

Home and Community Based Services (HCBS) Waiver Providers Orientation

Updated April 2026

Agenda

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- Member ID card examples

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1. Meridian and its Family of Plans

Medicaid and D-SNP products



Meridian Medicaid Plan

- HealthChoice Illinois Medicaid plan
- Includes **Managed Long Term Supports & Services (MLTSS) plan** and supports members enrolled in one of five Home and Community-Based Services (HCBS) waiver programs



Regulatory Agency –
Healthcare and Family Services

ILMeridian.com

Member Name: John Sample
Plan Name: HealthChoice Illinois
Medicaid ID: 123456789
Member Services: 866-606-3700 (TTY: 711)

PCP: Jane Smith
Phone: 555-555-5555

RxBIN: 003858 **RxPCN:** MA **Group:** 2EHA



YouthCare HealthChoice Illinois

- Specialized program for Illinois Department of Children and Family Services (DCFS) youth in care and former youth in care
- Includes current youth in care, up to age 18, and eligible to former youth in care through age 21



Regulatory Agency –
Healthcare and Family Services

ILYouthCare.com

Member Name: Jane Doe
Plan Name: YouthCare HealthChoice Illinois
Medicaid ID #: 123456789
Effective Date: 09/23/2023

PCP Name: Healthcare Center for Kids, Ltd.
PCP Number: 555-555-5555

RxBIN: 003858 **RxPCN:** MA **RxGROUP:** 2EJA



Wellcare Meridian Dual Align (HMO D-SNP)

- Integrates managed care for individuals eligible for Medicaid and Medicare Parts A & B
- Excludes individuals participating in the HCBS Adults with Developmental Disabilities waiver

Wellcare Meridian Dual Align (HMO D-SNP)
Wellcare Meridian Dual Align is a plan that contracts with both Medicare and Illinois Medicaid.



Member Name: Jamie Sample
Member ID: C12345678-01
Effective Date: 01/01/2026
MEMBER CANNOT BE CHARGED
Copays: PCP/Specialist: \$0 ER: \$0
H6071 001



RxBIN: 610014
RXPCN: MEDDPRIME
RXGRP: 2FFA

Marketplace and Medicare products (Not applicable to waiver providers)



Ambetter of Illinois

- Marketplace product
- Plans are available in bronze, silver, and gold levels and provide a balance of monthly premium payment and out-of-pocket expenses

ambetter
of Illinois | Insured by Celtic Insurance Company | REFERRAL NOT REQUIRED

MEMBER: Jane Doe
Subscriber: John Doe
Policy: 123456789 | **Member ID:** U123456789 | OF
Plan: Plan Name
Premier Network Coverage Only
RXBIN: 610014 | **RXPCN:** A1 | **RXGROUP:** 2000A
Effective Date: 01/01/2025

PREMIER

COPAYS
PCP: \$0 Co-pay
Specialist: \$0 Co-pay
Urgent Care: \$0 Co-pay
ER: \$0 Co-pay

COST SHARES
INN DED Ind/Fam: \$0,000/\$0,000
OON DED Ind/Fam: \$0,000/\$0,000
INN MOOP Ind/Fam: \$0,000/\$0,000
OON MOOP Ind/Fam: \$0,000/\$0,000

www.ambetterhealth.com/copyys



Wellcare of Illinois

- Medicare product
- Plans offer members access to affordable **Medicare Advantage and Prescription Drug Plans**

wellcare
Wellcare Plan Name (PPO)

MEMBER ID #: 123456789012
PLAN #: HXXX-XXX-XXX
ISSUER #: (80840) 9151014609

SAMPLE A SAMPLE

2025

Medicare limiting charges apply.
In Network PCP Office Visit: \$0
Out of Network PCP Office Visit: \$0

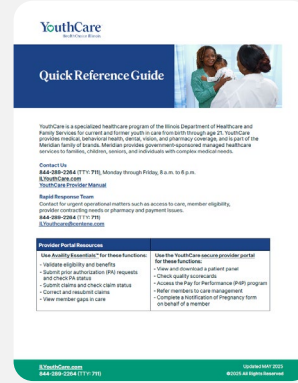
Card Issued: 10/15/2024

RXBIN: 610014
RXPCN: MEDDPRIME
RXGRP: 2FFA

MedicareRx
Prescription Drug Coverage

2. Essential Provider Resources

Provider manuals & quick reference guides



- Our **provider manuals** are comprehensive guides to doing business with Meridian and our family of plans
- Available online for each product under *Provider Resources*:
 - [Meridian Medicaid Plan](#)
 - [YouthCare](#)
 - [Wellcare Meridian Dual Align \(HMO D-SNP\)](#)
 - [Ambetter](#)
 - [Wellcare](#)

- **Quick reference guides** are condensed reference tools with key information about routine operational functions
- Available online for each product under *Provider Resources*:
 - [Meridian Medicaid Plan](#)
 - [YouthCare](#)
 - [Wellcare Meridian Dual Align \(HMO D-SNP\)](#)
 - [Ambetter](#)
 - [Wellcare](#)

