meridian

Provider Manual

January 2026

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 augment and clarify this information. Major revisions will result in the publication of a revised edition.

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

Please contact your Provider Engagement representative or Member and Provider Services at **866-606-3700 (TTY: 711)** with any questions or concerns.

Thank you for your participation in Meridian's provider network.

January 2026 Manual Updates

This table highlights the most notable additions and updates to this edition. Not all changes are listed. Providers are encouraged to review the complete document and become familiar with its contents.

Section	Description	Page
General Information – Provider Portal	Updated Availity Essentials functionality information	8
Provider Functions and Responsibilities – After Hours Access Standards	Updated standards for specialty care appointments	16
Provider Functions and Responsibilities – Fraud, Waste, and Abuse	Revised mailing address for prepayment review documentation	21
Member-Related Information – Member Grievances and Appeals	Revised timeframes for Expedited External Independent Review	31
Member Benefit Information – Health Benefits for Immigrant Seniors (HBIS)	Updated language to reflect Illinois' termination of the Health Benefits for Immigrant Adults (HBIA) program	37
Utilization Management – Service Authorization Program Overview	Updated to reflect all components of Meridian's service authorization program	40
Utilization Management – Facility admission guidance	Revised prior authorization and notification requirements for facility admissions	41
Utilization Management – Behavioral Health Prior Authorization and Notification Requirements	Updated requirements for mental health and substance use disorder services to reflect Illinois legislation effective 1/1/26	46
Utilization Management – Turnaround Times for Processing Prior Authorization Requests	Updated timeframes for standard pre-service review requests	48
Utilization Management – Peer-to-Peer Discussion	Updated timeframe for providers to request Peer-to-Peer review	49
Utilization Management – Administrative Days	Added information about Administrative Days and criteria for consideration	49

Table of Contents

SECTION 1:

General Information

Our Mission, Vision, and Philosophy

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

About Meridian

Meridian Health Plan of Illinois, Inc. and its family of health plans provide government-sponsored managed care services to families, children, seniors, and individuals with complex medical needs. This includes Meridian Medicaid Plan, YouthCare HealthChoice Illinois, Wellcare (Medicare Advantage plans), Wellcare By Meridian (Medicare-Medicaid plans), and Ambetter marketplace plans. YouthCare is a specialized program designed to address the healthcare needs of Illinois Department of Children and Family Services (DCFS) youth in out-of-home placement and former foster youth. Meridian connects members to care and offers comprehensive services to support lifelong health and wellness. Meridian is a Centene Corporation company.

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
Meridian Departments	
Provider Services • Fee Schedule Assistance • Claims and Billing Questions • Contractual Issues • Initiate Affiliation, Disaffiliation, and Transfers **Member Services** • General Information and Assistance • Verify Member Eligibility • Benefit Information • Claims Status • File Grievances • Verify/Report Newborn Information • Coordination of Benefits • Interpretation Services **Behavioral Health** • Inpatient and Outpatient Mental Health • Substance Abuse Treatment **Care Coordination and Long Term Services and Supports** • Speak to a Member's Care Coordinator • Request Individualized Plans of Care • Check Waiver Eligibility Information **Quality Improvement** • Request Clinical Practice Guidelines • Request Preventive Healthcare Guidelines • Quality Initiative Information • Quality Regulatory Requirements • Disease Management Program Information **Utilization Management** • Submit Prior Authorizations • Notification of Emergent and Urgent Hospital Admissions • Requests for Clinical Criteria • Peer-to-Peer Discussions • Discharge Planning Information	**Medicaid** **866-606-3700 (TTY: 711)** **MLTSS** **866-821-2308** Hours of operation: Monday through Friday, 8 a.m. to 5 p.m.

Key Contact Information (continued)

Contact and Service Function	Telephone Number
External Contacts	
Illinois Client Enrollment Broker (ICEB) • Managed Care Enrollment Questions	**877-912-8880** **(TTY: 866-565-8576)**
Illinois Relay Services	**711**
Pharmacy • Pharmacy and Formulary Questions and Concerns • Pharmacy-Utilization Management Information	**855-580-1688**
Transportation • Member Non-Emergent Transportation	**866-796-1165**
Availity Client Services	**800-AVAILITY (282-4548)**

Provider Portal Resources

Meridian offers time-saving tools through 24/7 access to our secure portals to manage administrative tasks. To make it easier to work with us, Meridian has begun transitioning to **Availity Essentials™** and expects the migration to be complete in 2027. Our current **secure provider portal** is still available during the transition.

Availity Essentials™

Utilize **Availity Essentials** for the following operational tasks:

- Validate eligibility and benefits
- Submit authorization requests and attachments
- Correct and update pending authorization requests
- Submit claims
- Check claim status (24 months from date of service)
- Correct and resubmit claims
- View payment history and Explanation of Payment
- View member gaps in care with the Risk Condition Validation (RCV) and Clinical Quality Validation (CQV) tools
- Receive PCP notifications

Providers working in Availity with other payers can use their existing credentials to access resources for Meridian members. New users must register and create an account. Training resources are available. For assistance, contact Availity Client Services at **1-800-AVAILITY**.

