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CHAPTER 1 – INTRODUCTION TO AETNA BETTER HEALTH OF NEBRASKA

Welcome
Aetna Better Health of Nebraska is pleased that you are part of our network of providers. Aetna is committed to providing accessible, high quality service to our members in Nebraska, and we greatly appreciate all our providers’ efforts in helping us achieve that goal.

In order to ensure that Aetna Better Health of Nebraska communicates effectively with providers, we have developed this Provider Handbook to assist our providers. This document is designed to guide providers through Aetna Better Health of Nebraska’s administrative processes. Aetna Better Health will continue to provide providers with updates via letters, the provider website, newsletters and contact with provider relations representatives as changes occur.

Thank you for your participation and interest in caring for our members.

About Aetna Better Health
Aetna Medicaid has been a leader in Medicaid managed care since 1986 and currently serves more than 2 million people in multiple states. Aetna Medicaid and its affiliates currently own plans and administer Medicaid services in Arizona, Florida, Illinois, Kentucky, Louisiana, Michigan, Missouri, Maryland, Nebraska, New York, Ohio, Pennsylvania, Texas, Virginia and West Virginia. Aetna Medicaid also provides Medicaid-related administrative services to New Hampshire’s Medicaid Program.

Aetna Medicaid has more than 25 years’ experience in managing the care of the most medically vulnerable, using innovative approaches to achieve successful health care results.

Model of Care
Our model of care offers an integrated care management approach, which offers enhanced assessment and management for enrolled members. The processes, oversight committees, provider collaboration, care management and coordination efforts applied to address enrollee needs result in a comprehensive and integrated plan of care for members.

Our program's combined provider and care management activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:
  • Improve access to affordable care.
  • Improve coordination of care through an identified point of contact.
  • Improve seamless transitions of care across healthcare settings and providers.
  • Promote appropriate utilization of services and cost-effective service delivery.

Our efforts to promote cost-effective health service delivery include, but are not limited to the following:
  • Review of network for adequacy and resolve unmet network needs.
  • Clinical reviews and proactive discharge planning activities.
  • An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care/services.

Many components of our integrated care management program influence member health. These include:
  • Comprehensive member assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.

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• Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status, and allow enrollees to reside in the least restrictive environment possible.
• Assessments and care plans that identify an enrollee's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
• Case Manager referrals and predictive modeling software that identify enrollees at increased risks, functional decline, hospitalization, and emergency department visits.

Service Area
Aetna Better Health of Nebraska serves all 93 counties in Nebraska.

About this Provider Handbook
This provider handbook serves as a resource to providers and outlines operations for Aetna Better Health of Nebraska. Through the provider handbook, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health. Questions, problems, or concerns that the provider handbook does not fully address can be directed to the Provider Services department at 1-888-784-2693. Additional information for providers and members is available online at www.aetnabetterhealth.com/nebraska.

Disclaimer
Providers are contractually obligated to adhere to and comply with all terms of Aetna Better Health of Nebraska. This handbook and the provider agreement, combined with all federal and state regulations governing a provider, comprise the terms of participating as an Aetna Better Health of Nebraska Medicaid provider. While this handbook contains basic information about Aetna Better Health of Nebraska and the Nebraska Department of Health and Human Services (DHHS), providers are required to fully understand and apply DHHS requirements when administering covered services. Please refer to dhhs.ne.gov/medicaid/ for further information on DHHS.
CHAPTER 2 – CONTACTS

Important Numbers
Aetna Better Health of Nebraska’s standard business hours are Monday through Friday from 8 a.m. to 5 p.m. (Central Time).

<table>
<thead>
<tr>
<th>Aetna Better Health Contacts</th>
<th>Toll-Free</th>
<th>Fax</th>
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<tbody>
<tr>
<td>Provider Services (Claims Inquiry and Claims Research)</td>
<td>1-888-784-2693</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>1-888-784-2693</td>
<td>1-860-607-7029</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>1-888-784-2693</td>
<td>1-844-797-7602</td>
</tr>
<tr>
<td>Member Services</td>
<td>1-888-784-2693</td>
<td>1-860-607-7030</td>
</tr>
<tr>
<td>Appeals</td>
<td>1-888-784-2693</td>
<td>1-844-295-6761</td>
</tr>
<tr>
<td>Case Management/Disease Management</td>
<td>Contact Prior Authorization</td>
<td></td>
</tr>
<tr>
<td>Omaha Office</td>
<td>1-800-471-0240</td>
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The Aetna Better Health of Nebraska office is closed on these federal holidays:
- New Year’s Day
- Labor Day
- Martin Luther King, Jr. Day
- Thanksgiving Day
- Memorial Day
- Day after Thanksgiving
- Independence Day
- Christmas Day

Important Addresses

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<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>Aetna Better Health of Nebraska</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 63188</td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85082</td>
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<thead>
<tr>
<th>Aetna Better Health of Nebraska</th>
<th>Attn: Reconsiderations</th>
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<tbody>
<tr>
<td>P.O. Box 63188</td>
<td></td>
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<tr>
<td>Phoenix, AZ 85082</td>
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<tr>
<th>Aetna Better Health of Nebraska</th>
<th>Attn: Appeals Coordinator</th>
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<tr>
<td>15950 West Dodge Road</td>
<td></td>
</tr>
<tr>
<td>Omaha, NE 68118</td>
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Websites
In addition to the telephone numbers above, participating providers may access the Aetna Better Health of Nebraska website 24 hours a day, 7 days a week at: [www.aetnabetterhealth.com/nebraska](http://www.aetnabetterhealth.com/nebraska) for up-to-date information, forms and other resources.

Within the website, a secure provider web portal is maintained. The web portal can be accessed directly at [aetnabetterhealth-nebraska.aetna.com](http://aetnabetterhealth-nebraska.aetna.com). The secure provider web portal provides a platform for Aetna Better Health of Nebraska to communicate health care information directly to providers. The health plan’s
eligibility and claims information can be accessed via the web portal. Additional information regarding the website and secure web portal is available in the Provider Services chapter.

### Vendor Contacts

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<th>Vendor</th>
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<tr>
<td>Superior Vision</td>
<td>1-888-632-3937</td>
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<tr>
<td>Emdeon</td>
<td>1-800-845-6592 <a href="mailto:hdsupport@webmd.com">hdsupport@webmd.com</a></td>
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### State of Nebraska Medicaid Program

General information regarding the Nebraska Medicaid Program and Department of Health and Human Services can be found online at [dhhs.ne.gov/medicaid/](http://dhhs.ne.gov/medicaid/).

#### Topics

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<td>Web: <a href="http://dhhs.ne.gov/medicaid/Pages/med_pb_index.aspx">dhhs.ne.gov/medicaid/Pages/med_pb_index.aspx</a></td>
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| Provider Enrollment            | Web: [dhhs.ne.gov/medicaid/Pages/med_providerenrollment.aspx](http://dhhs.ne.gov/medicaid/Pages/med_providerenrollment.aspx)  
|                                | E-mail: DHHS.MedicaidProviderEnrollment@Nebraska.gov            |
|                                | Phone: 402-471-9128 or 1-877-255-3092                           |
| Fee Schedules                  | Web: [dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx](http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx) |
| Nebraska Medicaid Eligibility (NMES) Line | Phone: 402-471-9580 or 1-800-642-6092                  |
| ACCESSNebraska                 | Web: [accessnebraska.ne.gov](http://accessnebraska.ne.gov)    |
| Adult and Child Abuse & Neglect Hotline | Phone: 1-800-652-1999                                      |
| Magellan (Mental Health Services) | Phone: 1-800-424-0333                                      |
| IntelliRide (Transportation)   | Phone: 402-401-6999 or 1-844-531-3783                        |

### Reporting Suspected Fraud and Abuse

Participating providers are required to report to Aetna Better Health of Nebraska and to the State of Nebraska all cases of suspected fraud and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud or abuse to Aetna Better Health of Nebraska in the following ways:

- By phone to Aetna Better Health of Nebraska at **1-800-338-6361**
- By email to [NEMedicaidFraudandAbuse@AETNA.com](mailto:NEMedicaidFraudandAbuse@AETNA.com)

Fraud or abuse can also be reported to the State of Nebraska:

- Nebraska Medicaid Program, Program Integrity
  - Phone: **1-877-255-3092**
  - E-mail: [DHHS.MedicaidProgramIntegrity@nebraska.gov](mailto:DHHS.MedicaidProgramIntegrity@nebraska.gov)
- Medicaid Fraud and Patient Abuse Unit of the Nebraska Attorney General’s Office
  - Phone: **1-800-727-6432**
  - E-mail: [ago.medicaid.fraud@Nebraska.gov](mailto:ago.medicaid.fraud@Nebraska.gov)

Additional information can be found at the Nebraska DHHS Program Integrity website: [http://dhhs.ne.gov/medicaid/Pages/med_pi_fraud.aspx](http://dhhs.ne.gov/medicaid/Pages/med_pi_fraud.aspx)
CHAPTER 3 – PROVIDER SERVICES

Provider Services Department Overview
The Provider Services department serves as a liaison between Aetna Better Health of Nebraska and the provider community. This department also supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards. Provider Services includes both Claims Inquiry and Claims Research and Provider Relations.

Claims Inquiry and Claims Research
Provider Representatives are available by phone to provide telephonic or electronic support to all providers. Below are some of the areas where Claims Inquiry and Claims Research provide assistance:

- Assist with claims questions, inquiries and reconsiderations
- Review claims or remittance advice information
- View recent updates
- Locate forms
- Find a participating provider or specialist
- Assist with prior authorization questions
- Notify the plan of a provider termination
- Notify the plan of changes to a practice
- Obtain secure web portal or member care login information
- Receive reports of suspected fraud, waste or abuse

Claims Inquiry and Claims Research can be reached at 1-888-784-2693.

Provider Relations
Provider Relations assists providers by providing education and assistance regarding a variety of topics. Provider Relations will:

- Provide education to provider offices
- Provide support on Medicaid policies and procedures
- Provide provider contract clarification
- Assist with demographic changes, terminations, and initiation of credentialing
- Monitor compliance with applicable State and Federal agencies
- Conduct annual Provider Satisfaction Survey
- Conduct member complaint investigation
- Maintain the provider directory
- Be a point of contact for provider concerns

The Provider Relations department is responsible for the field service, ongoing education, and training of Aetna Better Health of Nebraska’s provider community. Aetna Better Health of Nebraska maintains a strong commitment to meeting the needs of our providers. In order to accomplish this, a provider relations representative is assigned to specific groups of participating providers. This process allows each office to become familiar with its representative and form a solid working relationship. Each provider representative has a thorough understanding of Aetna Better Health of Nebraska’s operations and is well versed in the managed care program.

A provider relations representative will visit or phone provider offices periodically to ensure providers’ experiences with Aetna Better Health of Nebraska are seamless. Representatives are available to meet with office staff and providers upon request. Provider News electronic messages and specialized mailings are sent to providers periodically as well, including updates to the provider manual, changes in policies or benefits, and
general news and information of interest to our provider community. To contact a local provider relations representative, please call **1-888-784-2693**.

**Joining the Network**
Providers interested in joining the Aetna Better Health of Nebraska network should contact Provider Relations at **1-888-784-2693** for additional information regarding contracting and credentialing.

**Provider Orientation**
Aetna Better Health of Nebraska provides initial orientation for newly contracted providers after joining our network. In follow up to initial orientation, Aetna Better Health of Nebraska provides a variety of forums for ongoing provider training and education, such as routine site visits, group or individualized training sessions on select topics (i.e. enrollee benefits, Aetna Better Health website navigation), distribution of provider newsletters and bulletins containing updates and reminders, and online resources through our website at [www.aetnabetterhealth.com/nebraska](http://www.aetnabetterhealth.com/nebraska).

**Informed Health® Line (24-hour nurse line)**
Aetna Better Health of Nebraska provides a free 24-hour ® for members. The ® uses Clinical Triage Services that consists of a package of health care information services, call center services and triage and other services. In providing the Clinical Triage Services, the program uses algorithms, clinical tools and supporting software designed to enable Registered Nurses to assess a Member’s level of health risk based on the presenting symptoms and to route them to an appropriate level and timing of care.

Informed Health Line services are provided based on the answers to the questions in the algorithms, the nurse can help the member decide if the member needs to go to the hospital, urgent care facility, or to their doctor or if the member can care for him or herself or family member at home. The Informed Health Line does not have benefit information.

The Informed Health Line call center is staffed seven (7) days a week, twenty-four (24) hours a day, including holidays and can be reached at **1-877-620-1945 (TTY:711)**.
CHAPTER 4 – PROVIDER RESPONSIBILITIES AND IMPORTANT INFORMATION

Provider Responsibilities Overview
This section outlines general provider responsibilities; additional responsibilities are included throughout the handbook. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with the terms of the Nebraska Medicaid program, provider contract, and requirements in this handbook. Aetna Better Health may or may not specifically communicate such terms in forms other than the provider contract and this handbook.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Advice given to potential or enrolled members should always be given in the best interest of the member.

State of Nebraska Medicaid Provider Enrollment
Providers who provide services to Aetna Better Health of Nebraska members must be enrolled as a Medicaid provider at each practice location with the State of Nebraska and credentialed by Aetna Better Health of Nebraska before they can provide health care to our members. To access enrollment forms and other information about how to enroll with the State of Nebraska, please refer to the department’s website at: http://dhhs.ne.gov/medicaid/Pages/med_providerenrollment.aspx.

National Provider Identifier (NPI) Number
The National Provider Identifier Number (NPI) is a ten (10) digit number that is provider specific assigned by CMS. For additional information please visit the National Plan/Provider Enumeration System (NPPES) Web site at https://nppes.cms.hhs.gov/. NPI numbers are required for claims submission to Aetna Better Health of Nebraska. The CMS 1500 and UB04 claim forms contain fields specifically for the NPI information. On the CMS 1500 form the rendering provider’s (box 31) NPI number is placed in the bottom half of the 24 J fields. The NPI for the billing provider in box 33 is placed in the 33A field.

Access and Availability Standards
Ten-County Area
Appointment Accessibility standards for Primary Care Physicians (PCP’s) and Specialists in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties are:

Service Area 1 Urban Counties

<table>
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<th>Timely Access</th>
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<tr>
<td>Timely Access- Standards for hours of operation for PCP’s:</td>
</tr>
<tr>
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</tr>
<tr>
<td>• Two (2) or more MD practice-30 hours per week</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Type</th>
<th>Appointment Type</th>
<th>Availability Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>Emergency</td>
<td>Twenty-four (24) hours per day, seven (7) days per week</td>
</tr>
<tr>
<td></td>
<td>Medically Necessary/Urgent Care</td>
<td>Same Day</td>
</tr>
<tr>
<td></td>
<td>Routine</td>
<td>Fourteen (14) working days</td>
</tr>
</tbody>
</table>

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High Volume Specialists (Cardiologist, Neurologist, Hematologist-Onocologist, Orthopedics)

<table>
<thead>
<tr>
<th>Routine</th>
<th>Thirty (30) working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal</td>
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</tr>
<tr>
<td></td>
<td>Initial Second (2nd) Trimester</td>
</tr>
<tr>
<td></td>
<td>High Risk</td>
</tr>
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Availability standards for travel time between member's home/work sites and healthcare provider are:

<table>
<thead>
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<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic Distance (Location) to PCPs for Members</td>
<td>2 PCPs within thirty (30) miles of residence.</td>
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<td>Geographic Distance (Location) to High Volume Specialists for Members (Cardiologist, Neurologist, Hematologist-Onocologist, Orthopedics)</td>
<td>1 High Volume Specialist within thirty (30) miles of residence.</td>
</tr>
<tr>
<td>Geographic Distance (Location) to Hospitals for Members</td>
<td>1 Acute Care Hospital within 30 miles of the member’s residence or as required by state.</td>
</tr>
<tr>
<td>Urgent Care Centers</td>
<td>Inclusion of Urgent Care Centers within the network</td>
</tr>
<tr>
<td>FQHC’s and RHC’s</td>
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</tr>
<tr>
<td>Cultural Competency</td>
<td>Provider access to more than (1) PCP that is multilingual and culturally diverse.</td>
</tr>
<tr>
<td>Geographic Distance (Location) to DME and HHC Ancillary Providers for Members</td>
<td>1 DME or HHC provider within 60 miles of the member’s residence.</td>
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</tbody>
</table>

Expansion Counties
Appointment Accessibility standards for Primary Care Providers (PCP’s) and Specialists in the remaining 83 Nebraska counties are:

Service Area 2 Urban, Rural and Frontier Counties

<table>
<thead>
<tr>
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<td>Thirty (30) working</td>
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<tr>
<td></td>
<td>Initial Second (2nd) Trimester</td>
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</tr>
<tr>
<td></td>
<td>High Risk</td>
<td>Three (3) working days</td>
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<td><strong>Geographic Distance (Location) to PCP’s for Members</strong></td>
<td>Urban Counties: Two (2) PCP’s within thirty (30) miles of residence. Rural Counties: One (1) PCP within forty-five (45) miles of residence. Frontier Counties: One (1) PCP within sixty (60) miles of residence.</td>
</tr>
<tr>
<td><strong>Geographic Distance (Location) to High Volume Specialists for Members (Cardiologist, Neurologist, Hematologist/Onocologist, Orthopedics)</strong></td>
<td>Urban Counties: One (1) High Volume Specialist within thirty (30) miles of residence Rural Counties: One (1) High Volume Specialist within sixty (60) miles of residence Frontier Counties: One (1) High Volume Specialist within 90 miles of residence.</td>
</tr>
<tr>
<td><strong>Geographic Distance (Location) to I/T/U Provider for Members</strong></td>
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Notes:
- Primary Care Practice (PCP) is defined as Family Practice, Internal Medicine, Pediatrics, and General Practice.
- High Volume Specialists are determined by the Health Plan through annual High Volume Specialist Reports. OB/GYN Providers are considered mandatory High Volume Specialist providers and will be added to the annual High Volume Specialist listing.
- When developing the network, Aetna Better Health of Nebraska takes into account the linguistic and cultural preferences of health plan membership. Provider access to more than 1 PCP that is multilingual and culturally diverse is required for Medicaid.
- Selection of Ancillary Provider access as determined by the State.

PCP providers must be available to members twenty-four (24) hours a day, seven (7) days a week. When the provider is unavailable, arrangements must be made for another primary care physician to cover services.

Providers must offer hours of operation to members of Aetna’s Nebraska Medicaid managed care program (“Nebraska Medicaid Members”) that are no less (in number or scope) than the hours of operation offered to other non-Medicaid patients, or if a provider serves only Medicaid beneficiaries, hours of operation comparable to the hours of operation offered to members of the State of Nebraska’s Medicaid Fee for Service.
Program. Provider agrees to provide covered services to Nebraska Medicaid Members on a twenty-four (24) hour per day, seven (7) day per week basis. Further, provider agrees to meet Nebraska state standards for timely access to care and services, taking into account the urgency of need for services.

Monitoring of Standards
Monitoring of network provider access and availability will be completed to ensure that the sufficiency of its network will meet the health care needs of members for both Primary Care Physicians (PCPs) and specialists, as appropriate. To monitor compliance with the Access and Availability Standards the health plan will:

• Review quarterly results of the Geo-mapping reports, completed by utilizing industry-standard software, to monitor compliance with the Availability standards.
• Review the annual results of the Consumer Assessment of Health Plans Study (CAHPS), a member satisfaction survey, to monitor compliance with the Accessibility standards.
• Monitor member complaints.
• Monitor after-hour telephone accessibility through member complaints and member and/or provider surveys or after hours phone audits to ensure that the physician or an associate is available twenty-four (24) hours per day, seven (7) days per week.

Resolution of Insufficiencies
• Physicians out of compliance will be required to submit a Corrective Action Plan (CAP) and will be monitored until the CAP enables them to be compliant.
• If any insufficiencies are identified through the quarterly Geo-mapping review, applications or requests for participation will be sent to non-contracted facilities or providers in the affected service area(s).
• The health plan will also monitor and trend any member complaints regarding accessibility and availability of providers by product. If trends are identified, the health plan will promptly begin the recruiting process.

Covering Providers
Aetna Better Health of Nebraska must be notified of covering providers. This notification must occur in advance of providing authorized services. Reimbursement to a covering provider is based on Nebraska Medicaid Fee Schedule and dependent on enrollment as a provider with both Aetna Better Health of Nebraska and the State of Nebraska Medicaid program. Failure to notify Provider Services of covering providers may result in claim denials.

