Division of Medicaid and Long-Term Care
Heritage Health Quarterly Report, April-June 2018

September 7, 2018

Prepared for the
Health and Human Services Committee
of the Nebraska Legislature

September 7, 2018

Senator Merv Riepe
Chairman, Health and Human Services Committee
Room #1402
P.O. Box 94604
Lincoln, NE 68509

Dear Chairman Riepe and Members of the Health and Human Services Committee:

We are pleased to submit for your review the 2018 2nd Quarter report on Heritage Health, Nebraska's Medicaid managed care program. This report is organized into five sections: business performance; stakeholder engagement; quality management and performance improvement; medical necessity; and the future state, an update on recent and upcoming changes in Medicaid and Long-Term Care (MLTC).

The committee will find the data and metrics in this report familiar, as they are updates on all relevant items presented last quarter. New to this report in section IV, you will find a detailed overview of the process for determining medical necessity, the member's appeal process, and the process for requesting a state fair hearing.

I thank the committee for its continued support and interest in the Heritage Health program.

My regards,

Matthew A. Van Patton, DHA
Director, Division of Medicaid and Long-Term Care

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I. BUSINESS PERFORMANCE

The Division of Medicaid and Long-Term Care (MLTC) closely monitors the performance of each of the three Managed Care Organizations (MCOs) in Heritage Health. The MCOs continue using the biweekly dashboard for reporting performance data, which originally launched in spring 2018. This dashboard has evolved to clarify and standardize the MCOs' reporting requirements. These adjustments ensure the dashboard data is useful in assessing performance trends over time.

The data included reflects Heritage Health's performance metrics between April and June 2018. Some figures are quarterly aggregates, while others are monthly totals. Sources include the MCO biweekly dashboard and other periodic reports. The following acronyms are used for each MCO:

- Nebraska Total Care - NTC;
- UnitedHealthcare Community Plan of Nebraska - UHCCP; and
- WellCare of Nebraska - WHP.

Provider Network

Figure 1: New Contracts

	April	May	June
NTC	24	13	10
UHCCP	7	8	5
WHP	10	14	13

Figure 1 Source: Bi-Weekly Dashboard

The MCOs' networks are always evolving. New contracts represent contracts signed, rather than the number of individual providers added, as contracts may include a number of providers.

Figure 2: Providers Who Left Network

	April	May	June
NTC	14	40	58
UHCCP	51	46	44
WHP	12	8	12

Figure 2 Source: Provider Network Changes Report

It is not uncommon for providers to leave networks for various reasons. Monitoring the above metrics helps MLTC monitor each MCO's overall network adequacy. The most common reasons this quarter include: the provider left the practice, retirement, and voluntary removal from the network.

Claims

Heritage Health is an integrated program. As such, figures 3-6 include all claims: physical health, behavioral health, and pharmacy claims.

Figure 3: Number of Claims Received

	April	May	June
NTC	362,094	377,877	359,861
UHCCP	316,399	327,673	302,298
WHP	193,741	207,491	186,959

Figure 3 Source: Monthly Claims Report and Pharmacy Claims Report

This information is representative of the volume of claims for the member mix of each MCO on a monthly basis.

Figure 4: Number of Claims Adjudicated

	April	May	June
NTC	415,737	435,756	402,448
UHCCP	314,553	334,906	298,792
WHP	191,587	208,421	190,140

Figure 4 Source: Monthly Claims Report and Pharmacy Claims Report

This data set shows all claims that have adjudicated through the MCO's system. After a claim is entered into the system, the MCOs either pay or deny the claim in whole or in part.

MCOs often adjudicate more claims than they receive in a given month because the adjudication number includes re-processed claims. Claims can be re-processed for a variety of reasons, including retroactive rate changes.

Similar to measuring the volume of claims received, this metric is another useful data point correlated to the amount of services provided for Heritage Health members.

Figure 5: Percentage of Claims Rejected

	April	May	June
NTC	2.25%	1.88%	1.66%
UHCCP	1.19%	0.95%	1.09%
WHP	4.13%	4.45%	4.16%

Figure 5 Source: Monthly Claims Report and Pharmacy Claims Report

Rejected claims do not meet basic legibility, format, or completion requirements and therefore are not accepted into an MCO's system for adjudication.

Figure 6: Percentage of Claims Denied

	April	May	June
NTC	13.19%	14.60%	15.28%
UHCCP	18.18%	18.96%	18.44%
WHP	19.06%	20.33%	19.23%

Figure 6 Source: Monthly Claims Report and Pharmacy Claims Report

A claim can be denied by the MCO for various reasons. The denial reasons are submitted by each MCO on a monthly basis. Common denial reasons include: duplicate claims, need to bill primary insurance, prior authorization needed but not obtained, and adjustment to a previously submitted claim filed as a new claim.

This metric is useful when monitoring for systemic failures within the adjudication systems, gaps in provider education, as well as fraud, waste, and abuse. Consistent denial rates indicate providers are generally submitting claims correctly and only for Medicaid-covered services.

Figure 7: Claims Dollars Paid, Non-Pharmacy

	Q1 18	Q2 18
NTC	$ 75,545,344.03	$ 83,975,943.87
UHCCP	$ 67,001,228.63	$ 66,914,668.68
WHP	$ 60,988,118.26	$ 59,309,523.21

Figure 7 Source: Quarterly Financial Report

This spend is reflective of the population managed by each MCO and shows the volume of dollars paid to providers on a quarterly basis. These are inclusive of medical and behavioral health services rendered.

Figure 8: Claims Dollars Paid, Pharmacy

	Q1 18	Q2 18
NTC	$ 24,802,414.64	$ 22,849,497.30
UHCCP	$ 24,774,227.55	$ 22,275,846.31
WHP	$ 13,340,927.90	$ 12,136,822.94

Figure 8 Source: Quarterly Financial Report

Processing of pharmacy claims is unique in that pharmacy operates as a ‘point of sale’ system, whereas the claims for medical and behavioral health are filed after the provider has seen the member.

Figure 9: Percentage of Claims Adjudicated Within 10 Days

	April	May	June
NTC	99.60%	99.27%	99.34%
UHCCP	97.66%	97.91%	98.61%
WHP	98.03%	97.38%	98.13%

Figure 9 Source: Monthly Claims Report and Pharmacy Claims Report

The MCOs are required to process claims in a timely manner and MLTC monitors data for contract compliance. Per the contracts, 90% of claims must be adjudicated within 15 business days; the Quality Payment Program threshold is 95% within 10 business days.

Figure 10: Percentage of Claims Adjudicated Beyond 60 Days

	April	May	June
NTC	0.13%	0.30%	0.18%
UHCCP	0.01%	0.01%	0.01%
WHP	0.02%	0.01%	0.01%

Figure 10 Source: Monthly Claims Report and Pharmacy Claims Report

The MCOs are contractually required to adjudicate all claims within 60 days. Any claims paid beyond 60 days are subject to being paid with interest.

Monitoring these adjudication percentages helps MLTC ensure the MCOs are operating within the terms of their contracts and offering timely payment to Medicaid providers.

Care Management

Active engagement with patients and their caregivers helps patients successfully navigate the continuum-of-care to achieve better health outcomes, improve experiences, and reduce the cost of health care, otherwise known as The Triple Aim.

Due to the unique nature of each MCO's population, each MCO is able to identify for itself which of its members are in high, medium, and low-level care per MLTC guidelines. Therefore, the data varies between MCOs accordingly.

Figure 11: Members in High-Level Care

	April	May	June
NTC	37	74	76
UHCCP	884	925	778
WHP	152	148	140

Figure 11 Source: Care Management Report

Figure 12: Members in Medium-Level Care

	April	May	June
NTC	49	90	109
UHCCP	7,121	6,480	6,043
WHP	34	37	39

Figure 12 Source: Care Management Report

Figure 13: Members in Low-Level Care

	April	May	June
NTC	191	360	341
UHCCP	82	81	85
WHP	24	28	33

Figure 13 Source: Care Management Report

NOTE: There are differences in reporting methods currently used between plans, therefore there is no way to make plan-to-plan comparisons within the data collected.

Pharmacy

MLTC is monitoring the pharmacy spend through the Heritage Health program and working with stakeholders to identify strategies to address increasing costs. MLTC continues to be involved in the national conversation around managing the pharmacy benefit, quantifying market performance, and understanding utilization trends.

Figure 14: Percentage of Generic Drugs Dispensed

	April	May	June
NTC	84.73%	83.49%	83.28%
UHCCP	86.84%	86.81%	86.95%
WHP	86.35%	86.11%	86.16%

Figure 14 Source: Pharmacy Claims Report

Figure 15: Preferred Drug List (PDL) Compliance

	Q1 18	Q2 18
NTC	96.99%	95.33%
UHCCP	96.53%	97.15%
WHP	97.86%	98.01%

Figure 15 Source: PDL Compliance Report

Through the Pharmacy and Therapeutics Committee, MLTC creates and manages a preferred drug list (PDL). The importance of the PDL lies in the professional review of each drug for safety, efficacy, and cost savings.

While most generics are priced lower than brand names, expenditures for name brand drugs can be reduced even further through rebates paid to the State from drug manufacturers. In limited instances, this makes brand name products more cost-effective than their corresponding generic drugs.

II. STAKEHOLDER ENGAGEMENT

Maps of Engagement Events

Engagement between the MCOs and both health care providers and plan members is an essential part of making the Heritage Health program a success. These events bring additional value to members and providers and serve as important arenas for feedback that can lead to program improvements. The following maps detail the locations of various provider and member engagement events by each MCO throughout the state in April through June 2018. These events include provider orientation sessions, community baby showers, and health fairs.