Secure Provider Portal

Providers should utilize the Meridian **secure provider portal** for the following administrative tasks:

- View and download a PCP panel (patient list)
- Update and edit authorization requests
- Submit administrative denial and provider claim disputes

- Check quality scorecards
- Access the Pay for Performance (P4P) program
- View fee schedule information
- Refer members to care management
- Complete patient assessments such as the Notification of Pregnancy
- Secure messaging with the health plan
- Submitting credentialing documentation and updating practice data
- Waiver provider billing

For additional questions about Availity or the Meridian secure provider portal, contact your Provider Engagement representative.

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 the Centers for Medicare and Medicaid Services (CMS), state regulators, 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, 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 Engagement 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 at **ILmeridian.com**. If you complete mandatory training with another health plan, fill out the **Attestation Form [PDF]** and return it to Meridian via one of the following methods:

Fax: **312-980-0418**

Email: **ILproviderrelations@mhplan.com**

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

In addition, the Provider Engagement department holds monthly training **webinars**.

To request a training session, call your Provider Engagement representative or email **ILproviderrelations@mhplan.com**.

Cultural Competency

Cultural Competency requires the tailoring of services and supports to meet the unique social, cultural, and linguistic needs of your patient.

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, call Member and Provider Services at 866-606-3700 and ask for an interpreter.

Meridian maintains a Cultural Competency Plan that monitors the availability of the following services at the health plan and provider level:

- Language services
- Transportation services
- Reasonable accommodations for members with disabilities to access services and/or facilities

In addition, Meridian and participating providers share responsibility for:

- Informing members of the availability of cultural, linguistic and disability access services, at no cost to Medicaid recipients
- Providing diversity and cultural competency training to all staff
- Promoting a culturally, linguistically, and disability diverse workforce that reflects the diversity of its patients

Provider IMPACT Enrollment, Credentialing, and Re-Credentialing

Providers applying for participation with Meridian (Medicaid) must be credentialed with Illinois Medicaid through the Illinois Medicaid Program Advanced Cloud Technology (**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 five years.

Additionally, Meridian requires enrollment information to load providers accurately for the Meridian Medicaid Plan. Submission of the Illinois Association of Medicaid Health Plans (IAMHP) Universal Roster, found on their **website**, is also required.

Providers wishing to participate with Meridian and non-contracted providers seeking reimbursement must be enrolled within HFS' IMPACT system to provide services to members. If you are already enrolled with IMPACT, complete a **Network Intake Form** on our website to request to join our provider network. You may also email **ILJoinOurNetwork@centene.com** to obtain a contract for participation and enrollment criteria.

Providers with general questions about IMPACT or provider enrollment should contact:
Email: **IMPACT.Help@illinois.gov**
Phone: **1-877-782-5565** (select option #1)

All providers credentialed in IMPACT may submit for participation in 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 based on that license or certification.

Time Frame of the Enrollment Process

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

Checking the Status of a Contract

Providers can check on the status of their contract application by emailing **ILJoinOurNetwork@centene.com**.

Submission of Full Provider Roster

Providers are encouraged to submit the IAMHP Universal Roster found on the **IAMHP website** on a monthly or quarterly basis, with all current provider, group, and facility detail. Submit completed rosters using Meridian's **Provider Updates tool** (preferred method) or email **ILrostersubmission@mhplan.com**.

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

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 tool**.

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

Timely Submission of Provider Updates

Use the **Provider Updates tool** to inform Meridian of changes to individual practitioners or your group so member can access current information. Meridian reminds providers that updates submitted to the health plan should also be reported to the Illinois Department of Healthcare and Family Services (HFS).

Use the **Provider Updates tool** for:

- Requesting 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, Meridian, or an authorized vendor, may contact our network of providers through various methods, such as letters, phone campaigns, or email outreach. We request timely responses to these communications to ensure member access to care.

Home and Community Based Services (HCBS) Providers

Service requirements for HCBS providers:

- HCBS providers will render services in accordance with the person-centered plan of care (POC) including the amount, frequency, duration, and scope of each service in accordance with the member's service schedule
- HCBS services require prior authorization, and HCBS providers are responsible for confirming an active authorization for services being rendered
- 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 monthly, 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 the provider will be selected by the member as the service provider should program enrollment occur

- Communicating with existing program members via telephone, face-to-face, or written communication for the purpose of petitioning the member to change providers

If 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*** of the manual.

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 healthcare. This may include, but is not limited to, ensuring that all medically necessary care is made available and delivered to facilitate continuity of member healthcare and to promote and deliver the highest quality healthcare.

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

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

Identification of Medical Homes

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

Medical Homes must provide high-quality, evidence-based primary care services; acute illness care; behavioral healthcare (as appropriate); chronic health condition management; and referrals for specialty care and Long Term Services and Supports (LTSS). Medical Homes provide all PCP services and are 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 the 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. To obtain the self-assessment tool, contact your Provider Engagement representative to ensure your practice meets PCMH requirements.

B. Support

Meridian supports 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 embeds care coordinators (as appropriate) onsite at FQHCs, CMHCs, and high-volume providers, to support the integration of behavioral and physical healthcare if providers request this service.

