PROVIDER MANUAL

Revised April 2022

Illinois
Provider Manual
300 S. Riverside Plaza, Suite 500
Chicago, IL 60606
312-705-2900
866-606-3700

Dear Medicaid Provider,

Meridian offers three managed care plans in Illinois, Meridian Medicaid Plan (Medicaid), Meridian Medicare-Medicaid Plan (MMP), and Meridian Managed Long Term Services & Supports (MMLTS). We welcome you to the Meridian network of providers. Our Provider Manual is a reference tool for you and your staff, designed to assist you in understanding plan policies, procedures, and other protocols.

The Provider Manual is a dynamic tool which evolves with Meridian. Minor updates and revisions are communicated to you via *Provider Notices and Newsletters*, and replace related information in this Provider Manual. Major updates and revisions are communicated to you via an updated edition of the Provider Manual. Furthermore, any material modifications to the Provider Manual shall be communicated to you with a 60-day written notice.

The current Provider Manual is available on our website at **ilmeridian.com**.

Please contact your local Network Provider Relations representative or our member and provider services department at **866-606-3700** with any questions or concerns.

Thank you for your valued participation and helping our members live *healthier* lives.

Meridian

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Our Mission, Vision, and Philosophy

Our mission is to deliver better health outcomes at lower costs guided by the philosophy that quality healthcare is best achieved locally to ensure our vision of transforming the health of the community, one person at a time.

About Meridian

Meridian is the most extensive Medicaid health plan in Illinois, providing healthcare to nearly 900,000 Medicaid members in every county throughout the state. In 2008, the Illinois Department of Healthcare and Family Services (HFS) partnered with Meridian specifically to increase quality outcomes for the Medicaid population. Meridian currently provides care to those beneficiaries enrolled in the AllKids, Family Care, and Moms and Babies programs.

Meridian Advantage Plan of Illinois (HMO SNP) was approved in the summer of 2012 by the Centers for Medicare and Medicaid Services (CMS) to coordinate Medicare benefits for the dual-eligible Special Needs (D-SNP) population starting January 1, 2013.

On July 1, 2013, Meridian began serving the Seniors and Persons with Disabilities (SPD) population in the central and metro east regions of Illinois. On January 1, 2014, Meridian began serving the Affordable Care Act (ACA) population. Meridian began providing healthcare services to the Managed Long-Term Services & Supports (MLTSS) population on July 1, 2016.

About Meridian HealthChoice Illinois

Meridian HealthChoice Illinois (Meridian), provides government-sponsored managed care services to families, children, seniors, and individuals with complex medical needs primarily through Meridian Medicaid Plan (Medicaid), Medicare Advantage (WellCare), Medicare-Medicaid Plans ((MMP), Medicare Prescription Drug Plans (WellCare), and the Health Insurance Marketplace (Ambetter of Illinois). Meridian is a wholly owned subsidiary of Centene Corporation, a leading multi-national healthcare enterprise committed to helping people live healthier lives.

About Centene Corporation

Centene Corporation, a Fortune 500 company, is a leading multinational healthcare enterprise committed to helping people live healthier lives. The Company takes a local approach – with local brands and teams – to provide fully integrated, high quality, and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. Centene offers affordable and high-quality products to nearly 1 in 15 individuals across the nation, including Medicaid and Medicare members (including Medicare Prescription Drug Plans) and individuals and families served by the Health Insurance Marketplace, the TRICARE program, and individuals in correctional facilities. The Company also serves several international markets, and contracts with other healthcare and commercial organizations to provide a variety of specialty services focused on treating the whole person. Centene focuses on long-term growth and the development of its people, systems and capabilities so that it can better serve its members, providers, local communities, and government partners.

Contact Information

Contact and Service Function	Telephone Number
Behavioral Health • Inpatient Mental Health • Outpatient Mental Health • Substance Abuse Treatment	**866-796-1167**
Illinois Client Enrollment Broker (ICEB) • Managed Care Enrollment Questions	**877-912-8880**
Illinois Relay Services	**711**
Member Services • General Information and Assistance • Verify Member Eligibility • Benefit Information • Status Claims • File Complaints/Grievances • Verify/Report Newborn Information • Coordination of Benefits • Interpretive Language Services	**Medicaid** **866-606-3700** **MLTSS** **866-821-2308**
Pharmacy (PBM) • Pharmacy Questions and Concerns • Formulary Information • Pharmacy-Utilization Management Information	**Medicaid** **855-580-1688**
Provider Services • Fee Schedule Assistance • Discuss Problems and Concerns • Contractual Issues • Primary Care Administration • Initiate Affiliation, Disaffiliation and Transfers	**866-606-3700**
Quality Improvement • Request Clinical Practice Guidelines • Request Preventive Healthcare Guidelines • Quality Initiative Information • Quality Regulatory Requirements • Disease Management Program Information	**866-606-3700**
Transportation • Member Non-Emergent Transportation	**866-796-1165**
Utilization Management • Prior Authorizations • Notification of Emergent and Urgent Hospital Admissions • Requests for Clinical Criteria • Peer to Peer Discussions • Discharge Planning Information	**866-606-3700**

Care Coordination and Long Term Services and Supports • Speak to a member's care coordinator • Request Individualized Plans of Care • **Check waiver eligibility information**	**866-606-3700**

Section 2: Member-Related Information

Member and Provider Services Department

Meridian's Member and Provider Services department exists to benefit both our members and providers. Member and Provider Services is available to respond to all questions about Meridian benefits, policies, and procedures.

Member and Provider Services Representatives are available Monday through Friday, 7 a.m. to 5:30 p.m., to assist with questions and resolve issues related to the following:

- Member eligibility
- Approval of non-emergency services
- Primary Care Provider (PCP) and site changes
- Women's healthcare provider changes
- Complaints/grievances
- Disenrollment requests
- Claim status
- Rights and responsibilities

Member and Provider Services is available Monday through Friday, 7 a.m. to 5:30 p.m., to confirm eligibility of benefits and ensure access to Emergency Services and Post-Stabilization Services.

Members and providers are encouraged to call any time they have a question or concern. Questions outside the purview of Member and Provider Services will be routed to the appropriate Meridian department for investigation and follow-up.

Member Rights and Responsibilities

Meridian prides itself on the care and high quality customer service it delivers to all members. Please familiarize yourself and your staff with the following member rights in order to provide the best possible care. Both Meridian and its contracted providers must comply with all requirements concerning member rights.

Members Have the Right to:

- Be treated with respect and dignity at all times
- Be protected from discrimination and file or appeal any complaints of discrimination on the basis of race, color, national origin, age, or disability in the receipt of health services
- Have their personal and health information kept private
- Receive information from Meridian, Meridian providers and Meridian contractors in a manner they can understand
- Receive all of the services that Meridian is required to provide

- Have their questions about Meridian answered
- Have access to doctors, other healthcare providers, specialists and hospitals
- Learn about treatment choices in a manner they can understand and participate in treatment decisions, including the right to refuse treatment
- Formulate advance directives
- Receive emergency care when and where they need it
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive a decision about healthcare payment, coverage of services and prescription drug coverage
- Request a review (appeal) of certain decisions about healthcare payment, coverage of services and prescription drug coverage
- Request and receive a copy of their medical records, and request that their medical records be amended or corrected
- Exercise their rights without fear of reprisal from Meridian or Meridian providers
- File complaints (grievances), including complaints related to the quality of the care they receive

Members Have the Responsibility to:

- Supply information (to the extent possible) that Meridian and its providers require to coordinate the member's care
- Follow plans and instructions for care that they have agreed on with Meridian or its providers
- Understand their health problems and participate in developing mutually agreed-upon treatment goals (to the extent possible)
- Contribute toward their own healthcare, including exhibiting appropriate behavior

Interpretive Services and Alternative Formats

Meridian can arrange for an interpreter to speak to members in most languages, free of charge. Alternative formats of member communications are also available to members free of charge. Alternative formats help members with different reading skills, backgrounds, or disabilities understand Meridian materials. A member may call Member Services at 866-606-3700 to inquire about interpretive services or alternative formats.

If the member is hearing or speech impaired, TTY/TDD services are available by calling the Illinois Relay Service at 711, 24 hours a day, seven days a week. The Illinois Relay Service makes it possible for hearing-impaired and/or speech-impaired persons to call Meridian.

For members with vision problems, the Meridian Member Handbook and other materials are available in large print and Braille. The Meridian website also has buttons to make the print bigger and simpler to read.

Eligibility Requirements

Medicaid

Meridian has an executed contract with the Illinois Department of Healthcare and Family Services (HFS) to provide Medicaid-covered benefits to the beneficiaries of the AllKids, Family Care, Moms and Babies Participants and the Seniors and Persons with Disabilities (SPD) population, as well as Managed Long Term Services and Supports (MLTSS). In order to enroll in Meridian, Medicaid recipients must have the qualifying program codes of 01 – 04, 06, 07, 91 – 94, 96 or 97 listed on their state MEDI card and reside in Meridian's service area.

Eligible members will not have Third Party Liability (TPL) or be part of the Spend Down Program.

Member Identification

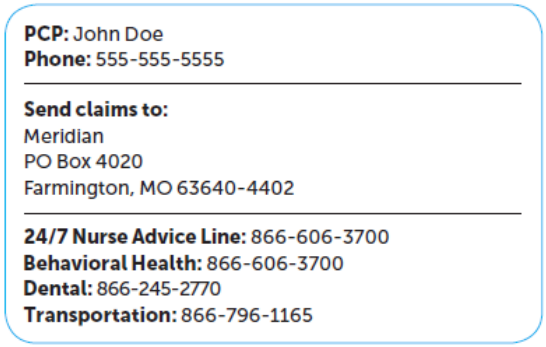
All Meridian members receive a Meridian Member ID Card that includes the following information:

- Member Name
- Medicaid ID Number
- Effective Date
- Member Services Phone Number
- Medical Claims Processing Information (on back)
- Pharmacy Claims Processing Information (if applicable)
- Other Instructions and Important Information

Meridian Medicaid Plan ID Card (example):

Front

Back



Eligibility Information

It is important to verify eligibility before rendering services to a Meridian member. To verify a member is currently eligible to receive services:

- Request to see the member's Meridian ID Card (and other health insurance ID cards if appropriate) at each encounter
- Check eligibility in Meridian's Provider Portal
- Review your PCP monthly eligibility report or verify the member's eligibility online through Meridian's Provider Portal each time the member appears at the office for care or referrals
- Call our Member and Provider Services department at 866-606-3700 for assistance with eligibility determinations
- Please note: Member and Provider Services can only give verbal eligibility; we can no longer fax eligibility

If you find any discrepancies in the information on either the member's Meridian ID Card and/or your monthly eligibility report, contact our Member and Provider Services department at **866-606-3700** for further assistance.

Medicaid

In addition to the steps outlined above, the eligibility of Meridian members can be verified by:

- Calling Meridian's Eligibility Self-Service Application by dialing 866-606-3700 and following the directions as prompted. The system will then verify if the member is eligible on the date of service indicated, and/or
- Utilizing the State of Illinois' HFS MEDI website at www.myhfs.illinois.gov/

PCP Identification and Verification

To verify a Meridian member's PCP, you may call the Member and Provider Services department or utilize Meridian's online provider portal.

PCP Changes

Meridian members can call the Member and Provider Services department at 866-606-3700 to request a PCP change, or request the change through Meridian's Member Portal. Providers may also elect to send in a PCP change request by completing and sending a Primary Care Provider Reassignment Form. The form is available online by visiting ilmeridian.com, "Manuals, Forms and Resources" then "Documents and Forms." The provider can then have the member sign the form, authorizing a PCP change, and fax it directly to Network Provider Relations Development at 312-980-0445. A Provider Relations Representative will also be able to accept the completed form from the PCP. Please note: PCP changes may take 24 to 48 hours to update on the member and provider portals.

Non-Emergent Transportation: Medicaid

Meridian ensures that non-emergency transportation and travel expenses, determined to be required for members to secure medically necessary medical examinations and treatment, are readily available and accessible. This non-emergent transportation is available for all covered services including prenatal care, preventive services, mental health services, obtaining prescription medicine, and DME supplies.

Meridian is contracted with a transportation agency with a network capable of providing non-emergent transportation to the entire Meridian geographic coverage area. Information on how and when members can access non-emergent transportation is available in the Member Handbook or by calling Member and Provider Services at 866-606-3700.

Transportation Procedure

To arrange for non-emergent transportation services, the member, their PCP or a Meridian representative should call 866-796-1165 to schedule the appointment.

The non-emergent transportation vendor will transport the following individuals:

- Members
- Parents or legal guardians of minor or disabled members
- Other family members (such as siblings) to the appointment may be allowed

Transportation services must be scheduled at least three days in advance. The transportation provider uses confidential eligibility information provided by Meridian to verify the member's eligibility. Members are then assigned the most appropriate and cost effective means of transportation. Routine appointments can be scheduled from 8 a.m. to 6 p.m. CST seven days a week. Members requiring transportation for next-day appointments should contact the Member and Provider Services department at 866-606-3700 as soon as possible for scheduling assistance. Members also have gas mileage reimbursement available to them when pre-approved.

Non-emergent transportation service abuse reported to Meridian by the non-emergent transportation vendor is investigated by Meridian. Examples of abuse of the service would include securing transportation for reasons outside of medical necessity and abusive behavior towards the transportation provider. Meridian reserves the right to withhold non-emergent transportation services from members found to be abusing the service.

Members who must access non-emergent travel expenses outside of the Meridian geographical area for medically necessary care, and incur costs for such services, may contact Meridian Member and

Provider Services at 866-606-3700 for assistance. Meridian will review the appropriateness of the request before the service being scheduled.

Member Enrollment and Disenrollment

Enrollment and disenrollment in Meridian is processed by the Illinois Client Enrollment Broker (ICEB). The ICEB is contracted with HFS to process both member eligibility and enrollment. If the member wishes to enroll or disenroll from Meridian, they should contact Meridian Member and Provider Services at 866-606-3700 for more information or call the ICEB at 877-912-8880.

Notice of Privacy Practices

Members may obtain a copy of Meridian's Notice of Privacy Practices by visiting Meridian's website and selecting "Privacy Practices" from the bottom of any page. The Notice of Privacy Practices describes how Meridian uses and discloses member information pursuant to the Health Insurance Portability and Accountability Act.

Member Satisfaction

Meridian and its network providers are committed to providing and maintaining a consistently high level of member satisfaction. All providers and their office staff are expected to maintain a friendly and professional image and office environment for members, other physicians, and the general public. Providers must maintain adequate levels of staff to provide for timely and effective services for Meridian members. Member Services functions are a requirement of a provider's initial orientation and ongoing network provider education.

HFS and the National Committee for Quality Assurance (NCQA) require that Meridian conduct annual surveys (e.g., Consumer Assessment of Healthcare Provider Systems (CAHPS) and Health Outcomes Survey (HOS)) to determine current levels of member satisfaction with the health plan and to identify areas of potential health plan improvement. Providers and their office staff are expected to cooperate and assist Meridian with obtaining data necessary for these surveys. Providers will be notified in advance of their required participation and the timeframes in which the surveys will be conducted annually.

Grievances and Appeals

Meridian provides information about the grievance and appeals procedures to all plan members annually and at the time of enrollment. The Member Handbook will explain how member grievances can be initiated. If a member is denied authorization for treatment, Meridian sends written notification to the member. This letter contains information concerning the denial and clearly explains to the member their appeal rights, including how to file an appeal.

Member Grievances

A grievance is any member expression of dissatisfaction, including complaints, directed to Meridian about any matter other than an administrative action that can be appealed. For example:

- A member cannot get an appointment with their doctor in a timely manner
- A member cannot get a referral from their doctor in a timely manner
- A member has been denied any of their rights as a Meridian member

- The quality of care or services received by the member was not satisfactory

For information regarding the Meridian grievance process or if they wish to file a grievance, members or their authorized representative should call the Member and Provider Services department at 866-606-3700, or by writing to the Meridian Grievance department at:

Meridian
Grievance Coordinator
PO Box 44287
Detroit, MI 48244
Fax: 833-669-1734

Meridian will validate and acknowledge the grievance within 48 hours of receipt. The matter will then be reviewed by our Grievance Coordinator. Meridian will thoroughly investigate the grievance and the member will receive a response from the Grievance Coordinator within 90 days.

Member Appeals

An appeal is a request for review of a decision made by Meridian to deny, reduce, or terminate a requested service. A few examples are:

- A service was denied based upon medical necessity
- A payment was denied (in whole or part) for a service
- A service was denied (such as physical therapy) that was previously authorized

Members have 60 days to file an appeal from the date of the denied service. All written or verbal communication by a member regarding dissatisfaction with a decision to deny, reduce or terminate a clinical service based on medical necessity or on benefit determination is to be considered an appeal.

A provider or other authorized representative of the member such as a family member, friend or attorney may file an appeal on the member's behalf with the member's written permission. The member must submit written permission to Meridian for an authorized representative to appeal on their behalf.

Members can appeal by calling Member and Provider Services toll-free at 866-606-3700 or by writing to the Meridian Appeals department at:

Meridian
ATTN: Appeals Department
PO Box 44287
Detroit, MI 48244
Fax: 833-383-1503

If the appeal is filed over the phone, it must be followed by a written signed appeal request. Within three business days of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. We will make a decision about the appeal and notify the member and their PCP, as well as any other providers involved in the appeal in writing within 15 business days of receiving all required information.

If a member files for continuation of benefits on or before the latter of 10 days of Meridian sending notice of action, or the intended effective date of the proposed Adverse Benefit Determination,

Meridian must continue the member's benefits during the appeal process. A provider, serving as member's authorized representative for the appeal process, cannot file for continuation of benefits. If the final resolution of the appeal is adverse to the member, Meridian may recover the cost of the services that were furnished to the member.

