2026 Provider Manual

PROV16-NE-00025 rev 01/2026

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WELCOME

Welcome to Nebraska Total Care and thank you for being part of our network of providers, hospitals, and other healthcare professionals. We look forward to working with you to improve the health of our state, one person at a time.

ABOUT US

Nebraska Total Care is a Health Plan awarded a contract with the Nebraska Department of Health and Human Services to provide healthcare services to a portion of Medicaid members.

ABOUT THIS MANUAL

This manual contains comprehensive information about Nebraska Total Care operations, benefits, billing, and policies and procedures. The most up-to-date version can always be viewed at NebraskaTotalCare.com. You will receive updates through notices posted on our online Provider News or within your secure provider portal.

KEY CONTACTS

The following chart includes several important telephone and fax numbers available to your office. When calling Nebraska Total Care, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN) number
- If calling about a member, two (2) of the following: Member's date of birth; member's health plan or Medicaid ID number; last four (4) of the member's social security number; valid claim number and date of service; and/or valid authorization number.

Department	Telephone Number	Fax Number
Provider Services Monday – Friday 7 a.m. to 6 p.m. CST	1-844-385-2192 (TTY 711)	1-844-305-8372
Member Services Monday – Friday 8 a.m. to 5 p.m. CST	1-844-385-2192 (TTY 711)	1-844-305-8372
Medical Management	1-844-385-2192 (TTY 711)	Admissions: 1-844-360-9454 Case Management: 1-844-340-4888 Concurrent Review: 1-844-845-5086 Prior Authorization: 1-844-774-2363
24-Hour Nurse Advice Line (24/7 Availability)	1-844-385-2192 (TTY 711)	NA
Pharmacy – Express Scripts	1-833-750-4471 Provider Services 1-844-330-7852 Prior Auth	1-833-404-2254

Department	Telephone Number	Fax Number
Nebraska Medicaid Eligibility System (NMES)	402-471-9580 1-800-642-6092	NA

POPULATIONS SERVED

Medicaid populations who are mandated to participate in the Nebraska Medicaid managed care program include:

- Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.
- Children, adults, and related populations who are eligible for Medicaid due to blindness or disability.
- Medicaid beneficiaries who are age 65 or older and not members of the blind/disabled population or members of the Section 1931 adult population.
- Low-income children who are eligible to participate in Medicaid in Nebraska through Title XXI, the Children's Health Insurance Program (CHIP).
- Medicaid beneficiaries who are receiving foster care or subsidized adoption assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.
- Medicaid beneficiaries who participate in an HCBS Waiver program. This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through the DHHS Division of Developmental Disabilities; Traumatic Brain Injury Waiver participants; and any other group covered by the State's 1915(c) waiver of the Social Security Act.
- Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters).
- Medicaid beneficiaries for the period of retroactive eligibility when mandatory enrollment for managed care has been determined.
- Members eligible during a period of presumptive eligibility.
- Members eligible for the State Disability Program-Medical (SDP Medical).
- Members with continuous eligibility who have a share of cost.
- Members eligible for Heritage Health Adult (HHA) expansion.
- Transitional Medical Assistance and Medical Insurance for Workers with Disabilities.

Heritage Health Adult (HHA) Expansion Population

Effective October 1, 2020, the Nebraska Medicaid Managed Care population was expanded to include adult members with an income level up to 138% of the federal poverty level under the provisions of the Patient Protection and Affordable Care Act. Retroactive benefits will remain available under the same conditions as today. Members eligible under the HHA Expansion program will receive the full benefits package which includes all Medicaid covered services.

Eligible Nebraskans will have a comprehensive benefits package that includes the following services:

- Ambulatory care
- Emergency care
- Hospitalization
- Maternity and newborn care

- Mental Health and Substance Use Disorder services, including integrated Behavioral Health
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive, wellness, and chronic disease management
- Other services such as long-term care, non-emergency medical transportation and durable medical equipment (dme)
- Dental services
- Vision services
- Over-the-counter medications

Excluded Populations

Within the groups identified above, the following categories of beneficiaries are excluded from managed care:

- Aliens who are eligible for Medicaid for an emergency condition only
- Beneficiaries who have excess income or who are required to pay a premium, and are intermittently eligible
- Beneficiaries who have received a disenrollment or waiver of enrollment
- Participants in the program for All-Inclusive Care for the Elderly
- Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles
- Inmates of public institutions

VERIFYING ELIGIBILITY

To verify member eligibility, please use one of the following methods:

- **Log on to our secure provider portal** at NebraskaTotalCare.com. Using our secure provider portal, you can check member eligibility. You can search by date of service and either of the following: Member name and date of birth, or member Medicaid ID and date of birth.
- **Call our automated member eligibility IVR system.** Call 1-844-385-2192 (TTY 711) from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the member's Medicaid ID and the month of service to check eligibility.
- **Call Nebraska Total Care Provider Services.** If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-844-385-2192 (TTY 711). Follow the menu prompts to speak to a Provider Services representative to verify eligibility before rendering services. Provider Services will need the member's name, member Medicaid ID, and member date of birth to verify eligibility.

Through Nebraska Total Care's secure provider portal, primary care providers (PCPs) can access a list of eligible members who have selected their services or were assigned to them. The Patient List is reflective of all demographic changes made within the last 24 hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. To view this list, log on to NebraskaTotalCare.com.

TIP Eligibility changes can occur throughout the month, and the Patient List does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on the date of service.

All new Nebraska Total Care members will receive a Nebraska Total Care member ID card. Members should retain their state-issued ID card for services not covered by the health plan. A replacement card will be issued if the information changes, the card is lost, or the member requests an additional card.

TIP Possession of a member ID card is not a guarantee of eligibility. Use one of the above methods to verify member eligibility on the date of service.

MEMBER IDENTIFICATION CARD

Whenever possible, members should present both their Nebraska Total Care member ID card, Nebraska Medicaid ID card, and a photo ID each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification.

If you suspect fraud, please contact Provider Services at 1-844-385-2192 (TTY 711) immediately.

Members must also keep their state-issued Medicaid ID card to receive benefits not covered by Nebraska Total Care.

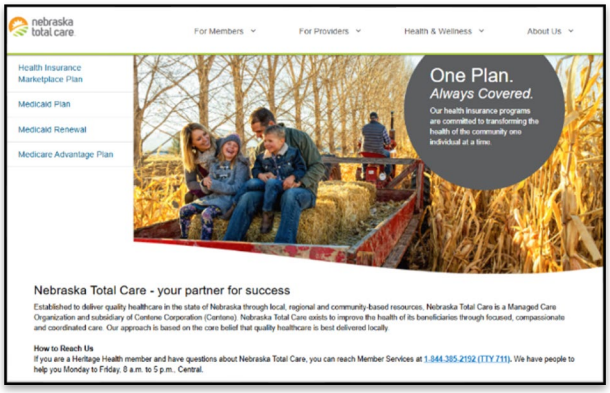
ONLINE RESOURCES

Our website can significantly reduce the number of telephone calls providers need to make to the health plan. Utilizing the website allows immediate access to current provider and member information 24 hours, seven (7) days a week.

Please contact your Provider Relations representative or our Provider Services department at 1-844-385-2192 (TTY 711) with any questions or concerns regarding the website.

Nebraska Total Care website is located at NebraskaTotalCare.com. Providers can find the following information on the website:

- Prior Authorization code check tool
- Forms and manuals
- Clinical guidelines
- Clinical and payment policies
- Contracting and credentialing
- Provider Relations contact information
- Provider education training schedule
- Provider news bulletins
- Provider email alerts
- Provider newsletters



SECURE PROVIDER PORTAL

Nebraska Total Care web portal services allow providers to check member eligibility and benefits, submit and check status of claims, request authorizations and send messages to communicate with Nebraska Total Care staff. All providers and their office staff can register for our secure provider portal in just a few easy steps. Here, we offer tools that make obtaining and sharing information easy. It is simple and secure. Go to NebraskaTotalCare.com to register. On the home page, select the Login link on the top menu to start the registration process.

This secure site allows you to:

- Check member eligibility.
- View members' health records.
- View the PCP panel (patient list).
- View and submit claims and adjustments.
- Verify claim status.

- Verify proper coding guidelines.
- View payment history.
- View and submit authorizations.
- Verify authorization status.
- View of member gaps in care.
- Contact us securely and confidentially.
- Add/Remove account users.
- Determine payment/check clear dates.
- Add/Remove TINs from a user account.
- See EPSDT reports.
- Send a member referral to the Care Management department.
- View PCP Quality Incentive Report.
- View and print Medical Explanation of Payment.

Please contact a Provider Relations representative for a tutorial on the secure provider portal.

Dental Claims

Dental providers (ADA or 837D): Dental claim forms can be submitted electronically. Information on submission of claims to Centene Dental Services can be found at CenteneDental.com.

LOCK-IN

Restricted Services

Restricted Services are methods used to limit the misuse or inappropriate utilization of medical services provided by Heritage Health.

Any identified members will be assigned a Care Manager and offered care management services. If a member declines care management participation, Nebraska Total Care will document this within the member's record.

Lock-in restriction can be any of the following, determined by Nebraska Total Care:

- No lock-in
- One pharmacy
- One prescribing physician and one pharmacy
- One prescribing physician, one prescribing specialist, and one pharmacy
- Emergency Medical Services will be handled on a case-by-case basis.

GUIDELINES FOR PROVIDERS

MEDICAL HOME MODEL

Nebraska Total Care is committed to supporting its network providers in achieving recognition as Medical Homes and will promote and facilitate the capacity of primary care practices to function as Medical Homes by using systematic, patient-centered and coordinated care management processes.

Nebraska Total Care will support providers in obtaining either NCQA's Physician Practice Connections®-Patient-Centered Medical Home (PPC®- PCMH) recognition or the Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation.

The Medical Home program is designed to improve care by promoting a model that delivers higher-quality healthcare, helps members manage their own health, and reduces avoidable costs over time. Nebraska Total Care will work closely with providers, community organizations, and member advocacy groups to increase the number of providers recognized as Medical Homes—or committed to becoming recognized.

Nebraska Total Care has dedicated resources to ensure its providers achieve the highest level of Medical Home recognition with a technical support model that will include:

- Readiness survey of contracted providers
- Education in the process of becoming certified
- Resource tools and best practices

Our secure provider portal offers tools to help support PCMH accreditation elements. These tools include:

- Online care gap notification
- Member panel roster including member detail information

For more information on the Medical Home model or to how to become a Medical Home, contact your Provider Relations representative.

DENTAL HOME MODEL

A Dental Home serves as the member's Primary Care Dentist (PCD) for all aspects of oral health care. The PCD has an ongoing relationship with the members to provide comprehensive, continually accessible, coordinated and family centered care. The PCD also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers, individuals who are general dentists, and pediatric dentists can serve as main Dental Homes.

The Dental Home is inclusive of all aspects of oral health and involves parents, the patient, dentists, dental professionals, and non-dental professionals. The Dental Home is the primary dental provider who has accepted the responsibility for providing or coordinating the provision of all covered dental care services.

PRIMARY CARE PROVIDERS (PCP)

The primary care provider (PCP) is central to Nebraska Total Care's service delivery model, acting as the member's Medical Home. This approach fosters a strong member-provider relationship, ensures continuity of care, and promotes patient safety. By reducing redundant services, it supports cost-effective care and leads to improved health outcomes.

Nebraska Total Care offers a robust network of primary care providers. This ensures every member has access to a Medical Home within the required travel distance standards.

- Two (2) PCPs within 30 miles of the personal residence of members in rural counties
- One (1) PCP within 45 miles of the personal residence of members in rural counties
- One (1) PCP within 60 miles of the personal residence of members in frontier counties

We request that PCPs inform our Provider Services department when a Nebraska Total Care member misses an appointment so we can monitor and provide outreach to the members on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of Emergency Room services.

Provider Types That May Serve as PCPs

- Family practitioner
- General practitioner
- Internist
- Pediatrician
- Obstetrician or gynecologist (OB/GYN)
- Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing within the scope and requirements of their license.

Members with disabling conditions, chronic illnesses or children with special health care needs may request that their PCP be a specialist. The designation of the specialist as a PCP must be in consultation with the current PCP, member, and the specialist. The specialist serving as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and provide those specialty medical services consistent with the member's disabling condition, chronic illness or special health care needs in accordance with the PCP responsibilities included in this manual.

MEMBER PANEL CAPACITY

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Nebraska Total Care DOES NOT guarantee any provider will receive a certain number of members.

If a PCP declares a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact Nebraska Total Care Provider Services at 1-844-385-2192 (TTY 711). A PCP shall not refuse to treat members if the provider has not reached their requested panel size.

Providers shall notify Nebraska Total Care in writing at least 45 calendar days in advance of his or her inability to accept additional Medicaid covered persons under Nebraska Total Care agreements. In no event shall any established patient who becomes a Nebraska Total Care member be considered a new patient.

Providers have the right to request a member's disenrollment from their panel and be reassigned to a new PCP. Nebraska Total Care facilitates these requests in a manner that continues to provide members with required health care in an environment acceptable to both the member and their provider. Providers can request the full policy for review, as necessary.

Acceptable reasons for disenrollment:

- Incompatibility of the PCP/patient relationship
- Inability to meet the medical needs of the member

Unacceptable reasons for disenrollment:

- A change in the member's health status
- A member's over or under-utilization of medical services
- A member's disruptive behavior caused by diminished mental capacity or special health care needs, unless such behavior prevents the PCP from providing services to the member or others
- Transfer requests shall not be based on race, color, national origin, handicap, age, or gender

The initial provider must continue serving the member for at least 30 calendar days, or until the new provider assumes care, unless ethical or legal concerns require otherwise.

The member has the right to appeal any transfer request.

PCP Assignment

Nebraska Total Care members have the freedom to choose a PCP from our comprehensive provider network. Within 10 calendar days of enrollment, Nebraska Total Care will send new members a letter encouraging them to select a PCP. For those members who have not selected a PCP during enrollment or within 30 calendar days of enrollment, Nebraska Total Care will use a PCP auto-assignment algorithm to assign an initial PCP.

Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester of gestation. If the pregnant member does not select a pediatrician or other appropriate PCP, Nebraska Total Care will contact pregnant members a minimum of 60 calendar days prior to the expected delivery date to encourage mothers to choose a PCP for their newborns. In the event a PCP is not selected, Nebraska Total Care will give the member a minimum of 14 calendar days after birth to select a PCP prior to auto assignment.

Primary Care Provider (PCP) Responsibilities

PCP's responsibilities include, but are not limited, to the following:

- Establish and maintain hospital-admitting privileges sufficient to meet the needs of all linked members with at least one (1) hospital within the required network adequacy distance requirements.
- Manage members' medical and overall health needs to ensure timely, culturally competent access to medically necessary services, prioritizing patient safety for all, including those with special needs and chronic conditions.
- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Provide screening, well-care and referrals to community health departments and other agencies in accordance with DHHS provider requirements and public health initiatives.
- Maintain continuity of each member's health care by serving as the member's medical home.
- Maintain hours of operation that are no less than those offered to commercial members, or comparable to commercial health plans when the PCP does not serve commercial members.
- Provide referrals for specialty and subspecialty care and other medically necessary services, which the PCP does not provide.
- Ensure follow-up and documentation of all referrals including services available under the State's fee-for-service program.

- Collaborate with Nebraska Total Care's Care Management program as appropriate to include, but not limited to, performing member screening and assessment, development of plan of care to address risks and medical needs, linking the member to other providers, medical services, residential, social, community and other support services as needed for physical or behavioral illness.
- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services.
- Adhere to the EPSDT periodicity schedule for members under age 21.
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care.
- Share results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned so services are not duplicated.
- Transfer members' medical records to the receiving provider upon the change of PCP at the request of the new PCP and as authorized by the member within 10 calendar days of the date of the request.
- Allows use of practitioner performance data for Nebraska Total Care quality improvement activities.
- Maintain the confidentiality of member information and medical records.
- Actively participate in and cooperate with all Nebraska Total Care quality initiatives and activities to improve quality of care and services to member experience. Cooperation includes collection and evaluation of data.
- Provide notice to Nebraska Total Care of any updates necessary to the provider directory such as new address, new phone number, or change in group practice affiliation at least 30 calendar days prior to the effective date of such changes, when possible.

REIMBURSEMENT TO FQHC'S AND RHC'S

Nebraska Total Care will reimburse FQHCs and RHCs in accordance with 471 NAC Chapters 29 and 34.

Nebraska Total Care will not enter into alternative reimbursement arrangements with FQHCs or RHCs, if initiated by the FQHC or RHC, without prior approval from MLTC.

If Nebraska Total Care is unable to contract with an FQHC or RHC within PCP access distance standards provided by MLTC, Nebraska Total Care is not required to reimburse that FQHC or RHC for out-of-network services without prior approval unless:

- The medically necessary services are required to treat an emergency medical condition
- FQHC/RHC services are not available through a minimum of one (1) MCO within MLTC's established travel standards

Nebraska Total Care may stipulate that reimbursement is contingent on receiving a clean claim and all medical information required to update the member's medical record.

PAYMENT FOR MEDICAID SERVICES – PROMPT PAYMENT

Nebraska Total Care follows title 471 Nebraska Administrative Code (NAC), Payment for Medicaid Services, outlined within Chapter 3. To better understand specific billing details, guidelines and requirements, please review the Provider Billing Guide found in the Provider Resources at NebraskaTotalCare.com.

Providers are required to submit claims for payment for medical services on the appropriate Medicaid billing forms and the appropriate health care claim format.

Nebraska Total Care will adjudicate a clean medical claim within sixty (60) calendar days of the date of receipt or be subject to a twelve percent (12%) annualized interest rate, calculated daily.

Nebraska Total Care will adjudicate 90% of all clean pharmacy claims within seven (7) calendar days of receipt and 99% of all clean pharmacy claims within fourteen (14) calendar days of receipt.

All claims' requests for reconsideration and corrected claims must be received within ninety (90) calendar days from the date of the explanation of payment (EOP), unless extenuating circumstances exist. Nebraska Total Care will determine whether extenuating circumstances were beyond the provider's control based on documentation submitted by the provider.