Verifying Enrollee Eligibility
All providers, regardless of contract status, must verify an enrollee’s enrollment status prior to the delivery of non-emergent, covered services. Providers are not reimbursed for services rendered to enrollees who lost eligibility. Enrollee eligibility can be verified through one of the following ways:

• Search member eligibility on the secure provider portal
• Contact Member Services (1-888-784-2693)

The State of Nebraska Medicaid Eligibility (NMES) Line (1-800-642-6092) will also have helpful information regarding the member’s assigned managed care company and program eligibility.
Secure Web Portal
The Secure Web Portal is a web-based platform that allows Aetna Better Health of Nebraska to communicate member healthcare information directly with providers. Providers can perform many functions within this web-based platform. The following information can be attained from the Secure Web Portal:

- **Member Eligibility** – Verify current eligibility of members
- **Panel Roster** – View the list of members currently assigned to the provider as the PCP
- **Provider List** – Search for a specific provider by name, specialty, or location
- **Claims Status Search** – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user’s account provider ID will be displayed
- **Remittance Advice Search** – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user’s account provider ID will be displayed.
- **Authorization List** – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user’s account provider ID will be displayed.
- **Submit Authorizations** – Submit an authorization request on-line
- **Healthcare Effectiveness Data and Information Set (HEDIS)** – Check the status of the member’s compliance with any of the HEDIS measures. A “Yes” means the enrollee has measures that they are not compliant with; a “No” means that the member has met the requirements.
- **Provider and member education and outreach materials**
- **Secure messaging to various departments of Aetna Better Health of Nebraska**

Registration for this secure online tool can be completed by accessing the “For Providers” page at www.Aetnabetterhealth.com/nebraska. You can also contact a Provider Relations representative to sign up over the phone. To submit a registration via fax, download the form from the Aetna Better Health of Nebraska website or request a copy from Provider Relations. Please remember that internet access with a valid e-mail is required for registration.

Note: provider groups must first register a principal user known as the "Provider Representative." Once registered, the “Provider Representative” can add authorized users within each entity or practice.

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

Member Care Web Portal
The Member Care Web Portal is another web-based platform offered by Aetna Better Health that allows members access to Aetna Better Health of Nebraska services and information. The member portal has been customized to better meet their needs. Members will have access to:

- **Health and Wellness Appraisal** – This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. The results will provide a summary of the member’s overall risk and protective factors and allow the comparison of current results to previous results, if applicable. The health assessment can be completed annually and will be accessible in electronic and print formats.
- **Educational resources and programs** – Members are able to access self-management tools for specific topics such as smoking cessation and weight management.
- **Claim status** – Members and their providers can follow a claim from the beginning to the end, including: current stage in the process, amount approved, amount paid, member cost (if applicable) and the date paid.

- **Personalized health plan services information** – Members can request a member ID card, change PCPs and update their address through the web portal (address update is a feature available for members and providers). Members can also obtain referral and information on authorization requirements. And they can find benefit and financial responsibility information for a specific service.

- **Innovative services information** – Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any disease management or wellness programs.

- **Health information Line** – The Informed Health® Line (24-hour nurse line) is available 24 hours a day, 7 days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.

- **Wellness and prevention information** – Member outreach will continue to include reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources and automated outreach efforts with references to web-based self-management tools.

We encourage our providers to promote the use of the member portal during interactions with their patients. Members can sign up online at Aetna Better Health of Nebraska. Or they can call Member Services at **1-888-784-2693 (TTY: 711 or TDD: 1-800-833-0920)**

For additional information regarding the Member Care Web Portal, please access the Enrollee Care Web Portal Navigation Guide located on our website.

**Educating Members**
The federal Patient Self-determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Aetna Better Health shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Nebraska Medicaid Member who is his or her patient:

- For the Nebraska Medicaid Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- For any information the Nebraska Medicaid Member needs in order to decide among all relevant treatment options.
- For the risks, benefits, and consequences of treatment or non-treatment.
- For the Nebraska Medicaid Member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Further, the Aetna Better Health of Nebraska shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. Additionally, each managed care member is guaranteed the right to request and receive a copy of his medical records, and to request that they be amended or corrected as specified in 45 CFR Part 164.

**Primary Care Providers (PCP)**
A health care provider you choose or assigned by Aetna Better Health to give your main health care (i.e. General Practice, Family Practice, Pediatrician, Internal, OB/GYN, Physician Assistant and Nurse Practitioner).
The Primary Care Provider’s role is to:

• Manage and coordinate the overall health care of members
• Make appropriate referrals to participating providers
• Obtain prior authorization for any referrals to non-participating providers
• Provide or arrange for on-call coverage 24 hours/day, 7 days/week
• Accept new members unless Aetna Better Health of Nebraska has been provided with written notice of a closed panel

Specialist Providers

• Agree to discuss treatment of members with the PCP
• Render or arrange any continuing treatment, including hospitalization, which is beyond the specific treatment authorized by the PCP
• Communicate any assessments or recommended treatment plans to the PCP
• Obtain prior authorization for specified non-emergent inpatient and specified outpatient covered services

Specialist Providers Acting as PCP

In limited situations, an enrollee may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. Providers must be enrolled with the State of Nebraska as a PCP. Please contact Provider Relations for additional assistance.

Emergency Services

Authorizations are not required for emergency services. In an emergency, please advise the member to go to the nearest emergency department. If a provider is not able to provide services to a member who needs urgent or emergent care, or if they call after hours, the member should be referred to the closest in-network urgent care or emergency department.

Urgent Care Services

Providers serve the medical needs of our members and are required to adhere to all appointment availability standards. In some cases, it may be necessary to refer members to a network urgent care center (after hours in most cases). Please reference the online directory on the Aetna Better Health of Nebraska website and select an “Urgent Care Facility” in the specialty drop-down list to view a list of participating urgent care centers located in the network.

Periodically, Aetna Better Health of Nebraska will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Skilled Nursing Facility (SNF) Providers

Skilled Nursing Facilities (SNFs) provide services to enrollees that need consistent rehabilitation care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs may provide additional services to meet the special needs of our members.

Home Health and Community Based Services (HCBS)

Home Health and Community Based service often provide services to Aetna Better Health of Nebraska members in their homes.

There may be times when an interruption of service may occur due to an unplanned hospital admission or short-term nursing home stay for a member. While services may have been authorized for caregivers and
agencies, providers should not be billing for any days that fall between the admission date and the discharge date or any day during which services were not provided. This could be considered fraudulent billing. HCBS providers may be required to work with Aetna Better Health of Nebraska Case Managers.

**Medical Home**
The Center for Medical Home Improvement defines as a community-based primary care setting which provides and coordinates high quality, planned, family-centered: health promotion, acute illness care and chronic condition management. Requirements of a medical home include:

- Provide comprehensive, coordinated health care for members and consistent, ongoing contact with members throughout their interactions with the health care system, including but not limited electronic contacts and ongoing care coordination and health maintenance tracking;
- Provide primary health care services for members and appropriate referral to other health care professionals or behavioral health professionals as needed;
- Focus on the ongoing prevention of illness and disease;
- Encourage active participation by an enrollee and the enrollee’s family, guardian, or authorized representative, when appropriate, in health care decision making and care plan development;
- Facilitate the partnership between the members, their personal physician, and when appropriate, the enrollee’s family; and
- Encourage the use of specialty care services and supports.

**Self-Referral/Direct Access**
Aetna Better Health of Nebraska has an open-access network, where members may self-refer or directly access services without notice from their PCP. Aetna Better Health encourages all members to discuss specialty care with their PCP, who can coordinate needed services.

Services must be obtained from an in-network Aetna Better Health of Nebraska provider. There are exceptions to this, however; emergency, family planning, and tribal clinic services do not require prior authorization for in-network or out-of- network providers. Enrollees may access these services from a qualified provider enrolled with the State of Nebraska Medicaid program.

**Second Opinions**
A member may request a second opinion from a provider within our network. Providers should refer the member to another network provider within an applicable specialty for the second opinion.

Aetna Better Health members have the right to a second opinion from a qualified health care professional any time the member wants to confirm a recommended treatment. Aetna Better Health members will incur no expenses other than standard copays for a second opinion provided by a participating provider. Out-of- network services must receive prior authorization and are approved only when an in-network provider cannot perform the service.

**Procedure for Closing a PCP Panel**
A PCP who no longer wishes to accept new Aetna Better Health of Nebraska members may submit a written notification (90 days in advance) to Provider Services. In this situation, any new member who is not an established patient of that PCP cannot select that PCP’s office.

A PCP may re-open a “closed/frozen” panel by submitting a written notification (30 days in advance) to Provider Services. This change will be made on the first of the month following submission of the request. Additional time may be necessary to update printed marketing materials.
When an Aetna Better Health of Nebraska member chooses a PCP who has a “closed/frozen” panel, Customer Service will notify the subscriber of the physician’s panel status. If the physician chooses to make an exception to accept the member, they should contact Member Services for instructions or questions regarding the procedure.

**Non-Compliant Members/PCP Transfer**

Providers are responsible for delivering appropriate services so that our enrollees understand their health care needs. Providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. Aetna Better Health of Nebraska will attempt, through education and case management to resolve difficulties with a member. Please contact Member Services for assistance.

The Nebraska Department of Health and Human Services Managed Care Program has a process in place for the PCP or Aetna Better Health of Nebraska (Health Plan) to request transfers of members to another PCP. (482 NAC 2-003.02) The PCP or Health Plan may request that the Member be transferred to another PCP, based on the following or similar situations:

- The PCP has sufficient documentation to establish that the Member’s condition or illness would be better treated by another PCP;
- The PCP has sufficient documentation to establish that the Member/provider relationship is not mutually acceptable, e.g., the Member is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.;
- The individual physician retired, left the practice, died, etc.;
- Travel distance substantially limits the Member’s ability to follow through the PCP services/referrals; or
- The PCP has sufficient documentation to establish fraud or forgery, or evidence of unauthorized use/abuse of the service by the Member.

The PCP and medical/surgical plan must not request a transfer due to an adverse change in the member’s health, or adverse health status. The above reasons do not include a situation where a PCP has terminated a PCP-member relationship prior to managed care enrollment, unless the PCP can establish that the reason(s) for termination still remains an issue. The criteria for terminating a Medicaid member from a practice must not be more restrictive than the PCP’s general office policy regarding terminations for non-Medicaid members.

**Member Termination Guidelines**

The PCP must follow the following guidelines in order to remove a member from his/her panel:

1. Provider notifies the member in writing within 30 days prior to the termination, by certified mail, of reason for termination and to choose another PCP.
2. Provider is required to maintain responsibility for providing the Medicaid Managed Care benefits to the member until the transfer is completed.
3. Provider sends Aetna Better Health of Nebraska Member Services a copy of the certified letter sent to the member, completed DHHS MS-24 Form, and copies of the documentation of unacceptable behavior.

**Required Documentation**

The PCP must provide the following documentation:

1. A completed DHHS MS-24 PCP Requested Transfer form.
2. Detailed accounting of the reason for the transfer.
3. Detailed accounting of the attempt(s) made by the PCP and Health plan to resolve the issue and work with the member. Before beginning the transfer request process, the PCP and Health plan must make
a serious effort to resolve the problem presented by the member, including warning him/her that his/her continued behavior may result in transfer. The Health plan must offer to discuss the problem and any potential solution with the member, or employ the plan's internal grievance procedure, or both;

4) Documentation that, in spite of reasonable efforts to accommodate the member's medical conditions (physical and behavioral) through service coordination, the member continues to have behavior that is disruptive, unruly, abusive, or uncooperative to the point that his/her continuing participation in managed care seriously impairs the ability of the PCP and Health plan to furnish services to either the member or others;

5) Documentation that the member's behavior has been evaluated to determine if the behaviors are due to a mental illness and whether the condition/behaviors can be treated/controlled through appropriate interventions; or

6) Documentation that the PCP and Health plan has explored appropriate alternatives with the member, and a recommendation as to the most appropriate alternative.

Approval Review Requirements
The Health plan must provide documentation showing attempts were made to resolve the reason for the transfer request through contact with the member or his/her legal representative, the PCP, or other appropriate sources.

The Health plan must document that accommodating the needs of the member would create an undue burden on the PCP and Health plan. Such documentation must include, but is not limited to, the following:

1) The Health plan has made reasonable efforts to locate another PCP within its network;

2) The Health plan does not have any PCPs in its network with special qualifications, as demonstrated by objective credentialing standards and standards for the care and management, to treat a particular condition;

3) The PCP has demonstrated that s/he does not have the requisite skills and training to furnish the care and that s/he has made reasonable efforts to attempt to enlist additional consultation; and

4) The PCP is unable, based on objective evidence, to establish a relationship with a member.

The Health Plan must assist its PCPs and specialists in their efforts to provide reasonable accommodations, e.g., provide additional funding and support to obtain the services of consultative physicians, etc., for members with special needs, e.g., HIV/AIDS.

Processing Procedure for PCP Transfer Requests
The following procedure applies when a PCP requests a transfer:

1) The PCP must contact the Health Plan and provide documentation of the reason(s) for the transfer to another PCP. The PCP must provide a copy of the completed MS-24 Nebraska Health Connection Plan/PCP Requested Transfer form. The Health Plan is responsible for investigating and documenting the reason for the request.

2) The Health Plan must review the documentation and conduct any additional inquiry to clearly establish the reason(s) for transfer;

3) The Health Plan will contact the member to assist them in voluntarily changing PCPs. If the Health Plan is unsuccessful in contacting the Member or the Member will not voluntarily change PCPs, the request is submitted to the Department of Health and Human Services. If the transfer request is for a lock-in member, the Health Plan forwards the request to DHHS. The Health Plan attempts to contact the Member to inform them that they must call DHHS to change their lock-in PCP and assist them in find a new PCP.

4) The Health Plan must submit the transfer request to DHHS within ten days of the request;
5) DHHS approves or denies the transfer request within five working days and responds to the Health Plan.
6) The Member, PCP, and Health Plan are notified by DHHS of the approval or denial of the transfer. The Member and PCP will receive a letter and the Health Plan is notified by fax.
7) If the request is approved, the Health Plan will auto-assign a new PCP for the member. If the transfer request is for a lock-in member the Health Plan lists the member’s PCP as "unassigned" until notified by DHHS that the PCP transfer is complete.

Interim PCP Assignment

The Health plan will be responsible for assigning an Interim PCP in the following situations:

1) The PCP has terminated his/her participation with the Health plan, e.g., PCP retires, leaves practice, dies, no longer participates in managed care;
2) The PCP is still participating with the Health Plan but is not participating at a specific location, i.e., change in location only; or
3) A PCP/plan initiated transfer has been approved (482 NAC 2-003.03A) but member does not select a new PCP.

In all situations, the Health plan is responsible for ensuring a smooth transition for the member through the assignment of an Interim PCP.

The Health plan must immediately notify the member, by mail or by telephone, that the member is being temporarily assigned to another PCP within the same Health plan and that the new PCP will be responsible for meeting the member's health care needs until a transfer can be completed/activated by the Health plan.

Member Notification

The notification sent to member by the Health plan must include the following information:

1) Member name, address and Medicaid number;
2) Reason for the change;
3) Name, address and telephone number of the new PCP;
4) Notification that the member has fifteen calendar days to contact the Health plan if s/he wishes to change the temporary PCP assignment and/or affiliation with the Health plan. If the member does not contact the Health plan to effect a change, the temporary PCP will "automatically" become permanent; and
5) Information on how to contact the Health. If a PCP changes location, the Health plan, after considering the needs of the member, may use its judgment in determining whether the member should be moved with the PCP or remain with a different PCP at the same location. The Health plan must notify the member of the change in location. If the member is not satisfied with the PCP's new location, s/he can request a new PCP in a different location, within the allowed fifteen calendar days.

Exception: If the PCP has actually moved out of state, and the PCP is no longer within coverage distance to the Nebraska Medicaid member, the PCP should be treated as a terminated PCP.

Department and Medical/Surgical Plan Coordination

The actual transfer of the member from the member's current PCP to the medical/surgical plan-designated Interim PCP will be accomplished by the medical/surgical plan and the Department via an exchange of information that will systematically be loaded into the Managed Care File by the Department. This information will be provided by the medical/surgical plan to the Department at the time the member letter is sent out. The Department will process the transfer immediately upon receipt of the information the first month possible, given system cutoff. The member can change the "interim" transfer at any time by following standard transfer procedures.
If a PCP changes location, the medical/surgical plan, after considering the needs of the member, may use its judgment in determining whether the member should be moved with the PCP or remain with a different PCP at the same location.

If the PCP has actually moved out of state, or the PCP is no longer within the availability standard coverage distance to the member, the PCP will be treated as a terminated PCP for that member.

The Department, based on a termination date on the Provider Network File, will automatically change the name of the PCP on the Department’s Internet Access for Enrolled Providers (www.dhhs.ne.gov/med/internetaccess.htm); the Nebraska Medicaid Eligibility System (NMES); the Medicaid Inquiry Line; and on the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) to indicate "Call your plan" (see 471 NAC). This will allow the medical/surgical plan to work with the member in applying the interim PCP regulations, if applicable.

If a medical/surgical plan becomes aware of a member’s desire to change the PCP and/or medical/surgical plan, the member must be referred to the Enrollment Broker Service (EBS). The medical/surgical plan may assist the member in contacting the EBS, but must not be involved in the member's choice. The medical/surgical plan is not required to contact the member during the fifteen calendar days. The effective date to transfer to the Interim PCP will be the date the state approval is received by the Medical/Surgical Plan.

Medical Records Review
All participating Primary Care Practitioners (PCP; defined as family practice, general practice, internal medicine, and pediatrics) who provide medical care in ambulatory settings must comply with the Health Plan’s Medical Record Documentation standards. The following standards are required:

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Annually, the Quality Improvement (QI) department will audit PCP clinics for compliance with the documentation standards. The review of adherence to Clinical Practice guidelines will be incorporated in the medical record review. Written notification of aggregated review results will be provided after the Medical Record audit has been completed.

The QI department will provide routine education to practitioners and their respective clinics. This may include, but is not limited to, articles on the medical record review (MRR) process, highlights of low compliance, adaptation of any universal forms by Aetna Health Care, and updates of any changes within the process and standards. Tools utilized to implement and maintain education may include Provider News (email or fax alerts), provider website, provider handbook, provider newsletters, and mailings.

Providers understand and agree that neither Aetna/Payor nor Members shall be required to reimburse Providers for expenses related to providing copies of patient records or documents to any local, State or Federal agency or Aetna or Payor: (i) pursuant to a request from any local, State or Federal agency (including, without limitation, the Centers for Medicare and Medicaid Services (“CMS”)) or such agencies’ subcontractors; (ii) pursuant to administration of Aetna’s or Payor’s Quality Improvement, Utilization Review, and Risk Management Programs, including the collection of HEDIS data; or (iii) in order to assist Aetna or Payor in making a determination regarding whether a service is a Covered Service for which payment is due hereunder; or (iv) for any other purpose.

All records, books, and papers of Provider pertaining to Members, including without limitation, records, books and papers relating to professional and ancillary care provided to Members and financial, accounting and administrative records, books and papers, shall be open for inspection and copying by Aetna and Payor, its designee and/or authorized State or Federal authorities during Provider’s normal business hours. Provider further agrees that it shall release a Member’s medical records to Aetna and Payor upon Provider’s receipt of a Member consent form or as otherwise required by law. Provider acknowledges that Member has provided consent to release such records to Aetna and Payor when Member enrolls in a Product. In addition, Provider shall allow Aetna and Payor to audit Provider’s records for payment and claims review purposes. Provider further agrees to maintain all such Members’ records for services rendered for a period of time in compliance with state and federal laws.

**Medical Record Audits**

Aetna Better Health of Nebraska or Nebraska Department of Health and Human Services may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, administrative responsibilities or quality of care issues. Providers should respond to these requests promptly. Medical records must be made available to Aetna, Nebraska Department of Health and Human Services, and/or CMS for quality review upon request.

**Access to Facilities and Records**

Federal and local laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to an enrollee or their contract with Aetna Better Health of Nebraska for inspection, evaluation, and audit for the longer of:

- A period of 10 years from the end of the contract with Aetna Better Health;
- The date the State of Nebraska or their designees complete an audit; or
- The period required under applicable laws, rules, and regulations.
Documenting Enrollee Appointments and Eligibility
When scheduling an appointment with a member over the telephone or in person (i.e. when a member appears at an office without an appointment), providers must verify eligibility and document the member’s information in the medical record. Please access the Aetna Better Health Provider Portal to electronically verify eligibility or call the Member Services Department at 888-784-2693.

Missed or Cancelled Appointments
Providers should:
- Document in the member’s medical record, and follow-up on missed or canceled appointments
- Conduct affirmative outreach to an enrollee who misses an appointment by performing minimum reasonable efforts to contact the member
- Notify Member Services when a member continually misses appointments

Please see above regarding non-compliant enrollees.

Health Insurance Portability and Accountability Act of 1997 (HIPAA)
The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit http://www.hhs.gov/ocr/hipaa/. In accordance with HIPAA guidelines, providers may not interview enrollees about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and enrollee information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:
- Train office staff on HIPAA;
- Consider the patient sign-in sheet;
- Keep patient records, papers and computer monitors out of view; and
- Have electric shredder or locked shred bins available.

The following enrollee information is considered confidential:
- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
  - The individual’s past, present or future physical or mental health, or condition.
  - The provision of health care to the individual.
  - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
  - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
— Providers’ offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health.

