



provider manual

Revised September 2022



[ILmeridian.com](https://ilmeridian.com)

Dear Medicaid Provider,

Welcome to the Meridian network of providers. Our provider manual is a reference tool for you and your staff, designed to assist you in understanding plan policies, procedures, and other protocols for Meridian Medicaid Plan (Meridian) and Meridian Managed Long Term Services & Supports (MLTSS).

The provider manual is a dynamic tool. Additional billing information can also be found in the [Illinois Association of Medicaid Health Plans \(IAMHP\) Comprehensive Billing Manual](#).

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 updates and revisions will be communicated to you via a revised edition of the provider manual. The revised edition will replace older versions of the provider manual. Any material modifications to the provider manual shall be communicated to you with a 30-day written notice.

The provider manual is available on our website at ILmeridian.com.

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

Thank you for your participation.

Meridian

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SECTION 1:

General Information

Our Mission, Vision, and Philosophy

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

About Meridian

Meridian provides government-sponsored, managed healthcare services to families, children, seniors, and individuals with complex medical needs throughout Illinois. We currently manage the care of more than 900,000 Medicaid members throughout the state as contracted by the Illinois Department of Healthcare and Family Services (HFS). We offer HealthChoice Illinois, Managed Long Term Services and Supports (MLTSS), and Medicare Medicaid Alignment Initiative (MMAI) plans, and also manage the YouthCare program for children in the foster care system.

Meridian is a wholly owned subsidiary of Centene Corporation, a leading multi-national healthcare enterprise committed to helping people live healthier lives. Centene offers affordable and high-quality products to nearly 1 in 15 individuals across the nation, including Medicaid and Medicare members (including Medicare Prescription Drug Plans) as well as individuals and families served by the Health Insurance Marketplace, the TRICARE program, and individuals in correctional facilities. Centene focuses on long-term growth and the development of its people, systems and capabilities so that it can better serve its members, providers, local communities, and government partners.

Key Contact Information

Contact and Service Function	Telephone Number
Behavioral Health <ul style="list-style-type: none"> Inpatient and Outpatient Mental Health Substance Abuse Treatment 	866-606-3700 (TTY: 711)
Illinois Client Enrollment Broker (ICEB) <ul style="list-style-type: none"> Managed Care Enrollment Questions 	877-912-8880 (TTY: 866-565-8576)
Illinois Relay Services	711
Member Services <ul style="list-style-type: none"> General Information and Assistance Verify Member Eligibility Benefit Information Claims Status File Grievances Verify/Report Newborn Information Coordination of Benefits Interpretation Services 	Medicaid 866-606-3700 (TTY: 711) MLTSS 866-821-2308 Hours of operation: Monday through Friday, 8 a.m. to 5 p.m.
Pharmacy <ul style="list-style-type: none"> Pharmacy and Formulary Questions and Concerns Pharmacy-Utilization Management Information 	Medicaid 855-580-1688
Provider Services <ul style="list-style-type: none"> Fee Schedule Assistance Claims and Billing Questions Contractual Issues Initiate Affiliation, Disaffiliation, and Transfers 	866-606-3700 (TTY: 711) Hours of operation: Monday through Friday, 8 a.m. to 5 p.m.
Quality Improvement <ul style="list-style-type: none"> Request Clinical Practice Guidelines Request Preventive Healthcare Guidelines Quality Initiative Information Quality Regulatory Requirements Disease Management Program Information 	866-606-3700 (TTY: 711)
Transportation <ul style="list-style-type: none"> Member Non-Emergent Transportation 	866-796-1165
Utilization Management <ul style="list-style-type: none"> Submit Prior Authorizations Notification of Emergent and Urgent Hospital Admissions Requests for Clinical Criteria Peer-to-Peer Discussions Discharge Planning Information 	866-606-3700 (TTY: 711)
Care Coordination and Long Term Services and Supports <ul style="list-style-type: none"> Speak to a Member's Care Coordinator Request Individualized Plans of Care Check Waiver Eligibility Information 	866-606-3700 (TTY: 711)

SECTION 2:

Provider Functions and Responsibilities

Provider Roles and Responsibilities

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

CMS requires providers to provide care to members in a culturally competent manner, being sensitive to language, culture, and reading comprehension capabilities. Meridian offers interpreter services to any non-English speaking member. There is no charge to access this service. To take advantage of free interpretation services, simply call Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. and ask for an interpreter.

Meridian promotes shared decision making by encouraging providers to freely communicate with patients regarding treatment regimens, including medication treatment options, regardless of benefit coverage limitations.

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 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 necessary to support care coordination

Annual mandatory training modules are available online by visiting Meridian's website at 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: **833-560-2915**

Email: ilproviderrelations@mhplan.com

Mail: **Meridian**

Network Development – Attestation

1333 Burr Ridge Parkway, Suite 100

Burr Ridge, IL 60527

In addition, the Provider Relations department holds monthly provider and staff training webinars. If you would like to request a training session or participate in one of Meridian's scheduled sessions, please call your Provider Relations Representative or the Member and Provider Services department at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. or via email to ProviderHelp.IL@mhplan.com.

Home and Community Based Services (HCBS) Provider Responsibilities

Service Requirements for HCBS providers:

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

In the event a member is admitted to the hospital or a facility setting, HCBS providers will notify Meridian Care Management staff the same day they are aware of the admission.

HCBS providers must comply with Critical Incident reporting and management requirements. See the "Provider Critical Incident Reporting" section.

Provider Enrollment, Credentialing, and Re-Credentialing

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

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

In addition to providers being credentialed through the IMPACT system, Meridian shall require other enrollment information in order to enroll providers into Meridian Medicaid. Enrollment data shall be submitted to Meridian by the provider via the Illinois Association of Medicaid Health Plans (IAMHP) Universal Roster.

IMPACT Enrollment

Providers wishing to participate with Meridian or non-contracted providers seeking reimbursement must be enrolled with HFS' IMPACT system to provide services to members. If you are already enrolled with IMPACT, simply contact the Network Development department at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. or send an email to ILcontracting@centene.com to obtain a contract for participation and enrollment criteria. Interested providers can also visit ILmeridian.com to obtain detailed instructions on how to enroll in IMPACT, access links to the appropriate paperwork, and get directions on where to send the completed forms.

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

Illinois Department of Healthcare and Family Services

Provider Participation Unit

PO Box 19114

Springfield, IL, 62794-9114

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

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

Directory Display

Meridian follows National Committee for Quality Assurance (NCQA) guidelines, displaying only those practitioner types that offer scheduled appointments in their office. Practitioners who provide services as the result of seeing a patient in a facility setting are not displayed in the directory.

Practitioner specialties not displayed in the directory include but are not limited to:

- Emergency Medicine
- Radiology
- Anesthesiology (excluding Pain Management)
- Pathology
- Practitioners who practice exclusively in a facility setting

Timely Notification of Provider Updates

Please let Meridian know when there are changes to any information regarding individual practitioners or your group to ensure that members can easily access services with your practice. Meridian would also like to remind providers and practitioners that any updates submitted to Meridian should also be reported to the Illinois Healthcare and Family Services.

Provider Data Validation

Providers should validate the Meridian Find a Provider (FAP) online directory information at least quarterly for accuracy and completeness. Providers must notify Meridian of changes needed as soon as possible. This should occur via the [Provider Updates page](#).

These include, but are not limited to:

- Change in office location(s), office hours, phone, fax, or email
- Change in practice name, Tax ID, and/or National Provider Identifier (NPI)
- Addition or closure of office location(s)
- Opening or closing your practice to new patients (PCPs only)
- Addition or termination of Provider(s) (within an existing clinic/practice)
- Any other information that may impact Member access to care

Submission of Provider Updates

Meridian offers most provider enrollment and update processes via the [Provider Updates page](#), as stated above, including:

- Request for a new contract
- Enrolling a practitioner to an existing contract
- Demographic updates, including address changes, panel updates, terminations, etc.

Provider Data Accuracy

Meridian is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we, or an authorized vendor, may reach out to our network of providers through various methods, such as letters, phone campaigns, email outreach, etc. Providers are requested to supply timely responses to these communications, so as to enhance prompt member access to care.

Provider Enrollment FAQs

Time Frame of the Enrollment Process

Once the Meridian Provider Network department has received a *complete* contract with necessary accompanying documentation, the entire loading process should be complete within 30 days and includes the notification to the practitioner in writing of the provider enrollment to the provider network.

Checking the Status of a Contract

Providers can check on the status of their contract application by contacting the Meridian Provider Services department at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m.

Submission of Full Provider Roster

Providers are encouraged to submit the [IAMHP Universal Roster](#) on a monthly or quarterly basis, with all current provider, group, and facility detail to the ilrostersubmission@mhplan.com inbox.

Primary Care Providers/Patient-Centered Medical Homes

Meridian promotes and encourages the Patient Centered Medical Home (PCMH) model of care delivery. In this system, the PCP is responsible for the comprehensive management of each member's health care. This may include, but is not limited to, ensuring that all medically necessary care is made available and delivered to facilitate continuity of member health care and to promote and deliver the highest quality health care per Meridian standards.