Member Expedited Appeal

If a member or their provider thinks that their situation is clinically urgent and reviewing the appeal in the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the member's medical condition, or would subject the member to severe pain that cannot be adequately managed without the care or treatment, they may call Member and Provider Services at 866-606-3700 to file an expedited appeal. A member will need confirmation from their provider that the appeal is urgent. Within 24 hours of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. We will make a decision about the appeal within 24 hours of receiving all required information.

The member and their PCP, as well as any other provider involved in the appeal, will be notified verbally of the outcome of the appeal. A written notification will follow.

Medicaid External Independent Review of Appeals (Home and Community Based Services excluded)

If the appeal regarding medical services is denied, members have the right to request an external independent review. This request can be filed by any of the parties involved in the initial appeal and must be submitted in writing. Members must request an external independent review within 30 days of Meridian's notification of the appeal decision.

The address to file a request for an external independent review is:
Meridian
ATTN: Appeals Department
PO Box 44287
Detroit, MI 48244
Fax: 833-383-1503

Within 30 days of receiving the request, Meridian will make arrangements to select an external reviewer and forward all information to that person. Members have the right to participate in the selection of the external independent reviewer. The reviewer will be a clinical peer with the same or like specialty as the treating provider. The reviewer will have no direct financial interest in connection with the case, and the reviewer will not know the member's identity.

The right to request an external independent review process is reserved for members only after an initial prior request or prior authorization is denied. The external independent review is not available for providers regarding claims payment, handling, or reimbursement for Covered Services. Meridian will not consider external independent review requests by providers made on behalf of members after services are rendered.
The reviewer will make a decision about the appeal within five days of receiving all required information.

Medicaid Expedited External Independent Review of Appeals (Home and Community Based Services excluded)

If the member's situation is clinically urgent, the member or a provider acting on the behalf of the member may call Meridian's Member and Provider Services department at 866-606-3700 to file an urgent request for external independent review. Members will need confirmation from their provider to do this.

The reviewer will make a decision within 24 hours of receiving all required information. The member and their PCP, as well as any other provider involved in the case will be notified verbally of the outcome of the appeal. A written notification will follow.

The address to file a request for an expedited external independent review is:

Meridian
ATTN: Appeals Coordinator
PO Box 44287
Detroit, MI, 48244
Fax: 833-383-1503

State Fair Hearing

At any time, within 120 days of receipt of the Decision Notice from the health plan, the member may request a Fair Hearing. If the member wants to continue to receive services that were previously approved, they must ask for a State Fair Hearing Appeal within **10 calendar days** of the date on the Decision Notice. The member may be responsible for paying for the services provided during the appeal process.

If the member or their authorized representative wants to file a State Fair Hearing Appeal related to *medical services or items, or Elderly Waiver (Community Care Program (CCP)) services*, they can submit their request in writing to:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL, 60602
Fax: 312-793-2005
Email: HFS.FairHearings@illinois.gov Or call **855-418-4421**, TTY **800-526-5812**

If the member or their authorized representative wants to file a State Fair Hearing Appeal related to *mental health services or items, substance abuse services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services, or any Home Services Program (HSP) service*, they can submit their request in writing to:

Illinois Department of Human Services
Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL, 60602
Fax: 312-793-8573
Email: DHS.HSPAppeals@illinois.gov

Or call 800-435-0774, TTY: 877-734-7429

Provider Directory

A list of participating providers in the Meridian network is available by viewing the online provider directory at ilmeridian.com. To receive a list of participating providers via hard copy, contact Meridian and a provider directory can be mailed to you or the member requesting it.

Section 3: Member Benefit Information

Member Benefits

Covered services are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care. Meridian will implement changes to its coverage guidelines pursuant to any new guidance issued by HFS and/or CMS. For a complete list of covered services or to verify prior authorization requirements, please contact Member and Provider Services or visit the Meridian website at ilmeridian.com.

Medicaid services covered by Meridian include, but are not limited to, the following (For MLTSS services please refer to the *Services Covered Under MLTSS* section):

- Advanced practice nurse services
- Alcohol and substance abuse services
    - Inpatient rehabilitative services for alcohol and/or drug abuse are limited to 30 days per calendar year for adults
    - Detoxification services are limited to once every 60 days
- Ambulatory surgical treatment center services
- Assistive/augmentative communication devices
- Audiology services
- Blood, blood components and the administration thereof
- Chiropractic services
    - Medicaid population: < 21 years
- Practice visits for members with special needs (SPD only)
- Dental services
    - Medicaid SPD members receive coverage for medically necessary oral surgery services from an oral surgeon who is a Participating Provider, upon referral by a participating physician and authorized by Meridian
- Diagnostic testing
- Durable medical equipment and supplies
- Emergency and urgent care
- Immunizations
- Family planning and services and supplies
- FQHCs, RHCs, and other encounter rate clinic visits
- Home health agency visits
- Hospital emergency room visits:
    - Hospital ambulatory services

- Inpatient hospital services
- Long Term Services and Supports (LTSS)/Home and Community Based Services (HCBS) (for members eligible to receive HCBS)
- Laboratory and X-ray services
- Medical supplies, equipment, prosthesis and orthosis, and respiratory equipment and supplies
- Mental health services, including inpatient psychiatric admissions and outpatient services
- Nursing care for members <21 years not in the HCBS waiver for individuals who are Medically Fragile Technology Dependent (MFTD)
- Outpatient hospital and provider services
- Nursing care (for members <21 years for transitioning from a hospital to home or other appropriate setting)
- Nursing facility services for the first 90 days
- Optical services and supplies
- Optometrist services
- Palliative and hospice services
- Pediatric services
- Pharmacy
- Preventive services
- Physical, Occupational, and Speech Therapy services
- Physician services
- Podiatric services
- Post-stabilization services
- Primary care services
- Specialist services
- Renal dialysis services
- Respiratory equipment and supplies
- Surgery
- Sub-acute alcoholism and substance abuse services
- Therapy services
- Transplant services
- Vision services
- Transportation to secure covered services
- Well-Child & Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (up to age 21)
- Women's care
- Abortion

Services Covered under MLTSS

- Alcohol and Substance Abuse Rehabilitation Services
- Exceptional Care
- Targeted case management service (mental health)
- Mental Health Rehabilitation Option Services
- Non-Emergency Ambulance Transportation
- Medicare Transportation
- Taxicab Services
- Service Car
- Auto Transportation (private)
- Other Transportation

- Long-Term Care (LTC) - Skilled
- LTC - Intermediate
- LTC - Recipient ages 22-64 in IMD not MI or MR
- LTC - Supportive Living Facility (SLF) Dementia Care
- LTC - Supportive Living Facility (Waivers)
- Homemaker
- Agency Providers RN, LPN, CNA and Therapies
- Individual Providers PA, RN, LPN, CNA and Therapies
- Adult Day Health
- Habilitation Services
- Respite Care
- Other Healthcare Finance Administration (HCFA) Approved Services
- Electronic Home Response (EHR)/EHR Installation (MARS), MPE Certification (Provider)
- Social Work Service
- Psychologist Service
- Other Behavioral Health Services
- Licensed Clinical Professional Counselor (LCPC)

Services not listed are not covered under MLTSS.

Medicaid Benefits Not Covered by Meridian

The following services are not covered by Meridian, but are covered by Illinois HFS. Members must use their HFS Medical ID card to access the following service(s):

- Routine dental services for children under the age of 21

Meridian providers are required to assist with and provide members with referrals for the above mentioned services. The above mentioned services should be billed to HFS directly.

Non-Covered Services

Services not covered by Meridian for any Meridian member include, but are not limited to, the following:

- Elective cosmetic surgery
- Abortions; coverage for abortions may be available directly from HFS Infertility Services
- Nursing Facility Services beginning the 91st day (excluding SPD members who are residents of a nursing facility)
- Services prohibited by State or Federal law
- Non-medically necessary services

Non-Covered For Medicaid Only

- Custodial services (TANF only)
- Services provided in a State Facility operated as a psychiatric hospital as a result of forensic commitment (SPD only)
- Services provided through a Local Education Agency (LEA) (SPD only)
- Services provided in an Intermediate Care Facility for the Developmentally Disabled
- Services provided through Local Education Agencies

Member Self Referrals – Medicaid

Members may access certain services without a referral from their PCP. These services are described below.

Family Planning

Family planning services are any medically approved means, including diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, or for the detection or treatment of sexually transmitted diseases (STDs). These services are provided in a confidential manner to individuals of childbearing age, including minors who may be sexually active, who voluntarily choose not to risk initial pregnancy, or who wish to limit the number and spacing of their children. Treatment for infertility is not included under the family planning benefit.

The PCP should work with the member in providing for family planning services or assisting them in selecting a provider, as requested. Members may also contact Member and Provider Services at 866-606-3700 for additional assistance with family planning referrals or family planning information.

Women's Health

Women enrolled in Meridian may select a Women's Healthcare Provider (WHCP) in addition to their PCP. The WHCP must be a provider specializing by certification or training in obstetrics, gynecology, or family practice. Women may receive services from their WHCP without a referral from their PCP. Members may select or change their WHCP at any time. However, members must select a WHCP that is a part of the Meridian network. A list of participating WHCP providers is available on our website at ilmeridian.com or by calling the Meridian Member and Provider Services department. Members are not required to select a WHCP.

PCPs and WHCPs are required to identify maternity cases presenting a potential for high-risk maternal or neonatal complications and arrange for the appropriate referrals to a specialist or transfer to a Level III Perinatal Facility. For assistance with referrals, contact the Meridian Member and Provider Services department.

Children's Health

A dependent minor may seek treatment from any in-network pediatrician without prior authorization if the dependent minor is assigned to a PCP who is not a pediatrician.

Clinical Laboratory Improvement Amendment (CLIA)

What is CLIA? CLIA refers to the federal legislation commonly known as the Clinical Laboratory Improvement Amendments of 1988, as found in Section 353 of the Federal Public Health Services Act (42 United States Code §263a – Certification of laboratories) and Centers for Medicare & Medicaid Services Title 42 CFR Part 493.

The objective of the federally regulated CLIA program is to ensure quality laboratory testing. Under CLIA, any laboratory performing testing is required to have the appropriate CLIA certification for the

tests being performed. They must enroll in the CLIA program and obtain their CLIA certification in order to receive payment under Medicare and Medicaid programs.

Who does CLIA apply to? CLIA is applicable to any facility or individual Provider that performs any laboratory service.

Who administers the CLIA program? The Centers for Medicare and Medicaid Services (CMS) along the
Centers for Disease Control and Prevention (CDC) and the U.S. Food & Drug Administration (FDA) have
specific agency administration responsibilities for administering the CLIA program.

For information on the specific types of certifications visit: https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.

Tips

- Only one CLIA number may be reported per claim
- Denied claims will have a NOT COVERED reason of CLIA: Provider has no CLIA waiver on file
- CLIA number contains 10 alphanumeric characters, where the third character is a "D"
- A CLIA certificate is required for each location (with few exceptions, mobile labs, Not-for-profit or Federal, State or local government laboratories, laboratories within a hospital campus)

Starting June 1, 2020, if a CLIA lab services is performed outside of the State and Federal Regulations, Meridian will reject the claim line. For reference, please see the below regulations.

State Rule: CMS identifies the rules regarding CLIA.

Referenced links:
http://www.dph.illinois.gov/sites/default/files/publications/clia-how-obtain-cliacertificate-041316.pdf
https://www.illinois.gov/hfs/SiteCollectionDocuments/LabPolicyTopicL21012Rev060118.pdf
https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index?redirect=/clia

Therapy

Therapy providers billing guidelines should follow the Illinois Provider Handbook and use correct modifiers so Meridian can accurately adjudicate the claim. Without a correct modifier, Meridian will reject the claims. For reference, please see the below correct modifiers:

- Physical therapist should use the **GP** modifier
- Occupational therapist should use **GO** modifier
- Speech therapist should use **GN** modifier

State Rule: The below link is a reference to the state requirements:
https://www.illinois.gov/hfs/SiteCollectionDocuments/j200a.pdf (section *HFS Appendix J-1 (5))*

Section 4: Pharmacy Benefit Management

Prescription Drug Plan Coverage

Meridian utilizes the Pharmacy Benefit Manager (PBM), Pharmacy, to manage the Medicaid member's pharmacy benefit. Pharmacy, as the PBM, provides Meridian members with an extensive pharmacy network, pharmacy claims management services, a complete drug formulary, and pharmacy claims adjudication.

The PBM provides support to providers at the number below. Meridian providers may also speak with a clinical pharmacist regarding any pharmaceutical, medication administration, or prescribing issue.

Medicaid
855-580-1688

All providers have access to the Meridian Pharmacy Drug Formulary. The drug formularies are available on our website at ilmeridian.com. Drug formularies should be readily accessible and be referred to when prescribing medications for Meridian members.

Pharmacy benefits and prescription drug coverage are not available through Meridian for MLTSS members.

Medicaid-Specific Benefits

Medicaid members have both prescription and specific over-the-counter medication coverage. All providers must prescribe from within the drug formulary unless a formulary exception is obtained from the PBM. Some medications also require prior authorization or step therapy, which is noted in the formulary documents.

Obtaining a Formulary Exception

If a medication that is required is not on the drug formulary, a "Formulary Exception Request Form" must be filled out and can be obtained at ilmeridian.com. The form must include all required information to make a determination on the request. The form must then be faxed to the fax numbers below. **In emergency situations, please call the number below.**

Formulary exceptions should be obtained **before** providing the member with a written prescription. If an exception is not obtained in advance, the member will not be able to have the prescription filled at their pharmacy, causing a delay in the member's treatment.

Medicaid	
Phone	**855-580-1688**
Fax	**833-433-1078**

Obtaining a Drug Prior Authorization

If a medication that is required has prior authorization criteria, a "Drug Prior Authorization Request Form" must be filled out. The form must include all required information to make a determination on the request and faxed to the PBM at the fax number above.

In emergency situations, please call the number above.

Prior authorizations should be obtained before providing the member with a written prescription. If a prior authorization is not obtained in advance, the member will not be able to have the prescription filled at their pharmacy, causing a delay in the member's treatment.

Federally Qualified Health Centers and Rural Health Centers

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are important community providers. All Meridian members have access to FQHCs and RHCs located within Meridian's geographic service area. For assistance in accessing a FQHC or RHC, members should contact the Meridian Member and Provider Services department at 866-606-3700.

Advance Directives

Advance directives are legal documents that allow members to convey their decisions about end of life care ahead of time. There are three main types of advance directives in Illinois:

Living Will – A living will lets a member tell someone how he or she feels about care that will continue their life if they have a terminal condition. This kind of care includes:

- The use of dialysis and breathing machines
- Tube feeding, unless it would be the only cause of death
- Organ or tissue donation
- Whether the member wants to be saved when his or her breathing or heartbeat stops
- A living will becomes active ONLY when the member is no longer able to make decisions on their own

Healthcare Power of Attorney – A healthcare power of attorney lets members choose someone to make healthcare decisions for them in the future, if they are no longer able to make these decisions for themselves. The member is called the "principal" in the power of attorney form and the person the member chooses to make decisions is called their "agent." The member's agent is someone who can make decisions about their care when the member is not able to. Members may give their agent specific directions about the healthcare he or she does or does not want. If the member becomes seriously injured or sick, he or she may not be able to make healthcare decisions. In these cases, the healthcare agent can make decisions about the member's care.

With a healthcare power of attorney, the member's agent can:

- See their medical information and other personal information
- Choose and dismiss their healthcare providers
- Approve or deny medical treatment
- Sign waivers and other documents to allow or stop medical care

Do-Not-Resuscitate Order - In addition to an advance directive, members may ask their providers about a Do-Not-Resuscitate order (DNR order). A DNR order is a medical treatment order stating that

cardiopulmonary resuscitation (CPR) will not be attempted if the member's heart and/or breathing stops.

Members should choose an agent that they trust, like a family member or a friend. The agent cannot be the member's physician or other healthcare provider. Members should be directed to talk with their agent about their values and wishes. The more the agent knows about the member, the better decisions he or she can make.

Mental Health Treatment Preference Declaration - A mental health treatment preference declaration lets a member say whether they want to receive electroconvulsive treatment (ECT) or psychotropic medicine when he or she has a mental illness and loses the ability to make these types of decisions. It also allows the member to say whether he or she wishes to be admitted to a mental health facility for up to 17 days of treatment. It operates similarly to a healthcare power of attorney by allowing the member to select an agent, known as an "attorney-in-fact" to make mental health decisions while he or she is incapacitated, or the member can write instructions to the attorney-in-fact. This declaration requires witnesses and expires two years from the date the member signs it.

It is Meridian's policy to respect member decisions as described in advance directive forms. It is also Meridian's policy to not limit the implementation of any of member advance directives because of personal beliefs or conscience.

Advance directives may be changed or canceled in writing at any time, according to the laws of Illinois. Providers should assist members who have questions about filling out an advance directive. Members can also be directed to speak with their mental health provider, attorney or other professional with experience with advance directives. Providers and hospitals should provide advance directive forms if requested.

If there are any questions about Meridian's Advance Directives policy, members and providers may call Member and Provider Services at:

Medicaid	MLTSS
866-606-3700	866-821-2308

If a member believes that their provider did not follow their wishes, they should contact:

Department of Financial and Professional Regulation
Division of Professional Regulation
Complaint Intake Unit
100 West Randolph Street, Suite 9-300
Chicago, IL, 60601
Phone: 312-814-6910

If a member believes that their hospital or other healthcare facility did not follow their wishes, they should contact:

Illinois Department of Public Health
Office of Healthcare Regulations
Central Complaint Registry

525 W. Jefferson Street, Ground Floor
Springfield, IL, 62761
Phone: 800-252-4343

Members can also visit the IDFPR website at https://www.idfpr.com/Admin/DPR/Complaint.asp to file complaints online.

If a member believes that Meridian did not follow their wishes, they should contact:

Illinois Department of Insurance
320 West Washington Street
Springfield, IL, 62767-0001
Phone: 866-445-5364 (toll-free)
TDD: 217-524-4872 or Fax: 217-558-2083
https://mc.insurance.illinois.gov/messagecenter.nsf

Section 5: Utilization Management, Care Coordination and Disease Management

Utilization Management

The objective of Meridian's Utilization Management (UM) department is to ensure that the medical services provided to members are medically necessary and/or appropriate, as well as in conformance with the plan benefits. To guide the decision-making process, UM applies systematic evaluations to appropriate medical necessity criteria and considers circumstances unique to the member.