Figure 16: UnitedHealthcare Community Plan's Q2 18 Community Connections:

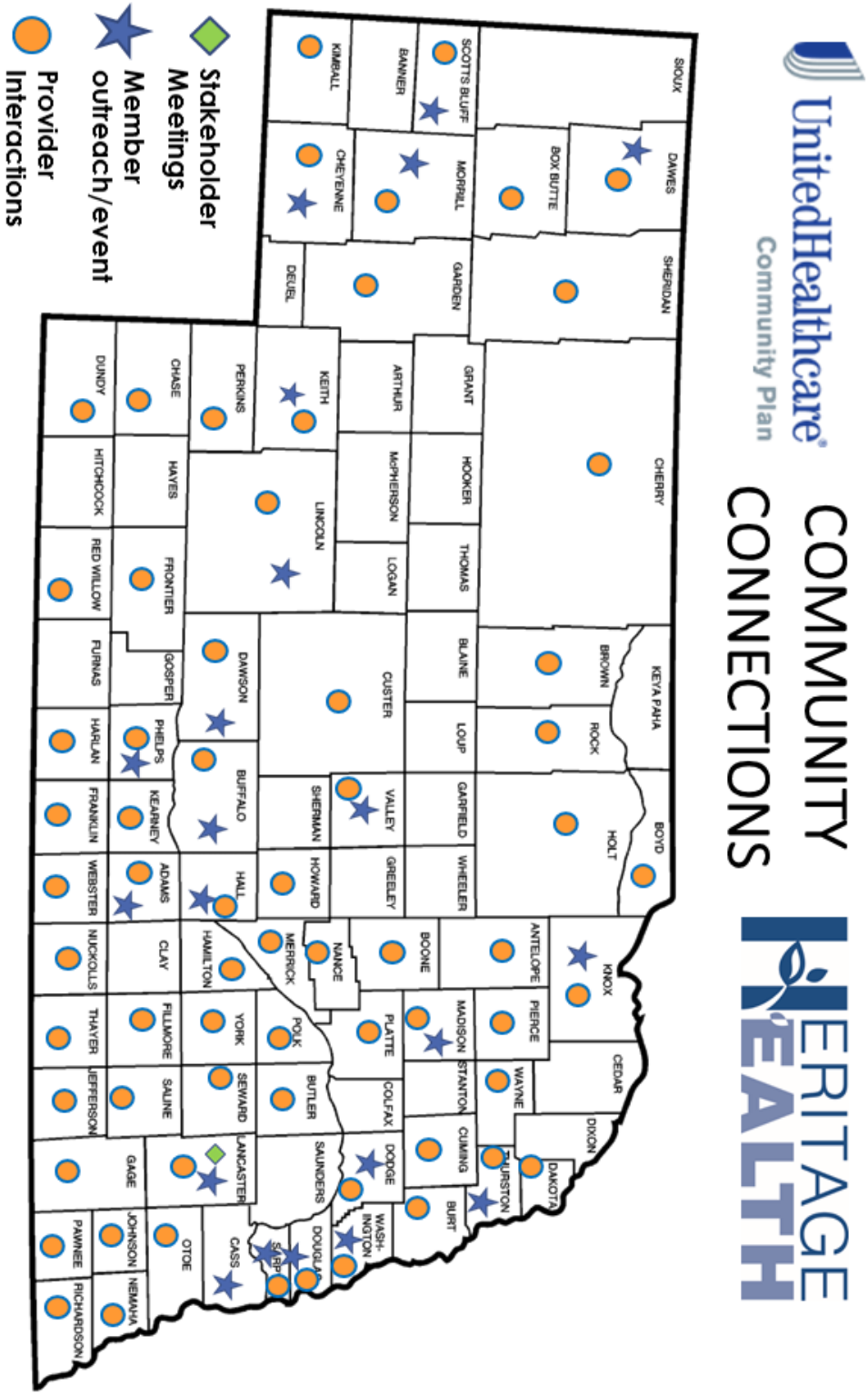


Figure 17: Nebraska Total Care's Q2 18 Community Connections:

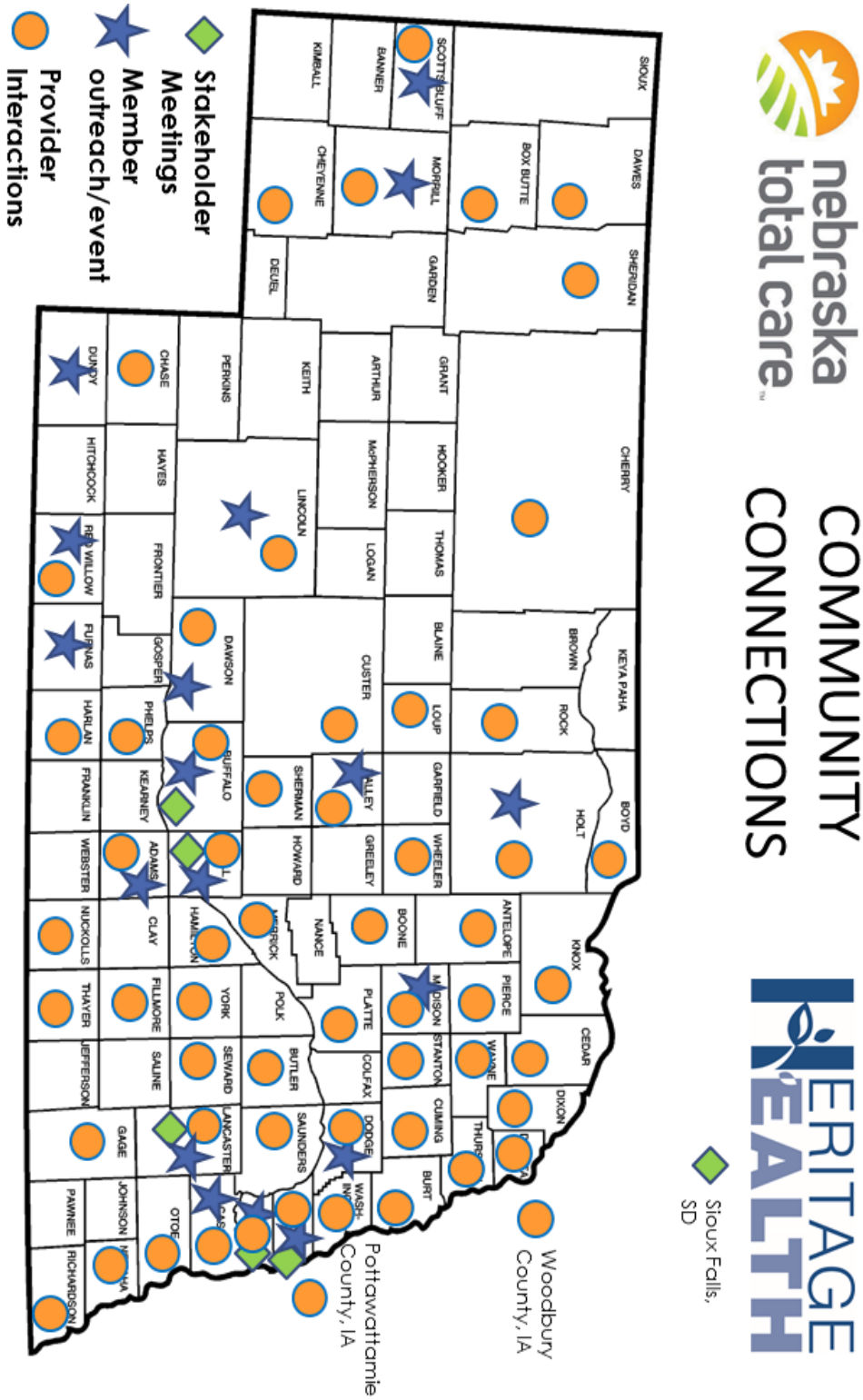
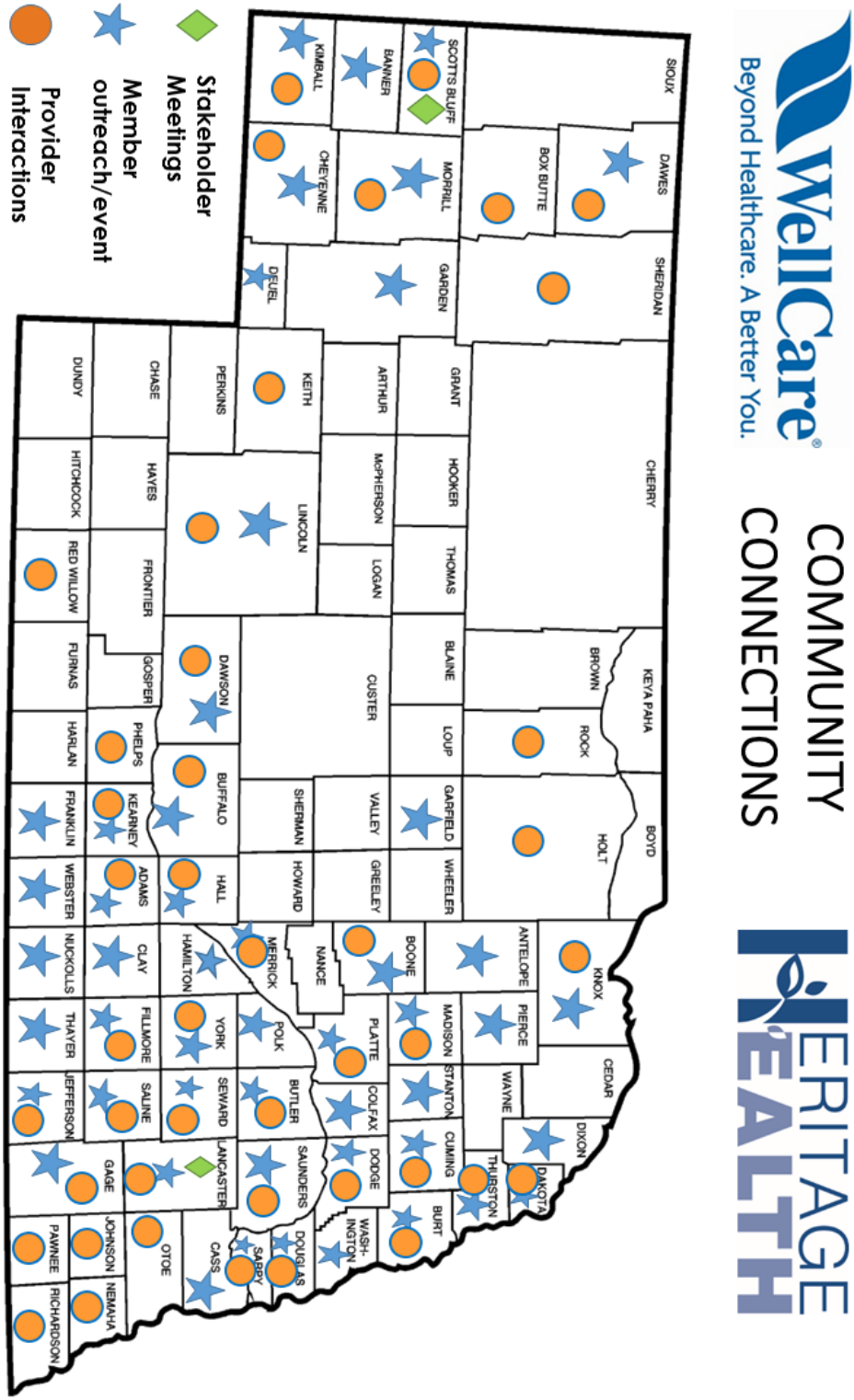


Figure 18: WellCare of Nebraska's Q2 18 Community Connections:



MCO member stories

Each of the three MCOs in the Heritage Health program submitted the following stories to highlight some of their recent member and provider outreach efforts.