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

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

Identification of Medical Homes

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

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

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

Assessment and Support of Medical Homes

A. Assessment

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

B. Support

Meridian will support Medical Homes in their efforts to actively engage with patients in need of care management by including providers in Interdisciplinary Care Teams, which function to coordinate member care across the full spectrum of available services and manage transitions between levels of care. Meridian will embed Care Coordinators (as appropriate) onsite at FQHCs, CMHCs, and high-volume providers to support the integration of behavioral and physical health care, if providers request this service

- Meridian's Provider Relations department, in collaboration with the Quality Initiative department, will educate Medical Homes on methods to improve care capacity and capabilities to provide wellness programs, preventive care, management of chronic health conditions and coordination, and continuity of care through orientation, office visits, the provider manual, provider newsletters, provider mailings, fax blasts, and website updates
- Meridian will provide general guidance or access to resources to practice utilization as part of the Medical Home's transformation and improvement efforts
- Health Information Technology (HIT) – Medical Homes will be supported by HIT, including but not limited to, electronic transfer of data and the Meridian Provider Portal
 - Medical Homes will meet federal requirements for meaningful use and agree to share quality and other clinical data
 - Medical Homes will have access to electronic medical record data collection to support quality improvement
 - Medical Homes will have access to Meridian's secure provider portal, which allows for electronic features, including but not limited to:
 - Verification of eligibility
 - Authorizations
 - Claims status and submission/correction
 - Member information and reports
 - Enrollment lists
 - HEDIS® bonus information
 - HEDIS self-reporting
 - Requests for HEDIS postcards

Specialty Care Providers

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

- Rendering covered services requested by the PCP
- Timely Communicating with the PCP regarding findings and recommendations in writing
- 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 prior-authorization number
 - The member's ID number
 - Comply with Meridian policies and procedures

Hospital Providers

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

- Coordination of discharge planning with Meridian staff
- Coordination of mental health/substance abuse care with the appropriate state agency or provider
- Obtaining the required prior authorization before rendering services
- Communication of all pertinent patient information to Meridian and the PCP
- Communication of all hospital admissions to the Meridian Utilization Management staff within one business day of admission
- Issuing all appropriate service denial letters to identified members
- Maintain medical and administrative records related to items and services provided to members
- Actively monitoring patient safety and addressing member, plan, provider, or community concerns regarding safety of care through robust root cause analysis process with delivery of action plan or quality improvement plan to all stakeholders
- Addressing whole person need for the members whenever possible with health plan and community-based resources

Ancillary Providers

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

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

Member Access and Availability Guidelines

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

Guidelines:

1. Providers must be available to address member/patient medical needs on a 24-hour a day, seven-day a week basis. The provider may delegate this responsibility to another Meridian physician or provider on a contractual basis for after-hours, holiday, and vacation coverage.
2. If the provider site utilizes a different contact phone number for an on-call or after-hours service, the provider site must provide Meridian with the coverage information and the contact phone or beeper number. Please notify the Meridian Provider Services department with any changes in provider medical care coverage.
3. Providers may employ other licensed physicians who meet the credentialing requirements of Meridian for patient coverage as required and necessary. It is the responsibility of the provider to notify Meridian each time a new physician is added to a provider's practice to assure that all physician providers are credentialed to Meridian standards. Providers may employ licensed/certified Physician Assistants (PAs) or Registered Nurse Practitioners (RNPs) to assist in the care and management of their patient practice.
4. Non-professional healthcare staff shall perform their functions under the direction of the licensed provider, credentialed physician, or other appropriate healthcare professionals such as a licensed PA or an RNP

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

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 appointment availability standards must also be met.

Office Visit Appointments

PCP Appointment Availability Standards (Excludes OB/GYNs)

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

Behavioral Health Appointment Availability Standards

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

Specialty Care Providers Appointment Availability Standards

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

After Hours Access Standards

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

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

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

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

Physician Intent to Discharge Member from Care

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

Confidentiality and Accuracy of Member Records

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

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

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

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

Obligations of Recipients of Federal Funds

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

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

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

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

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

Fraud, Waste, and Abuse

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

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

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

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

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

Examples of Fraud, Waste, and Abuse:

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

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

Non-Discrimination

Providers shall not unlawfully discriminate in the acceptance or treatment of a member because of the member's race, color, religion, sex, sexual orientation, gender identity, national origin, ancestry, age, or physical or mental disability, or such other categories of unlawful discrimination as are or may be defined by federal or state law.

Advance Directives

Advanced directives are an individual's written directives or instructions for the provision of that individual's healthcare if the individual is unable to make his or her healthcare wishes known. There are three main types of advance directives in Illinois:

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

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

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

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

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

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

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

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

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

In addition to an advance directive, members may ask their providers about a **Do-Not-Resuscitate (DNR) order**. A DNR order is a medical treatment order stating that cardiopulmonary resuscitation (CPR) will not be attempted if the member's heart and/or breathing stops.

If there are any questions about Meridian's Advance Directives policy, members and providers may call Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m.

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

Department of Financial and Professional Regulation

Division of Professional Regulation

Complaint Intake Unit

100 West Randolph Street, Suite 9-300

Chicago, IL, 60601

Phone: **312-814-6910**

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

Illinois Department of Public Health

Office of Health Care Regulations

Central Complaint Registry

525 W. Jefferson Street, Ground Floor

Springfield, IL, 62761

Phone: **800-252-4343**

Members can also visit the Illinois Department of Financial and Professional Regulation (IDFPR) website at <https://www.idfpr.com/Admin/DPR/Complaint.asp> to file complaints online.

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

Illinois Department of Insurance

320 West Washington Street

Springfield, IL, 62767-0001

Phone: **866-445-5364** (toll-free)

TDD: 217-524-4872 or Fax: **217-558-2083**

<https://mc.insurance.illinois.gov/messagecenter.nsf>

SECTION 3:

Member-Related Information

Member and Provider Services Department

Member and Provider Services is available to respond to questions about Meridian benefits, policies, and procedures.

Member and Provider Services Representatives are available Monday through Friday, 8 a.m. to 5 p.m. to assist with questions and resolve issues related to the following:

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

Member Rights and Responsibilities

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

Members Have the Right to:

- Be treated with respect and dignity at all times
- Be protected from discrimination and file or appeal any complaints of discrimination on the basis of race, color, national origin, age, or disability in the receipt of health services
- Have their personal and health information kept private
- Receive information from Meridian, Meridian providers and Meridian contractors in a manner they can understand
- Receive all of the services that Meridian is required to provide
- Have their questions about Meridian answered
- Have access to doctors, other healthcare providers, specialists and hospitals
- Learn about treatment choices in a manner they can understand and participate in treatment decisions, including the right to refuse treatment

- Formulate advance directives
- Receive emergency care when and where they need it
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive a decision about healthcare payment, coverage of services and prescription drug coverage
- Request a review (appeal) of certain decisions about healthcare payment, coverage of services and prescription drug coverage
- Request and receive a copy of their medical records, and request that their medical records be amended or corrected
- Exercise their rights without fear of retaliation from Meridian or Meridian providers
- File complaints (grievances), including complaints related to the quality of the care they receive

Members Have the Responsibility to:

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

Eligibility

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

- Request to see the member's Meridian member ID card (and other health insurance ID cards if appropriate) at each encounter
- Check eligibility in Meridian's Provider Portal
- Review your PCP monthly eligibility report or verify the member's eligibility online through Meridian's Provider Portal each time the member appears at the office for care or referrals
- Call our Member and Provider Services department at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. for assistance with eligibility determinations

Member and Provider Services can only give verbal eligibility verification.

If you find any discrepancies in the information on either the member's Meridian member ID card and/or your monthly eligibility report, contact our Member and Provider Services department at **866-606-3700 (TTY: 711)** for further assistance.

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

- Calling Meridian's Eligibility Self-Service Application by dialing **866-606-3700 (TTY: 711)** and following the directions as prompted. The system will then verify if the member is eligible on the date of service indicated, and/or
- Utilizing the State of Illinois' HFS MEDI website at www.myhfs.illinois.gov/

Member Identification


All Meridian members receive a Meridian member ID card that includes the following information:

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

PCP Identification

PCP and contact information can be found on back of the Meridian member ID card.

Sample Medicaid ID Card (Front)

	1333 Burr Ridge Parkway Suite 100 Burr Ridge, IL 60527
Member Name: Plan Name: HealthChoice Illinois Medicaid ID: Effective Date: Member Services: 866-606-3700 (TTY: 711)	
<hr/>	
RxBIN: 004336 RxPCN: MCAIDADV Group: RX5491 Pharmacy Help Desk: 888-624-1145	

Sample Medicaid ID Card (Back)

PCP: Phone:
<hr/>
Send claims to: Meridian PO Box 4020 Farmington, MO 63640-4402
<hr/>
24/7 Nurse Advice Line: 866-606-3700 Behavioral Health: 866-606-3700 Dental: 866-245-2770 Transportation: 866-796-1165

PCP Changes

Meridian members can call the Member and Provider Services department at **866-606-3700 – (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. to request a PCP change or request the change through Meridian's Member Portal. Providers may also elect to complete a Primary Care Provider Reassignment Form and fax it to **844-751-1870**. The form is available online by visiting ILmeridian.com, "Manuals, Forms and Resources" then "Documents and Forms." Please note: PCP changes may take 24 to 48 hours to update on the member and provider portals.

Interpretation Services and Alternative Formats

Meridian can arrange for an interpreter to speak to members in most languages.

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

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

For members with vision problems, the [Meridian Member Handbook](#) and other materials are available in large print and Braille. The [Meridian website](#) also has buttons to make the print larger and to turn the contrast on or off.

A member may call Member Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. to inquire about interpretation services or alternative formats. These services are free of charge.

Non-Emergent Transportation

Meridian ensures that non-emergency transportation and travel expenses, determined to be required for members to secure medically necessary medical examinations and treatment, are readily available and accessible. Meridian is contracted with a transportation provider with a network capable of providing non-emergent transportation to the entire Meridian geographic coverage area. This non-emergent transportation is available for all covered services including prenatal care, preventive services, mental health services, obtaining prescription medicine, and durable medical equipment (DME) supplies. Beginning with dates of service of January 1, 2022, non-emergent *ambulance* transportation will be arranged and paid for by HFS. MLTSS non-emergent ambulance transportation is paid for by Meridian. All ambulance services for MLTSS members can be billed directly to Meridian. No authorization is required.