Nebraska Total Care will process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status within thirty (30) calendar days of receiving the request.

Payment may be made by Nebraska Total Care for claims received more than six (6) months after the date of service, if the circumstances which delayed the submission were beyond the provider's control. Nebraska Total Care will determine whether the circumstances were beyond the provider's control based on documentation submitted by the provider.

Nebraska Total Care will pay claims within twelve (12) months of the date of receipt of a claim. This time limitation does not apply to:

i. Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system
ii. Claims which have been filed in a timely manner for payment to Medicare, for which payment may be paid on a Medicaid claim relating to the same services. Claims for the Medicaid portion must be filed within six (6) months from the date of the Medicare remittance advice.
iii. Claims for providers under investigation for alleged fraud or abuse
iv. Payments made:
    a. In accordance with a court order;
    b. To carry out hearing decisions or agency corrective actions taken to resolve a dispute;
    c. To extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it; or
    d. Third party casualty situations as specified in 471 NAC 3-004.06C.

Nebraska Total Care will not pay claims received more than two (2) years after the date of service, unless the above circumstances apply. Nebraska Total Care will determine whether the above circumstances apply, based on documentation submitted by the provider.

Medicaid is the payor of last resort. All third-party resources available to a Nebraska Total Care member must be utilized for all or part of their medical costs before Medicaid. Medicaid

payments are made only after all third-party resources have been exhausted or met their contractual or legal obligations to pay. Claim payment denial may result if the provider fails to apply third party payments to medical bills, to file necessary claims, or to cooperate in matters necessary to secure payment by insurance or other liable third parties. The Nebraska Chronic Renal Disease Program and the Medically Handicapped Children's Program are not included as a third-party resource.

A provider cannot refuse to furnish services to an individual who is eligible for Nebraska Medicaid because of a third party's potential liability for payment of service.

Nebraska Total Care reimburses only services that are medically necessary and covered through the program. Providers are not allowed to "balance bill" for covered services if the provider's usual and customary charge for covered service is greater than our fee schedule.

Providers may bill members for services NOT covered by either Medicaid or Nebraska Total Care or for applicable copayments, deductibles, or coinsurance as defined by the State of Nebraska. For providers to bill a member for services not covered under the program, or if service limitations have been exceeded, the provider must obtain a written acknowledgment. A member acknowledgement statement can be referenced within the Provider Billing Guide.

A provider who offers a discount to certain individuals will apply the same discount to a Nebraska Total Care member, who would otherwise qualify for the discount.

Payment for all approved medical services within the scope of Nebraska Medicaid will be made to the provider who supplied the services. If billed charges are less than the allowable payment, Nebraska Total Care will pay the submitted billed charges.

Individuals who are otherwise eligible but who have excess income must obligate the excess amount for medical care before payment for medical services can be approved by Nebraska Medicaid.

Monitoring compliance with payment policies is regularly completed through post-payment reviews. A refund request will be requested if post-payment review finds payment has been made for claims or services not in compliance with Nebraska Total Care policy. Claims submitted for payment may be subjected to further review or not processed, pending the outcome of a post-payment review.

If Nebraska Total Care requests a refund of all or part of a paid claim, the provider is allowed thirty (30) days to refund the amount requested, to show the refund has already been made, to document why the refund request is in error, or to appeal. Nebraska Total Care is at liberty to recoup future provider payments, until the refund is paid in full or to sanction a provider, for failure to respond within thirty (30) days. A refund request will constitute notice of the sanction to recoup from future payments.

If a third-party liability payment is received once a claim has been submitted to Nebraska Total Care, the provider must refund Nebraska Total Care within thirty (30) calendar days. This refund must be accompanied by a copy of the documentation, such as the explanation of benefits (EOB) or electronic coordination of benefits (COB).

It is the responsibility of the provider to review all payments and ensure no overpayment has been received. A provider must refund all overpayments to Nebraska Total Care within thirty (30) calendar days of identifying the overpayment.

Additional information outlining specific billing details, guidelines and requirements should be referenced within the Provider Billing Guide.

REFERRALS

Nebraska Total Care prefers that the PCP coordinate health care services; however, PCPs are encouraged to provide a member with a referral when medically necessary care is needed that is beyond the scope of what the PCP can provide. Nebraska Total Care can arrange standing or frequency-based prior-authorizations as determined by the member's course of treatment or regular care monitoring plan as appropriate for the member's condition or medical needs. Obtaining a referral from the PCP is not required as a condition of payment for services by Nebraska Total Care.

The PCP must obtain prior authorization from Nebraska Total Care for referrals to certain specialty providers as noted on the prior authorization list. All out-of-network services require prior authorization as further described herein except for family planning, emergency room, and tabletop x-ray services. A provider is also required to promptly notify Nebraska Total Care when prenatal care is rendered.

Nebraska Total Care encourages specialists to communicate to the PCP the need for a referral to another specialist. This allows the PCP to better coordinate their members' care and become aware of the additional service request.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the providers' family has a financial relationship.

Provider Requirements

- Only provide health care applicable to provider's license.
- Schedule outpatients follow-up and/or continuing treatment prior to discharge for all members that have received inpatient psychiatric services.
- Ensure outpatient treatment occurs within seven (7) calendar days from the date of discharge.
- Contact Nebraska Total Care Provider Services when a member has missed an appointment so we can provide outreach and attempt to reschedule.
- Maintain the confidentiality of member information and medical records.
- Actively participate in and cooperate with all Nebraska Total Care quality initiatives and activities to improve quality of care and services to member experience. Cooperation includes collection and evaluation of data.
- Allow use of practitioner performance data for Nebraska Total Care quality improvement activities.
- The minimum requirements for the Quality Mental Health Professional for Community Services (QMHP-CS) role are as follows:
    - Demonstrated competency in the work to be performed; and
    - Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or be a Registered Nurse (RN).
- A qualified provider of mental health targeted Care Management must:
    - Demonstrate competency in the work performed; and
    - Possess a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and

development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or be a registered nurse (RN).

SPECIALIST RESPONSIBILITIES

Nebraska Total Care encourages specialists to notify the PCP when a referral to another specialist is needed, rather than initiating the referral themselves. This approach helps the PCP coordinate care, confirm the referred provider participates in the Nebraska Total Care network, and remain informed of additional service requests. Specialists may order diagnostic tests independently by following Nebraska Total Care referral guidelines.

Emergency admissions will require notification to Nebraska Total Care's Medical Management department within the standards set forth in the Utilization Management section of this manual. All non-emergency inpatient admissions require prior authorization from Nebraska Total Care.

The specialist provider must:

- Maintain contact with the PCP.
- Obtain authorization from Nebraska Total Care Medical Management department ("Medical Management") if needed before providing services.
- Coordinate the member's care with the PCP.
- Provide the PCP with consultation reports and other appropriate records within five (5) business days.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of member information and medical information.
- Actively participate in and cooperate with all Nebraska Total Care quality initiatives and activities to improve quality of care and services to member experience. Cooperation includes collection and evaluation of data.
- Allows use of practitioner performance data for Nebraska Total Care quality improvement activities.

Nebraska Total Care providers should refer to their contract for complete information regarding their obligations and mode of reimbursement. Such reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both Nebraska Total Care and the provider in the provider contract.

Nebraska Total Care providers should refer to their contract for complete information regarding providers' obligations or contact their Provider Relations representative with any questions or concerns.

MAINSTREAMING

Nebraska Total Care considers mainstreaming of members an important component of the delivery of care. Mainstreaming of a member's care, such as integration of mental health and substance use disorder, or dental care, should be exercised whenever possible. This approach is especially useful in rural settings and within a Patient Centered Medical Home (PCMH). Nebraska Total Care expects its participating providers to treat members without regard to payer source, race, color, creed, sex, religion, age, national origin (including those with limited English proficiency), ancestry, marital status, sexual preference, gender identity, health status,

genetic information, income status, program membership, physical disabilities, or mental health and substance use disorders, except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered service or availability of facility
- Providing a Nebraska Total Care member a covered service that is different or in a different manner, or at a different time or at a different location than to other “public” or private pay members (examples: different waiting rooms or appointment times or days), except where medically necessary
- Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a member in any way in their enjoyment of any advantage or privilege enjoyed by others receiving any covered service
- Assigning times or places for provision of services based on the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, gender identity, income status, Medicaid membership, or physical or mental illnesses of the participants served

APPOINTMENT ACCESSIBILITY AND ACCESS STANDARDS

Nebraska Total Care adheres to accessibility standards established by relevant regulatory and accrediting bodies. The organization routinely monitors compliance and uses appointment availability data to ensure timely access to care and to help reduce avoidable emergency room visits.

Primary Care Provider Scheduling

PCP- Type of Appointment	Scheduling Timeframe
Emergency services	Immediate and available 24 hours a day, seven (7) days a week
Urgent care	The same day and be provided by the PCP or as arranged by Nebraska Total Care
Non-urgent sick care	Within 48 hours of presentation or sooner if the member’s medical condition(s) deteriorate into an urgent or emergent situation.
Non-urgent preventive care	Within four (4) weeks
Laboratory and x-ray services	Within three (3) calendar weeks for routine appointments and 24 hours (or as clinically indicated) for urgent care.
Family Planning Services	Within seven (7) calendar days.
High volume specialty care - high volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians.	Within 30 calendar days of referral.

PCP- Type of Appointment	Scheduling Timeframe
Maternity Care	Within 14 calendar days after request during the first trimester, within seven (7) calendar days after request during the second trimester, and within three (3) calendar days after request during the third trimester. For high-risk pregnancies, the member must be seen no later than three (3) calendar days of identification of high risk by the health plan or maternity care provider or immediately if an emergency exists.
After-Hours	An after-hours phone call from an appropriate practitioner within 60 minutes of the member contacting the organization.

Mental Health and Substance Use Services scheduling

Mental Health and Substance Use Service	Appointment Time
Emergent Behavioral Health Needs	Within one (1) hour generally and within two (2) hours in designated Rural and Frontier areas.
Non-Life-Threatening Emergency	Within six (6) hours
Urgent Care	Within 48 hours
Non-Urgent, initial visit for routine care	Within ten (10) business days

Dental Health Services scheduling

Dental Health Service	Appointment Time	Explanation
Dental Urgent Care (may be directed by primary care dentist or Nebraska Total Care)	Within 24 hours of request (per 42 CFR 438.206(c)(1)(i)).	Appointments shall be arranged within 24 hours of request
Routine or preventive dental services	Within six (6) calendar weeks for routine or preventive appointments	Appointments shall be arranged within six (6) calendar weeks for routine or preventive appointments

Office wait times.

Primary Care Provider, Mental Health and Substance Use Provider, Maternity, Dental and Specialist	Office Wait Times
Walk-in	Within two (2) hours or schedule an appointment within the standards of appointment availability
Previously scheduled appointment	Within 45 minutes of appointment
Life-threatening emergency	Immediate

Access standards

Nebraska Total Care offers a comprehensive network of PCPs, specialist physicians, hospitals, mental health and substance use disorder providers, dentists, dental specialists, retail pharmacies, diagnostic and ancillary service providers, to ensure every member has access to covered services. Below are the travel distance and access standards that Nebraska Total Care utilizes to monitor its network adequacy:

Provider Type	Minimum Number	Distance
PCP Urban Counties	Two (2) PCPs	Within 30 miles of member's personal residence
PCP Rural Counties	One (1) PCP	Within 45 miles of member's personal residence
PCP Frontier Counties	One (1) PCP	Within 60 miles of a member's personal residence
High Volume Specialists. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics	One (1) high volume specialist	Within 90 miles of member's personal residence
Pharmacy Urban Counties	One (1) retail pharmacy	Within five (5) miles of 90% of members' personal residence
Pharmacy Rural Counties	One (1) retail pharmacy	Within 15 miles of 70% of members' personal residence
Pharmacy Frontier Counties	One (1) retail pharmacy	Within 60 miles of 70% of members' personal residence
Mental Health and Substance Use Disorder inpatient and residential service providers		Sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas
Mental Health and Substance Use Disorder providers OP- Urban Counties	Two (2) mental health and substance use disorder outpatient assessment and treatment providers	Within 30 miles of member's personal residence
Mental Health and Substance Use Disorder providers OP- Rural Counties	Two (2) mental health and substance use disorder outpatient assessment and treatment providers	Within 45 miles of member's personal residence
Mental Health and Substance Use Disorder providers OP- Frontier Counties	Two (2) mental health and substance use disorder providers outpatient assessment and treatment providers	Within 60 miles of a member's personal residence

Provider Type	Minimum Number	Distance
Hospitals	One (1) hospital	Within 30 miles of member's personal residence, except in rural and frontier areas where access time may be greater
General Optometrists Urban Counties	One (1) general optometrist	Within 30 minutes of member's personal residence
General Optometrists Rural Counties	One (1) general optometrist	Within 60 minutes of member's personal residence
General Optometrists Frontier Counties	One (1) general optometrist	Within 90 minutes of member's personal residence
Ophthalmologists Urban Counties	One (1) ophthalmologist	Within 30 minutes of member's personal residence
Ophthalmologists Rural Counties	One (1) ophthalmologist	Within 90 minutes of member's personal residence
Ophthalmologists Frontier Counties	One (1) ophthalmologist	Within 90 minutes of member's personal residence
Dentists Urban Counties	Two (2) general dentists	Within 45 miles of member's personal residence
Dentists Rural Counties	One (1) general dentist	Within 60 miles of a member's personal residence
Dentists Frontier Counties	One (1) general dentist	Within 100 miles of member's personal residence
Dental Specialists Urban Counties	One (1) oral surgeon, one (1) orthodontist, one (1) periodontist, one (1) endodontist, one (1) prosthodontist, and one (1) pediadontist	Within forty-five (45) miles of 85% of members' personal residence
Dental Specialists Rural Counties	One (1) oral surgeon, one (1) orthodontist, one (1) periodontist, one (1) endodontist, one (1) prosthodontist, and one (1) pediadontist	Within 60 miles of 75% of members' personal residence
Dental Specialists Frontier Counties	One (1) oral surgeon, one (1) orthodontist, one (1) periodontist, one (1) endodontist, one (1) prosthodontist, and one (1) pediadontist	Within 10 miles of 75% of members' personal residence

MINIMUM PCP HOURS

PCPs with a single provider must offer at least 20 hours of office availability per week. Practices with two (2) or more providers must provide a minimum of 30 office hours weekly.

COVERING PROVIDERS

PCPs and specialty physicians must arrange for coverage with another provider during scheduled or unscheduled time off and preferably with another Nebraska Total Care network provider. In the event of unscheduled time off, please notify the Provider Services department of coverage arrangements as soon as possible. The covering physician is compensated according to the fee schedule outlined in their agreement. If the physician is not part of the Nebraska Total Care network, they will be paid as a non-participating provider.

TELEPHONE ARRANGEMENTS

PCPs and Specialists must:

- Answer the members' telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by the member.
- Identify missed or canceled appointments and, when appropriate, reschedule them.
- During appointment scheduling, identify special member needs (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or individuals with cognitive impairments).
- Adhere to the following response time guidelines for returning telephone calls:
    - After-hours care for non-emergent, symptomatic issues within 60 minutes
    - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method and then transferred to the member's medical record.

NOTE: If after-hour urgent care or emergent care is needed, the PCP or their designee should contact the urgent care center or emergency department to notify the facility. Notification is not required prior to members receiving urgent or emergent care.

Nebraska Total Care will monitor appointment and after-hours availability on an on-going basis through its Quality Assurance and Performance Improvement Committee (QAPIC).

24-HOUR ACCESS

Nebraska Total Care PCPs must ensure adequate access to facilities and staff to deliver covered provider services. These services must be available to members 24 hours a day, 365 days a year, as outlined below:

- During normal business hours, the office phone must be answered.
- After hours, providers must have one (1) of the following arrangements in place:
    - Access to a covering provider
    - An answering service
    - A triage service
    - A voice message that includes a secondary phone number that is answered

- If the practice serves a significant Spanish-speaking population, any recorded message must be available in both English and Spanish.

The following practices are considered unacceptable after-hours coverage:

- The provider's office telephone is only answered during regular business hours.
- After-hours calls are directed to a voicemail or recording instructing patients to leave a message.
- After-hours calls are directed to a recording that advises patients to seek care exclusively at an emergency department for any service needs; and,
- A clinician fails to return after-hours calls within 60 minutes of receipt.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can make a clinical decision or reach the PCP for a clinical decision. The PCP or covering clinician should return patient calls within 60 minutes of initial contact whenever possible. After-hours access must be available through the office's regular daytime phone number.

Nebraska Total Care will assess providers' after-hours coverage through surveys and periodic mystery shopper calls conducted by the Provider Network staff.

HOSPITAL RESPONSIBILITIES

Nebraska Total Care partners with a qualified network of hospitals to deliver services to members in compliance with Medicaid requirements, state and federal regulations, and the Heritage Health Agreement with Nebraska DHHS.

Hospitals are required to:

- Notify the member's PCP immediately, or no later than the close of the next business day, following an emergency room visit.
- Obtain prior authorization for all inpatient and designated outpatient services listed on the current authorization list, except emergency stabilization.
- Submit an electronic ER admission file to Nebraska Total Care Medical Management by the next business day, including member name, Medicaid ID, presenting symptoms/diagnosis, date of service, and phone number.
- Notify Nebraska Total Care Medical Management of all admissions within one (1) business day.
- Report newborn births for enrolled members within 24 hours.

ADVANCE DIRECTIVES

Nebraska Total Care is committed to ensuring members understand and can exercise their rights regarding advance directives. We also ensure that providers and staff comply with all federal and state requirements related to advance directives.

PCPs and providers delivering care to Nebraska Total Care members must ensure adult members 19 years of age and older receive information on advanced directives and are informed of their right to execute advance directives. Providers must document this in the permanent medical record.