— Release of data to third parties requires advance written approval from the Department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by enrollees or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this Handbook. For additional information, please visit: [http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Member Privacy Rights**

Aetna Better Health of Nebraska’s privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 CFR (Code of Federal Regulations): relevant sections of the HIPAA that provide enrollee privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health of Nebraska personnel and providers in meeting the privacy requirements of HIPAA when enrollees or authorized representatives exercise privacy rights through privacy request, including:

• Making information available to enrollees or their representatives about Aetna Better Health of Nebraska’s practices regarding their PHI
• Maintaining a process for enrollees to request access to, changes to, or restrictions on disclosure of their PHI
• Providing consistent review, disposition, and response to privacy requests within required time standards
• Documenting requests and actions taken

**Member Privacy Requests**

Members may make the following requests related to their PHI (“privacy requests”) in accordance with federal, state, and local law:

• Make a privacy complaint
• Receive a copy of all or part of the designated record set
• Request amendments/correction to records containing PHI
• Receive an accounting of health plan disclosures of PHI
• Restrict the use and disclosure of PHI
• Receive confidential communications
• Receive a Notice of Privacy Practices

A privacy request must be submitted by the enrollee or enrollee’s authorized representative. An enrollee’s representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the enrollee or the deceased enrollee’s estate. Except for requests for a health plan Notice of Privacy Practices, requests from enrollees or an enrollee’s representative must be submitted to Aetna Better Health in writing.

**Cultural Competency**

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or
population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health expects providers to treat all enrollees with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health of Nebraska has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on enrollees’ diverse backgrounds, including the various cultural, racial, and linguistic challenges that enrollees encounter, and we develop and implement proven methods for responding to those challenges.

Providers may receive education about such important topics as:

• The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage enrollees from such backgrounds to seek needed treatment.
• The impact that an enrollee’s religious and/or cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices).
• The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.).
• History of the disability rights movement and the progression of civil rights for people with disabilities.
• Physical and programmatic barriers that impact people with disabilities accessing meaningful care.

To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ Program. Aetna Better Health supports the Ask Me 3™ Program, as it is an effective tool designed to improve health communication between members and providers. For more information on Ask Me 3™ and office materials, please visit: http://www.npsf.org/for-healthcare-professionals/programs/ask-me-3/

**Health Literacy – Limited English Proficiency (LEP) or Reading Skills**
In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health is required to ensure that Limited English Proficient (LEP) enrollees have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

• Those with limited English proficiency (LEP) or reading skills
• Those with diverse cultural and ethnic backgrounds
• The homeless
• Individuals with physical and mental disabilities
Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health of Nebraska makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible for associated costs.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health of Nebraska Member Services Representatives will assist the provider via a three-way call to communicate in the member’s native language.
- For outgoing calls, Member Services dials the language interpretation service and use an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Aetna Better Health of Nebraska staff (e.g., Case Managers or Member Services) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health to link with an interpreter.

Aetna Better Health of Nebraska provides alternative methods of communication for enrollees who are visually impaired, including large print and/or other formats. Contact our Member Services for alternative formats.

Aetna strongly recommends the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific enrollee needs. Providers must also deliver information in a manner that is understood by the member. If interpreter services are declined, please document this in the members’ medical record. This documentation could be important if a member decides that the interpreter he or she has chosen has not provided him/her with full knowledge regarding his/her medical history, treatment or health education.

During the credentialing process for Aetna Better Health of Nebraska, we ask what other languages are spoken in the office so we may refer our members with special language needs.

**Individuals with Disabilities**
Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician’s office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Site visits may be conducted by our Provider Services staff to ensure that network providers are compliant.

**Receipt of Federal Funds, Compliance with Federal Laws and Prohibition on Discrimination**
Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84;
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91;
- The Rehabilitation Act of 1973;
- The Americans With Disabilities Act;
• Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law;
• The False Claims Act (31 U.S.C. §§ 3729 et. seq.);
• The anti-kickback statute (section 1128B(b) of the Social Security Act); and
• HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

In addition, our network providers must comply with all applicable CMS laws, rules and regulations for the Demonstration Program, and, as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any enrollee on the basis of health status.

Providers shall provide covered services to members that are generally provided by a provider and for which the provider has been credentialed by Aetna Better Health. Such covered services shall be delivered in a prompt manner, consistent with professional, clinical and ethical standards and in the same manner as provided to provider’s other patients. Provider shall accept Members as new patients on the same basis as Provider is accepting non-Members as new patients. Provider shall not discriminate against a member on the basis of age, race, color, creed, religion, gender, sexual preference, national origin, health status, use of covered services, income level, or on the basis that Member is enrolled in a managed care organization or is a Medicare or Medicaid beneficiary.

**Out-of-Network Services**
If Aetna Better Health of Nebraska is unable to provide necessary medical services, covered under the contract, within the network of contracted providers, Aetna Better Health will coordinate these services adequately and in a timely manner with out-of-network providers, for as long as the organization is unable to provide them. Aetna Better Health will provide any necessary information for the member to be able to arrange the service. The member will not incur any additional cost for seeking these services from an out-of-network provider that are coordinated by Aetna Better Health of Nebraska.

**Clinical Guidelines**
Aetna Better Health of Nebraska has Clinical Guidelines and treatment protocols available to providers to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to enrollees and the general community. These guidelines are not intended to:

• Replace the duty of a qualified health professional to provide treatment based on the individual needs of the enrollee;
• Constitute procedures for or the practice of medicine by the party distributing the guidelines; or,
• Guarantee coverage or payment for the type or level of care proposed or provided.

Clinical Guidelines are available on our website at [www.aetnabetterhealth.com/nebraska](http://www.aetnabetterhealth.com/nebraska).

**Financial Liability for Payment for Services**
In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health. However, a network provider may collect deductibles, coinsurance, or copayments from members in accordance with the terms of their member handbook. Providers must make certain that they are:

• Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health, and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health for services furnished by providers that have been authorized by Aetna to service such members, as long as the member follows Aetna’s rules for accessing services described in their Member Handbook.
• Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
• Agreeing to clearly advise a member, prior to furnishing a non-covered service, of the member’s responsibility to pay the full cost of the services.
• Agreeing that when referring a member to another provider for a non-covered service must ensure that the member is aware of his or her obligation to pay in full for such non-covered services.

Health Care Acquired Conditions
Procedures performed on the wrong side, wrong body part, wrong person or wrong procedure are referred to in this policy as “Wrong Site/Person/Procedure,” or WSPPs. Centers for Medicare and Medicaid Services (CMS) has adopted a national payment policy that all WSPP procedures are never reimbursed to facilities. CMS prohibits providers from passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse providers for WSPPs or for any WPSS-associated medical services. In addition, Aetna Better Health prohibits passing these charges on to patients.

HACs are preventable conditions that are not present when patients are admitted to a hospital, but become present during the course of the patient’s stay. These preventable medical conditions were identified by CMS in response to the Deficit Reduction Act of 2005 and meet the following criteria:
1) The conditions are high cost or high volume or both;
2) Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and
3) Could reasonably have been prevented through the application of evidence-based guidelines.

Effective October 1, 2008, CMS will end payment for the extra care resulting from HACs. CMS also prohibits passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse hospitals for the extra care resulting from HACs. In addition, Aetna Better Health prohibits passing these charges on to patients.

General Reminders to All Providers
• Obtain prior authorization from Aetna Better Health of Nebraska for all services requiring prior authorization.
• Referrals to non-participating providers, regardless of level-of-care must be pre-authorized, unless specifically exempted from authorization, such as Family Planning and Emergency services.
• Authorization approval does not guarantee authorized services are covered benefits
• Benefits are always contingent upon member eligibility at the time of service.
• Understand that prior authorization is approved by Aetna Better Health of Nebraska based upon the present information that has been made available to the health plan. Payment for prior-authorized, covered services is subject to the compliance with Aetna Better Health of Nebraska’s Utilization Management Program, contractual limitations and exclusions, and coordination of benefits.
• Accept medical necessity and utilization review decisions; refer to the Grievance and Appeal Section of this provider handbook if a provider disagrees with a review decision or claim that has been processed.
• Agree to collect only applicable copayments, coinsurance and/or deductibles, if any, from members. Except for the collection of copayments, coinsurance and/or deductibles, providers shall look only to Aetna Better Health of Nebraska for compensation for medically-necessary covered services.
• Agree to meet credentialing and recredentialing requirements of Aetna Better Health of Nebraska.
• Providers must safeguard the privacy of any information that identifies a particular member in accordance with federal and state laws and to maintain the member records in an accurate and timely manner.
• Providers shall provide covered benefits and health care services to members in a manner consistent with professionally recognized standards of health care. Providers must render or order only medically appropriate services.

• Providers must obtain authorizations for all hospitalizations and confinements, as well as services specified in this handbook and other provider communications as requiring prior authorization.

• Providers must fully comply with the terms of their agreement and maintain an acceptable professional image in the community.

• Providers must keep their licenses and certifications current and in good standing and cooperate with Aetna Better Health of Nebraska’s recredentialing program. Aetna must be notified of any material change in the provider’s qualifications affecting the continued accuracy of the credentialing information submitted to Aetna Better Health of Nebraska.

• Providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health of Nebraska through the credentialing/recredentialing process. Providers must furnish Aetna Better Health of Nebraska with evidence of coverage upon request and provide the plan with at least fifteen (15) days notice prior to the cancellation, loss, termination or transfer of coverage.

• Providers shall ensure the completeness, truthfulness and accuracy of all claims and encounter data submitted to Aetna Better Health of Nebraska including medical records data required and ensure the information is submitted on the applicable claim form.

• In the event that the provider or Aetna Better Health of Nebraska seeks to terminate the agreement, it must be done in accordance with the contract.

• Providers must submit demographic or payment data changes at least sixty (60) days prior to the effective date of change.

• Providers shall be available to Aetna Better Health of Nebraska members as outlined in the Access and Availability Standards section of this handbook. Providers will also arrange 24-hour, on-call coverage for their patients by providers that participate with Aetna Better Health of Nebraska, as outlined within this handbook.

• Providers must become familiar and to the extent necessary, comply with Aetna Better Health of Nebraska members’ rights as outlined in the “Members Rights and Responsibilities” section of this handbook.

Participating providers agree to comply with Aetna Better Health of Nebraska’s Provider Handbook, quality improvement, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures and any other policies, procedures and programs that Aetna Better Health of Nebraska may implement, including amendments made to the mentioned policies, procedures and programs from time to time, including but not limited to QI activities, maintain the confidentiality of member information and records, and allow Aetna Better Health of Nebraska to use their performance data.

• Providers will ensure they honor all Aetna Better Health of Nebraska members’ rights, including, but not limited to, treatment with dignity and respect, confidential treatment of all communications and records pertaining to their care and to actively participate in decisions regarding health and treatment options.

• Providers of all types may be held responsible for the cost of service(s) where prior-authorization is required, but not obtained, or when place of service does not match authorization. The member shall not be billed for applicable service(s).

• Aetna Better Health of Nebraska encourages providers to contact Provider Relations at any time if they require further details on requirements for participation.

• Contracted practitioners and providers are required to:

  a. **Provider Responsibilities to Aetna Better Health of Nebraska**

Federal Law and Statutes (as outlined in the contract) are detailed below.
Civil Rights, Equal Opportunity Employment, and Other Laws
Provider shall comply with all applicable local, State and Federal statutes and regulations regarding civil rights laws and equal opportunity employment, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act. Provider recognizes that the Nebraska Fair Employment Practice Act prohibits Provider, in connection with its provision of services under this Amendment, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions or privileges of employment because of race, color, religion, sex, disability, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). Provider guarantees its compliance with the Nebraska Fair Employment Practice Act. Breach of this provision shall constitute a material breach of this Agreement.

Debarment and Prohibited Relationships
Provider acknowledges that Aetna Better Health is prohibited from contracting with parties listed on the non-procurements portion of the State of Nebraska’s General Services Administration’s “Lists of parties Excluded for Federal Procurement or Non-procurement Program.” This list contains the names of parties debarred, suspended, or otherwise excluded by State agencies, and contractors declared ineligible under State statutory authority. Provider warrants that it is not on this list at the time of entering into this Amendment. Should Provider’s status with respect to this list change, Provider agrees to notify Aetna Better Health immediately.

Provider acknowledges that Aetna Better Health may not contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. Provider warrants that it is not so excluded. Should Provider’s exclusion status change, Provider agrees to notify Aetna Better Health immediately. Further, Provider shall not employ or contract for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

Provider acknowledges that Aetna Better Health is prohibited from maintaining a relationship with entities that have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, and that Aetna Better Health is prohibited from having relationships with “affiliates” as the term is defined under the Federal Acquisition Regulation. Provider warrants that Aetna Better Health is not prohibited from maintaining a relationship with Provider on these grounds, and Provider agrees to notify Aetna Better Health immediately should its status change.

Federal Sanctions
In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100 - 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program. The Centers for Medicaid and Medicare Services (CMS) requires Aetna Better Health Health Care, Inc. and its subsidiaries to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid. The Controlling Interest Worksheet will be included with the credentialing application, as well as, the recredentialing application. This Form must be completed, signed and dated when returned from the provider.
**Medically Necessary Services**
All Services provided to Medicaid Members must be medically necessary:
- Health care services and supplies which are medically appropriate
- Necessary to meet the basic health needs of the member
- 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 government agencies
- Consistent with the diagnosis of the condition
- Required for means other than convenience of the member 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 intense level of service than can be safely provided

**New Technology**
Emerging technologies are a daily occurrence in health care. Aetna has a Medical Technology Committee to review new and emerging technology. The committee uses evidence-based clinical research to make determinations regarding the efficacy of the new technologies.

**Notice of Provider Termination**
Aetna Better Health will make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. It is the provider’s responsibility to provide timely notification as indicated in the provider contract if they are requesting a termination from the network.

**Healthcare Reform Update Payments Outside the United States**
Effective January 1, 2011, Section 6505 of the Patient Protection and Affordable Care Act prohibits Medicaid health plans from making payments to financial institutions or entities located outside of the United States. This includes payments to physicians, hospitals, and ancillary healthcare providers for items or services provided to Medicaid enrollees through the Aetna Better Health contract with the State of Nebraska. If you or your organization are located outside of the United States, or utilize a financial institution located outside of the United States, your payments will not be sent until you are located in the United States, or in the latter instance, establish a relationship with an entity located in the United States.

**Provider Satisfaction Survey**
Annually, Aetna Better Health of Nebraska will perform a provider satisfaction survey. The survey is sent to providers who have had contact with customer service during the period of time the survey is being conducted, and who have agreed to complete the survey. If you have not been asked to complete the survey and would like to participate, please call customer service at **1-888-784-2693**.

**Enhanced Payments for Primary Care Services**
Effective January 1, 2013, certain physicians and non-physician practitioners who provide eligible primary care services to Aetna Medicaid members are eligible to be paid the Medicare rates in effect in calendar years 2013 and 2014, as implemented by the state Medicaid agency. The enhanced payment rate will only be available for primary care services provided in calendar years 2013 and 2014. Enhanced payment rates will only be made to those physicians, or non-physician practitioners under the supervision of an eligible
physician, who qualify under Section 1902(a) (13) (C) of the Social Security Act and its implementing regulations and who properly complete the self-attestation process.

In order to qualify for the enhanced rates, eligible enrolled Nebraska providers must attest to being a primary care physician by one of the following:

1) Board certification as a primary care physician by the American Board of Medical Specialties (ABMS); the American Board of Physician Specialties (ABPS); or the American Osteopathic Association (AOA); or

2) Have furnished evaluation & management (E&M) and vaccines services (codes specified by federal regulation) that equal at least 60% of the Medicaid codes billed during the most recently completed fiscal year.

For eligible practitioners, the primary care services eligible for the enhanced payment include evaluation and management procedure codes between 99201 and 99499 and vaccine and toxoid administration codes 90460, 90461, 90471, 90472, 40473, 40474, or their successor codes. No other services qualify for the enhanced payment rate. In cases where Aetna does not make payments directly to the rendering practitioner, Provider must fully pass through the enhanced payment to such eligible practitioner.

Aetna retains the right to audit Provider to ensure compliance with this requirement. If Aetna determines through an audit that the enhanced payment has not been passed through to the eligible practitioner, Aetna may take action, including, but not limited to, terminating Provider’s participation in its network. If payments are made to a physician or non-physician practitioner who is later determined to be ineligible, Aetna will recoup the overpayment in accordance with state and federal law.

**Provider Responsibilities to Members**

This section outlines the provider responsibilities to members and to Aetna Better Health of Nebraska members. This information is provided to providers to assist in understanding the requirements in place for the Medicaid Program.

Having a primary care physician is the key to ensuring that every Aetna Better Health of Nebraska member has access to necessary health care and to providing continuity and coordination of care. The member will already have chosen a primary care physician on the date their enrollment is effective. If necessary, Aetna Better Health will assign a primary care physician in the event that no selection is made.

**PCP Qualifications and Responsibilities**

To participate in the as a Nebraska Managed Medicaid provider, the PCP must:

1) Be a Medicaid-enrolled provider and agree to comply with all pertinent Medicaid regulations;

2) Sign a contract with the MCOs physical health plan as a PCP which explains the PCP’s responsibilities and compliance with the following Managed Medicaid requirements:
   a) Treat Managed Medicaid members in the same manner as other patients;
   b) Provide the services in the Basic Benefits Package per 471 NAC to all members who choose or are assigned to the PCP’s practice according to the Enrollment Report and comply with all requirements for referral management and prior-authorization;
   c) Provide the Managed Medicaid member with a medical home including, when medically necessary, coordinate appropriate referrals to services that typically extend beyond those services provided directly by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community based agency services.
d) As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDS, self-referrals for women’s health services, family planning services, etc.;

e) Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24-hour, 7 days per week, access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine that must immediately page an on-call medical professional so referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours;

f) Not refuse an assignment or transfer a member or otherwise discriminate against a member solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when that illness or condition can be better treated by another provider type;

g) Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the physician’s office, e.g., TTY/TDD and language services, to accommodate the member’s special needs.

h) Request transfer of the member to another PCP only for the reasons identified in 482 NAC 2-003.03 and continue to be responsible for the member as a patient until another PCP is chosen or assigned;

i) Comply with 482 NAC 4-002.05 if disenrolling from participation in the NHC and notify the health plan in a timely manner so that an Interim PCP (see 482 NAC 2-003.03E) can be assigned;

j) Maintain a medical record for each member and comply with the requirement to coordinate the transfer of medical record information if the member selects another PCP;

k) Maintain a communication network providing necessary information to any MH/SA services provider as frequently as necessary based on the member’s needs. Note: Many MH/SA services require concurrent and related medical services, and vice versa. These services, include, but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans. The responsibility for coordinating services between the Basic Benefits Package and the MH/SA Package (see 482 NAC 4-004.05), and in sharing and coordinating case management activities, is shared by providers in both areas. A focused effort to coordinate the provision, authorization, payment and continuity of care is a priority for providers participating in the NHC. Each medical/surgical plan must monitor overall coordination between these two service areas (i.e., medical/surgical and MH/SA). The medical/surgical plan must ensure the PCP is knowledgeable about the MH/SA Package and other similar services and ensure that appropriate referrals are made to meet the needs of the member;

l) Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccines for Children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.;

m) Comply with all disease notification laws in the State;

n) Provide information to the Department as required;

o) Inform members about all treatment options, regardless of cost or whether such services are covered by the Nebraska Medical Assistance Program; and

3) Provide accurate information to the health plan in a timely manner so that PCP information can be exchanged with the Department via the Provider Network File

Advanced Directives
Aetna Better Health of Nebraska maintains written policies and procedures related to advance directives that describe the provision of health care when the member is incapacitated. These policies ensure the member’s ability to make known his/her preferences about medical care before they are faced with a serious injury or illness.

Aetna Better Health of Nebraska’s policy defines advance directives as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (statutory or as recognized by the courts of the State) relating to the provisions of health care when the individual is incapacitated. The Advance Directive policy details our obligation for Advance Directives with respect to all adult individuals receiving medical care by or through the health plan. These obligations include, but are not limited to:

- Providing written information to all adult individuals concerning their rights under state law to make decisions concerning their medical care, accept or refuse medical or surgical treatment and formulate Advance Directives for health care.
- Documenting in a prominent part of the individual’s medical record whether the individual has executed an Advance Directive.
- Not conditioning the provision of care or otherwise discriminating against an individual based on whether that individual has executed an Advance Directive.
- Ensuring compliance with requirements of state law concerning Advance Directives.
- Educating Health Plan staff and providers on Advance Directives.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.

Aetna Better Health of Nebraska’s policies provide guidance on Aetna’s obligations for ensuring the documentation of any Advance Directive decisions in the provider’s member records, and monitoring provider compliance with advance directives including the right of the member to note any moral or religious beliefs that prohibit the member from making an advance directive.

Aetna Better Health of Nebraska will ensure that our providers are informed of their responsibilities in regards to advance directives. Our Provider Relations staff educates network providers on information related to advance directives through the Provider Contract, Provider Handbook, provider newsletters and during Provider Relations’ on-site office visits.

The Network Manager is responsible for:

- Ensuring provider contracts contain requirements that support members’ opportunity to formulate advance directives
- Ensuring the Provider Handbook contains guidance on Advance Directives for Aetna Better Health of Nebraska members

Aetna Better Health of Nebraska’s Quality Improvement (QI) staff distributes Medical Record Documentation Standards annually to the providers. One of the Medical Record Documentation standards requires that if a member has an executed Advance Directive, a copy must be placed in the member’s medical record. If the member does not have an executed Advance Directive, the medical record would provide documentation that a discussion regarding Advance Directives has occurred between the provider and the member.