Beginning with dates of service on or after July 1, 2022 HFS has reinstated the use of the Certificate of Transportation Services (CTS) form (HFS 2271) for all non-emergency transports originating at a Meridian member's private residence. The HFS 2271 form will be used for prior and post approval purposes to determine the appropriate level of medically necessary transport. Contact your provider relations representative with questions.

Information on how and when members can access non-emergent transportation is available in the [member handbook](#) or by calling Member and Provider Services at **866-606-3700 (TTY: 711)**.

Transportation Procedure

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

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

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

Transportation services must be scheduled at least three days in advance. The transportation provider uses confidential eligibility information provided by Meridian to verify the member's eligibility. Members are then assigned the most appropriate and cost-effective means of transportation. Routine appointments can be scheduled from 8 a.m. to 6 p.m. seven days a week. Members requiring transportation for next-day appointments should contact the Member and Provider Services department at **866-606-3700 (TTY: 711)** as soon as possible for scheduling assistance. Members also have gas mileage reimbursement available to them when pre-approved.

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

Members who must access non-emergent travel expenses outside of the Meridian geographical area for medically necessary care, and incur costs for such services, may contact Meridian Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. for assistance. Meridian will review the appropriateness of the request prior to the service being scheduled.

Member Enrollment and Disenrollment

Member enrollment and disenrollment in Meridian is processed by the Illinois Client Enrollment Broker (ICEB). If the member wishes to enroll or disenroll from Meridian, they should contact Meridian Member and Provider Services at **866-606-3700 (TTY: 711)** for more information or call the ICEB at **877-912-8880**.

Notice of Privacy Practices

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

Member Satisfaction

Meridian and its network providers are committed to providing and maintaining a high level of member satisfaction. All providers and their office staff are expected to maintain a friendly and professional image and office environment for members, other physicians, and the general public.

Providers must maintain adequate levels of staff to provide timely and effective services for Meridian members. Member Services functions are a requirement of a provider's initial orientation and ongoing network provider education.

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

Member Grievances and Appeals

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

Member Grievances

A grievance is any member expression of dissatisfaction, including complaints, about any matter other than an administrative action that can be appealed. Examples include:

- A member cannot get an appointment with their doctor in a timely manner
- A member cannot get a referral from their doctor in a timely manner
- A member has been denied any of their rights as a Meridian member
- The quality of care or services received by the member was not satisfactory

To file a grievance, a member or their authorized representative should call the Member and Provider Services department at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. or submit in writing to:

Meridian

ATTN: Member Grievances Dept.

PO Box 44287

Detroit, MI 48244

Fax: **833-669-1734**

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

Member Standard Appeals

An appeal is a request for review of a decision made by Meridian to deny, reduce, or terminate a requested service. Examples include:

- A service was denied based upon medical necessity
- A service was denied (such as physical therapy) that was previously authorized

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

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

A member can submit written permission by completing the Meridian [Authorized Representative Designation](#) form and send it to:

Members can file a standard or expedited appeal by calling Member Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. by fax, or in writing.

Meridian
ATTN: Member Appeals Dept.
(Non-Rx and Non-BH)
PO Box 716
Elk Grove Village, IL 60009
Non-Rx Fax: **833-383-1503**

Meridian
ATTN: Member Appeals Dept.
(Rx and BH)
PO Box 44287
Detroit, MI 48244
Rx Fax: **833-433-1078**
BH Fax: **866-714-7991**

Within three (3) business days of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. We will make a decision about the appeal and notify the member and their PCP, as well as any other providers involved in the appeal in writing within 15 business days of receiving all required information.

Members seeking continuation of existing services during the appeals process must notify Meridian within 10 days of the Adverse Benefit Determination Letter date. Meridian must continue the member's benefits during the appeal process. A provider, serving as a member's authorized representative for the appeal process, cannot file for continuation of benefits. If the final resolution of the appeal is adverse to the member, Meridian may recover the cost of the services that were furnished to the member.

Member Expedited Appeal

If a member or their provider thinks that their situation is clinically urgent and reviewing the appeal in the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the member's medical condition, or would subject the member to severe pain that cannot be adequately managed without the care or treatment, they may call Member and Provider Services at **866-606-3700 (TTY: 711)** to file an expedited appeal. Within 24 hours of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. Meridian Medical Directors will make a decision about the appeal within 24 hours of receiving all required information. The member and their PCP, as well as any other provider involved in the appeal, will be notified verbally of the outcome of the appeal. A written notification will also follow. All member appeals may be sent to the Member Appeals Department fax number or PO Box noted above.

Meridian Member Appeals Dept. Fax Numbers:

Non-Rx Fax: **833-383-1503**
Rx Fax: **833-433-1078**
BH Fax: **866-714-7991**

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

If the appeal regarding medical services is denied, members have the right to request an external independent review. This request can be filed by any of the parties involved in the initial appeal and must be submitted in writing. Members must request an external independent review within 30 days of Meridian's notification of the appeal decision. An external independent review of appeals or an expedited external independent review may be sent to the Member Appeals Department fax number or PO Box noted below.

Addresses and fax numbers to file a request for an external independent review and an expedited external independent review:

Meridian

ATTN: Member Appeals Dept.

(Non-Rx and Non-BH)

PO Box 716

Elk Grove Village, IL 60009

Non-Rx Fax: **833-383-1503**

Meridian

ATTN: Member Appeals Dept.

(Rx and BH)

PO Box 44287

Detroit, MI 48244

Rx Fax: **833-433-1078**

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

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

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

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

If the member's situation is clinically urgent, the member or a provider acting on the behalf of the member may call Meridian's Member Services department at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. to file an urgent request for external independent review. Members will need confirmation from their provider to do this.

The reviewer will make a decision within five (5) business days of receiving all required information. The member and their PCP, as well as any other provider involved in the case will be notified verbally of the outcome of the appeal. A written notification will also follow.

State Fair Hearing

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

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

Illinois Department of Healthcare and Family Services

Bureau of Administrative Hearings

69 W. Washington Street, 4th Floor

Chicago, IL, 60602

Fax: **312-793-2005**

Email: HFS.FairHearings@illinois.gov

855-418-4421, TTY: 800-526-5812

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

Illinois Department of Human Services

Bureau of Administrative Hearings

69 W. Washington Street, 4th Floor

Chicago, IL, 60602

Fax: **312-793-8573**

Email: DHS.HSPApeals@illinois.gov

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

Provider Directory

A list of participating providers in the Meridian network is available by viewing the online provider directory at ILmeridian.com. To receive a hardcopy list of participating providers, contact Meridian Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. and a provider directory can be mailed to you or the member requesting it.

SECTION 4:

Member Benefit Information

Member Benefits

Covered Services

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

The following services are covered by Meridian.

Medicaid Covered Services (for MLTSS services please refer to the *Services Covered Under MLTSS section*):

- Abortion (claims for services to be submitted directly to HFS)
- Advanced practice nurse services
- Alcohol and substance abuse services
 - Inpatient rehabilitative services for alcohol and/or drug abuse are limited to 30 days per calendar year for adults
 - Detoxification services are limited to once every 60 days
- Ambulatory surgical treatment center services
- Applied behavior analysis (ABA) services
- Assistive/augmentative communication devices
- Audiology services
- Blood, blood components and the administration thereof
- Chiropractic services
 - Medicaid population: < 21 years of age
- Practice visits for members with special needs (Seniors and Persons with Disabilities (SPD) only)
- Dental services
 - Routine dental services
 - Medicaid SPD members receive coverage for medically necessary oral surgery services from an oral surgeon who is a Participating Provider, upon referral by a participating physician and authorized by Meridian
- Diagnostic testing
- Durable medical equipment and supplies
- Emergency and urgent care

- Gender-affirming services
- Immunizations
- Family planning and services and supplies
- FQHCs, RHCs, and other encounter rate clinic visits
- Home health agency visits
- Hospital emergency room visits
- Inpatient hospital services
- Outpatient hospital and provider services
- Long Term Services and Supports (LTSS)/Home and Community Based Services (HCBS) (for members eligible to receive HCBS)
- Laboratory and X-ray services (laboratories must be Clinical Laboratory Improvement Amendments (CLIA) certified)
- Medical supplies, equipment, prosthesis and orthosis, and respiratory equipment and supplies
- Mental health services, including inpatient psychiatric admissions and outpatient services
- Nursing care for members <21 years of age not in the HCBS waiver for individuals who are Medically Fragile Technology Dependent (MFTD)
- Outpatient hospital and provider services
- Nursing care (for members <21 years of age for transitioning from a hospital to home or other appropriate setting)
- Nursing facility services for the first 90 days
- Optical services and supplies
- Optometrist services
- Palliative and hospice services
- Pediatric services
- Pharmacy
- Preventive services
- Physical, Occupational, and Speech Therapy services
- Physician services
- Podiatric services
- Post-stabilization services
- Primary care services
- Specialist services
- Renal dialysis services
- Respiratory equipment and supplies
- Surgery
- Sub-acute alcoholism and substance abuse services
- Therapy services
- Transplant services
- Vision services
- Transportation to secure covered services

- Well-Child & Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (up to age 21)
- Women's care

Services Covered under MLTSS

Services not listed are not covered under MLTSS.

