[Language Block]

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF PAYMENT
[health plan logo]

(Notice only – This is not a bill)

[Date]

[Member's Name]
[Address of member]

Member number:
Reference/Case number:

Re: Notice of Adverse Benefit Determination – Denial of Payment

Dear [Member's name]:

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about our decision whether to pay for a service you received.

We recently received a claim for <<service(s)>> _____
_____
_____
_____
provided to you by <<provider name>> _____
on <<date(s) of service(s)>> _____.

We will not pay for <<service(s)>> _____
_____
_____
_____
because (Insert appropriate reason: "the request did not meet the established medical necessity criteria or guidelines at this time." "the service is not a covered service under Medicaid/The Plan." or other reason)
_____
_____
_____
_____

What If I Do Not Agree With This Decision?

You have the right to ask (health plan name) for an appeal. File your appeal in writing within 60 calendar days after the date of this notice.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standards on which this decision was based at no cost to you.

We have also told <<provider>> that we will not pay for (Insert appropriate term: this, these) <<service(s)>>.

Signature: (Medical Director)
cc: Member (when applicable)
[Language block at end of document]

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can file:

Standard (decision no later than 30 calendar days) – You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. If a written statement is not received within the timeframe, we will be unable to process your request. We will give you a decision no later than 30 calendar days after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

Fast (decision no later than 72 hours) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a fast appeal.**
- If you ask for a fast appeal without information from your doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File An Appeal?

For a Standard Appeal: Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

For a Fast Appeal: Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

What Happens Next?
If you appeal we will review our decision again. After you get our decision, if you still disagree with the decision you will have the right to request a State administrative hearing. You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY:

RESOLUTION OF APPEAL
[Health plan logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Resolution of appeal

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] received your written appeal on (Date received) about (issue):

The request has been reviewed. The review was completed by a [licensed doctor/licensed dentist/ appeals committee]. The [doctor(s)/dentist] is/are also board certified. The [doctor(s)/dentist] was not a part of the first review or the findings from that review.

The Medical Director(s) involved is/are [Board Certified MD/DO with a specialty in [List Specialty and Title]].

What Is Our Decision?

(Insert decision here. Include: Date review was completed, department and/or staff involved, include title/qualifications/specialty, and any source used during the review)

Your medical records that we had available were reviewed. The first decision [First Determination] has been [upheld/overturned] based on this review. This denial was [upheld/overturned] because [List Reasons]. [The reasons for denial are based on a set of standards/criteria. This included [List Standards/Criteria]].

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standards on which this decision was based at no cost to you.

What If I Do Not Agree With This Decision?

You have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a State administrative hearing.

You may present your appeal independently or be represented by an authorized representative whom you have authorized, such as legal counsel, a relative, a friend, or another person of your choice. Also, available are interpreter services for individuals with limited English proficiency, and auxiliary aids for individuals with disabilities.

File your request for a State administrative hearing in writing within 120 calendar days of the date of this notice. Send it to:

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

How Do I Request for Services to Continue during a State administrative hearing?

If the services you appealed about had already been approved and the health plan decided to stop, reduce or suspend them, you can ask that they continue during the State administrative hearing process. To do this:

- You must ask for services to continue during the State administrative hearing. Do this when you ask for your hearing.
- Your request for an administrative hearing must be filed within 10 calendar days from when the health plan mailed this final appeal decision, or by the date services will be changed; whichever date is later.
- Your original appeal must be about services or treatment that was already approved that the health plan decided to stop, reduce or suspend before it was completed.
- The services must have been ordered by an authorized provider.
- The original approval (authorization) period for your services has not ended.

If the State administrative hearing decision is the same as the appeal decision (to deny, stop, or reduce the services), you may have to pay for the services that you asked us to continue during the State administrative hearing process.

What Happens Next?

When the Administrative Appeals Office gets your request for a hearing, they will write to you and tell you more about the hearing process. If the decision to stop, reduce or suspend services is reversed, you will receive services right away.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)

TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

Signature:
cc: Member (when applicable)

[Language Block]

RESOLUTION OF FAST APPEAL
(Health Plan Logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Resolution of fast appeal

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] received your (Insert appropriate term: oral, written) request for a fast appeal on (Date received) about (issue):

_____

_____

_____

The request has been reviewed. The review was completed by a [licensed doctor/licensed dentist]. The [doctor(s)/dentist] is/are also board certified. The [doctor(s)/dentist] was not a part of the first review or the findings from that review.