Support options for providers

- **Secure provider portals**
Availity and the Meridian secure provider portal are available 24/7 and are the fastest way to verify member eligibility, manage claims, process authorizations, view patient lists, and more.
- **Provider Engagement team**
Contact your organization's assigned representative for seamless support. For organizations without an assigned representative, use our intake form to be connected to the team member best equipped to assist you.
- **Provider Services**
Contact Provider Services for the appropriate health plan during business hours for support with a wide range of functions

Meridian Medicaid Plan

866-606-3700 (TTY: 711)
[ILmeridian.com/providers](https://www.ILmeridian.com/providers)

YouthCare

844-289-2264 (TTY: 711)
[Ilyouthcare.com/providers/
provider-resources](https://www.Ilyouthcare.com/providers/provider-resources)

Wellcare By Meridian D-SNP

844-536-2175 (TTY: 711)
[wellcare.ILmeridian.com/
for-providers](https://www.wellcare.ILmeridian.com/for-providers)

Secure provider portals

To make it easier to work with us, Meridian began transitioning to **Availity Essentials** as its exclusive provider portal and expects the migration to be complete in 2027.

Visit the [For Providers](#) page and use each health plan's secure provider portal for these functions

Waiver provider claims submission

Check quality scorecards

Access the Pay for Performance (P4P) program

Refer members to care management

View and download a patient panel

[Availity Essentials™](#) functions

Validate member eligibility and benefits

Submit prior authorization (PA) requests and check PA status

Submit claims and check claim status

Correct and resubmit claims

View member gaps in care

Provider Engagement team

Provider Engagement Account Managers and Network Specialists are the primary liaisons between Meridian's health plans and our provider network

Key Reasons to Contact Us

- 1 Help with **secure provider portals**
- 2 Clarification on **reimbursement rates** and **operational policies**
- 3 Support with **escalated claims** questions
- 4 Ask questions about **updating facility and practice information** using the Provider Update Tool or via the universal roster template
- 5 Request **staff education** and in-service training



How to reach us

Our **Waiver Provider Support Team** assists waiver providers across Illinois.

Email us: Waiver_PR_Team@centene.com

Intake form: Get connected to the team member best equipped to assist you with our [online intake form](#).



[Find contact information on our Provider Engagement page](#)

3. Important Procedures and Policies

Member eligibility verification



Verify eligibility at each encounter before rendering services

Request to see the member's ID Card

Check eligibility in **Availity** or the **secure provider portal**

Utilize Illinois' MEDI system at **medi.hfs.illinois.gov**

For **Meridian**, call Member and Provider Services at 866-606-3700*

Check other health insurance ID cards if appropriate

For **YouthCare**, call 844-289-2264 for assistance*



Avoid rejected claims

Member ineligibility for the date of service billed is among the most common reasons for claims rejections

*Member and Provider Services can only give verbal eligibility



Provider updates & roster submissions



All standard requests to update **contracted** provider data are submitted through Meridian's **Provider Updates Tool** at ILmeridian.com/providers/provider-updates.html

Keeping your agency information up to date ensures our Care Management team can facilitate **accurate member referrals**

Address changes

Demographic changes

Update member assignment limitations

Add a new provider or term an existing provider

Make a change to an IRS number

Submit multiple request types (5+)

*Contracted providers should submit an updated roster through the link above using the **IAMHP Universal Roster template***

IAMHP Universal Roster

- Template utilized by all Illinois Medicaid health plans
- Access at iamhp.org/providers under “Quick Links”

Key Contact & Escalation Documents

Resource Documents

COMPREHENSIVE BILLING MANUAL

In partnership with our provider partners, IAMHP and its member plans have developed a Comprehensive Billing Manual to better assist providers:



Health Plan HEDIS® & Quality Resources

Navigate to each plan's page below for up-to-date quality improvement resources.

- [Aetna Better Health of Illinois](#)
- [Blue Cross Blue Shield of Illinois](#)
- [CountyCare](#)
- [Humana](#)
- [Meridian](#)
- [Molina Healthcare](#)

Quick Links

[HFS Managed Care Provider Resolution Portal Link](#)

[HFS & IAMHP Joint Accountability Meeting Material](#)

[Key Contact & Escalation Documents](#)

[MCO Mandated Training Material](#)

[Peer To Peer Review](#)

[Provider Manuals](#)

[Universal IAMHP Roster Template \(Updated 02/12/2026\)](#)


[Communication](#)

→ [Provider Roster Template FAQ's](#)

Update the “GROUP AGENCY DATA” tab

	A	B	C	D	E	F	G	H	I	J
1	Provider Status				Practice Information					
	New/No Change/ Update/ Term	Update Requested-Term from Service location, Add to Group	Effective Date	Change Effective Date	Group NPI	Medical Group Practice Name	Legal Business Name	Primary Taxonomy	Secondary Taxonomy	Additio Taxono
2										
3										
4										
5										
6										
7										
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28										

Find instructions here



Utilization Management (UM)