Nebraska Total Care recommends:

- At the initial point of contact, staff should ask if the member has an advance directive and documents the response in the medical record.
- If an advance directive exists, request that the member provide a copy and record this request in the medical record.
- The advance directive, including any mental health directives, must be included in the member's medical record.

If an advance directive exists, the provider should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring provider, if applicable. Any such discussion should be documented in the medical record.

VOLUNTARILY LEAVING THE NETWORK

Providers must give Nebraska Total Care notice of voluntary termination following the terms of their participating agreement with our health plan. For a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to Nebraska Total Care or the member.

Nebraska Total Care will notify affected members in writing of a practitioner or practice group's termination, including but not limited to, general, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the practitioner's effective termination date, or within fifteen (15) calendar days of receipt of the termination notice from the provider.

Providers must continue to render covered services to members who are existing patients at the time of termination. For members in active treatment for a chronic or acute medical condition, Nebraska Total Care allows continuation of such services for the defined continuity of care period, through the current period of active treatment, until the member is reasonably transferred to a network practitioner without interruption of care, or for up to 90 calendar days, whichever is less (or as required by contract).

For members in their second or third trimester of pregnancy, Nebraska Total Care provides continued access to the practitioner through the postpartum period, which begins immediately after childbirth and extends for approximately six (6) weeks.

CULTURAL COMPETENCY

Cultural competency within Nebraska Total Care is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused, and family oriented.

It is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Nebraska Total Care is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When health care services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their health care needs in an insensitive environment, reducing effectiveness of the entire healthcare process. Providers should note that the experience of a member begins at the front door.

Failure to use culturally competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Treatment non-compliance
- Feelings of being uncared for, looked down on, and devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time
- Increased grievances or complaints

Nebraska Total Care as part of its credentialing will evaluate the cultural competency level of its network providers and provide access to training and on-line resources to assist providers in developing culturally competent and culturally proficient practices. Network providers must ensure:

- With interpretation services now covered by Medicaid, providers can supply, deliver, and submit claims when appropriate to Nebraska Total Care. As such, members understand that they have access to qualified medical interpreters, signers, and TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the member's race/ethnicity and language and its impact/influence on the member's health or illness.
- Office staff that routinely interact with members have access to and participate in cultural competency training and development.
- Office staff responsible for data collection make reasonable attempts to collect race- and language-specific member information. Staff will also explain race/ethnicity categories to a

member so that the member is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, gender identity, and other characteristics that may influence the member's perspective on healthcare.

Office sites have posted and printed materials in English and Spanish, and other prevalent non-English languages required by the Nebraska Department of Health and Human Services (DHHS).

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Nebraska Total Care is committed to helping you reach this goal. Take into consideration the following as you provide care to Nebraska Total Care members:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients' healing process?

The U.S. Department of Health and Human Services' Office of Minority Health has published a suite of online educational programs to Advance Health Equity at Every Point of Contact through development and promotion of culturally and linguistically appropriate services. Visit Think Cultural Health at ThinkCulturalHealth.hhs.gov to access these free online resources.

BENEFIT EXPLANATIONS AND LIMITATIONS

Nebraska Total Care network providers supply a variety of medical and mental health and substance use disorder benefits and services, some of which are itemized on the following pages. For specific information not covered in this provider manual, please contact Provider Services at 1-844-385-2192 (TTY 711).

Nebraska Total Care covers, at a minimum, those core benefits and services specified in our Agreement with Nebraska DHHS and defined in the administrative rules, and department policies and procedure handbook.

Nebraska Total Care claims payment will preclude payment to providers for provider-preventable conditions (PPCs) in compliance with 42 CFR 447.26(b). PPCs, including health care acquired conditions (HACs), are those conditions that occur in inpatient hospital settings. Nebraska Total Care will reference CMS– 2015 Health Care Acquired Conditions for a listing of HACs that apply to this provision, with the exception of deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients.

COVERED SERVICES

All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.

Use the Pre-Auth Check Tool at NebraskaTotalCare.com to quickly determine if a specific service requires authorization.

All out-of-network (Non-Par) services require prior authorization, excluding family planning, emergency room, and tabletop x-ray.

Service	Comments
Inpatient hospital services	Including transitional hospital services and transplant services
Outpatient hospital services	NA
Ambulatory surgical center (ASC) services.	NA
Physician services	Including services provided by nurse practitioners, certified nurse Midwives, physician assistants, clinic-administered injections/medications, and anesthesia services including those provided by a certified registered nurse anesthetist.
Federally qualified health centers (FQHCs) services	NA
Rural health clinics (RHCs) services	NA
Indian Health Service (IHS)	NA
Laboratory services	Clinical and anatomical
Radiology services	NA

Service	Comments
Health Check (EPSDT) services	NA
Home health services	NA
Private duty nursing services	NA
Therapy services	Including physical, occupational, and speech pathology and audiology.
Durable medical equipment and medical supplies	Including hearing aids, orthotics, prosthetics, and nutritional supplements
Podiatry services	NA
Chiropractic services	NA
Vision services	NA
Free standing birth center services	NA
Hospice services	Except when provided in a nursing facility.
Skilled/rehabilitative and transitional nursing facility services	NA
Ambulance services	NA
Non-emergency ambulance transportation	NA
Transplant services	NA
Pharmacy services	NA

Mental Health and Substance Use Services	Limitations	Comments
Crisis stabilization services	NA	Includes treatment crisis intervention
Inpatient psychiatric hospital	NA	Acute and sub-acute
Psychiatric residential treatment facility	Covered for age 19 and under	NA
Outpatient assessment and treatment	Covered for individuals aged 20 and under	• Partial hospitalization • Day treatment • Intensive outpatient • Medication management • Outpatient therapy (individual, family, or group) • Injectable psychotropic medications • Substance use disorder treatment. • Psychological evaluation and testing • Initial diagnostic interviews • Sex offender risk assessment • Community treatment aide (CTA) services

Mental Health and Substance Use Services	Limitations	Comments
Outpatient assessment and treatment (continued)	Covered for individuals aged 20 and under	• Partial hospitalization • Day treatment • Intensive outpatient • Medication management • Outpatient therapy (individual, family, or group) • Injectable psychotropic medications • Substance use disorder treatment. • Psychological evaluation and testing • Initial diagnostic interviews • Sex offender risk assessment • Community treatment aide (CTA) services
Outpatient assessment and treatment	covered for adults aged 21 and over.	• Ambulatory detoxification • Day treatment • Electroconvulsive therapy • In-home psychiatric nursing • Initial diagnostic interviews • Injectable psychotropic medications • Intensive outpatient • Medication management • Outpatient therapy (individual, family, or group) • Peer Support • Partial hospitalization • Psychological evaluation and testing • Social detoxification • Substance use disorder treatment
Rehabilitation services	covered for individuals aged 20 and under.	• Day treatment/intensive outpatient • CTA services • Professional resource family care • Therapeutic group home
Rehabilitation services	Covered for individuals aged 21 and over	• Dual-disorder residential • Intermediate residential (SUD) • Short-term residential • Halfway house • Therapeutic community (SUD only) • Community support • Psychiatric residential rehabilitation • Secure residential rehabilitation • Assertive community treatment (ACT) and Alternative (Alt) ACT • Community support • Day rehabilitation

SPECIAL SERVICES TO ASSIST MEMBERS

Non-Emergent Medical Transportation (NEMT)

Nebraska Total Care works with MTM, Inc. to provide non-emergent medical transportation for eligible members for their medical and mental health appointments. This includes substance use and dental appointments. Visit NebraskaTotalCare.com to access our NEMT provider webpage that contains key information on doing business with MTM, claims submissions, tracking ride assignments, FAQ and using the MTM provider portal.

Members are to schedule rides at least two (2) business days before an appointment and can schedule a ride up to 60 calendar days before an appointment. Sometimes urgent medical trips can be requested by members with less than two (2) calendar days' notice. In those instances, MTM may check with the provider to confirm the appointment is urgent.

NEMT can go to providers within 30 miles one way in urban counties or 75 miles one way in rural and frontier counties by car. In situations where there is not a provider within those parameters by car, they can take the member to the closest provider. When members choose a provider farther away transportation services may not be available.

MTM also can offer other transportation options. Those could be:

- Public transportation
- Commercial vehicle
- Wheelchair lift equipped vehicle.
- Escort
- Commercial air, bus, and train

Providers can file a transportation complaint if you are dissatisfied with MTM's services, processes, or any other part of working with MTM.

You can make your complaint to Nebraska Total Care following the provider grievance process outlined in this manual.

Women's Health Care

Nebraska Total Care will provide direct access to a health specialist in-network for core benefits and services necessary to provide women routine and preventive health care services in addition to the member's PCP if the provider is not a women's health specialist. Members are allowed to utilize their own PCP or any family planning service provider for family planning services without the need for a referral or prior authorization.

In addition, members will have the freedom to receive family planning services and related supplies from an out-of-network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception, and inter-conception care services.

Nebraska Total Care will make every effort to contract with all local family planning clinics and providers and will ensure accuracy in claims processing whether the provider is in-network or out-of-network.

VALUE ADDED SERVICES

Adult Vaccines

Nebraska Total Care will offer vaccines administered at a participating pharmacy to members 19 years of age and over based on medical necessity. Covered vaccines include:

- Influenza vaccine
- Meningitis vaccine
- Tetanus/Diphtheria/Pertussis vaccine
- Human Papillomavirus vaccine
- COVID-19 vaccine
- Shingles vaccine
- Pneumonia vaccine (age 65 and older)

Second EpiPen and/or Nebulizer for School

Nebraska Total Care provides members who have severe allergies or asthma access to a second EpiPen and/or a nebulizer to eliminate the need for children to have to remember to bring the device back and forth from home while being able to address acute episodes, should they occur while the child is in school. Available to member ages five (5) to eighteen (18) who have severe allergies or asthma and are enrolled in school.

CAP Sessions for Mental Health and Substance Use

The Client Assistance Program (CAP sessions) covers up to five (5) outpatient therapy sessions per calendar year without an Initial Diagnostic Interview. Members can contact providers directly to receive services.

Enhanced Transportation Benefit

Nebraska Total Care has enhanced transportation benefits through MTM to certain non-covered health related activities such as:

- Alcoholics Anonymous or Narcotics Anonymous meetings
- Approved exercise and nutrition classes
- Birthing and parenting classes, and Start Smart for Your Baby® showers
- Weight Watchers meetings
- WIC (Women, Infant and Children) appointments

Waive Co-pays

Nebraska Total Care is waiving co-pays for medical, generic pharmacy, and mental health and substance use services, as we have found that waiving co-pays helps reduce barriers to accessing care and encourages the utilization of care in the appropriate setting.

Sports/Camp Physical

To promote healthier lifestyles and to encourage members to exercise more regularly and participate in regular team and independent fitness activities, Nebraska Total Care reimburses providers for Sports Physicals for members aged four (4) to eighteen (18). It is recognized that Sports Physicals are required by junior and high school athletic programs and some youth sports leagues, as well as camps, to check both medical history and to conduct a physical exam. These exams are important to ensure that children are in good physical condition and that it is safe for them to participate in a sport that requires physical exertion and provides an opportunity to limit risk or injury. The Sports/Camp Physical must be rendered by a participating Nebraska Total Care provider.

GED Testing Materials

Nebraska Total Care wants to provide members with opportunities to further their education and assist them in taking the necessary steps to reduce the need for reliance on programs such as Medicaid. For some members, that step includes completing their high school education. Nebraska Total Care provides vouchers to eligible members to be used toward the purchase of official GED testing practice materials to prepare them for the official GED test.

Free Membership to Boys and Girls Club

To assist Nebraska Total Care members in developing social and leadership skills, Nebraska Total Care sponsors the membership fee to the local Boys and Girls Club. According to their website, the Omaha Boys and Girls Club aims to minimize violence, peer pressure, and other risky activities by engaging young people in activities with positive adult role models and peers, enabling them to learn powerful life skills. This benefit will be available to all Nebraska Total Care members aged six (6) to eighteen (18) years old. The Boys and Girls Club will bill Nebraska Total Care for membership fees.

Weight Watchers

Nebraska Total Care has partnered with Weight Watchers to provide eligible members free membership for online Weight Watchers participation for members who meet BMI criteria. Members receive vouchers for registration for fourteen (14) weeks of online tools. They have the option of receiving additional vouchers if criteria are met.

Community Gardens

Nebraska Total Care will pay for one (1) community garden plot per household, to established community garden organizations.

ConnectionsPlus® Cell Phone

Nebraska Total Care has partnered with a certified Nebraska Telecommunications Assistance Program (NTAP) select carrier to refer qualifying individuals to the program as well as enhancing the service by providing unlimited texting, discount on additional minutes above the 250 minutes allotted with the phone and unlimited calls with Nebraska Total Care health plan staff. In addition, for those members that are in care management and stratified as high risk and/or unable to qualify for the Nebraska program, Nebraska Total Care will implement our ConnectionsPlus® free cell phone program. Even for members who do qualify for the Nebraska Telecommunications Assistance Program, the minimum allotted minutes can present as a barrier to successful and regular care management; decreases member likelihood of participating in a health program that requires usage of minutes; and is not enough minutes to support the extent of care coordination and social support services some members require.

Nebraska Total Care’s free ConnectionsPlus® phones are available to high-risk members who would benefit from unlimited talk and text, and we are also able to offer a smart phone and data plan for select members with a specific chronic condition or disease where an app exists to encourage healthy lifestyles and help manage their condition.

The objective of the program is to reduce preventable adverse events such as inappropriate ER use or hospital admissions through improved access to health care information and treating providers. Members are educated on observing their health status and calling promptly for advice and support rather than waiting until the next appointment. The cell phones are also used so that Care Managers can send the member a text message with health information targeted to the individual member's condition.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is an evidence-based intervention aimed at improving the overall health and well-being of individuals who are using alcohol and illicit substances in a risky and harmful manner and increasing access to evaluation and treatment for individuals with a substance use disorder. Nebraska Total Care covers the initial SBIRT service code, in addition to training providers on valid screening tools to assist providers in determining the appropriate level of intervention or referral for services.

For a provider to provide this service, the provider must participate in the Nebraska Total Care SBIRT training program or a SAMHSA endorsed SBIRT training program.

Start Smart for Your Baby® Prenatal and Postpartum Incentives

Start Smart for Your Baby® (Start Smart) is our prenatal/postpartum support program that incorporates care management, care coordination, and disease management to improve the health of pregnant mothers and birth outcomes. To further incentivize members to attend prenatal and postpartum appointments, Nebraska Total Care provides the following additional incentives:

- **Notification of Pregnancy (NOP) Member Incentive**. If a member completes the Notification of Pregnancy (NOP), they can earn a reward. They must complete the form at least 60 days before the baby is due. Once the health plan receives the form, a Care Manager will call the member. They will arrange for members to choose and receive one (1) of these items:
    - Car seat
    - Stroller
    - Pack and Play
    - Meal deliver of 10 meals

Healthy Rewards

Nebraska Total Care rewards members' healthy choices through our Healthy Rewards program. This card can be used to purchase items and products to drive healthy behavior and outcomes. Members can earn dollar rewards by staying up to date on preventive care, including well-child visits and immunizations. Members can buy things like fresh foods and groceries, frozen foods, baby items and clothing (diapers, formula, baby foods, etc.), as well as certain over-the-counter drugs (allergy, cold meds, etc.) and other personal care items (deodorant, soap, shampoo, etc.). Members can use their Healthy Rewards card at a select number of retailers, including Wal-Mart. The rewards card may be used to help pay for utilities, transportation, telecommunications, childcare services, education and rent at eligible retailers. Members can visit the secure member portal for the most up-to-date listing of approved items and retailers.

Psychiatric Assistance Line (PAL)

Nebraska Total Care will provide a 24/7 Psychiatric Assistance Line to support primary care providers in appropriate BH prescribing, screening, identification, and referral. The Psychiatric Assistance Line (PAL) is a telephone-based consultation system for primary care providers. PAL is staffed by psychiatrists and has master's-level social workers who can assist with support on prescribing, screening, identification, and referral. PAL is available to primary care doctors, nurse practitioners and physician assistants in Nebraska. PAL provides rapid consultation responses for any type of mental health issue that arises via a toll-free number. To access the PAL line, please call Nebraska Total Care at 1-844-385-2192 (TTY 711). Select "3" for Providers, then "5" for Mental Health Services. Ask for the PAL Line.

NETWORK DEVELOPMENT AND MAINTENANCE

Nebraska Total Care maintains a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of members, both adults and children, without excessive travel requirements, and that follows DHHS' access and availability requirements.

Nebraska Total Care offers a network of primary care providers to ensure every member has access to a Medical Home within the required travel distance standards.

In addition, Nebraska Total Care will have available, at a minimum, the following providers.

Specialists:

- Applied Behavior Analyst
- Allergist
- Anesthesiologist
- Mental health and substance use counselors
- Cardiologist
- Cardiovascular surgeon
- Dermatologist
- Gastroenterologist
- General surgeon
- Neurologist
- OB/GYN
- Oncologist
- Ophthalmologist
- Optometrist
- Orthopedic surgeon
- Psychiatrist
- Psychologist
- Pulmonologist
- Radiologist
- Urologist
- Facilities
- Hospitals
- Inpatient psychiatric hospitals
- Laboratory services
- End Stage Renal Disease treatment and transplant centers
- Outpatient mental health centers / community mental health centers
- Substance use programs
- Independent radiology centers

In the event Nebraska Total Care's network is unable to provide medically necessary services required under the contract, Nebraska Total Care shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

For assistance in making a referral to a specialist or subspecialties for a Nebraska Total Care member, please contact our Medical Management department at 1-844-385-2192 (TTY 711) and we will identify a provider to make the necessary referral.

NON-DISCRIMINATION

Nebraska Total Care does not limit the participation of any provider or facility in the network, and/or otherwise discriminate against any provider or facility based solely on any characteristic protected under state or federal discrimination laws.