The utilization management process consists of the following:

Pre-service Review: Also known as prior authorization or precertification, pre-service review is the review of medical information before the delivery of the healthcare services. The purpose of preservice review is to determine if the care and setting are medically appropriate, according to established criteria/guidelines.

Concurrent Review: The review of ongoing clinical care to determine if the services that are being provided meet the clinical guidelines/criteria for the appropriate level of care and setting.

Retrospective Review: The process of reviewing a service request and making an organization determination after a service has been rendered by the provider.

Meridian requires review of select services before they are provided. The primary reasons for clinical review are to determine whether the service is clinically appropriate, is performed in the appropriate setting, and is a covered benefit. Clinical information is necessary for all services that require clinical review for medical necessity.

Utilization decisions are based on appropriateness of care and service, as well as the member's eligibility. Meridian does not reward our providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

Utilization Management staff refer to plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by Meridian's medical directors. These guidelines include McKesson InterQual® criteria, Meridian Medical Review Criteria (developed by Meridian medical directors in conjunction with community physicians), and applicable federal and state benefit guidelines.

Meridian's Medical Necessity Guidelines are based on current literature review, consultation with practicing physicians and medical experts in their particular field, government agency policies, and standards adopted by national accreditation organizations. It is the responsibility of the attending physician to make all clinical decisions regarding medical treatment. These decisions should be made consistent with generally accepted principles of professional medical practice and in consultation with the member.

Copies of the criteria utilized in decision-making are available free of charge upon request by calling the Utilization Management department at 866-606-3700. In certain circumstances, an external review of service requests are conducted by qualified, licensed physicians with the appropriate clinical expertise. Utilization management decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the member's eligibility and benefits at the time the services are rendered.

Services that are not listed on the Illinois Medicaid Fee Schedule are not reimbursable to the provider.

A provider who is not enrolled in the Illinois Medicaid program will not receive reimbursement for services rendered.

Behavioral Health Utilization Review

Meridian's approach to administering behavioral health services is in an effort to improve the overall health and quality of life for our members. We do this by supporting an integrated, whole person model of care that includes consideration of the physical, behavioral, and social issues of each individual member necessary for receiving the appropriate care at the appropriate time. Our philosophy is to support and encourage the delivery of services in a context of providing hope, recovery, resiliency, and independence. Additionally, we strive to maintain a proactive, collaborative relationship with our behavioral health providers to ensure access to all covered and medically necessary behavioral health services.

Meridian's Behavioral Health Utilization Management team works with providers to support all levels of care:

- Inpatient psychiatric hospitalizations
- Inpatient detoxification services
- Residential Substance Use Treatment (Substance Use Prevention and Recovery–SUPR)
- Partial Hospitalization Programs
- Intensive Outpatient Services
- Psychological and Neuropsychological testing
- Outpatient Mental Health therapy and Substance Use counseling
- Community Mental Health Center services (CMHC Rule 132)

For a complete list of covered behavioral health services and the most current authorization requirements, please visit provider authorization and referral guidelines listed on our website.

All behavioral health utilization reviews are completed by licensed qualified mental health practitioners, and any adverse determination where coverage of a service may be denied are made by Meridian's behavioral health medical directors. The guidelines utilized to make any such coverage decision include Change Healthcare InterQual criteria, American Society of Addiction Medicine (ASAM) criteria, Meridian Medical Review Criteria (developed by Meridian medical directors in conjunction with community physicians), and applicable federal and state benefit guidelines. Copies of the criteria utilized in decision-making are available free of charge upon request.

The Meridian behavioral health utilization reviewers and care coordinators are available to support discharge planning efforts and transitions between levels of care. Discharge planning is a process that should begin at the time of admission to services. Meridian recognizes that transitions between levels of care are critical points in treatment and can contribute to a member being successful in receiving behavioral health services in community settings. Meridian's Behavioral Health Discharge Transition of Care Form is located on ilmeridian.com under "Documents and Forms". This document can be completed and submitted to Meridian as soon as possible (recommend within 24 hours of discharge from your care), or you may submit your own discharge summary information to Meridian making sure to include the following core components:

- Scheduled appointment with a behavioral health specialist within seven days of discharge
- Scheduled follow-up appointment with member's PCP
- List of medications prescribed

Concurrent Review, Discharge Planning, and Transition of Care:

Meridian's nurse reviewers are assigned to members at specific acute care facilities to promote collaboration with the facility's review staff and management of the member across the continuum of care.

Meridian's nurse reviewers assess the care and services provided in an inpatient setting and the member's response to the care by applying InterQual® criteria. Together with the facility's staff, Meridian's Utilization Management clinical staff coordinates the member's discharge needs.

Meridian's nurse reviewers' interface with the hospital/facility discharge planners to:

- Obtain the member's discharge planning needs
- Identify the member's discharge planning needs
- Facilitate the transition of the member from one level of care to another level of care
- Obtain clinical information and facilitate the authorization of post discharge services, such as DME, home health services, and outpatient services

Requesting Prior Authorization/Precertification

After July 1, 2022, Prior Authorizations will be processed online at **www.ilmeridian.com/providers/preauth-check.html.** Using Meridian's online Prior Authorization (PA) tool offers timely and efficient service.

Please Note: Some authorizations cannot be processed via phone as clinical review and supporting documentation is required.

When submitting a Prior Authorization request, please include the following information:

- Member's name
- Member's identification number
- Date(s) of service
- Facility where services are to be rendered
- Diagnosis/Procedure code(s), as applicable

Clinical information is required for all clinical review requests to ensure timely decisions by Meridian. The decision timeframe is based on the date we receive the supporting clinical information. To ensure a timely decision, make sure all supporting clinical information is included with the initial request. The online PA form makes it easy to submit clinical information after the initial request is received. When submitting additional clinical information, be sure to enter both the Confirmation Number and Attachment Reference Number provided on the confirmation page of the initial request.

Clinical information includes relevant information regarding the member's:

- History of presenting problem
- Physical assessment
- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Response to treatment

Clinical information should be provided at the time the initial request is submitted. The provider or facility is responsible for ensuring authorization. Meridian provides a reference number on all authorizations.

- **Failure to obtain prior authorization may result in denial of the claim**
- **All services (except emergency services) for out-of-network providers require prior authorization**

Services Requiring Authorization

The list below provides Meridian's general Prior Authorization requirements. This list is not all inclusive and is subject to change. Providers will be given 60-day advance notice to additions to the Prior Authorization list. Please verify requirements at the time of the request.

- All inpatient admissions
- All transplant surgeries
- DME requests whose sum totals >$1000 always require prior authorization
    - Please see the Online Prior Authorization Form site for more prior authorization requirements of DME services/items
- Certain outpatient diagnostic radiology procedures
- Certain outpatient Services/Treatments/Procedures
- Certain inpatient surgical procedures
- Home health visits
- Inpatient admissions to a Rehabilitation Facility
- Inpatient behavioral healthcare services for certain diagnoses
- Long Term Acute Care admissions
- Select pharmaceuticals
- Skilled Nursing Facilities admissions

- All out-of-network services: If referring a member outside of Meridian's network please include supporting documentation with your prior authorization request indicating why services are being rendered out of network

Note:

- IP authorizations must be obtained within **1** business day of admit.
- Authorizations for OP services must be obtained before rendering service.
- Observation does not require authorization but any diagnostic procedure may require authorization. Please check the portal for authorization requirements.

Services that DO NOT require prior authorization (regardless of network status) include:

- Emergency services
- Post stabilization services
- Women's Health
- Family Planning & Obstetrical Services
- Child & Adolescent Health Center Services – Child Mobile Crisis services do not require prior authorization. However, SASS providers are required to notify Meridian of a completed crisis assessment within 24 hours
- Local Health Department (LHD) services
- Long Acting Reversible Contraception (LARCs)
- School-based services and School Dental Services
- Other services based on state requirements

Classifying Your Prior Authorization Request

Standard Organization Determination (Non-urgent Pre-service Request): Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than four calendar days after Meridian receives the request for service.

Expedited Organization Determination (Urgent/Expedited Pre-service Request): Expedited organization determinations are service requests made when the member or the provider believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. The service request will be made as expeditiously as the member's health condition requires, but no later than 48 hours after Meridian receives the request for services.

Expedited requests will require physician attestation as to the urgency of the request.

Turnaround Times for Processing Service Requests

Review Type	Decision Time Frame	Fax/Phone Notification	Written Notification (Denials)
Non-Urgent preservice review: Standard	Within 4 days of receipt of the request	Within 4 days of receipt of the request	Within 4 days of receipt of the request

Urgent preservice review: Expedited	Within 48 hours of the request	Within 48 hours of the request	Within 48 hours of the request
Urgent/ Concurrent Review	Within 24 hours of receipt of the request. 72 hours if clinical information is incomplete or is not included	Within 24 hours of receipt of the request. 72 hours if clinical information is incomplete or not included	Within 72 hours of the request
Retrospective Review	Within 14 days of receipt of the provider's request. N/A for members Meridian believes there are very few situations that justify requesting retrospective authorization and most often will be denied	N/A	Within 14 days of receipt of the request

Notification of Determination

Notification of all review determinations are provided verbally and/or in writing to providers within the established time frames.

All medically necessary denial determinations are rendered by a Meridian Medical Director.

The written denial notification will include the following:

- Reason for the denial
- Reference to the benefit provision and/or clinical guideline on which the denial decision was based
- Opportunity to discuss the determination with a Medical Director
- Appeal rights
- Directions on how to obtain a copy of the reference

Peer-to-Peer Discussion

Treating physicians who would like to discuss a utilization review determination with the decision-making Medical Director may do so at any time during the review process by contacting the Utilization Management department at 866-606-3700. A peer-to-peer discussion performed after a denial decision may result in an overturn if requested within 10 calendar days of the initial denial notification.

Specialized Services

Active Vendors

- **National Imaging Associates (NIA):** Effective July 1, 2021, NIA will begin managing prior authorizations for interventional pain management and therapy services (once HFS lifts the waiver for PT/OT/ST) for Meridian members. Requests for dates of service July 1, 2021 and

beyond should be submitted directly to NIA. Please access the Bulletins page on our website for a detailed notification and delegated code list.

NIA will continue to manage non-emergent, advanced, outpatient imaging services (cardiology and radiology), which went live on April 1, 2021.

- **New Century Health:** Effective July 1, 2021, New Century Health will begin managing prior authorizations for radiation therapy and medical oncology services for Meridian members. Requests for dates of service July 1, 2021 and beyond should be submitted directly to New Century Health. Please access the Bulletins page on our website for a detailed notification and delegated code list.

<u>Reconsideration of an Adverse Determination</u> (Does not apply to Behavioral Health Utilization Management)

In addition to the appeals process, providers may request a reconsideration of a denial determination within 10 calendar days of the date of the initial notification of denial. The request for reconsideration may be requested verbally or via fax. The reconsideration will be reviewed by Meridian's Medical Director. The provider will be notified verbally at the time of the determination of the denial reconsideration. If the decision is to overturn the denial, Meridian will notify the provider in writing no later than 10 business days following Meridian's receipt of the request. No physician will be involved in an appeal for which he/she made the original Adverse Determination. No physician will render an appeal decision who is a subordinate of the physician making the original decision to deny. If the decision is to uphold the initial denial, the provider may appeal the decision by following the appeal process provided with the initial written denial notice.

<u>Pre-Service Appeal</u>

Refer to Section 2: Member Grievances and Appeals.

<u>Post-Service Appeal</u>

Refer to Section 6: Billing and Payment for directions on Post-Service Appeals.

PRIOR AUTHORIZATION CONTACT INFORMATION	
ONLINE PRIOR AUTHORIZATION FORM SUBMISSIONS	
The Online Prior Authorization (PA) form is the method of PA submission. The Online PA Form should be utilized to send all requests for Emergent Admission, Behavioral Health (and non-behavioral health), Residential Substance Abuse, Skilled Nursing Facility, Inpatient Rehab, Transplants, Long-Term Acute Care Hospitals (LTACH), Surgeries, Home Care, Hospice, Office Visits, Therapies, DME, and Pain Management.	
Phone	**Web**
888-322-8844	www.ilmeridian.com/providers/preauth-check.html
STANDARD FAX SUBMISSIONS	
Please note: Utilizing the Online PA Form is the preferred method of PA submission.	
UM Phone	**UM Fax**
888-322-8844	313-202-3968
BH Phone	**BH Fax**
800-845-8959	Inpatient: 833-544-1827 Outpatient: 833-544-1828
CLAIMS	

Plan	Phone	Fax
All Plans	800-203-8206	313-324-3642
PHARMACY PA REQUESTS		

Plan	Phone	Fax
Medicaid	855-580-1688	855-580-1695

PROVIDER SERVICES	
Plan	**Phone**
Medicaid	866-606-3700
Fax	
Type of Request	**Fax Number**
Inpatient Admissions	833-544-0590
Pre-Service request	833-544-0590
Post-Acute Request	833-544-0590
Behavioral Health Inpatient	833-544-1827
Behavioral Health Outpatient	833-544-1828

Care Coordination Program

The purpose of Meridian's Care Coordination program is to link the member's needed services and resources in a coordinated effort, achieve better access to needed care, navigate the member through the complex healthcare system, and increase self-management and self-advocacy skills. The program is designed to ensure the coordination of services across various domains, such as primary care, substance abuse, mental health, and community supports. Care Coordination is a program that approaches care by ensuring that those enrolled receive the most appropriate services in the most appropriate setting at the appropriate time. Care Coordination uses a holistic approach to care to link patients to services and resources in the community that will help improve their health and overall well-being. Meridian's Care Coordination program focuses on coordination and collaboration between behavioral health, medical care, and the members themselves to ensure coordinated care with a strong emphasis on patient education, coaching and knowledge.

Some of the goals of Care Coordination are to:

- Complete health risk screenings or assessment, as appropriate
- Develop and implement an individual plan of care
- Provide self-management education
- Conduct medication reconciliation and adherence
- Collaborate with an interdisciplinary care team (ICT)
- Ensure safe transitions of care

Target Population: Through assessments and predictive modeling, Meridian identifies and stratifies the member population to identify the clinical risk of each member to determine the appropriate coordination of needs. All Meridian members have varying degrees of care coordination. This ranges from preventive and population health, to disease management care coordination, all the way through the healthcare continuum to high needs coordination and complex case management.

Members can be enrolled into the Care Coordination program upon request by the member, their caregiver, or provider.

If you wish to make a referral for a member you can do so by:

A. Notifying Meridian through the Provider Portal
    1. Log in to the Provider Portal (ilmeridian.com and select "Login", then "Provider Portal" at top right). Enter your username, password, and state
    2. Select "Member" on the left menu
    3. Enter the Member ID number
    4. Click "Notify Health Plan" at the bottom of the "Demographics" screen
    5. Select "Case Management" (middle tab) and fill out the reason for referral

B. Completing the "Care Coordination/Complex Case Management Referral Form" and faxing it to Meridian. To get the form:
    1. Go to ilmeridian.com, and select the state and plan in question. Navigate to the Provider page
    2. Click on "Provider Resources" and choose Documents & Forms
    3. Fax the completed form to 312-508-7251
C. You can also request a Care Coordination Referral Form from your local Provider Network Development Representative

Your role as a provider in the Care Coordination process:

Health risk screenings or assessments
All Meridian members receive a health risk screening (HRS) or assessment (HRA), as appropriate, upon enrollment into the plan and annually. As a provider, you may be contacted to support us with reaching your assigned members to complete the HRS or HRA.

Develop and implement an individual plan of care (IPoC)
Upon completion of the health risk screening or assessment, members enrolled into Care Coordination will have an IPoC developed by their Care Coordinator. The IPoC is a person-centered tool that provides a structured format to organize a member's individual care needs and desires and how those needs will be met. The focus is to support the member, caregiver, and his/her interdisciplinary care team (ICT) to achieve personally-defined goals for improving his/her overall health and well-being in the most integrated setting, with an emphasis on providing for those needs that allow members to remain in their home and community to the extent possible. PCPs will receive a copy of the member's IPoC to foster participation in the ICT. If you have recommendations for the IPoC, you can contact the member's Care Coordinator.

Collaborate with an interdisciplinary care team (ICT)
ICT meetings are a chance for focused coordination of care with the ICT that includes the member, the member's family, physical health provider, behavioral health (BH) provider, Meridian ICT professionals, and any other appropriate community and social support providers. Care Coordinators may be reaching out to you to discuss your participation in the ICT and IPoC.

Transitions of care

Meridian is committed to ensuring that members have transitions from one environment to the next. The transition coordination process assures the right systems and supports are in place to complete successful transitions for members with additional needs at the time of discharge. The member is reminded at each point of transition that his/her consistent point of contact at the plan is the Meridian CC as he/she moves through the continuum of care. Providers can expect to receive notification when members enrolled in Care Coordination experience a transition so you can participate in the ICT, updates to the IPoC, and also ensuring the member has a visit with you or the appropriate specialist within seven days or 14 days of discharge.