UnitedHealthcare Community Plan:

A 66-year-old member who lives in Grand Island had been experiencing homelessness and a number of intensive physical and behavioral health issues. When the member's UnitedHealthcare clinical coordinator first contacted him, she discovered he had limited minutes on his cell phone and wasn't able to engage in meaningful care management. The clinical coordinator recognized this was a barrier and took the opportunity to offer to meet with the member face to face. She called the member to meet for lunch.

Over lunch, the clinical coordinator learned the member had been homeless most of his life and had no family supports. He is on disability and had been diagnosed with many medical conditions including throat cancer, COPD, congestive heart failure, and a seizure disorder. He had several hospitalizations and shared that his cardiologist informed him that his life expectancy is limited due to a serious heart condition.

When the clinical coordinator attempted to work with the member to secure housing, he was firm in his position that he was not interested in securing housing and had no desire to spend his last few months pursuing a place to live. He said he really needed help with reapplying for SNAP benefits, getting eye glasses and understanding the medications he needed to manage his health issues.

The member's coordinator made sure he knew how to access local food pantries and assisted him with updating his information with DHHS. She was also able to get eye appointments scheduled for the member, who is nearly blind and unable to read anything. The clinical coordinator also reached out to the local pharmacy to refill the member's medications. In the following visits with the member, the clinical coordinator reviewed his Medicaid benefits, scheduled an appointment with an audiologist, and helped coordinate services with Social Security.

The member now has new glasses, receives SNAP benefits, and continues to maintain sobriety. He is taking his medications as prescribed and going to his doctor appointments. The member overcame some of his adversities and when he sees his clinical coordinator, he gives her a hug and calls her his guardian angel.

Nebraska Total Care:

A member who was diagnosed with post-traumatic stress disorder and paranoia was recently enrolled in case management. Prior to participating in case management, the member would spend days hiding under his bed and avoiding interaction with others. In addition, the member was often unable to move or leave the house. He had isolated himself from friends and family and was not keeping health appointments.

Shortly after engaging in case management, he joined the YMCA. He had initially been paying for the membership but was unable to afford it beyond the short term. The member also had difficulty paying for transportation. To address both issues, the case manager enrolled him in the YMCA value-added program and assisted in obtaining free bus passes. These activities have improved the mental health of this member, who has expressed that exercise has a calming benefit, and that he spends much less time under his bed.

While he still suffers from paranoia, he has developed a trusting relationship with his case manager. He will now initiate contact with her if he has questions or concerns. He has indicated an overall "healthier feeling" and at times has said he is "happy." These are new feelings for him. He has been keeping his medical appointments and has engaged in classes at Community Alliance. He finds the classes very informative and acknowledged that it is helping him with coping mechanisms and life skills.

The member has expressed that he is very appreciative of the support from case management and the money that he has saved because NTC's value-added programs.

"I can see my granddaughter and maybe take her for ice cream or buy her a Christmas present," the member said.

WellCare of Nebraska:

This member is a 38-year-old male with multiple sclerosis who was residing in a homeless shelter. WellCare's care manager began working with him in September 2017. The member had been using an electric wheelchair on loan from the homeless shelter. However, the wheelchair often broke down.

The care manager and the member established two goals for his care management: finding housing and obtaining his own wheelchair.

The care manager and team took a number of actions to help the member. They began by assisting the member in obtaining a photo ID so he could apply for housing. Then, they met the member at the shelter to complete Housing Authority and Section 8 Accommodation paperwork, wrote a letter of medical necessity, and submitted the request.

In addition to addressing the member's housing needs, the care management team also took care of the member's medical needs. The team contacted the member's primary

care provider to schedule an appointment and advised of the need for PT/OT evaluation for a wheelchair. The team also coordinated communications between the PCP, the member's neurologist, and the DME supplier.

Things have improved significantly for the member this year. The member moved into his own apartment in March 2018 under Douglas County Housing Authority. The member also received a blood pressure cuff and training on how to test and record his readings. Finally, his power wheelchair was approved in July and was scheduled for delivery mid-August.

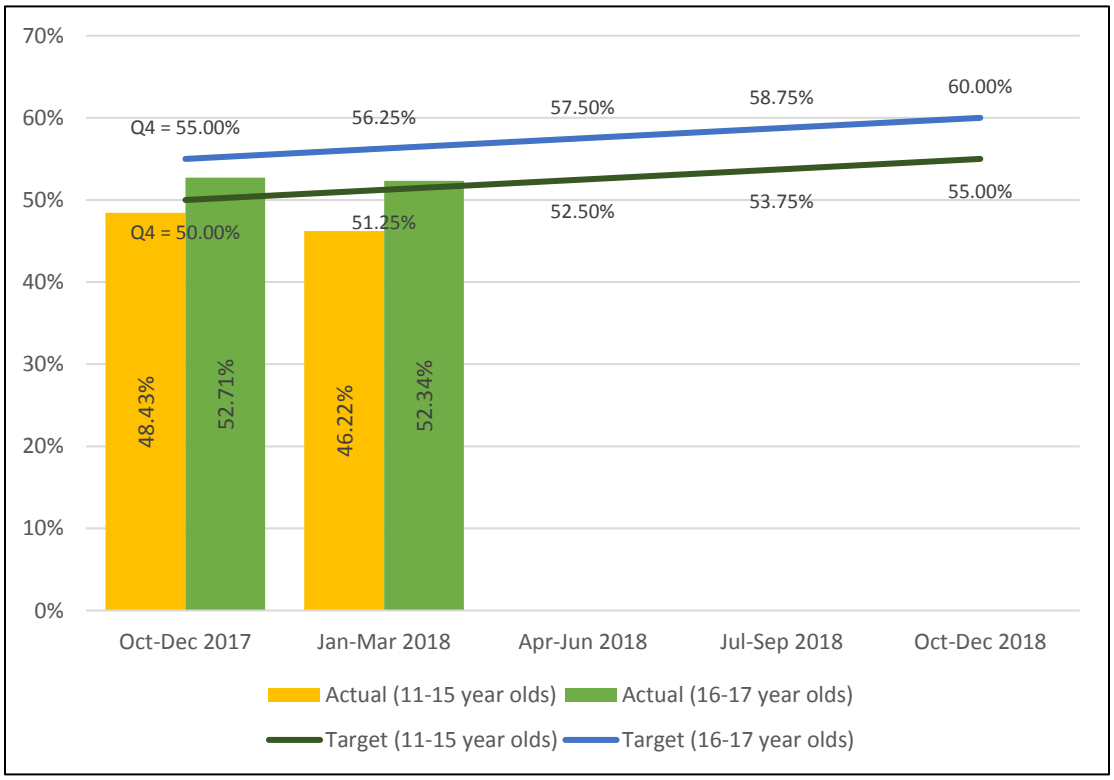
III. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

Dashboard Metrics

The reporting requirements included in each MCO's contract with the State of Nebraska allow for highly measurable results and outcomes from the Heritage Health program. These metrics were developed in consultation with the MLTC Medical Director, Dr. Lisa White. This information is tracked in the Department of Health and Human Services (DHHS) Dashboard.

The objective of monitoring these measures is to provide a consistent feed of information on the performance of the Medicaid program relative to established benchmarks in areas aligned with Division goals and the DHHS business plan, as well as to promote better health outcomes through clinical efficacy and cost effectiveness.

Figure 19: Tdap Immunization Rates for Adolescents

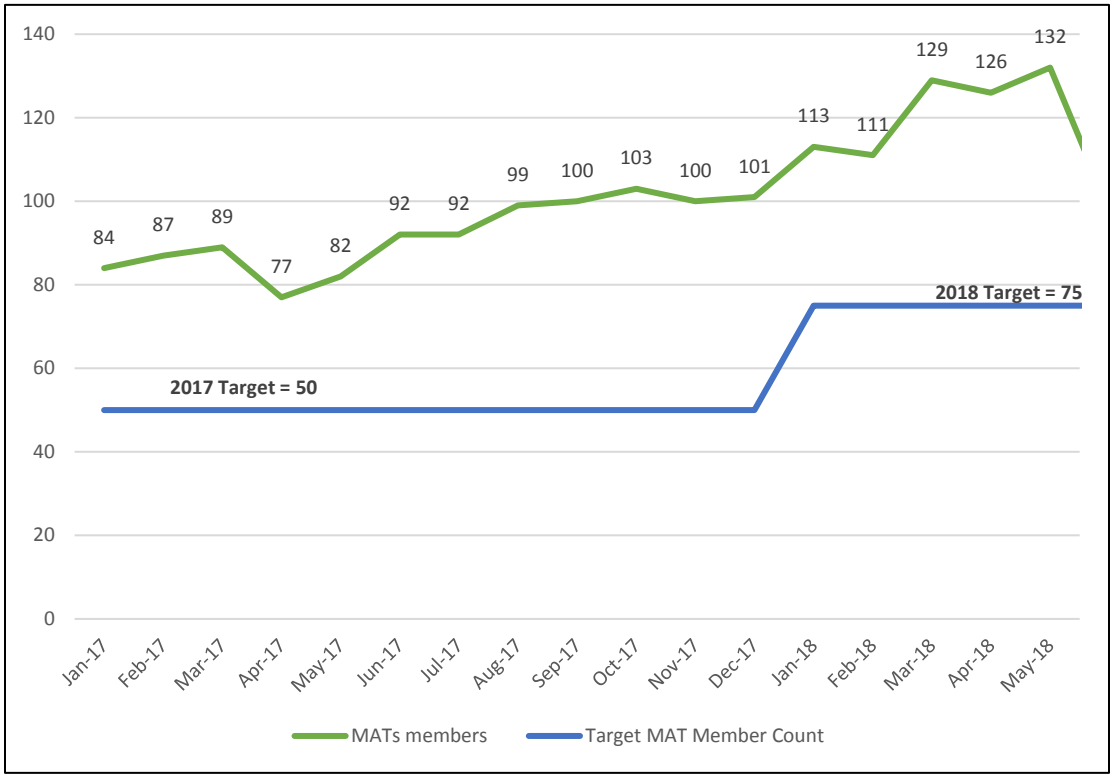


Here, we note the number of adolescents who have received a Tetanus, Diphtheria, and Pertussis (Tdap) immunization prior to their 18th birthday, split into two age categories: children ages 11-15, and those ages 16 and 17.