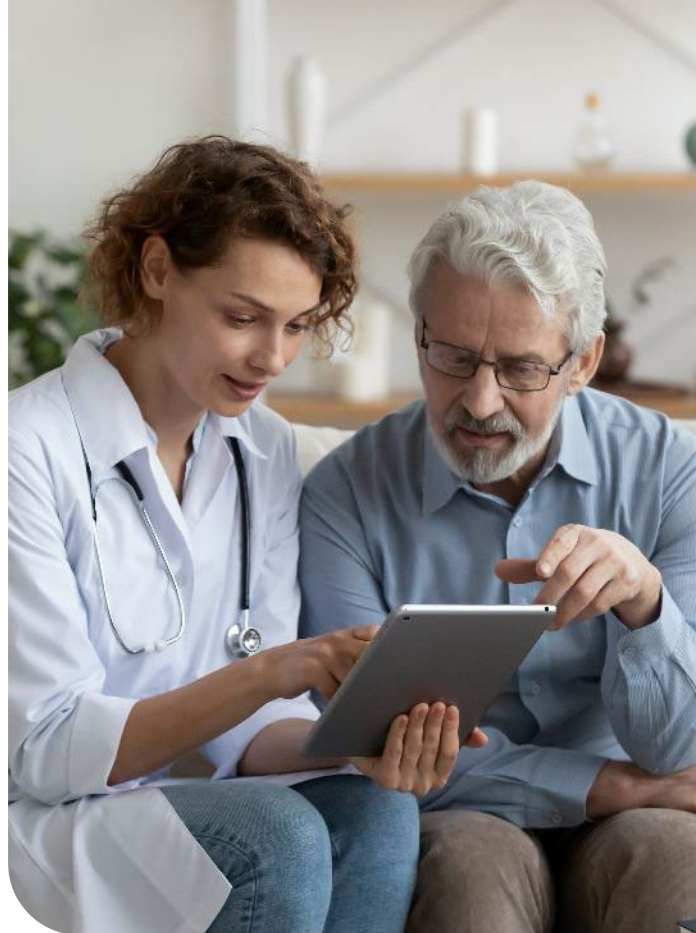


Waiver providers: Contact our LTSSUM@mhplan.com inbox for questions about an existing or recently terminated authorization

Meridian's service authorization program aligns members' plan benefits with evidence-based medical guidelines. To guide the decision-making process, UM applies systemic evaluations to appropriate medical necessity criteria and considers circumstances unique to the member. Meridian's UM program consists of:

- **Pre-Service Review (Prior Authorization)**
- **Concurrent Review**
- **Retrospective Review**

All authorization requests may be emailed, faxed, or submitted through the secure provider portal. PA requests are processed within 5 days of receipt.



4. Waiver Services

HealthChoice Illinois

Home and Community-Based Waiver Programs

Persons
who are
Elderly
(IDoA)

Persons
with
Disabilities
(DRS)

Persons
with HIV or
AIDS
(DRS)

Persons
with Brain
Injuries
(DRS)

Supportive
Living
Program
(SLP)

The SLP waiver only covers services delivered in a licensed residential setting and has unique billing procedures.



Illinois Medicaid Program Advanced Cloud Technology (IMPACT) Registration

- Provider must be registered as an “atypical provider”
- You do not need to register with an NPI

HFS HCBS WAIVER PROVIDER TYPES

HFS Provider Type	HFS Description
090	Waiver service provider—Elderly (IDoA)
092	Waiver service provider—Disability (DHS/DRS)
093	Waiver service provider—HIV/AIDS (DHS/DRS)
098	Waiver service provider—TBI (DHS/DRS)

HFS Legacy Category of Service	IMPACT Subspecialty
090	Case Management
091	Home Maker
092	Agency Providers PA, RN, LPN, CAN, and Therapist
093	Individual Providers PA, RN, LPN, CAN, and Therapist
094	Adult Day Service
095	Habilitation Services
096	Respite care
097	Other HCFA approved services
098	Electronic Home Response/EHR installation

Depending on the agency... that can mean multiple IMPACT registrations!

Tax ID 123456789: Homemakers For You

- Provider Type 90 (IDOA) – Medicaid ID#: 123456789901
- Provider Type 92 (PD) – Medicaid ID#: 123456789201
- Provider Type 93 (HIV/AIDS) – Medicaid ID#: 123456789301
- Provider Type 98 (TBI) – Medicaid ID#: 123456789801

Tax ID 987654321: Caregivers For You

- Provider Type 90 (IDOA) – Medicaid ID#: 987654321901
- Provider Type 92 (PD) – Medicaid ID#: 987654321201
- Provider Type 93 (HIV/AIDS) – Medicaid ID#: 987654321301
- Provider Type 98 (TBI) – Medicaid ID#: 987654321801

Waiver vs. Traditional home health services

The most common combination would be a provider that delivers waiver services and home health, but there can be other combinations. They will be on the IMPACT file with waiver and non-waiver provider types.