Home and Community Based Services (HCBS) Program

The Meridian HCBS program provides services to five waiver groups, each with distinct eligibility/enrollment requirements and benefits. Members can only qualify for one of the five waiver groups:

- **Persons who are Elderly Waiver:**
  Age 60 or older, who are otherwise eligible for nursing facility as evidenced by the Determination of Need (DON) assessment
- **Persons with Disabilities Waiver:**
  Persons age 0-59 with disabilities (those 60 or older who began this waiver before age 60 may remain in this waiver); persons with a severe disability which is expected to last for at least 12 months or for the duration of life; persons otherwise eligible for a nursing facility as evidenced by the DON assessment

  Persons with Brain Injury (BI) Waiver
  Persons of any age with a brain injury; have functional limitations directly resulting from an acquired brain injury, infection, (encephalitis, meningitis) anoxia, stroke, aneurysm, electrical injury, malignant or benign neoplasm of the brain, and toxic encephalopathy. Due to these conditions, has a severe disability which is expected to last for at least 12 months or for the duration of life; persons otherwise eligible for nursing facility as evidenced by a total of 29 points on the DON assessment
- **Persons with HIV or AIDS Waiver**
  Persons of any age diagnosed with HIV or AIDS; persons otherwise eligible for nursing facility as evidenced by a total score of 29 points on the DON assessment
- **Persons residing in Supported Living Facilities (SLF) Waiver**
  Operated by the Medicaid agency, HFS. Persons age 65 or older or persons with disabilities (as determined by the Social Security Administration) age 22 and older, screened by HFS and found to be in need of nursing facility level of care and SLF is appropriate to meet the needs of the individual. These persons can be without a primary or secondary diagnosis of a developmental disability or serious and persistent mental illness

Home and Community Based Services include the following:

• Personal care aides • Adult day health • Attendant care • Community transitional services (nursing • facility residents only) • Emergency alert system • Group respite • Habilitation • Home delivered meals • Home health service • Homemaker • Home safety modification	• Out-of-home respite • Supplemental adaptive and assistive devices • Physical and speech therapy Specialized medical equipment and supplies • Environmental accessibility adaptations • Transportation with/without attendant • Skilled nursing • Peer support services • Caregiver support program – nutritional training, personal care techniques, fall prevention, and how to use respite care

HCBS Provider Responsibility

Service Requirements for HCBS providers:

- HCBS will provide services in accordance with the person-centered POC including the amount, frequency, duration, and scope of each service in accordance with the member's service schedule
- HCBS providers will complete and forward all requested documentation verifying both the services provided, in accordance with the POC service authorizations and goal outcome documentation on a monthly basis, or as requested by the Meridian Community Care Coordinator. Documentation will include the information listed in the above bullet as well as the member's signature approving and verifying provision of services
- HCBS providers are prohibited from soliciting members to receive services including:
    - Referring an individual for screening and intake with the expectation that should program enrollment occur, the provider will be selected by the member as the service provider
    - Communicating with existing program members via telephone, face-to-face, or written communication for the purpose of petitioning the member to change providers

In the event a member is admitted to the hospital, LTSS providers will notify Meridian Community Care Coordination staff the same day they are aware of the admission.

HCBS providers must accept and agree to start services for Money Follows the Person (MFP) eligible members with a faxed authorization. HCBS providers must comply with Critical Incident reporting and management requirements. See the "Provider Critical Incident Reporting" section.

Smoking Cessation Program

Meridian offers a free telephonic outreach program and toll-free quit line called New Beginnings, to help members quit smoking. Members may call 844-854-5576. Providers may also call to refer members to the program. Our program covers multiple topics: setting a quit date, quit tips, health & wellness, cost savings & detours, and how to maintain a healthy smoke-free lifestyle. Meridian's quit coaches provide education and healthy cessation tips and aid in creating a cravings journal. Quit coaches also work with the member's physicians to obtain prescription for medications such as nicotine patches and lozenges. In addition, we ask that our providers take the time to ask patients about their smoking habits at every visit and if the patient is a smoker, please advise them to quit. Providers should also discuss smoking cessation strategies. Medications as part of nicotine replacement therapy are available through each plan's pharmacy benefit. For a complete list of covered medications, members and providers can review the formulary at ilmeridian.com or call the Pharmacy Help Desk at 855-580-1688.

Disease Management

The goal of Meridian's Disease Management programs is to improve member outcomes and well-being by supporting the practitioner/patient relationship and plan of care. We do this by combining up-to-date information and resources for our providers with self-management education and outreach strategies for members. The Disease Management programs were developed to assist members in gaining a better understanding of their condition, to update them on new information about their disease and to provide them with assistance from our staff to help manage their disease. The programs are designed to reinforce your treatment plans for the patient.

The targeted populations within are identified through data produced from HRAs, medical claims, encounter data, and pharmacy claims. Interventions are created for members in targeted populations that relate to specific diseases. The goal of these interventions is to improve health outcomes for those with chronic conditions, such as asthma, cardiovascular diseases, and diabetes.

Members of Meridian do not have to enroll in a Disease Management program; they are automatically enrolled when we identify them as members with one or more of the targeted chronic diseases through claims, the UM/CC program, pharmacy information, or Health Risk Assessments (HRA). Once a member is identified on our stratification list, claims history is used to determine the appropriate intervention level. Meridian will:

- Distribute tailored educational materials to assist members in understanding and managing their condition(s)
- Educate members on importance of medication adherence, self-management of conditions, and communication with providers

  Promote collaboration among physicians, providers and the health plan for comprehensive plans of care

Providers play an important role in the Disease Management programs. As a provider, you educate patients on the best ways to manage and improve their health. Meridian hopes our PCPs will support these programs and encourage their patients to take advantage of this service.

If you would like to enroll a Meridian member who is not in the program, please contact the Meridian Disease Management department by phone at 866-606-3700, by fax at 312-508-7213, or via the Provider Portal "Notify" button.

Enrollment in these Meridian Disease Management programs is voluntary. If at any time your patients wish to stop participating in the program, they can call Meridian at the number listed above.

Section 6: Billing and Payment

Claims Billing Requirements

When billing for services rendered to Meridian members, providers must use the most current Medicaid-approved coding format (ICD-10, CPT, HCPCS, etc.) and/or state Medicaid guidelines for claims payment.

Please follow these guidelines for claims submission to Meridian:

- Providers must use a standard CMS 1500 Claim Form or UB-04 Claim Form for submission of claims to Meridian
- Providers must use industry standard procedure and diagnosis codes such as HCPCS, CPT, Revenue, or ICD-10, and Taxonomy codes billed in accordance with state Medicaid, as well as industry standard guidelines when submitting a claim to Meridian
    - Provider should be familiar with and adhere to the billing guidelines as set forth in the Illinois Association of Medical Health Plans (IAMHP) Billing Guidelines https://iamhp.net/resources/Documents/IAMHP_Billing-Manual_v22_4_21_21%20(1).pdf
- Prior-Authorization – If required, must be submitted via www.ilmeridian.com/providers/preauth-check.html
- Providers must submit and check the status of claims electronically via Meridian's Provider Portal
- The standard submission of Medicaid Claims must be within 180 days of the date of service.
- Adjudication of a claim is based on the benefit coverage and meeting medical necessity criteria and the codes being submitted and considered for review, which can be found on the Illinois Medicaid Fee Schedule: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx

In order to receive reimbursement in a timely manner, please ensure each claim:

- Is submitted according to the timely filing submissions outlined in the provider's Meridian Participating Provider Agreement
- Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service, as well as the corresponding NPI number
- Identifies the patient (member ID number assigned by Meridian, or recipient identification number address, and date of birth)
- Identifies Meridian (plan name and/or ID number)
- Date (mm/dd/yyyy) and place of service and applicable modifiers
- Is for a covered service – See Section 3 of Provider Manual. (Services must be described using uniform billing coding and instructions (ANSI X12 837) and ICD 10CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered clean claims)

- If necessary, substantiates the medical necessity and appropriateness of the care or services provided; this includes any applicable authorization number if prior authorization is required by Meridian
- Includes additional documentation based upon services rendered as reasonably required by Meridian Policies
- Is certified by provider that the claim is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information; is certified that the claim identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim
- Is a claim for which the provider has verified the member's eligibility and enrollment in Meridian before the claim was submitted
- Is not a duplicate of a claim submitted within 45 days of the previous submission
- Is submitted in compliance with all of Meridian's prior authorization and claims submission guidelines and procedures
- Is a claim for which provider has exhausted all known other insurance resources
- Is submitted electronically if the provider has the ability to submit claims electronically
- Uses the data elements of UB-04 or CMS 1500 as appropriate
- All laboratory charges should be submitted to Meridian on a CMS 1500

SUBMIT ALL INITIAL CLAIMS FOR ADJUDICATION THROUGH ELECTRONIC CLAIM SUBMISSION OR BY MAIL TO:

For DOS before July 1, 2022
Meridian
Attn: Claims Department
1 Campus Martius, Suite 720
Detroit, MI 48226

For DOS on or after July 1, 2022
Meridian
PO Box 4020
Farmington, MO 63640-4402

Timely Filing:

- The standard submission of professional Medicaid claims for both in-network and out-of-network providers is 180 days from the date of service to submit an initial claim.
- The standard submission of institutional Medicaid claims for both in-network and out-of-network providers is 180 days from the discharge date to submit an initial claim.
- Providers have 180 days from the initial claim to resubmit or dispute a claim. There are two exceptions to the timely filing guideline:
    - Retroactive eligibility: These claims must be accompanied by documentation demonstrating proof of the eligibility change and must be received within 365 days of notification of the eligibility change
    - Third party liability-related delays: These claims must be accompanied by a third party liability (TPL) explanation of benefits and received within 90 days of the TPL process date

For claims not requiring corrections, but the provider is not satisfied with the claim disposition, a **claim dispute** may be submitted via the Secure Provider Portal at **provider.ilmeridian.com** (preferred) or via mail. Disputes must be submitted within 90 days from the EOP. All disputes must be received within 365

days of the DOS to be considered for review, unless otherwise specified within the provider contract. If mailing a dispute, please include a Provider Dispute form available at **ilmeridian.com**. If you chose to mail your dispute, please send it to:

Meridian
Attention: Claim Disputes
PO Box 4020
Farmington, MO 63640-4402

If you are replacing or voiding/cancelling a UB-04 claim, please use appropriate bill type of 137 or 138. If you are replacing or voiding/cancelling a CMS 1500 claim, please complete box 22. For replacement or corrected claim, enter resubmission code 7 in the left side of item 22 and enter the original claim number of the claim you are replacing in the right side of item 22. If submitting a void/cancel claim, enter resubmission code 8 in the left side of item 22 and enter the original claim number of the paid claim you are voiding/canceling in the right side of item 22.

Meridian uses claims editing software programs to assist in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and regulations. These software programs may result in claim edits for specific procedure code combinations.

Coordination of Benefits (COB)

Meridian appreciates your assistance and cooperation in notifying us when any other coverage exists, such as, but not limited to, other healthcare plans and worker's compensation benefits. In the event that Meridian is not the only insurance coverage for the member, Meridian should be billed as secondary payer for all services rendered and is responsible only for the difference between what the primary insurance pays and the allowable Medicaid fee schedule. Please submit claims that have other insurance payers to Meridian with an attached explanation of benefits (EOB) payment or rejection.

Claims Guidelines for Dual-Eligible Members

Services provided to patients who are covered by Meridian for both Medicare and Medicaid should follow the guidelines below:

- Submit one authorization request – Meridian will coordinate authorization requirements, benefits, and services between the two products
- Submit one claim to Meridian – There is no need to submit two claims. Claims processing information will be reported on two Remittance Advice (RA) forms:
    - The first Remittance Advice will come from Meridian Medicare indicating how the claim was processed and informing you that the claim was forwarded to Meridian Medicaid for secondary processing
    - The second Remittance Advice will show how the claim was processed for Meridian Medicaid

Explanation of Benefits (EOB)

Meridian sends its providers Remittance Advice as a method of explanation of benefits.

Balance billing: When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for the difference between the provider's charge and the Medicaid payment for service.

Encounter Billing Guidelines – ERC, FQHC, and RHC

Meridian requires that ERC, FQHC, and RHC providers submit claims on a CMS 1500 form using the Encounter Code T1015 for medical services or behavioral health services including required modifiers. All services provided during the encounter visit need to be a line item listed below the Encounter Code as a detail code on the claim using the appropriate E/M CPT Code(s).

Electronic Claims Submission

Date of Service	Health Plan Name	Payer ID
On or before Dec. 31, 2020	MeridianTotal	68069
	MeridianComplete	13189
	Meridian Illinois	13189
On or after Jan. 1, 2022	MeridianComplete	MHPIL
	Meridian Illinois	13189
On or after July 1, 2022	Meridian Illinois	MHPIL

For DOS before 7/1/2022, please submit claims with Payer ID 13189 for Meridian via established clearinghouses.

For DOS on or after 7/1/2022, please submit claims with Payer ID MHPIL via our direct connection clearinghouse, Availity.

Availity
Customer Support: 800-282-4548
www.availity.com

Special instructions: PROFESSIONAL – PIN must be the NPI #. FACILITY – Use the NPI # for provider ID (Locator 51), attending physician ID (Locator 82), and the other physician ID (Locator 83).

Providers using electronic submission shall submit all claims to Meridian or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format or a CMS 1500 and/or UB-04, or their successors. Claims shall include the provider's NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record before the initial submission of any claim.

Provider Appeal and Claim Dispute Process

Definitions:

- ***Provider Appeals*** – provider appeals are administrative or pre/post service related to services that are denied
- ***Provider Claim Disputes*** – provider claim disputes are related to claim payment denials, processing and/or payment discrepancies

Meridian's provider appeal and claim dispute process is available to all providers, regardless of whether they are in- or out-of-network.

What Types of Issues Can Providers Appeal?

The chart below outlines the differences between a provider appeal (administrative, pre-service and post-service) and a provider claim dispute and how to file each one respectively.

Please note that the provider appeal process is in place for two main types of issues:
1. The provider disagrees with a determination made by Meridian. In this case, the provider should send additional information (such as medical records) that support the provider's position.
2. The provider is requesting an exception to a Meridian policy, such as prior authorization requirements. In this case, the provider must explain the circumstances and why the provider feels an exception is warranted in that specific case.

A provider's lack of knowledge of a member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to a member being ineligible on the date of service or non-covered benefits.

How to File an Appeal

The chart below outlines the differences between a provider appeal (administrative, pre-service and post-service) and a provider claim dispute and how to file each one respectively.

Appeal Type	Where to Submit
Administrative Appeals Appeal of a claim denied for failure to authorize services according to timeframe requirements. This includes: • Inpatient Admission/Skilled Nursing Facility • Surgery • Physical/Occupational/Speech Therapy • Hospice	**Meridian** ATTN: Appeals Department PO Box 4020 Farmington, MO 63640-4402 Fax Number: 833-383-1503
Pre-Service Appeal Providers may file an appeal of a denial before rendering the service (pre-service) or during an ongoing course of treatment (concurrent) if they are appealing on behalf of the member. For expedited/urgent* pre-service appeals, the treating provider will be automatically deemed	**Meridian** ATTN: Appeals Department PO Box 44287 Detroit, MI 48244 Fax Number: 833-383-1503

the authorized representative for the member. For all other appeals, a signed authorized representative form **must** be obtained from the member. ***Expedited appeals** mean you feel that a delay in treatment could seriously jeopardize the life or health of the member.* Examples of pre-service appeals include, but are not limited to: • Denied Elective Surgery • Denied Continued Stay at a Skilled Nursing Facility • Denied Prior Authorization for an Inpatient Admission	
Post-Service Provider Appeals Appeals of services that were denied or reduced and have a denied authorization request on file. This excludes administrative denials (denials for lack of authorization). Examples of services that can be appealed through the post-service provider appeal process: • Denied Days for an Inpatient Stay or Denied Level of Care for an Inpatient • Denied Air Ambulance Transport • Denied Hospice Stay • Combined 15-30 Day Readmission	**Meridian** ATTN: Appeals Department PO Box 4020 Farmington, MO 63640-4402 Fax Number: 833-383-1503
Provider Claim Dispute **Disputes may be filed via the web Secure Provider Portal (Preferred) or via mail. If mailing please clearly identify the request as a dispute:** **Dispute Portal:** **For DOS before July 1, 2022:** Claims Dispute Form (ilmeridian.com) **For DOS on or after July 1, 2022:** **provider.ilmeridian.com** Disputes related to claims processing are handled separately from Administrative Appeals or Post-Service Provider Appeals. Claim disputes are disputes regarding the following: • Inaccurate Payment • Coding Edits (Correct Coding Initiative (CCI) edits) • Claims Denied as a Duplicate • Untimely Filing • Claims Denied for No Primary Payer EOB	**For DOS on or after July 1, 2022 use:** Meridian Attn: Claims Appeals PO Box 4020 Farmington, MO 63640-4402

Timeframe for Filing a Post Service Appeal

Appeals must be filed within **90 days** from the remittance date. Appeals submitted after the timeframe has expired may not be reviewed.

Response to Post-Service Appeals

Meridian typically responds to a post-service claim appeal within 30 days from the date of receipt. If additional information is needed, such as medical records, then Meridian will respond within 30 days of receiving the necessary information. Providers will receive a letter with Meridian's decision and rationale.

There is only one level of appeal available within Meridian. All appeal determinations are final. If a provider disagrees with Meridian's determination regarding an appeal, the in- or out-of-network provider may pursue other options below depending on the health plan the member is enrolled with.

Medicaid-Specific Guidelines

Binding Arbitration – A provider may initiate arbitration by making a written demand for arbitration to Meridian. The Provider and Meridian agree to mutually select an arbitrator and the process for resolution.

If you have any questions about the Meridian Medicaid post-service claim appeal process, please call 866-606-3700 for more information.

Section 7: Quality Improvement (QI)

QI Introduction

The primary objective of Meridian's Quality Improvement Program (QIP) is to continuously improve the delivery of healthcare services in a low resource environment to enhance the overall health status of its members. The QIP objectively and systematically monitors and evaluates the quality, appropriateness, and outcomes of care and services, and the processes by which they are delivered. Direct improvement in individual and aggregate member health status is measured using the applicable HEDIS® quality measures, State of Illinois mandated performance indicators, internal performance improvement projects, and health outcomes data. Indirect improvement in individual and aggregate member health status is measured using critical operational metrics designed to monitor accessibility and availability of care.

