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Telligen’s Ability to Combine Extensive Clinical and Technical Expertise

To Intelligently Solve Our Clients' Complex Healthcare Challenges

Section 1: Introduction
Purpose of the Telligen’s Utilization and Quality Management Program
The purpose of the Telligen’s Utilization and Quality Management (UM and QM) program is to ensure that appropriate medical services are provided with medical necessity and Quality of Care in accordance with state and federal regulations, statutes and policies to clients of Nebraska Medicaid.

Corporate Background and Experience
As a Medicaid utilization management and Medicare Quality Improvement Organization (QIO) contractor for over 40 years, Telligen has developed contract specific UM plans for all elements of utilization review including admission, quality, invasive procedure, length of stay, outliers, coverage, discharge review and DRG validation. As a URAC accredited organization, we have corporate policies and procedures for utilization management that we will use as the foundation for the Nebraska Medicaid contract.

Mission
We optimize the quality of medical care and health through collaborative relationships, education, and health information management.

Vision
To be recognized for leadership, innovation and excellence in improving the health of individuals and populations.

Core Values

Excellence ~ Integrity ~ Dedication ~ Community

Section 2: Review Plan Overview
Authority
The Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care contracts with Telligen to implement and manage quality and utilization control program for hospital acute inpatient, outpatient, prior authorization for home care, durable medical equipment, prosthetic, orthotic and medical supplies, hearing aids and acute rehabilitation services provided to Nebraska Medicaid clients in the fee-for-services system.

Telligen will perform professional and technical services and other duties in accordance with, and subject to applicable Federal and State statutes and regulations, any DHHS departmental policies which may be contained in the DHHS Provider Bulletins, DHHS Provider Handbooks and any other law and regulation which may be issued or promulgated from time to time.
Purpose of Review Plan
The purpose of this document is to notify providers of the process that Telligen will follow for review of hospital acute inpatient, outpatient, prior authorization for home care, durable medical equipment, prosthetic, orthotic and medical supplies, hearing aids and acute rehabilitation services provided to Nebraska Medicaid clients in the fee-for-services system.

Objectives
DHHS contracts with Telligen to review services provided to Nebraska Medicaid clients to:
1. Evaluate the medical care that was provided for medical necessity, reasonableness and appropriate use of Medicaid funds.
2. Assess for the Quality of Care of those services so that they meet the professionally recognized standards of health care; and
3. Assess the setting the care was delivered in was appropriate for the type of service provided by the standards of practice.
4. Determine if the level of care was appropriate for the services rendered.

The Primary Objectives of the UM Plan
To provide a monitoring system to determine that medical services are delivered at the appropriate level of care in a timely, effective and cost-effective manner, to examine and improve the quality of medical care, and to evaluate practice patterns of healthcare delivery.

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

The fact that the physician 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 that it is covered by Medicaid.

Services and supplies that do not meet the definition of medical necessity set out above are not covered.
Section 4: Security HIPAA

Regulation and Guidance
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 enacted by Congress, includes Administrative Simplification provisions that mandated the adoption of federal privacy protections for individually identifiable health information, national standards for electronic health care transactions and code sets, unique health identifiers, and security. Under terms of this contract and as a contracted partner with the Department, the contractor will be subject to the HIPAA Administrative Simplification Statue and Rules published by the U.S. Department of Health and Human Services (http://www.hhs.gov/ocr/privacy/hipaa/administrative). As defined in the Enforcement Rule provisions 45 CFR Part 160, Subparts C, D, and E, the contractor will be held accountable for criminal and civil money penalties imposed for violation of the HIPAA Administrative Simplification Rules.

Section 5: Patient Eligibility
It is the responsibility of the requesting provider to verify Medicaid patient eligibility and to contact Telligen with the requested information. Medicaid eligibility (both pending and final) can be verified through the Nebraska Medicaid Eligibility System (NMES). Providers may register for internet access to the Nebraska DHHS Eligibility System, which allows electronic access to client eligibility and claim status. Information is available at http://dhhs.ne.gov/medicaid/Pages/med_eligibility.aspx.

Section 6: Utilization Review

Utilization Review Procedures
All cases subject to review will be evaluated for medical necessity, appropriateness, timeliness of services, and level of care, as determined by the Medicaid services/benefits. Cases subject to review are dependent upon the Medicaid benefit plan but may include inpatient admissions, outpatient procedures, or other services, as the UM contract specifies. It is the policy of Telligen to perform the following reviews:

- Procedure Review for certain operations and diagnostic test using clinical criteria. The review determines whether the requested service is medically necessary and delivered in the most appropriate setting. This is completed within the time frames specified by state laws and contractual obligations;
- Prospective Review or Pre-Service Medical Necessity reviews prior to an admission or proposed service using clinical criteria. The review determines whether an admission or service is medically necessary and delivered in the most appropriate setting. This is completed within the time frames specified by state laws and contractual obligations;
- Concurrent Medical Necessity Review after the client/member has been admitted to an inpatient facility using updated information required for continued stay and appropriate level of care. The review determines whether service is medically necessary and delivered in the most appropriate setting. This is completed within the time frames specified by state laws and contractual obligations;
- Continued Stay Review after the initial admission certification is completed. These reviews are performed during the institutional stay to ensure the client/member continues to meet medical necessity criteria and services continue to be delivered in the most appropriate setting. This is completed within the time frames specified by state laws and contractual obligations; and
- Retrospective Medical Necessity Review (also known as Post Service) when the client/member has been discharged or the services have been completed. The review determines if the

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[Image]
admission/continued stay or services were medically necessary and whether care was delivered in the most appropriate setting. In addition, review of outlier cases can be conducted. The outlier cases are reviewed to ensure provider treatment is consistent with practice guidelines. This is completed within the time frames specified by state laws and contractual obligations.

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

The fact that the physician 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 that it is covered by Medicaid.

Services and supplies that do not meet the definition of medical necessity set out above are not covered.

Approval by the federal Food and Drug Administration (FDA) or similar approval does not guarantee coverage by Nebraska Medicaid. Licensure/certification of a particular provider type does not guarantee Nebraska Medicaid coverage.

Section 7: Quality of Care Review
Overview
Quality of Care reviews are performed on all services reviewed by Telligen. The purpose of Quality of Care reviews is to determine whether the quality of service provided to Medicaid clients meet the professionally recognized standard of health care. The processes for these retrospective reviews are found below.

Quality Review Criteria
Medical records are initially reviewed by the clinical reviewer utilizing InterQual® criteria and Centers for Medicare and Medicaid Services (CMS) Quality of Care screens. Determinations of Quality of Care concerns are based on generally recognized standards of medical care and physician professional medical judgment. See Appendix B for Centers for Medicare and Medicaid Services (CMS) Quality of Care screens.

Quality Review Process
Telligen clinical reviewer completes the initial Quality of Care review of the complete medical record. If there are no concerns and all screening criteria are met, the case will be approved by the Telligen clinical
reviewer. If one or more potential Quality of Care concerns is identified by the clinical reviewer, the case if referred to the Medical Director. The Medical Director reviews the complete medical record to determine:

1. If the Quality of Care concerns identified and referred by clinical reviewer are valid; and
2. If the review of the medical record demonstrates additional concerns not identified by the clinical reviewer.

The Medical Director makes his determination based on the above mentioned findings.

**Quality of Care Issue Notification**

Qualities of Care concerns are tracked by Telligen to identify developing trends. Issues across institutions are addressed in educational communication, such as the Telligen Newsletter. Trends within a single institution result in a notification letter to the designated hospital contact liaison and, if appropriate, to the physician. Notification letters will include any requested response. Each concern results in written notification to the designated Hospital Contact Liaison or involved physician (in some instances both) indicating the identified concern. Providers and/or the attending physician have 60 calendar days to respond to quality concerns, to request a reconsideration of the review. The date of the letter of notification is considered Day (0) zero.

**Review for Quality of Care Issues**

Either the attending physician and/or facility may request a reconsideration of the Quality of Care determination. The reconsideration must be requested in writing within 60 days of the final determination notification along with any additional information and the reason the provider believes the quality level determination was in error. The date of the notification is considered Day (0) zero. If a reconsideration request is received, Telligen will ask a physician reviewer, not involved in the initial determination, to review the medical record. Physician reviewers are board certified or have adequate training and experience, and to the extent possible, are of the same specialty and practice setting as the involved physician. The patient’s medical information supplied by the facility and/or attending physician is forwarded to the physician reviewer. The physician reviewer is asked to address the initial determination based on the medical information they have received, and any other concerns that are noted. The designated hospital contact liaison and physician will be notified in writing of the reconsideration determination. Upon completion of the reconsideration, written notification is sent to the entity who requested the reconsideration indicating the determination.