- Meridian's Provider Engagement department, in collaboration with the Quality Improvement department, educates 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 orientations, office visits, the provider manual, provider newsletters, provider mailings, fax blasts, and website updates
- Meridian provides general guidance and access to resources to practice utilization as part of the Medical Home's transformation and improvement efforts
- Health Information Technology (HIT) – Medical Homes are supported by HIT, including but not limited to, electronic transfer of data and the Meridian **secure provider portal**
  - Medical Homes must meet federal requirements for meaningful use and agree to share quality and other clinical data
  - Medical Homes can access electronic medical record data collection to support quality improvement
  - Medical Homes can access Meridian's secure provider portal for:
    - Verification of eligibility
    - Authorizations
    - Claims status and submission/correction
    - Member information and reports
    - Enrollment lists
    - HEDIS® bonus information — See ***Quality Improvement (QI) Program Activities section***
    - HEDIS medical record submission

Specialty Care Providers

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

- Rendering covered services requested by the PCP
- Communicating in a timely way 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
- Complying with Meridian policies and procedures

Hospital Providers

Meridian recognizes that hospitals are valuable in the provision of care. 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 PA before rendering services
- Communication of all pertinent patient information to Meridian and the PCP
- Notification of all hospital admissions to the Meridian Utilization Management staff (see ***Utilization Management section***)
- Maintaining 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

Ancillary Providers

Meridian recognizes that the ancillary provider is a 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 PA before rendering services
- Communication of all pertinent patient information to Meridian and the PCP

After-Hours Access Standards

All participating provider agreements with PCPs, specialists, and behavioral health providers 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 pager/cell phone
- Call forwarded to practitioner's home or other location
- Published after-hours phone number and recorded message directing enrollee to a practitioner for urgent and non-life-threatening conditions

There must be a method to talk to a physician 24 hours a day, seven days a week regarding after-hours care for urgent or non-life-threatening conditions, as well as instructions to call 911 or go to the Emergency Department in the event of a life-threatening condition or serious trauma.

Messages should not instruct members to obtain treatment at the Emergency Department for non-life-threatening conditions. The patient must be able to leave a message for an on-call doctor, speak with an on-call doctor, or be forwarded to an on-call doctor.

After-hours voice messages must contain ONE of the following:

- Message forwarding members to on-call provider
- Message forwarding members to an answering service
- Message providing members with the on-call practitioner's phone number and/or pager number
- Message referring members to another office, practitioner, or on-call service

Member Access and Availability Guidelines

Through their Participating Provider Agreement, Meridian providers have a responsibility to provide access to their Meridian patients 24 hours a day, seven days a week. 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 medical needs on a 24-hour a day, seven-day-a-week basis. The provider may delegate this responsibility to another Meridian contracted 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 pager number. Notify Meridian Provider Services of 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 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.

Appointment and Timely Access to Care Standards

Primary Care Appointments (Excludes OB/GYNs)	
Type of Care/Appointment	**Length of Wait Time**
Preventative/Routine Care (Child < 6 months)	Within two (2) weeks of request
Preventative/Routine Care (Child ≥ 6 months)	Within five (5) weeks of request
Preventative/Routine Care (Adult)	Within five (5) weeks of request
Urgent/Non-Emergent (Medically Necessary) Care	Within one (1) business day of request
Non-Urgent/Non-Emergent Conditions	Within three (3) weeks of request
Initial Prenatal w/o Problems (First Trimester)	Within two (2) weeks of request
Prenatal (Second Trimester)	Within one (1) week of request
Prenatal (Third Trimester)	Within three (3) calendar days of request
Office Wait Time	Within thirty (30) minutes
Different Hours for Member Plans?	No, hours must be the same for all members and patients

Behavioral Health Appointments	
Type of Care/Appointment	**Length of Wait Time**
Life-Threatening Emergency	Immediate admittance or referred to the Emergency Room
Non-Life-Threatening Emergency	Within six (6) hours of request
Urgent Care Visit	Within forty-eight (48) hours of request
Initial Visit for Routine Care	Within ten (10) business days of request
Follow-Up Visit for Routine Care	Within twenty (20) business days of request
Office Wait Time	Within thirty (30) minutes
Different Hours for Member Plans?	No, hours must be the same for all members and patients

Specialty Care Appointments	
Type of Care/Appointment	**Length of Wait Time**
Routine Care (Child < 6 months)	Within two (2) weeks of request
Routine Care (Child ≥ 6 months)	Within five (5) weeks of request
Routine Care (Adult)	Within five (5) weeks of request
Urgent/Non-Emergent (Medically Necessary) Care	Within one (1) business day of request
Non-Urgent/Non-Emergent Conditions	Within three (3) weeks of request
Office Wait Time	Within thirty (30) minutes
Different Hours for Member Plans?	No, hours must be the same for all members and patients

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 communicated 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. PCPs 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 such 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 **exclusions.oig.hhs.gov**.

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

Fraud, Waste, and Abuse

Meridian takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with both state and federal regulations.

What is FWA?

Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program (18 U.S.C. § 1347).

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Abuse includes any action(s) that may, directly or indirectly, result in one or more of the following: unnecessary costs to the healthcare system, including the Medicare and Medicaid programs; improper payment for services; payment for services that fail to meet professionally recognized standards of care; and services that are medically unnecessary.

