meridian

June 2023

Medicare-Medicaid Plan (MMP) Provider Manual

mmp.ILmeridian.com

Using the Medicare-Medicaid Plan (MMP) Provider Manual

Welcome to the Meridian Medicare-Medicaid Plan (MMP) 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 for Meridian MMP.

The provider manual is a dynamic tool. Minor updates and revisions will be communicated to you via provider notices and newsletters, which serve to replace the information found within this provider manual. Major revisions of the information in the provider manual will result in publication of a revised edition that will be distributed to all providers.

Please contact your local Network Provider Relations Representative or our Member and Provider Services Department at **1-866-606-3700 (TTY: 711)** with any questions or concerns.

Thank you for your participation.

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Member Services	
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Provider Services	
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Quality Improvement (QI)	
• Requests and questions about clinical practice guidelines – Find the CPGs on our website at **mmp.ILmeridian.com** located under Training and Education or through the provider portal • Requests and questions about preventive healthcare guidelines • Questions about QI initiatives • Questions about QI regulatory requirements • Questions about disease management programs	**1-855-580-1689**
Pharmacy	
• Prior authorize non-formulary medications	**1-800-867-6564**

Member Services Department

The Meridian MMP Member Services Department exists for the benefit of our members and providers, to respond to all questions about benefits, services, policies, and procedures. Full-time professional Member Services Representatives are available from 8 a.m. to 5 p.m. Alternative technologies are used outside of business hours for UM inquiries and requests.

Meridian MMP Member Services Department
Toll-Free: **1-855-580-1689 (TTY: 711)**

Membership

Member Eligibility and Enrollment

Beneficiaries who wish to enroll in Meridian MMP should reach out to their local Department of Health and Human Services office. **Meridian MMP does not actively submit enrollment or disenrollment for MMP to the state or to Centers for Medicare & Medicaid Services (CMS).** Members who wish to enroll in the Meridian MMP must meet the following criteria:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Have full Medicaid benefits
- Are ages 21 or older
- Permanently reside in the Meridian MMP service areas
- Not enrolled in hospice
- Be a U.S. citizen or lawfully present in the United States

Additionally, individuals must meet all the following criteria to be eligible to enroll:

- Enrolled in the Medicaid Aid to the Aged, Blind, and Disabled (AABD) category of assistance

The following populations will be excluded from enrollment in the demonstration:

- Individuals under the age of 21
- Individuals previously disenrolled because of Special Disenrollment from Medicaid managed care
- Individuals not living in a demonstration region
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI)
- Individuals without full Medicaid coverage (spend-downs or deductibles)
- Individuals with Medicaid who reside in a state psychiatric hospital
- Individuals with commercial HMO coverage
- Individuals with elected hospice services
- Individuals who are incarcerated
- Individuals who have presumptive eligibility
- Individuals receiving developmental disability institutional services or participate in the Home and Community Based Services (HCBS) waiver for Adults with Developmental Disabilities

- Individuals in the Illinois Medicaid Breast and Cervical Cancer program
- Individuals enrolled in partial benefit programs
- Individuals who have Comprehensive Third-Party Insurance

Meridian MMP will accept all members that meet the criteria in this section at any time without reference to race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family status. We will not limit or conditionally cover plan benefits based on any factor that is related to the member's health status. Including but not limited to medical condition, claims history, receipt of healthcare, medical history, genetic information, evidence of insurability, or disability.

Disenrollment

Meridian MMP staff may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare member to disenroll, except when the member:

- Permanently moved outside the geographic service area
- Committed fraud
- Abused their membership card
- Displayed disruptive behavior
- Lost Medicaid eligibility
- Lost Medicare Parts A or B
- Is deceased

When members permanently move out of the service area, we encourage them to notify Medicare-Medicaid, Social Security Administration, and the local Department of Health and Human Service office as soon as possible to update their address information. Members will be submitted for disenrollment once relocation outside of the service area is confirmed. If a member leaves the service area for over six consecutive months, they are involuntarily disenrolled from our plan. There are several ways that Meridian MMP staff may be informed that the member has relocated:

- Out-of-area notification will be received from CMS on the daily Transaction Reply Report (TRR)
- Other means of notification can be made through the Claims Department, if out-of-area claims are received with a residential address other than the one on file
- Provider notification to the plan
- Directly from the member or member's responsible party

Members may request disenrollment from Meridian MMP. Members should call Illinois' Client Enrollment Services to request disenrollment, or go online at **enrollhfs.illinois.gov/enroll**, but may request disenrollment directly by calling **1-877-912-8880** or by enrolling directly in a new Medicare Advantage (MA), MMP or Medicare prescription drug plan, or MLTSS plan (if eligible).

The effective date for all voluntary disenrollments is the first day of the month following the state's receipt of the disenrollment request. The state has a reconciliation process to address any retroactive enrollment changes.

Meridian MMP may not accept enrollment, disenrollment, or opt-out requests directly from members and process such requests themselves but must refer members or prospective members to call Illinois' Client Enrollment Services.

Requested Disenrollment

Meridian MMP will request disenrollment of members only as allowed by CMS regulations and state regulations. Requests will be placed to the state that a member be disenrolled under one of the following circumstances:

- The member provided fraudulent information
- The member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment

Other reasons the plan may submit a request to the state for a member's disenrollment:

- The member abuses the enrollment card by allowing others to use it to obtain fraudulent services
- The member leaves the service area and directly notifies us of the permanent change of residence
- The member has NOT informed the plan of a permanent move, but has been out of the service area for six months or more
- The member loses entitlement to Medicare Part A or Part B benefits
- The member is deceased
- Meridian MMP loses or terminates its contract with CMS. In the event of plan termination by CMS, we will send CMS-approved notices to the member and a description of alternatives for obtaining benefits. The notice will be sent in accordance with CMS regulations, prior to the termination of the plan
- Meridian MMP discontinues offering services in specific service areas where the member resides

In all circumstances, a written notice will be provided to the member or member's estate with an explanation of the reason for the disenrollment. All notices will comply with CMS rules and regulations.

Meridian MMP will not directly submit requests for enrollment or disenrollment to the State or to CMS per the three-way contract agreement. Meridian MMP can initiate requests to the State, but enrollment and disenrollment processing is handled solely by Illinois' Client Enrollment Services.

Member Rights and Responsibilities

- Members have a right to receive information about the Medicare-Medicaid managed care organization, its services, its providers, and members' rights and responsibilities
- Members have a right to privacy and to be treated with respect and dignity
- Members have a right to participate with providers in decision-making regarding their healthcare
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Members have a right to file complaints or appeals about the managed care organization (MCO) or the care provided
- Members have a right to make recommendations regarding the organization's members' rights and responsibilities policies
- Members have a right to change their Primary Care Provider (PCP) at any time. Changes that occur on or before the tenth of the month will be effective for the current month. Changes that occur after the tenth of the month will be effective on the first of the following month
- Members have a responsibility to provide, to the extent possible, information that the MCO and its providers need to care for them
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their providers, including referral and authorization rules
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- Members have the right to receive information in a way that works for them
- Meridian MMP provides member materials in alternate formats, languages other than English and provides a language line for members who speak languages other than English
- Members have the right to get timely access to covered services
- Members have the right to directly access through self-referral: screening mammography, influenza vaccine, and pneumococcal vaccine through contracted providers at no cost
- Members have the right to adequate access to plan providers, and as such Meridian MMP will maintain and monitor a network of providers including but not limited to primary care providers, specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics and other providers. Furthermore, Meridian MMP will ensure that members have access to network providers that can furnish all plan benefits, including supplemental benefits. If a network provider cannot perform a medically necessary service for a member, then Meridian MMP will arrange for an out-of-network provider to furnish the service