If no request is received for reconsideration, the Quality of Care determination is considered final.
Section 8: Telligen’s Nebraska QIO Organization Chart

Telligen Board of Directors

Chief Executive Officer
Jeff Chungath

Corporate Support
Chief Financial Officer, Denise Sturm
VP, Information Management, Brian Barry
VP, State Contracts, Mike Speight
VP, HR & Communications, Doug Ventling

VP, Health Management
David Hancock

Program Director
Jeanne Schirmer

Contract Manager
Melissa Felt, RN, BSN

Project Assistant
Beth Culver

IS Coordinator
Becky Metzger

Lead Review Coordinators:
Nancy Johnson

Medical Coding Analyst
Joyce Castonguay

Chief Medical Officer
Paul Mulhausen, MD

Medical Director
Stuart Schlanger, MD

Nebraska Peer Review Panel

Key Staff

Telligen
Section 9: Nebraska Medicaid Review Team Positions

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<th>UM/QM Position</th>
<th>Responsibilities</th>
<th>Qualifications</th>
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</thead>
<tbody>
<tr>
<td>Senior Review Coordinator / Review Coordinator</td>
<td>• Performs prospective, concurrent or retrospective utilization review/medical management for all services including appropriateness of Quality of Care based on contract, state, or URAC requirements. Screens individual cases according to specific criteria to determine if care is appropriate. • Refers cases that fail to meet criteria to peer review • Enters medical information into system(s)</td>
<td>• Registered nurse or other licensed healthcare professional directly relevant to the type of review performed • One to two years’ experience in a healthcare setting • Valid Nebraska license • Functional PC knowledge • Knowledge of medical coding, billing and/or utilization management preferred</td>
</tr>
<tr>
<td>Medical Coding Analyst</td>
<td>• Performs coding validation to ensure submitted diagnoses/procedures on claim are supported by clinical record documentation and appropriate billing • Screens individual situations according to applicable coding guidelines to determine if coding is appropriate • Refers cases that fail to meet criteria to peer reviewer • Performs preliminary research on topics such as coverage determinations, coding guidelines or standards of care.</td>
<td>• Experience with ICD coding and concepts as well as CPT and HCPCS coding required • Two years minimum experience in inpatient and/or outpatient coding. • Certified Professional Coder or Certified Coding Specialist or Certified Coding Assistant or Registered Health Information Technician or Registered Health Information Administrator required</td>
</tr>
<tr>
<td>Project Assistant</td>
<td>• Support functions including scheduling • Assists in creating and editing documents including manuals, policies &amp; procedures and reports • Prepares documentation for internal and external meetings (agenda, minutes, handouts, etc.)</td>
<td>• Two year degree in business or related field • Three to four years’ experience in project administrative support • Proficient with handling confidential information • Ability to multi-task and problem solve in a deadline driven environment</td>
</tr>
</tbody>
</table>

Telligen’s local office is in Lincoln at 206 South 13th Street, Suite 100. Our Call/Review Center is staffed from 8:00 a.m. to 5:00 p.m. central time Monday through Friday. The office will be closed on Nebraska State Holidays.

Our Prior Authorization Program allows providers to submit requests for prior authorization via secure web portal, fax or by mail 24 hours a day, seven days a week.
Section 10: Review Management
Utilization and Quality Reviews
The Utilization and Quality Reviews include prior authorization, concurrent, and retrospective reviews in inpatient and outpatient hospital settings including physical rehabilitation, ambulatory surgery centers, home health agencies and other outpatient settings.

Scope of Work
Contracting with a QIO ensures the Department meets its State Plan requirements for a statewide medical and utilization review program.

Telligen’s Utilization and Quality Management Program ensures the Nebraska Medicaid and Long-Term Care program only pays for services which are medically necessary, delivered in the correct setting, in the appropriate amount or duration and which meets the highest level of quality.

Medicaid clients who are enrolled in a Medicaid Managed Care Plan for their physical and behavioral health services are exempt from review under this contract.

In addition, services for clients dually eligible for Medicare and Medicaid are exempt from review except for home health and private duty nursing services, durable medical equipment (DME) and hearing aids for which prior authorization of services is required.

Section 11: Medicaid Authorization Requests
Providers may submit Medicaid authorizations by three methods:
1. Portal – (preferred method)
2. Fax
3. Mail

Providers will continue to be responsible for the costs associated with copying and mailing medical records requested for review completion.

Authorization Requests via Portal
Telligen offers a secure HIPAA-compliant web portal for providers to submit requests for authorization and to supply clinical documentation to support the requested service. The portal is pre-loaded with request information for prior authorizations per Nebraska Medicaid criteria. Providers may start a case with the member’s Medicaid ID number and date of birth. The embedded request questionnaires will move each provider through the request and at the completion allow for uploading the clinical documentation. Please see the Telligen’s portal manual for more details or the Telligen’s webpage for a webinar on the portal’s use. The web portal is accessible to providers 24 hours per day, seven days per week.

Requests and supporting information received electronically are automatically processed and available to our review staff in Qualitrac™.

This method streamlines processes, saving Nebraska Medicaid valuable dollars on contractor staff time. To access the Telligen Portal go to the web page http://telligen.nemedicalauth.com/ and the logon will be in the upper right hand corner.
Authorization Requests via Fax
Providers will also be able to submit authorization requests to Telligen through a secure fax transmission. Nebraska Medicaid criteria based request questionnaires are available on the Web page. This is the same information found on the questionnaires in the portal. This option will be available 24 hours per day, seven days per week.

We process requests received by secure fax transmission within four business hours following receipt. Our fax system is integrated with Qualitrac™, so once a fax is received, it is automatically added into the queue for our operations team. This allows them to immediately begin review activities without any delays resulting from manual entry of the case into the system.

Secure Toll Free Fax: 855-638-8017

Authorization Requests via Mail
Providers will be able to submit authorization requests through the mail, if they do not have access to Telligen’s Portal system or fax services. The mailing address is:
Telligen
206 South 13th Street, Suite 100
Lincoln, Nebraska 68508

Section 12: Review Types

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<th>Review Type</th>
<th>Submission Method/Review Components</th>
<th>Documentation Requirements</th>
<th>Time Frame to Completion &amp; Notification</th>
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<tbody>
<tr>
<td>Prior Authorization</td>
<td>• Web Portal or Fax; Portal Preferred • Medical Necessity</td>
<td>• History &amp; Physical • Physicians’ Orders • Other Supporting Documentation</td>
<td>• Notification to Provider Within Number of Days Specified By Review Type • Electronic Notification to MMIS within Two Business Days or within One Business Day With Additional Information</td>
</tr>
<tr>
<td>Prior Authorization and Continued Service Clinical Reviews for Home Health and Private Duty Nursing</td>
<td>• Web Portal or Fax; Portal Preferred</td>
<td>• Diagnoses • Physicians’ Orders • Home-Bound Status • Assessment • Treatment Plan</td>
<td>• Within One Business Day or within One Business Day Following Receipt of Additional Information • Immediately for Clients Pending Hospital Discharge</td>
</tr>
<tr>
<td>Continued Service Non-Clinical Reviews for Home Health and PDN</td>
<td>• Web Portal or Fax; Portal Preferred</td>
<td>• Valid Provider ID • Diagnosis Codes • Medicaid Eligibility • Service Dates &amp; Units</td>
<td>• Within One Business Day</td>
</tr>
<tr>
<td>Select Surgical Procedures Including Cosmetic, Reconstructive &amp; Other Procedures</td>
<td>• Web Portal or Fax; Portal Preferred</td>
<td>• History &amp; Physical • Physicians’ Orders • Other Supporting Documentation</td>
<td>• Within Two Business Days or within One Business Day with Additional Information</td>
</tr>
<tr>
<td>Review Type</td>
<td>Submission Method/Review Components</td>
<td>Documentation Requirements</td>
<td>Time Frame to Completion &amp; Notification</td>
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<tr>
<td>Out-Of-State Services</td>
<td>• Complete MR By Portal, Fax or Mail&lt;br&gt;• Medical Necessity&lt;br&gt;• Appropriate Service Location&lt;br&gt;• Billing Accuracy</td>
<td>• History &amp; Physical&lt;br&gt;• Physicians’ Orders&lt;br&gt;• Other Supporting Documentation</td>
<td>• Within Five Business Days or within Two Business Days with Additional Information</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>• Web Portal or Fax; Portal Preferred</td>
<td>• Ms-79 and Signed by Physician for DME&lt;br&gt;• Form DM-5H for Hearing Devices&lt;br&gt;• Hearing Aids &amp; Devices &gt; $500.00;&lt;br&gt;• Repairs &amp; Accessories &gt; $150</td>
<td>• Within Ten Business Days of Request or within Two Business Days of Receipt of Additional Information</td>
</tr>
<tr>
<td>Inpatient Acute Rehabilitation</td>
<td>• Requests Via Portal or Fax&lt;br&gt;• Complete MR for Prepayment Review&lt;br&gt;• Medical Necessity&lt;br&gt;• Admission Review&lt;br&gt;• Quality of Care</td>
<td>• Initial Assessment&lt;br&gt;• Team Conference&lt;br&gt;• Short/Long Term Goals</td>
<td>• Facility Notified by Phone Within One Business Day;&lt;br&gt;• Written Denial Letter within 24 Hours&lt;br&gt;• Recon Request within One Business Day of Receipt of Additional Information</td>
</tr>
<tr>
<td>Inpatient Acute Rehabilitation</td>
<td>• Continued Stay Review&lt;br&gt;• Stability at Discharge&lt;br&gt;• Transfer Review&lt;br&gt;• Quality of Care</td>
<td>• See Provider Manual for Specific Documentation Required</td>
<td>• Facility Notified by Phone Same Day if Documentation Received by Noon for Approvals And Denials;&lt;br&gt;• Written Denial Notification within 24 Hours</td>
</tr>
<tr>
<td>Reconsiderations</td>
<td>• Requests Via Portal, Fax or Mail&lt;br&gt;• Expedited Recon Available for PA and Concurrent Reviews</td>
<td>• Additional Supporting Documentation</td>
<td>• 30 Days From Request Date To Complete;&lt;br&gt;• Expedited Within 4 Hours</td>
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<tr>
<td>Review Type</td>
<td>Submission Method/ Review Components</td>
<td>Documentation Requirements</td>
<td>Time Frame to Completion &amp; Notification</td>
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<tr>
<td>Retrospective Review</td>
<td>• Complete Medical Record by Portal, Fax or Mail</td>
<td>• Inpatient Review Categories Include:</td>
<td>• 20 Business Days for Approved Cases</td>
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<tr>
<td>• Inpatient &amp; Outpatient Critical Access Hospitals</td>
<td>• DHHS Determined Sample Sizes; Includes Inpatient Admissions within 31 Days Prior to Outpatient Procedure or Within Three Days Following Outpatient Procedure</td>
<td>• Admission &amp; Invasive Procedure Medical Necessity</td>
<td>• 20 Additional Days for Provider Opportunity to Respond to Request for Additional Information</td>
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<td>• Ambulatory Surgical Centers</td>
<td></td>
<td>• Quality Review</td>
<td>• Recommend 60 Days to Submit Complete Records if Requested to Avoid Technical Denial</td>
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<td>• ASC – All Categories Except Admission</td>
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<tr>
<td>Retrospective Review</td>
<td>• Complete Medical Records By Portal, Fax or Mail</td>
<td>• Inpatient Review Categories Include:</td>
<td>• 20 Business Days for Approved Cases</td>
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<tr>
<td>• Inpatient &amp; Outpatient DRG Hospitals</td>
<td>• DHHS Determined Sample Sizes Plus DRG 468, 477;</td>
<td>• DRG Validation</td>
<td>• 20 Additional Days for Provider Opportunity to Respond to Request for Additional Information</td>
</tr>
<tr>
<td>• Cost Outlier Review In DRG Hospitals</td>
<td>• Inpatient Admissions Within 31 Days Prior To Outpatient Procedure or Within Three Days Following the Outpatient Procedure</td>
<td>• Admission &amp; Invasive Procedure Medical Necessity</td>
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<td>• Outliers</td>
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<td>• Discharge Stability</td>
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<td>Appeals Fair Hearings</td>
<td>• Written Request to DHHS for Adverse Decisions with Payment Consequences</td>
<td>• 465 NAC 6-009</td>
<td>• DHHS Schedules</td>
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<td>• Appeal Requests Received within 90 Days of Reconsideration Decision Date</td>
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Section 13: Prior Authorizations