Examples of FWA:

- Upcoding
- Unbundling
- Billing incorrect CPT code to identify a service
- Incorrect use of modifiers
- Billing for services outside of the provider's scope of practice
- Billing and performing services that are not medically appropriate
- Excessive units of service or excessive services per day
- Billing for services not rendered
- Member identity theft

Meridian, with its parent company Centene Corporation, operates a Special Investigations (SIU) unit to detect, investigate, and prosecute FWA. Meridian performs front- and back-end audits to ensure compliance with billing regulations. Our sophisticated code-editing software performs systematic audits during the claims payment process. To better understand this system, review the ***Billing and Payment section*** of the manual.

Centene's SIU performs prepayment and retrospective audits, which in some cases may result in taking actions against those who, individually or as a practice, commit FWA, including but not limited to:

- Conducting remedial education and/or training intended to eliminate the inappropriate or egregious action(s)
- Implementation of more stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Referral to appropriate agencies for civil and/or criminal prosecution
- Implementation of any other remedies available to rectify the FWA

The SIU uses a variety of mechanisms to detect potential FWA. All key functions, including Claims, Provider Services, Member Services, Medical Management, as well as providers and members, share the responsibility to detect and report fraud. Review mechanisms include auditing, review of provider billing patterns, hotline reporting, claim review, data validation, and data analysis.

FWA Safeguards

Federal program payments may not be made for items or services furnished or prescribed by an excluded provider or entity. Meridian may not use federal or state funds to pay for services, equipment, or drugs prescribed or provided by a provider, supplier, employee, contractor, or subcontractor excluded by the Office of the Inspector General (OIG).

The SIU conducts two types of reviews:

Prepay – Submitted claims are pended for further review, and medical records must be submitted for the claims to be considered for payment. Pended claims will be documented on the Explanation of Payment (EOP).

The code *EXye* will be attached to all pended claims, and a letter will be sent with details. If you receive a prepay notification advising that claim services have been pended *EXye*, follow the instructions in the letter.

Do NOT submit the requested records to Meridian; submit hard copies of all documentation, including a copy of the relevant EOP(s) to the following address:

Meridian
Attn: Claim Department
P.O. Box 4020
Farmington, MO 63640-4402

You may also submit requested prepayment review documentation via the **secure provider portal** under the "Reconsider Claim" section. Select "Audit-Medical Records requested" from the drop-down menu to ensure the records are correctly routed for review.

Retrospective review – Comprehensive review of member medical records is performed for claims previously paid.

A retrospective review may consist of a request for medical records. If required, a letter will be sent outlining the documents necessary to conduct the review. Follow the instructions in the letter explaining how to submit documentation. Do NOT send requested documents directly to Meridian; instead, follow the instructions in the letter for submitting documentation through the **secure provider portal**, or mail copies of the records to the following address:

Centene Special Investigations
7700 Forsyth Blvd, Suite 519
Clayton, MO 63105

Once a retrospective review has been completed, notification of the results will be provided. The notification will include instructions on how to remedy any identified overpayment or, alternatively, guidance on submitting an appeal request.

A request to appeal must be submitted within sixty (60) calendar days from receipt of the Proposed Action – Findings letter. Follow instructions in the letter to obtain access to our **secure provider portal** to upload records, or you may submit the appeal request, including all supporting documentation, to the following address:

Centene Special Investigations
7700 Forsyth Blvd, Suite 519
Clayton, MO 63105

Note that the Illinois Department of Healthcare and Family Services' (HFS) "Handbook for Practitioners Rendering Medical Services" outlines that in the absence of proper and complete medical records, claim payments will not be made, and payments previously made will be recouped. Additionally, lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

Sampling and Extrapolation

HFS and Meridian audits may involve the use of sampling and extrapolation. Audit sampling is the application of an audit procedure to less than 100 percent of claims in an audit universe. Under this procedure, Meridian selects a statistically valid random sample of claims during the audit period in question and audits the provider's records for those claims. Meridian uses random sampling to estimate the parameters of a population to measure and control sampling risk. Using random sampling, every sample unit of the population is equally likely to be in the sample. Random sampling allows Meridian to achieve statistical validity and ensures the sample represents the entire population of claims.

All overpayments determined by an audit of the claims in the sample are totaled and extrapolated to the entire universe of claims during the audit/review period. Following final determinations, the provider must pay Meridian the entire extrapolated amount of any overpayments calculated using this process.

Reporting Suspected FWA

Participating providers are required to report to Meridian any cases of suspected FWA, inappropriate practices, or other inconsistencies of which they have knowledge or suspicion.

Providers can confidentially report suspected FWA in the following ways:

- By phone 24/7 to the confidential FWA Hotline at **1-866-685-8664**
- By emailing **special_investigations_unit@centene.com**

Relevant FWA Laws

There are several relevant laws that apply to FWA.