QIP Goals and Objectives

The main goal of the QIP is to ensure that Meridian members receive high quality, medically appropriate, and cost-effective healthcare. The QIP is integrated within clinical, non-clinical, and operational services provided to Meridian members. The program encompasses services rendered in ambulatory, inpatient, and transitional care settings and is designed to resolve identified areas of concern on an individual and system-wide basis. The QIP reflects the population serviced by Meridian in terms of age, gender, ethnicity, culture, disease, or disability categories and level of risk stratification.

Meridian demonstrates its commitment to quality through the implementation of the QIP and through participation on various State of Illinois committees, sub-committees, and partnerships. Objectives include, but are not limited to the following:

- Improve member health outcomes and risk status
- Ensure member access to medically appropriate care
- Assure accessibility and availability of quality medical, behavioral health, substance abuse, and home and community based services (HCBS) waiver care

- Develop programs to manage disease, improve (completion rates of) preventive screenings, and coordinate care for members with acute and chronic care needs
- Develop and evaluate efforts to reduce unnecessary Emergency Department utilization, inpatient services, and readmissions
- Increase appropriate follow-up services after inpatient care for behavioral health services or complex medical care
- Improve member and provider satisfaction
- Ensure member access to culturally and linguistically appropriate services
- Promote establishment of Integrated Health Homes (IHH) and Patient-Centered Medical Homes (PCMH)
- Report HEDIS®, CAHPS, HCBS waiver performance measures accurately and timely
- Improve coordination and transition across care settings and among ancillary providers
- Improve communication between the member and their PCP
- Monitor adherence to Meridian-approved, evidence-based clinical practice guidelines

Medicaid Performance Improvement Projects

Meridian is engaged in the two following collaborative performance improvement projects (PIP) mandated by the State of Illinois for Medicaid Managed Care Organizations:

- Community-Based Care Coordination
- Follow-Up After Hospitalization for Mental Illness (FUH)

Community Based Care Coordination Overview

The Community-Based Care Coordination Performance Improvement Project (PIP) is a three year study focused on improving the way care coordination is provided to members. It measures how targeted interventions affect three study indicators: 30-day readmission rates, care coordination interactions during hospitalization and/or post-acute care discharge, and accessing ambulatory care services and/or community resources within 14 days of discharge. To measure these healthcare services, the PIP uses inpatient hospital 30-day readmission rates, contact codes that track care coordination interactions, and Illinois Department of Healthcare and Family Services Performance Measure guidelines for ambulatory care follow-up with a provider within 14 days of inpatient discharge.

Follow-Up After Hospitalization Overview

The Follow-Up After Hospitalization for Mental Illness (FUH) PIP was determined by a directive from Centers for Medicare & Medicaid Services (CMS) and the State of Illinois. The main focus is to improve the follow-up care of individuals with a mental illness after hospitalization and discharge. The PIP is broken down into two study indicators: seven-day follow-up and 30-day follow-up. Data is derived from claims/encounters while being pulled into Meridian's Managed Care System (MCS) using the billed codes from each claim.

QIP Processes and Outcomes

Meridian uses the Plan Do Check Act (PDCA) methodology for its quality improvement activities, initiatives, and performance improvement projects. Integrated into the PDCA methodology are the following components: identification, performance goals and benchmarks, data sources, data collection, establishment of baseline measurements, analysis and evaluation, trends, intervention development and implementation, re-measurement, additional analysis, evaluation, addition, modification, or discontinuation of intervention development and implementation as indicated.

Clinical and operational performance indicators provide a structured, organized framework of standardized metrics to consistently:

- Measure, monitor, and re-measure performance and outcomes at prescribed intervals
- Assess and evaluate outcomes against predefined performance goals and benchmarks
- Identify and address potential barriers
- Promote early identification and remediation of potential quality issues to mitigate risk
- Recommend revision, addition, modification, or discontinuation of a quality improvement activity or initiative
- Re-measure, reassess, and re-evaluate the impact of quality activities and improvement initiatives

Meridian's QIP focuses on both clinical and operational outcomes, including all State of Illinois-required NCQA HEDIS® measures; State of Illinois contractually-required clinical performance measures; State of Illinois Performance Improvement Projects for EPSDT and Perinatal Care; and operational outcomes, such as patient experience, provider satisfaction, utilization management, and complaint and grievance resolutions.

Outcomes of the QIP are tracked, analyzed, and reported to the QIC and Board of Directors annually. Meridian identified key areas for performance improvement in SFY 2017-2018 and developed interventions to address. The key areas are:

- HEDIS® measures performing at or below the 50th percentile
- Addressing key health disparities in the member population
- Development of strategic partnerships to drive performance and improve member health outcomes (i.e., in-home service provider for diabetes)
- Develop and improve data sources for accurate and consistent improvement, measurement, and reporting of HEDIS® and member satisfaction

Meridian is one of the top Medicaid plans in IL according to NCQA's Medicaid Health Insurance Plans Ratings 2019-2020.

Provider Opportunities in QIP Activities

Provider involvement is integral to a successful QIP. By ensuring accessibility and delivering high quality care, providers contribute to the goals and objectives of the Meridian QIP. Providers also have the opportunity to contribute administratively by becoming active participants in Meridian committees. To

express interest in joining any of the following committees, or to request more information, please contact Quality Improvement at 866-606-3700.

Quality Improvement Committee

The Quality Improvement Committee (QIC) continuously monitors the medical necessity, medical appropriateness, accessibility and availability and use of medical, behavioral health and substance abuse healthcare resources. The QIC, which meets quarterly, is chaired by the corporate Chief Medical Officer and is comprised of members including the Medical Director, Chief Operating Officer, Director of Quality Improvement, Director of Utilization Management, and a minimum of one community-based physician representative.

The QIC is responsible for the following:

- Report QIP status (including recommendations) to the Board of Directors (BOD) quarterly and annually
- Review and approval of all Meridian Corporate and Departmental Policies and Procedures
- Review and adoption of all Meridian Medical Necessity Review Criteria, Medical Policies, and Clinical Practice Guidelines
- Provide direction to and ensure coordination among the QIC subcommittees
- Review and approve the annual QIP, work plan, and previous year's evaluation
- Identify opportunities for improvement
- Establish performance goals and benchmarks
- Review, approve, and prioritize all quality improvement activities, programs, and initiatives, including satisfaction
- Ensure all quality improvement activities, programs, and initiatives are fully implemented as approved
- Analyze and evaluate quarterly and annual QIP performance metrics
- Monitor urgent and routine determination decision time frames
- Implement use of approved Medical Necessity Review Criteria, Meridian Medical Policies, and Clinical Practice Guidelines to monitor the medical appropriateness of care
- Identify and report aberrant or substandard care practices, including sentinel events and near misses, to the Physician Advisory Committee and QIC for further investigation and corrective action as necessary
- Monitor determination decision-making appropriateness and inter-rater reliability testing
- Monitor approval and denial rates
- Monitor appeal and overturn rates
- Analyze and evaluate utilization resource trends
- Identify barriers and facilitate resolution
- Identify and remediate instances of over- and under-utilization
- Evaluation of new technology
- Monitor satisfaction with all care coordination processes including utilization review, care coordination, and disease management

Credentialing Committee

The Credentialing Committee continuously ensures the Meridian provider network is comprised of practitioners and providers that deliver quality healthcare services in a safe and sanitary environment and use medical record practices that are consistent with the applicable standards set forth by Meridian in accordance with the NCQA accreditation and the State of Illinois and the Centers for Medicare and Medicaid (CMS) regulatory requirements. The Subcommittee is chaired by the Medical Director and is comprised of committee members including a minimum of three community-based physicians.

The Credentialing Committee is responsible for the following:

- Review and recommend approval, pending, or denial of applicants for initial credentialing or recredentialing and inclusion in the Meridian network
- Perform peer review of practitioner or provider-specific quality of care or service issues and recommend remedial corrective action as necessary
- Ensure and monitor impact of remedial corrective action recommendations by contracted physicians
- Review performance indicators of all Meridian contracted providers at least every three years

The Credentialing Committee meets at a minimum on a quarterly basis.

Physician Advisory Committee

The Physician Advisory Committee (PAC) works to promote quality of healthcare delivery through compliance with the standards put forth by Meridian in accordance with NCQA accreditation, the State of Illinois, and the Centers for Medicare and Medicaid (CMS) regulatory requirements. The Subcommittee is chaired by a Medical Director and is comprised of committee members including a minimum of three community-based physicians.
The Physician Advisory Committee is responsible for the following:

- Review and approve all Medical Necessity Review Criteria, including medical, behavioral health, and substance abuse
- Recommend adoption of all approved Medical Necessity Review Criteria to the QIC
- Facilitate development of Meridian Medical Policies and evidence-based Clinical Practice Guideline
- Review and approve Meridian Medical Policies
- Recommend adoption of Meridian Medical Policies and evidence-based Clinical Practice Guidelines to the QIC
- Facilitate implementation and monitor adherence to Meridian Medical Necessity Review Criteria, Medical Policies, and Clinical Practice Guidelines
- Educate internal staff and external peers on Meridian Medical Necessity, Medical Policy, and Clinical Practice Guideline requirements
- Make provider appeal determinations
- Review and resolve provider complaints and grievances

The Physician Advisory Committee meets at a minimum on a quarterly basis.

Grievance Committee

The Grievance Committee continuously identifies opportunities for quality improvement and corrective actions through the review, analysis, and evaluation of provider and member appeals, complaints, and grievances. The Committee is chaired by the Director of Quality Improvement and is comprised of staff members, including the Chief Operating Officer and Medical Director. The Director of Member Services and/or the Director of Utilization Management may participate as needed, based on the substance of the grievance. Individuals involved in the previous decision or subordinates of individuals making the previous decision cannot participate in the Grievance Committee hearing that grievance. The Grievance Committee also includes a 25 percent representation of members.

The Grievance Committee is responsible for:

- Analyzing and evaluating complaints and grievances
- Proposing complaint and grievance resolutions
- Identifying areas for quality improvement initiatives and/or corrective action

The Grievance Committee meets on an ad-hoc basis, depending on the receipt of complaints and grievances.

Contractual Arrangements

Non-Delegated

By signing a contractual agreement with Meridian to be part of its provider network, the practitioner, provider, facility, or ancillary service agrees to:

- Abide by the policies and procedures of the Meridian QIP
- Participate in peer review activity
- Provide Meridian with required data as part of the initial provider enrollment process
- Provide credentialing and re-credentialing information in accordance with Meridian standards every three years
- Provide Meridian with updated provider enrollment information to support accurate claims payment, member enrollment, and provider directory information
- Serve on the QIC or other subcommittee as necessary
- Allow Meridian to collect data and information for quality improvement purposes
- Cooperate with the utilization management, care coordination, and disease management programs as applicable, including but not limited to:
    - Clinical data submission with the initial corporate prior authorization request
    - Timely response to outreach requests for information or to discuss member's plans of care
    - Participate in care coordination conferences as necessary
    - Resolve appeals, complaints, and grievances

Delegated

Meridian occasionally delegates administrative, clinical, or operational functions. Most often credentialing functions may be delegated to large provider groups. Occasionally, other functions are delegated. Meridian conducts significant oversight and monitoring of its delegates. Meridian prefers to delegate to NCQA or URAC certified organizations.

Quality Improvement Program Activities

Monitoring Quality Performance Indicators – Clinical and Operational

The purpose of HEDIS® is to ensure that health plans collect, analyze, evaluate, and report quality, utilization, cost, and outcome data using a standardized, consistent methodology so that accreditors, regulators, providers, and the plan itself can compare performance against other regional health plans and state and national benchmarks. Meridian uses HEDIS® measures to provide its network practitioners standardized individual and aggregate feedback regarding their performance in delivering key preventive and maintenance healthcare services. All HEDIS® data is collected through claims data, supplemental data submission and entry, and/or medical record data extraction in the HEDIS® software program by departmental staff and providers through the provider portal. The data is aggregated, stored, and analyzed using a proprietary, in-house developed HEDIS® software program that is certified by the Health Services Advisory Group (HSAG) and Healthcare Data Company annually. Meridian conducts additional analysis, evaluation, and monitoring continuously at the departmental, committee and organizational levels to:

- Ensure members have timely access to and availability of necessary preventive and maintenance healthcare services to maintain their optimum level of health
- Identify opportunities for quality improvement
- Identify and proactively resolve barriers to care, including linguistic and cultural
- Develop and implement new, or refine existing, quality initiatives to meet the ongoing, dynamic needs of the member population

The purpose of the operational metrics is to ensure:

- Members and providers are satisfied with the level and quality of services provided by Meridian
- The provider network access and availability is adequate to meet members' care needs in a timely manner
- Meridian makes initial corporate prior authorization and appeal determinations in a timely manner
- Meridian is responsive to the timely investigation and resolution of appeal and grievances
- Meridian is readily available by telephone to assist its providers and members with their administrative, operational, and clinical needs and questions

Monitoring Quality Performance Indicators – Surveys

Members

Surveying member satisfaction provides Meridian with information about member experience with the plan and provider network. Meridian assesses member satisfaction in several ways including, but not

limited to, CAHPS®, HOS, and member experience surveys. The results of these surveys help Meridian identify areas of member dissatisfaction for corrective action, as well as areas of member satisfaction in order to continue improvement. Based upon these survey results, the QIC is able to make sure member input is incorporated in the selection, approval, and prioritization of quality improvement activities, initiatives, and programs that are most beneficial and meaningful to its member population.

Providers

Surveying provider satisfaction, access, and availability helps Meridian collect information about provider experience with the plan and its members. Meridian assesses provider satisfaction in several ways including, but not limited to, the Annual Provider Survey. Results from this survey help Meridian identify areas of provider dissatisfaction for corrective action, identify areas of satisfaction so as to identify opportunities for continuous improvement, assess ongoing education and training needs, and quantitatively access the adequacy of the Meridian provider network. Based on these survey results, the QIC uses the information in its selection, approval, and prioritization of quality improvement activities, initiatives, and programs that are most beneficial and meaningful to its provider in balance with those that are most beneficial and meaningful to its member population.

Meridian Medical Policies and Clinical Practice Guidelines

The Physician Advisory Committee develops and the QIC approves evidence-based Meridian specific medical policies and clinical practice guidelines applicable to specific conditions and treatments that are prevalent in the member population. The medical policies are complementary to local, regional, and national standards of medical practice and are in accordance with the State of Illinois Medicaid Program benefit coverage rules and CMS National and Local Coverage Determinations as applicable. Additionally, the clinical practice guidelines are complementary to the established medical best practices of the plan and are in accordance with local, regional, and national standards of practice. Providers are educated about Meridian Medical Policies and Clinical Practice Guidelines through the Meridian website, provider newsletters, and this Provider Manual. Providers are informed they may receive copies of Meridian medical policies and clinical practice guidelines free of charge upon verbal or written request.

Monthly Provider HEDIS® Education

The Quality Improvement department develops monthly provider HEDIS® educational materials to be distributed by Provider Network Development Representatives. Each piece addresses the following:

- The clinical significance of the HEDIS® measure service in the overall care and management of the member by the PCP
- The beneficial impact on the performance of the clinical HEDIS® measure to help the member maintain their optimal level of health
- How to correctly bill for the HEDIS® measure services rendered for data collection

Peer Review

Peer Review is conducted in accordance with the applicable accreditation standards, contractual requirements and state and federal regulatory requirements. The Physician Advisory Committee in

collaboration with the Credentialing Committee manages the Peer Review process. Cases requiring Peer Review are identified through member or provider complaints, grievances, the initial application or reapplication processes, sentinel event or near-miss occurrences, unexpected poor care and treatment outcomes, allegations of substandard or aberrant care practices, allegations of fraud, waste, and abuse and other sources. The Physician Advisory Committee performs the Peer Review in accordance with Meridian policies and procedures. Remedial, corrective, and/or disciplinary actions are taken in a timely manner in accordance with Meridian policies.

Management of Quality of Care Complaints

All complaints, grievances or other issues generated by members, providers, Meridian staff, external State oversight agencies, or other entities that involve quality of care are managed by the Grievance Committee in accordance with Meridian policies, procedures, and processes. Member contacts regarding access and availability for a current illness or condition are routed to a clinician in the appropriate utilization management or care coordination area for investigation, resolution, and disposition outcome reporting to the Committee in accordance with Meridian policy.

The QIC performs an objective review of all quality of care complaints and grievances and issues investigations, resolutions, and dispositions quarterly to assess for appropriate management, adherence to timeliness standards, assess member, provider or other external agency satisfaction with the agreed upon resolution and evaluate the instance for a potential opportunity for system-wide improvement or corrective action.

Patient Safety

Patient safety needs are addressed through the following activities:

- Review of appeals, complaints, and grievances and determination of quality of care impact
- Review of initial HRA and periodic re-assessment by clinical staff
- Review of initial and periodic reassessment of the member's level of risk stratification
- Care Coordination and Disease Management programs targeted at educating members and their families on:
    - The member's condition including subtle changes which may warrant acute intervention
    - Medication use, safety, and interaction prevention
    - Self-management instructions including diet and exercise
    - Coordination of multiple or complex healthcare services
    - HEDIS® measure care reminders
- Notification to members and providers of medications recalled by the FDA
- Notification to the Quality Improvement and Care Coordination departments of any potential quality or safety cases:
    - Re-admission within 15 or 30 days of discharge
    - Emergency room visit within seven days of discharge
    - Significant provider treatment errors, including medication prescribing and medication interactions
    - Unexpected poor outcomes or death
    - Missed diagnoses

    - Avoidable delays in treatment
    - Missed post-discharge or post-diagnostic testing follow-up appointments
    - Insufficient discharge planning
- Provider site surveys
- Targeted and general member educational outreach via telephone or in writing
- Targeted and general provider educational outreach via telephone or in writing
- Cultural competency education and training for contracted providers and their office staff
- Use of the language translation telephone service free of charge for contracted providers and members

Confidentiality and Conflict of Interest

Confidentiality

Meridian uses the following mechanisms to effectively govern confidentiality, integrity, and availability of protected health information (PHI) in written and electronic form:

- Corporate policies prohibiting Meridian employees and contractors from voluntarily disclosing any peer review information except where permitted or required by law
- HIPAA Privacy and Security policies and procedures developed and implemented by Meridian's Privacy and Security Officers and adherence monitored by the HIPAA Privacy and Security Committee through quarterly meeting and reports
- Corporate policies prohibiting Meridian employees from disclosing any member personally identifiable information (PII) or PHI except for treatment, payment, or healthcare operations, where permitted or required by law, or pursuant to written member authorization explicitly allowing such disclosure
- Corporate policy mandating disclosing only the minimum necessary amount of member and provider information to perform payment, treatment, and healthcare operations functions and meet the legal obligations of the health plan
- Corporate policies restricting access to member and provider information to only those employees who need access to perform each employee's job and controlled through the use of individual user identification and passwords

Each employee is required to sign a confidentiality statement and participate in HIPAA Privacy and Security training annually.