The Medical Director(s) involved is/are [Board Certified MD/DO with a specialty in [List Specialty and Title]].

What Is Our Decision?

(Insert decision here. Include: Date review was completed, department and/or staff involved, and any source used during the review, date verbal notification was conducted (or date message left))

Your medical records that we had available were reviewed. The first decision [First Determination] has been [upheld/overturned] based on this review. This denial was [upheld/overturned] because [List Reasons]. [The reasons for denial are based on a set of standards/criteria. This included [List Standards/Criteria]].

_____

_____

_____

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standards on which this decision was based at no cost to you.

What If I Do Not Agree With This Decision?

You have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a fast State administrative hearing. File your request for a fast State administrative hearing in writing within 120 calendar days of the date of this notice. Send it to:

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

How Do I Request for Services to Continue during a fast State administrative hearing?

If the services you appealed about had already been approved and the health plan decided to stop, reduce or suspend them, you can ask that they continue during the State administrative hearing process. To do this:

- You must ask for services to continue during the State administrative hearing. Do this when you ask for your hearing.
- Your request for an administrative hearing must be filed within 10 calendar days from when the health plan mailed this final appeal decision, or by the date services will be changed; whichever date is later.
- Your original appeal must be about services or treatment that was already approved that the health plan decided to stop, reduce or suspend before it was completed.
- The services must have been ordered by an authorized provider.
- The original approval (authorization) period for your services has not ended.

If the State administrative hearing decision is the same as the appeal decision (to deny, stop, or reduce the services), you may have to pay for the services that you asked us to continue during the State administrative hearing process.

What Happens Next?

When the Administrative Appeals Office gets your request for a hearing, they will write to you and tell you more about the hearing process. If the decision to stop, reduce or suspend services is reversed, you will receive services right away.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

Signature:
cc: Member (when applicable)

[Language Block]

RESOLUTION OF GRIEVANCE
(Health plan logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Resolution of grievance

Dear (Insert name):

[Health plan greeting with MQD approval]
[Health plan name] received your (Insert appropriate term: written, oral) grievance on (Date received) about (issue)

_____
_____
_____
_____

What is the Result?

(Insert resolution here. Include: Date review was completed, findings/resolution/ outcomes, department and/or staff involved, and any source used during the review)

_____
_____
_____
_____

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standards on which this decision was based at no cost to you

What If I Do Not Agree With This Result?

You have the right to ask the Med-QUEST Division for a State grievance review. File your request for a State grievance review by writing or calling them within 30 calendar days of the date of this notice. **Here is the address and phone number to use:**

Med-QUEST Division
Health Care Services Branch
P.O. Box 700190

Kapolei, HI 96709-0190
or call: (808) 692-8094

What Happens Next?

If you ask for a State grievance review, the Med-QUEST Division will review your grievance and give you a decision within 90 calendar days after they get your grievance review request. The grievance review decision made by the Med-QUEST Division will be final. You will not have any other grievance rights after that.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

Signature:
cc: Member (when applicable)

[Language Block]

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF SERVICE
(health plan logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Notice of Adverse Benefit Determination – Denial of Service

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you are receiving. We have (Insert appropriate term: stopped, reduced, suspended) coverage of the following medical services or items that you have been receiving:

_____
_____
_____
_____

We will make this change to your services on (EFFECTIVE DATE OF CHANGE).

[Your transition plan to (insert appropriate term: stop, reduce, suspend) services is (insert information about transition plan).]

We made the decision to (Insert appropriate term: stop, reduce, suspend) this service because:

_____
_____
_____
_____

What If I Do Not Agree With This Decision?