The QI staff monitors provider compliance with the Advance Directive documentation standard during the annual provider medical record audit. The QI staff will review with the VP of Medical Affairs those providers that are found to be non-compliant with the Advance Directive Medical Record Documentation standard. Actions will be determined based off this review. Actions may include, but are not limited to:

- Requesting corrective action plans from the providers
• Sending educational newsletters regarding Advance Directive requirements
• Discussing Advance Directive requirements with the provider
• Coordinating additional provider education during the Provider Relations on-site office visits

Aetna Better Health of Nebraska is committed to ensuring that adult members understand their rights to make informed decisions regarding their health care. Aetna Better Health of Nebraska’s Advance Directives Medicaid Policy and Procedure provides guidance on our obligations for educating members and providers. Aetna Better Health of Nebraska educates providers on advance directives processes to ensure our members have the opportunity to designate advance directives.

At the time of enrollment, the Medicaid Department distributes written information to members on advance directives (including Nebraska State law) through the Member Handbook. The information in the materials includes:
  • Member’s rights under State law, including a description of the applicable State law.
  • Aetna Better Health’s policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
  • The member’s right to file complaints regarding non-compliance with the State survey and certification agency.

Aetna Better Health of Nebraska is responsible to educate members and providers about advance directives rights. The Chief Operating Officer and Compliance Officer are responsible for ensuring advance directives information appears, no less than annually, in our materials. Advance directives information is available in the:
  • Member Handbook
  • Member Newsletter
  • Website
  • Provider Handbook
  • Provider Newsletters

Our case managers educate and offer advance directives information when appropriate. Additionally, providers are audited during on-site reviews to ensure policy and procedure compliance.

**Treatment of a Provider’s Family Members**
Aetna Better Health of Nebraska does not provide benefits or reimburse for the professional services of a provider rendered to a member who is related to the provider by blood or marriage or who lives in the provider’s household. Payments made in error on these claims are subject to refund recovery.
CHAPTER 5 – CREDENTIALING AND PROVIDER CHANGES

Requests for Participation
All potential new practices or non-contracted practitioners who submit a request/application for participation within the provider network(s) of Aetna Better Health of Nebraska are subject to the same processes to ensure consistency is established and followed when making a determination whether a provider’s request for request/application to the network will be accepted or denied.

Aetna Better Health of Nebraska will only accept as participating providers those providers/practitioners:
  1) For which there is a network need
  2) That willingly accept the terms of the negotiated contracts, including reimbursement rates
  3) Who have obtained a Nebraska Medicaid provider ID number from NE DHHS
  4) Successfully pass the health plan's credentialing standards

Once a request is received for provider/practitioner participation within the Health Plan network(s) it will be reviewed for network need.
• If determined there is a network need the provider will be contacted to begin the contracting and credentialing process.
• If it has been determined there is not a network need, the requestor is notified by letter that there is no current need in his/her specialty area and/or in his/her service area. The requestor is also informed that they may request application to the network one year from the date of the notification letter.

CAQH
Aetna Better Health uses current NCQA standards and guidelines for the review, credentialing and re-credentialing of providers and uses the CAQH Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America’s leading health plans collaborating through the Council for Affordable Quality Healthcare, or CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers’ most redundant administrative tasks: the credentialing application process.

The Universal Credentialing DataSource Program allows practitioners to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the practitioners obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the practitioner for the same standard information. Providers update their information on a quarterly basis to ensure data is maintained in a constant state of readiness. CAQH gathers and stores detailed data from more than 600,000 practitioners nationwide. All new providers, (with the exception of hospital and ancillary providers) including providers joining an existing participating practice with Aetna Better Health, must complete the credentialing process and be approved by the Credentialing Committee. Please note: there are non-credentialed provider types who will not be required to complete the CAQH application; please contact Provider Relations for further information.

Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required. Please note providers may NOT treat members until a provider is fully credentialed and an effective date assigned. Providers may be required to be board certified.
Additions or Provider Terminations
In order to meet contractual obligations and state and federal regulations, providers who are in good standing are required to report any terminations or additions to their agreement at least ninety 90 days prior to the change in order for Aetna Better Health to comply with CMS and/or accreditation requirements. Providers are required to continue providing services to enrollees throughout the termination period.

Providers are responsible to notify Provider Services on any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact Provider Relations to discuss staff training, if needed.

State and accreditation guidelines require Aetna Better Health make a good faith effort to provide written notice of a termination of a network provider at least thirty (30) days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating. However, please note that all enrollees who are patients of that PCP must be notified when a provider termination occurs.

Continuity of Care
Providers terminating their contracts without cause are required to provide a sixty (60) day notice (or otherwise determined by their contract) before terminating with Aetna Better Health. Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Providers may also contact our Case Management Department for assistance with continuity of care.

Facility Licensure and Accreditation
Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as otherwise indicated.

Credentialing/Recredentialing
Goal: Use of credentialing and recredentialing procedures to exercise reasonable care in the selection, evaluation and retention of competent, participating providers for use by the plan’s members.

Objectives:
• To establish minimum standards for participation of network providers
• To provide a sufficient number of participating providers by specialty/type to service the plan’s members
• To review, through appropriate application of credentialing standards, on a scheduled basis, at least every three years, network providers’ credentials to assure that minimum standards for participation are maintained
• To apply standards for participation in a uniform and consistent manner
• To initiate and maintain contractual requirements by which participating providers must notify the plan of any changes in status relevant to the credentialing process
• To provide a means whereby issues concerning participating providers and data concerning the level of member satisfaction with participating providers may be brought to the attention of the plan and used during the recredentialing process
• To evaluate and recommend the approval, or denial of all new provider applications
• To evaluate the performance and credentialing information that changes over time
Application Requirements for Ancillary/Facility Providers
Requests for an ancillary/facility application should be directed to the provider relations department. The applicant must provide a completed, signed and dated Aetna ancillary/facility application to Aetna Better Health of Nebraska to properly verify the provider’s qualifications. Ancillary provider sites may require a facility review if they do not hold an acceptable accreditation. In addition to the ancillary/facility application, the following items must be provided:

- Signed Participating Provider Agreements (if applicable)
- List of licensed services offered
- Copy of current Nebraska or applicable License
- Copy of DEA (federal) certificate, if applicable
- Copy of other applicable narcotic certificate (if applicable)
- Copy of professional liability insurance or malpractice coverage
- Copy of accreditation certificate(s)
- Copy of accreditation organization’s letter indicating accreditation level
- Copy of CMS certificate or state audit report
- Copy of full CMS audit report
- Copy of completed IRS W-9 form
- Complete listing of service area, including cities and counties

Site Review
A site review will be conducted in response to member complaints, upon quality reviews, or for unaccredited ancillary/facility providers. The site review includes but is not limited to the following areas:

- Physical access
- Physical appearance
- Office hours
- Adequacy of waiting and examining areas
- Availability of appointments
- Emergency and safety
- Adequacy of equipment
- Emergency medication
- Medical record review

Providers who do not have an acceptable site review may be required to provide a corrective action plan.

Aetna’s Credentialing Policy
Aetna’s credentialing policy has adopted the highest industry standards, which are a combination of URAC/NCQA/CMS plus applicable state and federal requirements. Exceptions to these standards are reviewed and approved based on local access issues determined by the local health plan. Aetna must follow and apply the provisions of state statutes, federal requirements and accreditation standards that apply to credentialing activities.

Statement of Confidentiality
Provider information obtained from any source during the credentialing/recredentialing process is considered confidential and is used only for the purpose of determining the provider’s eligibility to participate with Aetna and to carry out the duties and obligations of Aetna operations, except as otherwise required by law.

Provider information is shared only with those persons or organizations who have authority to receive such information or who have a need to know in order to perform credentialing related functions. All credentialing records are stored in secured/locked cabinets and access to credentialing records is limited to authorized personnel only. Individual computer workstations are locked when employees leave their workstation. Access to electronic provider information is restricted to authorized personnel via sign-on security. All employees are trained and acknowledge training in accordance with federal HIPAA regulations. Disposal of all confidential documents must be via the locked confidential shred receptacles placed throughout the work area.
Non Discrimination
Aetna does not discriminate against any qualified applicant on the basis of race, color, creed, ancestry, religion, age, disability, sex, national origin, citizenship, sexual orientation, disabled veteran, or types of procedures performed or types of patients the practitioner specializes, or Vietnam veteran status, in accordance with Federal, State, and Local laws.

All employees of Aetna Better Health of Nebraska are required to attend online training within 60 days of hire and annually thereafter which requires passing a comprehensive quiz at the end of each training module. This training includes our Code of Business Conduct and Ethics and Unlawful Harassment, both of which address our non-discrimination policies and practices.

The Aetna compliance line 1-888-784-2693, which is available 24 hours per day, 7 days a week has been set up for all employees to call to report compliance matters. All Aetna Better Health of Nebraska employees have been educated on the compliance line and are encouraged to call if they suspect discrimination.

Verification Activity
This section presents the policy, sources, and procedures used by Aetna Better Health of Nebraska for verification activity. Here is a specific checklist the Nebraska health plan utilizes to reflect these standards and to ensure that all applicable verification tasks are completed. The following verification sources and processes apply:

- Complete Application
- Current State Licensure (Primary Source)
- Specialty Board Certification (ABMS) OR
- Residency Program Completion (Primary Source) OR
- Medical School of Graduation (Primary Source)
- Attestation statements signed and dated (within 180 days of the credentialing date)
- Completeness and Correctness of Application & Release of Information (Attestation)
- Verify liability insurance coverage is current (Secondary source, Ins. Carrier face sheet)
- Liability Insurance Coverage in minimum amount of $1/1 million (secondary source, Ins. Carrier face sheet)
- History of loss of admitting facility privileges or disciplinary activity (Attestation)
- Inability to perform essential functions of position (Attestation)
- Lack of present illegal use of drugs (Attestation)
- History of loss of license and/or felony convictions (Attestation)
- NPDB for malpractice history and state and federal sanctions
- DEA or CDS/BNDD (NTIS or Copy of certificate)
- OPM
- Review of Work History for previous 5 years for gaps of 6 months or more.
- Hospital privileges, Secondary (Application)
- Ownership/Controlling Interest

For any questions regarding the credentialing or recredentialing status of a provider, please contact Provider Relations:

Applicant Notification and Rights
Practitioners are notified of their credentialing rights when applying for participation which include the following:
• Each applicant is notified in writing if there is a delay in the credentialing process.

• Practitioners have the right to review the information submitted in support of their Credentialing application. This review is at the practitioner's request and, as applicable, is facilitated by the Network Operations staff and/or Medical Director.
  — Aetna may disclose to the practitioner information obtained from any outside primary source, including but not limited to, malpractice insurance carriers and state licensing boards.
  — Aetna will not disclose to the practitioner information prohibited by law, references, recommendations or other information that is peer review protected.

• Network Operations staff will notify practitioners in writing of any information obtained during the Credentialing process that varies significantly from the information provided to the Health Plan by the practitioner.

• Practitioners have the right, upon request, to be informed of the status of their credentialing application, the process is as follows:
  — Practitioners may contact the Credentialing staff via telephone or in writing and inquire as to the status of their application.
  — Credentialing staff will respond to the practitioner’s request for information either via telephone or in writing of the status of their application.

• Practitioners have the right to correct erroneous information submitted by another party, i.e. information obtained from other sources, that varies substantially from that of the practitioner. When discrepancies are identified, the process is as follows:
  — The practitioner will be notified in writing, within 30 days, from the date Aetna receives this information. CHC will not reveal the source of the information if the information is not obtained to meet organizational credentialing verification requirements or if law prohibits disclosure.
  — The practitioner will submit any corrections in writing, within 15 calendar days, to the Network Operations staff.
  — The Network Operations staff will document in the applicants file the date the information was received by Aetna.
  — All documentation and correspondence relative to this topic will be kept in the applicant's credential file.

• The following is how practitioners are notified of their right to correct erroneous information:
  — Practitioner Application/Practitioner Reappointment Application
  — Aetna Better Health of Nebraska website
  — Provider Manual
Aetna Better Health of Nebraska believes that the essence of a successful Medicaid program is the extent that members understand their benefits and how to access them. We also go beyond simply educating members about covered services, and put incentive programs in place to encourage benefit utilization.

**Covered services**
The table below is directly from the Member’s Handbook.

<table>
<thead>
<tr>
<th>Service or supply</th>
<th>Exclusions or limits</th>
<th>Pre-authorization required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance services—emergency</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Ambulance services—non-emergency</td>
<td>Pre-authorization is needed for ambulance services that are not for emergency care.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Breast pumps</strong></td>
<td><strong>Written prescription needed from your provider.</strong></td>
<td>Yes – for non-portable hospital grade (rented) pumps</td>
</tr>
<tr>
<td>Portable electric pumps and non-portable hospital grade pumps available.</td>
<td>• Limited to 1 per year.</td>
<td></td>
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<tr>
<td></td>
<td>• Non-portable hospital grade pumps are limited to rentals for 12 months and require pre-authorization.</td>
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</table>

*The exclusions and limitations listed in this table are not meant to be a complete list. Please contact Member Services at 1-888-784-2693 (TTY: 711 or TDD: 1-800-833-7352) with coverage questions.*
## Covered services, exclusions and limits

<table>
<thead>
<tr>
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</table>
| Chiropractic services                     | Coverage is limited to manual treatment of the spine and one set of spinal x-rays per year.  
  • Members under age 21 may get up to 25 treatments per benefit year.  
  • Members over age 21 may get up to 12 treatments per benefit year. | May require authorization in certain circumstances. |
| Durable medical equipment (DME) and medical supplies | Items that are for convenience, are not medically needed, or are not ordered by a provider are not covered.  
  Orthotics may not be covered for certain conditions. | Yes, for some equipment and supplies (including any rentals) |
| Early and Periodic Screening, Diagnosis and Treatment (EPSDT) | All children are given the care needed to promote health through the EPSDT Program.  
  Under Aetna Better Health, children may be eligible to receive certain otherwise non-covered services under EPSDT. EPSDT covers medically necessary services, which will cure an illness or condition or at least keep it from getting worse. | No |
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<tr>
<td>Eye care and eye glasses</td>
<td><em>All services must be performed by a licensed Superior Vision provider: optometrist or optician. Call Superior Vision at 1-888-632-3937 (TTY: 711 or TDD: 1-800-833-7352).</em></td>
<td>No</td>
</tr>
</tbody>
</table>
| Exams:                 | *Members under age 21 may get 1 routine eye examination per year.*  
*Members over age 21 may get 1 routine eye examination every 2 years.*  
*Eye exercises (orthoptics) are limited to 22 sessions for members under age 21.*  
| Eye glasses:           | *Members may get 1 pair of covered frames and lens in each 2 year period if certain guidelines are met.*  
*Any upgrades or add-ons are not covered.*  
*Contact lenses for routine vision correction are not covered.* | No                           |
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<td><strong>Family planning services and supplies</strong></td>
<td>Sterilization over age 21 is covered only when:&lt;br&gt;• You request and sign a sterilization consent form at your provider’s office.&lt;br&gt;• It has been 30 days since the sterilization consent form was signed at your provider’s office.&lt;br&gt;• You are mentally Competent&lt;br&gt;Hysterectomies performed solely for the purpose of sterilization are not covered.&lt;br&gt;Treatment of infertility or services to promote fertility is not covered.&lt;br&gt;Abortions are not covered by Aetna Better Health of Nebraska.</td>
<td>No</td>
</tr>
<tr>
<td><strong>Foot care</strong></td>
<td>House calls are only covered if you must stay in bed or if a trip to the foot provider would harm you.&lt;br&gt;The number of routine foot care visits may be limited.&lt;br&gt;Orthotics may not be covered for certain conditions.</td>
<td>No</td>
</tr>
</tbody>
</table>
## Covered services, exclusions and limits

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| Hearing aids and services         | For members age 20 and younger.  
• There are no limits.  
For members age 21 and older:  
• Hearing aids are limited to 1 aid per ear every 4 years.  
• Hearing tests are covered.  
**Non covered:** Accessories that are for convenience or in-the-canal (ITC) or completely in the canal (CIC) hearing aids. | Yes – for cochlear implants |
| High-risk prenatal and infant services | Aetna Better Health’s Healthy Mom, Happy Baby program provides care management for members at risk or who have complex or special health care needs.  
Please contact Member Services for limits.                                                                                           | Plan must be notified        |
| Home health care                  | The care must be prescribed by your provider.  
Your provider must state that you are unable to receive the care at the hospital or at the provider’s office.  
There are other limits to the services that may apply.                                                                                       | Yes                         |
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</table>
| **Inpatient and outpatient hospital care** | Items that are not covered:  
• Any service that is not medically needed.  
• Cosmetic surgery done only to make you look better.  
• Convenience or comfort items.  
• Private room when not medically needed. | Yes                        |
| **Maternity care**                         | Please see your provider as soon as you know you are pregnant.                                                                                                                                                            |                            |
| **Outpatient tests**                       | • Paternity testing is not covered.  
• Services for the treatment of infertility are not covered.  
• Some tests need pre-authorization.                                                                                                                               | Yes                        |
| **Physician services**                     | • Physical – one (1) routine physical exam every 12 months when performed by your PCP.  
• Sports and school physicals annually.                                                                                                                            | No                         |
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<th>Pre-authorization required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private duty nursing</td>
<td>• Private duty nursing care in your home is covered.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• There is a limit to the number of hours that can be used for overnight nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>services and respite care.</td>
<td></td>
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<tr>
<td></td>
<td>• Pre-authorization is needed for all private duty nursing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Work and school schedules may be requested.</td>
<td></td>
</tr>
<tr>
<td>Radiology (X-rays, MRIs, CT scans, PET</td>
<td>• X-rays are covered if they are ordered by a provider.</td>
<td>Yes</td>
</tr>
<tr>
<td>scans)</td>
<td>• Some radiology may need pre-authorization.</td>
<td></td>
</tr>
<tr>
<td>Reconstructive surgery</td>
<td>Any surgery that is performed only to make you look better and is determined to be</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>cosmetic is not covered.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility care</td>
<td><strong>Items that are not covered:</strong></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• Any service that is not medically needed.</td>
<td></td>
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<tr>
<td></td>
<td>• Convenience or comfort items.</td>
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<td></td>
<td>• Private room when not medically needed.</td>
<td></td>
</tr>
<tr>
<td>Service or supply</td>
<td>Exclusions or limits</td>
<td>Pre-authorization required</td>
</tr>
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<tr>
<td>Sterilization services</td>
<td>Sterilizations (male and female) require completion of informed consent forms at least 30 days prior to the date of the procedure. Hysterectomies are not covered if: • The sole purpose was to make the woman sterile. • The woman is under the age of 21. • The woman is legally not able to consent to the sterilization.</td>
<td>No</td>
</tr>
<tr>
<td>Therapy services (physical, speech, occupational, PT/OT/ST)</td>
<td>There is a limit of 60 therapy sessions per benefit year for physical therapy, occupational therapy, and speech therapy services combined for members 21 and older. <strong>Non-covered:</strong> • Maintenance therapy • Therapy for delays in speech that is not due to a specific disease or brain injury</td>
<td>Yes for members under 21 years of age.</td>
</tr>
</tbody>
</table>
Copayments
Some services require a copayment. A copayment is the part of the medical bill that you pay. A copayment is usually only a small amount of the cost of the service. Providers will ask the member for the copayment amount at the time of the member’s visit or when the member gets services.

Some members 19 years old and over will have a copayment when they have certain medical services.

Some members are not required to have a copayment. These are:
- Children 18 years and younger
- Pregnant women through 60 days after delivery
- American Indian or Alaskan Native
- Members living in state defined living arrangements

Many services do not have a copayment. Some of them are:
- Primary care provider (PCP) office visits
- Maternity care
- Family planning services
- Emergency services/urgent care

<table>
<thead>
<tr>
<th>Covered services, exclusions and limits</th>
</tr>
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<tbody>
<tr>
<td>Service or supply</td>
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<tr>
<td>Tobacco cessation—stop—smoking program</td>
</tr>
<tr>
<td>Transplants</td>
</tr>
<tr>
<td>Urgent care</td>
</tr>
</tbody>
</table>
• Immunizations
• Allergy services at the member’s PCP office
• Sports and school physicals

Member Communications
Aetna Better Health of Nebraska has numerous ways to inform enrollees about covered health services. Communication tools are written at a sixth grade reading level. Some are available in alternate formats and in non-prevalent languages. The documents include:
• Member Handbook — A comprehensive members document that explains all covered benefits and services and exclusions and limitations.
• Public Website — General information and Member Handbook are available online.
• Member online portal — A web portal providing members easy access to health care information and materials. The member portal is a secure, password-protected site that ensures confidential information is only available to the member.
• Member newsletter — Member publication featuring articles about covered services such as immunizations, well-child checks, urgent and emergency care, mammograms, etc.