Work Flow

Prior Authorization Overview
Telligen review coordinators complete a detailed review of the submitted documentation including the plan of care to ensure services have been ordered in compliance with all coverage regulations identified in corresponding sections of 471 NAC.
The review includes analysis of the prior claims history to ensure there is no duplication of service and the member has a reasonable expectation to benefit from the Skilled Nursing, Home Health Aide and/or Physical Therapy, Occupational Therapy or Speech Therapy Services, Admissions for Acute Rehabilitation, Concurrent Rehabilitation Care, Durable Medical Equipment, Prosthetic, Orthotic and Medical Supplies (DMEPOS), and Hearing Aids.

Telligen encourages providers to use the web based portal for all prior authorization requests.

Telligen’s review system, Qualitrac™ will flag these authorization requests as a timed priority to ensure they receive immediate attention by the review coordinators and are completed within the time frame designated by DHSS for completion of specific review areas.

In situations where the member is being discharged from a hospital setting or other circumstance that requires a more timely authorization decision, the provider can mark the case as urgent if requesting authorization through the web portal.

Another option is Telligen’s ability to set up a dedicated fax line for urgent authorization requests.

Both situations would elevate the case to the top of the Qualitrac™ scheduler for priority completion by the review coordinators. Added features of the Qualitrac™ system include management tools to monitor authorization timeliness and staff productivity. Having these tools allows the contract manager to view the operations dashboard to assess the volume of pending reviews and corresponding due dates and times prompting action if indicated to ensure timely completion of all authorizations.

In situations where the review coordinator or the physician reviewer identifies additional information necessary to complete the review, Telligen will notify the provider and suspend the review until the additional information is received.

The final review and coverage decision will be completed and communicated to the provider within one business day of receipt of the additional information.

**Prior Authorization (PA) Initial Review**

For requests received via the portal, provider and client eligibility is confirmed through Qualitrac™.

For requests received via fax or mail, the review assistant verifies client eligibility, verifies the PA requested for the client is a service that requires authorization and builds the case in Qualitrac™.

The case is then referred to the review coordinator through the system scheduler.

The review coordinator reviews the information submitted by the provider including pertinent portions of the medical record if available to determine whether the requested service is medically necessary by applying the appropriate criteria set.

Our review coordinator may request additional information from providers to support the PA request. For example, during review of durable medical equipment PA requests, Telligen may request that providers submit medical clearance forms to justify DME or supplies.
Requests for Additional Information
If the information supplied by the provider is insufficient to complete the review, Telligen will suspend the case. Telligen will contact the provider for all suspended cases to request the additional information needed to complete the review. If the provider does not provide the additional information within two (2) days following the initial contact, Telligen will administratively deny the requested service. The case will be reopened if the provider submits the additional information at a later time.

Telligen records and tracks all information received from the provider and all requests for additional information in Qualitrac™. The information recorded includes supporting documentation from the provider and the date of all follow up requests for additional information. This enables us to respond immediately to a request from the Department regarding the status of any suspended review.

Upon receipt of the missing information, the review coordinator resumes the review process and completes the review within one (1) business day following receipt of the additional information. The review team has experience working collaboratively with providers offering education on the specific documentation needed to efficiently process authorization requests.

Criteria Application
All cases must meet Nebraska DHHS criteria before applying any other criteria. Telligen utilizes McKesson InterQual® criteria, which are updated annually to ensure the criteria continue to represent the latest clinical practices. During the criteria development process, McKesson uses a national network of over 800 practicing clinicians from settings that cover all major specialties. The criteria cover the healthcare continuum and can thus be applied to all service types and can be used as members move from one setting to the next.

Telligen’s use of InterQual® criteria offers a seamless transition for the provider community, since the current vendor also uses InterQual® criteria. This ensures consistency in review processes and eliminates the need for providers to learn and adapt to a new set of expectations.

InterQual® criteria will be used by the nurse review coordinators to conduct initial screening of the case. If criteria are met, the review coordinator approves the requested service(s) and the results are documented in the review system.

Review coordinators may only approve prior authorization requests based on application of criteria. Telligen ensures criteria are applied in a uniform manner through the inter-rater reliability process. If criteria are not met, the case is referred to the medical director or a physician reviewer licensed in Nebraska to perform a physician review.

Peer Review Referral
If the information provided for the review does not meet the criteria for approval, the review coordinator refers the case to our medical director or physician peer reviewer. Using clinical knowledge and medical judgment, the peer reviewer determines the appropriateness of the requested service(s) and provides a medical rationale for the decision(s).
Approved Requests
Following review coordinator or peer reviewer approval of the requested services, Telligen will document the outcome in Qualitrac™. Notification of the approval will be sent electronically to the provider generated from Qualitrac™.

Denied Requests
If the peer reviewer determines the requested service is not medically necessary or appropriate, he/she will deny or modify the service(s). The peer reviewer will document the outcome in Qualitrac™. Telligen will supply medical rationale for the denial or modified decision in plain language that the client can understand. Letters approved by DHHS will be generated from Qualitrac™.

Section 14: Notification for Approved, Denied or Modified Requests
Providers who access the secure web portal will receive a secure email regarding the outcome of the review request. The provider will be able to print the notification letter from the portal.

For authorization requests received via fax, we will notify the requestor by fax or by phone followed by a written notice generated by Qualitrac™. The notice will be mailed or faxed to providers without access to the web portal.

If any Quality of Care concerns are identified by the review coordinator and confirmed by the physician reviewer, we will notify the provider of the Quality of Care concern including any related reference to evidence-based care standards. If a pattern of concern occurs, we will refer the provider to the Nebraska Medicaid Program Integrity Unit.

Section 15: Prior Authorizations Review Types
Clinical Reviews for Home Health and Private Duty Nursing
There are established limits to the timeframe and/or the number of units or hours of home health and private duty nursing services that can be authorized for Medicaid members.

If the provider believes the member would benefit from additional services, the provider must request a new authorization for continued or additional services to be paid by the Medicaid program. Continued services will need a new request and clinical documentation to extend the services that are already in place. A new authorization number will be assigned for each request.

In clinical continuing authorizations, the review coordinators conduct medical necessity review by reviewing the physician’s orders, updated plan of care and supporting medical record documentation to determine if the member’s condition or functional limitations requires a continuation of the home health, private duty nursing or therapy services. As in the prior authorization review process, if the medical information supplied by the provider does not meet the criteria for continuing services, the case will be referred to our medical director or other physician reviewer.

These include retrospective eligibility reviews for children under the age of one (1).
Surgical Procedures
Select surgical procedures including cosmetic, reconstructive and other procedures like organ
transplants, gastric bypass or new procedures without proven value are subject to pre-procedure
review. Since these procedures are generally elective and not considered emergency procedures, the
physician responsible for admitting the patient must initiate the prior authorization review.

Telligen will follow standard prior authorization workflow to ensure the authorization is completed and
results communicated to the provider within two (2) business days of the request and submission of the
pertinent medical information or within one (1) business day of receipt of any additional information we
request.

Authorization requests identified as urgent based on the client’s clinical presentation will be completed
on a priority basis as previously described.

Specific Bariatric Checklists are provided to ensure that the provider submitting the authorization is
including all of the extensive but required information for this process. The checklist may be located on
the Nebraska Medicaid Webpage at http://telligen.nemedicalauth.com/.

Out-of-State Facilities Request for Medicaid Authorization
Telligen will review all services provided in out-of-state facilities or by out-of-state providers which
require prior authorization or in situations where the service is not available in the state of Nebraska.

Telligen will follow the standard prior authorization review process for similar services provided by in-
state providers and services.

Telligen will complete all out-of-state authorization requests and notify providers within five (5) business
days of the original request or within two (2) business days of receipt of any additional information we
request from the provider.

Typically these providers do not have access to the portal and would fax or mail the requests.

Durable Medical Equipment, Prosthetic, Orthotic and Medical Supplies (DMEPOS) and
Hearing Devices
Telligen will follow the prior authorization review workflow process and will complete all DMEPOS and
hearing device requests and notify providers within ten (10) business days of the original request or
within two (2) business days of receipt of any additional information we request from the provider.

Requests identified as urgent based on the client’s clinical presentation will be completed on a priority
basis as previously.