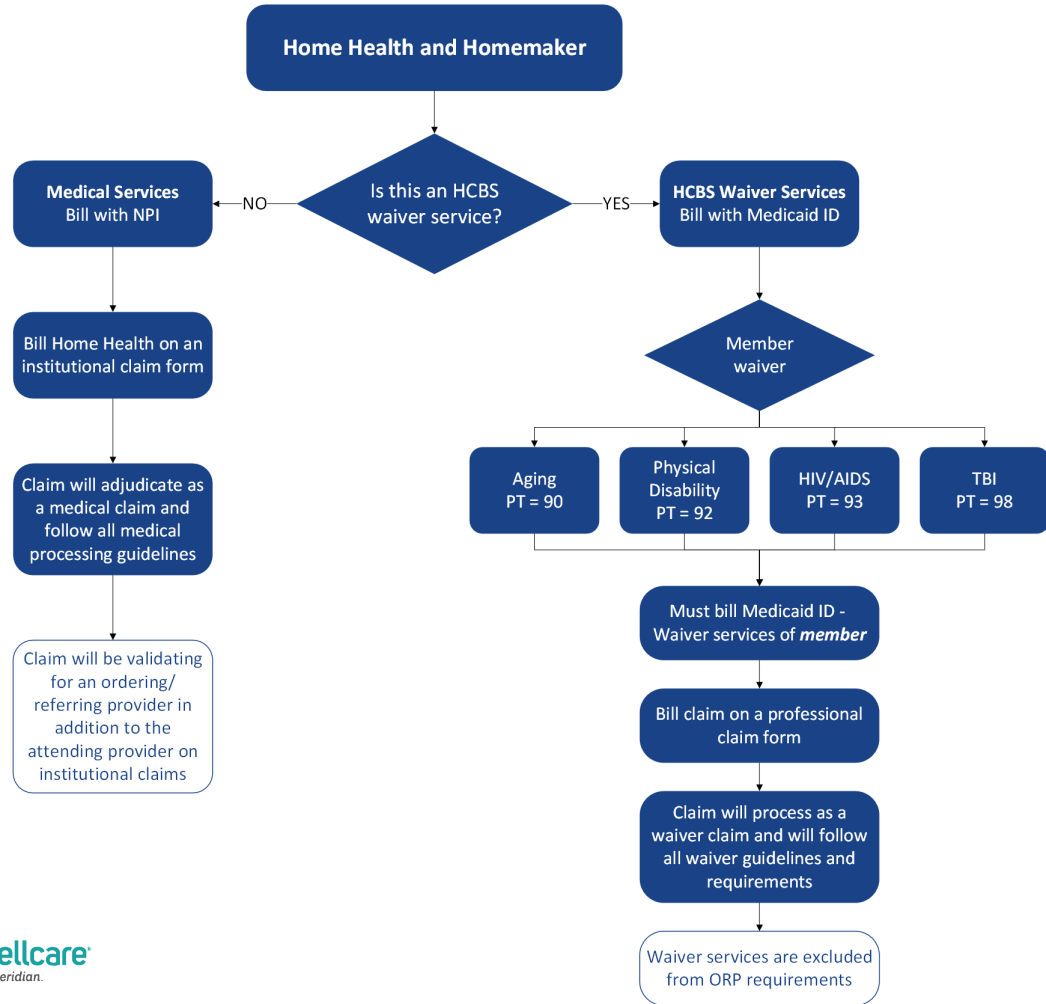
Example — Provider Type 50: Home Health, Provider Type 091: Waiver

Medicaid Number	Provider Name	Provider Type	COS1	COS2	COS3	COS4	COS5	COS6	COS7	COS8	COS9	COS10	COS11
333999333302	ABC Home Helpers	091	041	055	090	091	092	093	094	095	096	097	098
333999333301	ABC Home Helpers	050	010	016	066								

When enrolling, it is important to let Meridian know if you will be billing only waiver services or if other services will be billed, such as traditional home health.

Home health Waiver vs. Non-waiver

Guidance for providers who are registered in IMPACT as both a Home Health provider **AND** as an HCBS waiver provider



5. Electronic Visit Verification (EVV)

What is EVV?

- **Electronic Visit Verification (EVV)** is a timekeeping system that allows Personal Care Service (PCS) or Home Health Care Service (HHCS) workers to use a telephone or mobile application to **record the time they start and stop providing services.**
- **Compliance with EVV is required** for all Medicaid-funded PCS and HHCS through the 21st Century Cures Act.
- **HHAeXchange** is the state's EVV vendor and aggregator; Agencies can use any qualified EVV vendor, but EVV information must still be submitted to HHAeXchange.
- **Find Illinois's EVV policies and requirements on the EVV section of HFS' website.**

EVV Support Options

HFS Resources:

- Illinois EVV Helpline:
1-833-961-7429
- Email:
HFS.EVV@illinois.gov
- [EVV Updates and FAQs](#)

Meridian EVV Support:

- Email:
MeridianEVV@centene.com

6. Billing and Claims

Billing and Claims

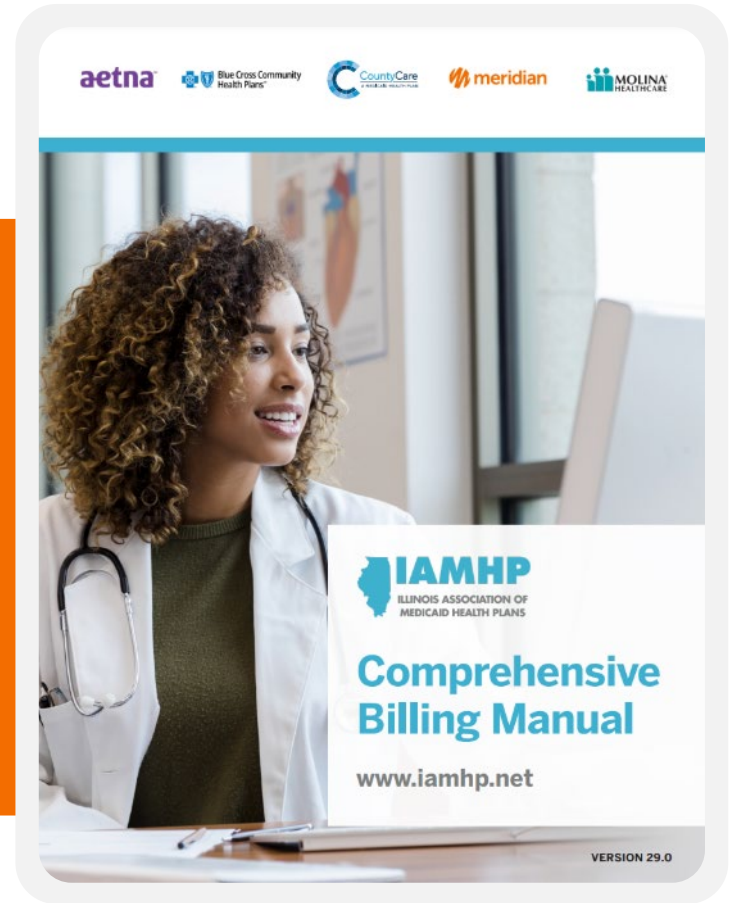
IAMHP billing manual

Your source for current, comprehensive guidelines



The Illinois Association of Medicaid Health Plans (IAMHP) Comprehensive Billing Manual is the best resource for detailed billing guidelines that are regularly updated.

Learn more at [iamhp.org/providers](https://www.iamhp.org/providers)



Coding and submitting a claim

The timely filing limit is **180 days** from the date of service

Follow General Claim Submission Guidelines in the **IAMHP Billing Manual**

File using either the **837P** or a **CMS-1500** paper claim (SLF providers will use the 837i for institutional billing)

Do not put an NPI on the claim. Use the **Medicaid Provider ID#** that matches the member's waiver type.

For Elderly Waiver members, ensure you bill with the Medicaid ID# **corresponding to the member's Planning and Service Area (PSA)**

Although Categories of Service (COS) are not directly added to a claim, specialties and subspecialties billed on the claim **MUST match the provider's registration in IMPACT**

Claims Filing Options



Electronic clearinghouse (EDI partner)



Secure provider portal



Paper claims

Claims submission: Electronic clearinghouse (EDI)

Availability

Customer Support:
800-282-4548

Claim Types:
Professional/Facility

Product	Payer ID
Meridian	MHPIL*
Wellcare Meridian Dual Align (HMO D-SNP)	68069
YouthCare	68069

**Providers utilizing Change Healthcare as their clearinghouse must submit with Payer ID MCCIL*

PaySpan: Meridian's free ERA and EFT solution

Settle claims electronically through Electronic Fund Transfers (EFTs) and Electronic Remittance Advices (ERAs)

- **Improve cash flow** by receiving payments faster
- **Eliminate re-keying of remittance data** by choosing how you want to receive remittance details
- **Create custom reports**
- **Maintain control over bank accounts** by routing EFTs to the bank account(s) of your choice
- **Match payments to advices quickly**, and easily re-associate payments with claims
- **Connect with multiple payers** using PaySpan to settle claims
- **Continuity of Care** provider payments for Centene will be administered via PaySpan

PaySpan
Resources



- **Getting started with PaySpan**
- **PaySpan online login & registration**
- **Registration assistance:**
 - 877-331-7154, option 1
 - providersupport@payspanhealth.com

Billing and Claims



Secure provider portal

The screenshot shows the Meridian Secure Provider Portal dashboard. At the top, there is a navigation bar with the Meridian logo and icons for Eligibility, Patients, Authorizations, and Claims. Below the navigation bar, there is a search area with a dropdown for TIN, a dropdown for Plan Type (set to IL Medicaid), and a GO button. The main content area is divided into several sections: a prominent orange banner for 'GET PATIENTS READY TO RENEW' with a warning about redetermination; a 'Welcome' section with a list of links (Add a TIN to My ACCOUNT, Reports, Patient Analytics--Coming Soon, Provider Analytics-); a 'Quick Eligibility Check' section with input fields for Member ID or Last Name and Birthdate, and a 'Check Eligibility' button; a 'Recent Claims' section showing 'No Data Found'; and a 'Quick Links' section with various resource links like Provider Manual, Billing Manual, and Provider Documents and Forms.