As this is a measure using claims data, rates may be affected when members receive vaccinations outside of the Medicaid program, or when an adolescent receives the vaccination outside of the prescribed timelines. MLTC estimates more adolescents have

received the vaccine. However, this method is the industry standard for measuring immunization rates.

Figure 20: Number of Individuals Receiving Medication-Assisted Treatment (MAT)



MAT, defined by the Substance Abuse and Mental Health Administration, is the use of a combination of behavioral therapy and medication to treat substance use disorders. This chart depicts the count of members receiving MAT-related prescriptions by month. MLTC has exceeded its target for this measure since the beginning of the Heritage Health program in January 2017. A successful MAT program is one component in fighting the national opioid crisis, although MAT can also be used to treat alcoholism and tobacco addiction.

Performance Improvement Projects

Performance Improvement Projects (PIPs) are collaborative projects between MLTC Medical Director Dr. White, the MCOs, and the External Quality Review Organization (EQRO) aimed at improving the health outcomes of Nebraska Medicaid's beneficiaries. MLTC currently has three PIPs in place:

1. Tracking follow-up visits after emergency department (ED) visits for mental illness or alcohol or drug dependency;
2. Monitoring Tdap immunization percentages in pregnant women; and
3. Monitoring Hydroxyprogesterone Caproate (17p) injection percentages in pregnant women.

MLTC is currently developing or has in place overall goals for these three projects. A goal for ED follow-up is currently being developed, as 2017 is the first full year that data is available for these measurements. With Tdap immunizations, MLTC is aiming for 85% and 75% for indicators 1 and 2, respectively. Finally, MLTC is aiming for a 35% Hydroxyprogesterone Caproate injection rate.

Complete 2017 data serves as a baseline of measurement. MLTC is anticipating improvement of these figures; long-term, sustained improvements of these figures are of greater interest to the division than single quarter-over-quarter improvements.

It is important to note that target rates differ among the MCOs due to their unique populations and varying baseline rates. These differing rates have been approved by both MLTC and the EQRO. Included below is the most recent aggregate data available for each of the three PIPs:

1. Follow-up Visits After ED Visits
    a. Figure 21: Follow-up to ED for Mental Illness

	7 Day Follow-Up	**30 Day Follow-Up**
Q1 to Q4 2017	28.94%	52.31%

By 2020, UHCCP aims to increase both of their figures to 79.8%. NTC aims to improve their 7-day rate to 65% and their 30-day rate to 87.5%, both by the end of 2019. WHP is currently aiming to increase their 7-day rate to 41.8% and 30-day to 66.5%.

b. Figure 22: Follow-up to ED for Alcohol or Drug Dependency

		7 Day Follow-Up	30 Day Follow-Up
Q1 to Q4 2017	13 to 17 Years	6.74%	14.61%
	18 Years and Over	5.33%	9.48%
	Total	5.50%	10.08%

By 2020, UHCCP aims to increase their 7-day figures to 30.4% and their 30-day figures to 33.2%. NTC aims to improve their 7-day percentage to 19.62% and their 30-day to 25.73%, both by the end of 2019. WellCare aims to increase their 7-day percentage to 18.2% for ages 18 and older and 16.4% for ages 13 to 17. They are seeking to improve their 30-day rates to 21.2% and 25.04%, respectively.

2. Figure 23: Monitoring Tdap Immunization Percentage in Pregnant Women

			Percentage
Q1 to Q4 2017	Continuously eligible for Medicaid	Indicator 1	61.23%
		Indicator 2	49.22%
	Not Continuously eligible for Medicaid	Indicator 1	58.42%
		Indicator 2	45.86%

Indicator 1 refers to mothers who received the service at any point in their pregnancies. Indicator 2 refers to mothers who received the service between weeks 27 and 36 of their pregnancies, which is when the immunization is most effective per the recommendation of the Advisory Committee on Immunization Practices.

UHCCP aims to improve their figures for indicator 1 to 85% and indicator 2 to 75%. NTC aims for 65% for indicator 1 and 58% for indicator 2. WHP seeks to improve their rates to 79.1% for indicator 1 and 15.95% for indicator 2.

3. Figure 24: Monitoring Hydroxyprogesterone Caproate Injection Percentage in Pregnant Women

			Percentage
Q1 to Q4 2017	**Continuously eligible for Medicaid**	**Indicator 1**	18.78%
		Indicator 2	24.87%
	Not Continuously eligible for Medicaid	**Indicator 1**	17.13%
		Indicator 2	23.15%

Hydroxyprogesterone Caproate injections improve health outcomes by reducing premature births in high-risk patients. Indicator 1 refers to mothers who received the injection between weeks 16 and 26 of their pregnancies, when the injection is most effective. Indicator 2 refers to mothers who received the injection at any point in their pregnancies.

UHCCP aims to increase their figures to 22.7% for both indicators. NTC is currently aiming for 35% for both indicators by 2020. WHP's current goal is 29.5% for both groups.

IV. In Focus: Medical Necessity

Overview

Historically, all Nebraska Medicaid programs have used the state's medical necessity requirements when prior authorizing services. In consideration of balancing the interests of stakeholders in all Nebraska Medicaid programs—including the Heritage Health program—all health care services that are covered under the program must be medically necessary. The general guidelines for medical necessity are outlined in Title 471 of the Nebraska Administrative Code, Chapter 1-002.02A. There are eight criteria that guide all services provided under Nebraska Medicaid. The state's established criteria for determining medical necessity is as follows:

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

Current medical necessity regulations require the Medicaid member's individual circumstances are taken into account. For example, a member's available community support and living arrangement may disqualify them for the same service that someone with the same diagnosis may receive through Medicaid living in a community where supports are different. The Heritage Health program allows for more accurate evaluation and appropriate application of services than was possible prior to 2017.

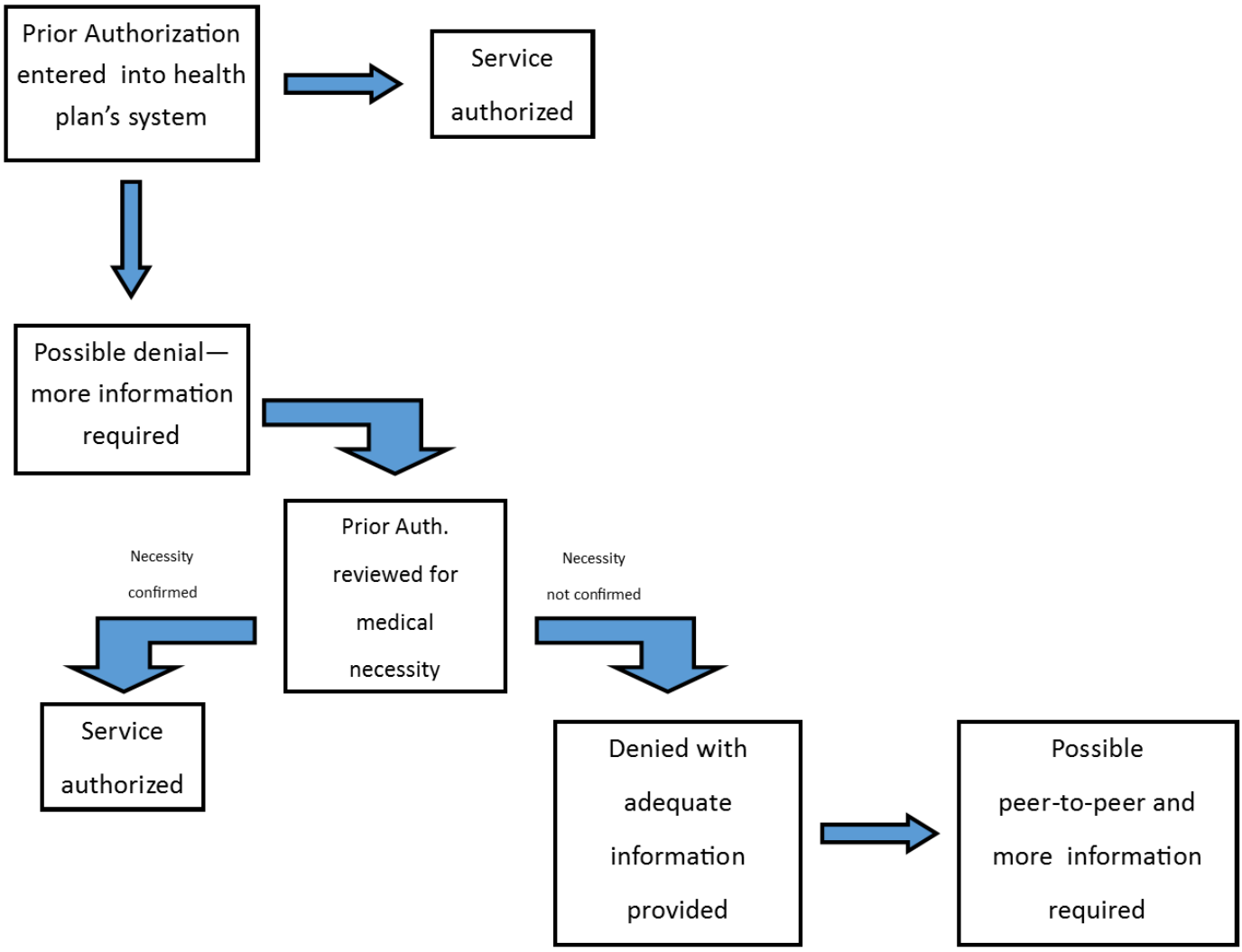
Medical Necessity and the Heritage Health MCOs

All of the MCOs in the Heritage Health program are required to follow the state's medical necessity definition. The MCO's contract requirements also specify the decision-making timeframes for service authorizations and appeals.