Aetna Better Health of Nebraska’s teams also communicate covered benefits and services to members on a regular basis.
• Member Services — Representatives are trained and dedicated to Nebraska’s Medicaid line of business. Service representatives describe benefits to members and answer questions. Interpretation services are available in several languages.
• Appeals and Grievances processes.
• Case Management staff.
• Prior authorization team.
• Outreach Coordinators — Our community partners help support our members’ understanding of Medicaid covered services.
• Network Providers — Training materials and the Provider Handbook include Nebraska Medicaid covered services information.
• Member Advisory Board — An integrated health plan and member committee that meets regularly to learn about Aetna Better Health of Nebraska benefits and services, and to provide feedback on Aetna Better Health of Nebraska materials, providers, and service.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
Early and periodic screening, diagnosis, and treatment (EPSDT) is a federally-mandated comprehensive child health program for Medicaid members. Aetna Better Health provides or arranges for EPSDT services for Aetna Better Health Medicaid members under the age of 21.

Our members are educated about EPSDT through the member handbook, the member newsletter, and a member reminder system.

Network providers are subject to Aetna Better Health’s documentation requirements for EPSDT services. EPSDT services shall also be subject to the following additional documentation requirements: 1) The medical record shall include the age-appropriate screening provided in accordance with the periodicity schedule. 2) Documentation of a comprehensive screening shall at a minimum, contain a description of the components described below. Aetna Better Health recommends that providers send reminders to parent when screenings, immunizations, and follow-up services are due.
**Screenings**

Providers should use the following guidelines to provide comprehensive EPSDT services to Aetna Better Health members.

Comprehensive, periodic health assessments or screenings, from birth through age 20 at intervals which meet reasonable standards of practice, as specified in the EPSDT medical periodicity schedule established by DHHS. The medical screening shall include:

- A comprehensive health and developmental history, including assessments of both physical and mental health development.
- A comprehensive unclothed physical examination, including vision and hearing screening, dental inspection and nutritional assessment.
- Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations must be administered.
- Appropriate laboratory tests at participating lab facilities. The following recommended sequence of screening laboratory examinations should be provided by Aetna Better Health’ participating providers; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.
  - Hemoglobin/hematocrit.
  - Urinalysis.
  - Tuberculin test.
  - Blood lead assessment using blood level determinations as part of scheduled periodic health screenings appropriate to age and must be done for children according to the following schedule:
    - Between 12 months and 24 months of age.
    - Between 36 and 72 months of age if the child has not previously been screened for lead poisoning.
    - All screenings shall be done through a blood lead level determination.
- Results of lead screenings, both positive and negative results, shall be reported to the local Department of Health.
- Health education/anticipatory guidance.
- Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected.
- EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the following schedule:
  - Neonatal exam.
  - Under 6 weeks.
  - 2 months.
  - 4 months.
  - 6 months.
  - 9 months.
  - 12 months.
  - 15 months.
  - 18 months.
  - 2 years.
  - 3 years.
  - 4 years.
  - 5 years.
  - Bi-annually from age 6 through 20 years for Medicaid.
  - One routine physical per calendar year.
Vision Services
Participating providers should perform periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum according to DHHS’ EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

Hearing Services
All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who do not pass the newborn hearing screening, those who are missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Participating providers should perform periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in DHHS’ EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant’s response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

Dental Services
Dental screening in this context shall mean, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. A referral to a dentist at or after one year of age is recommended. A referral to a dentist shall be mandatory at three years of age and annually thereafter through age 20 for Medicaid members.

Other Services
Participating providers should perform such other medically necessary health care, diagnostic services, treatment, and other measures as needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Direct Access to Care

Direct Access to Women’s Health Specialist
Aetna Better Health provides female members direct access to women’s health specialists for routine and preventive health care services. Routine and preventive health care services include, but are not limited to prenatal care, breast exams, mammograms and pap tests. Direct access means that Aetna Better Health cannot require women to obtain a referral or prior authorization as a condition to receiving such services from specialists in the network. Direct access does not prevent Aetna Better Health from requesting or requiring notification from the practitioner for data collection purposes. They may also seek these services from a participating provider of their choice, if their primary care provider is not a women’s health specialist.

Women’s health specialists include, but are not limited to, obstetricians, gynecologists and certified nurse midwives.

Direct Access for Family Planning Services
Aetna Better Health members have direct access for family planning services without a referral and may also seek family planning services at the provider of their choice.

The following services are included:

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• Annual gynecological exam
• Annual pap smear
• Lab services
• Contraceptive supplies, devices and medications for specific treatment
• Contraceptive counseling

Direct Access for Treatment for STDs
Aetna Better Health members can access any participating provider or Nebraska Medicaid provider for treatment of a sexually transmitted disease without prior approval from Aetna Better Health.

Direct Access for American Indians and Alaskan Natives
Aetna Better Health members that are an American Indian or Alaskan Native, may receive services from a tribal clinic or Indian Health Services without pre-authorization. These members may choose an Indian Health Service, tribal clinic provider, or Urban Indian Health Clinic as a PCP if the member is a registered American Indian or Alaskan Native.

Direct Access for Chronic or Severe Illness
Aetna Better Health members who have a chronic or severe illness, e.g. HIV/AIDS, can receive health care services without prior approval from Aetna Better Health. Contact Provider Services for additional information.

Newborns
Charges for newborn services must be billed on a separate claim from the mother’s claim. Claims received with mother and baby charges submitted on the same claim will reject and be sent back to the provider as denied for inconsistency with member’s age or sex. The provider would need to resubmit the claim with the mother’s charges on one claim, and the baby’s on another.

Transportation
Arrangements for transportation services are provided through a DHHS vendor. Members should call 402-401-6999 or 1-844-531-3783 to inquire about covered transportation services.

For Medicaid members, transportation is available for all covered services whether the service is reimbursed by Aetna Better Health of Nebraska or fee-for-service Medicaid through DHHS. Transportation includes: public transportation; taxicab; ambulance, and a wheelchair van. Aetna Better Health covers air travel for critical medical needs.

Members are required to take the least expensive mode of transportation. If a member is not able to use the least expensive mode of transportation, which is generally public transportation they will be asked to have their physician complete a form explaining the need for a different type of transportation.

Guidelines to determine transportation necessity:
• Transportation is only covered when no other means is available to the member. This includes the member not having a car that runs.
• Three day notice is need for non-urgent appointments
• Transportation is covered to the nearest available source of care capable of providing for the member’s medical needs. For transportation purposes, the nearest provider of care is defined as:
  — One who normally serves the community where the member resides. In most cases, the transportation should be within the city or county where the member resides unless transportation to another city or county would be less costly, or
— The closest provider of specialized care required by the member’s medical needs, or
— The provider of services with whom the member has maintained a long term relationship.

Transportation to the physician’s or other medical provider’s office is covered when it is within a reasonable distance from the member’s home.

For additional considerations regarding transportation, please contact the State of Nebraska DHHS or the transportation vendor.

Abortions
Nebraska Department of Health and Human Services covers medical procedures and abortions only when the life of the mother would be endangered if the fetus were carried to term. A physician shall certify the diagnosis by medical reports which include the name and address of the member. The treating physician shall request and receive prior authorization before providing the service from:

Medical Director Medicaid Division
Nebraska Department of Health and Human Services
Finance and Support
301 Centennial Mall South, Fifth Floor
P.O. Box 95026
Lincoln, NE 68509

If approved, DHHS sends a letter of authorization to the provider and retains one copy of the letter of authorization. In cases of documented emergencies, authorization may be requested after the service has been provided.

Required Forms:
The provider shall submit a copy of the notification of authorization with all claims (surgeon, assistant surgeon, anesthesiologist, and hospital) submitted for abortions to DHHS.

Sterilizations
Age Requirement: The Nebraska Medical Assistance Program (NMAP) is prohibited from paying for sterilization of individuals who are:

• Under the age of 21 on the date the member signs Form MMS-100; or
• Legally incapable of consenting to sterilization.

Coverage Conditions: NMAP covers sterilizations only when:

• The sterilization is performed because the member receiving the service made a voluntary request for services;
• The member is advised at the outset and before the request or receipt of his/her consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized;
• Members whose primary language is other than English must be provided with the required elements for informed consent in their primary language.

Procedure for Obtaining Services: Non-therapeutic sterilizations are covered by Aetna Better Health of Nebraska only when:

• Legally effective informed consent is obtained on Form MMS-100, "Consent Form," from the member on whom the sterilization is to be performed. The surgeon shall submit a properly completed and legible Form MMS-100 to Aetna Better Health before payment of claims can be considered; and
The informed consent must be signed at least 30 days prior to the sterilization procedure. To calculate this time period, day 1 is the first day following the date on which the form is signed by the member. Day 31 in this period is the first day on which the procedure could be covered by NMAP. The consent is effective for 180 days from the date Form MMS-100 is signed. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since s/he signed the informed consent for the sterilization. For a premature delivery, the member must have signed the informed consent at least 72 hours before the surgery is performed and at least 30 days before the expected date of delivery; the expected delivery date must be entered on Form MMS-100.

Informed Consent
Informed consent means the voluntary, knowing assent of the member who is to be sterilized after s/he has been given the following information:

- A clear explanation of the procedures to be followed;
- A description of the attendant discomforts and risks;
- A description of the benefits to be expected;
- Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure;
- An offer to answer any questions concerning the procedures; and
- An instruction that the individual is free to withhold or withdraw his/her consent to the sterilization at any time before the sterilization without prejudicing his/her future care and without loss of other project or program benefits to which the member might otherwise be entitled.

This information is shown on Form MMS-100, which must be completed by the member. The consent form must be submitted with the claim form.

Sterilization Consent Forms
Form MMS-100, "Sterilization Consent Form," is included in this manual, please see the Forms Section. It may also be ordered by the physician directly from the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, or from the local HHS office. The surgeon shall submit a properly completed and legible Form MMS-100 to Aetna Better Health before payment of claims can be considered.

Hysterecromies
Aetna Better Health covers hysterectomies when medically necessary. For payment of claims for hysterectomies (hospital, surgeon, assistant surgeon, anesthesiologist), the surgeon shall submit to Aetna Better Health, Form MMS-101, "Informed Consent Form," properly signed and dated by the member in which she states that she was informed before the surgery was performed that this surgical procedure results in permanent sterility before claims associated with the hysterectomy can be considered.

Exception: Aetna Better Health does not require informed consent if

- The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was already sterile before the hysterectomy and states the cause of the sterility.
- In the case of a post-menopausal woman, the Department considers the woman to be sterile. All claims related to the procedure must indicate that the member is post-menopausal.
- The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible, and the physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which s/he determined prior acknowledgment was not possible. The physician must also include certification of the emergency.
A copy of the physician’s certification regarding the above exceptions must be submitted to Aetna Better Health before consideration for payment for claims associated with the hysterectomy can be submitted.

Non-Covered Hysterectomies
Aetna Better Health shall not cover a hysterectomy if
• It was performed solely to make the woman sterile; or
• If there was more than one purpose for the procedure, it would not have been performed except to make the woman sterile.

Emergency Services
Prior-approval by the member’s primary care physician and medical/surgical plan is not required for receipt of emergency services. Education to the member is necessary to ensure they are informed regarding the definition of an "emergency medical condition," how to appropriately access emergency services, and encourage the member to contact the PCP and medical/surgical plan before accessing emergency services. Aetna Better Health Customer Services and Medical Management will also assist in educating members regarding Emergency Services.

An emergency medical condition is a medical condition, which manifests itself by acute symptoms of sufficient severity, (including severe pain), that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in

a) 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;

b) Serious impairment to bodily functions; or

c) Serious dysfunction of any bodily organ or part.

Extra Benefits
• Adult flu shots
• Routine adult immunizations
• Routine adult checkups
• Referrals not needed to see an in-network specialty care provider/specialist
• Disease management programs
  – Asthma
  – Congestive heart failure
  – Coronary artery disease
  – COPD
  – Diabetes
  – Hypertension
  – Obesity
• Informed Health® Line (24-hour Nurse Line) 1-877-620-1945 (TTY: 711)
• Pregnancy programs:
  – Healthy Mom, Happy Baby
  – Portable Crib program
  – After-baby delivery care program
  – Healthy Mom Gift Card program
  – Childbirth education classes
  – High-risk pregnancy program
  – Text4baby text messaging program
  – Breast pump coverage
- Member Advisory Board: This committee allows Aetna Better Health to hear from members about how we can better serve you. For more information, call
- Member Services at 1–888–784–2693 (TTY: 711 or TDD: 1–800–833–7352)
- Member ID card
- Member newsletter
- Online access to health information www.aetnabetterhealth.com/nebraska
- Preventive health education mailings

Aetna Better Health of Nebraska also offers, programs that incent, empower and motivate members to participate in programs such as EPSDT and maternity care. The intent of an incentive program is to encourage members to participate in preventive health care, getting early diagnosis and treatment before health issues escalate.

Many community organizations also provide incentive programs for Medicaid members taking steps towards healthier lifestyles. These programs award families with active program participation “points” to use towards baby and children items such as diapers, books and baby equipment.

24-hour Informed Health® Line (24-hour nurse line)
Aetna Better Health of Nebraska provides a free 24 informed health line for members. Informed Health Line services are provided based on the answers to the questions in the algorithms, the nurse can help the member decide if the member needs to go to the hospital, urgent care facility, or to their doctor or if the member can care for him or herself or family member at home. The call center is staffed seven (7) days a week, twenty-four (24) hours a day, including holidays and can be reached at 1-877-620-1945 (TTY: 711).

Healthy Mom Happy Baby Program
To help promote a healthy pregnancy, Aetna Health Care of Nebraska, Inc. has developed a Healthy Mom Happy Baby Program for its expectant members. Healthy Basics encourages prenatal care and a healthy lifestyle, provides educational material and identifies pregnancies that may be of greater than average risk. Healthy Basics is a free enhancement to the regular obstetrical care mothers receive during pregnancy. Expectant members are enrolled in this program when Aetna Better Health of Nebraska is notified of the pregnancy.

To enroll expectant mothers into the Health Basics for a Health Baby Program the member’s OB/GYN can contact Aetna Better Health Case Management.

Pharmacy
Aetna Better Health of Nebraska does not currently contract with the State of Nebraska for retail pharmacy benefits. Please contact the State of Nebraska for further information regarding pharmacy benefits for Nebraska Medicaid members.

Vaccines
Preventive medicine is a high priority for Aetna Better Health of Nebraska. Not only do vaccines provide quality health care, childhood immunizations are perhaps one of the most cost effective forms of medical care available. Aetna supports the CDC Advisory Committee on Immunization Practices (ACIP) guidelines for pediatric vaccine administration. Pediatric vaccination rates are also a quality performance measure under HEDIS, and we are striving for 100% compliance with this standard.
Aetna Better Health of Nebraska follows the CDC recommendations for required immunizations for both adults and children/adolescent. To access copies of these schedules providers may access the links provided below:
Immunization Schedule:  http://www.cdc.gov/vaccines/schedules/index.html

Vaccines For Children (VFC) Program
Aetna Better Health of Nebraska facilitates the payment of allowable fees for the administration of childhood immunizations to see that vaccines administered to enrolled and eligible members under the Vaccines For Children (VFC) program are appropriately reimbursed. Aetna Better Health will reimburse participating providers for administration costs for vaccines provided to eligible members under the VFC program. Please check VFC program eligibility with the State of Nebraska.

Vision
Aetna Better Health of Nebraska contracts with Superior Vision for routine vision services to our members. Superior Vision maintains a network of providers and reimburses for routine vision services only. Services which are medical in nature should be billed to the medical benefits under Aetna Better Health of Nebraska.

Dental
The State of Nebraska Medicaid program is currently the carrier for dental services. Please contact the State of Nebraska for further information regarding dental benefits for Aetna Better Health of Nebraska and Nebraska Medicaid members.

Behavioral Health and Substance Abuse
Aetna Better Health of Nebraska does not currently contract with the State of Nebraska for behavioral health, mental health or substance abuse services. Magellan is currently the behavioral health managed care carrier. Please contact Magellan or the State of Nebraska for further information regarding behavioral health and substance abuse benefits for members.

Interpretation Services
Please see Interpretation Services section in Provider Responsibilities and Important Information chapter.
CHAPTER 7 – MEMBER ELIGIBILITY AND ENROLLMENT

Eligibility
Eligibility determinations are made by the State of Nebraska Medicaid program prior to enrollment with a managed care plan, including Aetna Better Health of Nebraska. Any coverage prior to the enrollment effective date with Aetna Better Health of Nebraska is also determined by the State of Nebraska Medicaid program.

Nebraska operates a program of mandatory participation in a managed care program for the following groups of members:

• Families, children, and pregnant women eligible for Medicaid.
• Blind/Disabled Children, Adults, and Related Populations who are eligible for Medicaid due to blindness or disability.
• Aged and Related Populations. Those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population.
• Foster Care Children
• Children’s Health Insurance Program (CHIP)
• Medicaid members who have certain other health insurance, excluding Medicare. Certain children with disabilities who are receiving in-home services, also known as the Katie Beckett program.
• Medicaid members who have other health insurance.

Within the groups identified above, the following groups of members are currently excluded from managed care:

• Medicaid members who have Medicare.
• Medicaid members who reside in Nursing Facilities at custodial levels of care or in Intermediate Care Facilities for the intellectually disabled.
• Medicaid members enrolled in the Enhanced Care Coordination (ECC) program.
• Medicaid members who participate in a Home and Community Based Services Wavier (HCBS). This includes adults with mental disabilities or related conditions, aged persons or adults or children with disabilities, children with mental retardation and their families, members receiving Developmental Disability Targeted Case Management Services, Traumatic Brain Injury waiver recipients and any other group for whom the State has received approval of the 1915(c) waiver of the Social Security Act.
• Members residing out-of-state or those who are considered to be out-of-state (i.e., children who are placed with relative out-of-state or those who are designated as such by DHHS personnel).
• Undocumented Residents who are eligible for Medicaid for maternity or an emergency condition only.
• Members participating in the Refugee Resettlement Program.
• Members who have excess income or who are designated to have a Premium Due.
• Members participating in the State Disability Program.
• Members eligible during the period of presumptive eligibility.
• Organ transplant recipients from the day of transplant forward.
• Members who have received a disenrollment/waiver of enrollment.
• Members who are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000.
• Members receiving Medicaid Hospice Services.
• Individuals who are patients of Institutions of Mental Disease (IMD) who are between the ages of 21-64.
• Participants in subsidized adoption programs.
Verification of Eligibility
Member eligibility and enrollment can and should be confirmed by utilizing one of several methods:
- Nebraska Medicaid Eligibility System 1-800-642-6092
- Provider web portal eligibility search
- Member Services at 1-888-784-2693

Enrollment
Upon initial eligibility determination and during the annual enrollment period for Medicaid, members wishing to select a managed care program can contact the enrollment broker for the State of Nebraska.

Identification Cards
Members are provided an ID card from the State of Nebraska. Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled in the Aetna Better Health of Nebraska plan. An ID card will be mailed to each new member when a PCP is selected or assigned.

Members are told to keep the identification card with them at all times. If the card is lost or stolen, the member should call Member Services immediately to get a new card.

The Aetna Better Health of Nebraska identification card will include the following information:
- Aetna Better Health’ name
- Member name
- Member/State Medicaid ID number
- Primary care provider name
- Primary care provider telephone number
- Member Services telephone number
- Claim submission information
- 24-hour Informed Health® Line (24-hour nurse line) telephone number

Member Services
Member Services provides information for members on eligibility, benefits, grievances, education and available programs. Member advocates can provide services for members having trouble with their health care needs, finding providers, filing grievances or appeal, as well as assist providers with non-compliant members and/or discharges.

Member Services can be reached at 1-888-784-2693.

PCP Assignment
Each Aetna Better Health of Nebraska member is assigned a PCP. Members are allowed to select a PCP at the time of enrollment. Members or their representatives may change their PCP voluntarily at any time by contacting Member Services. For involuntary termination of a PCP, please see Non-Compliant Members/PCP Transfer in Provider Responsibilities and Important Information chapter.

**Member Rights and Responsibilities**

Members of Aetna Better Health of Nebraska have the right to:

- Choose a primary care provider (PCP) as the member’s medical home.
- Be treated with respect, dignity and privacy.
- Be free from any form of restraint and or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Get covered benefits or services regardless of gender, race, ethnicity, age, religion, national origin, sexual orientation, physical or mental disability, type of illness or condition, genetic information, ability to pay or ability to speak English.
- Not have the member’s medical records shown to others without the member’s approval, unless allowed by law.
- Privacy when the members are at an office visit, getting treatment or talking to the health plan.
- Seek advice and help.
- Receive considerate, respectful, timely, and appropriate care, treatment and services for physical and emotional problems.
- Tell us ways to improve our policies and procedures, including the Member Rights and Responsibilities.
- Request additional information about the structure and operation of Aetna Better Health.
- Receive information regarding physician incentive plans, if applicable.
- Be involved in deciding on the kind of care the member wants or does not want.
- Get information about Aetna Better Health, the services we cover, the providers who provide care, and the Member’s Rights and Responsibilities, annually.
- Have the member’s provider tell how he or she plans to treat the member:
  - The member’s provider should tell the member if other treatments can be used and the risks for each one no matter how much they cost or if we will pay for it. This information should be easy to understand.
- Receive and understand current information concerning your diagnosis, treatment and prognosis.
- Receive considerate, respectful, timely and appropriate care, treatment and services for physical and emotional problems.
- Get guidance for more medical care if the member’s health care coverage ends.
- Find out what is in the member’s medical records, as allowed by law, and request a copy of the member’s records. The member may be charged for this.
- Ask that changes be made to the member’s medical records, if there are any errors on the records.
- Voice the member’s complaints, grievances and appeals, and or request a State Fair Hearing about Aetna Better Health and the care the member receives from a provider.
- Know how Aetna Better Health pays providers, controls costs and uses services.
- Say no to treatment, services or PCPs, and be told what may happen if the member does not have the treatment:
  - The member can continue to get Medicaid and medical care without any repercussions even if the member says no to treatment.
- Get information about changes in benefits at least 30 days before the change.
- Ask for an emergency transfer from the member’s PCP if the member’s health or safety is in danger.