You have the right to ask (health plan name) for an appeal. File your appeal in writing within 60 calendar days after the date of this notice. If you want your services to continue during the appeal, all of the following must be met:

- You must ask for services to continue when you give us your appeal;
- Your appeal must be filed within 10 calendar days of this Notice of Adverse Benefit Determination or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider; and
- The original authorization period cannot have ended yet.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standards on which this decision was based at no cost to you

Signature: (Medical Director)
cc: PCP, Service Provider, and Service Coordinator (when applicable)

[Language Block at end of document]

There are two kinds of appeals you can file:

Standard (decision no later than 30 calendar days) – You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. If a written statement is not received within the timeframe, we will be unable to process your request. We will give you a decision no later than 30 calendar days after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

Fast (decision no later than 72 hours) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a fast appeal.**
- If you ask for a fast appeal without information from your doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of

How Do I File An Appeal?

For a Standard Appeal: Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

For a Fast Appeal: Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

How Do I Request for Services to Continue During My Appeal?
ALL of the following must be met:

- You must ask for services to continue when you give us your appeal;
- Your appeal must be filed within 10 calendar days of this Notice of Adverse Benefit Determination or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider; and
- The original authorization period cannot have ended yet.

(If you lose your appeal, you may have to pay for these services that you asked us to continue.)

What Happens Next?
If you appeal, we will review our decision again. If we decide to continue your services without any changes, you will receive services right away. If we decide again that your services should be stopped, reduced or suspended, and you still disagree with that decision, you will have the right to request a State administrative hearing. You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY:

the guidelines we used to make our decision.

IMPORTANT INFORMATION ABOUT YOUR APPEAL

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF SERVICE AUTHORIZATION REQUEST
(Health plan logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/case number:

Re: Notice of Adverse Benefit Determination – Denial of Service Authorization Request

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you or your doctor requested. We have decided to deny the request for coverage of the following medical services or items:

_____
_____
_____
_____
_____
_____

We made the decision to deny this service because:

_____
_____
_____
_____
_____
_____

What If I Do Not Agree With This Decision?

You have the right to ask (health plan name) for an appeal. File your appeal in writing within 60 calendar days of the date of this notice.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standards on which this decision was based at no cost to you

Signature: (Medical Director)
cc: PCP, Service Provider, and Service Coordinator (when applicable)

[Language Block at end of document]

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

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Standard (decision no later than 30 calendar days) – You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. If a written statement is not received within the timeframe, we will be unable to process your request. We will give you a decision no later than 30 calendar days after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

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Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File An Appeal?

For a Standard Appeal: Mail, fax, or deliver your
written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

For a Fast Appeal: Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

What Happens Next?
If you appeal, we will review our decision again. If we decide to give you your services, you will receive services right away. If we decide again that your services should not be given to you and you still disagree with that decision, you will have the right to request a State administrative hearing. You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY:

DAVID Y. IGE
GOVERNOR

CATHY BETTS
DIRECTOR

JOSEPH CAMPOS II
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
P.O. Box 700190
Kapolei, Hawaii 96709-0190

May 18, 2022

MEMORANDUM

MEMO NO.
QI-2206 [Update to QI-2116A]
FFS 22-04 [Update to FFS 21-06A]
CCS-2205 [Update to CCS-2106A]

TO: Hospitals, QUEST Integration (QI) Health Plans, Community Care Services (CCS) Plans

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: APR DRG BILLING GUIDANCE

This memorandum is an update to memorandum QI-2116A, CCS-2106A, FFS 21-06A "IMPLEMENTATION OF ALL PATIENT REFINED DIAGNOSIS RELATED GROUPS (APR DRG)."

This memo is intended to give new and modified billing guidance to affected hospitals and health plans related to the Med-QUEST (MQD) implementation of the 3M™ All Patient Refined Diagnostic Related Groups (APR DRG) scheduled for July 1, 2022.

APR DRGs are a patient classification system developed by 3M™and used by payers and providers to classify hospital inpatient stays into clinically meaningful diagnostic groups with similar average resource requirements. APR DRGs provide a mechanism for healthcare payers to make a single case rate payment for similar services provided in a hospital inpatient stay.

APR DRGs are the most widely used DRG software, or "grouper", by Medicaid agencies for determining payments for inpatient acute services. Due to APR DRGs' enhanced granularity (particularly for key Medicaid service lines) and widespread adoption of across states, MQD will use the APR DRG grouper as the patient classification system for its new Medicaid inpatient prospective payment methodology.