For the MCOs, medical necessity is determined by a licensed clinician. A clinician (physician, nurse, or therapist) is able to use professional judgment (i.e. clinical practice guidelines) in determining whether the service being requested meets medical necessity criteria. All denials or limitations of requested coverage for services are determined by a licensed health care professional. Peer-to-peer clinician review is brought into the process in the event of disagreement by the requesting practitioner when an adverse determination is rendered. Peer-to-peer reviews are performed with a clinician in a similar specialty during an appeal.

Applying medical necessity is a tool by which utilization is monitored, ultimately to optimize care in the appropriate setting and at the appropriate cost. The following graphic details how the MCOs utilize medical necessity when preauthorizing services:

Figure 25: Medical Necessity and Authorizing Services



Note: If an adverse determination is made, then a notification is given to both the member and provider. Peer-to-peer can be requested up to 14 days after the notification, and appeals can be made up to 60 days post notification. Appeal rights are contained in the letter to member.

For a list of service types that require prior authorizations with each MCO, see attachments 1-3.

Service Decision Types

Medical necessity is a component of the authorization process for all service types. The timeframe depends on the type of decision. Below are three of the most common utilization management decision types that each of the Heritage Health MCOs make. Timeframes are expressed in calendar days unless otherwise noted.

Nonurgent Pre-Service Decisions

These decisions, also referred to as standard prior authorizations, must be made within 14 days of the MCO receiving the request from the provider. The MCO can extend this timeframe for an additional 14 days if it is unable to make a decision due to factors it cannot control, such as incomplete information. When the MCO makes its decision, it must be communicated to the provider within 1 business day. This day must be within the timeframe of the 14-day period.

Urgent Pre-Service Decisions

This decision type is the same as the previous type, but on an expedited timeframe. The MCOs must make these decisions within 72 hours. An extension of 14 days is allowed if needed, such as if requested by the member or if additional information is needed. When a decision is made, it must be relayed to the provider within 1 business day inside of the MCO's decision timeframe.

Urgent Concurrent Decisions

Urgent concurrent decisions are needed when a member is currently receiving ongoing care, such as inpatient hospital care, and the care provider determines the member needs care in addition to what was originally authorized by the MCO. When a provider submits an urgent concurrent request to the member's MCO, the MCO has 24 hours to make a decision and communicate the decision back to the provider. There are a few situations in which this timeframe may change. One such case would be if the provider requests an extension more than a day before the initially authorized period would end; another would be if a provider is requesting an additional authorization for care unrelated to the initial approval. In both of these cases, the MCO will have 72 hours to make a decision.

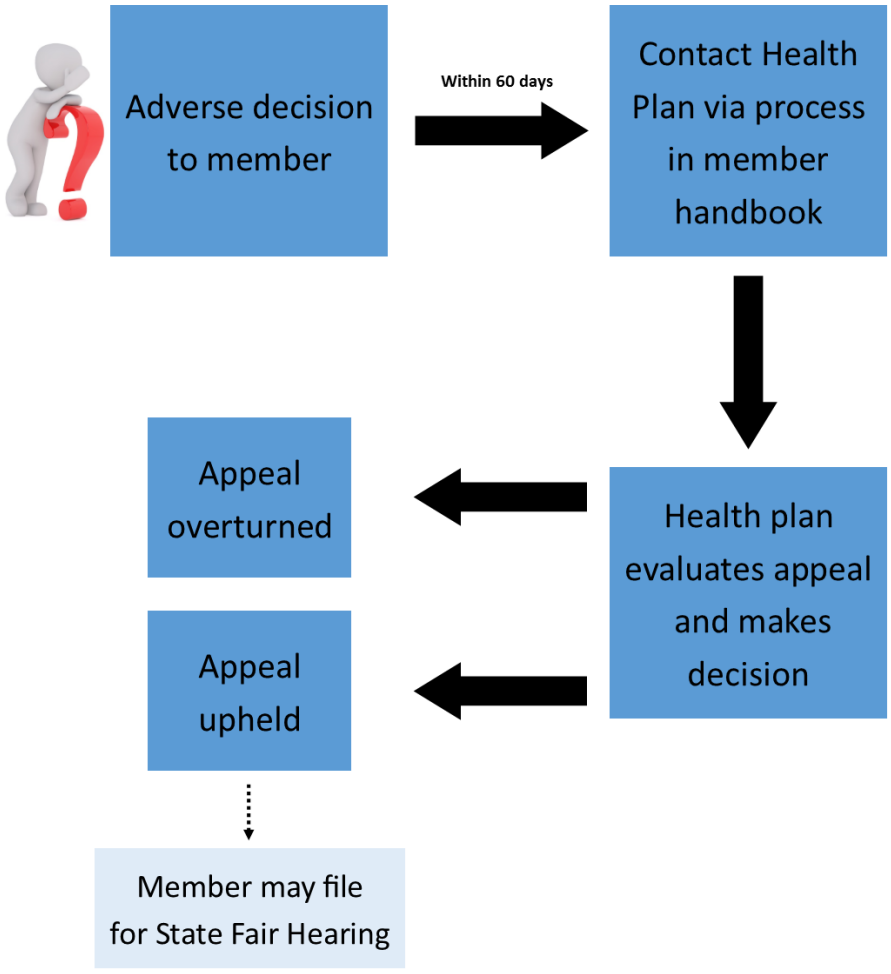
Member Appeals

All Heritage Health members have the right to appeal their MCO's adverse decision. This encourages members to be engaged in their own health care. Per federal regulations, members must appeal decisions to their MCO before the appeal is escalated to the state (42 CFR 438.402). The following are examples of instances when a member may decide to file an appeal:

- The health plan denies or limits a service approval request;
- The health plan does not approve a service in an amount, length of time, or scope that was requested;
- The health plan denies payment for a service;
- The health plan suspends, reduces, discontinues, or terminates services; and/or
- The health plan does not act upon a grievance or appeal within required timeframes.

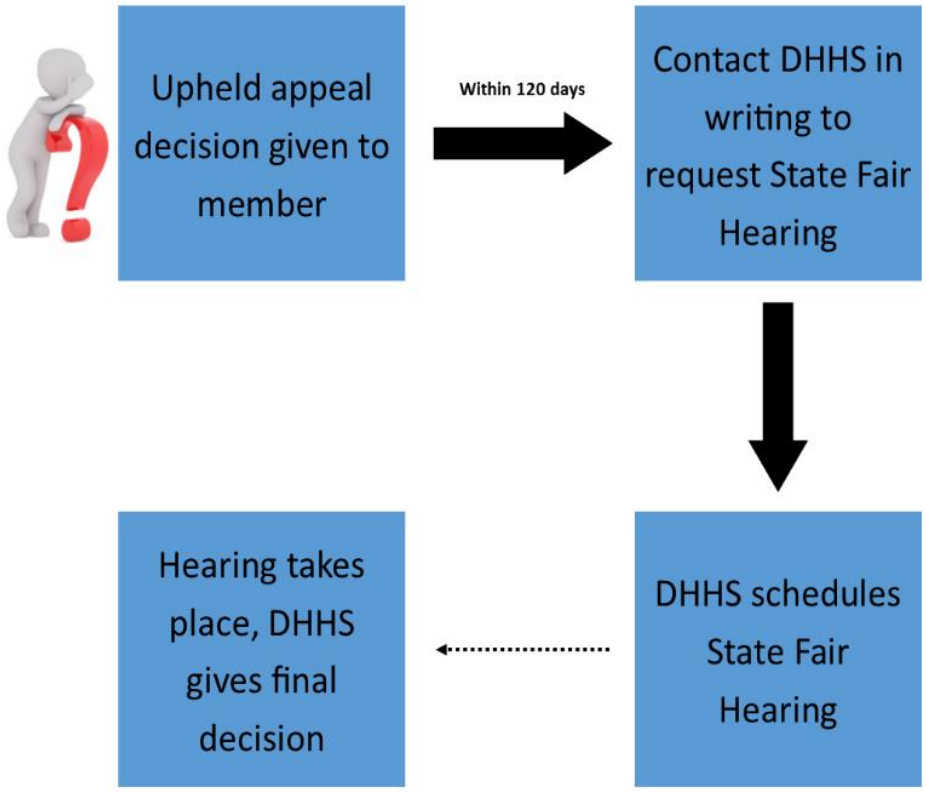
The member appeals process is illustrated below:

Figure 26: Requesting an Appeal with a Heritage Health MCO



Members can file for a State Fair Hearing after completing the appeals process with their MCO if they still disagree with the MCO's decision.

Figure 27: Requesting a State Fair Hearing with DHHS



The process for contacting DHHS to request a State Fair Hearing is available in MCO member handbooks, as well as in the adverse decision letter sent to the member. In the event the appellant member is not satisfied with the State Fair Hearing outcome, the appellant has the right to take the case to state district court. The court will then decide if the law was accurately interpreted in the State Fair Hearing.

V. Future Roadmap: Upcoming Changes in MLTC

Non-Emergency Medical Transportation Carve In

As addressed in DHHS's July 2018 – June 2019 Business Plan, MLTC is currently working towards carving the non-emergency medical transportation (NEMT) service in to managed care. An example of this service would be transportation to routine doctor's appointments. Including NEMT in the Heritage Health benefits package contributes to DHHS's division-wide goal of integrating services and partnerships and will help MLTC realize the advantages of managed care.