Furthermore, we do not and have never had a policy of terminating any provider who:

- Advocated on behalf of a member
- Filed a complaint against us
- Appealed a decision of ours

TERTIARY CARE

Nebraska Total Care offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical sub-specialists available 24 hours per day in the geographical service area. In the event Nebraska Total Care's network is unable to provide the necessary tertiary care services required, Nebraska Total Care shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

MEDICAL MANAGEMENT

Nebraska Total Care Medical Management department hours of operation are Monday through Friday from 8 a.m. to 5 p.m., CST (excluding holidays). After normal business hours, our 24/7 Nurse Advice Line staff are available to answer questions about prior authorization.

Medical Management services include the areas of utilization management, care management, population management, and quality review. The department clinical services are overseen by the Nebraska Total Care medical director ("Medical Director"). The Vice President (VP) of Medical Management has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact Medical Management at 1-844-385-2192 (TTY 711). Utilization management and care management policies are available to be furnished to providers upon their request.

INTEGRATED CARE

Nebraska Total Care uses an Integrated Care approach, using a holistic approach, focusing on the *whole person*, and includes integrating needed covered, carved out, and community-based services in its approach to care.

We use a multi-disciplinary Integrated Care team to offer and coordinate integrated care. Our staff coordinates care with all necessary members of the designated care team, including the members' primary and specialty providers, other care team members, and those identified as having a significant role in the member's life, as appropriate.

Our overarching goal is to help each, and every Nebraska Total Care member achieve the highest possible levels of wellness, functioning, and quality of life, while demonstrating positive clinical results. Integrated care is an integral part of the range of services that we provide to all members. Through this program, we continually strive to achieve optimal health status through member engagement and behavior change motivation. Integrated care does this through a comprehensive approach that includes:

- Strong support for the integration of both physical and mental health including substance use disorder provider services
- Assisting members in achieving optimum health, functional capability, and quality of life
- Empowering members through assistance with referrals and access to available benefits and resources
- Working collaboratively with members, family and significant others, providers, and community organizations to assist members using a holistic approach to care
- Maximizing benefits and resources through oversight and cost-effective utilization management
- Rapid and thorough identification and assessment of program participants, especially members with special health care needs
- A team approach that includes staff with expertise and skills that span departments and services
- Information technologies that support care coordination within plan staff and among a member's providers and caregivers
- Multifaceted approaches to engage members in self-care and improve outcomes
- Multiple, continuous quality improvement processes that assess the effectiveness of integrated care and identify areas for enhancement to fully meet member priorities
- Assessment of member's risk factors and needs

- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members understand treatment recommendations
- Active coordination of care linking members to mental health and/or substance use practitioners and as needed medical services; including linkage with a physical health Care Manager for members with coexisting behavioral and physical health conditions; and residential, social, and other support services where needed.
- Development of a care management plan of care
- Referrals and assistance to community resources and/or mental health and substance use programs or practitioners
- For members not hospitalized but in need of assistance with overcoming barriers to obtaining mental health and/or substance use services or compliance with treatment, we offer Care Coordination.

The model emphasizes direct member contact, such as telephonic outreach and educational materials. Additionally, some specific programs may provide face-to-face education, because it more effectively engages members, allows staff to provide information that can address member questions in real time and better meet member needs. Participating members also receive written materials, preventive care and screening reminders, invitations to community events, and can call any time regarding health care and psychosocial questions or needs.

Recognizing that each member's clinical condition and psychosocial situation is unique, integrated care interventions and information meet each member's unique circumstance, and will vary from one member to another, including those with the same diagnosis.

COMPLEX CARE MANAGEMENT PROGRAM

Nebraska Total Care's Care Management model helps members access needed services—whether covered by Nebraska Total Care, available through community resources, or from other sources. Our model supports providers of all sizes, from individual practices to large multi-specialty groups.

Our program follows a coordinated care model with a multi-disciplinary Care Management team, recognizing that a holistic approach delivers better outcomes. We aim to help members achieve optimal wellness, functioning, and quality of life while minimizing administrative disruptions for PCPs and specialists.

The program uses a structured process to identify eligible members early, assess their needs, and create an individualized care plan. This plan includes member and family education, coordination with providers and support services, and ongoing outcome monitoring with feedback to the primary care provider (PCP). It is the PCP's responsibility to contact Care Management for updates. We will coordinate access to services included in our core benefit packages such as dental, vision and pharmacy services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver support, impaired cognitive abilities, and transportation needs.

A Care Management team is available to help all providers manage their Nebraska Total Care members. Listed below are the programs and components of special services that are available and can be accessed through the Care Management team. We look forward to hearing from you about any Nebraska Total Care members that you think can benefit from the addition of a Care Management team member. To contact a Care Manager, call 1-844-385-2192 TTY 711

High Risk Pregnancy Program

The Maternity team will implement our Start Smart for Your Baby® program (Start Smart), which incorporates care management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart for Your Baby is a unique perinatal program that follows women for up to one (1) year after delivery and includes neonates and qualified children up to one (1) year of age.

The program goals are to improve maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing care management to high and moderate risk members through the postpartum period. A nursing care manager with obstetrical experience will serve as lead care manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead care manager for newborns being discharged from the NICU and will follow them through the first year of life (if they remain eligible with the Plan) as needed based on their specific condition or diagnosis.

The Maternity team has physician oversight advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to Nebraska Total Care Medical Director on obstetrical care standards and use of appropriate preventive treatments.

Nebraska Total Care offers a premature delivery prevention program. The Maternity team works in collaboration with local PCPs, FQHCs, Health Homes and local health departments to support this program with the goal of improved maternity/neonate care in Nebraska.

Contact Nebraska Total Care's Care Management department for enrollment in the obstetrical program by calling 1-844-385-2192 (TTY 711) or using the secure provider portal.

Medically Complex Members

Members must be assessed for health conditions to determine if they qualify for designation as medically complex based upon their physical health, mental health and substance use, or social drivers of health (SDOH) needs. All members identified as medically complex will be offered care and case management services to support their integrated health and SDOH needs. Multifaceted approaches are utilized to assess the member's needs.

Care and Case Management planning includes, but is not limited to the following resources:

- MLTC's Homelessness Identification form
- MLTC's Medically Complex Self-Identification form (provided to the member in the member benefit packet)
- MCO specific health risk assessment
- Medical records
- Predictive analytic tools which are technology-based patient stratification tools that help identify high-risk and rising-risk members.
- Historical claims data
- Provider referrals
- Statewide HIE
- State-registries
- Prescription Drug Monitoring Program (PDMP)
- Health Risk Screening (HRS)

Identification of members who are appropriate for Case Management include those with or who are:

- A disabling mental disorder
- A chronic substance use disorder
- A physical, intellectual, or developmental disability with functional impairment that significantly impairs the individual from performing one or more activities of daily living each time the activity occurs (see 471 NAC 12 for the definition of activities of daily living for adults)
- A disability determination based on Social Security or SRT criteria
- DHHS Medically Complex ICD-10 Diagnosis code listing
- Complex medical condition(s)
- Currently homeless or at risk of homelessness
- Foster care children and adolescents aging out of the foster care system
- Dual eligibles
- Transitioning from incarceration into the community
- Special Needs adolescents who will be aging out and no longer eligible for EPSDT services

Standardized forms are available and supplied to members to support Medically Complex self-identification and assessment:

- Medically Complex Self-Identification form:
    - The form may be completed by the member, their caregiver, family member or friend, authorized representative, or a healthcare provider.
    - This form is included in the welcome packet provided to the members by Nebraska Total Care
    - Medically Complex Self-Identification forms received by Nebraska Total Care are processed and the member is referred to care and/or case management.
- Homelessness Identification form:
    - This form is used to identify members who are currently experiencing homelessness or are at risk of becoming homeless.
    - The form can be completed by the member, their caregiver, family member or friend, authorized representative, a healthcare provider, or provider of homeless services.
    - This form is included in the welcome packet provided to the members by Nebraska Total Care
    - Homelessness Identification forms received by Nebraska Total Care are processed and the member is referred to care and/or case management.

Complex Teams

These teams will be led by licensed registered nurses, or licensed mental health and substance use clinicians, with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers, and obstacles they face, and socioeconomic impacts on their ability to access services. The complex teams will manage care for members whose needs are primarily functional as well as those with such complex conditions as HIV, diabetes, Congestive Heart Failure (CHF), and renal dialysis. Foster care members and children

with special health care needs are at special risk and are also eligible for enrollment in care management.

Community Health Workers

Community Health Workers for Nebraska Total Care conduct outreach designed to provide education to members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our Care Management program to link Nebraska Total Care and the community. The program recruits staff from the community to establish grassroots support and awareness of Nebraska Total Care within the community. The program has various components that can be provided depending on the needs of the member.

Members can be referred to a Community Health Worker through numerous sources. Members who call Nebraska Total Care Member Services may be referred for a more personalized discussion on the topic they are inquiring about. Care Managers may identify members who would benefit from Community Health Worker services and complete a referral request. Providers may request Community Health Worker referrals directly to a team representative or their assigned Care Manager. Community groups may request that a Community Health Worker come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community Connections: Community Health Workers are available to present to group settings during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care is all about, overview of services offered by Nebraska Total Care, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and Nebraska Total Care.

Home Connections: Community Health Workers are available on a full-time basis to support the needs or requests from a care manager, member, or provider. Home visits may occur without prior scheduling if the care manager is unable to reach the member through other means. These visits are commonly arranged when Community Health Workers deliver a cell phone to the member and work to engage the member in care management services. Topics covered during a home visit include an overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive health care, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

Phone Connections: Community Health Workers may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

ConnectionsPlus® Cell Phone: Community Health Workers work together with the high-risk OB team or Care Management team for high-risk members who do not have safe, reliable phone access. When a member qualifies, a Connections Representative visits the member’s home and gives them a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan care manager, PCP, specialty physician, 24/7 Nurse Advice Line, 911, or other members of their health care team.

To contact Community Health Workers, call 1-844-385-2192 (TTY 711).

Chronic Care/Disease Management Programs

As a part of Nebraska Total Care services, Chronic Care Management Programs (CCMP) are offered to members. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic Care Management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Nebraska Total Care programs include but are not limited to asthma, diabetes, congestive heart failure, depression, anxiety, perinatal depression, perinatal substance use and ADHD. Our programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions.

Not all members having the targeted diagnoses will be enrolled in the CCMP. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions will be referred to the Care Management program for evaluation.

To refer a member for Chronic Care Management call 1-844-385-2192 (TTY 711).

Coordination of Care

Our Care Coordinators are not licensed clinical staff and cannot make clinical decisions about what level of care is needed or assess members who are in crisis. Our Care Coordination functions include:

- Coordinate with Nebraska Total Care, member advocates or providers for members who may need mental health and substance use services.
- Assist members with locating a provider.
- Coordinate requests for out-of-network providers by determining need/access issues involved.

Our coordination of care process is designed to ensure the coordination and continuity of care during the movement between providers and settings. During transitions, patients with complex medical needs are at risk for poorer outcomes due to medication errors and other errors of communication among the involved providers and between providers and patients/caregivers.

Continuity of health care means different things to different types of caregivers, and can be of several types:

- Continuity of information includes information of prior events which is used to give care that is appropriate to the patient's current circumstance.
- Continuity of personal relationships recognizes that an ongoing relationship between patients and providers is the foundation that connects care over time and bridges discontinuous events.
- Continuity of clinical management

Providers must adhere to the covered services and authorization guidelines located at NebraskaTotalCare.com when rendering services. We do not retroactively authorize treatment.

Communication with Primary Care Provider

Nebraska Total Care requires primary care provider (PCPs) to consult with their member's mental health and substance use providers. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situations. Communication of this information at the point of referral or during treatment is encouraged with member consent.

Practitioners/Providers should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment. Providers should communicate not only with the member's PCP whenever there is a mental health or substance use problem or treatment plan that can affect the member's medical condition or the treatment being rendered by the PCP, but also with other mental health and substance use providers who may be providing service to the member. Examples of some of the items to be communicated include:

- Prescription medication, especially when the medication has potential side effects, such as weight gain, could complicate medical conditions, such as diabetes.
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or mental health and substance use treatment.
- The member has lab work indicating need for PCP review and consult.
- The member is receiving treatment for a mental health or substance use diagnosis that can be misdiagnosed as a physical disorder (panic symptoms can be confused with heart attack symptoms).
- The member's progress toward meeting the goals established in their treatment plan.

If you are unable to locate or contact other providers serving your member, please contact us for additional information.

We require that providers report specific clinical information to the member's PCP to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the provider's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner. Such consent shall meet the requirements set forth in 42 CFR 2.00 et seq., when applicable. If the member requests this information not be given to their PCP, the provider must document this refusal in the member's treatment record, and if possible, the reason why.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment
- Written notification of member's noncompliance with treatment plan (if applicable)
- Member's completion of treatment
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s)
- The results of functional assessments

Caution must be exercised by conveying information regarding substance use disorders, which is protected under separate federal law. Nebraska Total Care monitors communication with the PCP and other caregivers through audits. Failure to adhere to these requirements can be cause for termination from the network.

Continuity of Care

When members are newly enrolled and have previously received mental health and/or substance use disorder services, we will continue to authorize the provision of medically necessary services. Services that are required for the member during the transition period are covered as needed to minimize disruption and promote continuity of care. We will work with non-participating practitioners/providers (those that are not contracted and credentialed in our provider network) to continue treatment or create a transition plan to facilitate transfer to a participating provider.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision, dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

Nebraska Total Care and its providers will provide the full range of EPSDT services as defined in, and in accordance with, Nebraska state regulations and American Medical Association (AMA) policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization schedules using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventive care.

This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein.

The following minimum elements are to be included in the periodic health screening assessment:

- Comprehensive health and development history (including assessment of both physical and mental development)
- Comprehensive unclothed physical examination
- Immunizations appropriate to age and health history
- Assessment of nutritional status
- Laboratory tests (including finger stick hematocrit, urinalysis [dip-stick], sickle cell screen, if not previously performed); blood lead levels must be tested pursuant to the EPSDT provider manual
- Developmental assessment
- Vision screening and services, including at a minimum, diagnosis, and treatment for defects in vision, including eyeglasses
- Dental screening and services
- Hearing screening and services, including at a minimum, diagnosis, and treatment for defects in hearing, including hearing aids
- Health education and anticipatory guidance
- Annual Well-Child visits for members under age 21

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member.

EMERGENCY CARE SERVICES

Nebraska Total Care defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairments of bodily functions
- Serious dysfunction of any bodily organ or part as per 42 CFR 438.114.(a)

Nebraska Total Care does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Members may access emergency services at any time without prior authorization or prior contact with Nebraska Total Care. Providers should inform members that if they are unsure as to the urgency or emergency of the situation, they are encouraged to contact their primary care provider (PCP) and/or Nebraska Total Care's 24/7 Nurse Advice Line for assistance. However, this is not a requirement to access emergency services. Nebraska Total Care contracts with emergency services providers as well as non-emergency providers who can address the members' non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by Nebraska Total Care when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Nebraska Total Care. Emergency services will cover and reimburse regardless of whether the provider is in Nebraska Total Care's provider network and will not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or
- A representative from the health plan instructs the members to seek emergency services.

Once the member's emergency medical condition is stabilized, Nebraska Total Care requires notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this manual.

Please note that for Medicaid reimbursement, "a qualified provider" will be required to register with Maximus, the state's provider enrollment contractor.

MEDICAL NECESSITY

“Medical Necessity” or “Medically Necessary Care” means any health care services and supplies that are medically appropriate and:

- Necessary to meet the basic health needs of the members
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies
- Consistent with the diagnosis of the condition
- Required for means other than convenience of the client or his/her provider
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Of demonstrated value
- No more intensive level of service than can be safely provided

UTILIZATION MANAGEMENT

The Nebraska Total Care Utilization Management Program (UMP) is designed to ensure members of Nebraska Total Care Network receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all eligibility types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, mental health and substance use, maternity care, and ancillary care services.

Nebraska Total Care UMP seeks to optimize a member’s health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Development of quality standards for the region with the collaboration of the Provider Standards Committee
- Monitoring utilization patterns to guard against over- or under- utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of case and/or population management for members at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all Nebraska Total Care members establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with members/providers to enhance cooperation and support for Utilization Management program (UMP) goals

Prior Authorizations

Failure to obtain required approval or prior authorization may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. Nebraska Total Care providers are contractually prohibited from holding any Nebraska Total Care members financially liable for any service administratively denied by Nebraska Total Care for the failure of the provider to obtain timely authorization. All out-of-network services require prior authorization except for family planning, emergency room, post-stabilization services and tabletop x-rays.

Nebraska Total Care does not reward practitioners, providers, or employees who perform utilization reviews, including those of the delegated entities for issuing denials of coverage or care. UM decision-making is based only on appropriateness of care, service, and existence of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Utilization denials are based on lack of medical necessity or lack of covered benefit.

Nebraska Total Care and its delegated health plan partners have utilization and claims management systems in place in order to identify, track, and monitor the care provided and to ensure appropriate health care is provided to the members.

Nebraska Total Care has implemented the following measures to ensure appropriate utilization of health care:

- A process to monitor for under and overutilization of services and take the appropriate intervention when identified
- A system in place to support the analysis of utilization statistics, identification of potential quality of care issues, implementation of intervention plans and evaluation of the effectiveness of the actions taken
- A process to support continuity of care across the health care continuu

Services That Require Prior Authorization

Ancillary Services

- Air ambulance transport (non-emergent fixed wing airplane)
- Durable Medical Equipment above $750
- Private Duty Nursing
- Furnished medical supplies and DME
- Orthotics/prosthetics
- Genetic testing
- Quantitative urine drug screen

Out-of-Network Providers

- All out-of-network providers require prior authorization excluding emergency room, family planning, and tabletop x-ray services.