Telligen shall evaluate and make determinations regarding DMEPOS and hearing device authorization
requests to include, but not limited to:
- Wheelchair and Seating Systems;
- Hearing Devices;
- Other Items or Equipment:
  - Blood Ketone or Reagent Strips for Home Blood Glucose Monitors;
  - Tracheal Suction Catheter, any type other than Closed System;
Walker, Rigid (Pickup) Adjusted or Fixed Height;
- Tub Stool or Bench;
- Hospital Beds;
- Safety Enclosure Frame/Canopy for Use with Hospital Bed, any type;
- Oximetry Device for Measuring Blood Oxygen Levels Non-Invasively;
- Nebulizer;
- Patient Lift or Seat Lift;
- Ultraviolet Light Therapy System;
- Transcutaneous Electrical Nerve Stimulation (Tens);
- Functional Electrical Stimulator, Transcutaneous Stimulation of Nerve and/or Muscle Groups,
- Any Type, Complete System, Not Otherwise Specified;
- External Ambulatory Infusion Pump, Insulin;
- Whirlpool, Non-Portable;
- Communication Board, Non-Electronic Augmentative or Alternative Communication Device;
- Negative Pressure Wound Therapy Electrical Pump, Stationary or Portable (Wound Vacuum);
- Speech Generating Devices and Accessories;
- Artificial Larynx, any type;
- Headset/Headpiece for use with Cochlear Implant Device;
- Microphone for use with Cochlear Implant Device, Replacement;
- Transmitting Coil for use with Cochlear Implant Device, Replacement;
- Transmitter Cable for use with Cochlear Implant Device; Cochlear Implant; and
- Auditory Osseo Integrated Device, External Sound Processor, Replacement.

Telligen shall review authorization requests and submit the review decision to the provider within ten (10) business days of the date the information is submitted by the provider, or as expeditiously as the client's health requires as indicated by the medical service provider.

When additional information is required, the review shall be completed and the coverage decision shall be sent to the provider within two (2) business days of the date the additional information is received by the contractor.

471 NAC 7-007 DMEPOS Documentation of Medical Necessity
The provider shall obtain written documentation from the prescribing physician which justifies the medical necessity for DMEPOS and related services provided. The original documentation of medical necessity must be kept on file by the provider. The documentation must:

1. Be signed by the physician's own hand (stamps or other substitutes may not be used) and dated, using the date the documentation is signed;
2. Specify the start date of the order if the item is provided before the date the documentation is signed;
3. Include the physician's name, address and telephone number;
4. Include the diagnosis and/or condition necessitating the item(s) and an estimate of the total length of time the item will be needed (in months or years). The estimated total length of time the item will be needed must be completed by the physician or physician's office staff;
5. Be sufficiently detailed, including all options or additional features which will be separately billed or will require an upgraded procedure code;
6. Describe the ordered item(s) using either a narrative description or a brand name/model number, including all options or additional features (this may be completed by someone other than the physician, but the physician must review the order and sign and date it to indicate agreement);
7. For supplies provided on a periodic basis, include appropriate information on the quantity used, frequency of change and duration of need (PRN or "as needed" may not be used); and
8. Include information substantiating that all Nebraska Medicaid coverage criteria for the item(s) are met.

**471 NAC 7-010.01 DMEPOS Coverage Criteria**
Criteria for Nebraska Medicaid coverage of DMEPOS is outlined in 471 NAC 7-013. Items not specifically listed may not be covered by Nebraska Medicaid. In order to be covered by Nebraska Medicaid, the client’s condition must meet the coverage criteria for the specific item. Documentation which substantiates that the client’s condition meets the coverage criteria must be on file with the provider (see 471 NAC 7-007 for documentation of Medical Necessity Requirements).

**471 NAC 8-007.03 Hearing Aids Prior Authorization Procedures**
Nebraska Medicaid requires that the following information be submitted when requesting prior authorization for a hearing aid or assistive listening device.

1. A complete audiogram (pure tone, air bone, masking, speech);
2. The name of the examiner or dispenser performing the audiogram;
3. The type of hearing aid or assistive listening device being recommended and any accessories;
4. The estimated cost of the hearing aid or assistive listening device;
5. The estimated cost of each accessory;
6. The hearing aid dispenser's provider number; and
7. The hearing aid dispenser's name, address and phone number.

**471 NAC 18-004.44A Apnea Monitors Cross Reference 471 NAC 10-005.22A**
Nebraska Medicaid covers home infant apnea monitoring services for infants who meet one of the following criteria. Nebraska Medicaid defines infancy as birth through completion of one year of age.

1. Infants with one or more apparent life-threatening events (ALTE's) requiring mouth-to-mouth resuscitation or vigorous stimulation. ALTE is defined as an episode that is frightening to the observer and characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually limpness), choking, or gagging. In some cases, the observer fears the infant has died;
2. Symptomatic preterm infants;
3. Siblings of one or more SIDS victims; or
4. Infants with certain diseases or conditions, such as central hyperventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants with substance-abusing mothers, or infants with less severe ALTE's.
Nebraska Medicaid recognizes the Nebraska Chapter of the American Academy of Pediatrics Standard of Care for home phototherapy. Home phototherapy services will be covered when the following conditions are met:

1. Infant evaluation by the physician and parent/caregiver training occurs before placement of equipment;
2. Documentation must be available with the supplier to show that:
   a. The physician certifies that the infant's condition meets the medical criteria outlined below and that the parent/caregiver is capable of administering home phototherapy; and
   b. The provider certifies that the parent/caregiver has been adequately trained and consent forms used by the provider have been signed; and
3. The infant's medical condition meets the following criteria:
   a. Greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 gms (5 lbs);
   b. Greater than 48 hours of age;
   c. Bilirubin levels at initiation of phototherapy (greater than 48 hours of age) are 14-18 mgs per deciliter;
   d. Direct bilirubin level less than 2 mgs per deciliter;
   e. History and physical assessment (if the service begins immediately upon discharge from the hospital, the newborn discharge exam will suffice); and
   f. Required laboratory studies to include CBC, blood type on mother and infant, direct Coombs, direct and indirect bilirubin (additional laboratory data may be requested at physician’s discretion). At a minimum, one bilirubin level must be obtained daily while the infant is receiving home phototherapy.

Ambulatory Uterine Monitors will be covered when the following conditions are met:

1. Evaluation by the physician and training on use of the monitor occurs prior to placement of the monitor;
2. Documentation must be available with the supplier to show that:
   a. The physician certifies that the client meets the medical criteria outlined below; and
   b. The provider certifies that the client has been adequately trained; and
3. The client must be at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy. The pregnancy must be greater than 20 weeks gestation and the client must meet one of the medical conditions listed below:
   a. Recent preterm labor with hospitalization and discharge on tocolytic therapy;
   b. Multiple gestation;
   c. History of preterm delivery;
   d. Anomalies of the uterus;
   e. Incompetent cervix;
   f. Previous cone biopsy;
   g. Polyhydramnios; or
   h. Diethylstilbestrol exposure.
Others at high risk for preterm labor and delivery may be covered for this service upon approval by the Department’s Medical Director through written communication from the client’s physician (preferably in consultation with a perinatologist).

**Section 16: Acute Hospital Rehabilitation Admissions**

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**Supporting Information**

- Initial Assessment
- Team Conference
- Short/Long Term Goals

**Notification**

- Facility notified by phone within one (1) business day; written denial letter w/in 24 hours
- Reconsideration request within one (1) business day of receipt of additional information

Telligen’s methods for reviewing admissions requests for acute inpatient hospital rehabilitation services will follow the prior authorization process with the following modifications:

1. Each acute hospital rehabilitation admission will be reviewed and authorized with requested dates of service if it meets admission criteria;
2. The request will be applying InterQual® criteria, the review coordinator will identify any case which does not meet criteria or where the Quality of Care is questioned and will refer to our medical director or physician reviewer for continuation of the peer review process;
3. In cases where the admission meets criteria and is approved, our review coordinator will assign the length of stay; and
4. Telligen will complete all admission inpatient hospital rehabilitation service requests and notify the hospital of the approval or denial within one (1) business day of receiving the pertinent medical information.

Denial notices will be followed by written communication to the hospital, attending physician and client.

Authorization requests identified as urgent based on the member’s clinical presentation will be completed on a priority basis

**Prepayment**

If the client becomes retroactively eligible for Medicaid and has been discharged from the acute inpatient rehabilitation hospital, the hospital must contact us to complete a prepayment review.
This review is conducted prior to the hospital submitting the claim for payment and the entire hospitalization will be reviewed.

We will request hospitals to submit medical record copies for review via the portal or by mail.

The review coordinator will complete the review by applying the criteria and determining the medical necessity of both the admission and continued stay in the rehabilitation hospital setting.

Any case which does not meet criteria or where the Quality of Care is questioned will be referred to our medical director or physician reviewer for continuation of the peer review process.

**Continued Stay**

Each acute inpatient rehabilitation hospital admission will be authorized with dates of service. If the patient requires a continuation of services beyond the approved dates of service, a new request will be sent to Telligen with supporting documentation for the continuation of care, if the continuation of care is approved, a new authorization number will be issued for the continued dates of service.

The request will be reviewed initially by applying InterQual® criteria, the review coordinator will identify any case which does not meet criteria or where the Quality of Care is questioned and will refer to the medical director or physician reviewer for continuation of the peer review process.

Telligen will follow the prior authorization review workflow process and will complete all acute inpatient rehabilitation hospital continued stay service requests and notify the hospital of the approval or denial within one business day of receiving the pertinent medical information.

Denial notices will be followed by written communication to the hospital, attending physician and client.