- Adult Day Health
- Agency Providers RN, LPN, CNA and Therapies
- Alcohol and Substance Abuse Rehabilitation Services
- Auto Transportation (private)
- Electronic Home Response (EHR)/EHR Installation (MARS), MPE Certification (Provider)
- Exceptional Care
- Habilitation Services
- Homemaker
- Individual Providers PA, RN, LPN, CNA and Therapies
- Licensed Clinical Professional Counselor (LCPC)
- Long-Term Care (LTC) - Skilled
- LTC - Intermediate
- LTC - Recipient ages 22-64 in IMD not MI or MR
- LTC - Supportive Living Facility (SLF) Dementia Care
- LTC - Supportive Living Facility (Waivers)
- Medicare Transportation
- Mental Health Rehabilitation Option Services
- Non-Emergency Ambulance Transportation
- Other Behavioral Health Services
- Other Health Care Finance Administration (HCFA) Approved Services
- Other Transportation
- Psychologist Service
- Respite Care
- Service Car
- Social Work Service
- Targeted case management service (mental health)
- Taxicab Services

Non-Covered Services

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

- Elective cosmetic surgery
- Nursing Facility Services beginning the 91st day (excluding Seniors and Persons with Disabilities (SPD) members who are residents of a nursing facility)
- Services prohibited by State or Federal law
- Non-medically necessary services
- Diagnosis and treatment of infertility

Non-Covered Benefits for Medicaid Only

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

Home and Community Based Services (HCBS) Program

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

- **Persons who are Elderly Waiver:**

Persons aged 60 or older, who are otherwise eligible for nursing facility as evidenced by the Determination of Need (DON) assessment

- **Persons with Disabilities Waiver:**

Persons aged 0-59 with disabilities (those 60 or older who began this waiver prior to age 60 may remain in this waiver); persons with a severe disability which is expected to last for at least 12 months or for the duration of life; persons otherwise eligible for a nursing facility as evidenced by the DON assessment

- **Persons with Brain Injury (BI) Waiver**

Persons of any age with a brain injury; have functional limitations directly resulting from an acquired brain injury, infection, (encephalitis, meningitis) anoxia, stroke, aneurysm, electrical injury, malignant or benign neoplasm of the brain, and toxic encephalopathy. Due to these conditions, has a severe disability which is expected to last for at least 12 months or for the duration of life; persons otherwise eligible for nursing facility as evidenced by a total of 29 points on the DON assessment

- **Persons with HIV or AIDS Waiver**

Persons of any age diagnosed with HIV or AIDS; persons otherwise eligible for nursing facility as evidenced by a total score of 29 points on the DON assessment

- **Persons residing in Supported Living Facilities (SLF) Waiver**

Operated by the Department of Healthcare and Family Services (HFS). Persons aged 65 or older or persons with disabilities (as determined by the Social Security Administration) aged 22 and older, screened by HFS and found to be in need of nursing facility level of care where a SLF is appropriate to meet the needs of the individual. These persons can be without a primary or secondary diagnosis of a developmental disability or serious and persistent mental illness

Home and Community Based Services include the following:

HCBS Covered Services				
Service	Aging	Disability	HIV/AIDS	Brain Injury
Adult day service	X	X	X	X
Adult day service transportation	X	X	X	X
Environmental modification		X	X	X
Supported employment				X
Home health aide		X	X	X
Nursing: Intermittent		X	X	X
Nursing: Skilled		X	X	X
Occupational therapy		X	X	X
Physical therapy		X	X	X
Speech therapy		X	X	X
Prevocational services				X
Day habilitation				X
Homemaker	X	X	X	X
Personal assistant		X	X	X
Home delivered meals		X	X	X
Emergency home response system	X	X	X	X
Respite		X	X	X
Adaptive equipment		X	X	X
Behavioral services				X
Automated Medication Dispenser	X			

Persons who are elderly under the Aging Waiver may receive home delivered meals outside of their waiver service plan. Meridian Care Management staff can assist with Aging waiver members with applying for and obtaining home delivered meals as needed. Providers are to notify the Meridian Care Management team if they identify members in need of home delivered meals even if it is not a waiver benefit.

Member Self Referrals

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

Family Planning

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

The PCP should work with the member in providing for family planning services or assisting them in selecting a provider, as requested. Members may also contact Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. for additional assistance with family planning referrals or family planning information.

Women's Health

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

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

Children's Health

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

SECTION 5:

Pharmacy Benefit Management

Prescription Drug Plan Coverage

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

The pharmacy phone number listed below should be used for prior authorization and to speak with a clinical pharmacist regarding any pharmaceutical, medication administration, or prescribing issue.

Medicaid Phone:

855-580-1688

All providers have access to the Meridian Preferred Drug List (PDL). The PDL is available on the [pharmacy page](#) on our website at ILmeridian.com and should be referred to when prescribing medications for Meridian members.

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

Medicaid-Specific Benefits

Medicaid members have both prescription and specific over-the-counter medication coverage. Providers can reference the PDL when prescribing medications. For medications not listed on the PDL, a formulary exception can be obtained. Some medications also require prior authorization or step therapy, which is noted in the formulary document.

Prior Authorization or Formulary Exception

If a medication that is required is not on the PDL, a "[Prescription Drug Prior Authorization Request Form](#)" must be filled out and can be obtained at ILmeridian.com. The form must include all required information to make a determination on the request. The form must then be faxed to the fax number below. The prior authorization form can also be entered online via [CoverMyMeds](#).

In emergency situations, call 855-580-1688.

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

Medicaid

Phone: **855-580-1688**

Fax: **855-580-1695**

SECTION 6:

Utilization Management, Care Coordination, and Disease Management

Utilization Management

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

The utilization management process consists of the following:

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

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

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

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

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

Meridian's Utilization Management staff refer to plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. These guidelines include items such as McKesson's InterQualR criteria, Meridian's Medical Necessity Guidelines, Meridian's Medical Review Criteria (developed by Meridian medical directors in conjunction with community physicians), applicable federal and state benefit guidelines, consultation with practicing physicians and medical experts in their field, and standards adopted by national accreditation organizations. It is the responsibility of the attending physician to make all clinical decisions regarding medical treatment. These decisions should be made consistent with

generally accepted principles of professional medical practice and in consultation with the member. All utilization review decisions to deny coverage are made by Meridian's medical directors.

Copies of the criteria utilized in decision-making are available free of charge upon request by calling the Utilization Management department at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. The criteria can also be accessed on the [provider portal](#) when you submit an electronic authorization request. In certain circumstances, an external review of service requests is conducted by qualified, licensed physicians with the appropriate clinical expertise.

Utilization management decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the member's eligibility and benefits at the time the services are rendered.

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

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

Behavioral Health Utilization Review

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

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

- Inpatient psychiatric hospitalizations
- Inpatient detoxification services
- Residential substance use disorder treatment (Substance Use Prevention and Recovery (SUPR))
- Partial hospitalization programs
- Intensive outpatient services
- Psychological and neuropsychological testing
- Outpatient mental health therapy and substance use counseling
- Community Mental Health Center services (CMHC Rule 132)

For a complete list of covered services and the most current authorization requirements, please visit [provider authorization and referral guidelines](#) listed on our website.

All behavioral health utilization reviews are completed by licensed qualified mental health practitioners, and any adverse determination where coverage of a service may be denied are made by Meridian's behavioral health medical directors. The guidelines utilized to make any such coverage

decision include Change Healthcare InterQual criteria, American Society of Addiction Medicine (ASAM) criteria, Meridian Medical Review Criteria (developed by Meridian medical directors in conjunction with community physicians), and applicable federal and state benefit guidelines. Copies of the criteria utilized in decision-making are available free of charge upon request.

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

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

Concurrent Review, Discharge Planning, and Transition of Care:

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

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

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

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

Requesting Prior Authorization/Precertification

Services requiring Prior Authorization (PA) can be determined by using our online [Pre-Auth Tool](#). Prior Authorizations can be submitted electronically using our [online tool](#) located on the provider portal. Using Meridian's online Prior Authorization (PA) tool offers timely and efficient service. PAs can also be done by fax. Please use fax numbers and document examples on the following page.

Prior Authorization Fax Numbers

Document Description	Fax Number	Examples of when to use fax number
Meridian Medicaid Admissions – Census Report	833-544-1650	Documents containing list of multiple patients admitted and/or released from a facility.
Meridian Medicaid – Concurrent Review	833-544-1630	Review or authorization for procedures or services during the time such services are being rendered. An example of concurrent review is when a physician calls a Managed Care Organization (MCO) and requests an initial length of stay for a patient (PA) and then after the patient has been admitted into the hospital, the physician calls the MCO and explains that due to extenuating circumstances the patient needs to stay in the hospital for a longer time and the physician requests an extended length of stay (ELOS). The ELOS would be classified as a request for concurrent review.
Meridian Medicaid – Face Sheets	833-544-1826	Documents which inform the MCO when a member is admitted to a hospital or other inpatient facility for emergency or elective inpatient care.
Meridian Medicaid – Medical Records	833-544-1649	Additional clinical documents required for Outpatient prior authorization request on file already.
Meridian Medicaid – Prior Authorization	833-544-0590	Only used if the below forms (Inpatient and Outpatient) for services are filled out appropriately. https://www.ilmeridian.com/content/dam/centene/meridian/il/pdf/IV-IP-PAF-6146_01262022.pdf https://www.ilmeridian.com/content/dam/centene/meridian/il/pdf/IV-OP-PAF-6149_01262022.pdf
Meridian Medicaid Behavioral Health- Inpatient – Prior Authorization	833-544-1827	Used for BH services on inpatient form.
Meridian Medicaid Behavioral Health- Outpatient – Prior Authorization	833-544-1828	Used for BH services on outpatient form.