Procedures/Services

- Potentially cosmetic
- Bariatric surgery
- High tech imaging administered by Evolent, i.e., CT, MRI, PET at RadMD.com
- Obstetrical ultrasound — two (2) allowed in nine (9) months; prior authorization required for additional u/s except if rendered by a perinatologist
- Pain management

Inpatient Authorization

All elective/scheduled admission notifications requested at least five (5) calendar days prior to the scheduled date of admit including but not limited to:

- Medical admissions
- Surgical admissions
- All services performed in out-of-network facilities.
- Acute Rehabilitation Facilities
- Skilled Nursing Facilities
- Mental Health and Substance Use Disorder
- Observation stays exceeding 48 hours require Inpatient Authorization/Concurrent Review
- Mental Health and Substance Use Disorder admissions
- Partial Inpatient, PRTF, and/or Psychiatric Residential services

Outpatient Programs

- IOP and partial hospitalization
- Mental Health and Substance Use Disorder rehabilitation services
- Certain Mental Health and Substance Use Disorder outpatient services

Please visit NebraskaTotalCare.com and use the Pre-Auth Check tool to determine if a service requires Prior Authorization.

Procedures for Requesting a Medical Prior-Authorization

The preferred method for submitting authorizations is through the secure provider portal at NebraskaTotalCare.com. The provider must be a registered user on the secure provider portal. If the provider is not already a registered user on the secure provider portal and needs assistance or training in submitting prior authorizations, the provider should contact his or her dedicated Provider Relations representative.

Other methods of submitting the prior authorization requests are as follows:

- Call the Medical Management department at 1-844-385-2192 (TTY 711). Please note: The Medical Management normal business hours are Monday – Friday 8 a.m. to 5 p.m. CST. Voicemails left after hours and will be responded to on the next business day.
- Fax prior authorization requests utilizing the Prior Authorization fax forms posted on NebraskaTotalCare.com. Please note the faxes will not be monitored after hours and will be responded to on the next business day.

Timeframes for Prior Authorization Requests and Notifications

Authorization must be obtained prior to the delivery of certain elective and scheduled services. The following timeframes are required for prior authorization and notification.

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five (5) business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within two (2) business days

Service Type	Timeframe
Observation	Notification within one (1) business day for non-participating providers (all observation services for non-participating providers require authorization)
Unplanned Observation – greater than 48 hours	Requires inpatient prior authorization within one (1) business day
Planned Observation – greater than 48 hours	Prior Authorization required five (5) business days prior to the scheduled service admission date
Emergency room and post stabilization, urgent care, and crisis intervention	Notification within two (2) business days
Maternity admissions	Notification within one (1) business day, with delivery outcome
Newborn admissions	Notification within one (1) business day
Neonatal Intensive Care Unit (NICU) admissions	Prior Authorization within one (1) business day
Mental Health and Substance Use Disorder Services	See “Inpatient Notification Process” below

Any prior authorization request that is faxed or sent via the secure provider portal after normal business hours (Monday – Friday 8 a.m. to 5 p.m. CST, excluding holidays) will be processed the next business day.

Failure to obtain authorization may result in claim denials.

Authorization Determination Timelines

Nebraska Total Care decisions are made as expeditiously as the member’s health condition requires.

Type	Timeframe
Preservice/Urgent	72 hours
Preservice/non-urgent	Seven (7) calendar days
Concurrent review	72 hours

Clinical Information

Nebraska Total Care clinical staff request clinical information minimally necessary for clinical decision-making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Nebraska Total Care is entitled to request and receive protected health information (PHI) for purposes of treatment, payment, and healthcare operations, without the authorization of the member.

The Outpatient and Inpatient Prior Authorization Forms required to be sent in with all authorization requests can be found at NebraskaTotalCare.com under “Provider Resources” then “Practice Improvement Resource Center (PIRC)”. Information necessary for authorization of covered services may include but is not limited to:

- Member’s name, member ID number
- Provider’s name and telephone number

- Facility name if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary, and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate including the date of birth and gender of infant must be provided to Nebraska Total Care within one (1) business day or before discharge.

If additional clinical information is required, a nurse or medical service representative will notify the submitting or requesting provider of the specific information needed to complete the authorization process.

Clinical Decisions

Nebraska Total Care affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Nebraska Total Care does not reward practitioners or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Nebraska Total Care Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established PC criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Review Criteria

Nebraska Total Care utilizes review criteria including Nebraska Administrative Code, McKesson InterQual, clinical judgement and ASAM criteria. Nebraska Total Care has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria is established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment.

Substance Use services are authorized utilizing ASAM criteria. Mental Health and Substance Use Services are reviewed to include Medicaid Behavioral Health Service Definitions posted on both the Nebraska Department of Health and Human Service website and on NebraskaTotalCare.com The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting Medical Management at 1-844-385-2192 (TTY 711). Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted through Provider Services by calling Nebraska Total Care at 1-844-385-2192 (TTY 711). The provider may request a Peer Review with the Medical Director. A Care Manager may also coordinate communication between the Medical Director and the requesting practitioner.

Members or healthcare professionals with the member's consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process by calling Nebraska Total Care at 1-844-385-2192 (TTY 711) or writing to:

Nebraska Total Care
Attn: Complaint and Grievance Coordinator
2525 N 117th Ave, Suite 100
Omaha, NE 68164

The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Nebraska Total Care network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network and in-network providers require prior authorization by Nebraska Total Care when performing second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

New Technology

Nebraska Total Care evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs, and/or devices. The Chief Medical Officer and/or Medical Management staff may identify relevant topics for review pertinent to the Nebraska Total Care population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-844-385-2192 (TTY 711).

Notification of Pregnancy

Members that become pregnant while covered by Nebraska Total Care may remain a Nebraska Total Care member during their pregnancy. The managing physician should notify the Nebraska Total Care prenatal team by completing the Notification of Pregnancy (NOP) and / or the MLTC Obstetric Needs Assessment Form (ONAF) within five (5) calendar days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility.

See Complex Care Management within this manual for information related to our Start Smart for Your Baby® program. There is a Notification of Pregnancy (NOP) provider incentive program. More details can be found on at NebraskaTotalCare.com under Pregnancy Support.

Concurrent Review and Discharge Planning

Nurses and other appropriately licensed care managers, as appropriate, perform ongoing concurrent reviews for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The care manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 72 hours of receipt of clinical information. For length of stay extension request, clinical information must be submitted by 3 p.m. CST on the day review is due. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, however; the hospital must notify Nebraska Total Care within one (1) business day of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

To request retro-authorization:

- Provider will submit a retro-authorization request through the standard authorization request channels (phone, fax, secure provider portal).
- Provider explicitly identifies in the submission that they are making a retro-authorization request.
- Nebraska Total Care Utilization Management will receive the request and:
    - Determine if it has been made timely based on plan notification of eligibility
    - If the authorization request is timely, the retro authorization will be reviewed against Medical Necessity criteria.
    - If the authorization request is not timely based on the information identified by the provider or meet the extenuating circumstances, it will be administratively non-authorized.
- For retro-authorization requests received timely and reviewed for Medical Necessity, an authorization determination will be made and communicated to the provider.
- For retro-authorizations that are not approved upon review, appeal rights apply and signed release to act on the member's behalf if appealing a retro authorization applies in line with Nebraska Total Care's existing appeals policy.

Nebraska Total Care will not retroactively authorize routine services, except in cases where one of the valid extenuating circumstances is documented:

- Services authorized by another payor who subsequently determined member was not eligible at the time of services. This may be demonstrated by inclusion of Explanation of Payment (EOP) demonstrating recovery of initial payment.
- Members received retro-eligibility from the Department of Health and Human Services, Division of Medicaid and Long-Term Care.
- Services occurred during a transition of care period between two (2) Heritage Health Managed Care Organizations.
- Members were not capable of providing insurance information due to incapacitation.

Speech, Occupational or Physical Therapy Services

Nebraska Total Care offers members access to all covered, medically necessary outpatient physical, occupational and speech therapy services.

Physical, occupational, and speech therapy services are managed by the Nebraska Total Care utilization management team which employs PT/OT/ST clinical reviewers. PT/OT/ST services require prior authorization, for all members. Treatment request forms and information on the authorization process for these services can be found at NebraskaTotalCare.com.

All PT/OT/ST claims must contain the appropriate modifier when submitted to the health plan in order to ensure appropriate adjudication. Failure to include a specialty modifier (GN, GO, GP), may result in the inability to process your claim.

Providers are responsible for ensuring that members have not exhausted their PT/OT/ST benefit and/or has a restorative benefit prior to providing services.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to members, Nebraska Total Care is using Evolent to provide prior authorization services and utilization. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA

Key Provisions

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in a claim non-payment.

To reach Evolent and obtain authorization, please call 1-844-385-2192 (TTY 711) and follow the prompt for radiology authorizations. Evolent also provides an interactive website, which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

As part of a continued commitment to further improve the quality of cardiac studies delivered to members, Nebraska Total Care is using Evolent to provide prior authorization services and utilization for members aged 21 and over.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. Evolent also includes references to the

Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed
- Quality assessment of imaging providers to ensure the highest technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through Evolent:

- Inpatient advanced radiology services
- Observation setting advanced radiology services.
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call 1-800-327-0641 or contact RadMDSupport@Evolent.com.

Evolent also provides an interactive website which may be used to obtain on-line authorizations and more information on Cardiology guidelines and documents. Please visit RadMD.com for more information.

Mental Health and Substance Use Disorder Medical Necessity Criteria and Tools

Our utilization management decisions are based on Medical Necessity and established Clinical Practice Guidelines. We do not reimburse unauthorized services and each agreement with us precludes providers from balance billing (billing a member directly) for covered services with the exception of copayment and/or deductible collection, if applicable. Our authorization of covered services is an indication of medical necessity, not a confirmation of member eligibility, and not a guarantee of payment.

Member coverage is not an entitlement to utilization of all covered benefits but indicates services that are available when medical necessity is satisfied. The application of Medical Necessity to Medicaid Services is required under Title XIX of the Social Security Act, Sections 1902 and 1903, and mandates utilization control of all Medicaid services under regulations found at Title 42, Code of Federal Regulations, Part 456. Member benefit limits apply for a calendar year regardless of the number of different mental health and substance use disorder practitioners providing treatment for the member. Network providers are expected to work closely with our Utilization Management department in exercising judicious use of a member's

benefit and to carefully explain the treatment plan to the member in accordance with the member's benefits offered by Nebraska Total Care.

We use InterQual Criteria for mental health for both adult and pediatric guidelines and the American Society of Addiction Medicine Patient Placement Criteria (ASAM) for substance use MNC. InterQual is a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes appropriate use of services and improved health outcomes.

American Society of Addiction Medicine (ASAM) and the McKesson InterQual criteria sets are proprietary and cannot be distributed in full, however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. Both ASAM and InterQual criteria are reviewed on an annual basis by our health plan committees, which are comprised of network providers as well as our clinical staff. We are committed to the delivery of appropriate service and coverage, and offer no organizational incentives, including compensation, to any employed or contracted UM staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on the appropriateness of care and service criteria, and UM staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director.

Inpatient Notification Process

Emergency mental health and substance use requests indicate a condition in clinical practice that requires immediate intervention to prevent death or serious harm (to the member or others) or acute deterioration of the member's clinical state, such that gross impairment of functioning exists and is likely to result in compromise of the member's safety. An emergency is characterized by sudden onset, rapid deterioration of cognition, judgment or behavioral functioning and is time limited in intensity and duration (usually occurs in seconds or minutes, rarely hours, rather than days or weeks). Thus, elements of both time and severity are inherent in the definition of an emergency.

All inpatient admissions require notification within one (1) business day following the day of admission. Failure to provide notification may result in an administrative denial.

The number of initial days authorized is dependent on medical necessity and continued stay is approved or denied based on the findings in concurrent reviews. The receiving hospital should also notify Nebraska Total Care of the admission to acute care when the member arrives and is admitted. The facility will be required to provide clinical review information the next business day and at subsequent intervals for concurrent review depending upon the consumer's specific symptoms and progress.

Members meeting criteria for inpatient treatment must be admitted to a contracted hospital or crisis stabilization unit. Members in need of emergency and/or after-hours care should be referred to the nearest participating facility for evaluation and treatment, if necessary.

The following information must be readily available for the Utilization Manager when requesting initial authorization for inpatient care:

- Name, age, health plan and identification number of the member
- Diagnosis, indicators, and nature of the immediate crisis
- Alternative treatment provided or considered
- Treatment goals, estimated length of stay, and discharge plans
- Family or social support system
- Current mental status

For a listing of providers participating in our network, please refer to our online Find A Provider directory.

Outpatient Notification Process

When authorizations are required, network providers must contact us to obtain authorized sessions for continued services. We do not retroactively authorize treatment.

For prior authorizations during normal business hours, network providers should call or contact us at: 1-844-385-2192 (TTY 711).

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions

When requesting sessions for those outpatient services that require authorization, the network practitioner must complete an Outpatient Treatment Request (OTR) form and fax the completed form to us 1-866-593-1955 or submit via secure provider portal for clinical review. Network Practitioners may call the Provider Services department at 1-844-385-2192 (TTY 711) or review the secure provider portal to check the status of an OTR authorization request. Network practitioners should allow up to seven (7) calendar days to process non-urgent requests. OTR forms for services requiring authorization are located at NebraskaTotalCare.com.

Important:

- The OTR must be completed in its entirety. The diagnoses as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delays and/or denials.
- We will not retroactively certify routine services. The dates of the authorization request must correspond to the dates of expected services. Treatment must occur within the dates of the authorization.

Our utilization management decisions are based on medical necessity and established Clinical Practice Guidelines. We do not reimburse unauthorized services and each provider's agreement with us precludes network providers from balance billing (billing a member directly) for covered services with the exception of copayment and/or deductible collection, if applicable. Our authorization of covered services is an indication of medical necessity, not a confirmation of member eligibility, and not a guarantee of payment.

Guidelines for Psychological Testing

Psychological testing must be prior authorized for outpatient services. Testing, with prior authorization, may be used to clarify questions about a diagnosis as it directly relates to treatment. OTR forms for services requiring authorization are located at NebraskaTotalCare.com.

It is important to note:

- Testing will not be authorized by us for ruling out a medical condition.
- Testing is not used to confirm previous results that are not expected to change.
- A comprehensive initial diagnostic interview (procedure code 90791) should be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the practitioner is contracted and credentialed with us.
- Providers should submit a request for Psychological Testing that includes the specific tests to be performed. Providers may access our Psychological Testing Authorization Request Form within our Provider Forms and Resources.

- Testing requested by the court or state agencies for the purpose of placement is not considered medically necessary and may not be reimbursed.

Adverse Benefit Determination (Notice of Action)

When it is determined a specific service does not meet medical necessity criteria and will therefore not be authorized, we will submit a written adverse benefit determination to the treating network practitioner, provider rendering the service(s), and the member. The notification will include the following information/ instructions:

- The reason(s) for the proposed action in clearly understandable language.
- A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy-to-understand summary.
- A statement that the criteria, guideline, benefit provision, or protocol will be provided upon request.
- Information on how the provider may contact the Peer Reviewer to discuss decisions and proposed actions. When a determination is made where no peer-to-peer conversation has occurred, the Peer Reviewer who made the determination (or another Peer Reviewer if the original Peer Reviewer is unavailable) will be available within one (1) business day of a request by the treating provider to discuss the determination.
- Instructions for requesting an appeal including the right to submit written comments or documents with the appeal request; the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision.
- For all urgent precertification and concurrent review clinical adverse decisions, and instructions for requesting an expedited appeal.
- The right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

Peer Clinical Review Process

If the Utilization Manager is unable to certify the requested level of care based on the information provided, the Utilization Manager will initiate the peer review process.

For outpatient service requests, the clinical information submitted will be forwarded to an appropriate clinician of like specialty of the requesting provider for review and response. When a determination is made where no peer-to-peer conversation has occurred, a provider can request to speak with the Clinical Consultant who made the determination. If the member is dissatisfied with the decision of the medical director, the member may within 10 calendar days of notification of the decision file a written or oral notice of appeal, with an oral filing followed by a written, signed notice of appeal within five (5) calendar days, with Nebraska Total Care to be heard by a Peer Review committee.

As a result of the Peer Clinical Review process, we will decide to approve, modify, or deny authorization for services. Treating practitioners may request a copy of the medical necessity criteria used in any denial decision. The treating practitioner may request to speak with the Peer Reviewer who made the determination after any denial decision. If you would like to discuss a denial decision, contact us at 1-844-385-2192 (TTY 711).

In addition, if we determine that a member needs services that are not covered benefits, the member will be referred to an appropriate provider, and we will continue to coordinate care including discharge planning.

Clinical Training

The Provider Training team will provide training for network providers, stakeholders, and caregivers within our network. Training opportunities will support the provider's ability to provide quality services to members. All trainings are provided free of charge, and are conducted in person, group, regional, facility based, and/or remote webinar training. Training is available for mental health and substance use disorder providers, physical health providers, stakeholder groups, caregivers, and other non-clinical professions. Topics offered to providers include, but are not limited to:

- Motivational Interviewing (certified trainers)
- Mental Health First Aid (certified trainers)
- Screening Brief Intervention and Referral to Treatment (certified trainers)
- CPI Dementia Training (certified trainers)
- Alzheimer's Training (certified to offer train-the-trainer courses)
- PCP Toolkits
- Mental Health and Substance Use / physical health screening and referral
- Recovery Principles
- Integrated Healthcare
- Trauma Informed Care
- Diagnosis-specific Overviews
- Substance Use Overview
- Stages of Change
- SMART Goals
- Behavioral Management and De-escalation
- Behavioral Management in the Long-Term Care Population
- HIPAA and Privacy Laws
- Cultural Competency
- Poverty Competency
- Person Centered Approach
- Evidence Based Practices (including but not limited to)
    - Trauma Focused Cognitive Behavioral Therapy
    - Recovery Model
    - Strengths Based Model
    - Positive Psychology
- Peer Support
- When to refer to Primary Care
- Referral for Care Management
- Mental Health and Substance Use 101
- Physical Health 101
- Psychiatric Medications
- Medical Necessity Criteria

The Training team is committed to achieving the following goals:

- Promoting provider competence and opportunities for skill-enhancement across disciplines
- Promoting member recovery through integrated, member-centered care
- Sustaining and expanding the use of evidence based practices (e.g., motivational interviewing, stages of change, impact model, positive psychology, trauma focused cognitive behavioral therapy
- Assisting providers in meeting mandatory state or licensure requirements
- Providing continuing education credits when applicable

The Training team can be reached directly at BH_training@centene.com to request any of the above training topics or request a new topic.