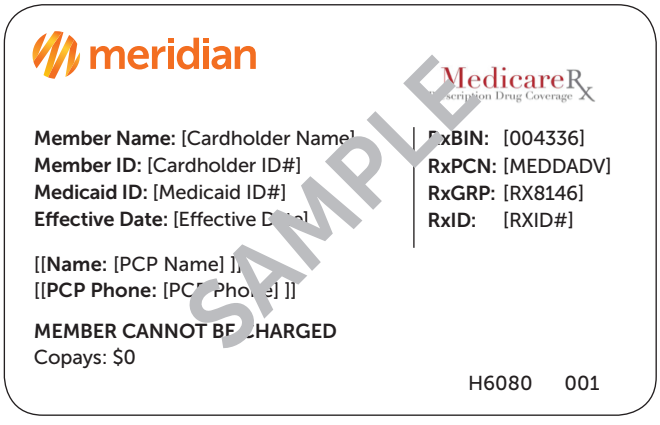
- Members have the right to direct access to an in-network women's health specialist without having to obtain a referral from their PCP or plan authorization
- Members have the right to out-of-network specialty care if network providers are unavailable or inadequate to meet a member's medical needs
- Members have the right to a continuation of benefits for the contract period the plan has with CMS. Furthermore, if the member is hospitalized on the date the plan's contract ends with CMS, the plan will still be responsible for furnishing a continuation of benefits per Meridian MMP's contractual obligation with CMS
- Meridian maintains policies to protect enrollees from incurring liability (for example, as a result of organizational insolvency or other financial difficulties) for payment or fees for covered services/benefits through the member's enrollment period with the plan. Per contractual agreements, providers may not hold members liable for covered services
- Members have the right to receive upon enrollment and annually thereafter an evidence of coverage that explains all plan benefits, rights, and responsibilities of the plan and rights and responsibilities of the member, including but not limited to appeal rights, cost sharing and plan premium responsibilities and how to locate and select providers in Meridian MMP's network. Members can also call Member Services if they have questions about their rights and responsibilities, think they are being treated unfairly or want more information about the plan
- Members have the right to be notified in writing at least 30 days in advance before a provider that they are currently receiving care from is terminated. Meridian MMP will assist the member in finding a new provider prior to the termination date of their current one

Meridian MMP staff and contracted providers must comply with all requirements concerning member rights.

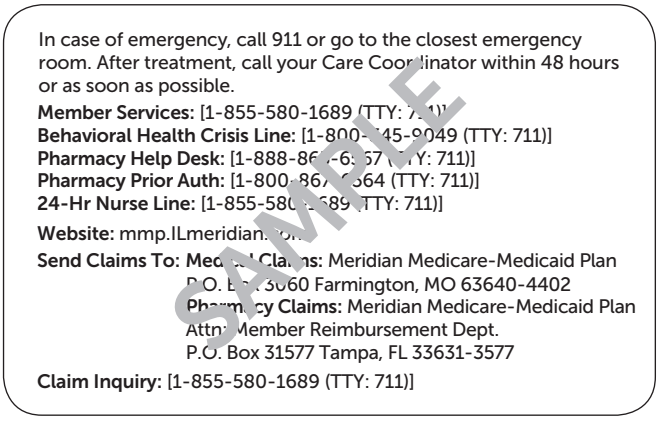
Member Identification

All members receive an ID card at the time of enrollment that has Meridian MMP's Member Services phone number and pharmacy contact information on it. Below are examples of a Meridian MMP Member ID Card.

Sample Medicaid ID Card (Front)



Sample Medicaid ID Card (Back)



Eligibility Verification

How to Identify a Member's Eligibility

Providers must verify member eligibility prior to rendering services to a member.

To verify if a member is currently eligible to receive services as a Meridian MMP member, the following steps must be followed:

1) Request that the member present his or her member ID card at each encounter
2) Review your PCP monthly eligibility report each time the member presents at your office for care or referrals
3) Call the Member Services Department at the number listed on the member's ID card for assistance with eligibility determinations
4) Utilize the Meridian Provider Portal to verify eligibility, or verify eligibility through state Medicaid enrollment systems (e.g., MEDI)

If you find any discrepancies between a member's ID card, an Eligibility Verification System, and/or your monthly eligibility report, please contact the Member Services Department for further assistance.

Eligibility changes that occur on or before the tenth of the month will be effective for the current month. Changes that occur after the tenth of the month will be effective on the first of the following month.

Notice of Privacy Practices

Meridian is regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules. In accordance with these regulations, Meridian provides a Notice of Privacy Practices on our website that describes member rights and responsibilities to safeguard protected health information.

While providers must have their own Notice of Privacy Practices per the HIPAA Privacy and Security Rules, a copy of our Privacy Practices may be accessed on our website:

Meridian MMP: **mmp.ILmeridian.com/privacy-policy.html**

You may contact Meridian's Privacy Officer with questions regarding member privacy or if you wish to file a privacy-related complaint.

Meridian MMP
Attn: Privacy Officer
1333 Burr Ridge Parkway, Suite 100
Burr Ridge, IL 60527

Email: **privacy.il@mhplan.com**
Phone: **1-855-580-1689**

Advance Directives

Meridian MMP providers are responsible for maintaining written policies and procedures regarding advance directives, educating members regarding advance directives, providing members with advance directive forms and obtaining forms from members for attachment to the member's medical record. Providers must have written information available to members explaining their rights while describing the provider's role and limitations in implementing the advance directive. All completed advance directive forms must be maintained in front of each member's health record. To learn more about advance directives in Illinois, use the Illinois Department of Public Health's website at: **dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives**.

Provider Participation

Provider Credentialing and Recredentialing

Credentialing and recredentialing requirements of 42 C.F.R. §422.504(i)(4)(iv) will be waived for providers enrolled in the state's IMPACT system.

Meridian has written policies and procedures for the selection and evaluation of providers. There is a documented process with respect to providers and suppliers who have signed contracts or participation agreements. Meridian will not prohibit a provider from informing members of the provider's affiliation or change in affiliation.

For physician group practices, PHOs, IPAs, etc., CMS requires copies of the arrangements/contracts between the contracting entity and the providers covered under the MA agreement with Meridian. CMS requires copies of each of these downstream contracts as part of the application to apply for a MA contract with CMS.

The provider credentialing and recredentialing processes require that all providers keep Meridian Credentialing Specialists 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.

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 Specialist regarding discrepancies.

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

Meridian recredentials each provider in the network at least every three years. Approximately six months prior to the provider's three-year anniversary date, the provider will be notified of the intent to recredential. All necessary forms will be sent for completion. In certain instances, a site visit will also be scheduled.

The provider recredentialing process also includes the review of QI studies, member surveys, complaints and grievances, utilization data, and member transfer rates.

Member Access and Availability Guidelines

Meridian contracted providers are responsible and accountable to Meridian members/patients 24 hours a day, seven days a week. Providers will be expected to abide by state and federal standards of timeliness of access to care and services based on the urgency of a member's needs and when medically necessary.

The following guidelines will be continuously monitored to ensure compliance with these network standards.

1) PCPs and specialists must be available to address member/patient medical needs 24 hours a day, seven days a week. The PCP may delegate this responsibility to another Meridian provider on a contractual basis for after-hours, holiday, and vacation coverage. Voicemail alone is not acceptable.
2) If the PCP or specialist site uses a different contact phone number for an on-call or after-hours service, the PCP site must provide Meridian with the coverage information and the contact phone or beeper number. Please notify the Meridian Provider Services Department of any changes in PCP medical care coverage.
3) PCPs may employ other licensed providers who meet the credentialing requirements of Meridian for patient coverage as required and necessary. It is the responsibility of the PCP to notify Meridian each time a new provider is added to a PCP's practice to ensure that all providers are credentialed to Meridian standards. PCPs may employ licensed/certified Physician's 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 PCP or the designated and credentialed provider 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 PAs or RNPs are within 30 minutes.
4) Non-professional healthcare staff shall perform their functions under the direction of the licensed PCP, credentialed provider, or other appropriate healthcare professionals such as licensed PAs or RNPs.

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 Practitioner Agreement, placing the provider at risk of due consequences.

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

1) Emergency services are available immediately
2) Urgently needed (nonemergency) services are scheduled immediately
   a. or within one business day
   b. Routine and symptomatic appointments are scheduled within 48—72 hours
3) Routine and preventive care appointments are scheduled within five weeks
4) Nonurgent and nonemergent visits are scheduled within three weeks (contract verbiage: Enrollees with problems or complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care)
5) Initial prenatal visits:
   a. Appointments for members in first trimester are available within two weeks
   b. Appointments for members in second trimester are available within one week
   c. Appointments for members in third trimester are available within three days

Behavioral Health (BH) Office Visit Appointments

1) Life-threatening emergency appointments are scheduled immediately
2) Non-life-threatening emergency/urgent visits are scheduled within six hours
3) Urgent visits are scheduled within 48 hours
4) Initial routine office visits are scheduled within 10 business days
5) Follow-up routine visits are scheduled within 14 business days

Office Waiting Time

To ensure that members have *timely access to patient care and services*, Meridian providers are expected to monitor waiting room times on a continual basis. PCP offices will be surveyed periodically regarding this process. **Member waiting room times should be less than 30 minutes to be seen by a provider with no more than six scheduled appointments made for a provider per hour.** Supervising providers may routinely account for more than six visits. If a longer wait is anticipated, office staff members should explain the reason for the delay and offer to schedule the patient for another appointment.