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• Ask for materials to be presented in a manner or language that the member understand at no cost to the member, including enrollment notices, informational materials, instructional materials and treatment options.

• Have managed care and health plan materials explained if the member does not understand.

• Get a full description of the member’s disenrollment rights at least once a year.

• Get interpretation services if the member does not speak English or have a hearing impairment to help you get the medical services you need at no cost.

• Get services that are correct. They should not be denied or reduced because of the member’s diagnosis, type of illness or medical condition.

• Exercise the member’s rights. It will not affect the way Aetna Better Health, our providers or ACCESSNebraska agency treats the member.

• Pick a provider who works with Aetna Better Health’s provider network.

• Know the cost to the member if the member chooses to get a service we do not cover.

• Get a second opinion from a qualified participating health care professional at no cost to the member.

  — If an Aetna Better Health provider is not available, we will help the member get a second opinion from a non-participating provider at no cost to the member.

• Use the methods listed in this Handbook to share questions and concerns about the member’s health care or Aetna Better Health.

• Develop advance directives or a living will, which tell how to have medical decisions made for the member if not able to make them for themselves.

• Get emergency health care services without the approval of your primary care provider (PCP) or Aetna Better Health when the members have a true medical emergency.

• Be told in writing by us when any of the member’s health care services requested by a PCP are reduced, suspended, terminated or denied. The member must follow the instructions in their notification letter.

• Receive reasonable continuity of care.

• Respect and privacy.

• Be free from restraints.

• Have privacy in the member’s room.

• Receive a timely, courteous and reasonable response from Aetna Better Health, health care providers and staff.

• Receive requests or grievances - in writing, if requested.

• Manage the member’s own financial affairs.

• Be fully informed of all rights and responsibilities.

• Receive a written itemized statement of charges and services.

• Inspect all records pertaining to the member.

The responsibilities of an Aetna Better Health of Nebraska member are to:

• Tell us and ACCESSNebraska about changes in the member’s family that might affect eligibility or enrollment:

  — Some examples are change in family size, employment and moving out of the state of Nebraska.

• Tell us and ACCESSNebraska when the member’s name, telephone number or address changes.

• Treat Aetna Better Health staff and the member’s health care providers with respect and dignity.

• Protect the member’s member identification (ID) card: Do not lose or share it with others.

• Call Member Services if you lose the member’s Aetna Better Health Member ID card or if it is stolen.

• Show the member’s identification (ID) card to each provider before getting health services.
• Make and keep appointments with your providers: If the member needs to cancel an appointment, it must be done at least 24 hours before the scheduled visit.
• Get medical care from in-network providers. This does not include care for family planning or for emergencies, which may be provided by out-of-network providers.
• Follow what the member and the member’s provider agree to do: Make follow-up appointments.
• Take medicines and follow provider’s care instructions.
• Use the emergency room (ER) for true emergencies only.
• Give all information about the member’s health to Aetna Better Health and the member’s provider.
• Understand what medicine to take.
• Tell the member’s provider if the member does not understand what he or she says about the member’s health so that the member and the member’s provider can make plans together about the member’s care.
• Read this Member Handbook:
  — It tells the member about Aetna Better Health services and how to file a complaint or grievance.
• Follow Aetna Better Health rules.
• Know the name of the member’s assigned PCP.
• Schedule wellness checkups: Members under 21 years of age need to follow the Early Periodic Screening Diagnosis and Treatment (EPSDT) schedule.
• Get care as soon as the member knows they are pregnant: Keep all prenatal appointments.
• Tell us if the member has other health insurance, including Medicare.
• Give the member’s provider a copy of any living will and/or advance directive.

Members have a responsibility to follow Aetna Better Health of Nebraska rules. Aetna Better Health of Nebraska may ask for members to be disenrolled if they do not follow the rules. Our Member Rights and Responsibilities statement is updated each year. For more information on rights and responsibilities, call Member Services at 1-888-784-2693 (TTY: 711 or TDD 1-800-877-8973). Aetna Better Health of Nebraska does not take action against members who exercise their rights.

Members with Special Health Care Needs
For members determined to need a course of treatment or regular care monitoring, Aetna Better Health of Nebraska will allow the member to directly access a specialist or select a specialist as a PCP to appropriately identify and serve the needs and conditions of the member.

The following procedure applies when a member, PCP, medical/surgical plan, or other person on behalf of the member requests such an arrangement:
• The requester must contact Enrollment Broker Services (EBS) and provide documentation, in the form of a letter, stating the reason(s) for the request;
• The EBS must review the documentation and conduct any additional inquiry to clearly establish the reason(s) for request;
• The EBS must submit the request to the medical/surgical plan within two days of the request;
• The medical/surgical plan approves or denies the request within five working days and responds to the EBS, along with written justification in the case of a denial, and alternatives for the member to consider (e.g., expanded consultative services);
• The EBS must inform the Department of the medical/surgical plan’s decision;
• The Department must notify the member of the decision. The medical/surgical plan must notify the PCP and specialist; and
• The medical/surgical plan must monitor the effectiveness of the PCP and specialist in providing continuity of care for the member.
**PCP Selection**

Primary care physicians include physicians in the following specialties: Internal Medicine, Pediatrics, General Practice, Family Practice, Physician Assistant, or Nurse Practitioner. Every family member enrolled in the Plan must choose a primary care physician, although it does not have to be the same physician. All members have the option of changing their primary care physician. The member can call Member Services at (888) 784-2693, report that he/she wants to change primary care physicians, and if necessary, will be assisted in selecting another primary care physician. The change in primary care physician will be effective the first day of the month following the request. Aetna Better Health of Nebraska may initiate a change in a member’s primary care physician under the following circumstances:

- The member’s primary care physician ceases to participate in Aetna Better Health of Nebraska’s network.
- The physician/patient relationship will not work to the satisfaction of either the physician or the patient.
- The physician requests the patient to select another primary care physician and has sent written notification to the member, giving a minimum of 31-day notice and completed and returned to Aetna Better Health of Nebraska a MC-24 form. (MC-24 forms are available on the DHHS website or by calling Aetna Better Health of Nebraska Member Services).

Members are advised to get to know and maintain a relationship with their primary care physician. They are instructed to always contact their primary care physician before obtaining specialty services or going to the emergency room. It is the responsibility of all primary care physicians to manage the care of each patient, directing the patient to specialty care services as necessary. It is the responsibility of the specialist physician to work closely with the primary care physician in the process.

Advanced Directives
Please see Provider Responsibilities to Members in Provider Responsibilities and Important Information chapter.

**Member Grievance and Appeal Process**

Members, or their representatives have the right to file a complaint (grievance) or dispute an adverse determination (appeal). The health plan asks that all providers cooperate and comply with all Aetna, Medicaid, and/or CMS requirements regarding the processing of member complaints and appeals, including the obligation to provide information within the timeframe reasonably requested for such purpose.

For further guidance on the member grievance and appeal process, please contact Member Services at 1-888-784-2693.

**Member Handbook**

A Member Handbook is provided to actively enrolled Aetna Better Health of Nebraska members upon enrollment and annually. Changes to any program or any service site changes are provided to members in a timely manner. The Member Handbook includes information about covered and non-covered services. The Member Handbook covers key topics such as: how to choose and change a PCP, copays, and guidance to emergency care. The Member Handbook is available electronically on the Aetna Better Health of Nebraska website or contact Member Services for a copy.
CHAPTER 8 – MEDICAL MANAGEMENT

Tools to Identify and Track At-Risk Enrollees
Aetna Better Health uses data-driven tools to provide early detection of members who are at risk of becoming high cost, who have actionable gaps or errors in care and/or who may benefit from case management. These tools have two main components. The first is our predictive modeling tool. The second, more comprehensive component is known as the CORE model, or Consolidated Outreach and Risk Evaluation. We supplement information from these tools with data collected from Health Risk Questionnaires (HRQs). We also track information in a customized care management tracking application.

These tools, described below, enable us to work closely with providers, members and their families or caregivers to help improve clinical outcomes and enhance the quality of members’ lives.

Predictive Modeling
Aetna Better Health’s predictive modeling software identifies and stratifies members who are eligible for our care management programs. It sorts, analyzes, and interprets historical claims, pharmacy, clinical and demographic data to identify gaps in care and to make predictions about future health risks for each member. The application funnels information from these various sources into a member profile that allows our Case Managers to access a concise 12-month summary of activity. This data then links to our customized care management tracking application.

Once analyzed, our predictive modeling software ranks members and prepares a monthly “target” report of the members most likely to require care management services. In addition to the scoring methodology, predictive modeling also looks at certain “triggers” to alert Case Managers to potential risk factors, including:

- Members with new hospital authorizations (currently inpatient) or authorizations for certain scheduled services (i.e. home health or selected surgical procedures)
- Call tracking from Aetna Better Health’s Member Services Department

The CORE (Consolidated Outreach and Risk Evaluation) accesses predictive modeling information and provides a more detailed analysis, including a member’s risk of using inpatient and/or emergency department services in the near future. By using the CORE, Aetna Better Health can further drill down to identify specific health factors and at-risk members who may benefit from intervention by our care management team.

Health Risk Questionnaires (HRQs)
Aetna Better Health also assesses members through HRQs. Aetna Better Health staff members go over the HRQ with the member or caregiver during a telephone call made to each member to welcome them to the health plan. The HRQ gathers:

- Member contact information
- PCP or medical home information
- Member’s health history
- Frequency of ER use
- Medication usage

Care Management Business Application Systems
Our care management business application systems store and retrieve member data, claims data, pharmacy data, and history of member interventions and collaboration. It houses a comprehensive assessment, condition-specific questionnaires; care plans and allows care management staff to set tasks and reminders to complete actions specific to each member. It provides a forum for clear and concise documentation of communication with providers, members, and caregivers. It retains history of events for use of the
information in future cases. The system also provides a care consideration function, in which the Care Manager can view and respond to correspondence with the providers on recommended standards of practice and HEDIS interventions for certain conditions and medications. The system interfaces with our authorization business application system, predictive modeling software, the inpatient census tool and allows documents to be linked into the case. It also provides multiple queries and reports that measure anything from staff productivity and staff interventions to coordination and collaboration and outcomes in care management.

**Medical Necessity**

- Health care services and supplies that are medically appropriate and:
  - Necessary to meet the basic health needs of the member
  - Delivered 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 organization or governmental agencies
  - Consistent with the diagnosis of the condition
  - Required for means other than convenience of the client or his or her provider
  - No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
  - Of demonstrated value and
  - At a level that is no more intense than can be safely provided

The fact that the provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean it is covered. Services and supplies which do not meet the definition of medical necessity are not covered. Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member’s family/caregiver and the PCP, as well as any other providers, programs, agencies that have evaluated the member. Medical necessity determinations must be made by qualified and trained health care providers.
CHAPTER 9 – CARE MANAGEMENT

Care Management/Condition Management:

Your member may have an ongoing illness, a history of health problems or problems following Aetna Better Health’s rules for getting health care. We want to work with you and your member to meet their health care needs.

Care management helps your member get the best care in the best way possible. Our care managers are registered nurses who can help you follow your treatment plan.

Our nurses can:
- Help members make appointments or find a provider in their area.
- Help members coordinate their physical and mental health care needs.
- Provide members with information about a living will or advance directive.

Condition management programs help members take good care of themselves. Aetna Better Health follows nationally recognized guidelines for any care requested by their provider. These programs provide information about:
- Asthma
- Congestive heart failure
- Coronary artery disease
- COPD
- High risk pregnancy
- Hypertension
- Obesity

Call us if your patients have special health care needs or to enroll in care management. For questions, call Member Services at 1-888-784-2693 (TTY: 711 or TDD: 1-800-833-0920) and ask to speak with a care manager. If the member no longer wants to be part of care management, they just need to call member services at 1-888-784-2693 (TTY: 711 or TDD: 1-800-833-0920).

Social Work

Aetna Better Health’s social work staff connects your member with community resources.

Social work services include:
- Education and support about Medicaid benefits
- Connections with providers and agencies that provide treatment for physical and mental health
- Information and referrals to government and community support services. Examples:
  - Referral to a shelter or safe house
  - Information about SNAP nutrition assistance
  - Food pantry and clothing donation resources

If your member has a need, please call Member Services at 1-888-784-2693 (TTY: 711 or TDD: 1-800-833-0920).
CHAPTER 10 – CONCURRENT REVIEW

Overview
Aetna Better Health conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member’s medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Hearst Corporation’s MCG evidence-based care guidelines (formerly Milliman Care Guidelines). Admission certification is normally conducted within one business day of receiving medical information but no later than 3 days of notification (if no information is received would give additional days to get information submitted before denying for medical necessity-lack of information), per NCQA guidelines.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. The nurses conduct these reviews and work with the medical directors in reviewing medical record documentation for hospitalized members.

Medical Criteria
Aetna Better Health uses the Hearst Corporation’s MCG evidence-based care guidelines (formerly Milliman Care Guidelines) to ensure consistency in utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. These guidelines are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

Discharge Planning Coordination
Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse (CRN) works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.
CHAPTER 11 – PRIOR AUTHORIZATION

The requesting practitioner or provider is responsible for complying with Aetna Better Health’s prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health will not prohibit or otherwise restrict practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health about the patient’s health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

A prior authorization request must include the following:
- Current, applicable codes (may include):
  - International Classification of Diseases, 9th Edition (ICD-10),
  - Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the member
- Name, address, phone and fax number of the treating practitioner
- Problem/diagnosis, including the ICD-10 code
- Presentation of supporting objective clinical information, such as:
  - Clinical notes
  - Laboratory and imaging studies
  - Prior treatments

All clinical information should be submitted with the original request.

Medical Criteria
Aetna Better Health uses the Hearst Corporation’s MCG evidence-based care guidelines (formerly Milliman Care Guidelines) to ensure consistency in utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. These guidelines are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

Timeliness of Decisions and Notifications to Practitioners, Providers, and/or Members
Aetna Better Health makes prior authorization decisions and notifies practitioners and/or providers and applicable members in a timely manner. Unless otherwise required by DHHS, Aetna Better Health adheres to the following decision/notification time standards.

<table>
<thead>
<tr>
<th>Decision</th>
<th>Decision timeframe</th>
<th>Notification to</th>
<th>Notification method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent pre-service approval</td>
<td>Seventy-two (72) hours from receipt of request</td>
<td>Practitioner/Provider</td>
<td>Oral or Electronic/Written</td>
</tr>
<tr>
<td>Urgent pre-service denial</td>
<td>Seventy-two (72) hours from receipt of request</td>
<td>Practitioner/Provider and Enrollee</td>
<td>Oral and Electronic/Written</td>
</tr>
<tr>
<td>Service Approval Type</td>
<td>Timeframe</td>
<td>Requestor</td>
<td>Communication Method</td>
</tr>
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<tr>
<td>Non-urgent pre-service approval</td>
<td>Fourteen (14) Calendar Days from receipt of the request</td>
<td>Practitioner/Provider</td>
<td>Oral or Electronic/Written</td>
</tr>
<tr>
<td>Non-urgent pre-service denial</td>
<td>Fourteen (14) Calendar Days from receipt of the request</td>
<td>Practitioner/Provider and Enrollee</td>
<td>Electronic/Written</td>
</tr>
<tr>
<td>Urgent concurrent approval</td>
<td>Twenty-four (24) hours of receipt of request</td>
<td>Practitioner/Provider</td>
<td>Oral or Electronic/Written</td>
</tr>
<tr>
<td>Urgent concurrent denial</td>
<td>Twenty-four (24) hours of receipt of request</td>
<td>Practitioner/Provider</td>
<td>Oral and Electronic/Written</td>
</tr>
<tr>
<td>Post-service approval</td>
<td>Thirty (30) calendar days from receipt of the request</td>
<td>Practitioner/Provider</td>
<td>Oral or Electronic/Written</td>
</tr>
<tr>
<td>Post-service denial</td>
<td>Thirty (30) calendar days from receipt of the request</td>
<td>Practitioner/Provider and Enrollee</td>
<td>Electronic/Written</td>
</tr>
<tr>
<td>Termination, Suspension Reduction of Prior Authorization</td>
<td>At least ten (10) Calendar Days before the date of the action.</td>
<td>Practitioner/Provider and Enrollee</td>
<td>Electronic/Written</td>
</tr>
</tbody>
</table>

**Out-of-Network Providers**

When approving or denying a service from an out-of-network provider, Aetna Better Health will assign a prior authorization number, which refers to and documents the approval. Aetna Better Health sends documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes such decisions on a case-by-case basis in consultation with Aetna Better Health’s medical director(s).

**Prior Authorization List**

Treating practitioner/providers must request authorization for certain medically necessary services. Services which require prior authorization can be found within ProPat which is accessible through the Provider Portal online. Unauthorized services will not be reimbursed and authorization is not a guarantee of payment.

**Prior Authorization and Coordination of Benefits**

If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow Aetna Better Health of Nebraska’s prior authorization rules.

**How to request Prior Authorizations**

A prior authorization request may be submitted by:

- 24/7 Secure Provider Web Portal located on the Aetna Better Health’s website
• Fax the request form to **1-844-213-9659** (forms are available on the health plan website)
  o Please use a cover sheet with the practice’s correct phone and fax numbers to safeguard the protected health information and facilitate processing, or
• Call Prior Authorization directly at **1-888-784-2693**.
CHAPTER 12 – QUALITY MANAGEMENT

OVERVIEW
The Aetna Better Health of Nebraska quality management program is designed to continuously improve and monitor the medical care, member safety, behavioral health services, and the delivery of services to members, including ongoing assessment of program standards to determine the quality, accessibility and appropriateness of care, case management and coordination. A key focus of our quality program is improving the member’s biological, psychological and social well-being with an emphasis on quality of care and the non-clinical aspects of all services. Where the member’s condition is not amenable to improvement, our goal is to maintain the member’s current health status by implementing measures to prevent any further decline in condition or deterioration of health status. Incorporating the continuous quality improvement (CQI) concept, our quality program is comprehensive and integrated throughout Aetna Better Health of Nebraska and the provider network. We promote the integration of our quality management activities with other systems, processes, and programs throughout Aetna Better Health of Nebraska.

Quality management is a company-wide endeavor, with crosscutting teams who work together to integrate by interdepartmental monitoring processes and activities (such as those for referring quality of care/risk issues, member/practitioner complaints, grievances and appeals), business application systems and databases that are accessible to all areas. Our quality program also includes a structure of oversight committees with representation not only from across Aetna Better Health of Nebraska but from the provider network and member population as well.

PROGRAM PURPOSE
The purpose of the quality management program is to:
• Promote improvement in the quality of care provided to enrolled members through established processes, including:
  – Monitoring and evaluating the service delivery system, provider network, and processes; assessing the quality of care and identifying potential areas for improvements
  – Implementing action plans and activities to correct deficiencies and/or improve process of care and clinical operations in a way that is expected to improve overall quality;
  – Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews, etc.
• Comply with federal, state, and accreditation requirements;
• Ensure executive and management staff participate in the quality management and performance improvement processes;
• Ensure the development and implementation of quality management and performance improvement activities include contracted provider participation and information provided by members, their family/representative and/or caregiver;
• Identify the best practices for quality management and performance improvement.
• Review all elements of care and service to enrollees to assure that all demographic groups, races, ethnicities, care settings and types of services are addressed.