Member Concerns About Provider

Members who have concerns about our providers should contact us to register their concerns by filing a grievance. This process is identified at NebraskaTotalCare.com. All concerns are investigated and feedback is provided on a timely basis. It is the provider's responsibility to provide supporting documentation to us if requested. Any validated concern will be taken into consideration when re-credentialing occurs and can be cause for termination from our provider network.

Monitoring Satisfaction

We conduct periodic satisfaction surveys of our members and providers. These surveys enable us to gather useful information to identify areas for improvement. Providers may be requested to participate in the annual survey process. The survey includes a variety of questions designed to address multiple facets of the provider's experience with our delivery system. Providers are encouraged to contact their assigned Provider Relations representative to address concerns as they arise. Feedback from providers enables us to continuously improve systems, policies, and procedures. We will also collect feedback from members of the Member Advisory Council and our Quality Committees.

Critical Incident Reporting

A critical incident is defined as any occurrence which is not consistent with the routine operation of a mental health and substance use provider. It includes but is not limited to; injuries to members or member advocates, suicide/homicide attempt by a member while in treatment, death due to suicide/homicide, sexual battery, medication errors, member escape or elopement, altercations involving medical interventions, or any other unusual incident that has high risk management implications.

Providers will follow the Nebraska DHHS process and requirements for submission of all critical incidents. Upon receipt and notification of critical incident review requests from DHHS, we may require providers to participate in the quality review process.

CLINICAL PRACTICE GUIDELINES

Medical

Nebraska Total Care clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Nebraska Total Care adopts guidelines that are published by nationally recognized organizations or government institutions as well as statewide collaborative and/or a consensus of healthcare professionals in the applicable field.

Nebraska Total Care providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. The following is a sample of the clinical practice guidelines adopted by Nebraska Total Care.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the medical practice guidelines adopted by Nebraska Total Care, visit NebraskaTotalCare.com.

Mental Health and Substance Use

We have adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services. Clinical practice guidelines adopted for adults include but are not limited to treatment of:

- Major Depressive Disorder
- Bipolar Disorder
- Substance Use Disorders
- Schizophrenia
- Post-Traumatic Stress Disorder (PTSD)
- Panic Disorders
- ADHD
- Psychotropic Medication

For children, we have adopted guidelines for Depression in Children and Adolescents, Assessment and Treatment of Children and Adolescents with Anxiety Disorders and Attention Deficit/ Hyperactivity Disorder.

Clinical practice guidelines may be accessed at NebraskaTotalCare.com, or you may request a paper copy of the guidelines by contacting your Network Manager. Copies of our evidence-based practices can be obtained in the same manner.

For links to the most current version of the behavioral health practice guidelines adopted by Nebraska Total Care, visit NebraskaTotalCare.com.

Speech, Physical or Occupational Therapy

The Specialty Therapy and Rehabilitation Services program utilizes current practice guidelines from the respective National Associations for each discipline to help guide reviewers in determining best practices and medical necessity. Some examples of current practice guidelines can be found in the following resources. This list is not all inclusive. Updated resources are utilized as they become available.

- Guide to Physical Therapist Practice 3.0. Alexandria, VA: American Physical Therapy Association; 2014. Available at: guidetoptpractice.apta.org (Accessed 4/26/2016.)
- American Speech Language Hearing Association, Medical Review Guidelines for Speech-Language Pathology Services (2001)
- Clark GF. Guidelines for documentation of Occupational Therapy (2003). Am J Occupational Therapy. 2003 Nov-Dec; 57(6):646-9

PHARMACY

Nebraska Total Care is committed to providing appropriate, high quality, and cost-effective drug therapy to all Nebraska Total Care members. We work with providers and pharmacists to ensure medications used to treat a variety of conditions and diseases are covered.

Nebraska Total Care covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by a Nebraska Medicaid provider. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, and/or maximum quantities.

This manual provides an overview of the Nebraska Total Care pharmacy program. For more detailed information and pharmacy claims billing information, please visit NebraskaTotalCare.com.

BILLING INFORMATION

RXBIN#: 003858
RXPCN: MA
RXGROUP: 2ETA
Express Scripts Pharmacy Help Desk: 1-833-750-4471
Pharmacy Prior Auth Phone: 1-844-330-7852
Pharmacy Prior Auth Fax: 1-833-404-2254

PREFERRED DRUG LIST (PDL) AND FORMULARY

The Nebraska Medicaid Preferred Drug List (PDL) is maintained by the state Medicaid department, can be found online at NebraskaTotalCare.com, and describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the Nebraska Medicaid program. The PDL includes all drugs available without PA and those agents that have restrictions. Medications requiring Prior Authorization (PA) are listed on the PDL with a “CL” notation with written coverage criteria information. The PDL is evaluated by the Nebraska Medicaid Department to promote the appropriate and cost-effective use of medications. The PDL and Nebraska Total Care Value-Add Formulary include a broad spectrum of generic and brand name drugs. The PDL and Nebraska Total Care Value-Add Formulary do not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the independent professional judgment of the provider or pharmacist.
- Relieve the provider or pharmacist of any obligation to the member or others.

The Nebraska Total Care Value-Add Formulary can be found at NebraskaTotalCare.com and will include any information regarding PA, quantity limits, or step therapy requirements.

PRIOR AUTHORIZATION PROCESS

Providers are requested to utilize the PDL when prescribing medications for Nebraska Total Care members. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the provider to request a change to a product included in the Nebraska Medicaid PDL. Drugs that require PA will be indicated on the PDL and Nebraska Total Care Value-Add Formulary.

These include:

- All medications not listed on the state Preferred Drug List (PDL) that are also not listed on the Nebraska Total Care Value-Add Formulary
- Some state PDL and Nebraska Total Care Value-Add Formulary drugs (designated prior authorization (PA) on the PDL and formulary)

Drug Prior Authorization requests are available at Centene Pharmacy Services through phone, fax or online.

- Centene Pharmacy Services Telephonic Prior Authorization
    - Providers may call Centene Pharmacy Services to initiate prior authorization by calling 1-844-330-7852.
    - Please have member information, including Medicaid ID number, member date of birth, complete diagnosis, medication history, and current medications readily available.
- Fax Prior Authorization

    Complete the Nebraska Total Care/Centene Pharmacy Services Medication Prior Authorization Request form found at NebraskaTotalCare.com. FAX to Centene Pharmacy Services at 1-833-404-2254.
    - Once reviewed and a decision is made, Centene Pharmacy Services notifies the prescriber by FAX. If the review results in a denial, the member receives a letter via mail.
    - If the clinical information provided does not explain the reason for the requested prior authorization medication, Centene Pharmacy Services responds to the prescriber by FAX, offering PDL alternatives.
- Online Prior Authorization
    - CoverMyMeds is an online drug prior authorization program through Centene Pharmacy Services that allows prescribers to submit prior authorization requests electronically. Electronic prior authorization (ePA) automates the PA process making it a quick and simple way to complete PA requests. The ePA process is HIPAA compliant and enables faster determinations. You may also use this link to track ePA requests.
    - CoverMyMeds can be found at CoverMyMeds.com/main/prior-authorization-forms

  Fax: 1-833-404-2254
  Web: CoverMyMeds.com/main/prior-authorization-forms/envolverx/
  Phone: 1-844-330-7852 (Monday – Friday 8 a.m. to 7 p.m. CST)

If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific member to receive the specific drug.

Nebraska Total Care will cover the medication if it is determined that:

- The request meets all the approved criteria.
- Depending on the medication, other medications on the PDL have not worked.

All reviews are performed by a licensed clinical pharmacist using the criteria provided by the state of Nebraska Medicaid program or by the Centene National P&T Committee. If the clinical information provided does not meet the coverage criteria for the requested medication,

Nebraska Total Care will notify the member and physician/clinician and pharmacy of alternatives and provide information regarding the appeal process. Mental health drugs prescribed for youth outside of established limits will be reviewed by a Nebraska licensed child and adolescent psychiatrist.

72-Hour Emergency Supply Policy

State and federal law require that a pharmacy dispense a 72-hour (3-day) supply of medication to any patient awaiting a PA determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee for the 72-hour supply of medication, whether or not the PA request is ultimately approved or denied.

Unless specifically instructed otherwise by Express Scripts or Nebraska Total Care, a provider is not authorized to enter overrides for an emergency fill without contacting the Pharmacy Help Desk. The pharmacy must call the Express Scripts Pharmacy Help Desk for a prescription override to submit the 72-hour medication supply for payment. Please call 1-833-750-4471 for the Express Scripts Pharmacy Help Desk.

The following drug categories are not part of the Nebraska Total Care PDL and are not covered by the 72-hour emergency supply policy:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Infusion therapy and supplies
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence

DESI drugs products and known related drug products are defined as less than effective by the Food and Drug Administration (FDA) because there is a lack of substantial evidence of effectiveness for all labeling indications and because a compelling justification for their medical need has not been established. State programs may allow coverage of certain DESI drugs. Any DESI drugs that are covered are listed in the PDL.

If the prior authorization request is denied, the members and physician/clinician, and pharmacy will be notified and provided information regarding the appeal process.

If a provider or member disagrees with the decision regarding coverage of a medication, the member, or the provider, on the member's behalf, may submit an appeal, verbally or in writing. For additional information about appeals, please see Appeals within this manual.

PHARMACY AND THERAPEUTICS COMMITTEE (P&T)

The responsibilities of the Centene National Pharmacy and Therapeutics Committee (P&T) include the review of new drugs, indications, and pharmacy policies. The P&T Committee addresses quality and utilization issues related to the provision of the pharmacy benefit. Nebraska Total Care Pharmacy department, in conjunction with Centene Pharmacy Services, maintains compliance with DHHS MLTC Preferred Drug List and Claim Limitations requirements. The P&T Committee discusses pharmacy quality initiatives such as e-prescribing and opioid prescribing practices. The Nebraska Total Care Pharmacy department provides reports to the Utilization Management Committee quarterly.

Voting members of the Centene National P&T Committee will include practitioners and pharmacists representing various clinical specialties that adequately represent the needs of health plan members. The community-based practitioners must be independent and free of conflict with respect to pharmaceutical manufacturers.

UNAPPROVED USE OF PREFERRED MEDICATION

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by Nebraska Total Care following requirements in the Social Security Act 1927. Experimental drugs and investigational drugs are not eligible for coverage.

NEWLY APPROVED PRODUCTS

New FDA approved drugs will be evaluated for safety and effectiveness for at least the first six (6) months. They will require prior authorization prior to P&T approval. If Nebraska Total Care does not grant prior authorization, the member and physician/clinician, and pharmacy will be notified and provided information regarding the appeal process.

MANDATORY GENERIC SUBSTITUTION

When generic drugs are available, the brand name drug will not be covered without Nebraska Total Care prior authorization unless specifically allowed on the Nebraska Medicaid PDL. Generic drugs have the same active ingredient, work the same as brand name drugs, and have lower copayments. If the member or physician/clinician thinks a brand name drug is medically necessary, the physician/clinician can ask for prior authorization. The brand name drug will be covered according to our clinical guidelines if there is a medical reason the member needs the particular brand name drug. If Nebraska Total Care does not grant prior authorization the member and physician/clinician will be notified and provided information regarding the appeal process.

DISPENSING LIMITS, QUANTITY LIMITS AND AGE LIMITS

Drugs may be dispensed up to a maximum 30-day supply for each new or refill non-controlled substance. A total of 80% of the days supplied must have elapsed before the prescription can be refilled. A prescription can be filled after 24 days. Controlled substances can’t be filled until 90% of the day supplied has elapsed.

Nebraska Total Care may limit how much of a medication you can get at one time. Some medications on the Nebraska Medicaid PDL or Nebraska Total Care Value-Add Formulary may have age limits. Age limits are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. The age limit aligns with current FDA alerts for the appropriate use of pharmaceuticals.

Dispensing outside the quantity limit (QL) or age limit (AL) requires prior authorization. If the physician/clinician feels a member has a medical reason for getting a larger amount, he or she can ask for prior authorization. If Nebraska Total Care does not grant prior authorization the member and physician/clinician, and pharmacy will be notified and provided information regarding the appeal process.

Nebraska Total Care members can get up to a 90-day prescription fill on maintenance medications. Maintenance medications are used to treat chronic, long-term conditions or illnesses. Nebraska Total Care has a list of 90-Day Maintenance Drugs.

COMPOUNDS

Compounded prescriptions must be submitted online, and each active ingredient must have an active and valid NDC. Compounded medications may be subject to prior authorization based on ingredients submitted. Compounds that have a commercially available product are not reimbursable. Pharmacy providers can access detailed instructions on how to submit a compound claim by accessing the Express Scripts Payer Sheets.

PROSPECTIVE DUR RESPONSE REQUIREMENTS

Nebraska Total Care is committed to providing a safe and quality pharmacy benefit. Our pharmacy program will utilize prospective and concurrent drug utilization review (DUR) edits to detect potential problems at the point-of-service. All DUR messages appear in the claim response utilizing NCPDP standards. This allows the provider to receive and act on the appropriate DUR conflict codes. Pharmacy providers can find detailed instructions on the DUR system by accessing the Express Scripts Provider Manual.

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

Each provider prescribing a controlled substance in Nebraska to a Medicaid client must check the prescription drug monitoring program (PDMP) established under Neb. Rev. Stat. Sec. 71-2454 before prescribing schedule II medication and at dosage adjustment. The provider may delegate checking of the prescription drug monitoring program to a delegate as defined in 71-2454 (14)(c). Schedule II medications include both opioids and non-opioids.

Good faith exceptions must be documented in the client's medical record and provided upon request to the department.

These requirements do not include a prescription to a client as set forth under 42 U.S.C. Sec. 1396w-3a and to a resident of a facility where schedule II medications are dispensed to a client through a single pharmacy.

When reviewing prior authorization requests for opioids in excess of the state limit, Nebraska Total Care requires that providers attest to checking the PDMP before approval of the opioid prior authorization.

INJECTABLE DRUGS

Injections that are self-administered by the member and/or a family member and appear on the PDL or Value-Add Formulary are covered by the Nebraska Total Care pharmacy program. Examples of self-injectable drugs include insulin pens, glucagon Kit, EpiPen, Imitrex, and injectable antipsychotics. These are covered by Nebraska Total Care and may be subject to prior authorization or other claims limitations. See NebraskaTotalCare.com for a full list of covered injectable drugs.

Injectable drugs that are administered by a healthcare professional may be covered as an outpatient service. Please refer to the Covered Services and Authorization Guidelines to identify which services require authorization.

SPECIALTY DRUGS

Any pharmacy in the Nebraska Total Care pharmacy network can dispense specialty drugs, including injectables, for Nebraska Total Care members. A specific list of Hemophilia Network pharmacies may dispense drugs to treat hemophilia for Nebraska Total Care members. The list of in-network Hemophilia Pharmacies is available at NebraskaTotalCare.com. Some specialty drugs may also be covered as an outpatient service. Please refer to the Covered Services and Authorization Guidelines to identify which of these drugs require authorization.

OVER-THE-COUNTER MEDICATIONS

The pharmacy program covers a large selection of OTC medications as approved by the Nebraska Medicaid program. All OTC medications must be written on a valid prescription by a licensed physician/clinician to be reimbursed.

PHARMACY PORTAL AND PROVIDER LINKS

For access to the Express Scripts (ESI) Pharmacy Portal go to ESIprovider.com. Click on “New Account” to register.

- Express Scripts Provider Manual
- Express Scripts Payer Sheets
- Express Scripts Pharmacy Help Desk and Contact Numbers
- Paper Claim Information can be found within the ESI Provider Manual at ESIprovider.com
- Express Scripts MAC Pricing

PROVIDER RELATIONS AND SERVICES

PROVIDER RELATIONS

Nebraska Total Care's Provider Relations team is committed to supporting our providers as they care for our members. Through provider orientation, ongoing training, and support of daily business operations, we will strive to be your partners in good care. Upon credential approval and contracting, within 30 calendar days of the provider's effective date, the Provider Relations representative will contact the provider to schedule an orientation. All participating providers have a dedicated provider relations representative. A contact list for the Provider Relations team can be found at NebraskaTotalCare.com.

Reasons to Contact a Provider Relations Representative

- Provider education
- Data Analytics Tool training and support
- HEDIS/care gap reviews
- Claims analysis
- Facilitating inquiries related to administrative policies, procedures and operational issues
- Monitoring performance patterns
- Assisting in secure provider portal registration and Payspan

PROVIDER SERVICES

Provider Services is available at 1-844-385-2192 (TTY 711) Monday through Friday 7 a.m. to 6 p.m. CST.

CREDENTIALING AND RE-CREDENTIALING

The credentialing and re-credentialing process ensures Nebraska Total Care maintains a high-quality healthcare delivery system by verifying provider competency and conduct. This includes confirming licensure, board certification, education, and reviewing adverse actions such as malpractice claims through state and federal agencies and the National Practitioner Data Bank. Providers must meet Nebraska Total Care criteria, comply with government regulations and accrediting standards, and be enrolled with Nebraska Medicaid.

Nebraska Total Care requires re-credentialing at least every three (3) years to ensure provider information remains current. Accurate data is essential for maintaining our provider directory, which members rely on for up-to-date information.

Note: To maintain a current provider profile, providers are required to notify Nebraska Total Care of any relevant changes to their credentialing information in a timely manner.

WHICH PROVIDERS MUST BE CREDENTIALED AND RECREDENTIALED?