After-Hours Access Standards

Meridian has established acceptable mechanisms for use by PCPs, specialists, and BH providers to ensure telephone access and service for members 24 hours a day. All provider agreements require providers to supply members with access to care 24 hours a day, seven days a week and have a published after-hours telephone number; voicemail alone after hours is not acceptable.

Acceptable after-hours access mechanisms include:

- Answering service
- On-call pager
- Call forwarded to provider's home or other location
- Recorded telephone message with instructions for urgent or non-life-threatening conditions and instructions to call 911 or go to the emergency room in the event of a life-threatening condition or serious trauma This message should not instruct members to obtain treatment at the emergency room for non-life-threatening emergencies.

Facility Site Reviews

As part of the Meridian MMP annual monitoring audits, a sampling of provider office facilities will be evaluated against Meridian MMP site review and medical record-keeping requirements noted below.

Access to Service
• Each PCP is available 20 hours per week. • The provider is available 24 hours a day, 7 days a week. • The provider has mechanisms in place to meet Meridian MMP after-hours access standards
Provisions for People with Disabilities
• Are there designated handicap parking spaces close to the building entrance? • Is the building entrance accessible by wheelchair, walker, etc.? • Are interior building spaces including but not limited to office hallways, doorways, bathrooms, office reception areas and exam rooms accessible to wheelchairs, walkers, etc. (all hallways should have a minimum of 42 inches clearance)? • Are doors able to be operated by people with physical limitations? • Are there accommodations for sight or hearing-impaired patients?
General Office Appearance
• Are NO SMOKING signs and Patient's Rights posted? • Is business conducted at the registration desk in a confidential manner (discussion, sign-in sheet, etc.)? • Is staff aware of the office's confidentiality policy? • Are restroom facilities available for waiting patients? • Are hours of operation posted? • Are all public and patient care areas clean, orderly, and ample enough to accommodate patients? • Is teaching literature available for the patient?

Staff Competency
• Personnel file for each employee contains a copy of his or her current licensure, if applicable, or documentation of formal training or certification. • Each personnel file contains documentation of orientation to the facility, duties of the position, office medical equipment, and procedures. • Each personnel file contains documentation of regular evaluations. • There is documentation of ongoing education for all staff (e.g., office in-services, staff meetings, conferences). • There is documentation of annual Occupational Safety and Health Administration (OSHA) training for blood borne pathogens/hazardous materials. • Job descriptions are available for each position. • Staff has current CPR Training. • There is documentation of acceptance or denial of hepatitis B immunization.
Documents
• Current Clinical Laboratory Improvement Amendments (CLIA) License • Written medical waste plan reviewed annually • Current radiology registration • Written emergency preparedness and disaster plan with disaster drill documentation • Copies of appropriate Material Safety Data Sheets (MSDS) sheets for the office • Blood borne pathogen exposure control plan • Manifests from material waste processing company • Documented QI efforts • Documentation of well water safety, if appropriate • Documentation of Septic System Maintenance if appropriate • Documentation of quarterly fire drills and yearly disaster drills

Policies

- Confidentiality
- Conflict resolution
- Staff competency and orientation
- Medication storage and administration (include narcotics and method to dispose of expired medication)
- Infection control
- Radiology (e.g., pregnancy, safety apparel, maintenance of equipment, use of dosimeters, verification of proper technique)
- Maintenance of medical equipment (plan for broken equipment and routine maintenance and calibration — include emergency box, if appropriate)
- Staffing plan (to include call-in vacation coverage and delegation of responsibilities)
- Purging and storing of records
- Sterilization/high-level disinfectant
- Advance directives
- Abuse and neglect
- Policy for reporting communicable diseases to the state
- Sentinel events
- Documentation of "no-show" follow-up and phone contacts

Medications

- All stock and sample medications stored in a secure area away from patient access and in an appropriate location (shelf, refrigerator).
- No oral and injectable medications stored together.
- Documentation of regular review of all medications for expiration dates.
- A log is kept of all sample medications dispensed (to include patient name, drug, lot number, and name of person giving the medication).
- Multi-dose vials are marked with the initials of the person opening the vial and the date opened.
- Medications and laboratory specimens are stored in separate refrigerators.
- All narcotics are stored under double lock system and the key is secure.
- A narcotic log is maintained each working day (to include current number of each item, name of drug and dosage given, name of patient given medication, date, medication given, and number remaining). All wastage should also be documented. Any count should be accomplished using two staff people.
- No medication identified for an individual is stored with stock medication.
- Medication is not stored in a refrigerator with food or drink and a temperature log for the fridge is maintained (staff should be aware of the proper temperature to be maintained).
- The office participates in the Vaccines for Children Program and submits data to the MICR database.

Diagnostic Medical Equipment

- Thermometers
- Pulse Oximetry
- EKG Machine
- Glucometer
- Treadmill
- Oxygen Tanks
- Aerosol Machines
- Cryocautery Machine
- Colposcopy Equipment
- Ultrasound Machine
- Peak Flow Meter
- Autoclave
- Other
- Equipment manuals are available for all medical equipment

Safety

- All emergency exits are indicated. Emergency lights and electric exit signs are in working order.
- Universal precautions are always observed.
- Fire extinguishers are inspected at least yearly and have current markings.
- Staff is aware of the location of fire pulls and fire extinguishers.
- All fire exits are free of obstruction on both sides of the door (open all doors to check)
- Staff has been educated regarding the use and accessibility of MSDS sheets
- Appropriate staff has received annual blood borne pathogen training and is aware of the exposure control plan.
- Appropriate protective apparel is provided (e.g., gowns, marks, gloves, face shields).
- All gases are stored appropriately (intact tanks, upright and secured position). Staff is aware of the process for determining volume.
- Sharps containers are used and discarded when three fourths full (disposed of with biohazard material) and not within reach of children.

Laboratory

- Quality checks are done and documented on each waived lab test each day used.
- No food, drink, or medication is ingested near or stored with collected lab specimens (lab reagents may be stored with them in a separate container).
- No lab reagent is kept or used beyond its expiration date (proper disposal).
- All specimens are discarded properly after use.
- All specimens should be labeled with the patient's name or ID number when multiple specimens are being tested.

X-Ray

- Pregnancy precautions for X-ray are posted.
- Protective apparel is available and maintained, including dosimeters.
- Written plan for disposal of old films and developing agents.
- X-ray room is identified with a system to protect other staff from exposure.

Sterilization/High-Level Disinfectant
• All items to be sterilized or disinfected are first cleaned with an enzymatic detergent, dried, and then processed, maintaining a soiled-to-clean workflow. • Sterilized items are packaged appropriately, marked with a chemical test strip, the date processed, an expiration date, and then stored appropriately. • A log documenting each run and the chemical test strip is maintained, including the date and the signature of the person processing the run. • A monthly spore check is done and documented. • All containers holding chemical solutions are marked with the name of the solution, date of expiration, and the date solution was mixed. • Solution strength documentation exists for each day the solution is used. • Staff is aware of when sterilization with autoclave vs. high-level disinfectant should be done. • Glass thermometers are cleaned with alcohol and disposable probe covers are used for electronic thermometers. • Work surfaces soiled with biohazard materials are wiped down with commercial disinfectant material or a 10% bleach solution after the completion of testing. • There are sinks with soap and paper towels available in-patient care areas. (Bar soap on the sink is not acceptable.) Liquid hand disinfectants may be used in instances where the activity has taken place in an area not supplied with a sink and then hands are washed as soon as a sink is available. • Hand washing is an expected practice before and after each patient encounter. • No food or beverage is consumed in any work area. • All equipment and surfaces are cleaned appropriately after patient use. • The staff is aware of the process for reporting communicable diseases to the state. • Staff has been educated for the instance of tuberculosis and the screening process.
Exam Rooms
• Each room ensures patient privacy. • No medications, needles, or syringes are stored in exam rooms unless in a locked cabinet. • Exam room is childproofed as appropriate (e.g., electrical outlet covers, no harmful solutions within reach) • Area is clean and organized with opaque bags in wastebaskets. • No patient care supplies, or cardboard boxes stored on the floor or under the sinks. • There is an 18-inch clearance for sprinkler heads. • Clean laundry is covered. • No outdated material is stored.