Paper claims

While electronic claim submission is preferred, paper claims can be submitted by **mail to:**

Meridian Claims Department
P.O. Box 4020
Farmington, MO 63640-4402

Understanding claims requirements

Clean claim

A clean claim is received in a nationally accepted **format in compliance with standard coding guidelines**, and requires no further information, adjustment, or alteration for payment

Explanation of Payment (EOP)

A claim will be paid or denied with an **Explanation of Payment (EOP)** mailed to the provider who submitted the original claim

BILLING PROHIBITIONS

- Providers may not bill members for services when the provider **fails to obtain authorization** and the claim is denied
- **Dual-eligible members** are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance, and copayments.
- Providers **may not balance bill** members

Claims submission as a waiver provider

- Claims should always be billed on a CMS-1500 or 837P with the Medicaid number in Box 33b or Loop 2010BB
- You must use the G2 Qualifier in Box 33b or Loop 2010BB along with your Medicaid number
- Do not use **G2 Qualifier twice**:
 - *Correct format*
G23339992201
 - *Incorrect Format*
G2 G23339992201

Example of a correctly billed claim

MM	DD	YY	MM	DD	YY	SERVC	EMG	OPTNSPCS	MODIFIER	POSTER	\$ CHARGES	OR UNITS	Qty/Pr	MT QUAL	PROVIDER ID #				
07	01	21	07	09	21	12		S5130		A	702	00	120	NPI					
HOMEMAKER SERVICE NOS PER 15 MEN																			
1																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER						SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For print claims, see tab 1)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Pkgs for NUCC Use		
123456789								[REDACTED]			YES NO		\$ 702 00 \$						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse so apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH#							
Signature on File.						ABC Home Helpers 123 Main Street Chicago, IL 60601						ABC Home Helpers 123 Main Street Chicago, IL 60601							
SIGNED						DATE						a NPI		b NPI		G2 33399933301			
NUCC Instruction Manual available at: www.nucc.org																			
PLEASE PRINT OR TYPE																			
APPROVED CMB-0936-1197 FORM 1500 (02-12)																			

How to enter a HFS Medicaid ID# in the secure provider portal

- When utilizing the Meridian secure provider portal, only enter the Medicaid number in the billing loop – leave the NPI and taxonomy blank
- There is no need to enter the G2 qualifier when using the portal; it is added behind the scenes

The screenshot displays a multi-step form for provider information. The 'Billing Provider' section (step 33) is highlighted. It contains the following fields:

- Tax ID: 262338882
- Name*: ABC Waiver Provider
- NPI: (empty)
- Medicaid Provider #: 123456789001
- Taxonomy*: (empty)
- Address*: (empty)
- City*: (empty)
- State*: (dropdown menu)
- Zip*: (empty)

The 'Service Facility Location' section (step 32) is also visible, with a 'Same As Billing Provider' button. It includes an 'Ambulance' section with 'Yes' and 'No' radio buttons, and fields for Name, NPI, Address, City, State, and Zip.

Avoiding common claims rejections & denials

Rejection

Claim that **never enters the Meridian claim system** because of invalid or missing data elements.

Rejected claims will receive a claim number and are reported back to the clearing house or provider.

Denial

Claim that has **passed minimum edits** and is entered into the system but was **billed with invalid or inappropriate information**, causing the claim to be denied.

An explanation of payment (EOP)/835 will be sent that includes the denial reason.



All electronic and paper claims **must include the taxonomy code**, appropriate Medicaid ID#, and provider TIN for services as registered in IMPACT

- Reference the HFS *Handbook for Electronic Processing*



Taxonomy code on the claim **must match the taxonomy code Meridian has on file** for the rendering provider



Rejected claims must be resubmitted as a first-time claim within the timely filing guidelines



Verify member eligibility for DOS billed using the HFS MEDI system

Claims disputes and reconsiderations

- Claim disputes must be filed **within 90 days of the remittance date**
 - 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, Meridian will respond within 30 days of receiving the requested information
- **If the original determination is overturned**, the provider will see payment details on the EOP

Guidance on claim disputes

- **Submit via the provider portal** (preferred) or by mailing a Provider Claim Dispute form (*see provider manual*)
- All dispute determinations are final
- If a provider disagrees with Meridian's determination regarding a dispute, they may pursue arbitration options as outlined in the provider manual

7. Supportive Living Facilities (SLF) Special Billing Considerations

Supportive Living Facilities (SLF)



Provider Type 87 LTC –
Supportive Living Facility
(Waivers)



The **Patient Credit File** is the **source of truth** submitted to Meridian weekly by HFS. The PCF incorporates data regarding eligible services rendered to an MCO's membership for a rolling 36-month period.