To meet APR DRG processing requirements the following new or modified edits and billing guidance are provided for UB Inpatient claims forms.

APR DRG implementation methodology
MQD's APR DRG methodology is applicable for certain inpatient stays with admission dates beginning on or after July 1, 2022.

Claims and encounters for inpatient stays with an admission date before July 1, 2022 will be processed using existing protocols. For eligible hospitals and qualifying bill types (111, 112, 117), covered services for inpatient stays with an admission date after July 1, 2022 will be processed using APR DRG. APR DRG rules do not apply to Department of Public Safety (DPS) claims unless the patient is actively enrolled in Medicaid.

Pricing of APR DRG codes require the APR DRG code and the APR DRG system calculated "severity of Illness" (SOI) value. SOI has four values (1 through 4). The 835 form has defined locations for the APR DRG code, MQD will work with the Health Plans to provide SOI data.

Eligible Hospital Provider IDs
The following Hospitals and associated MQD Provider IDs are eligible to submit claims for DRG payment:

Hospital	MQD Provider ID	Provider NPI on file with MQD
Castle Medical Center	082268	1316937691
Hilo Medical Center	251745	1780757856
Kapiolani Medical Center for Women & Children	085498	1043263080
Kona Community Hospital	005774	1639217300; 1952332991
Kuakini Medical Center	006236	1215939335
Maui Memorial Medical Center – General	803678	1013379460
North Hawaii Community Hospital	078352	1477559029
Pali Momi Medical Center	085499	1013961408
Straub Clinic and Hospital	506074	1598976540; 1720031701
The Queen's Medical Center – General	490417	1801298708; 1184612764
Wahiawa General Hospital	490368	1689643553
Wilcox Memorial Hospital	085500	1225113442
Kaiser Foundation Hospital	082521	1396813861
Shriners Hospital for Children	684804	1316065360

Billing Guidance

While MQD is publishing the below billing guidance that will apply to claims processing for our Fee-for-service program, QI and CCS plans may determine their own policies for their claims processing unless otherwise noted.

Billing for Pre-admission Services

Facility services provided within 72 hours of admission that quality as "pre-admission" services can be billed for by the hospital. All providers should include UB appropriate pre-admission services that were provided up to 72 hours prior to the admission on inpatient hospital claims.

Administrative or "Waitlisted" Days

This occurs when a patient's level of care is "downgraded" indicating that the patient is still hospitalized but waiting to be admitted to (1) an Intermediate Care Facility (ICF) indicated by the Occurrence Span Code = 74 or (2) a Skilled Nursing Facility (SNF) indicated by an Occurrence Span Code = 75.

When Medicaid is the primary or only payor, administrative or "waitlisted" days should be included on the UB claim. When Medicare or another third-party payer is the primary payor, ICF waitlisted days are listed on separate UB claim and paid using the existing per diem methodology.

If there is a change in a patient's level of care (e.g. from ICF to acute), the move back to acute care should be considered a separate stay and billed on a separate claim.

Hospital Admission and Discharge Occurring on the same day

UB inpatient claims with the same admission and discharge date will be processed through the APR DRG methodology when the patient status indicates that the patient expired or if the patient was transferred.

Hospitals should not submit an inpatient UB form for a patient that was admitted and discharged from the hospital on the same calendar day unless the patient expired (patient discharge status equals '20', '40', '41' or '42') or was transferred to another acute care hospital. FOR ALL OTHER INSTANCES where the admission date is the same as the discharge date, the claim should be billed on the UB outpatient form.

Per QI-2141, which replaces QI-1714, for acute inpatient hospitalizations, the admitting health plan is responsible for hospital services from admission to discharge or to change in level of care, whichever comes first.

Billing for Interim Inpatient Claims

As allowable by health plan policy, hospitals may submit an interim bill 30 days after the admission date and every 30 days after that. The initial claim should include type of bill '112'

(interim, 1st claim). Subsequent interim claims should use type of bill '117' (Replacement of prior claim).

For interim billing, the first interim claim can be billed 30 days after the admission day. Providers should use type of bill = 112 for the first interim claim. Subsequent interim bills can be submitted every 30 days. Subsequent interim bills should use type of bill = 117 (replacement claim). Patient discharge status on interim bills should remain 30 (Still Patient) until the patient is discharged.