Medical Records

- The medical record is retrievable for review for 10 years.
- Patient information is kept confidential. Files are maintained away from accessibility of other patients, as are fax machines. Desktops do not have identifiable information in sight of other patients. Sign-in sheet is not left in view of others.
- There is organization of the medical record, with dividers by type of service (e.g., lab, X-ray, consultations, discharge summaries, preventive services, progress notes, durable power of attorney/advance directives, informed consent).
- All diagnostic and therapeutic services for which the provider referred the member are documented in the chart (e.g., home health nursing reports, consults, hospital discharges, physical therapy).
- There is a Problem List of significant illnesses and medical conditions with date of onset.
- Medication allergies and adverse reactions or NKDA as appropriate are prominently displayed in the medical record.
- A past medical history for patients seen more than three times that is easily identified and includes serious accidents, operations, and illnesses. For children 18 and under, past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- The medical record is a unit record.
- There is an appropriately signed and dated Release of Information in the medical record.
- The entries in the medical record are legible.
- The entries in the medical record are signed and dated by the author.
- There is an acknowledgement of receipt of privacy notice in the record (if not in individual records, there is a central file with an acknowledgement of receipt of notice).
- 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.
- Medical records should be provided to Meridian within 10 business days of request, unless otherwise agreed.
- Accommodations can be arranged for individuals designated by Meridian to assist in extracting medical records to ease the burden on providers for this request.
- Where possible, electronic access to medical records should be arranged.

Required Training

OSHA Training

Employee training and annual in-service education must include:

1) Universal precautions
2) Proper handling of blood spills
3) HBV and HIV transmission and prevention protocol
4) Needle stick exposure and management protocol
5) Blood borne pathogen training
6) Sharps handling
7) Proper disposal of contaminated materials
8) Information concerning each employee's at-risk status

At-risk employees must be offered hepatitis B vaccination free of charge. Each employee file of an at-risk employee must contain informed consent or informed refusals for hepatitis B vaccines. Personal protective equipment must be provided to each at-risk employee. Necessary equipment must be provided for the administration of mouth-to-mouth resuscitation.

Documents to be posted in the facility are:

1) Pharmacy Drug Control license issued by the state if dispensing drugs other than samples
2) Section 17757a from the Board of Pharmacy (if dispensing drugs other than samples)
3) Controlled Substances License from the State of Illinois and the U.S. Drug Enforcement Administration (DEA)
4) CLIA certificate or waiver
5) Medical Waste Management certificate
6) X-ray equipment registration
7) R-H 100 notice
8) Radiology protection rules
9) OSHA poster (#2010)

Provider/Staff Education and Training

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 include, but are 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 long-term services and supports (LTSS) and HCBS populations
- Self-determination
- Disability literacy training
- Care coordination
- Quality improvement
- 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 (HIT) necessary to support care coordination

Annual **mandatory training modules** are available online by visiting Meridian's website at **mmp.ILmeridian.com**. If you complete mandatory training with another health plan, please fill out the **Attestation Form** and return to Meridian via one of the following methods:

Fax: **1-833-560-2915**
Email: **ilproviderrelations@mhplan.com**

Mail:
Meridian
Network Development – Attestation
1333 Burr Ridge Parkway, Suite 100
Burr Ridge, IL 60527

Also, the Provider Relations Department holds monthly provider and staff training webinars. To request a training session or participate in a scheduled session, please contact your Provider Relations Representative or the Member and Provider Services Department at **1-866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m., or via email to **ProviderHelp.IL@mhplan.com**.

PCP Roles and Responsibilities

CMS requires providers to provide care to members in a culturally competent manner, being sensitive to language, cultural, and reading comprehension capabilities. Meridian offers a language service to members speaking a non-English language. There is no charge to members for this service. To access this service for Meridian members in your practice, please contact Member Services at the numbers listed in the contact information section of this booklet and ask for language services.

Providers must ensure that their hours of operation are convenient for the aged, disabled, chronically ill, and low-income populations that they serve. Providers must provide all plan benefits covered by Medicare and by Meridian in a manner consistent with professionally recognized standards of healthcare. Providers must also ensure continuity of care and develop procedures that ensure that members are informed of their healthcare needs that require follow-up visits or provide training in self-care as necessary.

Providers must provide to Meridian, upon request, member's medical records both in support of complete and accurate risk adjustment data and for the validation of risk adjustment data for auditing purposes.

Providers shall not distribute any marketing materials that mention Meridian or include Meridian's logos without first obtaining approval from both Meridian and CMS. Providers must comply with all CMS marketing requirements in Chapter 3 of the Medicare Managed Care Manual.

Providers must make a good faith effort to provide 60 calendar days notice prior to effective date to plan regarding contract changes and terminations. Providers must make a good faith effort to provide written notice of request to terminate or contract changes to Meridian MMP at least 30 calendar days before the termination or change effective date, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care provider, Meridian MMP will notify all enrollees who are patients of that primary care provider. The provider shall also make a good faith effort to provide appropriate notification to members.

Roles and Responsibilities

Each Meridian member selects a PCP who is responsible for coordinating the member's total healthcare. PCPs are required to work 20 hours per week per location, and be available 24 hours a day, seven days a week.

Except for required direct access benefits or self-referral services, all covered health services are either delivered by the PCP or are referred/approved by the PCP and/or Meridian.

Specialty Care Provider Roles and Responsibilities

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

- Rendering services requested by the PCP by referral
- Communicating with the PCP regarding the findings in writing
- Obtaining prior authorization (PA) from the PCP and plan before rendering any additional services not specified on the original referral form
- Confirming member eligibility and benefit level prior to 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 PA number
  - The member's ID number

Hospital Roles and Responsibilities

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

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

Ancillary/Organization Provider Roles and Responsibilities

Meridian recognizes that the ancillary provider is another valuable team member in delivering care to Meridian MMP 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 MMP members
- Obtaining the required PA from the plan before rendering services
- Communication of all pertinent patient information to Meridian and to the PCP

Confidentiality and Accuracy of Member Records

Medical records and other health and enrollment information of a member 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

- Respect member rights to access, amend errors in, request confidentiality for, or an accounting of disclosures of the member's health information
- Identify when and to whom member information may be disclosed
- Safeguard the privacy of any information that identifies a particular member
- Secure information through robust controls designed to maintain the confidentiality, integrity, and availability of medical records and to protect against threats or hazards to the security or integrity of such information and any uses or disclosures of such information that could violate law
- Maintain such records and information in a manner that is accurate and timely, ensure timely access by enrollees to the records and information that pertain to them for what purpose the information will be used within the organization, and identify when and to whom member information may be disclosed

In addition to the obligation to safeguard the privacy and security of any information that identifies a particular member, the health plan and all participating providers are each 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 (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, within requested time frames ,and maintain records a minimum of 10 years.

Obligations of Recipients of Federal Funds

Providers participating in Meridian MMP are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including but not limited to Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act, the Anti-Kickback Statute, and HIPAA laws.

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

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at **exclusions.oig.hhs.gov/**
- The General Services Administration List of Debarred Contractors can be found at **www.sam.gov**
- The Preclusion List can be found at **www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Preclusion-List**

Disclosures to CMS and Beneficiary

Meridian must disclose to CMS and Illinois Department of Human Services (IDHS) information on ownership and control, business transactions, and people convicted of crimes. Meridian must obtain federally required disclosures from all network providers and applicants, obtaining such information through providers' enrollment forms and credentialing and recredentialing packages. Meridian is required to obtain such disclosed information in a manner that can be periodically searched for exclusions and provided by IDHS and CMS.

Meridian is required to provide the necessary information to enable CMS to provide current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage. This must happen annually and, in a format, using standard terminology that may be specified by CMS.