NEMT is currently provided via a fee-for-service (FFS) broker contract with Intelliride. These FFS claims are currently paid in the state's aging MMIS system. The State of Nebraska's current contract with Intelliride will expire at the end of June 2019. With the goal of sunsetting the claims broker function of the MMIS, combined with an increased focus on our health plans to deliver cost-effective whole-person care, MLTC sought alternative ways to administer this service. After assessing options in light of The Triple Aim (better quality, cost containment, and an improved experience for both providers and members), MLTC decided the best way to administer the NEMT service was to carve it in to the Heritage Health benefit package.

The Heritage Health MCOs are both contractually bound and financially incentivized to ensure their members access the health services they need, especially in regards to preventative and primary care. Thus, the MCOs have a vested interest in providing transportation to members who would otherwise have difficulty in keeping their health care appointments. Carving NEMT into Heritage Health bridges a gap in the continuum-of-care for all members and enhances Heritage Health's ability to provide person-centered care management. Additionally, DHHS will be able to set performance standards for NEMT, similar to other performance standards in Heritage Health. These standards can be tied to financial withholds to promote quality service for Heritage Health members.

MLTC will engage stakeholders, including both members and NEMT providers. NEMT providers will be advised of MLTC's target launch date of July 1, 2019.

The following table from the 2018-2019 DHHS Business Plan details the timeline and project deliverables planned in order to implement the NEMT carve in.

Figure 28: NEMT Carve in Timeline

Deliverable	Target Completion
Begin engagement with NEMT providers for a July 1, 2019 carve in	July 2018
Begin work with actuary on contract amendments, develop capitative rates for plans, and receive CMS approval in order to implement	November 2018
Finalize contract amendment to current Heritage Health plans for NEMT providers	May 2019
Add NEMT services to the Heritage Health benefit package	July 2019

Heritage Health "Public Dashboard"

The Heritage Health online "Public Dashboard" (available at http://dhhs.ne.gov/medicaid/Pages/HeritageHealthPlans.aspx) is currently under redevelopment. A team including members of MLTC Communications, Plan Management, and Data and Analytics are developing a new dashboard that is more concise and useful to all stakeholders.

This dashboard will be updated on a quarterly basis. The team aims to launch the dashboard at the beginning of October 2018. When the new DHHS website launches in 2019, MLTC Communications will begin exploring ways to continue improving the "Public Dashboard."

Administrative Simplification

The Heritage Health Administrative Simplification Committee has recently completed two projects at the advice of stakeholders across the state. The Nebraska Home Health Prior Authorization Request form, a project that began with a suggestion from the Nebraska Home Care Association (NHCA), is nearing completion and is currently with the NHCA for the association's review. This form is a common prior authorization form for all home health services, including nursing and therapy services.

Additionally, a common prior authorization form for hearing aids is nearing completion. This project began with an idea from the Nebraska Speech-Language Hearing Association (NSLHA) to streamline the process by having a universal form that is accepted by all three Heritage Health MCOs. The draft form was formally reviewed by the NSLHA earlier this week and will soon be finalized by MLTC.

Staffing

MLTC is excited to announce that Dr. Larra Petersen joined the staff last month as the new Deputy Director of Healthcare Informatics & Business Integration. Dr. Petersen previously oversaw population health, episode payment models, post-acute care, and analytics at the Methodist Health System in Omaha. Recently, she developed and oversaw the Nebraska Health Network's strategic plan on clinical and organization priorities for accountable care. She also oversaw the development and implementation of strategies, policies, and procedures facilitating clinical integration and population health across a multi-disciplinary network of physicians and clinical staff from separate institutions. Her background and skills will help her fit well into her new role, which began on August 20, 2018.

The division thanks Kris Azimi for serving as deputy director in the interim.

VI. APPENDIX

a) Index

b) Attachments

Attachment 1 — Nebraska Total Care Quick Reference Guide Information for Medical Services

nebraska total care

Quick Reference Guide Information for Medical Services

Phone: 1-844-385-2192 TTY: 1-844-307-0342

www.NebraskaTotalCare.com

Member/Provider Services (7a-8p CST):
1-844-385-2192

Prior Authorization (8a-5p CST):
Toll Free: 1-844-385-2192
You may also fax requests:
PA requests – 1-844-774-2363
Med Records – 844-252-4644
Inpatient Admissions:
Concurrent Review – 844-845-5086
Admissions – 844-360-9454

High Tech Imaging Requests:
www.radmd.com

Care Management Fax:
1-844-340-4888

Pharmacy Requests (Excluding Bio pharmacy):
Toll Free - 1-888-321-2351
Fax – 1-844-330-7852

Secure Website available 24/7:
www.NebraskaTotalCare.com

- Obtain listing of Nebraska Total Care members, their benefits, eligibility, other insurance, and PCP
- Find a Network Provider
- Submit and view authorizations
- Submit claims, check claim status, payment history, and EOPs
- View patient health records

92016

PRIOR AUTHORIZATION REQUIREMENTS

This list is not all-inclusive. Visit our website and use the Prior Auth Needed Tool or call our Authorization Department with questions. Failure to obtain the required prior approval or pre-certification may result in a denied claim(s). All services are subject to benefit coverage, limitations and exclusions as described in applicable plan coverage guidelines.

All Out of Network (Non-Par) services require prior authorization, excluding ER, urgent care, and family planning

Ancillary Services

- ✓ Air Ambulance Transport (non-emergent fixed wing airplane)
- ✓ DME purchases or rental (excludes items included in content of service for inpatient, Rehab facility, SNF or Nursing home facility)
- ✓ Home health care services including home hospice, home infusion, skilled nursing, personal care services, and therapy
- ✓ Orthotics/Prosthetics
- ✓ Therapy (ongoing services)
  - Occupational
  - Physical
  - Speech
- ✓ Cochlear implants
- ✓ Genetic Testing
- ✓ Quantitative Urine Drug Screen

Inpatient Authorization

All Observation Stays and Urgent/Emergent admissions require notification within *1 business day* following the date of admission.

Newborn deliveries must include birth outcomes.

All elective/scheduled admission notifications should be requested at least *5 business days* prior to the scheduled date of admit including:

- ✓ All services performed in out-of-network facility
- ✓ Medical Inpatient
- ✓ Psychiatric Inpatient
- ✓ Hospice care
- ✓ Rehabilitation facilities
- ✓ Skilled nursing facility
- ✓ Transplants, including evaluation

Procedures/Services

Requests for authorization require all applicable CPT procedure codes by provided at the time of request.

- ✓ All procedures and services performed by out-of-network providers *exclusion apply for ER, urgent care, and family planning
- ✓ Hearing Aid devices including cochlear implants
- ✓ Drug Testing
- ✓ Experimental or Investigational
- ✓ High Tech Imaging (i.e. CT, MRI, PET)
- ✓ Obstetrical Ultrasound; two allowed in 9 month period, any additional will require PA, except those rendered by perinatologists.
- ✓ Pain Management; does not apply to post-operative pain management

Prior Authorization (PA) may be submitted by fax or phone. After normal business hours and on holidays, calls are directed to our, 24-hour nurse advice line. Notification of authorization decision will be returned by mail, phone, or fax.

Attachment 2 — UnitedHealthcare Community Plan Prior Authorization Requirements for Nebraska

Prior Authorization Requirements for Nebraska Effective April 1, 2018

UnitedHealthcare Community Plan

General Information

This list contains prior authorization review requirements for UnitedHealthcare Community Plan of Nebraska participating care providers for inpatient and outpatient services. To request prior authorization, please submit your request online, or by phone or fax:

- **Online:** Use the Prior Authorization and Notification app on Link. Go to **UHCprovider.com** and click on the Link button in the top right corner. Then, select the Prior Authorization and Notification app tile on your Link dashboard.
- **Phone:** 866-604-3267
- **Fax:** 866-622-1428; fax form is available at UHCCommunityPlan.com > For Health Care Professionals > Nebraska > Provider Forms > Medical Prior Authorization Request Fax Form.

Prior authorization is not required for emergency or urgent care. Out-of-network physicians, facilities and other health care providers must request prior authorization for all procedures and services, excluding emergent or urgent care.

Procedures and Services	Additional Information	Current Procedural Terminology (CPT) Codes
Abortion	Prior authorization required	59840 59841 59850 59851 59852 59855 59856 59857 59866
Bariatric surgery Bariatric surgery and specific obesity-related services	Prior authorization required	0312T 0313T 0314T 0315T 0316T 0317T 43644 43645 43648 43659 43770 43775 43842 43845 43846 43847 43848 43860 43865 43881 43882 64590 95980 95981 95982
Bone growth stimulator Electronic stimulation or ultrasound to heal fractures	Prior authorization required	20975 E0747 E0748 E0749 E0760
BRCA genetic testing	Prior authorization required	81162 81211 81212 81213 81214 81215 81216 81217 81432 81433
Breast reconstruction (non-mastectomy) Reconstruction of the breast except when following mastectomy	Prior authorization required	19316 19318 19324 19325 19328 19330 19340 19342 19350 19357 19361 19364 19366 19367 19368 19369 19370 19371 19380 19396 L8600
Cochlear implants and other auditory implants A medical device within the inner ear with an external portion to help persons with profound sensorineural deafness achieve conversational speech	Prior authorization required	69710 69714 69715 69718 69930 L8614 L8619 L8690 L8691 L8692