- The **Federal False Claims Act** (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud and abuse in government healthcare programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The FCA prohibits, among other things:

  - Knowingly presenting a false or fraudulent claim for payment or approval
  - Knowingly making or using, or causing to be made or used, a false record or statement to have a false or fraudulent claim paid or approved by the government
  - Conspiring to defraud the government by getting a false or fraudulent claim allowed or decrease an obligation to pay or transmit property to the government
- **Anti-Kickback Statute**
  - The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program. Remuneration includes anything of value, directly or indirectly, overtly, or covertly, in cash or in kind.
- **Self-Referral Prohibition Statute (Stark Law)**
  - Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship unless an exception applies
- **Health Insurance Portability and Accountability Act (HIPAA) requires, in part:**
  - Transaction standards
  - Minimum security requirements
  - Minimum privacy protections for protected health information
  - National Provider Identification (NPI) numbers

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

Advance 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 such 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 cannot. Members may give their agent specific directions about healthcare they do or do 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 the healthcare power of attorney, the member's agent can:

- See the member's medical information and other personal information
- Choose and dismiss the member's healthcare providers
- Approve or deny medical treatments
- 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 to 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 healthcare 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 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 to 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 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 experienced 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.

SECTION 3:

Member-Related Information

Member and Provider Services Department

The Member and Provider Services department 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:

- PCP and site changes
- Women's healthcare provider changes
- Complaints/grievances
- Disenrollment requests
- Rights and responsibilities

Member Rights and Responsibilities

Meridian prides itself on the care and high-quality customer service it delivers to all members and we encourage providers and staff to become familiar with member rights. Meridian and its contracted providers must comply with all requirements of 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 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 upon with Meridian or its providers
- Understand their health problems and participate in developing mutually agreed-upon treatment goals (to the extent possible)
- Contribute toward their own healthcare, including exhibiting appropriate behavior

Eligibility

It is important to verify eligibility before rendering services. Request to see the member's Meridian member ID card (and other health insurance ID cards if appropriate) at each encounter to support eligibility verification.

To verify a member is currently eligible to receive services:

Electronic Verification

- Check eligibility via **Availity Essentials**, where PCPs can also obtain a monthly eligibility report
- Utilize the State of Illinois' HFS MEDI website at **medi.hfs.illinois.gov**

Phone Verification

- Call our Member and Provider Services department at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m.
  - Member and Provider Services can only give verbal eligibility verification
- Call Meridian's Eligibility Self-Service Application at **866-606-3700 (TTY: 711)** and follow the directions as prompted. The system will then verify if the member is eligible on the date of service indicated.

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.

Member Identification

All Meridian members receive a 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 the Meridian member ID card.

Sample Medicaid ID Card (Front)

meridian
ILMeridian.com

Regulatory Agency –
Healthcare and Family Services

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

PCP: Jane Smith
Phone: 555-555-5555

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

Sample Medicaid ID Card (Back)

Effective Date:

Send claims to:
Meridian
PO Box 4020
Farmington, MO 63640-4402

Pharmacy Help Desk: 833-750-4407
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 Member and Provider Services 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 their secure member portal. Providers may also elect to download and complete a **Primary Care Provider Reassignment Form [PDF]** and fax it to **844-751-1870**. PCP changes take 24 to 48 hours to update on the secure 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 impairments, 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 broker 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.

The Certificate of Transportation Services (CTS) Form (HFS 2271) is used for all non-emergency transports originating at a Meridian member's private residence. The **HFS 2271 Form [PDF]** will be used for prior and post approval purposes to determine the appropriate level of medically necessary transport.

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 **at least three days in advance**.

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

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 includes securing transportation for reasons outside of medical necessity and abusive behavior toward the transportation provider. Meridian reserves the right to withhold non-emergent transportation services from members who abuse the service.

Members who must access non-emergent travel 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 (TTY: 1-866-565-8576)**.

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 (HIPAA). Members may obtain a copy of Meridian's Notice of Privacy Practices by visiting **Meridian's website** and selecting "Notice of Privacy Practices" 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 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 NCQA require that Meridian conduct annual surveys (e.g., Consumer Assessment of Healthcare Provider Systems (CAHPS®)) 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 assist Meridian with obtaining data necessary for these surveys. Providers will be notified in advance of their required participation and the time frames 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** explains 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 adverse determination and explains the member's appeal rights, including instructions on 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 obtain an appointment with their doctor in a timely manner
- A member cannot obtain a referral from their doctor in a timely manner
- A member has been denied 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:

Fax: **833-669-1734**

Email: **medicaidgrievances@mhplan.com**

Meridian
ATTN: Grievance Coordinator
PO Box 10353
Van Nuys, CA 91410-0353

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

A member's authorized representative, 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 downloading and completing the Meridian **Authorized Representative Designation Form [PDF]** and faxing or mailing it to the address listed on the form.

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 to the appropriate address listed below. **Please note that appeals for behavioral health services and pharmacy requests are managed separately from appeals for other healthcare services.**

Non-Rx and Non-Behavioral Health Services and Appeals	Behavioral Health Services and Appeals	Member Rx
Meridian Member Appeals Dept. PO Box 716 Elk Grove Village, IL 60009 Non-Rx Fax: **833-383-1503**	**Centene Behavioral Health Appeals (denied auth on file)** PO Box 10378 Van Nuys, CA 91410-0378 BH Fax: **866-714-7991**	**Meridian Pharmacy Appeals** PO Box 31398 Tampa, FL 33631-3398 Fax: **888-865-6531**

Within three (3) business days of receiving the appeal, Meridian will confirm receipt in writing. 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 situation is clinically urgent and reviewing the appeal in the standard time frame would jeopardize the member's life or well-being, a member or their provider can request an Expedited Appeal. Requests that do not meet these criteria will be processed within the standard time frame.