Meridian is required to provide to CMS all information that is necessary for CMS to administer and evaluate the program. Meridian is also required to provide information to CMS that would allow CMS to establish and facilitate a process for current and prospective enrollees to exercise choice in obtaining their Medicare services. This information includes, but is not limited to:

- Benefits covered under a MA plan
- MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for Meridian
- Service area and continuation area, if any, of each plan and the enrollment capacity of each plan
- Information about beneficiary appeals and their disposition
- Information regarding all formal actions, reviews, findings, or other similar actions by states, other regulatory bodies, or any other certifying or accrediting organization
- Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program

As a contracted provider with Meridian, you are required to comply with Meridian's request for information to meet disclosure obligations to CMS. Types of disclosures to CMS by Meridian include but are not limited to: plan disenrollment rates for the previous two years, enrollee satisfaction results, health outcome information, recent compliance record of the plan, and any other information that may be necessary for CMS to assist beneficiaries in making an informed health plan choice.

In meeting these requirements, the provider must cooperate with Meridian and assist in complying when applicable.

Clinical and Preventive Practice Guidelines

Meridian MMP and the Centene Advanced Behavioral Health (CABH) department, whenever possible, adopt preventive and clinical practice guidelines (CPGs) from recognized sources for the provision of acute, chronic, and BH services relevant to the populations served. The Meridian MMP also presents guidelines to the Quality Committee for appropriate physician review and adoption. CABH presents guidelines to the Clinical Policy Subcommittee (CPSC) and Quality Improvement Committee (QIC) for appropriate physician review and adoption. Guidelines are updated at least annually or upon significant new scientific evidence or changes in national standards.

The Meridian MMP/CABH adopt CPGs which are relevant to their population. Guidelines are based on the population's health needs and/or opportunities for improvement as identified through the Quality Assessment and Performance Improvement (QAPI) Program. Meridian MMP/CABH also adopts applicable preventive health guidelines for perinatal care, care for children up to 24 months old, care for children 2–19 years old, care for adults 20–64 years old, and care for adults 65 years and older.

Procedures for CPGs are as follows:

Development, Adoption and Revision

1) The Corporate Clinical Policy Committee (CPC) is responsible for researching physical health evidence-based guidelines, and the Centene Advanced Behavioral Health CPSC (CABH CPSC) is responsible for researching BH evidence-based guidelines. Whenever possible, guidelines from recognized sources are adopted. Source data is documented in the guidelines to include the scientific basis or the authority upon which it is based.
2) Board-certified practitioners who will utilize the guidelines can review and give advice on the guidelines through the Corporate CPC or CABH CPSC and the Meridian MMP/CABH's Quality Committee. Specialist review is documented in the meeting minutes, as applicable.
3) If guidelines from a recognized source cannot be found, Centene's CPC or the CABH CPSC is consulted for assistance in guideline sourcing or development.
4) Clinical policy staff update guidelines upon significant new scientific evidence or change in the national standards and guidelines are reviewed by the Corporate CPC/CABH and Meridian MMP/CABH Quality Committee at least annually.

Internal Use of Practice Guidelines

1) Utilization of evidence-based CPG, preventive health guidelines, and/or other scientific evidence, as applicable, in developing, implementing, and maintaining clinical decision support tools used to support utilization and care management.
2) When appropriate, the Meridian MMP/CABH may choose to use a vendor's clinical decision support tools. Meridian MMP/CABH will ensure through due diligence and regular updates that evidence-based practice is utilized in development of the clinical decision support tools.

3) When Meridian MMP/CABH deem necessary, customized assessments or UM tools are developed as follows:
   a. Utilize clinical sources with documented evidence-based practice.
   b. A team consisting of Meridian MMP/CABH and corporate staff, which includes licensed clinical staff, develops the necessary tools.
   c. The Vice President of Population Health and Clinical Operations, the Vice President of Medical Affairs and/or the Senior VP/Chief Medical Officer of Behavioral Health review and approve the modifications as applicable.
4) The clinical documentation system provides a link to the clinical practice or preventive health guideline as applicable for access by clinical staff during UM and care management.

Distribution to Practitioners and Members/Enrollees

1) Guidelines are distributed to all practitioners who are likely to use them and upon request to members/enrollees, potential members/enrollees, and other providers. Revised guidelines are distributed on a timely basis. New practitioners will receive a separate distribution if the original distribution has already occurred.
2) New or updated guidelines will be disseminated to providers via the **provider website** as soon as possible (or per state contract timeframe, if applicable) and are available in hard copy upon request.
3) Members/enrollees may be notified of their right to request guidelines in the member/enrollee handbook, member/enrollee newsletter, or other member/enrollee materials.
4) If a member/enrollee or potential member/enrollee requests a copy of the guidelines, it is noted in the member/enrollee services call tracking system, and the member/enrollee is referred to the **website**, or a hard copy is mailed to the member/enrollee if requested.
5) Mechanisms to notify and distribute guidelines may include, but are not limited to:
   a. New practitioner orientation materials
   b. Provider and member/enrollee newsletters
   c. Member/enrollee handbook
   d. Special mailings

Performance Measurement

1) If applicable, based on the state contract and accreditation (e.g., NCQA, URAC, etc.) requirements, Meridian MMP/CABH measures practitioner compliance with at least two important aspects of each of the four clinical guidelines (two of which must be BH) and two preventive health guidelines at least annually. This may be done in conjunction with delegated vendors as applicable.
2) The analysis can be either population or practice based.
   a. If population based, the services/treatments received by members/enrollees are assessed, via claims data or HEDIS rates, to measure compliance with the guidelines.
   b. If practice-based, a sample of practitioners' or practices' records may be evaluated for adherence to specific guidelines.

3) Whenever possible, applicable HEDIS measures are utilized to monitor practitioner compliance with adopted guidelines.
4) If the performance measurement rates fall below the Meridian MMP/CABH, state, and/or CMS goals, the Plan/CABH implements interventions for improvement, as applicable.

Delegation

1) Meridian MMP/CABH's delegated managed BH vendor (if applicable) performs the adoption, updating and distribution (i.e., to the delegated BH vendor's practitioner network) for the BH guidelines required by this policy.
2) May delegate adoption, updating, and performance monitoring of specific disease state CPGs to a disease management vendor.
3) Collaborates with delegates to monitor practitioner compliance with the adopted standards and to implement interventions for improvement, as applicable.
4) Oversight of delegated processes is conducted as outlined in the Oversight of Delegated Quality Improvement policy and procedure.

Patient-Centered Medical Home (PCMH) Program

Meridian MMP has a process to facilitate and incentivize medical homes in advancing towards National Committee for Quality Assurance (NCQA) PCMH recognition.

Providers are educated about the PCMH model and the importance of using it to integrate all aspects of each member's care, as well as how to become a PCMH. PCMHs must demonstrate effective care coordination, family and caregiver involvement, health promotion and wellness programs, self-management strategies, and chronic health condition management.

Meridian MMP recognizes the commitment required for PCMH recognition. PCMHs are patient-centered in approach and have the capacity to provide access to a personal clinician and care team that offers individualized, high quality comprehensive primary care and coordinates specialty and other needed services.

PCMHs 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 LTSS. PCMHs shall provide all PCP services and be supported by Integrated Care Teams and HIT.

Assessment and Support of Medical Homes

Providers and facilities interested in advancing towards PCMH recognition should visit **NCQA.org** and click on the PCMH link for more information including information about a coupon code to apply toward the evaluation and the incentive they can receive upon completion of the evaluation.

Care coordination will support Medical Homes in their efforts to actively engage with patients in need of care management by including providers in Interdisciplinary Care Teams (ICT), which function to coordinate member care across the full spectrum of available services and manage transitions between levels of care. Meridian MMP 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.

Education

Meridian's Provider Relations and QI Departments 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, provider education, quality provider webinars, provider newsletters, provider mailings, and website updates.

- Meridian MMP will provide general guidance or access to resources for practice utilization as part of the Medical Home's transformation and improvement efforts
- Medical Homes will be supported by HIT, including, but not limited to, electronic transfer of data and the Meridian Provider Portal
  - PCMHs will have access to electronic medical record data collection to support QI
  - PCMHs will have access to Meridian's Provider Portal, which allows for electronic features including, but not limited to:
    i. Verification of eligibility
    ii. Authorizations
    iii. Claims status and submission/correction
    iv. Member information and reports
    v. Enrollment lists
    vi. Healthcare Effectiveness Data and Information Set (HEDIS®) bonus information
    vii. HEDIS self-reporting, and
    viii. Requests for HEDIS postcards.