**471 NAC 10-001.05 Hospital Definition of Medical Necessity**

Nebraska Medicaid defines medical necessity as health care services and supplies which are medically appropriate, and:

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

The fact that the physician 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 that it is covered by Medicaid. Services and supplies that do not meet the definition of medical necessity set out above are not covered.
Section 17: Reconsideration

Nebraska Medicaid review procedures detail how Telligen processes reconsideration requests received from providers or the Department for reduced or denied admission, services or procedures.

Telligen will review all information submitted by the provider with the request for the reconsideration review. The following documentation must be submitted for reconsideration review requests for inpatient hospitalizations:

1. Original review documentation and physician review decision;
2. Letter from the requester including substantiation for medical necessity of the services; and
3. Documentation pertinent to the case including medical records, equipment consultations, progress notes, case histories, therapy evaluations, and etc.

The attending physician or facility, or the Department, may request a reconsideration of a case not meeting the criteria for all prior authorization reviews including:

1. Acute inpatient hospital rehabilitation services admissions;
2. Home care services;
3. DMEPOS;
4. Hearing aids; or
5. Surgical procedures.

The reconsideration review is required to be completed by a physician other than the physician making the original determination, and the approval or denial provided to the hospital within 60 days of receipt of the information relating to the request.

If the information provided for the reconsideration review does not meet the criteria for approval, the review coordinators will refer the case to a physician peer reviewer. When doing so, the review coordinator will select a peer reviewer of the same specialty and similar practice setting if available (rural or urban) as the provider requesting the service. The reconsideration peer reviewer will be a different physician from the initial physician reviewer who denied the admission.

Using medical judgment, the peer reviewer will determine the appropriateness of the admission and provide a medical rationale for their decision.

The review coordinator will notify the hospital typically within four hours but no longer than one (1) business day of the receipt of additional information, followed by written notification.

The review coordinator will review all submitted information and prepare a case summary for peer review.

Telligen will use a peer reviewer not involved in the original review decision to complete the reconsideration review. The peer reviewer will be Nebraska licensed and board certified. The peer reviewer will base the review decision on information used to make the initial determination, the decision and rationale of the original peer reviewer, and the additional supporting documentation supplied by the provider.

The reconsideration review determination may result in confirmation or modification of the original decision, or a complete reversal of the denial.
Telligen will notify the requesting provider and client of the reconsideration review result in writing following the review determination. The written notice will include the final determination and the rationale for the decision.

If any denied or modified service remains following reconsideration review, the notification letter will clearly advise the provider and the client of their right to request an appeal of the adverse decision.

In addition to denied or modified services, a reconsideration review is completed in situations where the client became eligible for Medicaid after medical services were provided and which required review and authorization prior to payment.

**Section 18: Retrospective Review Hospitals**

**Workflow for Retrospective Reviews**

Components of a retrospective review may include, but not limited to:

- Discharge Reviews;
- DRG Validation;
- Eligibility Related Review;
- Peer Review;
- Post-payment Review;
- Quality Review; and/or Prepayment Review

![Workflow Diagram](image-url)
<table>
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<tr>
<th>QIO Requirements</th>
<th>Method / Documentation Requirements</th>
<th>Time Frame of Request / Case Completion</th>
<th>Criteria</th>
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</table>
| Retrospective Review (Inpatient) Acute Care Hospitals Certified as Critical Access Hospitals | • Complete Medical Record Review  
• DHHS Determined Sample Sizes; Includes Inpatient Admissions within 31 Days Prior to Outpatient Procedure or within Three (3) Days Following Outpatient Procedure  
• Review Categories Include:  
  o Medical Necessity for Admission & Invasive Procedure  
  o Quality Review  
  o Transfers  
  o Level of Care | 30 Days to Provide Complete Medical Record / 20 Days to Complete for Approved Cases | • InterQual® Criteria  
• Professional Medical Judgment / Professionally Recognized Standards of Care |
| Retrospective Review (Inpatient) Acute Care Hospitals Reimbursed Under DRG Payment Methodology  
Cost Outliers in Acute Care Hospitals Reimbursed Under DRG Payment Methodology | • Complete Medical Records  
• DHHS Determined Sample Sizes Plus DRG 468, 477;  
• Inpatient Admissions within 31 Days Prior to Outpatient Procedure or within Three (3) Days Following Outpatient Procedure  
• Review Categories Include:  
  o Admission & Invasive Procedure Medical Necessity  
  o DRG Validation  
  o Outliers  
  o Quality Review  
  o Discharge Stability  
  o Transfers  
  o Level Of Care | 30 Days To Provide Complete Medical Records / 20 Days to Complete Approved Cases | • InterQual® Criteria  
• Professional Medical Judgment / Professionally Recognized Standards Of Care |
Retrospective Review Sampling
Telligen will collaborate with the Department to establish criteria for any additional samples identified by Telligen or by the Department. Through the tracking and trending of case review outcomes, Telligen will offer recommendations for adjustments to selection categories or volumes. In addition, using our experience in other utilization management programs, Telligen can identify trends seen in other populations that may be applicable in Nebraska. For example, in our QIO program we completed payment error reviews and identified trends of coding excisional debridement of decubitus ulcers. The up-coding resulted in significantly higher payments to providers. Telligen educated providers about proper coding for excisional debridement, and today it remains one of the focus areas for CMS’ Recovery Audit Contractors.

Telligen will also seek Department approval should it be determined that the sample sizes for the DRG and critical access hospital admissions need to be adjusted to account for changes in utilization patterns. Should it be determined that small hospitals are not well-represented in the sampling methodology; Telligen will collaborate and recommend to the Department an adjusted sampling methodology designed to ensure hospitals of all sizes are adequately represented in the sample. In another state Medicaid program, Telligen worked with that states health department and proposed categories for retrospective review based on analysis of our review results. Examples of the types of categories proposed included:

- Inpatient stays involving “Never Events” using CMS’ definitions
- Inpatient stays in DRG hospitals with a length of stay two days or less
- Inpatient stays for conditions usually treated in an outpatient setting
- Specific therapies with high utilization and high denial rates
- Outpatient observations stays

Medical Record Requests
Within five (5) working days following the sample selection, Telligen will produce detailed reports listing the cases selected for retrospective review from each hospital. Each hospital’s report will be uploaded to the secure web portal, Qualitrac™ and a notice will be emailed to the designated point of contact in each facility.

Telligen will instruct the hospital to submit copies of the complete medical record for each selected case within 30 calendar days of the date on the request letter. If the requested information has not been received within 15 calendar days following the initial request, a reminder notice will be sent to the hospital. If the medical record is not received by the 31st day following the original request, Telligen will issue a technical denial. The hospital will be notified of the technical denial in writing and a payment recoupment will be submitted to the Department.

If the case is later submitted for review, the case will be reopened and the initial review process will begin.

Telligen’s retrospective review program is based upon a combination of initial screening by the nurse review coordinator and/or medical coding analyst using applicable criteria/guidelines and physician peer review.
If any Quality of Care concerns are identified by the review coordinator and confirmed by the physician reviewer, Telligen will notify the provider of the Quality of Care concern including any related reference to evidence-based care standards.

If a pattern of concern occurs, Telligen will refer the provider to the Nebraska Medicaid Program Integrity Unit.

The review process includes three levels:

**Inpatient & Outpatient DRG Hospitals and Cost Outlier Reviewing DRG Hospitals**
Telligen will complete the initial level nurse review and, if indicated, the second level physician review within 20 business days of receipt of the medical record. If the physician reviewer is unable to complete the review based on lack of documentation (e.g., lack of medical necessity for admission, procedure or length of stay in non-DRG hospitals), Telligen will place a pending on the case and request additional information from the provider. In all cases, Telligen will complete the retrospective review within 20 business days of receipt of the requested information.

**Section 19: Appeals and Fair Hearings**

**Notice of Action**
A core functionality of the Qualitrac™ system is sending notifications. Features are built-in to create the notification based on the outcome of the authorization and the client specific language that is desired to be sent. As a part of the implementation process, Telligen will configure Qualitrac™ with the Department’s logic to determine the appropriate time to generate notifications, the appropriate notification content including authorization numbers, and the appropriate party to send the notification to (providers, Medicaid clients, and/or the Department). Written notice of approved services will be sent to providers electronically via the portal or by mail for providers without internet access.

Telligen shall provide written notification to the client of all adverse determinations. Telligen shall generate and mail letters to clients no later than the next business day following the date a decision was made. The Department may mandate certain language be used in the written notification and may add, modify, or delete content as determined necessary.

The written notification shall include, at a minimum:
- Name, address, and Medicaid ID# of client;
- What action the contractor has taken;
- The reasons for the action;
- Description of requested service, which may include HCPCS codes, CPT codes, and any pertinent information regarding the service;
- Date of service(s) that is (are) being denied or reduced;
- Name of provider;
- The date of notice;
- The relevant regulatory citation for the determination;
- The client’s right to request a State Fair Hearing; and simplified instructions on how to request a State Fair Hearing, and
- A statement that the client may be liable for the cost of the services if the denial or reduction of payment is upheld in accordance with 42 CFR 431.230.

The contractor shall establish a procedure for notification to the provider of an adverse determination through written notice or an enhanced Internet security communications system no later than the next business day following the date a decision was made. In addition to the information listed above, the provider notification shall include:
- Description of the process, address, and deadline for requesting continuation of current level of services;
- The applicable time period within such a request for reconsideration must be filed and to whom to submit the request;
- A brief statement of the Contractor’s authority and responsibility for review;
- Name, address, fax number, and e-mail address of person or office to contact; and
- Statement that the client may be liable for payment of any denied or reduced payment in accordance with 42 CFR 431.230.

Telligen shall provide notification documents upon request to the Department no later than the next business day from the request. Telligen will also develop standard templates for all adverse determination letters which include provider and client identification and contact information, the requested service(s), reason the requested service(s) was not approved including dates and the right to have the decision reconsidered including timeframes, methods and contact information to submit requests. All Medicaid denial letters include a statement that the client may be liable for payment of any denied or reduced service(s) if the decision is upheld in an appeal.