When submitting a PA request, please include the following information:

- Member's name
- Member's Medicaid Identification number
- Date(s) of service

- Facility where services are to be rendered, please include TIN and NPI
- Diagnosis/Procedure code(s), as applicable

Clinical Review Requests

Clinical information is required for all clinical review requests to ensure timely decisions by Meridian. The decision timeframe is based on the date we receive the supporting clinical information. To ensure a timely decision, make sure all supporting clinical information is included with the initial request.

- Failure to obtain prior authorization may result in denial of the claim
- All services (except emergency services) for out-of-network providers require prior authorization
- Please refer to Pre-Auth tool www.ILmeridian.com/providers/preauth-check.html.

Clinical information includes relevant information regarding the members':

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

Services Requiring Authorization

The list below provides Meridian's general PA requirements. This list is not all inclusive and is subject to change. Providers will be given a 60-day advance notice prior to any changes. Please verify requirements at the time of the request by utilizing our [Pre-Auth Check](#).

- All inpatient admissions
- All transplant surgeries
- Durable medical equipment (DME) requests greater than \$1000 always require prior authorization
- Certain outpatient diagnostic radiology procedures
- Certain outpatient Services/Treatments/Procedures
- Certain inpatient surgical procedures
- Home health visits
- Inpatient admissions to a Rehabilitation Facility
- Inpatient behavioral healthcare services for certain diagnoses
- Long Term Acute Care admissions
- Select pharmaceuticals
- Skilled Nursing Facilities admissions
- All out-of-network services: If referring to a member outside of Meridian's network please include supporting documentation with your prior authorization request indicating why services are being rendered out of network
- Inpatient authorizations must be obtained within two (2) business day of admission.

- Authorizations for outpatient services must be obtained prior to rendering services.
- Observation does not require authorization.
- Diagnostic procedures may require authorization. Please check the portal for authorization requirements.

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

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

Deliveries

Meridian does not pre-authorize deliveries for future dates. Please submit notification of admission once the member has been admitted. Include the following with your notification request.

- Member's name and date of birth
- Medicaid Identification number
- Date of birth and time of the delivery of baby
- Delivery type
- Gestational age/weeks
- Baby's weight
- Birth order, if it is multiple births
- Last menstrual period
- Apgar scores of the baby
- Birth and discharge status of the baby
- Delivering Physician information
- Pediatrician information

The plan approves all obstetrics delivery by the type of delivery. If a member's admission goes beyond the timeframe, please include clinical information for a medical necessity review.

- Vaginal Delivery: Up to 2 days approved
- C-Section Delivery: Up to 4 days approved

Behavioral Health

Listed below is an explanation of behavioral health services that require or do not require prior authorization:

Mental Health	
Prior authorization required	<ul style="list-style-type: none">• Inpatient hospitalization• Partial Hospitalization
Notification	<ul style="list-style-type: none">• Intensive Outpatient Program• Outpatient therapy (Continue Outpatient Treatment Notification Form)• CMHC Rehabilitation services• SASS Services
No prior authorization required	<ul style="list-style-type: none">• Psychiatric Evaluation and Medication Management• Crisis Intervention• Treatment Planning Development/Review/Modification• Psychological and Psychiatric Evaluation
Substance Abuse	
Prior authorization required	<ul style="list-style-type: none">• Inpatient hospitalization• Detoxification• Substance Abuse Residential
Notification	<ul style="list-style-type: none">• Intensive Outpatient Program• Outpatient therapy (Continue Outpatient Treatment Notification Form)
No prior authorization required	<ul style="list-style-type: none">• Medical administration

For a complete list of PA requirements, please visit ILmeridian.com, or call Meridian Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m.

Classifying Your Prior Authorization Request

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

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

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

Turnaround Times for Processing Prior Authorization Requests

Review Type	Decision Time Frame	Web/Fax/Phone Notification	Written Notification (Denials)
Non-Urgent Pre-Service Review: Standard	Within 4 days of receipt of the request	Within 4 days of receipt of the request	Within 4 days of receipt of the request
Urgent Pre-Service Review: Expedited	Within 48 hours of the request	Within 48 hours of the request	Within 48 hours of the request
Urgent/Concurrent Review	Within 24 hours of receipt of the request. 72 hours if clinical information is incomplete or is not included	Within 24 hours of receipt of the request. 72 hours if clinical information is incomplete or not included	Within 72 hours of the request
Retrospective Review	Within 30 days of receipt of the provider's request. N/A for members Meridian only reviews certain service types for Retrospective Review	N/A	Within 30 days of receipt of the request

Notification of Determination

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

All medical necessity adverse determinations are rendered by a Meridian Medical Director.

The written denial notification will include the following:

- Rationale for the adverse determination
- Reference to the benefit provision, clinical guidelines and/or clinical policy on which the adverse determination was based on
- Opportunity to discuss the determination with a Medical Director
- Appeal rights
- Directions on how to obtain a copy of the reference

Peer-to-Peer Discussion

Peer-to-peer discussion is an opportunity for a treating physician to discuss medical criteria and guidelines with the health plan medical director. Medical directors review cases based on medical information submitted to the health plan.

Treating physicians who would like to discuss a utilization review determination with the decision-making Medical Director may do so at any time during the review process by contacting the Utilization Management department at **833-541-2297**. A peer-to-peer discussion performed after

a denial decision may result in an overturn if requested within 10 calendar days of the initial denial notification.

Specialized Services

- **National Imaging Associates (NIA):** NIA will manage prior authorizations for interventional pain management and therapy services for Meridian members. Requests should be submitted directly to NIA.

NIA will also manage non-emergent, advanced, outpatient imaging services (cardiology and radiology).

- **New Century Health:** New Century Health will manage prior authorizations for radiation therapy and medical oncology services for Meridian members. Requests should be submitted directly to New Century Health.

Care Coordination Program

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

Some of the goals of Care Coordination are to:

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

Target Population: Through assessments and predictive modeling, Meridian identifies and stratifies the member population to identify the clinical risk of each member to determine the appropriate coordination of needs. All Meridian members have varying degrees of care coordination including:

- Preventive and Population Health
- Disease Management
- Healthcare Continuum
- High Needs Coordination
- Complex Case Management

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

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

1. Notifying Meridian through the provider portal
 - a. Log in to the [provider portal](#). Enter your username, password, and state
 - b. Select "Member" on the left menu
 - c. Enter the Member ID number
 - d. Click "Notify Health Plan" at the bottom of the "Demographics" screen
 - e. Select "Case Management" (middle tab) and fill out the reason for referral
2. Completing the "[Provider Referral to Care Coordination & Complex Case Management](#)" and faxing it to Meridian. You may also go online to download the form.
 - a. Go to ILmeridian.com and navigate to the [Provider Resources](#) page
 - b. Fax the completed form to **833-560-2908**

Care Coordination – Provider's Role

Providers also have a role in the care coordination process which includes:

Health Risk Screenings or Assessments

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

Develop and implement an Individual Plan of Care (IPoC)

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

Collaborate with an Interdisciplinary Care Team (ICT)

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

Transition of Care

Meridian is committed to ensuring that members have transitions from one environment to the next. The transition coordination process assures the right systems and supports are in place to complete successful transitions for members with additional needs at the time of discharge. The member is

reminded at each point of transition through the continuum of care that his/her consistent point of contact at the plan is the Meridian Care Coordinator. Providers can expect to receive notification when members enrolled in Care Coordination experience a transition so you can participate in the ICT, updates to the IPoC, and also ensuring the member has a visit with you or the appropriate specialist within seven days or 14 days of discharge.

The Start Smart for Your Baby® (SSFB)

[The Start Smart for Your Baby®](#) (SSFB) maternity program is an evidenced-based program that leverages advanced analytics to identify and engage members to improve obstetrical and pediatric care services, reduce pregnancy-related complications, premature deliveries, low birth weight deliveries, and infant disease. To accomplish this, SSFB incorporates the concepts of care management, care coordination, disease management, and health education in an effort to improve the health of pregnant birthing parents and their newborns.

The key program driver of the SSFB program consists of pregnancy risk stratification, which helps to identify pregnant members who are at elevated risk for having babies with adverse birth outcomes. As a result of risk stratification and care management engagement, there are several important improvements to key outcomes such as:

1. Preterm delivery rate
2. C-Section rate
3. Low birth weight rate
4. Neonatal admission rate

All pregnant members should have a [Notification of Pregnancy \(NOP\)](#) form completed. A completed NOP will:

- Enroll the member into the SSFB Program
- Assign a preliminary risk score for the member
- Identify the risk of poor birth outcome
- Assess social needs
- Ensure the member receives a pregnancy information packet

The NOP can be completed by members or providers. Members can complete the NOP by logging into the [Member Portal](#) or calling Member Services. Providers can complete the NOP form located at the bottom of the [Prior Authorization and Referral page](#) and fax it to **833-544-1629** or through the [provider portal](#).

Disease Management

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

Enrollment is voluntary for Meridian members who meet qualifying criteria for a specific chronic condition. Eligible members may be identified for enrollment in a variety of ways including claims data (i.e. medical, behavioral, pharmacy, etc.), encounter data, health appraisal results, referrals from the health plan (i.e. Utilization Management, Case/Care Management, etc.), physician (i.e. lab values, etc.), a current or previous program participant, eligible individual list from client organizations (i.e. Population Health Category 5a Health Coaching Report), data from wellness or health coaching programs, and advanced data sources such as Enterprise Data Warehouse.

Meridian will:

- Send an introductory mailing to targeted Members with program information and informing Members they will receive a phone call
- Establish telephonic behavior change health coaching with a licensed Primary Health Coach with clinical experience matched to the participant's needs
- Educate members on importance of medication adherence, self-management of conditions, and communication with providers
- Promote collaboration among physicians, providers and the health plan for comprehensive plans of care

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

If you would like to enroll a Meridian member so they can receive benefits like clinical support, our smoking cessation program, or diabetes education classes, please contact the Meridian Disease Management department by phone at **833-796-0683**.