PCMH Incentive

Meridian MMP offers a financial incentive to providers for achieving NCQA recognition as a PCMH. The PCMH incentive rewards a discount on the initial application for the NCQA PCMH recognition program. This incentive will be available to any provider who is not currently NCQA PMCH recognized, has a fee for service contract with Meridian, and is accepting new Meridian MMP members. Additional quality incentives may also be available to qualifying providers who are NCQA PCMH recognized. Incentives are subject to change and are communicated via Meridian's Provider Relations and QI Department staff. Providers are educated about Meridian's PCMH Incentive Program during provider orientation, provider training, and via Meridian's provider facing **website**. Ongoing information is

provided by Provider Relations Representatives (PRRs) during office site visits to support and encourage provider participation.

The Provider Impact on Member Surveys

There are currently two member surveys sent out each year: Health Outcome Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The HOS measures members reported physical and mental health status. It also asks members about physical activity, improving bladder control, and fall risk management. The CAHPS measures patient experience. The patient's experience could include communication with providers, if medications were reviewed clearly, and if the provider showed respect for what the patient said.

Our partnership goals with our providers are to:

- Increase member engagement at provider offices through tailored member outreach
- Improve member outcomes by addressing open care gaps at every visit

Billing and Claims

When billing for services rendered to Meridian MMP members, providers must use the most current Medicare-approved coding (ICD-10, CPT, HCPCS, etc.) available.

Claims must be submitted using the proper claim form/format, e.g., for paper claims, submit a CMS1500 or UB04 and for an electronically submitted claim, submit in approved ANSI/ HIPAA format. It is recommended that claims be submitted as if they are being billed to Medicare fee-for-service. **Meridian will apply Medicare benefits and, when applicable, Medicaid benefits.**

Billing Requirements

- Providers must use a standard CMS 1500 Claim Form or UB-04 Claim Form for submission of claims to Meridian
- Claim must be original, using national or state form types as applicable. Photo or scanned copies are not accepted. The claim information must be typed with no handwritten information other than applicable signatures
- Taxonomy code must be included on ALL claims
- Claims for Meridian MMP members must be submitted within **180 days** from the end of the date of service. Failure to submit claims data within the prescribed time period may result in payment delay or denial. This guidance is in accordance with CMS' expectations concerning timely submission of claims/encounter data by the MMP

Claims Mailing Requirements

Beginning January 1, 2021, Submit all initial claims for payment to:

Attn: Meridian MMP Claims Department Meridian
P.O. Box 4020
Farmington, MO 63640

If you are resubmitting a claim for a status or a correction, please indicate the claim number of the claim that is being corrected and a code in the appropriate field indicating it is a corrected claim.

Explanation of Payments (EOP)

Meridian sends providers two remittance vouchers as a method of EOB.

When to Bill an Enrollee

All providers must adhere to federal protection laws and are prohibited from balance billing any enrollee beyond the enrollee's cost sharing, if applicable. You may not balance bill for services and supplies furnished to Meridian MMP members. Any difference between what you bill and what Meridian pays cannot be billed to the member.

An enrollee may be billed ONLY when the enrollee knowingly agrees to receive non-covered services under Meridian MMP.

- The provider MUST notify the enrollee in advance that the charges will not be covered under the program.
- The provider MUST have the enrollee sign a statement agreeing to pay for the services and place the document in the enrollee's medical record.

Electronic Claims Submission

Meridian is currently accepting electronic claims using the following payer ID information. Providers are responsible for ensuring that they receive a confirmation file for claims submitted via EDI. Effective January 1, 2021, the **Payor ID is MHPIL**.

Payment to Non-Contracted Providers

Meridian will make timely and reasonable payment on behalf of or to the member for the following services if obtained by an out-of-network provider in accordance with 422.100(b):

- Ambulance services dispatched through 911 or its local equivalent
- Emergency and urgently needed services
- Maintenance and post-stabilization care services
- Renal dialysis services provided while the member was temporarily outside the plan's service area
- Services for which coverage has been denied by Meridian and found (upon appeal) to be services the member was entitled to have furnished, or paid for, by Meridian

Provider Appeals and Claim Dispute Process

- **Provider Appeals (Post-Service Medical Necessity Appeals)** – provider appeals are related to authorizations that were denied in whole or in part for medical necessity. Providers appeals are submitted post-service. An authorization denial will result in a denied claim.
- **Provider Claim Disputes** – provider claim disputes are related to claim payment denials, including claims denied for authorization when the provider failed to obtain a required authorization, and claim 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.

Medical Necessity Appeals

A medical necessity appeal is the first and only level of plan appeal for the member and provider relating to medical necessity determinations. Medical necessity appeals must be filed by one of the following: the member, the member's authorized representative, the member's provider of record, or a healthcare practitioner with knowledge of the member's medical condition acting on the member's behalf. They may be filed pre-service on the member's behalf with permission, or post-service on the provider's behalf. Medical Necessity appeals may be for the following:

- Denied Days for an Inpatient Stay or Denied Level of Care for an Inpatient Stay
- Denied Air Ambulance Transport
- Denied Hospice Stay
- Readmissions

Pre-service medical necessity appeals must be filed as outlined in the **Member Grievances and Appeals section** in this manual.

Providers have 90 days to file an appeal from the date of the Adverse Benefit Determination letter.

Post-service medical necessity appeals must be filed in writing as outlined below.

For Non-Behavioral Health Services:

Fax: **1-833-383-1503**

Mail:
Meridian Medicare-Medicaid
Appeals and Grievances
Medicare Operations
7700 Forsyth Blvd.
St. Louis, MO 63105

For Behavioral Health Services:

Fax BH: **1-866-714-7991**

Mail:
Centene Advanced Behavioral Health (CABH)
Appeals Dept.
13620 Ranch Road 620 N, Bldg. 300C,
Austin, TX 78717-1116

Claim Disputes

Disputes must be filed within 90 days of the remittance date. Disputes submitted after the timeframe has expired may not be reviewed. All disputes must be received within 365 days of the date of service (DOS) to be considered for review, unless otherwise specified within the provider contract.

If the original determination is upheld, the provider will be notified within 30 days of receipt of the dispute. If additional information is needed, such as medical records, then Meridian will respond within 30 days of receiving the necessary information. The written determination will include a detailed explanation of the determination. If the original determination is overturned, the provider will see payment details on the EOP.

There is only one level of dispute available within Meridian. All dispute determinations are final. If a provider disagrees with Meridian's determination regarding a dispute, the in or out-of-network provider may pursue other options as outlined below.

Claim Dispute Types

Type	Where to Submit
Administrative Denial Claim Disputes Appeal of a claim denied for failure to obtain authorization according to timeframe and PA requirements. If your claim is denied for authorization due to a denial or partial denial of the PA request, you must follow the member appeal process. IMPORTANT: If you have a PA number for a denied or partially denied auth and are appealing the authorization denial please follow the post service medical necessity denial process.	Two ways to submit: 1. **provider portal** 2. Via mail: **Meridian** **ATTN: Provider** **P.O. Box 4020** **Farmington, MO 63640-4402**

Type	Where to Submit
Provider Claim Dispute Disputes related to claims processing are handled separately from Administrative Denial Disputes. Claim disputes are disputes regarding the following: • Inaccurate Payment or Denial • Coding Edits (Correct Coding Initiative (CCI) edits) • Claims Denied as a Duplicate • Untimely Filing Providers electing to dispute the disposition or reimbursement level of a claim for DOS after July 1, 2021, may do so via the provider portal (preferred): • Select the claim and provide appropriate reason for the dispute. • Supporting documents can be attached, i.e., medical records, etc. • The dispute will be reviewed by a dispute analyst. • If your original claim reimbursement is updated, you will receive new reimbursement • If your original claim reimbursement is upheld, a letter will be sent acknowledging the reason for dispute being upheld. You may also submit a **dispute form** via mail. Additional information about claims disputes prior to or after July 1, 2021 can be found on **ILmeridian.com** under Provider Resources, then Manuals, Forms and Resources.	Two ways to submit: 1. **provider portal** 2. Via mail: **Meridian** **ATTN: Provider Claim Disputes** **P.O. Box 4020** **Farmington, MO 63640-4402**

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 the Provider Services Department at **1-855-580-1689 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. for more information.