All SLF claims must be billed in an electronic format using the HIPAA10 837i format

Details from the IAMHP Comprehensive Billing Manual

Form Locator Field	Explanation	Completion Needed	Comments
01	Provider Name	Required	
02	Pay-To Name and Address <i>Required if the Pay-To NPI is different than the Billing Provider</i>	Conditional	4-digit code required 089X X= 1 for admit through discharge X=2 first claim in a series (discharge status = 30) X=3 ongoing series claims (discharge status = 30) X=4 final series claim (discharge status not equal to 30) X=7 for corrected claim
04	Type of Bill	Required	
05	Federal Tax ID	Required	
06	Statement Covers Period	Required	Billed in no more than a 1-month increment
12	Admission Date	Optional	
17	Patient Discharge Status	Required	Examples include but are not limited to: 01= Discharge to home or self-care 03= Discharged to a Skilled Nursing Facility 20= Expired (patient died) 30= Still a patient

Details from the IAMHP Comprehensive Billing Manual (cont.)

Form Locator Field	Explanation	Completion Needed	Comments
31-34	Occurrence Code	Conditional	
35-36	Occurrence Span Code	Conditional	74 only when billing a LOA Must have a LOA revenue code on the claim 018x
39-41	Value Codes	Required	<p>80= must equal “covered days” 81= any non-covered days and all LOA days (whether payable or not)</p> <p>Example 1: 3/1 – 3/31/19 No LOA days, therefore value code 80 should be reported with a unit value of 31</p> <p>Example 2: 3/1 – 3/31/19 5 LOA days, therefore value code 80 should be reported with a unit value of 26 and value code 81 should be reported with a unit of 5 and the required Occurrence Code and/or Occurrence Span Code</p> <p>Both scenarios created a total of 31 units</p>

Details from the IAMHP Comprehensive Billing Manual (cont.)

Form Locator Field	Explanation	Completion Needed	Comments
42	Revenue Codes	Required	<p>Rev code 0240: All-inclusive Ancillary General Services Rev code 0182: Leave of Absence Patient Convenience Rev code 0183: Leave of Absence Therapeutic Leave Rev code 0185: Hospitalization</p> <p>Leave of absence revenue codes are reimbursed as follows:</p> <ul style="list-style-type: none"> • Days 1-30 reimbursable each SFY (July – June) • Days >30 not reimbursable each SFY (July – June) <p>SLFs receive a total of 30 payable LOA days per fiscal year, regardless of type. Any LOA days exceeding 30 should be priced at \$0.00. 0185 days are included in the payable LOA count.</p>
44	HCPCS/Accommodation Rates	Optional	
45	Service Date	Required	When there is a LOA, must group service dates, rev codes, together when consecutive
46	Service Units	Required	Each unit is defined as a calendar day and should match the billed units in the span/day
47	Total Charges (By Rev Code Category)	Required	

Details from the IAMHP Comprehensive Billing Manual (cont.)

Form Locator Field	Explanation	Completion Needed	Comments
48	Non-Covered Charges	Conditional	
50	Payer	Required	Name of Managed Care Organization (MCO)
51	Health Plan Identification Number	Conditional	Not applicable for SLF
54 A, B	Prior Payments	Conditional	Not applicable for SLF
56	NPI of Billing Provider	Required	NPI of the Billing SLF Provider
57	Other (Billing) Provider Identifier	Optional	HFS legacy provider number
58	Insured's Name	Required	Member's name as it appears in MEDI
60	Recipient ID number	Required	MCO member ID
64	Document Control Number	Conditional	If submitting a corrected claim, include the previous claim number here
67	Principle Diagnosis Code and Present on Admission Indicator	Required	Enter the ICD-10 code Present on Admission is NOT required for SLF
67 A-Q	Other Diagnosis Codes	Conditional	If multiple Dx on the claim, ok to include

Details from the IAMHP Comprehensive Billing Manual (cont.)

Form Locator Field	Explanation	Completion Needed	Comments
69	Admitting Diagnosis Code	Required	ICD-10 code
72 A-C	External Cause of Injury	Conditional	Include the ICD-10 when there is an external cause of injuries, poisoning, or adverse effect
76	Attending Provider Name and NPI	Required	Include the NPI of the attending provider
81	Taxonomy Number	Required	COS 86 Dementia Care: 311500000X COS 87 SLF (Waivers): 310400000X

8. Resources to Support You and Your Agency

Care coordination

Connecting members with chronic conditions to care coordinators for ongoing support

1 What is Care Coordination?

Our Care Coordination program **helps members connect to care they need.**

- All members are eligible
- Members with certain health conditions are proactively engaged to enroll

2 Who can benefit?

Care Coordination can benefit everyone. It's especially helpful for members with:

- **Chronic health problems**
- **Disabilities**
- **Difficulty accessing care**
- **Special care needs**
- **Multiple providers**

3 Why choose Care Coordination?

Care Coordinators can

- **Work** with members on a plan to meet their healthcare needs
- **Help** members understand their coverage
- **Connect** members with community resources
- **Be an advocate**



How do providers refer a member? Notify us through the **secure provider portals** or **fax** a completed [care coordination referral form](#)

Language services

Facilitating clear communication with all members

Meridian provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

Alternative formats are available to help members with different reading skills, backgrounds, or disabilities understand Meridian materials

- Contact Meridian for interpretation services in American Sign Language (ASL) for people who are deaf or hard of hearing



Call Member & Provider Services at 866-606-3700 (TTY: 711) to inquire about interpretation services or alternative formats