Each external committee participant must agree in writing to abide by these confidentiality policies and sign a Committee Member Confidentiality Statement.

Conflict of Interest

All Meridian employees who are directors or above and community-based physician advisors are required to sign conflict of interest statements annually.

Meridian code of conduct and business ethics and corporate policies prohibits any Meridian employee or community-based physician advisor from performing utilization review or making medical necessity

determinations on any member for which they are providing care for or from which he or she may directly or indirectly financially, or in kind, benefit personally or professionally other than standard remuneration from the company.

Meridian does not bonus, reward or financially incentivize any Medical Director, physician advisor, or utilization management employee based upon the number of adverse initial and appeal determinations made.

Member Safety

Meridian encourages and supports practitioners in creating a safe practice environment. Meridian demonstrates this support through:

- The development and implementation of clinical practice guidelines based on national standards
- Provider and member newsletters that convey new, revised, and/or updated initiatives and provide safety-related information
- The development and delivery of effective and ongoing fraud and abuse education and training for employees, members, and providers through various methods (i.e., member and provider websites, newsletters, Member Handbook, Provider Manual, Provider Network Development Representative visits with providers, and on-site training for all employees)
- The inclusion of provider office safety evaluations in the annual site visits for quality
- A safety action plan to ensure safety measures are assessed and incorporated in day-to-day operations

Meridian also demonstrates a strong commitment to legal and ethical conduct through the prevention, detection, and reporting of fraud and abuse activities. Other safety related program components include:

- Information distributed to members designed to improve their knowledge with respect to clinical safety in their own care (i.e., questions to ask surgeons before surgery)
- Collaborative activities with network practitioners targeting safe practices (i.e., improving medical record legibility)
- Monitors for continuity and coordination of care between practitioners and between medical and behavioral health to avoid miscommunications that lead to poor outcomes
- Analysis and actions on complaint and satisfaction data related to clinical safety
- Mechanisms for pharmaceutical oversight that safeguard member safety
- Written policies and procedures that identify specific areas of risk for fraud and abuse
- The designation of a Chief Compliance Officer and a Compliance Committee to ensure the optimum functioning of Meridian operations for the detection and elimination of fraud, waste, and abuse
- Comprehensive and ongoing fraud, waste, and abuse education and training programs to all Meridian employees, members, and providers
- The development, implementation, review, and evaluation of internal and external audits and other proactive risk management tools intended to monitor compliance and assist in the identification of problem areas

Provider Critical Incident Reporting

Meridian requires participating program providers to report all Critical Incidents that occur in a home and community-based long-term services and supports delivery setting, including assisted living facilities, community-based residential alternatives, adult day care centers, other HCBS provider sites, and a member's home (if the incident is related to the provision of HCBS). Providers will be provided with Critical Incident education materials and will have access to additional information via Meridian's website. Providers must participate in trainings offered by Meridian to ensure accurate and timely reporting of all Critical Incidents.

Critical Incidents include but are not limited to:

- Unexpected death of a member
- Any abuse, such as physical, sexual, mental, or emotional
- Theft or financial exploitation of a member
- Severe injury sustained by a member
- Medication error involving a member
- Abuse and neglect and/or suspected abuse and neglect of a member
- Suicide ideation/suicide attempt

Providers must contact Meridian's Quality Improvement department with a verbal report of the incident within 24 hours. The verbal report, at a minimum, must include member name, date of birth, date and time of incident, a brief description of the incident, member's current condition, and actions taken to mitigate risk to the member.

A written Critical Incident report must be submitted to Meridian via phone to 866-606-3700 or secure email at criticalincidents@ilmeridian.com no later than 48 hours following the discovery of the incident. Providers must cooperate fully in the investigation of reported critical incidents, including submitting all requested documentation. If the incident involves an employee or HCBS provider, the provider must also submit a written report of the incident including actions taken within 20 calendar days of the incident. To protect the safety of the member, actions that can be taken immediately include but are not limited to the following:

- Providers must contact 911 if the incident can cause immediate/severe harm to the member
- Remove worker from the member's case (if incident includes allegation of improper behavior by that worker)
- Remove accused worker from servicing all Meridian program members until the investigation is complete (may take up to 30 calendar days)
- Order immediate drug screen or appropriate testing if allegation includes theft of drugs or use of substances including alcohol while on the job
- Interview involved employee(s) as soon as possible following the incident. Have the employee(s) submit a written account of events. Fax these written accounts to Meridian along with documentation to support completion of pre-employment screenings including background checks, drug screening, and a statement that the employee did not begin to perform services for Meridian program members until all required pre-employment screenings were completed and verified. Fax numbers can be obtained by calling Meridian

Based upon the severity of the incident, any identified trend, or failure on the part of the provider to cooperate with any part of the investigation, the provider may be required to submit a written plan of correction to address and correct any problem or deficiency surrounding the Critical Incident. Required forms can be found on the Meridian website at ilmeridian.com.

When a provider has reasonable cause to believe that an individual known to them in their professional or official capacity may be abused, neglected, or exploited, the provider must also report the incident to the appropriate State agency. The following phone numbers should be used to report suspicion of abuse, neglect, or exploitation.

Illinois Reporting Table

Illinois Department of Children & Family Services Website:
https://www.illinois.gov/dcfs/safekids/reporting/Pages/index.aspx

If there is immediate risk of serious injury or death, call the local dispatch office.

Providers and Meridian staff must notify the Department of Healthcare and Family Services (HFS) immediately if there is a member death related to alleged abuse, neglect, or exploitation or any type of incident

If Meridian or provider perceives an immediate threat to the member's life or safety, contact 911.

Incident Involves	Contact	Time Frame	Special Instructions
Children (under 18)	State Central Register 800-25-ABUSE (800-252-2873)	*Immediately*	For any incident involving the abuse, neglect, or exploitation of a child, the CANTS 5 form (https://www.illinois.gov/dcfs/aboutus/notices/Documents/cants5.pdf) needs to be completed and sent to the external agency immediately
All adults **(including those with disabilities)**, ages 18-59, living in an **institutional setting** • Cases of suicidal ideation for members with developmental disabilities (DD) or mental health concerns residing in an institutional setting	Illinois Department of Human Services Office of the Inspector General Hotline 800-447-8477 (Voice and TTY)	*Immediately*	
Adults with disabilities, ages 18-59, living in a **community setting** • Older adults (60 years of age and older) regardless of residence	Adult Protective Services Hotline 866-800-1409 800-206-1327	*Immediately*	
All adults, ages 18-59, living in a **community setting**	Local Police Department	*Immediately*	
Nursing facility resident	Department of Public Health's Registry Hotline* 800-252-4343	*Immediately*	
Supportive living facility resident	Department of Healthcare and Family Services' SLF Complaint Hotline 800-226-0768	*Immediately*	

*The hotline also investigates allegations of actual or potential harm to patients, patient's rights, infection control, and medication errors. Complaints submitted are limited to hospitals, nursing homes, home health agencies, hospices, end-stage renal dialysis units, ambulatory surgical treatment centers, rural health clinics, critical access hospitals, clinical laboratories (CLIA), outpatient physical therapy, portable X-ray services, community mental health centers, accredited mental health centers (only Medicare Certified), comprehensive outpatient rehabilitation facilities, free-standing emergency centers, alternative healthcare delivery, and health maintenance organizations (HMOs).

Section 8: Provider Functions and Responsibilities

Provider Roles and Responsibilities

This section describes the expectations for contracted PCPs, specialists, hospitals, and ancillary providers. Meridian providers are responsible for knowing and complying with all Meridian network policies and procedures. Implementation of Meridian policies will facilitate the plan's periodic reporting of data to HFS and CMS, the state, and the federal agencies.

CMS requires providers to provide care to members in a culturally competent manner, being sensitive to language, culture, and reading comprehension capabilities. Meridian offers interpreter services to any member speaking a non-English language. There is no charge for members to access this service. To take advantage of this free translation service, simply call Member and Provider Services and ask for an interpreter.

Meridian encourages providers to freely communicate with patients regarding treatment regimens, including medication treatment options, regardless of benefit coverage limitations.

Provider/Staff Education and Training

In order to accommodate the needs of diverse populations, it is important for providers and their staff to annually participate in ongoing training and education efforts that encompass a range of activities from self-study education materials to interactive group learning sessions. The Meridian Provider Relations department supports these efforts by collaborating with providers and their staff to offer up-to-date training resources and programs. Training topics available includes, but is not limited to:

- Provider Orientation
- HIPAA Privacy and Security
- Fraud, Waste, and Abuse
- Recipient Rights and Reporting Abuse and Neglect and Critical Incidents
- Person-centered planning
- Cultural Competency
- Americans with Disabilities Act (ADA)
- Independent living and recovery
- Wellness principles
- Delivering services to LTSS and HCBS populations
- Self-determination
- Disability literacy training
- Care Coordination
- Interdisciplinary care team (ICT) training, including:
  - Roles and responsibilities of the ICT
  - Communication between providers and the ICT
  - Care plan development
  - Consumer direction
  - Any Health Information Technology necessary to support care coordination

Annual Mandatory training modules are available online by vising Meridian's website at ilmeridian.com. In addition, the Provider Relations department also holds monthly provider and staff training webinars. If you would like to request a training session or participate in one of Meridian's scheduled sessions, please call your Provider Relations Representative or the Member and Provider Services departmente at 866-606-3700 or via email to ProviderHelp.IL@ilmeridian.com.

Primary Care Providers/Patient-Centered Medical Homes

Meridian utilizes a PCP Patient Centered Medical Home system. In this system, the PCP is responsible for the comprehensive management of each member's healthcare. This may include, but is not be limited to, ensuring that all medically necessary care is made available and delivered to facilitate continuity of member healthcare and to promote and deliver the highest quality healthcare per Meridian standards.

Meridian providers are responsible for knowing and complying with all Meridian network policies and procedures. Implementation of Meridian policies will facilitate the plan's periodic reporting of data to HFS, the state, and the federal agencies.

Each Meridian member is required to choose a PCP responsible for coordinating all aspects of their healthcare. PCPs are to be available to see patients at least 24 hours per week at each practice site for solo practices and 32 hours per week for group practices.

Except for required direct access benefits or self-referral services, all covered health services are either delivered or coordinated by the PCP.

Identification of Medical Homes

The Vice President of Network Development, in collaboration with Network Development team, identifies and contracts with PCP offices that serve as Medical Homes, which may include but are not limited to:

- Federally Qualified Health Centers (FQHCs)
- Rural Health and Encounter Rate Clinics (RHCs, ERCs)
- Community Mental Health Centers (CMHCs)
- PCP-centered medical groups
- Private PCP offices
- Nurse Practitioner-led clinics

Medical Homes must provide high-quality, evidence-based primary care services; acute illness care; behavioral healthcare (as appropriate); chronic health condition management; and referrals for specialty care and Long Term Services and Supports (LTSS). Medical Homes shall provide all PCP services and be supported by Integrated Care Teams and Health Information Technology (HIT).

Assessment and Support of Medical Homes

A. Assessment

Meridian provides Medical Homes with a self-assessment tool to identify readiness of the provider group to become PCMH certified or to assess advancement to the next level of PCMH certification. The tool allows Medical Homes the ability to self-assess their organizational capacity; chronic health condition management approaches; coordination and continuity of care processes; community outreach knowledge and connections; data management; and quality improvement/change. The tool will be reviewed by Quality Improvement to ensure validity and thoroughness of supporting documentation.

B. Support

- Meridian will support Medical Homes in their efforts to actively engage with patients in need of care management by including providers in Interdisciplinary Care Teams, which function to coordinate member care across the full spectrum of available services and manage transitions between levels of care. Meridian will embed Care Coordinators (as appropriate) onsite at FQHCs, CMHCs, and high-volume providers to support the integration of behavioral and physical healthcare, if providers request this service
- Meridian's Provider Relations department, in collaboration with the Quality Initiative department, will educate Medical Homes on methods to improve care capacity and capabilities to provide wellness programs, preventive care, management of chronic health conditions and coordination, and continuity of care through orientation, office visits, the Provider Manual, provider newsletters, provider mailings, fax blasts, and website updates
- Meridian will provide general guidance or access to resources to practice utilization as part of the Medical Home's transformation and improvement efforts
- HIT – Medical Homes will be supported by HIT, including but not limited to, electronic transfer of data and the Meridian Provider Portal
    - Medical Homes will meet federal requirements for meaningful use and agree to share quality and other clinical data
    - Medical Homes will have access to electronic medical record data collection to support quality improvement
    - Medical Homes will have access to Meridian's Provider Portal, which allows for electronic features, including but not limited to:
        - Verification of eligibility
        - Authorizations
        - Claims status and submission/correction
        - Member information and reports
        - Enrollment lists
        - HEDIS® bonus information
        - HEDIS® self-reporting
        - Requests for HEDIS® postcards

<u>Specialty Care Providers</u>

Meridian recognizes that the specialty physician is a valuable team member in delivering care to Meridian members. Some of the key specialty physician roles and responsibilities include:

- Rendering services requested by the PCP
- Communicating with the PCP regarding findings in writing

- Confirming member eligibility and benefit level before rendering services
- Providing a consultation report to the PCP within 60 days of the consult
- Providing the lab or radiology provider with:
    - The PCP and/or corporate prior-authorization number
    - The member's ID number

Hospital Providers

Meridian recognizes that the hospital is a valuable team member in delivering care to Meridian members. Some essential hospital responsibilities include:

- Coordination of discharge planning with Meridian staff
- Coordination of mental health/substance abuse care with the appropriate state agency or provider
- Obtaining the required prior authorization before rendering services
- Communication of all pertinent patient information to Meridian and the PCP
- Communication of all hospital admissions to the Meridian Utilization Management staff within one business day of admission
- Issuing all appropriate service denial letters to identified members

Ancillary Providers

Meridian recognizes that the ancillary provider is another valuable team member in delivering care to Meridian members. Some critical ancillary provider responsibilities include:

- Confirming member eligibility and benefit level before rendering services
- Being aware of any limitations, exceptions, and/or benefit extensions applicable to Meridian members
- Obtaining the required prior authorization before rendering services
- Communication of all pertinent patient information to Meridian and the PCP

Medicaid-Specific Roles and Responsibilities

Providers wishing to participate with Meridian must be enrolled with the Illinois Medical Assistance Program (MAP). If you are already enrolled with MAP, simply contact the Network Development department at 866-606-3700 or send an email to ILCONTRACTING@CENTENE.COM to obtain a contract for participation and enrollment criteria. Interested providers can also visit ilmeridian.com to obtain detailed instructions on how to enroll in the MAP, access links to the appropriate paperwork, and get directions on where to send the completed forms.

Providers who have not submitted a claim to the State for reimbursement within 18 months may be at risk for inactivation of their Medicaid ID number. The provider must then call the Provider Participation Unit (PPU) at 217-782-0538 or write to the following location to verify their address:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
P.O. Box 19114
Springfield, IL, 62794-9114

Should too much time elapse before contacting the PPU, the provider could become inactive with MAP. If this happens, the provider would have to re-enroll with MAP before seeing a Meridian member. For additional information or questions regarding MAP participation, providers may visit www.il.gov\hfs.

All providers meeting the above affiliation requirements may submit for participation into the Meridian provider network. Meridian will not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment; nor will Meridian discriminate against any provider acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

Member Access and Availability Guidelines

Through their Meridian Participating Provider Agreement, Meridian providers have 24 hour a day, seven day a week responsibility and accountability to their Meridian members/patients. Providers will abide by state standards for timely access to care and services, taking into account the urgency of the need for service.

Guidelines:

1. Providers must be available to address member/patient medical needs on a 24-hour a day, seven-day a week basis. The provider may delegate this responsibility to another Meridian physician or provider on a contractual basis for after-hours, holiday, and vacation coverage

2. If the provider site utilizes a different contact phone number for an on-call or after-hours service, the provider site must provide Meridian with the coverage information and the contact phone or beeper number. Please notify the Meridian Provider Services department with any changes in provider medical care coverage

3. Providers may employ other licensed physicians who meet the credentialing requirements of Meridian for patient coverage as required and necessary. It is the responsibility of the provider to notify Meridian each time a new physician is added to a provider's practice to assure that all physician providers are credentialed to Meridian standards. Providers may employ licensed/certified Physician Assistants (PAs) or Registered Nurse Practitioners (RNPs) to assist in the care and management of their patient practice. If PAs or RNPs are utilized, the provider or the designated and credentialed physician must be readily available for consultation via telephone or beeper within a 15-minute call back time. They must also be able to reach the site where the PA or RNP is within 30 minutes

4. Non-professional healthcare staff shall perform their functions under the direction of the licensed provider, credentialed physician, or other appropriate healthcare professionals such as a licensed PA or an RNP

REMINDER: Failure to provide 24-hour medical coverage and/or make the appropriate arrangements for member/patient medical coverage constitutes a breach of the Meridian Participating Provider Agreement, placing the provider at risk of due consequences.

Encounter Reporting Requirements

Practices will be monitored for accurate and complete encounter reporting. The data that Meridian submits to the State of Illinois requires the provider's compliance with this requirement.

Other reporting requirements or data collection may be added, as data collection requirements are dynamic. PCP offices will be notified in writing of any additional reporting requirements.