Utilization Management (UM)

The objective of Meridian's 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.

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.

UM 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 covered benefits at the time the services are rendered.

Requesting Prior Authorization/Precertification

For all authorization questions, please contact us at the numbers listed in the contact information section of this manual.

Meridian offers multiple methods to submit authorization requests. For the most efficient and timely service, **Meridian's Online PA Form is the preferred method.**

1) **Electronic Submission** – The **Meridian Online PA Form** can be accessed in two ways:
   - Secure **Provider Portal**
   - Meridian website at **mmp.ILmeridian.com/provider/pre-auth-needed.html**

2) **Phone Submission**
   - Meridian MMP: **1-855-580-1689**
   - Requests should only be submitted via phone for services related to pending hospital discharges.
   - Other PAs cannot be processed via phone, as clinical review and supporting documentation are required.

3) **Fax Submission** – Please include pertinent clinical documentation with the request:
   - Member's name
   - Member's identification number
   - Member's date of birth
   - Date(s) of service
   - Facility where services are to be rendered
   - Diagnosis/Procedure code(s), as applicable

Type of Request	Fax Number
Inpatient, Post-Acute, and Pre-Service Standard Requests	1-844-409-5557
Concurrent Review (Clinical)	1-855-581-2251

All Pre-Service Expedited Requests should call **1-855-580-1689**.

UM Decision Clinical Review Criteria

Meridian must review and approve all 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.

UM staff uses plan documents for benefit determination and Medical Necessity Coverage Guidelines to support UM decision-making. All utilization review decisions to deny coverage are made by Meridian MMP Medical Directors. In certain circumstances, an external review of a service request is conducted by qualified and licensed providers with the appropriate clinical expertise.

Providers should refer directly to Medicare coverage policies for information on Medicare coverage policies and determinations. The two most common types of Medicare coverage policies are National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

As a MA plan, we must cover all services and benefits covered by original Medicare.

National Coverage Determinations (NCDs)

CMS explains NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals.

Local Coverage Determinations (LCDs)

LCDs provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

In coverage situations where there are no NCDs, LCDs or guidance on coverage in the Medicare manuals, Meridian may use current literature review, along with consulting with practicing providers and medical experts in their particular fields. Meridian also uses government agency policies and relies on standards adopted by a national accreditation organization and Meridian Medical Management policies for clinical decision making. Meridian may also adopt the coverage policies of other MA Organizations in its service area.

It is the responsibility of the attending provider 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.

To ensure timely decisions are rendered, Meridian requires completed and legible clinical information with each request. The preferred method of clinical review submission is via Meridian's online PA Form. If clinical information is not received with the request, the Meridian MMP UM staff will send a fax request for the information and/or contact the provider or specialist verbally to collect the necessary documentation.

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
- Discharge disposition

Clinical information should be provided at least 14 days prior to the service unless services are urgent. Meridian provides a request ID on all authorizations.

Inpatient Review

Our nurse reviewers are assigned to members at specific acute care facilities to promote collaboration with the facility's review staff and management of the members across their continuum of care. Meridian MMP 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 and care management's clinical staff, we are able to coordinate the member's discharge needs.

All elective hospital admissions initiated by the PCP or specialist require a PA. A provider may initiate a PA request by calling Member Services, entering the authorization request via the Meridian online PA form or by submitting the request via fax. Be sure to include clear and concise clinical documentation to support medical necessity, which will facilitate a quick determination.

Turnaround Time for Referral Processing

Review Type	Makes Decision	Written/Verbal Notification	Written Notification (Denials)
Pre-service non-urgent	Within 14 days of receipt of the request	Within 14 days of receipt of the request	Within 14 days of receipt of the request
Pre-service urgent	Within 72 hours of receipt of the request	Within 72 hours of the request	Within 72 hours of the request
Urgent concurrent	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 24 hours of receipt of the request, 72 hours if clinical not included with initial request	Within 72 hours of the decision

Required Notification to Members for Observation Services

In compliance with the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), contracted hospitals and Critical Access Hospitals (CAHs) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including an MA enrollee) who receives observation services asan outpatient for more than 24 hours. See the final at: **www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON#%3A~%3Atext%3DHospitals%20and%20CAHs%20are%20required%2Ccritical%20access%20hospital%20(CAH)**.

Care Management

The Meridian MMP Care Management (CM) Program provides patient-focused, individualized CM for all members in various levels of intensity based on member needs and services required. This encompasses those who qualify for a HCBS waiver, have a chronic condition appropriate for disease management services and those members who have appropriate services established and need occasional re-enforcement. Both telephonic and on-site CM services are provided. The following disease management coaching programs are available in collaboration with CM to personally support the healthcare needs of members asthma, diabetes, hypertension, weight management, coronary artery disease, and COPD.

The goals of Meridian's CM program are to:

- Assist members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition
- As soon as Meridian reaches the member, Meridian shall assign a care coordinator and begin offering CM services to the member; Meridian will ensure that members have access to a primary care coordinator who is responsible for the coordination of all benefits and services that the member may need
- Assist members in determining and accessing available benefits and resources
- Work collaboratively with members, providers, family, guardians, and community organizations to develop goals and assist members in achieving them
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting
- Maximize benefits and resources through oversight and cost-effective UM
- Serve as an advocate for the member
- Adhere to Centene's mission of providing better outcomes at lower costs
- Providing CM for members, and assisting in the development and implementation, and monitoring of the care plan, and when appropriate, service plans
- Assisting in the integration of services and coordination of care across the healthcare system
- Assigning a care coordinator with experience using motivational interviewing techniques, explaining alternative care options to member and family as appropriate, and maintaining frequent contact with the member through various methods including face to face visits, email, telephone, per assessment of the members need, risk level and member's request

Interdisciplinary Care Team (ICT):

Meridian supports an ICT for all Enrollees who are receiving CM. The ICT is person-centered, built on each of the enrollee's specific preferences and needs with the member's input. Each ICT consists of clinical and non-clinical staff whose skills and professional experience will complement and support one another in the oversight of each enrollee's needs.

Transition of Care Program:

Meridian's CM Associate(s) will facilitate communication between all appropriate clinical and administrative staff in transitions of care when enrollees move from one setting to another to ensure a safe, effective transition and to reduce potentially preventable readmissions.

Upon member request, our case managers will send you an individualized plan of care identifying the member's health status and short- and long-term goals for CM.

Our case managers may contact you for other reasons:

- To coordinate a plan of care
- To discuss recent hospitalization and discharge plan
- To confirm a diagnosis
- To verify appropriate follow-up such as cholesterol/LDL-C screening or HbA1c testing
- To identify compliance issues
- To discuss medication non-adherence
- To discuss other problems and issues that may affect outcomes of care
- To inform you of a member's potential need for BH follow-up

Member Appeals and Grievances

Members, or their representatives, have the right to make a complaint if they have concerns or problems related to their coverage or care. "Appeals" and "grievances" are the two types of complaints members can make. All contracted providers must cooperate with the MA appeals and grievances process.

Definitions

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the healthcare services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and, if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Grievance: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the way a Medicare health plan or delegated entity provides healthcare services, regardless of whether any remedial action can be taken. A member or their representative may make a complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organizational determination or reconsideration, or invoked an extension.

Appeals

Expedited Appeal

An Expedited Appeal is a request to change a denial decision for urgent care. Urgent care is a request for medical care or treatment with respect to the application of the time period for making nonurgent care determinations 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.

Inpatient services that are denied while a member is in the process of receiving the services are considered an urgent concurrent request and are therefore eligible for an Expedited Appeal.

Pre-Service Nonurgent Appeal

Members, their representatives, or providers, acting on behalf of a member, may request an appeal of denial in advance of the member obtaining care or services. Meridian will provide acknowledgement of the appeal within three days of receipt of the request. No provider will be involved in an appeal for which he or she made the original adverse determination. No provider will render an appeal decision who is a subordinate of the provider making the original decision to deny.

Refer to the **Billing and Payment section** for directions on Post-Service Appeals.