If at any time your patients wish to stop participating in the program, they can call Meridian at **833-796-0683** to disenroll.

Smoking Cessation Program

We ask that our providers take the time to ask patients about their smoking habits at every visit and if the patient is a smoker, please advise them to quit. Providers should also discuss smoking cessation strategies. Medications as part of nicotine replacement therapy are available through the pharmacy benefit. For a complete list of covered medications, review the formulary at <https://www.ilmeridian.com/providers/pharmacy.html> or call the pharmacy help desk at **855-580-1688**.

SECTION 7:

Quality Improvement (QI)

Quality Improvement Introduction

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

Quality Improvement Program Goals and Objectives

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

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

- Improve member health outcomes and risk status
- Ensure member access to medically appropriate care
- Assure accessibility and availability of quality medical, behavioral health, substance abuse, and home and community-based services (HCBS) waiver care
- Develop programs to manage disease, improve (completion rates of) preventive screenings, and coordinate care for members with acute and chronic care needs
- Develop and evaluate efforts to reduce unnecessary Emergency Department utilization, inpatient services, and readmissions
- Increase appropriate follow-up services after inpatient care for behavioral health services or complex medical care
- Improve member and provider satisfaction
- Ensure member access to culturally and linguistically appropriate services

- Report HEDIS, CAHPS, HCBS waiver performance measures accurately and timely
- Improve coordination and transition across care settings and among ancillary providers
- Improve communication between the member and their PCP
- Monitor adherence to Meridian-approved, evidence-based clinical practice guidelines

Medicaid Performance Improvement Projects

Meridian is engaged in the following collaborative Performance Improvement Projects (PIP) mandated by the State of Illinois for Medicaid Managed Care Organizations:

PPC-Prenatal Care Overview

The Prenatal Care (PPC-Prenatal) PIP was established by a directive from the State of Illinois. The main focus is to increase overall prenatal care rates. The PIP focuses on improving prenatal care within the first trimester of pregnancy which can help to reduce both the risk of pregnancy complications and the risk of complications for the mother, fetus, and infant. Without proper care, rates of preterm delivery and fetal death increase.

Transportation Overview

The Transportation PIP and QIP was established by a directive from Centers for Medicare and Medicaid Services (CMS) and the State of Illinois. The focus is on the administration of the transportation benefit, specifically focusing on the rate of scheduled trips resulting in the member arriving to their scheduled appointment on time. Targeted interventions are outlined to determine if there is an increase in the percentage of scheduled trip requests where the member arrived before or on time for scheduled appointments.

Quality Improvement Program Processes and Outcomes

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

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

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

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

Outcomes of the QIP are tracked, analyzed, and reported to the Quality Improvement Committee (QIC) and Board of Directors annually. Meridian identified key areas for performance improvement and developed interventions to address them. The key areas are:

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

Meridian is one of the top Medicaid plans in IL according to NCQA's Medicaid Health Insurance Plans Ratings 2020-2021.

Provider Opportunities in Quality Improvement Program Activities

Provider involvement is integral to a successful QIP. By ensuring accessibility and delivering high quality care, providers contribute to the goals and objectives of the Meridian QIP. Meridian also offers the opportunity to partner in Wellness Days, which are dates/times reserved specifically to schedule health plan members to close specific care gaps. Quality Provider Webinars are held monthly to offer education and resources to providers. Providers also have the opportunity to contribute administratively by becoming active participants in Meridian committees. To express interest in joining any of the following committees, or to request more information, please contact Quality Improvement at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m.

Quality Improvement Committee

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

The QI Committee is responsible for the following:

- Report QIP status (including recommendations) to the Board of Directors (BOD) quarterly and annually
- Review and approval of all Meridian Corporate and Departmental Policies and Procedures
- Review and adoption of all Meridian Medical Necessity Review Criteria, Medical Policies, and Clinical Practice Guidelines

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

Credentialing Committee

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

The Credentialing Committee is responsible for the following:

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

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

Physician Advisory Committee

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

The Physician Advisory Committee is responsible for the following:

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

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

Grievance Committee

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

The Grievance Committee is responsible for:

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

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

Contractual Arrangements

Non-Delegated

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

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

Delegation

Meridian occasionally delegates administrative, clinical, or operational functions. Meridian conducts significant oversight and monitoring of its delegates. Meridian prefers to delegate to NCQA or URAC certified organizations.

Quality Improvement (QI) Program Activities

Monitoring Quality Performance Indicators – Clinical and Operational

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

- Ensure members have timely access to and availability of necessary preventive and maintenance healthcare services to maintain their optimum level of health
- Identify opportunities for quality improvement

- Identify and proactively resolve barriers to care, including linguistic and cultural
- Develop and implement new, or refine existing, quality initiatives to meet the ongoing, dynamic needs of the member population

The purpose of the operational metrics is to ensure:

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

HEDIS Quick Reference Guide

Meridian utilizes the Healthcare Effectiveness and Data Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA), to assess our performance. HEDIS is a set of standardized performance measures to objectively measure, report and compare quality across health plans. Meridian has developed a HEDIS Quick Reference Guide for our Medicaid Plan and Medicare – Medicaid Plan to help you increase your practice's HEDIS rates and to use to address care gap opportunities for your patients. The [HEDIS Quick Reference Guide](#) can be viewed on the Meridian website.

For more information, visit www.ncqa.org.

Please note that recommendations and guidelines are subject to change. Providers can contact Meridian Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. with any questions.

Monitoring Quality Performance Indicators – Surveys

Members

Surveying member satisfaction provides Meridian with information about member experience with the plan and provider network. Meridian assesses member satisfaction in several ways including, but not limited to, CAHPS®, HOS, and member experience surveys. The results of these surveys help Meridian identify areas of member dissatisfaction for corrective action, as well as areas of member satisfaction in order to continue improvement. Based upon these survey results, the QI Committee is able to make sure member input is incorporated in the selection, approval, and prioritization of quality improvement activities, initiatives, and programs that are most beneficial and meaningful to its member population.

Providers

Surveying provider satisfaction, access, and availability helps Meridian collect information about provider experience with the plan and its members. Meridian assesses provider satisfaction in several ways including, but not limited to, the Annual Provider Survey. Results from this survey help Meridian identify areas of provider dissatisfaction for corrective action, identify areas of satisfaction so as to

identify opportunities for continuous improvement, assess ongoing education and training needs, and quantitatively assess the adequacy of the Meridian provider network. Based on these survey results, the QI Committee uses the information in its selection, approval, and prioritization of quality improvement activities, initiatives, and programs that are most beneficial and meaningful to its provider in balance with those that are most beneficial and meaningful to its member population.

Clinical Practice Guidelines

Meridian has adopted evidence-based Clinical Practice Guidelines from regional and national external sources. The Clinical Practice Guidelines are reviewed and approved annually, and as necessary, by Meridian's Physician Advisory Committee and Quality Improvement Committee. [Clinical Practice Guidelines](#) can be viewed on the Meridian website.

Site Visits

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

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

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

Meridian Medical Policies and Clinical Practice Guidelines

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

Peer Review

Peer Review is conducted in accordance with the applicable accreditation standards, contractual requirements and state and federal regulatory requirements. The Physician Advisory Committee in collaboration with the Credentialing Committee manages the Peer Review process. Cases requiring Peer Review are identified through member or provider complaints, grievances, the initial application

or reapplication processes, sentinel event or near-miss occurrences, unexpected poor care and treatment outcomes, allegations of substandard or aberrant care practices, allegations of fraud, waste, and abuse and other sources. The Physician Advisory Committee performs the Peer Review in accordance with Meridian policies and procedures. Remedial, corrective, and/or disciplinary actions are taken in a timely manner in accordance with Meridian policies.

Management of Quality of Care Complaints

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

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

Patient and Member Safety

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

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

Patient safety needs are addressed through the following activities:

- Review of appeals, complaints, and grievances and determination of quality of care impact
- Review of initial HRA and periodic re-assessment by clinical staff
- Review of initial and periodic reassessment of the member's level of risk stratification
- Care Coordination and Disease Management programs targeted at educating members and their families on:
 - The member's condition including subtle changes which may warrant acute intervention
 - Medication use, safety, and interaction prevention

- Self-management instructions including diet and exercise
- Coordination of multiple or complex healthcare services
- HEDIS measure care reminders
- Notification to members and providers of medications recalled by the FDA
- Notification to the Quality Improvement and Care Coordination departments of any potential quality or safety cases:
 - Re-admission within 15 or 30 days of discharge
 - Emergency room visit within seven days of discharge
 - Significant provider treatment errors, including medication prescribing and medication interactions
 - Unexpected poor outcomes or death
 - Missed diagnoses
 - Avoidable delays in treatment
 - Missed post-discharge or post-diagnostic testing follow-up appointments
 - Insufficient discharge planning
- Provider site surveys
- Targeted and general member educational outreach via telephone or in writing
- Targeted and general provider educational outreach via telephone or in writing
- Cultural competency education and training for contracted providers and their office staff
- Use of the language translation telephone service free of charge for contracted providers and members

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

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

Confidentiality and Conflict of Interest

Confidentiality

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

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

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

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

Conflict of Interest

All Meridian employees are required to sign conflict of interest statements annually.

Meridian's business ethics and code of conduct and corporate policies prohibits any Meridian employee or community-based physician advisor from performing utilization review or making medical necessity determinations on any member for which they are providing care for or from which he or she may directly or indirectly financially, or in kind, benefit personally or professionally other than standard remuneration from the company.