All of the following providers are required to be credentialed:

Medical practitioners

- Medical doctors
- Oral surgeons
- Chiropractors
- Osteopaths
- Podiatrists
- Physician assistants
- Nurse practitioners
- Other medical practitioners
- General Dentists and Dental Specialists (more information at CenteneDental.com)
- Optometrists and Ophthalmologists (more information at CenteneVision.com)

Mental health and substance use practitioners

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's-level psychologists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Other licensed mental health and substance use care specialists

INITIAL CREDENTIALING PROCESS AND REQUIREMENTS

Nebraska Medicaid approved the Centralized Verification Organization (CVO) selection by the three (3) Nebraska Managed Care Organizations (MCOs) (Nebraska Total Care, Molina Healthcare and United Healthcare Community Plan) of the shared CVO vendor, Verisys.

Beginning January 1, 2025, providers seeking initial credentialing with any MCO for Nebraska Medicaid will use the newly implemented centralized credentialing process along with an NCQA certified CVO. The CVO, Verisys, will conduct one streamlined verification process for all three

(3) Nebraska MCOs. A Centralized Credentialing system eliminates the need to perform a unique credentialing process with each MCO and is in alignment with Nebraska Medicaid's intent to alleviate the duration and reduce administrative burdens of the MCO specific credentialing processes.

Providers required to participate in the centralized credentialing process are medical, mental health and substance use and dental providers. If the MCO delegates credentialing to a national vendor e.g. physical health, routine vision, pharmacy, non-emergency medical transportation (NEMT) providers or other entities including Independent Physician Practice Associations (IPA) and Physician Hospital Organizations (PHO) who hold delegated credentialing agreements, these vendors and delegates will be excluded from the CVO.

This process adheres to NCQA and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process. The following items are required to begin the credentialing process:

- A completed CAQH application, including an attestation statement
- Current medical license, when applicable
- Current DEA certificate, when applicable
- Current professional liability insurance

The CVO will verify using primary sources licensure, education and training, board certification and malpractice claim history.

Please note that centralized credentialing does not replace the Medicaid provider enrollment screening process. All Medicaid providers must enroll with the program through Maximus. More information on how to enroll in the Nebraska Medicaid program can be found through the Nebraska DHHS Provider Data Management System.

Information Provided in Advance of Provider Enrollment and Credentialing

All new practitioners and those adding practitioners to their current practice or as a newly contracted individual practitioner or group practice must submit at a **minimum** the following information when applying for participation with Nebraska Total Care:

- A completed, signed and dated Credentialing application or complete profile, including current attestation on CAQH.org
- Providers can authorize Nebraska Total Care access to their information on file with the CAQH (Council for Affordable Quality Health Care) at CAQH.org
- Copy of W-9

Information That Will Be Collected and Validated by Verisys

All new practitioners and those adding practitioners to their current practice must submit at a **minimum** the following information when applying for participation with Nebraska Total Care:

- A signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation (attestation must be no more than 120 calendar days at time of submission for enrollment)

- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Nebraska regulations regarding malpractice coverage or alternate coverage
- Hospital admitting privileges or alternate admitting arrangements, when required for license type
- Copy of current Drug Enforcement Administration (DEA) registration certificate, and copy of state-controlled substance certificate, if applicable
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history (not required if work history is completed on the application)
- Signed and dated release of information forms are not older than 90 calendar days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable; and,
- Evidence of completion of cultural competency training

If applying as an individual practitioner or group practice, please submit the following information along with your signed participation agreement:

- A completed, signed and dated Credentialing application
  If applying as an ancillary or clinic provider, please submit the following information along with your signed participation agreement:
- Copy of state operational license
- Copy of current general liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicaid/Medicare certification (if not certified, provide proof of participation)
- Other applicable state/federal/licensures (e.g., CLIA, DEA, Pharmacy, or Department of Health)

The following will be validated by Verisys for all practitioners advanced to them:

- A current unrestricted state license through the appropriate licensing agency if license is required to practice
- The highest level of education and training obtained by the practitioner (graduates from medical school, residency, or board certification) National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements, if required for license type
- Five-year work history
- Federal and state sanctions and exclusions

The centralized credentialling process does not currently apply to facilities/entities. If applying for a hospital or other type of facility, please submit the following information along with your signed participation agreement:

- Hospital/ancillary provider credentialing application completed (one per facility/hospital/ancillary provider)

- Copy of state operational license
- Copy of Accreditation/certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO) - if not accredited by a nationally recognized body, site evaluation results by a government agency
- Copy of current general liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicaid/Medicare certification (if not certified, provide proof of participation)
- Copy of W-9

Once Nebraska Total Care has received an application, the following information will be reviewed and validated, at a minimum, as part of the provider enrollment process:

- Current participation in the Nebraska Medicaid program, credentialing will be finalized without a Nebraska Medicaid ID, but practitioner will not be reimbursed under the program until a Nebraska Medicaid ID is assigned

Nebraska Total Care will complete the credentialing process within 30 calendar days following receipt of a complete credentialing application. This will be increased to a 60-calendar day window for the first six (6) months of centralized credentialing. MLTC will assess the process timeline and determine if the extended window will remain.

CREDENTIALING COMMITTEE

The Credentialing Committee sets and adopts criteria for provider participation and oversees credentialing procedures, including approvals, denials, and terminations.

Committee meetings are held at least monthly, or more often, as necessary.

Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in closure of the application process prior to a committee decision.

RE-CREDENTIALING

To comply with accreditation standards, Nebraska Total Care re-credentials providers at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the provider is under contract to provide. This process includes all providers, primary care providers, specialists and ancillary providers/facilities previously credentialed to practice within the Nebraska Total Care network.

The health plan will be required to utilize the shared CVO vendor, Verisys, which was approved by Nebraska Medicaid for the three (3) Nebraska MCOs (Nebraska Total Care, Molina Healthcare and United Healthcare Community Plan).

Verisys will perform recredentialing for practitioners every three (3) years unless the provider is credentialed by a Nebraska approved vendor or delegated credentialing entity. Practitioners identified for credentialing will receive notification from Verisys by letter, which is sent to the practitioners' "mail to" address on their provider record. Providers will be made aware of the recredentialing process via letter, six (6) months in advance. In between credentialing cycles, Nebraska Total Care conducts ongoing monitoring activities on all network providers. Staff will ensure that network providers have not incurred exclusions, licensure sanctions, illegal activity,

or other negative indicators in between or prior to their standard recredentialing through this monthly monitoring.

A provider's agreement may be terminated at any time if Nebraska Total Care's Credentialing Committee determines that the provider no longer meets credentialing requirements.

RIGHT TO REVIEW AND CORRECT INFORMATION

All providers participating within the Nebraska Total Care network have the right to review information obtained by the health plan that is used to evaluate providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank (NPDB) Healthcare Integrity and Protection Data Bank (HIPDB), malpractice insurance carriers and state licensing agencies. This does not allow a provider to review peer review-protected information such as references, personal recommendations, or other information.

Should a provider identify any erroneous information used in the credentialing/recredentialing process, or should any information gathered as part of the primary source verification process differ from that submitted by the provider, the provider has the right to correct any erroneous information submitted by another party. To request release of such information, a provider must submit a written request to Nebraska Total Care's Credentialing department. Upon receipt of this information, the provider has 14 calendar days to provide a written explanation detailing the error or the difference in information. The Nebraska Total Care Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

RIGHT TO BE INFORMED OF THE APPLICATION STATUS

All providers who have submitted an application to join Nebraska Total Care have the right to be informed of the status of their application upon request. To obtain status, contact your Network Provider Specialist at 1-844-385-2192 (TTY 711).

RIGHT TO APPEAL ADVERSE CREDENTIALING DETERMINATIONS

Nebraska Total Care may decline an existing provider applicant's continued participation for reasons such as quality of care or liability claims issues. In such cases, the provider has the right to request reconsideration in writing within 30 calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Nebraska Total Care network. The Credentialing Committee will review the reconsideration request at its next regularly scheduled meeting, but in no case later than 60 calendar days from the receipt of the additional documentation. Nebraska Total Care will send a written response to the provider's reconsideration request within two (2) weeks of the final decision.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose:

- The identity of all owners with a control interest of five percent (5%) or greater
- Certain business transactions as described in 42 CFR 455.105
- The identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity

Per Health Plan Advisory 19-03, Disclosure of Ownership documents are to be collected by the state's provider enrollment contractor, Maximus.

RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

Members are informed of their rights as a Nebraska Total Care member, and our expectation is that providers respect these rights.

Member rights are:

- To have available and accessible healthcare services that are covered by Nebraska Medicaid
- To be treated with respect, dignity, and privacy
- To have their rights acknowledged
- To pick or change doctors from the provider network
- To be able to get in touch with their provider
- To go to any provider or clinic for family planning services
- To get care right away if they have a medical emergency
- To be told what their illness or medical condition is
- To be told appropriate or medically necessary treatment options
- To be told the alternatives that a provider thinks are best, regardless of cost or benefit coverage
- To get information on treatment options in a way that they can understand, regardless of cost or coverage
- To make decisions about their health care with their provider
- To give permission before the start of diagnosis, treatment, or surgery
- Refusing treatment without worrying that they will lose coverage
- To report any complaint or grievance about a provider, medical care, health plan, or Nebraska Total Care
- To appeal action that reduces or denies services based on medical criteria
- To receive interpretation services for free in any language
- To not be pressured into making decisions about treatment
- To request a second opinion
- To request disenrollment and be notified at the time of enrollment and annually of member disenrollment rights
- To make an advance directive
- To file any complaint with Nebraska DHHS if their advance directive is not followed
- To choose a provider who gives them care whenever possible and appropriate
- To receive available and accessible healthcare services like services given under Medicaid FFS. This includes similar amounts, duration, and scope
- To get enough services to be reasonable expected to achieve the goal of the treatment
- To not have services denied or reduced just because of a specific diagnosis, type of illness or medical condition
- To use their rights without any negative effects from Nebraska DHHS, Nebraska Total Care, its providers, or contractors
- To receive all written information from Nebraska Total Care:
    - At no cost to them
    - In languages other than English

    - In other ways, to help with the special needs of members who may have trouble reading the information for any reason

- To be told that interpretation services are available and how to get them
- To get help understanding the requirements and benefits of Nebraska Total Care from Nebraska DHHS and its enrollment broker
- To be able to get information about Nebraska Total Care plan, service, doctors and providers, and member rights and responsibilities policies
- To be able to give their ideas for Nebraska Total Care's rights and responsibilities policy
- If they are female, to be able to go to a woman's health provider from the provider network for covered women's health services
- To not be discriminated against due to race, creed, age, color, sex, religion, culture, national origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or the need for healthcare services
- To have equal access to services, health programs, or activities without discrimination based on gender identity and to be treat consistently with their gender identity
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, retaliation, convenience or to force them to do something they do not want to do
- To talk with their doctor about their medical records
- To ask for and receive a copy of their medical records and/or a summary of their records, free of charge
- To request that their medical records be changed or corrected
- To have their records kept private
- To be told if the healthcare provider is a student and to be able to refuse his/her care
- To be told of any experimental care and to refuse to be part of the care

MEMBER RESPONSIBILITIES

Members are informed of their responsibilities as Nebraska Total Care members, and that treatment can be more beneficial if they meet their responsibilities.

Member responsibilities are:

- Notify Heritage Health if:
    - Their family size changes
    - They move out of the state or have other address changes
    - They get or have health coverage under another policy, another third party, or there are changes to that coverage
- Work on improving their own health.
- Tell Nebraska Total Care when they go to the emergency room.
- Talk to their provider about the prior authorization of services their provider may recommend.
- Be aware of cost-sharing responsibilities and make any payments that they are responsible for.
- Inform Nebraska Total Care if their member ID card is lost or stolen.
- Show their member ID card and Nebraska Medicaid ID card when getting healthcare services.
- Know Nebraska Total Care procedures, coverage rules, and restrictions the best that they can.

- Contact Nebraska Total Care when they need information or have questions.
- Give providers accurate and complete medical information.
- Follow prescribed treatment, or tell their provider the reason(s) treatment cannot be followed, as soon as possible.
- Ask their providers questions to help them understand treatment.
- Learn about the possible risks, benefits, and costs of treatment alternatives.
- Make careful treatment decisions, after they have thought about all these things.
- Be actively involved in their treatment.
- Understand their health problems and be a part of making treatment goals with their provider as much as they can.
- Follow the grievance process if they have concerns about their care.
- Notify Nebraska Total Care, their provider, and Heritage Health of changes to their address and phone number.
- Treat providers and staff with respect.
- Cancel appointments in advance when they can't keep them, whenever possible.

PROVIDER RIGHTS

Nebraska Total Care providers have the right to:

- Be treated by their patients and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for members' care.
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- Expect other network providers to act as partners in members' treatment plans.
- Expect members to follow their directions.
- File a complaint/grievance against Nebraska Total Care.
- File a grievance with Nebraska Total Care on behalf of a member, with the member's written consent.
- File an appeal with Nebraska Total Care on behalf of the members, with the member's written consent.
- Have access to information about Nebraska Total Care quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
- Contact Nebraska Total Care Provider Services with any questions, comments, or problems.
- Collaborate with other healthcare professionals who are involved in the care of members.

PROVIDER RESPONSIBILITIES

Nebraska Total Care providers have the responsibility to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments.
    - Provide information regarding the nature of treatment options.
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered.

    - Be informed of the risks and consequences associated with each treatment option or choose to forego treatment as well as the benefits of such treatment options.

- Treat members with fairness, dignity, and respect.
- Not discriminate against members based on race, color, national origin, disability, age, religion, gender identity, mental or physical disability, or limited English proficiency.
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allow members to request restrictions on the use and disclosure of their personal health information.
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Allow members to refuse or discontinue treatment, provided they understand that doing so may worsen their condition or be life-threatening.
- Respect the member's advance directive and include these documents in the member's medical record.
- Allow members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions.
- Allow members to obtain a second opinion and answer members' questions about how to access healthcare services appropriately.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Participate in Nebraska Total Care data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow Nebraska Total Care to use performance data for quality improvement activities.
- Review clinical practice guidelines distributed by Nebraska Total Care.
- Comply with the Nebraska Total Care Medical Management program as outlined in this manual.
- Disclose overpayments or improper payments to Nebraska Total Care.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtain and report to Nebraska Total Care information regarding other insurance coverage.
- Immediately notify Nebraska Total Care in writing, if the provider is leaving or closing a practice.
- Contact Nebraska Total Care to verify member eligibility or coverage for services.
- Invite member participation, to the extent possible, in understanding any medical or mental health and substance use problems they may have and to develop mutually agreed upon treatment goals, to the extent possible.

- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- Office hours of operation offered to Medicaid members will be no less than those offered to commercial members.
- Not be excluded, penalized, or terminated from participating with Nebraska Total Care for having developed or accumulated a substantial number of patients in Nebraska Total Care with high-cost medical conditions.
- Coordinate and cooperate with other service providers who serve Medicaid members such as Head Start programs, Healthy Start programs, Nurse Family Partnerships, and school-based programs as appropriate.
- Object to providing relevant or medically necessary services based on the provider's moral or religious beliefs or other similar grounds.
- Disclose to Nebraska Total Care, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice, even if there is no substantial financial risk between Nebraska Total Care and the physician or physician group.
- Provide services in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the RFP.

PROVIDER GRIEVANCE PROCESS

A provider may file a grievance verbally or in writing to Nebraska Total Care, at any time. A provider's grievance is any provider expression of dissatisfaction regarding Nebraska Total Care policies, procedures, or any aspect of Nebraska Total Care's administrative function other than administrative review matters. This includes the process by which Nebraska Total Care handles notice of proposed actions and explanation of payments (EOPs) in addition to dissatisfaction with the resolution of the provider's claim adjustment/claim reconsideration. Providers are allowed to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues. Complaints may be filed directly with MLTC for issues that are not an MCO function without retaliation from Nebraska Total Care.

All grievances/complaints are handled and processed within the grievance department at Nebraska Total Care. Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. The same process for member grievances is followed for provider grievances. Providers will receive an acknowledgment letter within ten (10) calendar days and a resolution letter within 90 calendar days of the initial grievance notification.

Nebraska Total Care values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance. If you need help filing a grievance, contact our Provider Services department at 1-844-385-2192 (TTY 711).

Provider grievances may be submitted in writing to:

Nebraska Total Care
Attn: Grievances
2525 N 117th Ave, Suite 100
Omaha, NE 68164
FAX: 1-844-655-0567

MEMBER GRIEVANCE AND APPEAL PROCESS

A member, or member-authorized representative, may file a grievance or appeal verbally or in writing at any time. A provider, acting on behalf of the member and with the member's written consent, may file a grievance or appeal.

Nebraska Total Care will give members reasonable assistance in completing all forms and taking other procedural steps of the grievance and appeal system, including, but not limited to, providing translation services, communication in alternative languages and toll-free numbers with TTY and interpreter capability.

Member Grievances

A member grievance is defined as any member expression of dissatisfaction. A grievance does not include matters that constitute an "action."

The grievance process allows the member, the member's authorized representative, or a provider acting on the member's behalf with the member's written consent, to file a grievance either orally or in writing with Nebraska Total Care. Nebraska Total Care shall acknowledge receipt of each grievance in writing within ten (10) calendar days.

Grievance decisions must be made by individuals not involved in any prior review or decision-making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, Nebraska Total Care shall ensure that the decision

makers are healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease. [42 CFR § 438.406]

Nebraska Total Care values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf. Nebraska Total Care will help both members and providers with filing a grievance by contacting Member Services and Provider Services at 1-844-385-2192 (TTY 711).

Acknowledgement

Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. All grievances, including those resolved immediately, must be documented by staff. The Grievance and Appeals Coordinator will date-stamp each grievance upon receipt and send an acknowledgment letter within ten (10) calendar days, outlining the grievance process and resolution timeframes.

Grievance Resolution Time Frame

Grievance Resolution will occur as expeditiously as the member's health condition requires. Grievances will be resolved by the Grievance and Appeals Coordinator, in coordination with other Nebraska Total Care staff as needed. Many grievances can be resolved at the customer service level to the satisfaction of the member, authorized representative or provider acting on the member's behalf. Member notification of the grievance resolution shall be made in writing. Standard grievance resolution and notification will occur within 90 calendar days of receipt of the grievance.