Levels of the Appeals Process

The levels of the appeals process are listed below. If an appeal is not resolved at one level, it can proceed to the next.

1) Meridian standard or expedited appeals process
2) Review by an Independent Review Entity (IRE)
3) Review by an Administrative Law Judge (ALJ)
4) Review by a Medicare Appeals Council (MAC)
5) Review by a Federal District Court Judge

If your problem is about a **Medicaid** service or item, you can file a Level 2 Appeal yourself with the State Hearings office. The denial letter will tell you how to do this. If your problem is about a service or item that could be covered by **both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. If they also deny your appeal, you can ask for another Level 2 Appeal with the State Hearings office.

Members can appeal a medical decision within 60 calendar days of receiving Meridian's letter denying the initial request for services or payment on their own behalf. They can also designate a representative, including a relative, friend, advocate, provider, or other person, to act for them. The member and the representative must sign and date a statement giving the representative legal permission to act on the member's behalf ("Appointment of Representative" Form CMS-1696 may be used, or a similar statement). The Member can also call the Member Services Department at the number listed in the contact information section of this manual to learn how to name an authorized representative.

Expedited or Non-urgent Pre-service appeals, and/or the representative statement may be sent to Meridian at:

Appeals for Part D (Drugs):

Meridian MMP (Medicare-Medicaid Plan) Part D Appeals
1 Campus Martius, Suite 750
Detroit, MI 48226

Fax: **1-844-328-1906**
Phone: **1-855-898-1480 (TTY: 711)**

Appeals for Part C (Medical and Part B Drugs):

Meridian MMP (Medicare-Medicaid Plan) Appeals
Medicare Operations 7700 Forsyth Blvd
St. Louis, MO 63105

Fax Number: **1-844-273-2671**
Phone (Member Services): **1-855-580-1689**

Grievances

To file a grievance, a member or their authorized representative should call the Member and Provider Services Department at **1-855-580-1689 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m., or submit in writing to:

Meridian
Grievances
Medicare Operations 7700 Forsyth Blvd
St. Louis, MO 63105

Fax Number: **1-844-273-2671**

A review of the matter will be completed by our grievance coordinator. Meridian will thoroughly investigate the grievance and the member will receive a response from the grievance coordinator within 30 days.

Appeals and Grievances

A member may appeal an adverse initial decision by Meridian or a participating provider concerning authorization for or termination of coverage of a healthcare service. A member may also appeal an adverse initial decision by Meridian concerning payment for a healthcare service. A member's appeal of a decision about authorizing healthcare or terminating coverage of a service must generally be resolved by Meridian within 15 calendar days if the member's health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

Participating providers must also cooperate with Meridian and members in providing necessary information to resolve the appeals within the required time frames. Participating providers must provide pertinent medical records and any other relevant information to Meridian. In some instances, participating providers must provide the records and information very quickly to allow Meridian to make an expedited decision.

If the normal time period for an appeal could result in serious harm to the member's health or ability to function, the member or the member's provider can request an Expedited Appeal. Such an appeal is generally resolved within 24 hours unless it is in the member's interest to extend this time period. If a provider requests the Expedited Appeal and indicates that the normal time period for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

A special type of appeal applies only to hospital discharges. Hospitals are required to notify all Meridian MMP members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue *Important Message from Medicare About Your Rights (IM)*, a statutorily required notice, up to seven days before admission or within two calendar days of admission, obtain the signature of the member or of his or her representative, and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of the discharge as possible, but not less than two calendar days before discharge.

If the member thinks their hospital stay is ending too soon, the member can appeal directly and immediately to the QI Organization that is contracted with CMS. However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that Meridian's coverage of the stay is ending. If the member misses this deadline, the member can request an Expedited Appeal from Meridian.

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). Medicare regulations require the provider to deliver the standard *Notice of Medicare Non-Coverage (NOMNC)* to all members when covered services are ending, whether the member agrees with the plan to end services or not. Providers must distribute the NOMNC at least two days prior to enrollee's CORF or HHA services ending and two days prior to termination of SNF services. If the member thinks his or her coverage is ending too soon, the member can appeal directly and immediately to the QI Organization. If the member gets the notice two days before coverage ends, the member must request an appeal to the QI Organization no later than noon of the day after the member gets the notice. If the member gets the notice more than two days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to a QI organization, the member can request an Expedited Appeal from Meridian.

If a member has a grievance about his or her plan, a provider or any other issue, the member can call Member Services or submit a complaint in writing by mail or fax.

We will resolve the grievance as quickly as the case requires based on the member's health status, but no later than 30 calendar days after receiving the complaint. We may extend the time frame by up to 14 days if the member requests the extension, or if we justify a need for additional information and the delay is in the member's best interest.

Further Appeal Rights

If Meridian denies the member's appeal in whole or in part, it will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not part of Meridian. This organization will review the appeal and, if the appeal involves authorization for healthcare services, decide within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the member may be able to appeal to a Federal District Court of the United States.

Critical Incidents 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 **www.ILmeridian.com/providers/resources/forms-resources.html**. Providers must participate in training offered by Meridian to ensure accurate and timely reporting of all Critical Incidents.

Critical Incidents include but are not limited to:

- Unanticipated 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

A **Critical Incident Report** must be submitted to Meridian by email to **criticalincidents@mhplan.com** no later than 24 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. Email these written accounts to **criticalincidents@mhplan.com** 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.

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.

Incident Reporting

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 immediately if there is a member death related to alleged abuse, neglect, or exploitation or any type of incident.

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

Incident Involves	Contact	Time Frame
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: **1-800-368-1463** (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: **1-866-800-1409** **1-800-206-1327**	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*: **1-800-252-4343**	Immediately
Supportive Living Facility resident	Department of Healthcare and Family Services' SLF Complaint Hotline: **1-844-528-8444**	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).

Fraud, Waste, and Abuse (FWA)

Healthcare FWA affects every one of us. It is estimated to account for between 3% and 10% of the annual expenditures for healthcare in the U.S. Healthcare fraud is both a state and federal offense.

The following are the official definitions of FWA: 42 CFR §455.2 Definitions.

Fraud: 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 the law. Waste relates primarily to mismanagement, inappropriate actions, and inadequate oversight.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicare 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 costs to the Medicare program.

Here are some examples of FWA:

Fraud and Waste

- Providers billing for services not provided
- Providers billing for the same service more than once (i.e., double billing)
- Providers performing inappropriate or unnecessary services
- The misuse of a Medicare card to receive medical or pharmacy services
- Altering a prescription written by a provider
- Providers performing inappropriate or unnecessary services
- The misuse of a Medicare card to receive medical or pharmacy services
- Altering a prescription written by a provider
- Making false statements to receive medical or pharmacy services

Abuse

- Going to the emergency department for non-emergent medical services
- Threatening or abusive behavior in a provider's office, hospital, or pharmacy

Overpayment and Recovery

Meridian handles recovery of overpayments (take-backs) according to the situation that created the overpayment and the time frame between when the payment was made and when the overpayment was identified. Below are examples of overpayment and recovery situations:

- **Inaccurate payment:** This includes duplicate payment, system setup error, claim processing error and claims paid to wrong provider. Adjustment/notification date for recovery will be limited to 12 months from date of payment
- **Identified through a medical record audit:** Adjustment/notification date for recovery will be limited to 12 months from date of payment. If the audit reveals fraud, waste, or abuse, the 12-month look-back period will no longer apply
- **Fraud and abuse:** Adjustment/notification date for recovery time period will be the statute of limitations or the time limit stated in the Provider Agreement

In the event it is determined that an inaccurate payment was made, Meridian will not provide prior written notice of a recovery. In that case, Meridian will recover the overpayment by issuing an invoice or performing a take-back. Full details of this recovery will be provided in either the invoice or the remittance advice.

No time limit applies to the initiation of overpayment recovery efforts required by a state or federal program or where there is suspected fraud or intentional misconduct involved.

To report possible FWA:

Contact Meridian through the FWA Hotline at **1-866-685-8664**. All reporting of possible FWA may be done anonymously through this hotline. The Special Investigations Unit can be contacted by email at: **Special_Investigations_Unit@CENTENE.COM**, or by mail at:

Special Investigations
Unit 1 Campus Martius, Suite 700
Detroit, MI 48226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