Meridian medical directors will make a decision about the appeal **within 24 hours** of receiving all required information. The member and their provider will be notified verbally of the outcome of the appeal. A written notification will also follow.

All member Expedited Appeals may be sent to the Member Appeals department fax number or mailing address noted above.

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

If an adverse benefit determination is upheld following a standard or expedited appeal, members or their authorized representatives have the right to request an External Independent Review (EIR). Members must request an EIR **within 30 days** of Meridian's notification of the appeal decision. An EIR request or an expedited EIR request may be sent to the Member Appeals department by fax or to the mailing address noted below.

Addresses and fax numbers to file a request for an EIR and an expedited EIR:

Non-Rx and Non-Behavioral Health Services	Behavioral Health Services	Rx Services
Meridian **ATTN: Member Appeals Dept.** PO Box 716 Elk Grove Village, IL 60009 Non-Rx Fax: **833-383-1503**	**Meridian** **ATTN: Member Appeals Coordinator** PO Box 10378 Van Nuys, CA 91410-0378 BH Fax: **866-714-7991**	**Meridian Pharmacy Appeals** PO Box 31398 Tampa, FL 33631-3398 Fax: **888-865-6531**

The right to request an EIR process is reserved for members after completion of an appeal regarding a prior authorization denial. EIR is not available for providers regarding claims payment, handling, or reimbursement for covered services. Meridian will not consider EIR requests by providers made on behalf of members after services are rendered. The reviewer will make a decision about the appeal within five (5) days of receiving all required information.

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

If the member's situation is clinically urgent, the member or a provider acting on behalf of the member may call Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m., to file an expedited request for EIR.

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

State Fair Hearing

Final decisions of appeals, including expedited Appeals, not resolved wholly in favor of the enrollee may be appealed by the enrollee to the State under its fair hearings system **within 120 days** after the date of Meridian's decision notice. The adverse determination letter will outline the procedure for requesting 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.

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

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

Illinois Department of Human Services Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602
Fax: **312-793-8573**
Email: **DHS.HSPAppeals@illinois.gov**
Phone: **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 printed list of participating providers, contact Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m., and a provider directory or portions of a directory, can be mailed to you or the member requesting it. The Region 4 – Cook County Provider Directory is **available online** in digital form only. Contact Member and Provider Services for in-network services and providers.

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 (PA) requirements**, contact Member and Provider Services or visit 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 use services
- 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
- 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 use disorder 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
- Services provided through Local Education Agencies

Home and Community Based Services (HCBS) Program

The state's **HCBS program** provides services to five waiver groups covered by Medicaid managed care organizations, 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 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 the DON assessment
- **Persons residing in Supported Living Facilities (SLF) Waiver**
  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 need 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.

HCBS 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

HCBS Covered Services				
Service	**Aging**	**Disability**	**HIV/AIDS**	**Brain Injury**
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.

Health Benefits for Immigrant Seniors (HBIS)

Meridian will administer benefits for qualifying Meridian individuals aged 65 and over currently enrolled in the Health Benefits for Immigrant Seniors (HBIS) program. These members are eligible for all Medicaid benefits as described under the ***Medicaid Covered Services section***, except for the services noted below. Some exceptions apply, and applicable member cost share is outlined below.

HBIA and HBIS Membership Coverage Details	
Benefits/Services not covered	**Services that require copayments***
Long Term Care Services (exception is 90-day rehab stays in a nursing facility)	Non-emergency inpatient hospital stays: **$250**
Home and community-based services	Hospital or ambulatory surgical treatment center outpatient services: **10%** of the department rate
Transplant services (stem cell/bone marrow and kidney transplants are covered)	

** Meridian will waive the $100 non-emergent ER copayment.*

Providers can confirm eligibility for this population through MEDI or the member's Meridian ID card identifying their plan name as "Health*Choice* Illinois – HBIS."

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.

PCPs should work with their members to provide family planning services or assist them in selecting a provider, as requested. Members may also contact Member and Provider Services for family planning assistance at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m.

Women's Health

Women may select a Women's Health Care Provider (WHCP) in addition to their PCP. The WHCP must be a provider with 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 from among in-network Meridian providers. A list of WHCP providers participating is available 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 as 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, contact Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m.

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) Express Scripts® to manage members' pharmacy benefits. Express Scripts provides Meridian members with an extensive pharmacy network, pharmacy claims management services, and pharmacy claims adjudication.

Providers can call **855-580-1688** for prior authorizations (PA) or to speak with a clinical pharmacist regarding any pharmaceutical, medication administration, or prescribing issue.

When prescribing medications, providers should access the Meridian Preferred Drug List (PDL) and the associated interim updates listed on the **Pharmacy page** at **ILmeridian.com**.

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

Medicaid-Specific Benefits

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

Prior Authorization or Formulary Exceptions

If a medication is not on the PDL, a provider can submit an online exception request via **CoverMyMeds** or fill out a **Prescription Drug Prior Authorization Request Form [PDF]**. The form must include all required information for a determination. Fax completed forms to **855-580-1695** or submit online via **CoverMyMeds**. In emergencies, call **855-580-1688**.