Prior Authorization Requirements for Nebraska
Effective April 1, 2018

UnitedHealthcare Community Plan

Procedures and Services	Additional Information	Current Procedural Terminology (CPT) Codes			
Cosmetic and reconstructive Cosmetic procedures that change or improve physical appearance without significantly improving or restoring physiological function Reconstructive procedures that treat a medical condition or improve or restore physiologic function	Prior authorization required	11960	11971	15820	15821
		15822	15823	15830	15847
		15877	17106	17107	17108
		17999	21137	21138	21139
		21172	21175	21179	21180
		21181	21182	21183	21184
		21230	21235	21256	21275
		21280	21282	21295	21740
		21742	21743	28344	30620
		67900	67901	67902	67903
		67904	67906	67908	67909
		67911	67912	67914	67915
		67916	67917	67921	67922
		67923	67924	67950	67961
		67966	Q2026		
Durable medical equipment (DME): more than $750 DME codes listed with a retail purchase or cumulative rental cost of more than $750	Prior authorization required only in outpatient settings, to include patient's home Prosthetics are not DME – see *Orthotics and prosthetics.*	E0194	E0265	E0266	E0300
		E0445	E0457	E0466	E0483
		E0636	E0638	E0641	E0642
		E0656	E0669	E0670	E0675
		E0693	E0694	E0745	E0766
		E0784	E0984	E0986	E1002
		E1003	E1004	E1005	E1006
		E1007	E1008	E1009	E1010
		E1030	E1035	E1161	E1229
		E1231	E1232	E1233	E1234
		E1235	E1236	E1237	E1238
		E1239	E2100	E2227	E2228
		E2230	E2322	E2325	E2327
		E2329	E2331	E2351	E2373
		E2510	E2511	E2599	E8001
		K0005	K0008	K0013	K0108
		K0812	K0821	K0822	K0823
		K0824	K0825	K0826	K0827
		K0828	K0829	K0830	K0831
		K0848	K0849	K0850	K0851
		K0852	K0853	K0854	K0855
		K0856	K0857	K0858	K0859
		K0860	K0861	K0862	K0863
		K0864	K0868	K0869	K0870
		K0871	K0877	K0878	K0879
		K0880	K0884	K0885	K0886
		K0890	K0891		
Enteral services In-home nutritional therapy, either enteral or through a gastrostomy tube	Prior authorization required	B4155	B9000	B9002	B9998

Prior Authorization Requirements for Nebraska
Effective April 1, 2018

UnitedHealthcare Community Plan

Procedures and Services	Additional Information	Current Procedural Terminology (CPT) Codes
Experimental and investigational	Prior authorization required	0191T 33477 36514 55866 61863 61864 61867 61868 61886 64555 64722 65767 66180 95978 A4638 A9274 E1831 S0810 S2102 S9988 S9990 S9991
Femoroacetabular impingement syndrome (FAI)	Prior authorization required	29914 29915 29916
Functional endoscopic sinus surgery (FESS)	Prior authorization required	31240 31254 31255 31256 31267 31276 31287 31288
Home health services	Prior authorization required only in outpatient settings, to include patient's home	G0299 G0300 G0493 G0494 G0495 G0496 S9123 S9124 S9474
Hospice	Prior authorization required	T2042 T2043 T2044 T2045
Injectable medications	Prior authorization required	**Acthar®** J0800 **Botox®** J0585 J0586 J0587 J0588 **Brineura™** C9014 **Cerezyme®** J1786 **Cinqair®** J2786 **Elelyso®** J3060 **Exondys 51™** J1428 **Ilaris®** J0638 **IVIG** 90284 J1459 J1555 J1556 J1557 J1559 J1561 J1566 J1568 J1569 J1572 J1575 J1599 **Lemtrada®** J0202

UnitedHealthcare Community Plan

Procedures and Services	Additional Information	Current Procedural Terminology (CPT) Codes
Injectable medications (cont'd)		**Makena®** J1726 J1729 J2675 **Nucala®** J2182 **Ocrevus™** J2350 **Probuphine®** J0570 **Radicava®** C9493 **Soliris®** J1300 **Spinraza™** J2326 **Synagis®*** 90378 **Unclasssified**** C9399 J3490 J3590 **Xolair®*** J2357 Please check our *Review at Launch for New to Market Medications* policy for the most up-to-date information on drugs newly approved by the Food & Drug Administration (FDA) and included on our *Review at Launch Medication List*. Pre-determination is highly recommended for the drugs on the list. The *Review at Launch for New to Market Medications* policy is available at **UHCprovider.com** > Menu > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan. *Please obtain prior notification for Synagis and Xolair through OptumRx prior notifications services at **800-310-6826.** ****For Unclassified codes C9399, J3490 and J3590, prior authorization is only required for Brineura, Fasenra™, Luxturna™ and Radicava.

Prior Authorization Requirements for Nebraska
Effective April 1, 2018

UnitedHealthcare Community Plan

Procedures and Services	Additional Information	Current Procedural Terminology (CPT) Codes			
Joint replacement Joint, total hip and knee replacement procedures	Prior authorization required	23470	23472	23473	23474
		24360	24361	24362	24363
		24370	24371	27120	27122
		27125	27130	27132	27134
		27137	27138	27412	27446
		27447	27486	27487	29866
		29867	29868	J7330	S2112
Non-emergent air ambulance transport	Prior authorization required	A0430	A0431	A0435	A0436
		S9960	S9961		
Orthognathic surgery Treatment of maxillofacial/jaw functional impairment	Prior authorization required	21121	21123	21125	21127
		21141	21142	21143	21145
		21146	21147	21150	21151
		21154	21155	21159	21160
		21188	21193	21194	21195
		21196	21198	21199	21206
		21208	21209	21210	21215
		21240	21242	21244	21245
		21246	21247	21248	21249
		21255	21296	21299	
Orthotics and prosthetics: more than $750 Orthotics and prosthetic codes listed with a retail purchase or cumulative rental cost of more than $750	Prior authorization required only in outpatient settings, to include patient's home	L0112	L0456	L0462	L0464
		L0480	L0482	L0484	L0486
		L0629	L0631	L0636	L0637
		L0638	L0640	L0700	L0710
		L0810	L0820	L0830	L0859
		L1000	L1005	L1200	L1300
		L1310	L1499	L1680	L1685
		L1700	L1710	L1720	L1730
		L1755	L1840	L1844	L1846
		L1860	L1945	L2000	L2005
		L2010	L2020	L2030	L2034
		L2036	L2037	L2038	L2108
		L2126	L2128	L2136	L2350
		L2627	L2628	L3230	L3265
		L3649	L3671	L3674	L3730
		L3740	L3900	L3901	L3904
		L3905	L3961	L3971	L3975
		L3976	L3977	L3999	L4000
		L4020	L5010	L5020	L5050
		L5060	L5100	L5105	L5150
		L5160	L5200	L5210	L5220
		L5230	L5250	L5270	L5280
		L5301	L5312	L5321	L5331
		L5341	L5400	L5500	L5505
		L5510	L5520	L5530	L5535
		L5540	L5560	L5570	L5580
		L5585	L5590	L5595	L5600

UnitedHealthcare Community Plan

Procedures and Services	Additional Information	Current Procedural Terminology (CPT) Codes
Orthotics and prosthetics: more than $750 (cont'd) Orthotics and prosthetic codes listed with a retail purchase or cumulative rental cost of more than $750		L5610 L5613 L5614 L5616 L5639 L5643 L5651 L5702 L5703 L5706 L5716 L5718 L5722 L5724 L5726 L5728 L5780 L5795 L5814 L5816 L5818 L5822 L5824 L5826 L5828 L5830 L5848 L5930 L5950 L5960 L5961 L5964 L5966 L5968 L5979 L5980 L5981 L5987 L5988 L5990 L6000 L6010 L6020 L6050 L6055 L6100 L6110 L6120 L6130 L6200 L6205 L6250 L6300 L6310 L6320 L6350 L6360 L6370 L6380 L6382 L6384 L6400 L6450 L6500 L6550 L6570 L6580 L6582 L6584 L6586 L6588 L6590 L6624 L6693 L6696 L6697 L6707 L6708 L6709 L6712 L6713 L6714 L6881 L6900 L6905 L6910 L6915 L8040 L8042 L8043 L8044 L8045 L8046 L8047 L8499
Pediactirc medical daycare	Prior authorization required	T1024
Private duty nursing	Prior authorization required	T1000 T1002 T1003
Proton beam therapy Focused radiation therapy using beams of protons, which are tiny particles with a positive charge	Prior authorization required	77520 77522 77523 77525
Rhinoplasty and septoplasty Treatment of nasal functional impairment and septal deviation	Prior authorization required	30400 30410 30420 30430 30435 30450 30460 30462 30465
Sleep apnea procedures and surgeries Maxillomandibular advancement and oral-pharyngeal tissue reduction for treating obstructive sleep apnea	Prior authorization required	21685 41599 42145
Spinal stimulator for pain management Spinal cord stimulators when implanted for pain management	Prior authorization required	63650 63655 63685
Spinal surgery	Prior authorization required	22100 22101 22102 22110 22112 22114 22206 22207 22210 22212 22214 22220 22224 22532 22533 22548 22551 22554 22556 22558 22586 22590 22595 22600

UnitedHealthcare Community Plan

Procedures and Services	Additional Information	Current Procedural Terminology (CPT) Codes
Spinal surgery (cont'd)		22610 22612 22630 22633 22800 22802 22804 22808 22810 22812 22818 22819 22830 22849 22850 22852 22855 22856 22861 22864 22865 22899 63001 63003 63005 63011 63012 63015 63016 63017 63020 63030 63040 63042 63045 63046 63047 63050 63055 63056 63064 63075 63077 63081 63085 63087 63090 63101 63102 63170 63172 63173 63180 63182 63185 63190 63191 63194 63195 63196 63198 63199 63200 63250 63251 63252 63265 63267 63268 63270 63271 63272 63286 63300 63301 63302 63303 63304 63305 63306 63307 63308 64553 64570
Vagus nerve stimulation Implantation of a device that sends electrical impulses into one of the cranial nerves	Prior authorization required	61885 64568 L8680 L8682 L8685 L8686 L8687 L8688
Vein procedures Removal and ablation of the main trunks and named branches of the saphenous veins for treating venous disease and varicose veins of the extremities	Prior authorization required	36468 36473 36475 36478 37700 37718 37722 37780
Wound vac	Prior authorization required	E2402

Additional Prior Authorization Programs

Procedures and Services	Additional Information	Current Procedural Terminology (CPT) Codes and/or How to Obtain Prior Authorization
Behavioral health services	Prior authorization required Many of our benefit plans provide coverage for behavioral health services through a designated behavioral health network.	Please call the number on the member's health plan ID card when referring for mental health and substance abuse/substance use services.
Transplants	Prior authorization required	For transplant and CAR T-cell therapy services including Kymriah™ (tisagenlecleucel) and Yescarta™ (axicabtagene ciloleucel), please call the UnitedHealthcare Community and State