Telligen will provide management level staff and our medical director or other professional peer reviewers to represent the Department at provider or client requested appeals hearings.

**Provider Requested Appeals**

After exhausting the reconsideration review process, providers may request an appeal of a denial or modification of a requested service. Requests for appeals must be submitted in writing within 90 calendar days of the reconsideration review decision. Providers must send written appeal requests to the Director of Medicaid and Long Term Care at the Department. The Department will acknowledge receipt of the request via letter which will include the date, time and location of the hearing.
Member Requested Appeals
A member who disagrees with a denial or modification of service may file a written request for appeal to
the Director of Medicaid and Long Term Care at the Department. Clients must submit written requests
within 90 calendar days of the reconsideration notice. The Department will acknowledge receipt of the
request via letter which will include the date, time and location of the hearing.

Telligen will respond to all requests for appeal information promptly, generally within one business day.
The contract manager, in consultation with our medical director or expert peer reviewer, will conduct
research of the appealed case and prepare a written case summary. The contract manager will provide
the following written information to Department staff and administrative law judge prior to a scheduled
hearing:

- Overview of review process applicable to the case being appealed;
- Case summary of the review;
- Copy of denial and reconsideration letter(s);
- Medical record information; and
- Denial reason and rationale.

In addition, Telligen’s medical director and/or professional medical staff will provide expert testimony in
respect to best practices, standards of care, medical necessity, and reason and rationale for denial.
Telligen will coordinate hearing preparation efforts with the Department.

Telligen’s medical director will be available to the Department to provide expert medical testimony
when requested for the majority of the appeals. In situations where the medical director is unavailable
or where a medical or surgical specialist would be appropriate to represent the Department’s interests,
Telligen will identify a Nebraska-licensed physician reviewer to provide the medical testimony. Telligen
will not disclose the identity of the original or subsequent peer reviewers who rendered the adverse
determination. This practice maintains the integrity of the peer review process. Telligen will work with
the Department to ensure Telligen receives notification of the hearing date, time and location as soon as
possible following scheduling by the Department to effectively coordinate schedules.

Telligen’s contract manager will be the primary point of contact for the Department for discovery
requests and will coordinate draft responses with Telligen’s medical director for interrogatories, request
for production of documents and requests for admissions. Telligen’s contract manager will submit draft
responses to the Department’s legal counsel within the requested timeframe and will work directly with
legal counsel until all requests have been through the final approval process.

Discovery Obligations: Telligen must participate in responding to any discovery request made during the
Appeal process. Telligen will be required to complete draft responses to Interrogatories, Request for
Production of Documents, and Requests for Admissions among other discovery related requests. Draft
responses will be forwarded to the Department’s legal counsel for final approval and signature.

Section 20: Quality Monitoring Program
The values that drive Telligen as a leader in healthcare management also drive their
commitment to outstanding performance through their internal quality monitoring program. The quality monitoring program ensures that operational procedures are correctly documented and followed and that policies are correctly and consistently administered for all types of review activities we perform. As an organization dedicated to healthcare quality improvement, Telligen understands that their operations must demonstrate the same high level of quality they expect from providers.

Policies and Procedures
Telligen begins with having up-to-date, Department-approved operational procedures. These will reflect compliance with all Nebraska UM/QM program policies and procedures including medical review standards recognized in the Nebraska healthcare community. Their policies are developed and maintained in accordance with national URAC standards. The contract manager and lead review coordinator write and update the operational policies which link to processes with step-by-step directions. Besides supporting compliance, this detailed approach contributes to business continuity by enabling multiple users to correctly implement policies and operations.

Internal Quality Control
Telligen will develop a Nebraska Medicaid-specific Internal Quality Control (IQC) plan for review and approval by the DHHS. The plan will address how cases are selected for internal quality monitoring. Telligen’s lead review coordinator will work with the IS coordinator to randomly select cases quarterly completed by all review coordinators and data entered by our review assistants. The IQC survey conducted on each case will address:

- Compliance with procedures and policies;
- Accuracy in operations; and
- Inter-rater reliability agreement.

Each key step in the review process will be evaluated at numerous touch points for accurate data entry, compliant criteria utilization, and appropriate referrals to peer review. The IQC process for the call center will include listening to taped calls also from a random sample.

Again, key points of compliance will be tracked and documented. Telligen will enter data from each survey in their database. In all IQC reviews, Telligen will identify discrepancies and track trends to continuously measure individual staff performance. When discrepancies are noted, they will provide additional staff training and follow up with subsequent IQC review to ensure success of the corrective action.

Ensuring consistent responses to authorization requests is equally important. To ensure full transparency of a UM/QM program, providers should be able to anticipate the response they will receive to an authorization request if they have complied with criteria and coverage requirements. While each case will have individual medical differences, providers and members should expect consistent responses and clear explanations of decisions.

Inter-Rater Reliability
Telligen’s IQC plan continues with measures of Inter-Rater Reliability in a peer-to-peer review process. Quarterly, a sample of completed reviews will be evaluated in a peer-to-peer process requiring review of documentation submitted for the case, agreement with the decision and appropriate referrals to peer review. Initial disagreements in each case will be reviewed in a team process to maximize inter-rater agreement and ensure compliance. Discrepancies in results may also identify the need for additional
staff training, revisions to written policies or procedures or formal corrective action for individual employees. Any decisions that cannot be resolved through the team process will be resolved by our contract manager. If clarifications are needed in criteria or procedures to ensure ongoing consistency, our manager will consult with our medical director.

Telligen’s medical director will oversee the IQC process for physician peer reviewers. Following the same methodology, the medical director will evaluate a sample of cases that were referred to peer review to ensure consistent interpretation of criteria and agreement with the medical judgment of the peer reviewer. The medical director may solicit input from additional peer reviewers in the IQC process. Disagreements with decisions will be discussed with final resolution by the medical director. If patterns are noted (e.g. agreement rates below 90 percent), the medical director and/or manager will provide additional training and follow up with subsequent IQC review to ensure success of the corrective action.

Telligen will summarize the results of their IQC program including Inter-Rater Reliability Processes and provide this information to DHHS in a standard report twice annually on February 1 and August 1. Telligen will upload the report to Qualitrac™ within 30 days of the end of the six-month reporting period. Prior to this, Telligen will propose a report format for the Department’s approval. Please see the following table for a sample report proposed to summarize the results of the Inter-Rater Reliability Process.

<table>
<thead>
<tr>
<th>Inpatient Acute Rehabilitation</th>
<th>[Insert Month]</th>
<th>[Insert Month]</th>
<th>SFY to-Date Total</th>
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</thead>
<tbody>
<tr>
<td># of Admissions approved on PA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Admissions on retro review</td>
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<tr>
<td>% Agreement between PA/retro review</td>
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<tr>
<th>Home Health/Private Duty Nursing</th>
<th>[Insert Month]</th>
<th>[Insert Month]</th>
<th>SFY to-Date Total</th>
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<tbody>
<tr>
<td># of Admissions approved on PA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Admissions on retro review</td>
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<tr>
<td>% Agreement between PA/retro review</td>
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<table>
<thead>
<tr>
<th>Durable Medical Equipment</th>
<th>[Insert Month]</th>
<th>[Insert Month]</th>
<th>SFY to-Date Total</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
</tr>
<tr>
<td># of Services on retro review</td>
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</tr>
<tr>
<td>% Agreement between PA/retro review</td>
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</tr>
</tbody>
</table>

**Section 21: Appendices**

**Appendix A: Guidelines from NAC 471**

Telligen does not review for Dental, Mental Health, and Transplant Services. Please refer to DHHS for these services.

**471 NAC 1-002.02A Medical Necessity**

Nebraska Medicaid defines medical necessity as health care services and supplies which are medically appropriate and:

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

The fact that the physician 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 that it is covered by Medicaid. Services and supplies which do not meet the definition of medical necessity set out above are not covered.

Approval by the federal Food and Drug Administration (FDA) or similar approval does not guarantee coverage by Nebraska Medicaid. Licensure/certification of a particular provider type does not guarantee Nebraska Medicaid coverage.

471 NAC 3-002.02B Coverage Exception
Certain medical services, though medically necessary, may exceed the Nebraska Medicaid coverage guidelines which have been established by the Department. Under these circumstances, the determination of medical necessity for payment purposes is based upon the professional judgment of the Department's consultants and other appropriate staff.

471 NAC 4-002 Ambulance Covered Services
Nebraska Medicaid covers medically necessary and reasonable ambulance services required to transport a client to obtain or after receiving Medicaid-coverable medical care.

471 NAC 4-002.01 Medical Necessity of the Service
To be covered by Nebraska Medicaid, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client’s health, whether or not such other transportation is actually available, Nebraska Medicaid shall not make payment for ambulance service. Claims for ambulance services must include adequate documentation for determination of medical necessary.