In order to assess the quality of care, determine utilization patterns, and access to care for various healthcare services, qualified health plans are required to submit encounter data containing detail for each patient encounter reflecting all services provided by the providers of the health plan. The state will determine the minimum data elements of the encounter reporting. A format consistent with the formats and coding conventions of the CMS 1500 and UB-04 will be used initially. PCPs will submit their encounter data monthly to Meridian, who must then submit it to HFS. Both Meridian and provider agree that all information related to payment, treatment or operations will be shared between both parties and all medical information relating to individual members will be held confidential.

As part of Meridian's contract with providers, it is required that Provider Preventable Conditions (PPCs) associated with claims be reported to Meridian. PPCs address both hospital and non-hospital conditions identified by the state for non-payment. PPCs are broken into two distinct categories: Healthcare-Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). HCACs are conditions/secondary diagnosis codes identified when not present on an inpatient admission. OPPCs are conditions occurring in any healthcare setting that could have reasonably been prevented through the application of evidence-based guidelines.

Member Access and Availability Guidelines

Meridian recognizes that providing medical care is not always a predictable experience. Emergencies and episodic increases in the demand for services will challenge the ability of an office to meet the expectations for medical care access. However, in the normal course of providing medical care, provider offices should regularly meet these expectations. Office hours offered to Meridian members must be the same hours made available to other insurance types, such as commercial products. In addition, the following requirements must also be met.

Office Visit Appointments

PCP Appointment Availability Standards (Excludes OB/GYNs)

Appointment Type	Population	Standard
Preventive/Routine Care	Child < 6 Months	2 Weeks
Preventive/Routine Care	Child > 6 Months	5 Weeks
Preventive/Routine Care	Adult	5 Weeks
Urgent/Non-Emergent	Adult or Child	24 Hours
Routine/Symptomatic	Adult or Child	48-72 Hours
Non-Urgent/Non-Emergent Conditions	Adult or Child	3 Weeks
Initial Prenatal w/o problems (1st Trimester)	Female Members	2 Weeks
Prenatal (2nd Trimester)	Female Members	1 Week
Prenatal (3rd Trimester)	Female Members	3 Calendar Days
Office Wait Time	All	< 30 Minutes
Patients/Hour	All	≤ 6 per Hour
Different Hours for Medicaid	All	No; Must be the Same

Behavioral Health Appointment Availability Standards

Appointment Type	Standard
Life Threatening Emergency	Immediately or referred to the Emergency Department
Non-Life Threatening Emergency	Within 6 Hours
Urgent Visit	Within 48 Hours
Routine Office Visit	Within 10 Business Days
Follow-up Routine Care	Within 14 Business Days
Office Wait Time	< 30 Minutes
Patients/Hour	≤ 6 per hour
Different Hours for Medicaid	No; Must be the Same

Specialty Care Providers Appointment Availability Standards

Appointment Types	Population	Standard
Routine Office Visit	Adult	Within 30-45 Calendar Days
Routine Office Visit	Child	Within 21 Calendar Days
Urgent Visit	All	With 48-72 Hours
Office Wait Time	All	< 30 Minutes
Patients/Hour	All	≤ 6 per Hour
Different Hours for Medicaid	All	No; Must be the Same

After Hours Access Standards

Meridian has established acceptable mechanisms for use by PCPs, specialists, and behavioral health providers to ensure telephone access and service for members 24 hours a day.

All PCPs, specialists, and behavioral health provider contracts require physicians to provide members with access to care 24 hours a day, seven days a week. Acceptable after-hours access mechanisms include:

- Answering service
- On–call beeper
- Call forwarded to physician's home or other location
- Recorded telephone message with instructions for urgent or non-life threatening conditions must direct members to a practitioner

There must be a method to talk to a physician 24/7 regarding after-hours care for urgent or non-life threatening conditions, as well as instructions to call 911 or to the Emergency Department in the event of a life-threatening condition or serious trauma. This message should not instruct members to obtain treatment at the Emergency Department for nonlife threatening emergencies.

Physician Intent to Discharge Member from Care

PCPs must give reasonable notice to a member of his/her intent to discharge the member from his/her care. Meridian considers reasonable notice to be at least a 30-day prior written notice. This notice must be given by certified mail. Meridian must also be notified of this process concurrently in writing. Failure to give reasonable notice may result in allegations of patient abandonment against the treating physician. PCP must provide 30 days of emergent care and referrals.

Site Visits

Meridian may conduct provider site visits for any of the following reasons:

- When a member complaint/grievance is received about the quality of a practitioner's office (physical accessibility, physical appearance, or the adequacy of waiting or examining room) within six months
- Member satisfaction results indicate an office site may not meet Meridian standards
- Other data is required for quality improvement purposes and cannot be reasonably collected using other methods
- Other circumstances as deemed necessary

A Meridian staff member or designated representative with the appropriate training will perform the site visit once the determination is made that a site visit is warranted.

Confidentiality and Accuracy of Member Records

All medical records requested by Meridian are to be provided at no cost from the provider. This includes administrative fees, copying fees, paper fees, and fees delegated from a third party vendor.

A member's medical record and other health and enrollment information must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular member
- Maintain such records and information in a manner that is accurate and timely
- Identify when and to whom member information may be disclosed

In addition to the obligation to safeguard the privacy of any information that identifies a particular member, the health plan, including its participating providers, is obligated to abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and member information. First tier and downstream providers must comply with Medicare laws, regulations, and CMS instructions CFR (422.504(i)(4)(v)) and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested and maintain records for a minimum of 10 years.

Obligations of Recipients of Federal Funds

Providers participating in federal programs as Medicare or Medicaid are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including:

- Title VI of the Civil Rights Act of 1964
- Rehabilitation Act of 1973
- Age Discrimination Act of 1975
- Americans with Disabilities Act of 1990

Meridian is prohibited from issuing payment to a provider or entity that appears on the "List of Excluded Individuals/Entities" as published by the Department of Health and Human Services Office of the Inspector General or on the "List of Debarred Contractors" as published by the General Services Administration (with the possible exception of payment for emergency services under certain circumstances where permitted by federal law).

The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at https://exclusions.oig.hhs.gov.

The System for Award Management's list of Excluded Individuals/Entities can be found at https://www.sam.gov

Fraud, Waste, and Abuse

Healthcare fraud, waste, and abuse affects each and every one of us. It is estimated to account for between three and 10 percent of the annual expenditures for healthcare in the U.S. Healthcare fraud is both a state and federal offense. As stated in the HIPAA Act of 1996: (18USC, Ch. 63, Sec. 1347), a dishonest provider or member is subject to fines or imprisonment of not more than 10 years or both.

Meridian requires that our participating providers and members, as our partners, immediately report all cases of fraud, waste, and abuse. Failure to do so may result in sanctions, ranging from education and corrective action to termination of your participation in the network. To help you identify fraud, waste, and abuse, the following is a list of definitions and examples from 42 CFR § 455.2:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by players with control over or access to government resources (e.g., executive, judicial, or legislative branch employees, grantees, or other recipients). Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions, and inadequate oversight.

Examples of Fraud, Waste, and Abuse:

- Billing more than once for the same service (double billing)
- Billing for services never performed or medical equipment/supplies never ordered/delivered Performing inappropriate or unnecessary services
- Providing lower cost or used equipment while billing for higher cost or new equipment
- A specialty or ancillary provider completing an authorization log form or a PCP authorization for a PCP
- Using someone else's identity
- An altered or false pharmacy prescription

To report possible fraud, waste, or abuse cases, please contact the Fraud, Waste & Abuse Hotline at: **866-685-8664** or email: Special_Investigations_Unit@CENTENE.COM.

Non-Discrimination

Providers shall not unlawfully discriminate in the acceptance or treatment of a member because of the member's religion, race, color, national origin, age, sex, income level, health status, marital status, disability, or such other categories of unlawful discrimination as are or may be defined by federal or state law.

Provider Enrollment, Credentialing, and Re-Credentialing

Providers applying for participation with Meridian (Medicaid) must be credentialed and recredentialed with Illinois Medicaid through the IMPACT system as directed by HFS.

Providers will also be required to be re-credentialed with Illinois Medicaid through and in accordance with the IMPACT system every three years. Additionally, the provider re-credentialing process includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data, and member transfer rates.

In addition to providers being credentialed through the IMPACT system, Meridian shall require other enrollment information in order to enroll providers into Meridian Medicaid. Enrollment data shall be submitted to Meridian by the provider via Provider Enrollment Forms and/or the Provider Enrollment templates available online at ilmeridian.com.

Additional Meridian Products (MeridianComplete) – Providers applying for participation with Meridian for any other additional products (other than Medicaid) will be required to be credentialed and re-credentialed with Meridian. Additionally, the provider recredentialing process includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data, and member transfer rates.

Meridian shall require additional enrollment information in order to enroll providers into other Meridian products. Enrollment data shall be submitted to Meridian by the provider via Provider Enrollment Forms and/or the Provider Enrollment templates available online at ilmeridian.com.

The provider credentialing and re-credentialing processes require that all providers keep the Meridian Credentialing Coordinator updated with changes in credentials. In conjunction with this, providers should respond promptly to any requests to update information so that all credentialing files can be maintained appropriately.

For physician group practices (PHOs, IPAs, etc.), CMS requires copies of the arrangements/contracts between the contracting entity and the providers covered under the agreement with Meridian. CMS requires copies of downstream contract as part of the process to apply for a Medicare Advantage contract with CMS.

All providers shall be notified within 30 days of any substantial discrepancies between credentialing verification information obtained by Meridian and information submitted by the provider. The applicant shall have 30 days to respond in writing to the Credentialing Coordinator regarding discrepancies.

All providers will be given 30 days to correct any erroneous information obtained by Meridian during the credentialing verification process. The provider must inform Meridian in writing of their intent to correct any erroneous information.

The initial credentialing process includes verification of credentials by Meridian Credentialing staff. Recredentialing occurs every three years for contracted providers. Additionally, the provider recredentialing process includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data, and member transfer rates.

Provider Credentialing Rights and Responsibilities

Providers have the following rights during the credentialing process:

- All information received during the credentialing process that is not peer protected can be forwarded to the applicant upon written request to the Credentialing department
- If there are any substantial discrepancies noted during the credentialing process, the applicant is notified in writing or verbally by the Credentialing department within 30 calendar days. The applicant then has 30 calendar days to respond in writing regarding the discrepancies and correct any erroneous information. Meridian is not required to reveal the source of the information if the information is not obtained to meet the credentialing verification requirements or if disclosure is prohibited by law
- Upon written request to the Credentialing department, the provider has the right to be informed in writing or verbally of their credentialing status. When a practitioner contacts the Credentialing department, a Credentialing Specialist or Manager will either speak with the practitioner directly or send a Missing Information Letter with the purposes of informing the practitioner of the credentialing criteria that has been met or what information is still needed in order to continue the credentialing process
- Upon written request to the Credentialing department, an applicant may obtain all Meridian policies and procedures related to the credentialing process

Providers are notified of these rights in writing as part of the credentialing application packet.

Credentialing Criteria

The following table outlines Meridian's credentialing and re-credentialing criteria for providers. The ability of a provider to meet credentialing criteria does not guarantee acceptance as a Meridian participating provider. Meridian reserves the right to accept or deny any provider application, with or without cause.

Criteria	Means of Validation	Frequency of Validation
Current State License to Practice and Controlled Substance License (if applicable)	Verification with State Licensing Boards	Initial credentialing and every three years at re-credentialing
Current Federal Drug Enforcement Agency (DEA) License (if applicable)	Visual inspection of license and/or verification with DEA (NTIS) registration file	Initial credentialing and every three years at re-credentialing
Completion of Appropriate Medical Education and Post-Graduation Training (internship and/or residency program)	Primary source verification with certifying entity AMA/AOA, ECFMG for all foreign graduates, or verification from professional school and hospital	Initial credentialing

Board Certification (if applicable)	Primary source verification with certifying entity ABMS, AMA/AOA	Initial credentialing, every three years at re-credentialing, and on an ongoing basis
Current Malpractice Coverage as Required by Meridian with Minimum Coverage of $100,000/$300,000	Visual inspection of the malpractice image factsheet	Initial credentialing and every three years at re-credentialing
Acceptable Malpractice Claims History	NPDB/HIPDB and information from malpractice carrier, application information	Initial credentialing and every three years at re-credentialing
Privileges at Hospital(s) (if applicable)	Application information unless there are reports from NPDB/HIPDB reports then Primary Source Verification is required	Initial credentialing and every three years at re-credentialing
Appropriate Work History of Professional Activity	Information submitted on credentialing application and/or Curriculum Vitae	Initial credentialing
Free of Any Sanctions and/or Restrictions Through State, Federal, and Local Authorities	Disclosure information on credentialing application, NPDB/HIPDB information; verification with State Licensing Board, OIG, SAM	Initial credentialing, every three years at re-credentialing, and on an ongoing basis
System for Award Management (SAM)	Primary source verification via SAM website	Initial credentialing, every three years at re-credentialing, and on an ongoing basis
Office of Inspector General (OIG)	Primary source verification via OIG website	Initial credentialing, every three years at re-credentialing, and on an ongoing basis
Medicare Opt Out	Primary source verification via appropriate state website	Initial credentialing and every three years at re-credentialing

Corporate Credentialing Committee

The Meridian Corporate Credentialing Committee meets monthly and is chaired by the Meridian Medical Director. The responsibilities of the committee include:

- Reviewing and approving the Meridian credentialing plan
- Reviewing completed and verified files, done by the Medical Director. Applicant files that meet established Meridian criteria for “clean files” may be reviewed and signed by a Medical Director or Associate Medical Director. The signature date becomes the committee decision date. All other applicant files are reviewed by the Medical Director and brought forward to the Corporate Credentialing Committee for review and recommendation
- The Medical Director submits the applicant’s verified file for individual review at the next scheduled meeting to the Corporate Credentialing Committee if there are any malpractice claims within 10

years, adverse actions, State license or DEA actions, exclusion or debarment actions, government administrative actions, clinical, judgments, convictions, health plan or professional society actions for final acceptance or denial of practitioner participation. The Corporate Credentialing Committee has the right to pend any request for participation while it obtains additional information or verification it deems necessary based on the information within the applicant's file. If the Corporate Credentialing Committee decides to accept the provider into the Meridian network, the Medical Director or the Associate Medical Director will sign off on the file. The signature date becomes the committee decision date

- Reviewing provider performance data and individual instances of quality of care and recommending corrective action as necessary
- Making recommendations for acceptance or denial (Meridian reserves the right to accept, reject, or sanction providers at its sole discretion)

Credentialing Committee members include:

- Meridian Chief Medical Officer
- Meridian Medical Directors
- Meridian participating providers with a wide range of specialties
- Quality Improvement representatives

Peer Review

Peer review is a supportive process designed to improve the quality of care Meridian's members receive from our provider network. The process is governed by applicable State and federal laws and is protected by the immunity and confidentiality provisions of those laws. Peer reviews examine the medical necessity and quality of healthcare services and outcomes. The evaluations are conducted by Meridian's Corporate Credentialing Committee. A provider who is dissatisfied with the peer review findings may appeal a peer review recommendation. A provider may submit a written request to the Credentialing Committee stating the reason(s) for the appeal and may ask to present at the Corporate Credentialing Committee.

Appeals Process

The formal method of appeal for a provider/applicant who is denied participation within the Meridian Network is as follows:

When an Initial Applicant receives a non-approval notice, the affected provider has 30 calendar days from receipt of the notice to file a written request for a hearing. The request must be in writing and delivered in person or by Special Notice to the Meridian Medical Director at:

Meridian
ATTN: Appeals Department
PO Box 4020
Farmington, MO 63640-4402

Failure to deliver the request within 30 calendar days constitutes a waiver of hearing rights by the affected practitioner.

1. Level One Hearing:

- Level One Hearings are conducted at the Meridian corporate headquarters
- The Meridian Credentialing department or designee will notify the affected applicant of the date, time, and place of the hearing by Special Notice at least seven calendar days before the hearing date
- The hearing date will not be more than 45 calendar days from receipt of request for the hearing
- The Hearing Committee shall consist of at least two physician members of the Credentialing Committee who are not in direct economic competition with the provider applicant and one additional member appointed by the Medical Director. This member will be one of the following:
    - Meridian Medical Director
    - Meridian Associate Medical Director
    - Meridian Director of Utilization Management
    - Meridian Director of Quality Improvement
    - A Meridian participating provider who is not in direct economic competition with the provider applicant and of similar scope of practice
    - A member of the Meridian Board of Directors
- If the provider applicant scope of practice is not within the two appointed practitioner members' scope of practice, it is required to include a Meridian participating providers with a similar scope of practice
- Previous participation in the credentialing decision does not disqualify a practitioner from serving on the Hearing Committee
- All members of the Hearing Committee are required to consider and decide the case with good faith objectivity
- The Affected Practitioner represents him/herself at the Hearing Committee
- The presiding officer for the hearing is appointed by the Meridian Medical Director and determines the order of proceedings
- During the hearing, both the Affected Practitioner and the person appointed to represent the Meridian position have an opportunity to have their positions fairly heard and considered
- Both Meridian and the Affected Practitioner may submit to the hearing for consideration:
    - Written statements, letters, and documents relevant to the subject matter of the hearing, including relevant portions of the credentialing file
    - Oral statements
- Only the presiding officer may, at his/her discretion, authorize the appearance of witnesses
- The Affected Practitioner has the burden of proof and must demonstrate that the non-approval is:
    - Inconsistent with Meridian policies and procedures
    - Based on inaccurate or insufficient information through no fault of the affected practitioner

    - Not in the best interests of Meridian and/or its members
- A recording secretary selected by Meridian takes minutes of the hearing. The Affected Practitioner may request a copy of the minutes at his/her own cost
- The decision of the Hearing Committee will be issued within 30 calendar days of completion of the hearing and the Affected Practitioner will be notified by Special Notice
- The notice to the Affected Practitioner informs him/her of the right to appeal a non-approval decision to the Meridian Medical Director
- The Affected Practitioner may request a Level Two appeal within 30 calendar days of receipt of the notification
- Failure to request a Level Two appeal within 30 calendar days constitutes waiver of final appeal rights

2. Level Two:

- Upon receipt of a written request from the Affected Practitioner, the Medical Director determines if the hearing was conducted fairly and if the record reasonably supported the final recommendation. The Medical Director reviews the decision of the Hearing Committee, the hearing record, and any written statements or other documentation relevant to the matter

3. Final Decision:

- The decision of the Medical Director is immediately effective and final and is not subject to further hearing or review. The Affected Practitioner will be notified of the final decision by Special Notice within 30 calendar days of receipt of the request for a Level Two appeal

Denied applications are maintained in a confidential manner in a Denied Participation file and are maintained for a period of seven years from the date of denial. Denials of participation are kept confidential except where reportable by Meridian under Federal or State regulation.