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

Provider Critical Incident Reporting

Meridian requires participating program providers to report all Critical Incidents that occur in a home and community-based long-term services and supports delivery setting, including assisted living facilities, community-based residential alternatives, adult day care centers, other HCBS provider sites, and a member's home (if the incident is related to the provision of HCBS). Providers will be

provided with [Critical Incident education materials](https://www.ilmeridian.com/providers/resources/forms-resources.html) and will have access to additional information via <https://www.ilmeridian.com/providers/resources/forms-resources.html>. Providers must participate in trainings offered by Meridian to ensure accurate and timely reporting of all Critical Incidents.

Critical Incidents include but are not limited to:

- 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

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

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

- Providers must contact 911 if the incident can cause immediate/severe harm to the member
- Remove worker from the member's case (if incident includes allegation of improper behavior by that worker)
- Remove accused worker from servicing all Meridian program members until the investigation is complete (may take up to 30 calendar days)
- Order immediate drug screen or appropriate testing if allegation includes theft of drugs or use of substances including alcohol while on the job
- Interview involved employee(s) as soon as possible following the incident. Have the employee(s) submit a written account of events. 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.

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

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

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

Incident Involves	Contact	Time Frame	Special Instructions
Children (under 18)	State Central Register: 800-25-ABUSE (800-252-2873)	Immediately	For any incident involving the abuse, neglect, or exploitation of a child, the CANTS 5 form (https://www.illinois.gov/dcfs/aboutus/notices/Documents/cants5.pdf) needs to be completed and sent to the external agency immediately
All adults (including those with disabilities), ages 18-59, living in an institutional setting <ul style="list-style-type: none"> Cases of suicidal ideation for members with developmental disabilities (DD) or mental health concerns residing in an institutional setting 	Illinois Department of Human Services Office of the Inspector General Hotline: 800-368-1463 (Voice and TTY)	Immediately	
Adults with disabilities, ages 18-59, living in a community setting <ul style="list-style-type: none"> Older adults (60 years of age and older) regardless of residence 	Adult Protective Services Hotline: 866-800-1409 800-206-1327	Immediately	
All adults, ages 18-59, living in a community setting	Local Police Department	Immediately	
Nursing facility resident	Department of Public Health's Registry Hotline*: 800-252-4343	Immediately	

Incident Involves	Contact	Time Frame	Special Instructions
Supportive Living Facility resident	Department of Healthcare and Family Services' SLF Complaint Hotline: 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).

SECTION 8:

Billing and Payment

Billing Requirements

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

Following are the guidelines for claims submission to Meridian:

- Providers must use a standard CMS 1500 Claim Form or UB-04 Claim Form for submission of claims to Meridian, or the 837P or 837I formats if filing electronically.
- All paper claim submissions must be on an original “red” CMS-1500 claim form version 02/12.
- Providers must use industry standard procedure and diagnosis codes such as HCPCS, CPT, Revenue, or ICD-10, and Taxonomy codes billed in accordance with state Medicaid, as well as industry standard guidelines when submitting a claim to Meridian
 - Providers should be familiar with and adhere to the billing guidelines as set forth in the Illinois Association of Medical Health Plans (IAMHP) Billing Guidelines which can be found online at www.IAMHP.net/providers under RESOURCE documents
- Prior authorization, if required, must be obtained prior to submitting claims. Prior authorization requirements may be checked via www.ILmeridian.com/providers/preauth-check.html
- Providers may submit and check the status of claims electronically via [Meridian’s Provider Portal](#).
- The standard submission of Medicaid claims must be within 180 days of the date of service.
- Adjudication of a claim is based on benefit coverage, meeting medical necessity criteria and the codes being submitted and considered for review, which can be found on the Illinois Medicaid Fee Schedule: <http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx>

To receive reimbursement in a timely manner, please ensure each claim:

- Is submitted according to the timely filing submissions outlined in the provider’s Meridian Participating Provider Agreement
- Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service, as well as the corresponding NPI number
- Identifies the patient (member ID number assigned by Meridian, or recipient identification number, address, and date of birth)
- Identifies Meridian (plan name and/or ID number)
- Indicates the date (mm/dd/yyyy), place of service, and applicable modifiers

- Is for a covered service – See Section 4 of provider manual. (Services must be described using uniform billing codes and instructions (ANSI X12 837) and ICD 10-CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered clean claims)
- If necessary, substantiates the medical necessity and appropriateness of the care or services provided. This includes any applicable authorization number if prior authorization is required by Meridian
- Includes additional documentation based upon services rendered as reasonably required by Meridian Medical policies
- Is certified by the provider that the claim is true, accurate, prepared with the knowledge and consent of the provider, does not contain untrue, misleading, or deceptive information; is certified that the claim identifies each attending, referring, or prescribing physician, dentist, or other practitioner
- Is a claim for which the provider has verified the member's eligibility and enrollment in Meridian before the claim is submitted
- Is not a duplicate of a claim – providers must submit a corrected claim within **180 days of the DOS/discharge date, whichever is later**
- Is submitted in compliance with all of Meridian's prior authorization and claims submission guidelines and procedures
- Is a claim for which provider has exhausted all known other insurance resources
- Is submitted electronically if the provider has the ability to submit claims electronically
- Uses the data elements of UB-04 or CMS 1500 as appropriate
- Is submitted with appropriate NPI, taxonomy, and provider TIN for services as registered in IMPACT and rendered on the submitted claim. Information on appropriate taxonomy and category of service can be found at the following link: <https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx>

Claims Submission

Clean Claim Definition

A clean claim means a claim received by Meridian for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Meridian.

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in a request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and also include claims not submitted within the filing deadlines.

Electronic Submission

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

Please refer to the following table and instructions when submitting claims.

Electronic Claim Submission

Date of Service	Health Plan Name	Payer ID
On or after Jan. 1, 2021	Meridian Medicare-Medicaid	MHPIL
	Meridian	13189
On or after July 1, 2021	Meridian	MHPIL*

*Please note: Providers utilizing Change Healthcare as the clearinghouse must submit to Change Healthcare with Payor ID MCCIL. Please reach out to Change Healthcare with any questions.

Claim Rejection versus Claim Denial

All claims must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

- **REJECTION:** Rejections will not enter our claims adjudication system, so there will be no explanation or record of the claim in our system. A rejection is defined as an unclear claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. The provider will receive a letter if the claim was submitted on paper or a rejection report if the claim was submitted electronically. In these instances, the claim will need to be corrected and re-submitted as a new claim.
- **DENIAL:** If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A denial is defined as a claim that has passed minimum edits and is entered into the system; however, it has been billed with invalid or inappropriate information causing the claim to deny. An explanation of payment (EOP) will be sent that includes the denial reason.

Claim Corrections and Resubmissions (Adjustments)

If a provider's claim has been denied or paid only in part due to an error on the original claim submission and the provider needs to make any corrections to a claim, the provider must correct that section of the claim and resubmit a corrected claim within 90 days of the original date on the EOP to ask for a correction/adjustment.

CMS-1500 claim forms should be submitted with the appropriate resubmission code (value of 7) in field 22 with the *original* claim number for the corrected claim. EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

UB-04s should be submitted with the appropriate resubmission code in the 3rd digit of the bill type (for corrected claim this will be 7) and the original claim number in field 64 of the paper claim. EDI 837I, data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

If a corrected claim is submitted without this information, the claim will be processed as a first-time claim and will deny as a duplicate. Additionally, this process is only the process for correcting denied claims or claims that were submitted with incorrect information, *not correcting rejected claims*.

Meridian encourages you to submit corrected claims via EDI with the information in the appropriate loop list above. However, you may choose to also utilize our provider portal. While it is not necessary to attach the original EOP or a claim adjustment request form when submitting through the web, you may attach if you choose.

Recoupments

In the event Meridian has overpaid a claim, the provider will receive notice and explanation of the overpayment, with the option to refund the overpayment. If no refund is received the provider will have overpayments recouped from future payments. To refund claims overpayment, please send check and documentation to:

Meridian

PO Box 856407
Minneapolis, MN 55585-6407

Timely Filing:

The standard submission for professional and institutional Medicaid claims for both in-network and out-of-network providers is 180 days from the date of service to submit an initial claim. There are two exceptions to the timely filing guideline:

- Retroactive eligibility: These claims must be accompanied by documentation demonstrating proof of the eligibility change and must be received within 365 days of notification of the eligibility change
- Third party liability-related delays: These claims must be accompanied by a third-party liability (TPL) explanation of benefits and received within 90 days of the TPL processing date

Encounter Reporting Requirements

Providers in capitated or sub-capitated payment arrangements will be monitored for accurate and complete encounter reporting. The data that Meridian submits to the State of Illinois requires the provider's compliance with this requirement.

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

In order to assess the quality of care, determine utilization patterns, and access to care for various healthcare services, qualified health plans are required to submit encounter data containing detail for each patient encounter reflecting all services provided by the providers of the health plan. The

state will determine the minimum data elements of the encounter reporting. A format consistent with the formats and coding conventions of the CMS 1500 and UB-04 will be used initially. PCPs will submit their encounter data monthly to Meridian, who must then submit it to HFS. Both Meridian and provider agree that all information related to payment, treatment or operations will be shared between both parties and all medical information relating to individual members will be held confidential.

