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

September 25, 2026

MEMORANDUM

MEMO NO.
QI-2620
CCS-2604
FFS 26-08

TO: QUEST Integration (QI) Health Plans
Community Care Services (CCS) Health Plan
Medicaid Fee-for-Services (FFS) Provider

FROM: Meredith Nichols *me*
Med-QUEST Division Administrator

SUBJECT: THIRD-PARTY AUTHORIZATIONS FOR QUEST INTEGRATION (QI) HEALTH PLAN,
COMMUNITY CARE SERVICES (CCS) HEALTH PLAN, MEDICAID FEE-FOR-SERVICES
(FFS) PROVIDER AND HAWAII DENTAL SERVICES (HDS) GRIEVANCE AND APPEALS

This guidance clarifies the requirements associated with, and processing of, grievance and appeal requests submitted by third parties on behalf of a Member. This guidance is effective immediately.

A provider or authorized representative are third parties that may request a grievance or appeal, state-level grievance review, or "State Fair Hearing" on behalf of a Member only with the Member's written consent, in accordance with 42 CFR § 438.402(c)(1)(ii) and HAR 17-1703.1-3 (c).

The Member's written consent shall be documented as defined in QUEST Integration (QI) Health Plans contract § 9.5.D, CCS Health Plan contract § 9.8.D and HDS contract § 41.400.D.

If needed, MQD recommends making every reasonable effort to obtain the Member's consent within 30 calendar days of receiving the request from the provider or authorized representative. Staff should make three telephone attempts and send one letter by mail requesting the Member's consent, and each outreach attempt should be documented. These efforts help ensure that the Member has multiple opportunities to provide the required consent within the established timeframe.

Impact on QI-Health Plan, CCS Health Plan, FFS Providers and HDS Processing Timeline

Grievances: If reasonable attempts to obtain the signed authorization are made, and the *QI-Health Plan, CCS Health Plan, FFS Providers and HDS* is still unable to obtain Member's written consent by the 30th calendar day, the *QI-Health Plan, CCS Health Plan, FFS Providers and HDS* will dismiss the grievance request by sending a letter of dismissal to the Member. If written authorization is subsequently received, and it is within 60 calendar days from the receipt of the grievance request, the *QI-Health Plan, CCS Health Plan, FFS Providers and HDS* will start the grievance process on the date it receives the Member's written authorization.

Appeals: If reasonable attempts to obtain the signed authorization are made, and the *QI-Health Plan, CCS Health Plan, FFS Providers and HDS* is still unable to obtain Member's written consent by the 30th calendar day, the *QI-Health Plan, CCS Health Plan, FFS Providers and HDS* will dismiss the appeal request by sending a letter of dismissal to the Member. If written authorization is subsequently received, and it is within the 60 calendar days timeframe from the initial notice of adverse benefit determination, the *QI-Health Plan, CCS Health Plan, FFS Providers and HDS* will start the appeal process on the date it receives the Member's written authorization.

Any questions, please contact HCSBInquiries@dhs.hawaii.gov

Signature: 

Email: mnichols@dhs.hawaii.gov