Facility Criteria

Meridian contracts with and has a formal process and procedure for the initial credentialing and ongoing assessment of the following organizational providers:

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities
- Freestanding Ambulatory Surgical Centers
- Ambulatory Behavioral Health Centers

Specific criteria vary based upon the type of facility that is being reviewed. The general criteria for contracting with hospitals and ancillary sites are as follows:

- Completed application
- Acceptable accreditation, certification, or State or CMS site visit report if not accredited
- In good standing with Federal and State regulatory agencies
- Current State license, if applicable
- Appropriate insurance coverage

Delegated Credentialing

Meridian conducts pre-delegation site visits before delegating credentialing functions to another entity. On an annual basis, Meridian conducts a substantive evaluation of the delegate to assure that all Meridian requirements are continuing to be met. Meridian does not delegate oversight and monitoring of a credentialing delegate. Delegated activities may be sub-delegated to another organization with prior approval by Meridian. Any sub-delegate must adhere to the terms of the written agreement, as well as Meridian, National Committee on Quality Assurance (NCQA), and URAC standards. Meridian audits the activities of the sub-delegate through a site visit. Meridian retains the right to suspend or terminate individual practitioners, providers, and sites of care. Meridian conducts annual file audits and substantive evaluation of delegated activities against Meridian expectations, NCQA, and URAC delegated standards. Meridian also evaluates reports at least semi-annually from the delegates and identifies and follows up on any opportunities for improvement where applicable.

Delegated Credentialing Requirements

Once a provider group has been accepted as a "delegated" entity, provider information is submitted to the assigned Meridian Data Management Specialist via email. Provider information should be in the form of either a spreadsheet or profile, either of which should include ALL of the following (provider specific) and nothing not pertaining to Meridian:

1. Current credentialing dates
2. Tax ID Number (TIN) associated with group 3. General information regarding the provider:
    - Full name
    - Social Security Number (SSN)
    - NPI number
    - Gender
    - Date of birth
    - Provider type (MD, DO, etc.)
    - Provider's specialty and category (PCP, specialist, etc.)
4. School history (highest degree earned):
    - Name of school
    - Address of school
    - Degree earned
5. Office location information:
    - Name of office
    - Office address
    - Office phone and fax number
    - Accepting new members at location or not
    - Listed in Meridian's Provider Directory or not
    - Any age limitations
    - The provider's hours at specific offices
6. Licensing information:
    - Medical license
    - DEA license

- Controlled substance license (if applicable)
- Medicare ID number (if applicable)
- Medicaid ID number (if applicable)
- UPIN (if applicable)
- ECFMG number (if applicable)

7. Liability insurance:
    - Carrier name
    - Expiration date
8. Other information – if any/not required:
    - Covering colleagues
    - Foreign languages spoken by the provider
    - Current hospital affiliations
    - References
9. Copy of W-9 if pay-to address is new

Credentialing FAQs

Becoming Credentialed

Credentialing is the process by which an organization obtains and verifies specific professional and personal background data on physicians and other healthcare professionals. Meridian then determines whether that individual meets the specified criteria to serve as a contracted provider of services to Meridian members. A provider must be credentialed before becoming a part of the Meridian network and is re-credentialed every three years thereafter. Meridian's credentialing standards align with the requirements designated by the NCQA and URAC. To become credentialed with Meridian, a practitioner or healthcare provider should utilize CAQH to house all of their application information and should attest that the information is current at least once every 120 days.

Time Frame of the Credentialing Process

Once the Meridian Credentialing department has received a *complete* application, the entire credentialing process should be complete within 30 days and includes the notification to the practitioner in writing of the Credentialing Committee's decision on admittance to the provider network.

Checking the Status of a Credentialing Application

Providers can check on the status of their credentialing application by contacting the Meridian Member and Provider Services department at 866-606-3700.

CAQH

The Council for Affordable Quality Healthcare (CAQH) is a centralized online system used by Meridian, along with many other insurance companies, to gather credentialing and recredentialing data from practitioners and healthcare professionals. The use of this system streamlines the process of applying

for participation with a health plan for a practitioner and ultimately provides a more efficient credentialing process.

Providers benefit from using a centralized application system, such as CAQH, because it:

- Prevents practitioners from having to complete multiple applications for each health plan they wish to participate with
- Minimizes paper waste
- Allows providers to access their application anywhere that they have computer and internet access, providing standardization and portability
- Provides a secure location for their personal information

To set up a CAQH ID, a provider can call Meridian at 866-606-3700 and speak to a representative in the Provider Services department. This representative will gather basic information and begin the setup of your CAQH application. The CAQH ID number will be given to the provider at the end of the phone call and the provider can access their application anytime to complete it at http://www.caqh.org/accessupd.php.

If a provider already has a CAQH ID number but wishes to become a new provider in the Meridian network, please contact the Meridian Provider Services department to notify them of this and visit www.caqh.org/cred to authorize Meridian to access your data.

CAQH will send out automatic reminders to a practitioner to review and attest to the accuracy of their information online. The standard time frame for doing so is once every four months or 120 days. Meridian re-credentials practitioners every three years after initial credentialing and will notify the practitioner in writing at the start of the re-credentialing process.

To re-attest:

1. Go online to www.caqh.org at least every four months
2. Log in
3. At “Start Page,” select “Re-attest”
4. Run the audit
5. Review and update data as needed
6. Click on “Attest”

Section 9: Clinical Guidelines and Recommendations

Immunizations

The following table shows all of the required immunizations for children:

Immunization	When It is Needed	Why Children Need This Shot
Hepatitis B (Hep B)	A total of 3 shots before age 2: Birth, 1-2 months, and 6-18 months	These shots protect children from a type of hepatitis
Rotavirus (RV)	A total of 2 shots of a 2 dose vaccine: 2 months and 4 months **OR** 1 shot of the 2 dose vaccine and 2 shots of the 3 dose vaccine: 2 months, 4 months, and 6 months **OR** a total of 3 shots of a 3 dose vaccine: 2 months, 4 months, and 6 months	These shots protect children from rotavirus
Diphtheria, Tetanus, and Pertussis (DTaP)	At least 4 shots on different dates of service on or before children's 2nd birthday: 2 months, 4 months, 6 months, and 15-18 months	These shots protect children from diphtheria, tetanus, and pertussis (whooping cough)
Haemophilus Influenzae (HiB)	At least 3 shots on different dates of service on or before children's 2nd birthday: 2 months, 4 months, 6 months, and 15-18 months	These shots protect children from Haemophilus Influenzae (HiB)
Pneumococcal Conjugate	At least 4 shots with different dates of service before children's 2nd birthday: 2 months, 4 months, 6 months, and 15-18 months	These shots protect children from pneumonia
Polio (IPV)	At least 3 shots with different dates of service on or before children's 2nd birthday: 2 months, 4 months, 6-18 months, and again at age 4-6 years	These shots protect children from polio
Influenza (Flu)	A total of 2 shots before children's 2nd birthday: 6-12 months, 13-24 months, and yearly thereafter	These shots protect children from seasonal flu
Measles, Mumps, and Rubella (MMR)	At least 1 shot before children's 2nd birthday: 1215 months and again at age 4-6 years	These shots protect children from Measles, Mumps, and Rubella (German Measles)
Varicella (VZV)	At least 1 shot before children's 2nd birthday: 1215 months and again at age 4-6 years	These shots protect children from chicken pox
Hepatitis A (Hep A)	A total of 2 shots on different dates of service before children's 2nd birthday: 12-24 months	These shots protect children from a type of hepatitis
Tdap or Td	A total of 1 shot between children's 10th and 13th birthdays	This shot protects children from diphtheria, tetanus, and pertussis (whooping cough), Tdap, or tetanus (Td)
Meningococcal	A total of 1 shot between children's 11th and 13th birthdays	This shot protects children from a type of brain infection called meningitis
Combination Meningococcal and Tdap or Meningococcal and Td	A total of 1 shot between children's 10th and 13th birthdays	This shot protects children from diphtheria, tetanus, and pertussis (whooping cough), (Tdap), tetanus (Td), and a brain infection called meningitis

Providers should note that immunization guidelines are subject to change. There are several resources for up-to-date information on immunizations, including the American Academy for Pediatrics and the Centers for Disease Control. If you have any questions about immunizations, please contact the Quality Improvement department at 866-606-3700.

Well-Child Visits

According to the National Committee for Quality Assurance (NCQA) and HEDIS® specifications, infants need at least six Well-Child Visits between the ages of 0 and 15 months. Children between the ages of three and six years need one Well-Child Visit every year.

Infants Age 0-15 Months		Children Ages 2-12 Years
• 3-5 Days • 2 Weeks • 1 Month • 2 Months • 3 Months	• 4 Months • 6 Months • 9 Months • 12 Months • 15 Months	Children ages 2-12 should be seen for a well-child exam every year, not just when they are sick

Meridian wants providers to take advantage of every opportunity to provide the necessary preventive health services for our members, including Well-Child Visits, immunizations and lead testing. When a child comes to your office for an appointment and these preventive services are not performed, it results in a missed opportunity.

A Well-Child Visit includes the following five components:

1. ***Health History*** – Information collected from the patient or parent/guardian concerning the patient's physical, psychological, social, and/or sexual status. It can also include the history of present and/or previous illness, signs/symptoms, immunizations, allergies, transfusions, or hospitalizations
2. ***Physical Development History*** – How a child is developing physically by assessing the patient's current or past histories such as "patient rolls over from stomach to back," "patient is sexually active," etc.
3. ***Mental Development History*** – How a child is developing mentally, emotionally, or behaviorally by reviewing the patient's current or past mental status
4. ***Physical Exam*** – Descriptive physical exam of at least 10 parts of the patient's body for disease, diagnosis, or treatment
5. ***Health Education/Anticipatory Guidance*** – Age-appropriate counseling and education, such as encourage healthy eating, staying active, etc.

The first time you see a new patient, it is likely that you will need to perform a health and developmental history and a physical exam. Make sure you incorporate some health education and you have provided a Well-Child Visit. Just add the V20.2 diagnosis code to your claim, along with the appropriate CPT code for the new patient visit.

Adolescent Well-Care Visits

Immunizations help to protect children of all ages from diseases, but adolescents need more from a doctor than just shots. It is important to have your children who are ages 12-21 checked by a doctor every year. These checkups are called Adolescent Well-Care Visits. The chart below explains the key components of a Well-Care Visit.

Physical Exam	Immunizations	History and Counseling
• Height • Weight • Blood pressure	• **Tdap** (age 10-13) • **Meningococcal** (age 11-13) **MMR** (if second dose was missed, given at age 12) **Varicella** (if missed and no history of chickenpox, given at any age over 1 year) • **HepB** (if childhood series was missed, 3 doses as recommended) • **HPV** (3 doses, age 9-13) females only	• Nutrition • Exercise • Injury prevention – use of seatbelts and proper sporting equipment • Dental health • Tobacco, alcohol, drug use • Developmental assessment • Safe sexual practices – including abstinence and birth control methods, plus Chlamydia screening if sexually active • Sun exposure, skin lesions, use of sun block to prevent skin cancer

Young women ages 16-21 years also need a Chlamydia screening yearly if they are sexually active.

Pregnancy Care

Meridian encourages members to contact their PCP as soon as they think they might be pregnant. Early and regular check-ups will help with a good pregnancy and a healthy baby. Here is the schedule for checkups during and after the pregnancy:

Stage of Pregnancy	How Often to See the Doctor
Before 13 weeks (or as soon as you think you may be pregnant)	Schedule first prenatal visit as soon as possible
Between 13 and 28 weeks pregnant	Every 4 weeks
Between 29 and 36 weeks pregnant	Every 2 weeks
Between 37 and 40 weeks pregnant	Every week
After you have delivered your baby	Get a postpartum checkup* between 21 days and 56 days after delivery

*It is very important to have a postpartum checkup within 21-56 days after delivery.

If you have a patient who is pregnant and needs assistance, please call Meridian Member and Provider Services at 866-606-3700 as soon as possible! We can assist the member in making appointments and provide free transportation. The Women and Children's staff will be in touch with the member throughout her pregnancy.

Family Planning Services

Family planning offers counseling, supplies, and birth control. Members may also get treatment for sexually transmitted diseases (STDs). It does not include abortion services or infertility treatment. Family planning services are confidential. PCPs can refer to a family planning agency. Members may also go to any family planning agency without a referral. They will send a bill to Meridian.

Preventive Health Recommendations for Adults

This section will outline the preventive health recommendations for adults. All adults should see their PCP at least one time every year for a well checkup.

The following table shows the recommendations for men:

Men 20-39 Years Old	Men 40-59 Years Old	Men 60 Years and Older
Every 3-5 years: • Health maintenance exam • Clinical testicular exam with self-exam instructions • Cholesterol every 5 years starting at 35 years Discuss with doctor: • Prostate screening • Fecal occult blood test	Every year: • Fecal occult blood test starting at age 50 Every 3-5 years: • Health maintenance exam • Clinical testicular exam with self-exam instructions Every 5 years: • Cholesterol screening • Colon cancer screening after age 50 • Fecal occult blood test OR • Sigmoidoscopy every 5 years OR • Colonoscopy every 10 years Discuss with doctor: • Prostate screening	Every year: • Health maintenance exam • Clinical testicular exam with self-exam instructions • Prostate screening Every 5 years: • Cholesterol screening • Colon cancer screening after age 50 • Fecal occult blood test OR • Sigmoidoscopy every 5 years OR • Colonoscopy every 10 years

The following table shows the recommendations for women:

Women 20-39 Years Old	Women 40-59 Years Old	Women 60 Years and Older
Every year: • Health maintenance exam • Pelvic exam with Pap test • Chlamydia testing (ages 20-25) • Clinical breast exam with self breast exam instructions Discuss with doctor: • Baseline mammogram (ages 35-39) • Cholesterol screening	Every year: • Health maintenance exam • Pelvic exam with Pap test • Clinical breast exam with self-breast exam instructions • Mammogram Every 5 years: • Cholesterol screening • Colon cancer screening after age 50 • Fecal occult blood test OR • Sigmoidoscopy every 5 years OR • Colonoscopy every 10 years	Every year: • Health maintenance exam • Pelvic exam with Pap test • Clinical breast exam with self-breast exam instructions • Mammogram Every 5 years: • Cholesterol screening • Colon cancer screening after age 50 • Fecal occult blood test OR • Sigmoidoscopy every 5 years OR • Colonoscopy every 10 years

Adults need immunizations too. Here is a list of the shots that adults need at each age.

19-49 Years	50-64 Years	65 Years and Older
• Tetanus (Td) every 10 years (one dose of Tdap can be substituted) Pneumococcal Vaccine – Talk with your PCP • Flu every year if high risk. Talk to your doctor	• Tetanus (Td) every 10 years (one dose of Tdap can be substituted) • Pneumococcal and Flu Vaccine – Talk with your PCP	• Flu every year • Tetanus (Td) every 10 years Pneumococcal at age 65 (a booster may be needed every 5 years)

Please note that recommendations and guidelines are subject to change. Providers can contact the Quality Improvement department at 866-606-3700 with any questions.

Clinical Practice Guidelines

Meridian has adopted evidence-based Clinical Practice Guidelines from regional and national external sources. The Clinical Practice Guidelines are reviewed and approved annually, and as necessary, by Meridian's Physician Advisory Committee and Quality Improvement Committee. Clinical Practice Guidelines can be viewed on the Meridian website at ilmeridian.com under Training & Education Resources, as well as their original sources, including www.mqic.org.

Attestation of Training Completion

The undersigned Organization/Person ("Organization/Person") certifies and attests that as a first-tier entity, downstream entity or related entity (as such terms are defined by Centers for Medicare and Medicaid Services (CMS)), it has obtained and/or conducted required training for it and for all of its personnel and employees, as applicable, (including the Chief Executive, senior administrators or managers, and governing body members), as required for the provision of services under the contracts for Integrated Care Plan (ICP) and/or Medicare–Medicaid Alignment Initiative (MMAI).

Please mark the method(s) of training and education that you or your organization chose to comply with this requirement, as well as the date this training was completed:

Training Type		Date Completed	Training completed with: (Health Plan Name)
☐	Abuse, Neglect, Exploitation		
☐	Critical Incidents		
☐	Cultural Competency		
☐	Americans with Disabilities Act (ADA)		
☐	FWA		
☐	Medical Home		

In addition, the Organization/Person certifies and attests that it has required its downstream entities to certify and attest that they have obtained and conducted, as applicable, the required training for all personnel and employees, as applicable. Upon request by the State of Illinois or CMS, the Organization/Person will furnish training logs, as well as certifications or attestations it obtains from its downstream entities to validate that the required training was completed.

_____ _____
Name of Organization/Person NPI or Tax ID

_____ _____
Representative Title Name of Organization Representative

_____ _____
Signature Street Address

_____ _____
Date Signed City, State, ZIP Code

If more than one individual in your organization completed the training listed above, please complete page 2 of this form.

Attestation of Training Completion

Please list individuals in your organization that have completed the training noted on page 1 of this form:

NPI	Name – Please Print (Last, First)	Position

Please return this form to:

Fax –

Email –

Mail –