Notice of Resolution

The Grievance and Appeals Coordinator will provide a written resolution to the member, authorized representative or provider acting on the member's behalf, within the timeframes noted above.

The grievance response shall include, but not be limited to, the decision reached by Nebraska Total Care, the reason(s) for the decision, the policies or procedures that provide the basis for the decision, and a clear explanation of any further rights available to the member, if any.

A copy of the complaint and grievance logs and records of disposition shall be retained for 10 years.

Member grievances may be submitted by written notification to:

Nebraska Total Care
Attn: Grievances
2525 N 117th Ave, Suite 100
Omaha, NE 68164
FAX: 1-844-655-0567

Appeals

An appeal is the request for review of an adverse benefit determination. Adverse benefit determination, per 45 CFR 147.136(a)(2)(i) and 29 CFR 2560.503-1, means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an

item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. It also includes any rescission of coverage under 45 CFR 147.128 (whether or not the rescission has an adverse effect on a particular benefit at the time). They may include denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).

If the member is dissatisfied with the decision of Nebraska Total Care, the member, or member's authorized representative may file a written or oral notice of appeal not more than 60 calendar days of an adverse benefit determination.

The member appeal is acknowledged in writing within ten (10) business days of the receipt of a request for an appeal. The acknowledgement letter includes notification of member rights and appeal processes in a culturally and linguistically appropriate manner.

The member has the right to choose additional representation by anyone, including an attorney, physician, advocate, friend, or family member to represent him or her during the appeal process. The designation of their authorized representative must be submitted to Nebraska Total Care in writing.

Nebraska Total Care will inform the member of their rights to request continuation of benefits or services during the appeal process. This request must be made within ten (10) calendar days of receiving the notice—or before the effective date of the service termination or change. The member then has 60 calendar days to file the appeal. If the appeal is not resolved in the member's favor, they may be responsible for the cost of those continued benefits.

Nebraska Total Care will provide members with written notice of the reason for any extension to the timeframe for processing an appeal that is not requested by the members.

Nebraska Total Care shall make reasonable efforts to give the member prompt oral notice of the delay of any decisions that are not resolved wholly in favor of the member and shall follow up within two (2) calendar days with a written adverse benefit determination.

For a standard appeal, Nebraska Total Care will review, resolve and provide the enrolled and the attending or ordering provider with written or electronic notification of the appeal decision as quickly as the member's health condition requires but no later than 30 calendar days after the request for a review. In the case of standard appeals, appeals will be resolved and the members and provider notified within 30 calendar days of receipt. The timeframe for resolution may be extended by 14 calendar days by member request or if Nebraska Total Care provides evidence satisfactory to the DHHS that a delay in rendering a decision is in the member's best interest. There is only one level of appeal for members.

Call 1-844-385-2192 (TTY 711) or mail all appeals to:

Nebraska Total Care
Attn: Appeals
2525 N 117th Ave, Suite 100
Omaha, NE 68164

If the appeal is not resolved within 30 calendar days, the provider may file a grievance. Provider grievances may be submitted by written notification to:

Nebraska Total Care
Attn: Grievances
2525 N 117th Ave, Suite 100
Omaha, NE 68164
FAX: 1-844-655-0567

Expedited Appeals

A member has the right to request an expedited appeal. Expedited appeals may be filed when Nebraska Total Care or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the date of adverse benefit determination. Nebraska Total Care may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Nebraska Total Care provides evidence satisfactory to the DHHS that a delay in rendering the decision is in the member's interest. The services must be provided no later than 72 hours from the date Nebraska Total Care receives notice reversing the determination for any extension not requested by the member. Nebraska Total Care shall provide written notice to the member of the reason for the delay. If Nebraska Total Care denies a request for an expedited appeal, the appeal will automatically be transferred to the standard timeframe. In the notice denying an expedited appeal resolution, Nebraska Total Care will include the member's right to file a grievance. If he or she disagrees with the decision to deny the expedited review a reasonable attempt will be made to provide oral notification of the expedited request denial and follow up with written notice within two (2) calendar days.

State Fair Hearing Process

If the member is dissatisfied with Nebraska Total Care's decision to deny, reduce, change, or terminate payment for health care services, the member can request a State Fair Hearing.

Nebraska Total Care will include information in the Member Handbook, online and via the appeals process to inform members of their right to appeal directly to DHHS through the State Fair Hearing. A Nebraska Total Care member, or a provider acting as the member's authorized representative, can request a State Fair Hearing only after receiving notice that Nebraska Total Care is upholding the adverse benefit determination. Any adverse action or appeal that is not resolved wholly in favor of the member by Nebraska Total Care may be appealed by the member or the member's authorized representative through the State Fair Hearing process for a hearing conducted in accordance with 42 CFR § 431 Subpart E. Adverse actions include reductions in service, suspensions, terminations, and denials. State Fair Hearing appeals must be requested in writing by the member or the member's representative not more than 120 calendar days of the member's receipt of the adverse benefit determination.

Requests for a State Fair Hearing should be in writing and sent to:

Nebraska Department of Health and Human Services
MLTC Appeal Coordinator
PO Box 94967
Lincoln, NE 68509-4967

Nebraska Total Care shall comply with the State Fair Hearing decision. The decision in these matters shall be final and shall not be subject to appeal.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if Nebraska Total Care or the State Fair Hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Nebraska Total Care will authorize the disputed services promptly and as expeditiously as the member's health condition requires. Additionally, if services were continued while the appeal was pending, Nebraska Total Care will provide reimbursement for those services in accordance with the terms of the final decision rendered by the DHHS and applicable regulations.

FRAUD, WASTE AND ABUSE

Nebraska Total Care takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with Nebraska and federal laws. Nebraska Total Care, in conjunction with its management company, Centene, successfully operates a Special Investigations Unit (SIU). Nebraska Total Care performs front and back-end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claim payment process. To better understand this system please review the Provider Billing Guide found in the Practice Improvement Resource Center (PIRC) at NebraskaTotalCare.com. Nebraska Total Care performs retrospective audits, which in some cases may result in taking actions against those providers who, individually or as a practice, commit fraud, waste, and/or abuse. Nebraska Total Care takes the prevention, detection, and investigation of fraud waste and abuse very seriously. We have a robust program in place that complies with industry standards and state and federal law. These actions include but are not limited to:

- Remedial education and/or training to prevent billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify
- Unannounced onsite audit investigations
- Nebraska Total Care will notify DHHS Program Integrity of all provider audits

Nebraska Total Care instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

Nebraska Total Care requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, people, or entities providing care or services to all Nebraska Total Care members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, healthcare fraud, obstruction of a state and/or federal healthcare fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or members' medication fraud.

FWA Training is available via our Fraud, Waste and Abuse page. We also include FWA training in our provider orientation packets.

SPECIAL INVESTIGATIONS UNIT

Federal and state law requires that all managed care entities create and operate special investigations units (SIUs). The primary purpose of the SIU is to identify fraud, waste, and

abuse, refer fraud findings to state authorities, and recover overpayments related to FWA (recoupments). Nebraska Total Care SIU employs sophisticated code editing software (data analytics), which performs systematic audits during the claims payment process to identify billing aberrancies. Those aberrancies provide unit personnel with investigative leads. Common offenses that the SIU investigates include upcoding, billing for services not rendered, double billing, billing for unnecessary medical services, the overprescribing of controlled substances and billing for unauthorized services.

The SIU also investigates member fraud such as program eligibility issues, “doctor shopping” and member benefit fraud.

Nebraska Total Care requires all contractors and subcontractors to report suspected FWA committed by its employees, associates, and business partners.

TO REPORT SUSPECTED FRAUD: email NTC-Compliance@NebraskaTotalCare.com or call the fraud hotline at 1-866-685-8664.

Prepayment Review

Upon identifying a provider’s billing anomalies, a provider may be placed on prepayment review. Providers who are placed on prepayment review will receive a letter notifying the provider of the prepayment review from the SIU informing them that their claims will not be paid until requested medical records are submitted. If records are not received, the submitted claims will be denied, and the provider will continue prepayment review status. Providers will generally remain in prepayment review until a seventy percent (70%) approval rate of reviewed services is met.

If clinically reviewed medical records and/or documentation does not support services as billed, a letter will be sent for each claim detailing the findings, denial rationale, and resources utilized for the review. This letter includes appeal information if providers are not in agreement with the clinical findings. For more information regarding appeals please review the Nebraska Total Care Provider Billing Guide.

SIU Audits – Recoupment of Funds

If the SIU determines that a provider has been overpaid, the SIU will send a letter to the provider informing them that recoupment of funds is being sought. The letter details the investigative findings and requests reimbursement. Your review may be subject to extrapolation. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. The SIU employs a statistician who uses a CMS approved procedure to pull a statistically valid random sample of claims before an actual claim overpayment is determined. Using the actual amount, the statistician performs a valid extrapolation of the claims and determines a more realistic overpayment amount based on the universe of claims that the provider submitted. Claims are usually reviewed for an 18-month to 2-year period.

If you receive a demand letter, please read all correspondence related to the audit findings and submit your response to the address included in the demand letter. This will ensure timely and accurate processing.

NOTE: The SIU medical records submission process is different from the claim submission process. If you receive a request from the SIU to submit medical records, please use the process described in the letter.

SIU Appeals

When the SIU identifies overpayment and determines recoupment is appropriate, the SIU will send the provider a proposed action letter. The proposed action letter details how the SIU determined the amount of overpayment and offers the provider repayment options. If you do not agree with this proposed action determination, you may request an appeal review by submitting

your request in writing within 30 days from the date of the demand letter. Your request should detail why you disagree with the findings and must include any supporting evidence/documentation you believe is pertinent to your position. SIU will review your documentation and respond in writing.

If you identify an overpayment, please submit a reconsideration via the secure provider portal or send a refund check to our Claims Refund Address:

Nebraska Total Care
Attn: Refunds
PO Box 3713
Carol Stream, IL 60132-3713

POST PROCESSING CLAIMS AUDIT

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. Auditors will initiate an audit by requesting medical records for a defined review period. Providers have two (2) weeks to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Nebraska Total Care will recover all amounts paid for the services in question.

Auditors review cases for common FWA indicators, including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT.
- Diagnosis and/or procedure code not consistent with the member’s age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered.

Auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules when making determinations of claims payment appropriateness. If necessary, a clinician of a specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report which identifies all records reviewed during the audit. If the Auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Nebraska Total Care will seek recovery of all overpayments. Depending on the number of services provided during the review period, Nebraska Total Care may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

SUSPECTED INAPPROPRIATE BILLING

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Nebraska

Total Care and Centene take all reports of potential fraud, waste, and/or abuse very seriously and investigate all reported issues.

NOTE: Due to the evolving nature of fraudulent, wasteful, and abusive billing, Nebraska Total Care and Centene may enhance the FWA program at any time. These enhancements may include but are not limited to creating, customizing, or modifying claim edits, upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

QUALITY IMPROVEMENT

Nebraska Total Care culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs.

This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, mental health and substance abuse, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Nebraska Total Care recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings.

To that end, we will provide for the delivery of quality care with the primary goal of improving the health status of members.

Where the member's condition is not amenable to improvement, Nebraska Total Care will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Whenever possible, the Nebraska Total Care QAPI supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of members.

PROGRAM STRUCTURE

The Nebraska Total Care Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI program and has established various committees and ad-hoc committees to monitor and support the QAPI program.

The Quality Assurance Performance Improvement Committee (QAPIC) is a senior management committee with physician representation that is directly accountable to the Board of Directors. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the QI and Medical Management programs.

The following sub-committees report directly to the Quality Assurance Performance Improvement Committee:

- Pharmacy and Therapeutics Committee
- Performance Improvement Committee
- Provider Advisory Committee including:
    - Tribal Healthcare Advisory Committee (THAC)
    - Mental health and Substance Use Disorder Advisory Committee
- Clinical Advisory Committee
- Health Equity and Diversity Committee:
    - CLAS
- Dental QAPIC Committee
- Utilization Management Committee:
    - Dental Utilization Committee
- Credentialing Committee
- Member Advisory Council
- Joint Operations Committees
- Peer review Committee (Ad Hoc Committee)

PRACTITIONER INVOLVEMENT

Nebraska Total Care recognizes the integral role practitioner involvement plays in the success of its QAPI program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Nebraska Total Care encourages PCP, mental health and substance use, specialty, and OB/GYN representation on key quality committees such as but not limited to, the QAPIC and select ad-hoc committees.

Network practitioners and providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in the Nebraska Total Care's QI programs. Practitioner and provider contracts, or a contract addendum, also require that practitioners and providers allow Nebraska Total Care the use of their performance data for quality improvement activities.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM SCOPE AND GOALS

The scope of the Quality Assessment and Performance Improvement (QAPI) program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the Nebraska Total Care members. Nebraska Total Care's QAPI program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, ancillary services and operations.

Nebraska Total Care primary QAPI program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

To that end, the Nebraska Total Care QAPI program monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Mental health and substance use
- Delegated entity oversight
- Continuity and coordination of care
- Medical Management, including under and over utilization
- Compliance with member confidentiality laws and regulations
- Employee and provider cultural competency
- Provider appointment availability and geographic accessibility
- Provider and health plan after-hours telephone accessibility
- Member experience
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- Department performance and service
- Patient safety
- Marketing practices

PATIENT SAFETY AND QUALITY OF CARE

Patient Safety is a key focus of Nebraska Total Care QAPI program. Monitoring and promoting patient safety is integrated throughout many activities across the health plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member.

Nebraska Total Care employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues requires investigation of the factors surrounding the event to decide severity and need for corrective action up to and including review by the Peer Review Committee as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

PERFORMANCE IMPROVEMENT PROCESS

Nebraska Total Care QAPIC reviews and adopts an annual QAPI program and Work Plan based on managed care Medicaid appropriate industry standards. The QAPIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. These include proven methodologies such as Six Sigma and Rapid Cycle Improvements. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Nebraska Total Care to monitor improvement over time.

Annually, Nebraska Total Care develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QAPIC activities, reporting, and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QAPIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Nebraska Total Care communicates activities and outcomes of its QAPI program to both members and providers through avenues such as the member newsletter, provider newsletter and the Nebraska Total Care secure web portals. The Quality Improvement Program Evaluation is also posted at NebraskaTotalCare.com.

At any time, Nebraska Total Care providers may request additional information on the health plan programs including a description of the QAPI program and a report on Nebraska Total Care progress in meeting the QAPI program goals by contacting the Quality Improvement (QI) department.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Nebraska state Medicaid contract.

As both the Nebraska and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming increasingly important, not only to the health plan, but to the individual provider as well. Nebraska purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds. These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two (2) ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services, to name a few measures.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for

services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews See NebraskaTotalCare.com and the HEDIS brochure for more information on reducing HEDIS medical record reviews and improving your HEDIS scores. Measures typically requiring medical record review include childhood immunizations, well child visits, diabetic HbA1c, eye exam and nephropathy, controlling high blood pressure, cervical cancer screening, and prenatal care and postpartum care.

When Will Medical Record Reviews (MRR) be completed for HEDIS?

Nebraska Total Care may contract with a national MRR vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are conducted March through May each year. At that time, you may receive a call from a medical record review representative if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Nebraska Total Care, which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is a clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure the chart documentation reflects all the services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, body mass index (BMI calculations, eye exam and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-844-385-2192 (TTY 711).

QUALITY PRACTICE ADVISORY PROGRAM

Nebraska Total Care is dedicated to delivering high-quality healthcare services. As part of these efforts, Nebraska Total Care has invested resources in an innovative quality improvement program called the Quality Practice Advisory (QPA) program. The program focuses on generating positive member health outcomes, improving population health, and collaborating with community healthcare providers to ensure members are receiving the highest level of quality care. Our Associate Quality Practice Advisors act as a single point of contact for provider offices in support of member quality care, as well as assisting in the management of clinical requirements that are part of Healthcare Effectiveness Data and Information Set (HEDIS®), regulatory requirements, coding accuracy, performance and process improvement, and other priority quality measures.

MEDICAL RECORDS REVIEW

Nebraska Total Care providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Nebraska Total Care to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location.

Nebraska Total Care requires providers to maintain all records for members for at least 10 years. See the Member Rights within this manual for policies on member access to medical records.

REQUIRED INFORMATION

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Nebraska Total Care's practice guidelines
- Appropriate subjective and objective information pertinent to the members' presenting complaints is documented in the history and physical.
- Past medical history (for members seen three (3) or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- For children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations, and/or childhood illnesses
- Working diagnosis is consistent with findings
- Treatment plans are appropriate for diagnosis
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns

- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans. All entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services, and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol, and substance use (for members seen three (3) or more times substance use history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected
- Evidence that an advance directive has been offered to adults 19 years of age and older (or an emancipated minor)

MEDICAL RECORDS RELEASE

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Nebraska Total Care, which allows them to collect PHI on our behalf.

MEDICAL RECORDS TRANSFER FOR NEW MEMBER

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Nebraska Total Care members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

FEDERAL AND STATE LAWS GOVERNMENT THE RELEASE OF INFORMATION

The release of certain information is governed by a myriad of federal and/or state laws. These laws often place restrictions on how specific types of information may be disclosed, including,

but not limited to, mental health, alcohol /substance use treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) require that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment, and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance use treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the state level place further restrictions on the release of certain information such as mental health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- HIPAA - please visit the Centers for Medicare and Medicaid Services (CMS) at cms.gov and then select "Regulations and Guidance" and "HIPAA – General Information"
- Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at samhsa.gov
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide

Contracted providers within our network are independently obligated to know, understand, and comply with these laws.

We take privacy and confidentiality seriously. We have established processes, policies, and procedures to comply with HIPAA and other applicable federal and/or state confidentiality and privacy laws.

Please contact the Nebraska Total Care Privacy Officer at 1-844-385-2192 (TTY 711) or write to the address below with any questions about our privacy practices.

Nebraska Total Care
Attn: Compliance
2525 N 117th Ave, Suite 100
Omaha, NE 68164