Third Party Liability Payments

Third party liability payments occur when either Medicare or another insurer pays for services received by a Medicaid recipient. In these situations, Medicaid will pay ONLY if the recipient has a coinsurance or deductible. If the recipient is liable for a coinsurance or deductible, MQD will pay the lesser of the coinsurance plus deductible or Medicaid allowed minus Medicare paid. If the latter is less than zero, MQD payment is $0.

Retrospective Claims/Encounter reviews resulting in changes to covered services

If a retrospective review results in changes to covered services, the provider should submit the revised claim/encounter with a type of bill = 117.

QI/CCS Billing

For psychiatric inpatient services, providers should bill either CCS or QI for the services.
If the inpatient bill contains one of the following revenue codes, the entire inpatient bill should be paid by the CCS plan. Otherwise, the QI plan should pay the bill.

Code	Description
114	Room & Board Private (One Bed)-Psychiatric
124	Room & Board Semiprivate (Two Beds)-Psychiatric
134	Room & Board Three and Four Beds-Psychiatric
144	Room & Board Deluxe Private-Psychiatric
154	Room & Board Ward-Psychiatric
204	Intensive Care-Psychiatric

Carveouts

Long Acting Reversible Contraceptive (LARC)

A hospital can chose to bill for LARC services on either a UB or CMS 1500 form. Once a hospital decides to use either the UB or CMS1500 form, the hospital must use that selected form for billing of LARC services for all patients. Note that LARC services must be billed with an appropriate CPT-4 procedure code and the correct corresponding NDC code – see below.

Code	Code Description	NDC Code
11981	INSERTION OF DRUG DELIVERY IMPLANT INTO TISSUE	
11982	REMOVAL OF DRUG DELIVERY IMPLANT FROM TISSUE	
11983	REMOVAL WITH REINSERTION OF DRUG DELIVERY IMPLANT INTO TISSUE	
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (NEXPLANON)	00052027401
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (NEXPLANON)	00052433001
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (NEXPLANON)	78206014501
58300	PLACEMENT OF INTRA-UTERINE DEVICE (IUD) FOR PREGNANCY PREVENTION	
58301	REMOVAL OF INTRA-UTERINE DEVICE (IUD) FOR PREGNANCY PREVENTION	
J7296	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, (KYLEENA), 19.5 MG	50419042401
J7296	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, (KYLEENA), 19.5 MG	50419042408
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (LILETTA), 52 MG	00023585801
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (LILETTA), 52 MG	52544003554
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG	50419042101
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG	50419042301
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG	50419042308
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	50907038006
J7301	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (SKYLA), 13.5 MG	50419042201
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	50907038007
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	51285020401
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	51285020402
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	54765038001
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	59365512801

New Data Edits

The following edits will assess encounters eligible for DRG grouping. These edits will be effective for admission states beginning July 1, 2022 and will pend encounters that trigger the edits. Health plans are responsible for researching and correcting encounters that trigger these pends.

Birth weight

Birth weight is a required field for all inpatient claims where Recipient Age (calculated as Admit Date – Recipient Date of Birth) is less than or equal to 28 days. Birth weight shall be recorded in the Value Code fields as value '54'. Birth weight shall be recorded in grams. If birth weight is not recorded in these conditions, the claim will be denied and returned to the provider.

Encounters submitted to HPMMIS where birth weight is not present but recipient age is less than or equal to 28 will pend with R100: Birth Weight is Required.

Birth weight reasonableness

The birth weight value must be greater than or equal to 150 grams and less than or equal to 9,000 grams. If birth weight falls outside of the expected range, the claim will be denied and returned to the provider.

Encounters submitted to HPMMIS where birth weight is outside of the expected range defined above will pend with R105: Birth Weight is Out of Range.

Data gathering Error

In the case the 3M grouper is unable to assign a DRG code to an encounter, HPMMIS will return the error A956: DRG – Does not meet criteria for any DRG.

For questions on billing guidance, please contact Eric Nouchi at enouchi@dhs.hawaii.gov with any questions or concerns. For questions on encounter data edits, please contact Kate Allen at sallen@dhs.hawaii.gov.