PROGRAM GOALS
The quality management program goals are to:
• Promote collaboration among Aetna Better Health of Nebraska departments and systems to allow for the collection and sharing of quality management data and monitoring of outcomes
• Work in collaboration with providers to actively improve the quality of care provided to members
• Maintain compliance with federal, state, and accreditation regulatory requirements and consistency with the State’s quality strategy/quality plan and all other requirements of the contract
• Evaluate identified quality, risk and utilization issues, and develop follow-up measures (including action plans) to resolve the issues and prevent recurrences
• Define criteria for measuring clinical performance and assessing the outcomes against established standards and benchmarks, including HEDIS® measures, and utilization management patterns of care. CHIPRA Quality Measures and Adult Quality Measures as defined by the State will also be monitored
• Assess and identify opportunities for improvement by performing quality management and performance improvement activities as requested by internal and external customers (including regulatory agencies). This assessment process will ideally be based on solid data and focused on high volume/high risk procedures or other services that promise to substantially improve quality of care, using current practice guidelines and professional practice standards when comparing to the care provided
• Identify, monitor and evaluate high-volume, problem-prone or high-risk aspects of health care and service
• Provide feedback to members and their family/representative and/or caregiver, advocates, practitioners, providers and Aetna Better Health of Nebraska staff
• Maintain mechanisms for reviewing the entire range of care delivery systems, including all demographic groups, care settings, and services available to the member (e.g., annual population assessment)
• Monitor the provider network’s capacity to accommodate the diverse needs of the member population, including special health care needs as well as specific language or cultural needs and preferences
• Monitor outpatient and inpatient services to identify deviations from standard of care/service
• Identify opportunities to educate members and their family/representative and or caregiver, advocates, practitioners, providers, and Aetna Better Health of Nebraska staff about quality management and performance improvement activities and outcomes and ways to improve members’ health
• Additional special emphasis is placed on, but not limited to, clinical areas relating to disabled individuals, women, infants and children, adolescents and young adults and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
• Develop, maintain, and increase awareness of prevention and wellness and outreach programs available to members (to include programs addressing chronic and catastrophic illness, and care management)
• Incorporate an awareness of member safety into all quality activities

• Maintain technical business information systems to support quality management and performance improvement activities and improve them as necessary to meet program needs
• Inform members and practitioners of members’ rights and responsibilities

**PROGRAM OBJECTIVES**

The quality management program objectives are to:

• Take action on identified opportunities for improving health care outcomes for members and monitor for continued effectiveness
- Educate providers and members and their family/representative and/or caregiver on appropriate and efficient utilization of health care services and facilities
- Maintain systems for monitoring and tracking practitioner and provider quality management and performance improvement trends and medical record keeping practices. The QM department will annually monitor Primary Care Physician (PCP) compliance with documentation standards for medical record and clinical practice guidelines
- Maintain integrated processes to support quality management and performance improvement activities
- Manage quality and risk management referrals in order to promote optimum quality of care and service
- Evaluate practitioner and ancillary provider quality and utilization management and take action to improve areas showing opportunities for improvement
- Monitor the credentialing and re-credentialing of practitioners and other network providers in a thorough and timely manner, in accordance with state and NCQA standards
- Inform and educate members and their family/representative and/or caregiver, practitioners, providers, and other stakeholders about quality and health improvement programs in order to increase the utilization of preventive health care, care management and other services
- Monitor and evaluate the continuity, availability, and accessibility of care or services provided to members
- Compile practitioner and provider information (such as quality or risk management trends, outcomes, and other information) into practitioner and provider information files
- Provide feedback to members and their family/representative and/or caregiver, practitioners and providers on the success of quality management and performance improvement activities, including health outcomes
- Improve the satisfaction of members, practitioners and providers with health care delivery
- Assist members with navigating the health care delivery system
- Establish standards of clinical care and service utilizing objective criteria and processes to evaluate and continually monitor for improvement
- Develop and maintain integrated systems and processes for collecting and disseminating quality data and information
- Integrate oversight of practitioner/provider quality and utilization management and take action if needed to promote improvement
- Promote involvement of members and their family/representative and/or caregiver and practitioners in the quality management program and related activities by encouraging feedback (e.g., through member/provider satisfaction surveys, telephone calls, participation on committees, as applicable)

**SCOPE OF PROGRAM**

The quality management program activities apply to all Aetna Better Health of Nebraska departments and staff, members, and providers, including:

- All member populations, age groups, disease categories and special health care needs members
- All sites and facilities, both in-state and out-of-state, where contracted and/or non-contracted providers deliver health care or services to members
- Internal Aetna Better Health of Nebraska operations (programs and services, such as prior authorization, utilization management, care management, member services, provider services)
- All services, both clinical and non-clinical, provided to members by network or out-of-network providers or delegated entities at any point in the continuum of care and at any level of care
• All customer interactions
• Processes by which providers and members provide Aetna Better Health of Nebraska with feedback and recommendations for improving services

Aetna Better Health of Nebraska integrates all quality management and performance improvement processes into all departments, with each department responsible for selected processes, functions and monitoring activities. The departments carry out these monitoring activities as a part of daily operational routines and report the results to the appropriate internal departments, committees or external agencies as required.

Participating practitioners and providers are required by contract to:
• Cooperate with QI activities
• Maintain the confidentiality of member information and records
• Allow Aetna Better Health of Nebraska to use their performance data

Employees must avoid situations where their personal interest could conflict or appear to conflict with their responsibilities, obligations or duties to the Health plan’s interest or present an opportunity for personal gain apart from the normal compensation provided through employment. Aetna Better Health does not use incentives to reward restrictions of care. No reviewing physician may perform a review on one of his/her patients, or cases in which the reviewing physician has a proprietary financial interest in the site providing care.

It is Aetna Better Health’s policy to conduct business in a manner that protects the privacy of our members. Confidentiality will be maintained in accordance with federal and state laws. Confidential information requested, used and disclosed in the course of an investigation, is limited to the minimum amount necessary to accomplish the intended purpose; and controlled to maintain confidentiality and to minimize Health plan access to a “need to know” basis.

All committee minutes and reports are considered confidential. All external committee members are required to sign a confidentiality and conflict of interest statement prior to serving on a committee. All Health plan employees sign a confidentiality agreement as a condition of employment and receive annual training on HIPAA and confidentiality policies.

Patient Safety
The Quality Improvement program includes an emphasis on patient safety. A number of activities are in place to monitor aspects of patient safety that include but are not limited to:
• Physician credentials are verified in accordance with NCQA, URAC, State and Federal guidelines. Disciplinary actions against physicians are monitored on an ongoing basis.
• The Adverse Event Monitoring Program monitors potential adverse events through both standard reports of inpatient claims and the identification of potential and/or actual adverse events referred from any part of the health care delivery system.
• The process of utilization management plays a vital role in the monitoring of patient safety though concurrent review, identification of potential quality of care issues, and identification of potential trends in under and over-utilization.

Member complaints are monitored for adverse events. The QM Department in consultation with the Health Plan Medical Director and/or behavioral healthcare practitioner investigates, tracks, analyzes and brings referred events to the appropriate committee as needed.
Safety measures may be addressed through the collaboration with primary care providers by:

- Education of members regarding their role in receiving safe and effective services through member newsletters and website.
- Education of providers regarding improved safety practices in their clinical practice through provider newsletters and website.
- Evaluation for safe clinic and/or medical office environments during office site reviews.
- Education to members regarding safe practices at home through health education and discharge planning.
- Intervention for identified safety issues as identified through case management, potential quality of care assessment, and the grievance and clinical case review process.
- Collection of Hospital Acquired Conditions data regarding hospital activities, including adverse and never events, readmission rates and other relevant data relating to member safety issues.

Dissemination of information to providers and members regarding activities in the network related to safety and quality improvement.

**Governing Body**
The Aetna Better Health of Nebraska Board of Directors has delegated accountability for the management of the quality of clinical care and service provided to members to the Chief Medical Officer (CMO). The CMO is responsible for providing strategic direction and oversight of the QM Program for Aetna Better Health of Nebraska members. The CMO is supported in this effort by the QM department, other health plan departments, and committees.

**Committee Structure**
Annually the board of directors reviews the QI program documents – the program description, the work plan and the annual evaluation.

The Quality Management Oversight Committee (QMOOC) is designated to provide executive oversight of the quality program and make recommendations to the board of directors about the health plan quality management and performance management activities. The committee meets at a minimum of six times a year and more frequently if necessary.

Quality Management/Utilization Management Committee (QMUM) meets at a minimum quarterly and includes practitioners from the community and key staff at Aetna Better Health of Nebraska. The purpose of this committee is to advise and make recommendations to the CMO on matters pertaining to the quality of care and service provided to members including the oversight and maintenance of the QI program and UM program.

**Practitioner Profiling**
Aetna Better Health of Nebraska uses the practitioner profile to monitor practitioner’s utilization practices along with members’ health outcomes to identify opportunities for improvement. The objectives of the practitioner profiles are to identify practitioner utilization patterns that vary significantly from peer network practitioner groups; identify trends that can be addressed through practitioner outreach; and provide information to network practitioners about their practice patterns. In addition, the profiles safeguard confidentiality by maintaining secure access to the profile interface; provide information to use as a component of quality management oversight; and provide information to use as a component of practitioner incentive compensation.
The Medical Management Department is responsible for operations to oversee the profile process, including validation of data reasonableness and activities to monitor use of the profiles (e.g., site visits, mailings, tracking outcomes over time). The Aetna Informatics and Actuarial Systems departments are responsible for operations to maintain and regularly refresh the central database.

The Chief Medical Officer or designated medical director is responsible for accessing the profile interface quarterly to review identified practitioner’s utilization patterns, trends, and costs during the previous year. The profiles are printed and distributed to applicable network practitioners. If a profile reflects practices that do not further Aetna Better Health of Nebraska health care mission, e.g., low performance of Healthcare Effectiveness Data and Information Set (HEDIS®) measures, the Chief Medical Officer may request that the practitioner or patient centered medical develop a corrective action plan.

**Evidence-based Clinical Practice Guidelines**

The evidenced-based clinical practice guidelines used by Aetna Better Health of Nebraska represent best practices and are based on national standards, reasonable medical evidence, and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the Chief Medical Officer, applicable medical committees and, if necessary, external consultants. Clinical practice guidelines are reviewed at least every two years, or as often as new information is available.

Clinical guidelines are available on the Aetna Better Health of Nebraska website at [www.aetnabetterhealth.com/nebraska](http://www.aetnabetterhealth.com/nebraska). Practitioners are informed of the availability of new guidelines and updates in the provider newsletter. Practitioners may request a copy of a guideline at any time by contacting a provider services representative or the Aetna Better Health of Nebraska office of the Chief Medical Officer.

**HEDIS**

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public has the information it needs to reliably compare performance of managed health care plans. Aetna Better Health of Nebraska collects this data routinely.

**Frequently Asked Questions**

*Why do health plans collect HEDIS data?*

Accrediting bodies such as the National Committee for Quality Assurance (NCQA), along with the Nebraska Department of Health and Human Services Medicaid division, require that health plans report HEDIS data. The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

*How are HEDIS measures generated?*

HEDIS measures can be generated using three different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of members along with claims and encounter data)
- Survey

*Why does the plan need to review medical records when it has claims data for each encounter?*

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings and results of tests that may not be available in
claims/encounter data. Typically, a plan employee will call the physician’s office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the provider to secure email, fax or mail the specific information.

*How accurate is the HEDIS data reported by the plans?*
HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the plan may ask for copies of records for audit purposes. Plans also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

*Is patient consent required to share HEDIS related data with the plan?*
The HIPAA Privacy Rule permits a provider to disclose protected health information to the health plan for the quality related health care operations of the health plan, including HEDIS, provided the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506 (c) (4). Thus, a provider may disclose protected health information to a health plan for the plan’s HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

*May the provider bill the plan for providing copies of records for HEDIS?*
According to the terms of their contract, a provider may not bill either the plan or the member for copies of medical records related to HEDIS.

*How can providers reduce the burden of the HEDIS data collection process?*
We recognize that it is in the best interest of both the provider and the plan to collect HEDIS data in the most efficient way possible. Options for reducing this burden include providing the plan remote access to provider electronic medical records (EMRs) and setting up electronic data exchange from the provider EMP to the plan. Please contact a provider relations representative or the Quality Improvement department for more information.

*How can providers obtain the results of medical record reviews?*
The plan’s Quality Improvement department can share the results of the medical record reviews performed at provider offices and show how results compare to that of the plan overall. Please contact a provider relations representative or the Quality Improvement department for more information.
CHAPTER 13 – ENCOUNTERS, BILLING AND CLAIMS

Aetna Better Health processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable state and federal laws, rules and regulations. Aetna Better Health will not pay claims submitted by a provider who is excluded from participation in the Nebraska Medicaid program.

Aetna Better Health uses the Trizetto QNXT® system to process and adjudicate claims. Both electronic and paper claims submissions are accepted. To assist Aetna Better Health in processing and paying claims efficiently, accurately and timely, the health plan highly encourages providers to submit claims electronically, when possible. To facilitate electronic claims submissions, Aetna Better Health has developed a business relationship with Emdeon. Aetna Better Health receives EDI claims directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance and member enrollment and then uploads them into QNXT each business day. Within 24 hours of file receipt, Aetna Better Health provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

When to Bill a Member
All providers are prohibited from billing any member beyond the member’s cost sharing liability, if applicable, as defined on the Aetna Better Health of Nebraska remittance advice.

When to File a Claim
All claims and encounters with Aetna Better Health of Nebraska members must be reported to Aetna Better Health, including prepaid services.

Timely Filing
In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

- **New Claim Submissions** – Claims must be filed on a valid claim form within 90 days from the date services were performed (unless there is a contractual exception). For hospital inpatient claims, date of service means the date of discharge of the member.
- **Claim Resubmission** – Claim resubmissions must be filed within 180 days from the date of payment or denial. (The only exception to this is if a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit or correct a claim. Please submit any additional documentation that may effectuate a different outcome or decision.)

Failure to submit accurate and complete claims within the prescribed time period may result in payment delay and/or denial.

How to File a Claim
1) Select the appropriate claim form:
   a) Medical and professional services use current version of the CMS 1500 Health Insurance Claim Form
   b) Hospital inpatient, outpatient, skilled nursing and emergency room services use UB-04
   c) Rural Health Clinics and Federally-Qualified Health Centers use UB-04 or CMS 1500, as appropriate for the services rendered. Please contact Provider Relations with additional questions.
2) Complete the claim form
a) Claims must be legible and suitable for imaging for record retention. Complete ALL required fields and include additional documentation when necessary.

b) The claim form may be returned unprocessed (unaccepted) if illegible or poor quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

3) Submit claims electronically or original copies through the mail (faxed claims are not routinely accepted).
   a) Payer ID: 42130
      i) Electronic Clearing House - Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to vendors, which is the only accepted proof of timely filing for electronic claims.
         (1) Emdeon is the EDI vendor we use.
         (2) Contact the software vendor directly for further questions about electronic billing.
         (3) Contact our Provider Services Department for more information about electronic billing.
   b) Through the mail
      i) To include supporting documentation, such as enrollees’ medical records, clearly label and send to Aetna Better Health at the correct address:
         Aetna Better Health of Nebraska
         P. O. Box 63188
         Phoenix, AZ 85082

Claim Filing Tips

- Corrected claims must be clearly identified as a resubmission by stamping/writing “corrected claim” or “resubmission” on the paper claim form.
- Altered claims must be clearly initialed at the correction site. Initialing corrections insures the integrity of a corrected claim.
- Corrected claims must include all original claim lines, including those previously paid correctly. Resubmitted claims without all original claim lines may result in the recoupment of correct payments.
- Dates of service on the claim should fall within the prior authorized service date range. Including dates of services outside the authorized range may result in denials.
- Claims for services requiring an authorization should include the authorization number in block 23 on the CMS-1500 form and block 63 on UB-04 forms or in the appropriate field on EDI claims.
- The authorization number should not contain any pre-fixes or suffixes such as “R12345,” “#7890,” or “3456 by Laura.”
- Claims must have current, valid, and appropriate ICD diagnosis codes.
- The diagnosis codes must be coded to the highest degree of specificity (fifth digit) to be considered valid.
- Claims must be submitted with valid CPT, HCPCS and/or revenue codes.
- Claims submitted with nonstandard CPT, HCPCS, revenue codes or modifiers will NOT be processed and will be returned to the provider. These claims should be reworked and submitted timely to the initial claims address.
- Each CPT or HCPCS code line must have a valid place of service (POS) (block 24B) code when billing on a CMS-1500 form.
- Accident details should be provided when applicable (Block 10B of CMS-1500 Form).
- List all other health insurance coverage when applicable (Block 9A-D of CMS-1500 Form).
- Providers must submit the appropriate NPI numbers in Block 33A of the CMS-1500 and Block 56 of the UB-04.
• Billing provider taxonomy information should be submitted (Block 33B of the CMS-1500 form)
• All providers, including FQHCS and RHCs, must submit their claims listing out their usual and customary charges as the billed amounts on the applicable claim form.

Encounter Data
Aetna Better Health of Nebraska requires the submission of certain data for encounter data collection by the State of Nebraska. Please be sure to include the current, valid information below that corresponds to each provider’s enrolled location with the State of Nebraska Medicaid program. Failure to submit this information correctly will result in a denial of the claim.

Paper Billing
CMS 1500 Paper Claims (professional):
• Box 33 - Billing Provider Physical Address
• Box 33A - Billing Provider NPI
• Box 33B - Billing provider taxonomy
  — Enter the 2-digit qualifier of “ZZ” followed by the taxonomy code
  — Do not enter a space, hyphen, or other separator between the qualifier and number (e.g. ZZ207Q00000X)
• Box 24J - Rendering NPI - (bottom of box, non-shaded area)

UB-04 Paper Claims (institutional):
• Billing Provider NPI submitted in field 56, top row
• Billing provider taxonomy submitted in field 81
  — Enter the 2-digit qualifier of “B3” in the first column and then the taxonomy code immediately following

If there are questions regarding this information, please contact Provider Services.

Multiple Procedures
Multiple procedures performed on the same day and/or at the same session are processed at 100% of the contracted rate for the primary procedure, 50% of the contracted amount for the secondary procedure and 50% of the contracted amount for any subsequent procedures; or as defined by a provider’s current contract with Aetna Better Health or Medicaid guideline changes.

Modifiers
Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health can request copies of operative reports or office notes to verify services provided. Certain modifiers may affect payment amounts as defined by the State of Nebraska Medicaid Fee Schedule or contract with Aetna Better Health of Nebraska. Common modifier issue clarification is below:
• **Modifier 59** – Distinct Procedural Services - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).
• **Modifier 25** – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate
use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.

- **Modifier 50** – Bilateral Procedure - If no code exists that identifies a bilateral service as bilateral, a provider may bill the component code with modifier 50. Services should each be billed on one line reporting one unit with a 50 modifier.
- **Modifier 57** – Decision for Surgery – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period.


**Correct Coding**
Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

**Incorrect Coding**
Examples of incorrect coding include:

- “Unbundling” - Fragmenting one service into components and coding each as if it were a separate service or billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

**Correct Coding Initiative**
Aetna Better Health of Nebraska utilizes claims editing systems designed to evaluate the appropriate billing information and CPT coding accuracy on procedures submitted for reimbursement. Our edit guidelines are based on, but not limited to: NCCI, CPT-4, HCPCS and ICD coding definitions, AMA and CMS guidelines, specialty edits, pharmaceutical recommendations, industry standards medical policy and literature research input from academic affiliations.

The major areas of reviews are:

- **Procedure Unbundling** - Billing two or more individual CPT codes to report a procedure when a single more comprehensive code exists that accurately describes the procedure.
- **Incidental Procedures** - A procedure that is performed at the same time as a more complex procedure, however, the procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure.
- **Mutually-Exclusive Procedures** - Two or more procedures that are billed, by medical practice standards, should not be performed or billed for the same patient on the same date of service.
- **Multiple Surgical Procedures** - Surgical procedures are ranked according to clinical intensity and paid following percentage guidelines.
- **Duplicate Procedures** - Procedures that are billed more than once on a date of service.
- **Assistant Surgeon Utilization** - Determination of reimbursement and coverage.
- **Evaluation and Management Service Billing** - Review the billing for services in conjunction with procedures performed.
When reviewing a remittance advice, any CPT code that has been changed or denied by the editing system will be noted by the appropriate disposition code.

**Other General Claims Instructions**
Aetna Better Health of Nebraska claims are paid in accordance with the terms outlined in the provider contract for this product.

**Skilled Nursing Facilities (SNF)**
Providers submitting claims for SNFs should use CMS UB-04 Form. Providers should bill Aetna Better Health using Level of Care HCPCS coding (e.g. level of care 101 is billed under HCPCS code LC101). Please bill with the corresponding HCPCS code for services rendered. Please contact Claims Inquiry/Claims Research with additional questions or concerns.

**Home Health Care**
Providers submitting claims for Home Health should use UB-04 Form. Providers must bill in accordance with their contract and/or State of Nebraska Medicaid guidelines.

**Durable Medical Equipment (DME)**
Providers submitting claims for DME Rental should use CMS 1500 Form. DME rental claims are only paid up to the purchase price of the durable medical equipment.

**Hospice**
Aetna Better Health of Nebraska members currently receiving hospice services are routinely transitioned back to State of Nebraska Fee-For-Service Medicaid coverage. Please contact a Case Manager or Provider Services to discuss these services in greater detail.

**Remittance Advices**
Aetna Better Health generates checks weekly. The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates. Claims processed during a payment cycle will appear on a remittance advice as paid, denied, or reversed. Information provided on the remit includes:

- **Summary Box** found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- **Remit Date** represents the end of the payment cycle.
- **Beginning Balance** represents any funds still owed to Aetna Better Health for previous overpayments not yet recouped or funds advanced.
- **Processed Amount** is the total of the amount processed for each claim represented on the remit.
- **Discount Penalty** is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- **Net Amount** is the sum of the Processed Amount and the Discount/Penalty.
- **Refund Amount** represents funds that the provider has returned to Aetna Better Health due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- **Amount Paid** is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- **Ending Balance** represents any funds still owed to Aetna Better Health after this payment cycle. This will result in a negative Amount Paid.
- **Check #** and **Check Amount** are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the
bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.

- Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
- Claim Header area of the remit lists information pertinent to the entire claim. This includes:
  - Member Name
  - Member ID number
  - Date of Birth
  - Account Number
  - Authorization ID, if obtained
  - Provider Name
  - Claim Status
  - Claim Number
  - Refund Amount, if applicable
- Claim Totals are totals of the amounts listed for each line item of that claim.
- Code/Description area lists the processing messages for the claim.
- Remit Totals are the total amounts of all claims processed during this payment cycle.
- Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

Sample remittance advice and check:
Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that providers keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call Provider Services for more information about electronic remittance advices.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), a provider must currently submit claims through EDI and receive payment for claim by EFT. Providers must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for providers to receive payment and reconcile outstanding accounts. Please contact our Provider Services Department for assistance with this process.

Checking Status of Claims
Providers may check the status of a claim by accessing our secure provider portal website or by calling Claims Inquiry and Claims Research.

- **Online Status through Aetna Better Health’s Secure Provider Portal Website**
  - Aetna Better Health encourages providers to take advantage of using online status, as it is quick, convenient and can be used to determine status for multiple claims.

- **Claims Inquiry and Claims Research can:**
  - Answer questions about claims
  - Assist in resolving problems or issues with a claim
  - Provide an explanation of the claim adjudication process
  - Help track the disposition of a particular claim
  - Correct errors in claims processing

Corrected Claims and Resubmissions
Providers have 180 days from the date of payment or denial to resubmit a corrected version of a processed claim. The review and reprocessing of a corrected claim does not necessarily constitute a reconsideration or claim dispute. Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Please submit the Reconsideration/Reconsideration Form located on our website along with:

- An updated copy of the claim. All lines must be rebilled; even lines which paid appropriately on initial submission.
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction. Please remember corrections must be made on the claim form.
- Clearly label as “Resubmission” or “Corrected Claim” at the top of the claim in black ink and mail to appropriate claims address.

Failure to mail and accurately label the resubmission to the correct address may cause the claim to deny as a duplicate.

Claim Reconsiderations
Providers have 180 days from the date of claim processing to correct and resubmit claims.
• **Resubmission**: A claim originally denied because of missing documentation, incorrect coding, etc., that is now being resubmitted with the required information.

• **Reconsideration**: A request for the review of a claim that a provider believes was paid incorrectly or denied because of processing errors.

A resubmission or reconsideration should be submitted with the Provider Claims Resubmission/Reconsideration Form (available on the Aetna Better Health of Nebraska website) to the following address:

Aetna Better Health of Nebraska  
Attn: Reconsiderations  
P.O. Box 63188  
Phoenix, AZ 85082

Examples of reconsideration requests:

- Contract interpretation issues
- Timely Filing (please submit acceptance report if billed electronic)
- Entire claim denied for no authorization due to the member providing the incorrect insurance information
- Rejected as cosmetic and submitting medical records/documentation
- No authorization when it is required
- Coding edit reconsideration

**Timely Filing Denials**

It is the responsibility of the provider to maintain their account receivables records, and Aetna Better Health of Nebraska recommends that providers perform reviews and follow-up of their account receivables on at least a monthly basis to determine outstanding Aetna Better Health claims. Aetna Better Health of Nebraska will not be responsible for claims that were received outside timely filing limits.

Recognizing that providers may encounter timely filing claims denials from time to time, we maintain a process to coordinate review of all disputed timely filing claim denials brought to our attention by providers. If a claim is denied for timely filing, complete the Provider Claim Resubmission/Reconsideration Form available on the Aetna Better Health of Nebraska website and attach proof of timely filing.

**Electronic Submission**

Electronic claim submission (EDI) reports are available from each provider’s claims clearinghouse after each EDI submission. These reports detail the claims that were sent to and received by Aetna Better Health of Nebraska. Providers must submit a copy of the acceptance report from the provider’s respective clearinghouse that indicates the claim was accepted by Aetna Better Health of Nebraska within timely filing limits to override timely filing denial and pay the claim.

Please confirm that the claim did not appear on a rejection report. If Aetna determines the original claim submission was rejected, the claim denial will be upheld and communicated in writing to the provider.

**Paper Submission**

Providers must submit a screen print from the provider’s respective billing system or database with documentation that shows the claim was generated and submitted to Aetna Better Health of Nebraska within the timely filing limits. Documentation should include:

1. The system printout that indicates:
   - Claim was submitted to Aetna Better Health of Nebraska
• Name and ID number of the member
• Date of service
• Date the claim was filed to Aetna Better Health of Nebraska

2. A copy of the original CMS-1500 or UB-04 claim form that shows the original date of submission

Refunds
If it is necessary to issue Aetna Better Health a refund check, please mail it with a detailed explanation and claims affected to the following address:

Aetna Better Health of Nebraska
Attn: Refunds
15950 West Dodge Road
Omaha, NE 68118

If it is necessary to return a check issued to a practice by Aetna Better Health of Nebraska, please mail it with an explanation to the following address:

Aetna Better Health of Nebraska
Attn: Recoveries
15950 West Dodge Road
Omaha, NE 68118

Recoveries
Recoveries are adjustments to previously processed claims, duplicate payments, improper benefit interpretations, fee schedule corrections, ineligible member recoveries, etc.

Aetna shall not commence a recovery later than 36 months after the date of last payment (DOP), except as specifically noted in this policy. Providers are permitted to initiate the appeal of a recovery the later of one year from the DOP or 60 days from the date of the recovery request/withhold. Aetna Better Health shall not commence a recovery related to retroactive terminations, regardless of the reason for the retroactive termination, after the time periods specified below:

Provider Requests for Payment Reconsideration
• This policy in no way alters the timely claim submission requirements or appeals policy stated in the provider agreements.
• Providers shall have the opportunity to correct any billing or coding error within thirty (30) days of denial related to any such claim submission.

Aetna Better Health of Nebraska’s recovery policy allows for offsets to be performed on future payments if necessary.
CHAPTER 14 – APPEALS AND GRIEVANCES

Inquiry, Grievance and Appeals Process for Providers and Members
Aetna Better Health has an Inquiry, Grievance, and Appeals process for Members and providers to dispute a claim authorization or an Aetna Better Health decision. This includes both administrative and clinical decisions of Aetna Better Health. A member and provider have ninety (90) days from the Notice of Action to file an Appeal and thirty (30) days to file a Grievance. The Appeal or Grievance may be submitted orally or in written form to the health plan. If an oral Appeal is made by either the member or provider, a written acknowledgment will be sent to the member with a consent that the member must sign for the appeal to proceed through the appeal process. Members and Providers have a one-level internal appeal process through Aetna Better Health of Nebraska.

There are no punitive actions to members or providers for filing a complaint or requesting an appeal (standard or expedited). Members and providers have the right to submit written comments with all levels of the process.

Provider Inquiries and Grievances
In order to ensure a high level of satisfaction, Aetna shall provide a mechanism for Providers to express dissatisfaction with Plan decisions. Providers may express questions or dissatisfactions through our Provider Inquiry and Grievances Process.

If a provider has questions regarding member benefits/eligibility, claim status/payment, remittance advices, authorization inquiries, etc. please access the provider portal or contact with Claims Inquiry and Claims Research. Inquiries are handled on a daily basis and are normally resolved on the initial contact.

To submit a dissatisfaction regarding an issue in the Health Plan, you may contact Provider Services at 888-784-2693. Complaints received will be documented and forwarded to appropriate personnel for resolution. The resolution will be documented within our internal system and conveyed to the complainant.

After following these steps, if you are still dissatisfied you may have the right to file an appeal. Please refer to the Appeals section for instructions on filing an appeal.

Members and providers also have the right to request and receive a written copy of Aetna Better Health utilization management criteria, in cases where the Appeals are related to a clinical decision/denial. Aetna Better Health Members will receive assistance, if required, to file either a Grievance or an Appeal. Aetna Better Health also provides a toll-free number 1-888-784-2693, a TDD number 1-800-613-3087 and interpretive services.

The Member may request continuation of benefits during the Health Plan Appeal review or a State Fair Hearing. The request must be filed within 10 days of the mail date of the Notice of Action. If the Health Plan’s action is upheld in a hearing, the member may be liable for the cost of any disputed services furnished while the Appeal was pending determination.

Claim Reconsideration vs. Claim Appeal
Aetna Better Health of Nebraska has two separate and distinct processes designed to assist providers with issue resolution. The chart below illustrates the process to follow when filing a claims reconsideration/resubmission versus an appeal. If the provider has a dispute with the resolution of a claim they may challenge the claim denial or adjudication by filing an appeal. However, before filing an appeal, the provider should verify the claim does not qualify to be reviewed as a claims resubmission or reconsideration.
Provider Appeal of Claim Action

Providers may appeal any adverse claim action. Prior to appealing a claim action, providers may contact Claims Inquiry/Claims Research for claim information. In many cases, claim denials are the result of inaccurate filing practices. Please follow the filing practices listed in the above sections as well as the steps below, in order to minimize claims issues:

- Contact Claims Inquiry and Claims Research at 1-888-784-2693 (select option 2 then option 3) as the first step is to clarify any denials or other actions relevant to the claim. A representative will be able to assist a provider with a possible resubmission of a claim with modifications.
- If an issue is not resolved after speaking with Aetna representatives or by submitting a claims resubmission/reconsideration, providers may challenge actions of a claim denial or adjudication by filing a formal appeal with the Aetna Better Health of Nebraska Appeals department.
- The appeal request may be filed orally or in writing. The request must specifically state the factual and legal basis for the appeal, including a chronology of pertinent events and a statement as to why the provider believes the action by Aetna Better Health of Nebraska was incorrect.
- The provider must attach copies of any supporting documents, such as claims, remittance advices, medical records, correspondence, etc. If additional copies of medical records are requested for appeal consideration, such copies are created at the provider’s expense.
  - The provider must initiate any appeal challenging a claim denial or adjudication within ninety (90) days from the date the claim processed. Appeals on issues other than claim denials, such as authorization denials, must be filed no later than ninety (90) days after the date of the adverse action.
- Appeals should state Formal Provider Appeal on the document(s) and should be mailed to:

<table>
<thead>
<tr>
<th>Reconsideration</th>
<th>Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forms required</td>
<td>Resubmission/Reconsideration Form</td>
</tr>
<tr>
<td></td>
<td>Live claim</td>
</tr>
<tr>
<td>Address</td>
<td>Aetna Better Health of Nebraska</td>
</tr>
<tr>
<td></td>
<td>Attn: Reconsiderations</td>
</tr>
<tr>
<td></td>
<td>PO Box 63188</td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85082-1145</td>
</tr>
<tr>
<td>Appropriate Categories</td>
<td>1) Claim denials for timely filing</td>
</tr>
<tr>
<td></td>
<td>2) Claim denials for bundling, claim edits,</td>
</tr>
<tr>
<td></td>
<td>or CPT/HCPCS modifiers</td>
</tr>
<tr>
<td></td>
<td>Claim denials for incorrect CPT or</td>
</tr>
<tr>
<td></td>
<td>HCPCS codes</td>
</tr>
<tr>
<td></td>
<td>4) Coordination of benefits (missing or</td>
</tr>
<tr>
<td></td>
<td>illegible primary explanation of benefits)</td>
</tr>
<tr>
<td></td>
<td>Incorrect claim payment amounts</td>
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<tr>
<td>Timeframe</td>
<td>180 days from the date of processing/denial</td>
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The appeal determination will be communicated verbally and in writing. The letter explaining the appeal decision will be sent within 30 calendar days of when the appeal was initiated. If an extension of time was requested and utilized, the verbal and written notifications will be within 45 calendar days of when the appeal was initiated.

**Tips to Writing an Effective Appeal**

In the event that a provider does not agree with Aetna Health Care of Nebraska’s decision regarding requested services or benefit coverage, we have provided tips to writing an effective grievance or appeal letter:

- Include the name, address, and a phone number where the appealer can be reached in case there are any questions
- Include the patient’s name, date of birth, and insurance I.D. number
- Describe the service or item being requested
- Address issues raised in our denial letter
- Address the medical necessity of the requested service
- Include information about the patient’s medical history:
  - Prior treatments
  - Surgery Date
  - Complications
  - Medical condition and diagnosis

If applicable to an appeal situation, please also provide:

- Any unique patient factors that may influence our decision
- Why alternate methods or treatments are not effective or available
- The expected outcome and/or functional improvement
- An explanation of the referral to an Out-of-Network provider

When submitting an appeal, be sure to provide the necessary information to describe the patient, treatment, and expected outcomes as described above.

**Expedited Appeal Requests**

Expedited requests are available for circumstances when application of the standard Appeal time frames would seriously jeopardize the life or health of the member or the member’s ability to attain, maintain or regain maximum function. A verbal request indicating the need for an expedited review should be made directly to Prior Authorization at 1-888-784-2693. Those requests for an expedited review that meet the above criteria will have determinations made within seventy-two (72) hours or earlier as the Member’s physical or mental health requires. The determination will be communicated orally to both the member and the provider and followed up with a written notification of the determination within the timeframes provided below.

**Process Definitions and Determination Timeframes**

<table>
<thead>
<tr>
<th>Process</th>
<th>Definition</th>
<th>Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inquiry</td>
<td>Any question from an Enrollee or provider regarding issues received by a Customer Service Representative in</td>
<td>Fifteen (15) working days from receipt of</td>
</tr>
</tbody>
</table>
the Customer Service Operation. These questions may regard issues like benefit information, claim status and eligibility. Inquiries are handled on a daily basis and are normally resolved on the initial contact. To avoid delay in processing inquiries, do not label an Inquiry as a Grievance or Appeal. Written Inquiries should be mailed to the address listed below.

<table>
<thead>
<tr>
<th>Inquiry</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance</td>
<td>Any written or oral expression of dissatisfaction with any aspect of care other than the Appeal of actions, which is considered an Appeal expressed by an Enrollee or provider. The issue may be resolved by the Customer Service Representative in the CSO. This dissatisfaction refers to any reason other than dissatisfaction due to an adverse benefit determination or action made by the Health Plan. Most Grievances are categorized as Quality of Care, Quality of Service or Service Center Specific.</td>
</tr>
<tr>
<td>Appeal</td>
<td>An Appeal is a written or oral request by the Enrollee or provider to review an Adverse Determination or payment/reimbursement denial related to a health service request or benefit that the Enrollee or provider believes he or she is entitled to receive. A denial or a limited authorization of a requested service, including the type or level of service, that the service is determined to be experimental, investigational, cosmetic, not medically necessary or inappropriate. A failure to provide services in a timely manner as defined by the State and failure of the Health Plan to act within specified timeframes. The Appeal must be received by Health Plan within ninety (90) calendar days after the date of the Health Plan’s Notice of Action or the claim denial for it to be considered a valid Appeal.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Written Inquiries can be mailed to:</th>
<th>Written Grievances and Appeals can be mailed to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health of Nebraska</td>
<td>Aetna Better Health of Nebraska</td>
</tr>
<tr>
<td>Attn: Inquiries</td>
<td>Attn: Appeals Coordinator</td>
</tr>
<tr>
<td>P.O. Box 63188</td>
<td>15950 West Dodge Rd</td>
</tr>
<tr>
<td>Phoenix, AZ 85082</td>
<td>Omaha, NE 68118</td>
</tr>
</tbody>
</table>

**State Fair Hearing**

Aetna Better Health members, or their designated representatives, have ninety (90) days from the date of Aetna Better Health’s notice of Action or Appeal decision letter to initiate a State Fair Hearing. The Member is allowed to go directly to the State Fair Hearing level without first completing the Health Plan levels of Appeal. If the Member is dissatisfied with the state agency determination denying a member’s request to transfer plans or to disenroll they may also access the State Fair Hearing process. To arrange for a State Fair Hearing, members should write to:

- Nebraska Department of Health and Human Services
- Legal Services-Hearing Section
The member’s provider may request a State Fair Hearing if the provider is acting as the member’s authorized representative. In addition, the provider can request a State Fair Hearing without representing the member for claims issue resolution, as allowable per state law.

**Fraud and Abuse**

Aetna Better Health of Nebraska will not tolerate health care fraud or abuse in any of its relationships with either internal or external stakeholders. Aetna will identify, report, monitor and, when appropriate, refer for prosecution situations in which suspected fraud, waste or abuse occurs. To report fraud and abuse, please contact Aetna Better Health at 1-800-338-6361.

Aetna follows a mandatory corporate compliance plan that incorporates annual employee training, system controls, data mining tools, internal auditing and a designated Special Investigations Unit (SIU) to monitor, detect, investigate and report potential fraud. All Aetna staff complete required training in identifying potential fraud and the tools for reporting questionable situations upon hire and annually thereafter. Training includes how to detect and prevent member, employer, or agent fraud related to member eligibility as well as claim fraud by a member or provider. Additionally, the Customer Service staff receives thorough training for fraud and abuse. At Aetna, our goal is to operate at the highest level of ethical standards.

The Special Investigations Unit (SIU) detects and investigates cases of potential health care fraud and abuse. Health care fraud is committed when someone intentionally submits, or causes someone else to submit, false or misleading information for use in determining the amount of Health Care Benefits payable. Examples of fraud and abuse include but are not limited to the following:

- Submitting a Claim for services not furnished either by using genuine patient information to fabricate entire Claims or by padding Claims with charges for procedures or services that did not take place;
- Submitting a Claim with inaccurate diagnosis or procedure codes with the intent of maximizing payments or obtaining Coverage that the Member is not entitled to;
- Submitting a Claim knowing reimbursement has previously been remitted;
- Misrepresenting dates of services, description of service, or identity of Member or Provider in order to obtain reimbursement to which the Provider or Member is not entitled;
- Submitting a Claim for Non-Covered Services in a manner that categorizes them as Covered Services;
- Providing false Employer or Group membership information;
- Submitting a Claim for a more costly service than the one actually performed, commonly known as “upcoding” – i.e., falsely billing for a higher-priced treatment than was actually provided (which often requires the accompanying “inflation” of the patient’s diagnosis code to a more serious condition consistent with the false procedure code);
- Submitting unbundled Claim(s) for the purpose of avoiding these Claim policies and procedures;
- Waiving Co-payment or Deductibles for the purpose of inducing Member’s to receive services from a specific provider rather than a competitor;

The SIU utilizes state-of-the-art data analysis tools to detect irregularities which could be indicators of possible fraud. Clinical Investigators and experienced fraud and abuse investigators work collaboratively to conduct investigations identified through various sources.

The SIU reviews medical claims on a prospective and retrospective basis using sophisticated data mining technology tools to identify and investigate unusual or inappropriate billing patterns. This could lead to some claims being denied for supporting medical documentation. The SIU also may request supporting
documentation or schedule an on-site audit to investigate previously paid claims. The investigation does not mean that a provider is practicing fraud. In many cases, the SIU finds the provider billing practice was in error. In all cases, the SIU will work with the appropriate Provider Relations representative to communicate what is believed an inappropriate billing practice.

The Fraud Waste and Abuse Committee reviews all suspected fraud and abuse cases and, if warranted, findings will be reported to the appropriate regulatory agencies and legal authorities.

If a member is suspected of fraud or abuse, they are referred to our Fraud Committee for review. If it is determined that additional investigation is warranted, those cases are reported to appropriate external entities, including the State Department of Health and Human Services. Reports include the name and ID number of the party involved, the source of the complaint, the provider type, nature of the complaint, approximate dollar amount involved and the legal and administrative status of the case.

Our credentialing process for contracted providers includes a verification that the provider is eligible to participate. We specifically check the Excluded Provider Database on the HHS OIG Web site to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid or SCHIP. This information is also requested on the credentialing and re-credentialing application.

Aetna of Nebraska contract provisions with participating providers specifically state, that they shall not employ or contract for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. The provider hereby certifies that no such excluded person currently is employed by or under contract with them or with any “downstream” entity with which they contract relating to the furnishing of these services to Medicare Advantage Members.

Our Credentialing Verification Center conducts ongoing monitoring of the HHS OIG and State Professional Registration boards internet sites and any information found pertaining to participating Aetna of Nebraska providers are referred for review by the credentialing committee to ensure compliance.

Our delegated credentialing entities are required to verify that the providers with whom they contract are eligible to participate, including checking the HHS OIG Web site to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid or CHIP. Part of our ongoing evaluation of the delegated entities is confirmation of ongoing monitoring of state and federal Web sites to identify current sanctions or complaints.

As required by the Deficit Reduction Act of 2005, it is Aetna’s policy to provide detailed information to Aetna employees, vendors or other subcontractors, and other persons acting on behalf of Aetna, about the Federal False Claims Act, administrative remedies for false claims and statements established under 31 U.S.C 3801 et seq., and applicable State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (collectively, “False Claims Acts”). The False Claims Acts assist the Federal and State Government in preventing and detecting fraud, waste and abuse in Federal health care programs, such as Medicare and Medicaid.