UnitedHealthcare Community Plan

Additional Prior Authorization Programs

Procedures and Services	Additional Information	Current Procedural Terminology (CPT) Codes and/or How to Obtain Prior Authorization
Transplants (cont'd)		Transplant Case Management Team at **800-418-4994** or the notification number on the back of the member's health plan ID card. 32850 32851 32852 32853 32854 32855 32856 33930 33933 33935 33940 33944 33945 38208 38209 38210 38212 38213 38214 38215 38232 38240 38241 38242 44132 44133 44135 44136 44137 44715 44720 44721 47133 47135 47140 47141 47142 47143 47144 47145 47146 47147 48551 48552 48554 50300 50320 50323 50325 50340 50360 50365 50370 50380 50547 S2060 S2061 S2152 Prior authorization required for diagnosis codes C81.00-C88.9 and C91.00-C91.02 along with codes 38206 38999 J3490 J9999 S2107 Q2040 Q2041
Ventricular assist devices (VAD) A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow	Prior authorization required	Please call the notification number on the back of the member's health plan ID card. Then, fax the form provided by the nurse to the Optum VAD Case Management Team at **855-282-8929.** 33927 33928 33929 33975 33976 33979 33981 33982 33983 Q0507 Q0508 Q0509

Attachment 3 — WellCare Nebraska Medicaid Quick Reference Guide

WELLCARE'S PRIOR AUTHORIZATION LIST:

Prior Authorization (PA) Requirements

This WellCare prior authorization list supersedes any lists that have been distributed to our providers. Please ensure that older lists are replaced with this updated version. Authorization changes are denoted by a ⚑ symbol for easy identification. Requirements that have been edited for clarification only are denoted with a ⓘ symbol.

WellCare supports the concept of the PCP as the "medical home" for its members. PCPs may refer members to network specialists when services will be rendered at an office, clinic or free-standing facility. No communication with the plan is necessary. Specialists may not refer members directly to other specialists.

All services rendered by nonparticipating providers and facilities require authorization with the exception of services provided in a tribal facility, federally qualified health center, or rural health clinic. Primary care providers (PCPs) must refer members to participating specialists. It is the responsibility of the provider rendering care to verify that the authorization request has been approved before services are rendered.

***Urgent* Authorization Requests and Admission Notifications – 1-855-599-3811 and follow the prompts.**

- Notify the plan of unplanned inpatient hospital admissions within the next business day of admission (except normal maternity delivery admissions). Telephone authorizations must be followed by a fax submission of clinical information.
- Outpatient authorizations for urgent and time-sensitive services may be requested by phone when warranted by the member's condition. Please include **CPT and ICD-10 codes** with your authorization request. Standard authorization requests may be submitted **online** or via fax using the numbers listed below if you are unable to access the portal with your secure login at **https://provider.wellcare.com/**.
- **Web submissions** are faster, and if the procedure requested meets clinical criteria, the Web provides and approval that can be printed for easy reference.
- Obtaining authorization does not guarantee payment, but rather only confirms whether a service meets WellCare's determination criteria at the time of the request. WellCare retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, the medical necessity of services, and correct coding and billing practices.

Behavioral Health Services

WellCare Web Submission Portal

Outpatient Authorization Request Submissions **Fax 1-855-279-3683**

Inpatient Hospitalization Clinical Submissions **Fax 1-877-849-5071**

On the web: https://www.wellcare.com/Nebraska/Providers/Medicaid/Behavioral-Health

Urgent Authorizations and Provider Services **1-855-599-3811**

- Emergency behavioral services do not require authorization. **Inpatient admission notification is required on the next business day following admission.**
- Inpatient concurrent review and psychological testing are done telephonically or via fax. All other levels of care requiring authorization, including outpatient services, can be submitted online.
- For more detail regarding authorization requirements, **click here**.

PROCEDURES and SERVICES	Authorization Required	Comments
Electroconvulsive Therapy (ECT)	**Yes**	
Emergency Behavioral Health Services	**No**	
Intensive Outpatient Program (IOP)	**Yes**	
Non-contracted (nonparticipating) Provider Services	**Yes**	All services from nonparticipating providers require prior authorization.
Partial Hospitalization Program (PHP)	**Yes**	
Pharmacological Management	**No**	
Psychological Testing	**Yes**	

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and Forms when the *Quick Reference Guide* is viewed in an electronic format.

NOTE: This guide is not intended to be an all-inclusive list of covered services under WellCare Health Plans, Inc., but it substantially provides current referral and prior authorization instructions. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable plan coverage guidelines. (Revised April 2018)

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Emergency Services

PROCEDURES and SERVICES	Authorization Required	Comments
Emergency Behavioral Health Services	No	
Emergent Care Services	No	
Emergency Transportation Services	No	
Urgent Care Services	No	

Inpatient Services

WellCare Web Submission Portal

Inpatient Authorization Requests **Fax 1-877-431-8860**

Inpatient Discharge Planning Requests **Fax 1-855-591-7136**

PROCEDURES and SERVICES	Authorization Required	Comments
Elective Inpatient Procedures	Yes	Clinical updates required for continued length of stay.
Inpatient Admissions	Yes	Clinical updates required for continued length of stay.
Long-Term Acute Care Hospital (LTACH) Admissions	Yes	Clinical updates required for continued length of stay.
Newborn Deliveries	No	No authorization is required for participating and non-participating facilities performing newborn deliveries (includes vaginal and Cesarean Section) **Please continue to notify the plan of newborn deliveries by the next business day.**
NICU/Sick Baby Admissions	Yes	Clinical updates required for continued length of stay.
Observations	See Comments	Elective procedures that convert to an observation stay are subject to outpatient authorization requirements. Authorization Lookup Tool Services performed during a non-elective observation stay, such as Advanced Radiology or Cardiology, do not require authorization.
Rehabilitation Facility Admissions	Yes	Clinical updates required for continued length of stay.
Skilled Nursing Facility Admissions	Yes	Clinical updates required for continued length of stay.

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and Forms when the *Quick Reference Guide* is viewed in an electronic format.

NOTE: This guide is not intended to be an all-inclusive list of covered services under WellCare Health Plans, Inc., but it substantially provides current referral and prior authorization instructions. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable plan coverage guidelines. (Revised April 2018)

Outpatient Services

WellCare Web Submission Portal

Durable Medical Equipment (DME) Requests **Fax 1-877-431-8859**
Home Health Services **Fax 1-866-886-4321**
Inpatient Discharge Planning Requests **Fax 1-855-591-7136**
Outpatient Services **Fax 1-855-292-0240**
Speech Therapy Services **Fax 1-877-709-1698**
Transplant Services **Fax 1-813-283-5320**

PROCEDURES and SERVICES	Authorization Required	Comments
Select Outpatient Procedures	**Yes – See Comments**	Authorization Lookup Tool **Effective 3/31/18: Authorization Rules will be changing.**
Abortions	**Yes**	
Advanced Radiology Services: CT, CTA, MRA, MRI, Nuclear Cardiology, Nuclear Medicine, OB Ultrasounds, PET & SPECT Scans	**Yes – See Comments**	Contact eviCore for authorization: eviCore Provider Web Portal Phone Number **1-888-333-8641** **No Auth Required for the first 3 OB ultrasounds** Advanced Radiology Program Criteria Radiology Request Forms
Cardiology Services: Cardiac Imaging, Cardiac Catheterization, Diagnostic Cardiac Procedures and Echo Stress Tests	**Yes – See Comments**	Contact eviCore for authorization: eviCore Provider Web Portal Phone Number **1-888-333-8641** Cardiology Program Criteria Cardiology Worksheets
Dialysis and End Stage Renal Disease Services	**No**	
Durable Medical Equipment Purchases and Rentals	**Yes – See Comments**	DME items reimbursed at an amount that is equal to or greater than $750 as allowed or noted on the Nebraska Medicaid DMEPOS Medicaid Fee Schedule require authorization.
Home Infusion/Enteral Services	**Yes**	Please initiate requests through **Coram:** **Phone: 1-800-423-1411 or Fax 1-866-462-6726**
Hospice Care Services	**Yes**	
Laboratory Management (Certain Molecular and Genetic Tests)	**Yes - See Comments**	Contact eviCore for authorization: eviCore Provider Web Portal Phone Number **1-888-333-8641** WellCare Lab Management Criteria Molecular and Genetic Testing Quick Reference Guide
Medical Oncology Services	**Yes – See Comments**	Contact HealthHelp for authorization: HealthHelp Portal Phone Number **1-888-210-3736** Medical Oncology Program Services

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and Forms when the *Quick Reference Guide* is viewed in an electronic format.

NOTE: This guide is not intended to be an all-inclusive list of covered services under WellCare Health Plans, Inc., but it substantially provides current referral and prior authorization instructions. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable plan coverage guidelines. (Revised April 2018)

PROCEDURES and SERVICES	Authorization Required	Comments
Orthotics and Prosthetics	**Yes – See Comments**	O&P items reimbursed at an amount that is equal to or greater than $750 as allowed or noted on the Nebraska Medicaid DMEPOS Fee Schedule require authorization.
Pain Management Treatment	**Yes – See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **Pain Management Program Criteria** **Musculoskeletal Management Request Forms**
Physical and Occupational Therapy (including home-based therapy)	**Yes – See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **Physical and Occupational Therapy Criteria** **PT/OT Worksheets**
Radiation Therapy Management	**Yes – See Comments**	Contact HealthHelp for authorization: **HealthHelp Portal** Phone Number **1-888-210-3736** **Radiation Therapy Management Program Resources**
Sleep Diagnostics	**Yes – See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **Sleep Diagnostics Program Criteria** **Sleep Management Worksheets**
Speech Therapy	**Yes**	
Transplant Services	**Yes**	Please submit clinical records for prior authorization for all transplant phases
Tribal facility services	**See Comments**	Prior Authorization is required for Abortions and Transplants only** **Per 482 NAC 4-004.03

Prenatal Notifications

WellCare Web Submission Portal

Prenatal Notification Forms **Fax 1-877-647-7475**

PROCEDURES and SERVICES	Authorization Required	Comments
Obstetric Global Services	**No**	**Prenatal Notification Form**