Formulary exceptions should be obtained before giving the member 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.

SECTION 6:

Utilization Management

Service Authorization Program Overview

Meridian's **service authorization program** aligns members' plan benefits with evidence-based medical guidelines. The program assures members receive safe, high-quality, and equitable care through **pre-service**, **concurrent**, **retrospective**, and **peer-to-peer reviews**. For program definitions, refer to the **service authorization program glossary** on our website.

Meridian utilization management (UM) reviewers consider standards of practice and the member's overall condition. All adverse determinations are made by a medical director and are not based solely on guidelines. Clinical information is required to determine medical necessity for all services subject to clinical review. Meridian does not reward our providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

UM staff reference plan documents for benefit determination and evidence-based medical necessity guidelines to support decision-making. These guidelines can be found on our **Service Authorization Program** web page and include McKesson's InterQual guidelines, 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 from national accreditation organizations. Any proprietary criteria can be accessed in **Availity Essentials** 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.

It is the responsibility of the attending physician to make all clinical decisions regarding medical treatment. These decisions should be consistent with generally accepted principles of professional medical practice and in consultation with the member.

In addition:

- UM decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the member's eligibility and 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.

Pre-Service Review (Prior Authorization)

Prior authorization (PA) or precertification is a **pre-service review** of medical information before the delivery of healthcare services. The purpose is to determine if the care and setting are medically appropriate according to established guidelines, and to engage Meridian's Care Coordination team. Additional information about clinical guidelines can be found on our **Service Authorization Program** web page.

Determining Services That Require Prior Authorization

Providers can search code-specific criteria using the Meridian Medicaid Prior Auth Check Tool. 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.

Refer to the ***Services Requiring Authorization section*** for general guidance on services requiring PA.

How to Request Prior Authorization

- **Submit PAs through Meridian's provider portals**
- **Submit PAs for certain services through vendor solutions** for review as noted below.

Service Type	Vendor Links
Dental	**Centene Dental Services**
MRA, MRI, PET, CT Scans, and Cardiac Imaging	**Evolent**
Pain Management	**Evolent**
Speech, Occupational and Physical Therapy	**Evolent**
Musculoskeletal Services	**Evolent**
Oncology/Supportive Drugs for Members Age 18 and Older	**Evolent Specialty Services**
Pharmacy	**covermymeds**
Non-Emergent Non-Ambulance Transportation	**MTM**

- **Meridian fax submission options**

  If submitting a PA request to Meridian by fax, please use the following forms:
  - **Inpatient Medicaid Prior Authorization Form (PDF)**
  - **Outpatient Medicaid Prior Authorization Form (PDF)**
    - **Outpatient Authorization Supplemental Form (PDF)** – *For use when an authorization request exceeds four (4) procedure codes*

Services Requiring Authorization

General PA requirements are noted below. The list is not all-inclusive of services and is subject to change. Providers are given a 60-day advance notice prior to any changes. Verify requirements by utilizing our **Prior Auth Check** tool.

General PA requirements:

- Elective inpatient admissions
- All transplant surgeries
- Durable medical equipment (DME) requests greater than $1,000 always require PA

- 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 health services (see ***Behavioral Health section***)
- 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 include supporting documentation with your PA request indicating why services are being rendered out of network
- Authorizations for outpatient services must be obtained prior to rendering services
- Certain diagnostic procedures

Services that DO NOT require PA

Meridian does not require pre-service review for the following services (pre-service review may be required for out-of-network providers):

- Emergency services, including emergency medical screening
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
- Crisis stabilization care (outpatient mental health services for no less than 30 days post-crisis)*
- Unplanned inpatient hospital/observation admissions* – Observation status does not negate the need to secure authorization for services rendered during an observation stay that require PA (e.g., radiology services)
- Family planning and reproductive health services
- Child & Adolescent Health Center Services* – Child Mobile Crisis services do not require PA. 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

** Notification requirements may apply. See **Facility Admission Guidance section** below.*

Facility Admission Guidance

- **Planned (elective) inpatient hospital admissions** must have PA before the admission occurs.
- **Unplanned inpatient hospital admissions** require notification to Meridian within 48 hours of admission to the facility. If notification requirements are met, utilization review will not be initiated for the first 72 hours of admission.
- **Skilled nursing, long-term acute care, and rehabilitation facility admissions** require PA before the admission occurs.

Refer to the ***Behavioral Health Prior Authorization and Notification Requirements section*** for details specific to mental health and substance use disorder services.

Deliveries

Meridian does not require a PA for deliveries. Submit notification of admission when the member has been admitted. Include the following:

- Member's name and date of birth
- Medicaid Identification Number
- Baby's date of birth and time of delivery
- 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 time frame, include clinical information for a medical necessity review.

- Vaginal Delivery: Up to two (2) days approved
- C-Section Delivery: Up to four (4) days approved

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

Concurrent Review, Discharge Planning, and Transition of Care

Concurrent review is an assessment of ongoing clinical care to determine if services being provided meet clinical guidelines for the appropriate level of care and setting. Licensed clinical reviewers assess the care and services provided, and the member's response to the care, by applying clinical guidelines.