471 NAC 7-007 Durable Medical Equipment Documentation of Medical Necessity
The provider shall obtain written documentation from the prescribing physician which justifies the medical necessity for durable medical equipment, medical supplies, orthotics and prosthetics and related services provided. The original documentation of medical necessity must be kept on file by the provider. The documentation must:
1. Be signed by the physician's own hand (stamps or other substitutes may not be used) and dated, using the date the documentation is signed;
2. Specify the start date of the order if the item is provided before the date the documentation is signed;
3. Include the physician's name, address and telephone number;
4. Include the diagnosis and/or condition necessitating the item(s) and an estimate of the total length of time the item will be needed (in months or years). The estimated total length of time the item will be needed must be completed by the physician or physician's office staff;
5. Be sufficiently detailed, including all options or additional features which will be separately billed or will require an upgraded procedure code;

6. Describe the ordered item(s) using either a narrative description or a brand name/model number, including all options or additional features (this may be completed by someone other than the physician, but the physician must review the order and sign and date it to indicate agreement);

7. For supplies provided on a periodic basis, include appropriate information on the quantity used, frequency of change and duration of need (PRN or "as needed" may not be used); and

8. Include information substantiating that all Nebraska Medicaid coverage criteria for the item(s) are met.

471 NAC 7-007.01 Medicaid Certification of Medical Necessity Forms
Use of the following Medicaid Certification of Medical Necessity (CMN) forms is required. Form examples and completion instructions are included in the Medicaid Provider Handbook - Form MS-78, "Augmentative Communication Device Selection Report" Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" Form MS-80, "Air Fluidized and Low Air Loss Bed Certification of Medical Necessity"

471 NAC 7-010.01 Coverage Criteria
Criteria for Nebraska Medicaid coverage of durable medical equipment, medical supplies, orthotics and prosthetics is outlined in this Chapter's coverage index (see 471 NAC 7-013). Items not specifically listed may not be covered by Nebraska Medicaid. In order to be covered by Nebraska Medicaid, the client's condition must meet the coverage criteria for the specific item. Documentation which substantiates that the client's condition meets the coverage criteria must be on file with the provider (see 471 NAC 7-007 for documentation of medical necessity requirements).

471 NAC 9-002.02 Home Health Medical Necessity
All home health services must be:
1. Necessary to a continuing medical treatment plan;
2. Prescribed by a licensed physician; and
3. Recertified by the licensed physician at least every 60 days.

Therapies must be recertified every 30 days by the licensed physician.

471 NAC 10-001.05 Hospital Definition of Medical Necessity
Health care services and supplies which are medically appropriate and:
1. Necessary to meet the basic health needs of the client;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.
The fact that the physician 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 that it is covered by Medicaid. Services and supplies that do not meet the definition of medical necessity set out above are not covered.

**471 NAC 13-002.02 Private-Duty Nursing Medical Necessity**
All skilled nursing services must be:
1. Necessary to a continuing medical treatment plan;
2. Prescribed by a licensed physician; and
3. Recertified by the licensed physician at least every 60 days.

**471 NAC 18-004.44A Apnea Monitors Cross Referenced with 471 NAC 10-005.22A**
Nebraska Medicaid covers home infant apnea monitoring services for infants who meet one of the following criteria. Nebraska Medicaid defines infancy as birth through completion of one year of age.
1. Infants with one or more apparent life-threatening events (ALTE's) requiring mouth-to-mouth resuscitation or vigorous stimulation. ALTE is defined as an episode that is frightening to the observer and characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually limpness), choking, or gagging. In some cases, the observer fears the infant has died;
2. Symptomatic preterm infants;
3. Siblings of one or more SIDS victims; or
4. Infants with certain diseases or conditions, such as central hypoventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants of substance-abusing mothers, or infants with less severe ALTE's.

**471 NAC 18-004.45A Phototherapy Equipment Cross Referenced with 471 NAC 10-005.23A**
Nebraska Medicaid recognizes the Nebraska Chapter of the American Academy of Pediatrics Standard of Care for home phototherapy. Home phototherapy services will be covered when the following conditions are met:
1. Infant evaluation by the physician and parent/caregiver training occurs before placement of equipment;
2. Documentation must be available with the supplier to show that:
   a. The physician certifies that the infant's condition meets the medical criteria outlined below and that the parent/caregiver is capable of administering home phototherapy; and
   b. The provider certifies that the parent/caregiver has been adequately trained and consent forms used by the provider have been signed; and
3. The infant's medical condition meets the following criteria:
   a. Greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 grams (5 lbs);
   b. Greater than 48 hours of age;
   c. Bilirubin levels at initiation of phototherapy (greater than 48 hours of age) are 14-18 mgs per deciliter;
   d. Direct bilirubin level less than 2 mgs per deciliter;
   e. History and physical assessment (if the service begins immediately upon discharge from the hospital, the newborn discharge exam will suffice); and
f. Required laboratory studies to include CBC, blood type on mother and infant, direct Coombs, direct and indirect bilirubin (additional laboratory data may be requested at physician's discretion). At a minimum, one bilirubin level must be obtained daily while the infant is receiving home phototherapy.

471 NAC 18-004.46A Ambulatory Uterine Monitors
Ambulatory uterine monitors will be covered when the following conditions are met:
1. Evaluation by the physician and training on use of the monitor occurs prior to placement of the monitor;
2. Documentation must be available with the supplier to show that:
   a. The physician certifies that the client meets the medical criteria outlined below; and
   b. The provider certifies that the client has been adequately trained; and
3. The client must be at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy. The pregnancy must be greater than 20 weeks gestation and the client must meet one of the medical conditions listed below:
   a. Recent preterm labor with hospitalization and discharge on tocolytic therapy;
   b. Multiple gestation;
   c. History of preterm delivery;
   d. Anomalies of the uterus;
   e. Incompetent cervix;
   f. Previous cone biopsy;
   g. Polyhydramnios; or
   h. Diethylstilbestrol exposure.

Others at high risk for preterm labor and delivery may be covered for this service upon approval by the Department's Medical Director through written communication from the client’s physician (preferably in consultation with a perinatologist).
Appendix B: UM-QM Nebraska Medicaid Glossary of Terms

Administrative Review: A prospective (pre-payment) review is performed by the Contractor in specific situations previously approved by the Department. This review does not include evaluation of medical necessity or other clinical considerations. An administrative review includes, but is not limited to, Long Term Care reviews, checking for the validity of the provider’s identification number, diagnosis codes, client’s Medicaid eligibility and identification number, certification dates and units of service. An administrative review is often performed in combination with a post-payment review.

Admission Review: A review and determination by a review organization of the medical necessity and appropriateness of a patient’s admission to a specific facility or a review prior to a patient's admission to a hospital to determine, for payment purposes, the reasonableness, medical necessity, and appropriateness of placement at an acute level of care.

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any officer or agency established by the Constitution of Nebraska.

Agent: A person authorized by a superior or organization to act on their behalf.

Ambulatory Surgical Center (ASC): An entity that operates exclusively to provide outpatient surgical services to patients.

Business Day: Any weekday, excepting public holidays.

Calendar Day: Every day shown on the calendar; Saturdays, Sundays and State/Federal holidays included. Not to be confused with “Work Day”.

CMS: Centers for Medicare and Medicaid Services.

Complete Medical Record:
1. History and physical performed no more than 7 days before admission or with 48 hours after admission;
2. Admitting Diagnosis;
3. Results of all consultative evaluations;
4. Documentation of complications, hospital acquired conditions, and unfavorable reactions to anesthesia or drugs;
5. Properly executed consent forms for procedures and treatments;
6. All practitioner orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, vital signs, and other information necessary to monitor the patient’s condition; and

Concurrent Review: A review performed by the Contractor to evaluate whether the Medicaid client requires an extension of home health and/or private-duty nursing services, in light of ongoing clinical conditions and/or functional limitations.
Confidential Information: Unless otherwise defined below, “Confidential Information” shall also mean proprietary trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would provide.

Continued Stay Review: A periodic review of available pertinent medical information conducted during the hospitalization to ensure that the patient continues to require the level of care being provided, continues to receive the appropriate level of care, and the services provided meet professionally recognized standards of care.

Criteria: Predetermined elements of health care, developed by health professionals relying on professional expertise, prior experience, and the professional literature, with which aspects of the quality, medical necessity, and appropriateness of a health care service may be compared.

Critical Access Hospital (CAH): Section 1820 of the Social Security Act, as amended by 4201 of the Balanced Budget Act of 1997, established the Medicare Rural Hospital Flexibility Program by allowing a State to establish Critical Access Hospitals (CAHs) and at least one rural Health Network. This new program replaced the Essential Access Community Hospitals (EACHs) and the Rural Primary Care Hospitals (RPCHs) Program.

Department: Nebraska Department of Health and Human Services, Medicaid and Long Term Care

Diagnosis Related Group (DRG): A group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications. A system for classifying inpatient hospital discharges. DRGs are used for purposes of determining payment to hospitals for inpatient hospital services under the Medicaid prospective payment system.

Discharge Review: A component of a retrospective review that entails the review of all pertinent medical information to determine if the patient was medically stable and appropriate discharge planning had been completed prior to dismissal of the patient.

Documentation: The user manuals and any other materials in any form or medium customarily provided by the contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

DRG Validation: A part of either a) a retrospective review for inpatient hospital services reimbursed on a DRG payment methodology, or b) the prospective payment system, in which a QIO validates that DRG assignments are based on the correct diagnostic and procedural information for Medicaid payment purposes.
**Durable Medical Equipment (DME):** DME are items covered under the Medicaid Program including, but not limited to, oxygen equipment, wheelchairs, and other medically necessary equipment and supplies prescribed by a physician for a patient’s use.

**Eligibility Related Retrospective Review:** A review of pertinent medical information conducted after a service was delivered when the client was not eligible for Medicaid at that time a prior authorization or a pre-admission review would have been required. The review will be conducted using the same criteria as would have been used had the client been eligible at the time the service was delivered. The review is only available in cases where the client was not eligible at the time of service but was later determined retroactively eligible.

**Indicators:** Indicators are measures or measurement tools used to monitor and/or measure some component of health care delivery.

**Initial Denial Determination:** An initial negative decision by a review organization regarding the medical necessity, quality, or appropriateness of health care services furnished or proposed to be furnished, to a patient.

**Mandatory:** Required, compulsory or obligatory.

**May:** Denotes discretion.

**Medical Review Criteria:** Medical review criteria are systematically developed standards that can be used to assess specific health care decisions, services, and outcomes.

**Medically Reasonable and Necessary:** Health care services and supplies which are medically appropriate and:

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

The fact that the physician 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 that it is covered by Medicaid. Services and supplies that do not meet the definition of medical necessity set out above are not covered.