Resources to Support You

Centene Institute for Advanced Health Education

No-cost continuing education for all providers

- **Unlimited access** to dozens of accredited continuing education courses, **available online 24/7**, informed by the latest research, **designed and delivered by experts**
- Several courses are eligible for **continuing education credit** in accordance with regulations established by:
 - Accreditation Council for Pharmacy Education (ACPE)
 - American Medical Association (AMA PRA Category 1 Credit(s)™)
 - American Nurses Credentialing Center (ANCC)
 - American Psychological Association (APA)
 - Association of Social Work Boards (ASWB)
 - Commission for Case Manager Certification (CCMC)
 - Commission on Dietetic Registration (CDR)
 - Interprofessional Continuing Education (IPCE)



[Explore Centene Institute course catalog](#)

8. Required Annual Training

Required annual training & attestation

Required *every* year, for *every* contracted provider

Fraud, Waste, and Abuse (FWA)

Your role in preventing and detecting FWA

Cultural Competency

Ensuring the delivery of services that are responsive to a diverse patient population

Critical Incidents

How to recognize and report instances of member abuse and neglect



Have you completed mandatory training with us or another health plan?

Email your completed Mandatory Training Attestation form (PDF) to ILproviderrelations@mhplan.com or send it to us via **mail** or **fax** (see provider manual)

Fraud, waste, and abuse

Fraud is an **intentional deception** or **misrepresentation** made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person

Waste is an **overutilization of services or other practices** that, directly or indirectly, result in unnecessary costs to the healthcare system, including Medicaid and Medicare programs

Abuse includes **actions that are inconsistent with sound fiscal, business, or medical practices**, resulting in unnecessary cost to Medicaid and/or Medicare programs including payment for services that are not medically necessary or that fail to meet professionally recognized standards for health care



How to Report FWA

By phone:

24/7 to the confidential FWA hotline
at **1-866-685-8664**

By email:

special_investigations_unit@centene.com



[Access Meridian's FWA training](#)

Required Annual Training

Culturally appropriate care & health equity

Analyze how **addressing culture in healthcare** can improve patient care, safety, and experience

Define **unconscious bias** and its potential impact on patient health outcomes

Explore the **intersectionality** between unconscious bias, culturally appropriate care, and health equity

Centene Institute
FOR ADVANCED HEALTH EDUCATION



Access on-demand course
via the Centene Institute*

**Providers may be able to earn continuing education credits following course completion*

Critical incidents

Critical Incidents are classified as:

Abuse: Injury inflicted on an individual
other than by accidental means

Physical

Sexual

Emotional

Verbal

Neglect: Failure to provide someone with, or withholding someone of, **the necessities of life**

Exploitation: Unfair treatment of someone, or the use of a situation to **personally benefit**



It is everyone's responsibility to report critical incidents

Send a completed Critical Incident & Significant Event Intake Form (PDF) via secure email to criticalincidents@mhplan.com **immediately following the discovery of the incident**



Access Critical Incidents training

9. What's Next?

Tools & resources to explore and bookmark

[Meridian For Providers website](#)

Find resources and quick links to manuals, reference guides, forms, etc.

[Secure Provider Portals](#)

Complete essential clinical and operational functions

[Provider Updates Tool](#)

Submit rosters and practitioner changes online

[Provider Engagement](#)

Find available support options and Provider Engagement team contact information

[Provider Education](#)

Discover training opportunities on a variety of topics and sign up for upcoming webinars

[Provider Notices](#)

View recent provider notices and health plan news

[IAMHP Billing Manual](#)

Comprehensive billing resource with detailed guidance for HCBS waiver providers

[HFS IMPACT](#)

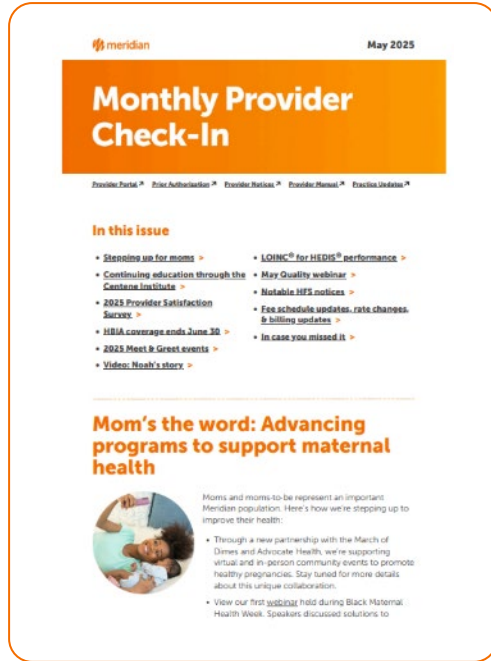
Illinois Medicaid provider enrollment and credentialing system

[HFS Electronic Visit Verification \(EVV\)](#)

State policies and resources related to EVV

The *monthly provider check-in*

Stay abreast of plan updates, manual releases, and news



Ensure we have the correct email address on file



Get timely news from Meridian



Q&A

Thank you