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

Claim Edits

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

Meridian utilizes code-auditing software for automated claims-coding verification and to ensure Meridian is processing claims in compliance with general industry standards. This auditing software applies to facility and professional claims. The code-auditing software takes into consideration the conventions set forth in the healthcare insurance industry, such as CMS policies, current health insurance and specialty society guidelines, and the American Medical Association's "CPT® Assistant Newsletter." Using a comprehensive set of rules, the code-auditing software provides consistent and objective claims review by:

- Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology as outlined by the association's CPT®-4 manual
- Evaluating the CPT®-4 and HCPCS codes submitted by detecting, correcting, and documenting coding inaccuracies including, but not limited to unbundling, up coding, fragmentation, duplicate coding, invalid codes, and mutually exclusive procedures
- Incorporating historical claims auditing functionality which links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service.

This software evaluates code combinations during auditing/processing of claims. Denial codes beginning with a lowercase x or y are generated by the code-auditing software or Meridian Payment Policies. The exact reason for denial will not show on the EOP (remittance). These denials cannot be reprocessed by Meridian Provider Services. A [claim dispute](#) with supporting documentation must be completed if the provider does not agree with the denial decision or adjustment request.

For detailed information on specific code-edit criteria, please access our [secure provider portal](#). Code edits can be reviewed in the "Clear Claim Connection" link.

Coordination of Benefits (COB)

Meridian appreciates your assistance and cooperation in notifying us when any other coverage exists, such as, but not limited to, other healthcare plans and worker's compensation benefits. In the event that Meridian is not the only insurance coverage for the member, Meridian should be billed as the secondary payer for all services rendered and is responsible only for the difference between what the primary insurance pays and the allowable Medicaid fee schedule. You can submit your COB claims electronically.

Third Party Coverage

Topic	Description
Identification of Third Party Resources	Providers must always identify third party resources and report third party payments in the appropriate item(s) on the claim. Third party resources must be identified even when the payer does not cover the services.
Commerical Insurance Payments	If payments are made by a commercial insurance, the EOB must be submitted with the claim.
Medicaid Deductible	If the beneficiary's Medicaid deductible amount is met in the middle of a service so that part of the charge is the beneficiary's responsibility and part is Medicaid's responsibility, enter the remaining Medicaid liability for the service in item 24F of the service line.
Evidence of Other Insurance Response	When billing on the CMS 1500 paper claim form, providers must submit evidence of other insurance responses (EOBs, denials, etc.) when billing for covered services. If billing electronically, no EOB is necessary, as all required data are part of the electronic format. However, in all cases where a provider is billing on the CMS 1500 claim form, a copy of the Medicare EOB must be submitted with the claim.
Injectable Drugs Covered as a Pharmacy Benefit by Third Party Payers	When billing for injectable drugs that are covered as a pharmacy benefit by a third party payer but covered as a physician service by Medicaid, the provider must reflect the payment from the carrier on the claim. The fixed copay/coinsurance/deductible must be reported in the appropriate field on the electronic claim form and in Item 24F on the CMS 1500 paper form.

Provider Portal COB Submission

Meridian does not require a copy of the Explanation of Payment (EOP) when COB claims are submitted electronically through your clearinghouse or via the Meridian Secure Provider Portal. When using the secure provider portal, input your COB information directly in the data fields or attach the EOP to the claim. The data fields used to populate COB information are outlined on the following page:

CMS-1500 (Professional)	UB-04 (Institutional)
Amount Allowed* <input style="width: 100%;" type="text" value="XXXX.XX"/>	Carrier Type <input style="width: 100%;" type="text" value="Select..."/>
Deductible <input style="width: 100%;" type="text" value="XXXX.XX"/>	Policy Number <input style="width: 100%;" type="text" value="XXXX.XX"/>
Copay <input style="width: 100%;" type="text" value="XXXX.XX"/>	Amount Allowed <input style="width: 100%;" type="text" value="XXXX.XX"/>
Co-Insurance <input style="width: 100%;" type="text" value="XXXX.XX"/>	Deductible <input style="width: 100%;" type="text" value="XXXX.XX"/>
Amount Paid <input style="width: 100%;" type="text" value="XXXX.XX"/>	Copay <input style="width: 100%;" type="text" value="XXXX.XX"/>
	Co-Insurance <input style="width: 100%;" type="text" value="XXXX.XX"/>
	Amount Paid <input style="width: 100%;" type="text" value="XXXX.XX"/>
	Denial Reasons <input style="width: 100%;" type="text" value="Select..."/> Amount <input style="width: 100%;" type="text" value="XXXX.XX"/> Add Denial Reason

Electronic Data Interchange (EDI) – Clearinghouse Submission

For clearinghouse 837 transactions, simply code the transaction to include the loop for COB as outlined below. For questions on setting up your 837, please contact your clearinghouse.

COB Field Name The below should come from the primary payer's Explanation of Payment	837I – Institutional EDI Segment and Loop	837P – Professional EDI Segment and Loop
COB Paid Amount	If 2320/AMT01=D, map AMT02 or 2430/ SVD02	If 2320/AMT01=D, map AMT02 or 2430/SVD02
COB Total Non-Covered Amount	If 2320/AMT01=A8, map AMT02	If 2320/AMT01=A8, map AMT02
COB Remaining Patient Liability	If 2300/CAS01=PR, map CAS03 Note: Segment can have six occurrences. Loop2320/ AMT01=EAF, map AMT02, which is the sum of all of CAS03 with segments presented with a PR.	If 2320/AMT01=EAF, map AMT02
COB Patient Paid Amount		If 2320/AMT01=F5, map AMT02
COB Patient Paid Amount Estimated	If 2300/AMT01=F3, map AMT02	
Total Claim Before Taxes Amount	If 2400/AMT01=N8, map AMT02	If 2320/AMT01=T, map AMT02

COB Field Name The below should come from the primary payer's Explanation of Payment	8371 – Institutional EDI Segment and Loop	837P – Professional EDI Segment and Loop
COB Claim Adjudication Date	If 2330B/DTP01=573, map DTP03	If 2330B/DTP01=573, map DTP03
COB Claim Adjustment Indicator	If 2330B/REF01=T4, map REF02	If 2330B/REF01=T4, map REF02 with a Y

Notes:

- Calculations can be required depending on how the Primary Payer paid the services, i.e., either individual service lines or rolled up to a claim level. Example: The sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (LOOP ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02). Expressed as a calculation for given payer: {Loop ID-2320 AMT02 payer payment} = {sum of Loop ID-2430 SVD02 payment amounts} minus {sum of Loop ID-2320 CAS adjustment amounts}.
- SBR01+S, then Loop 2320 is used to generate COB

Encounter Billing Guidelines – ERC, FQHC, and RHC

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

Electronic Remittance Advice and Electronic Funds Transfer

Meridian partners with PaySpan Health to offer a solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Using this free service, providers can take advantage of EFTs and ERAs to settle claims electronically without making an investment in expensive EDI software. Following a fast online enrollment, you will be able to receive ERAs and import the information directly into your Practice Management or Patient Accounting System, eliminating the need to key remittance data off paper remittances.

PaySpan Health Benefits to Providers

- **Free service** – Providers are not charged any fees to use the service.
- **Eliminate re-keying of remittance data** – Electronic remittance advices can be imported directly into Practice Management or Patient Accounting Systems, eliminating the need for manual keying off of paper advices.
- **Maintain control over bank accounts** – Providers keep control over the destination of claim payment funds. Multiple practices and accounts are supported.
- **Match payments to advices quickly** – Providers can associate electronic payments with electronic remittance advices quickly and easily.
- **Pursue secondary billings faster** – Accelerates the revenue life cycle.

- **Improve cash flow** – Electronic payments can mean faster payments, leading to improvements in cash flow.
- **Connect with multiple payers** – Providers can quickly connect with any payers using PaySpan Health to settle claims.

With PaySpan Health, you have several options for viewing and receiving remittance details. PaySpan Health will match your preference for remittance information with the following options (potentially constrained by payers):

- EDI 835 ERA data file that can be downloaded directly to your Practice Management or Patient Accounting System
- Electronic remittance advice presented online and printed in your location

You can enroll online at payspanhealth.com or by contacting Payformance Corporation at **877-331-7154**.

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 Section 6 of this manual. See [Standard & Expedited Member Appeals](#).

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:	For Behavioral Health Services:
Fax: 833-383-1503	Fax BH: 866-714-7991
Mail: Meridian ATTN: Medical Necessity Appeals Dept. PO Box 716 Elk Grove Village, IL 60009	Mail: Centene Advanced Behavioral Health (CABH) Appeals Dept. 13620 Ranch Road 620 N, Bldg. 300C, Austin, TX 78717-1116 Fax: 866-714-7991

Claim Disputes

Disputes must be filed within **90 days** from the remittance date. Disputes submitted after the timeframe has expired may not be reviewed. All disputes must be received within 365 days of the 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 prior authorization requirements. If your claim denied for authorization due to a denial or partial denial of the prior authorization request, you must follow the member appeal process. IMPORTANT: If you have an authorization 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 PO Box 4020 Farmington, MO 63640-4402

Type	Where to Submit
<p>Provider Claim Dispute</p> <p>Disputes related to claims processing are handled separately from Administrative Denial Disputes. Claim disputes are disputes regarding the following:</p> <ul style="list-style-type: none"> • Inaccurate Payment or Denial • Coding Edits (Correct Coding Initiative (CCI) edits) • Claims Denied as a Duplicate • Untimely Filing <p>Providers electing to dispute the disposition or reimbursement level of a claim for Date of Service (DOS) after July 1, 2021, may do so via the provider portal (preferred):</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	<p>Two ways to submit:</p> <ol style="list-style-type: none"> 1. provider portal 2. Via mail: <p>Meridian ATTN: Provider Claim Disputes PO Box 4020 Farmington, MO 63640-4402</p>

Binding Arbitration

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

If you have any questions about the Meridian Medicaid post-service claim appeal process, please call **866-606-3700 (TTY: 711)** for more information.



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ILMeridian.com