**MLTC:** Nebraska Medicaid and Long Term Care

**Must:** Denotes the imperative, required, compulsory or obligatory.

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Outliers: Those cases that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG.

Pattern Analysis: Pattern analysis is the clinical and statistical analysis of data from case review.

Peer Review: A review by health care practitioners of services ordered or furnished by other practitioners in the same professional field.

Post-Payment Review: A retrospective review performed by the Contractor following the provision of service and payment to the service provider by the Department. This review includes, but is not limited to a review of medical, clinical, and claim documentation, evaluation of medical necessity, appropriateness of the provided services and service location, accuracy of the billing and any other information required to support accurate and appropriate Medicaid reimbursement.

Pre-payment review: A review conducted prior to payment. This may, among others, include prior authorization review. Prior authorizations include inpatient rehabilitation services, select surgical procedures, and out-of-state services.

Pre-procedure Review: A review of a surgical or other invasive procedure prior to the conduct of the procedure.

Prior Authorization: An approval of a request for services before services are provided.

Quality: Quality is the degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge.

Quality Improvement Organization (QIO): QIOs are required under Sections 1152-1154 of the Social Security Act, and 42 CFR 476. For purposes of a review under section 1154(a)(4) of the Social Security Act, a QIO must determine whether the quality of services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. QIOs are required to offer providers quality improvement assistance pertaining to health care services.

Quality Review: For the purposes of this RFP, Quality Review applies to physical health services. Explicit review criteria and generally recognized medical standards of care are used to evaluate all services.

1. Appropriateness, adequacy, and timeliness of clinical and diagnostic evaluation;
2. Appropriateness, adequacy, and timeliness of treatment;
3. Monitoring of patient response;
4. Management of any complication; and/or use of specialists/consultants;
5. Documentation concerning patient status, clinical findings, and supporting rationale for the plan of care;
6. Achievement of adequate patient stability with appropriate discharge planning (beginning on the day of admission), support and/or follow up evidenced at dismissal; and
7. Appropriate and safe transfer/referral to another facility for specialized and/or complex care.

Random Sample: A random sample is a group selected for study which is drawn at random from the
universe of cases by a statistically valid method.

**Reconsideration:** Reconsideration results from a reexamination of an initial denial determination and is performed by a physician who was not involved in the original determination. There are further appeal rights to this determination.

**Retrospective Eligibility Review:** A review performed by the Contractor when Medicaid eligibility is established after services have already been provided. (Retrospective eligibility reviews of home health or private-duty nursing services for children under one year of age are considered Prior Authorization Reviews.)

**Retrospective Review:** A review conducted, upon the Department’s request, after services are provided to a patient. The review of pertinent medical information, using agreed upon criteria, is focused on, but is not limited to, determining the medical necessity, appropriateness of the setting, reasonableness and intensity of service and quality of health care services provided.

**Shall:** Denotes the imperative, required, compulsory or obligatory.

**Should:** Indicates an expectation.

**Special Reports and Consultation:** Reports determined in collaboration with the department that are generated, analyzed and interpreted by the Contractor to provide the Department with data and information necessary to comply with federal and state requirements to advise informed policy decisions. Reports may include, but not be limited to utilization analysis by diagnosis or service, non-certification reviews and closed reviews analysis.

**Will:** Denotes the imperative, required, compulsory or obligatory.

### Section 21: Centers for Medicare and Medicaid Services (CMS)

<table>
<thead>
<tr>
<th>Center for Medicare &amp; Medicaid Services (CMS) Quality of Care Screens Category</th>
<th>Description and Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>C01</td>
<td>Apparently did not obtain pertinent history and/or findings from examination. This category is used for a failure to provide an accurate history; this is also for failure to include information obtained by the performance of an appropriate physical exam.</td>
</tr>
<tr>
<td>C02</td>
<td>Apparently did not make appropriate diagnoses and/or assessments. This category is used for a failure to perform an appropriate assessment and establish a diagnosis.</td>
</tr>
<tr>
<td>Center for Medicare &amp; Medicaid Services (CMS) Quality of Care Screens Category</td>
<td>Description and Use</td>
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</tr>
<tr>
<td>C03</td>
<td>Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14)] This category is used for a lack of organized, appropriate diagnostic and management plans related to the condition for which the patient was admitted; incomplete, inappropriate, or lack of treatment plan for principal diagnosis.</td>
</tr>
<tr>
<td>C04</td>
<td>Apparently did not carry out an established plan in a competent and/or timely fashion (e.g., omissions, errors of technique, unsafe environment). This category is used for failure to take necessary precautions, lack of appropriate equipment maintenance, medication errors, technical and/or procedural errors, and failure to follow physician's orders, delayed completion or reporting of studies.</td>
</tr>
<tr>
<td>C05</td>
<td>Apparently did not appropriately assess and/or act on changes in clinical/other status results. This category is used for failure to recognize clinical changes which occur in the patient's condition; this category also applies if the clinical changes are noted but not acted on.</td>
</tr>
<tr>
<td>C06</td>
<td>Apparently did not appropriately assess and/or act on laboratory tests or imaging study results. This category is used for a failure to provide ongoing monitoring and evaluation of the patient's laboratory or imaging studies by failing to evaluate and/or act on diagnostic studies.</td>
</tr>
<tr>
<td>C07</td>
<td>Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed. This category is used for failure to document accepted indications for a procedure.</td>
</tr>
<tr>
<td>C08</td>
<td>Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09). This category is used for failure to perform a medically necessary procedure that is indicated by the patient's condition.</td>
</tr>
<tr>
<td>Center for Medicare &amp; Medicaid Services (CMS) Quality of Care Screens Category</td>
<td>Description and Use</td>
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<tr>
<td><strong>C09</strong></td>
<td>Apparently did not obtain appropriate laboratory tests and/or imaging studies. This category is used for failure to order diagnostic (laboratory and/or imaging) studies that are deemed appropriate for the patient’s condition.</td>
</tr>
<tr>
<td><strong>C10</strong></td>
<td>Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans. This category is used for a lack of follow-up arrangements or plans for conditions continuing to require treatment and/or monitoring prior to or following discharge; failure to develop a plan that reflects an appropriate transition of care; failure to identify additional needed resources; failure to provide appropriate teaching; failure to transmit pertinent information.</td>
</tr>
<tr>
<td><strong>C11</strong></td>
<td>Apparently did not demonstrate that the patient was ready for discharge. This category is used for failure to assure that the patient is stable enough for discharge to the setting into which the patient is being discharged.</td>
</tr>
<tr>
<td><strong>C12</strong></td>
<td>Apparently did not provide appropriate personnel and/or resources. This category is used for lack of sufficient staff to handle patient load; lack of credentialed staff for provision of offered services; equipment unavailable to carry out treatment plan.</td>
</tr>
<tr>
<td><strong>C13</strong></td>
<td>Apparently did not order appropriate specialty consultation. This category is used for those cases in which a specialty consultation that would have been necessary to adequately assess and treat the patient was not ordered. If there is a distinct clinical management concern over and above failure to order the consultation, cite that category as well, even if it is C03.</td>
</tr>
<tr>
<td><strong>C14</strong></td>
<td>Apparently specialty consultation process was not completed in a timely manner. This category is used when a specialty consultation is not ordered in a timely manner or is not completed in a timely manner. If the only issue is the delay, do not additionally cite C03. If there is a distinct clinical management concern over and above the delay in ordering or completing the consultation, cite that category as well, even if it is C03.</td>
</tr>
<tr>
<td>Center for Medicare &amp; Medicaid Services (CMS) Quality of Care Screens Category</td>
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<tr>
<td>C15</td>
<td>Apparently did not effectively coordinate across disciplines. This category is used when there is poor communication and coordination between specialists or clinicians that adversely impacts the patient's care.</td>
</tr>
<tr>
<td>C16</td>
<td>Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection). This category is similar to category C04 but is more specific to patient safety and protection from injury.</td>
</tr>
<tr>
<td>C17</td>
<td>Apparently did not order/follow evidence-based practices. This category of concern is used when there is a specific aspect of the treatment plan that doesn't follow current guidelines and evidence-based practices.</td>
</tr>
<tr>
<td>C18</td>
<td>Apparently did not provide medical record documentation that impacts patient care. This category is used for poor or missing documentation that makes it difficult to follow the plan of care and patient progress.</td>
</tr>
<tr>
<td>C99</td>
<td>Other quality concern not elsewhere classified. This category is used in exceptional cases. The vast majority of cases should be able to fit into the above listed categories.</td>
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</table>

**Section 22: Resources**


McKesson-InterQual®: [www.mckesson.com](http://www.mckesson.com)

Nebraska Medicaid website: [http://dhhs.ne.gov/medicaid/Pages/medicaid_index.aspx](http://dhhs.ne.gov/medicaid/Pages/medicaid_index.aspx)

The Nebraska Administrative Code, Title 471: [http://dhhs.ne.gov/Pages/reg_t471.aspx](http://dhhs.ne.gov/Pages/reg_t471.aspx)


Provider Bulletins are posted at: [http://dhhs.ne.gov/medicaid/Pages/med_pb_index.aspx](http://dhhs.ne.gov/medicaid/Pages/med_pb_index.aspx)

Telligen: [www.telligen.com](http://www.telligen.com)
Section 23: Contact Telligen

The Telligen Clinical Reviewers are available Monday through Friday 8:00 am to 5:00 pm central time. Information may be submitted to Telligen by:

Mail: Telligen Nebraska Medicaid Review Agent
206 S 13th Street, Suite 100
Lincoln, NE 68508

Web page/Portal: http://telligen.nemedicalauth.com/
General Email: telligen-nemedicaid@telligen.com
Secure Toll Free Fax: 855-638-8017
Toll Free Call Center: 855-638-7949
Local Phone: 402-484-2740