Inpatient concurrent review supports the coordination of the member's discharge plan. Meridian's reviewers work with the facility discharge planners to:

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

Examples of Services Eligible for Concurrent Review

Concurrent review may apply to care or services delivered in inpatient or outpatient settings. For inpatient concurrent review requests, if the discharge is confirmed at the time of the initial request/notification of the admission, retrospective review may be applied.

Examples of concurrent reviews:

- A continued stay review for an inpatient facility stay
- A new admission to a facility when the plan is notified after the admission has occurred, but before the member has been discharged
- An extension to a specified course of allergy injections
- An extension to a series of physical or occupational therapy treatments
- A specified plan of continuation of home health services
- Continued rental or purchase of oxygen and its related durable medical equipment (DME)

Clinical Review Requests

Clinical information is required for all clinical review requests to ensure timely decisions by Meridian. The decision time frame 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.

Clinical information includes relevant information regarding the member's:

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

Retrospective Review

Retrospective review is the process of reviewing a request for services that have already been received. Meridian applies the same medical necessity guidelines used for pre-service decisions and considers the member's needs at the time of service.

Examples of Services Eligible for Retrospective Review

Meridian may make retrospective medical necessity review decisions when:

- A member was discharged from an inpatient admission prior to timely notification to the health plan
- Non-routine obstetrical admissions require additional days of service
- Authorization or timely notification was not obtained due to extenuating circumstances
  - Services received prior to the date of notification may be retrospectively reviewed for up to five (5) calendar days if there are extenuating circumstances; dates prior to five (5) calendar days are administratively denied

Meridian does not retroactively authorize services rendered. Follow pre-service review procedures for services that require authorization.

Behavioral Health Utilization Review

Meridian's approach to administering behavioral health services aims 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 needs 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 that provides 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 UM team collaborates with providers to support all levels of care:

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

All behavioral health utilization reviews are completed by licensed qualified mental health practitioners, and any adverse determinations 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 McKesson InterQual guidelines, 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 guidelines/criteria utilized in decision-making are available free of charge upon request.

Discharge Planning and Transitions of Care

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 for 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 [PDF]** is available on the "Manual, Forms and Resources" page of **ILmeridian.com**. Complete and submit the form 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 with the following core components:

- Scheduled appointment with a behavioral health specialist within seven (7) days of discharge
- Scheduled follow-up appointment with member's PCP
- List of medications prescribed

Behavioral Health Prior Authorization and Notification Requirements

Utilize these notification and authorization requirements for behavioral health services.

Mental Health Services	
Notification required within 48 hours (Effective 1/1/26, notification is required within 48 hours of admission. If notification requirements are met, concurrent review will not be initiated for the first 72 hours of admission.)	• Inpatient hospitalization
Notification required within 24 hours (Effective 1/1/26, notification is required within 24 hours of initiation of services. Concurrent review may begin after the 24-hour notification period.)	• Partial hospitalization • Intensive outpatient program • Adaptive Behavior Treatment – initial assessment
Prior authorization required	• Adaptive Behavior Treatment (initial assessment requires notification within 24 hours)
No prior authorization required	• Community Support Team • Electroconvulsive therapy • Psychiatric evaluation • Psychological evaluation • Psychological and neuropsychological testing • Medication management • Crisis intervention • Treatment planning development/review/modification • Community Support Services, individual and group • Outpatient therapy
Substance Use Disorder Services	
Notification required within 24 hours (Effective 1/1/26, notification is required within 24 hours of initiation of services. Concurrent review may begin after the 24-hour notification period.)	• Inpatient hospitalization • Detoxification • Substance use – Residential
No prior authorization required	• Medication administration

Service Authorization Program 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 (For example, when a physician requests an extended length of stay (ELOS) for a previously authorized inpatient admission for a member currently in the hospital, the ELOS request would be classified as concurrent review.)
Meridian Medicaid – Face Sheets	**833-544-1826**	Documents that 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 for the submission of the following completed forms: **Inpatient Prior Authorization Form [PDF]** **Outpatient Prior Authorization Form [PDF]**
Meridian Medicaid Behavioral Health: Inpatient – Prior Authorization	**833-544-1827**	Used for BH services on inpatient form. **Inpatient Prior Authorization Form [PDF]**
Meridian Medicaid Behavioral Health: Outpatient – Prior Authorization	**833-544-1828**	Used for BH services on outpatient form. **Outpatient Prior Authorization Form [PDF]**

When submitting a PA request by fax, include the following information:

- Member's name
- Member's Medicaid Identification Number
- Date(s) of service (DOS)
- Facility where services are to be rendered; include TIN and NPI
- Diagnosis/Procedure code(s), as applicable

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 (4) calendar days after Meridian receives the request.

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 (Adverse Determinations)
Pre-Service Review: Standard	Within 5 days of receipt of the request	Within 5 days of receipt of the request	Within 5 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 72 hours of receipt of the request	Within 72 hours of receipt of the request	Within 72 hours of the request
Retrospective Review *Meridian only reviews certain service types for Retrospective Review*	Within 30 days of receipt of the provider's request (N/A for members)	Within 30 days of receipt of the request	Within 30 days of receipt of the request

Notification of Determination

Notification of a review determination is 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 adverse determination notification will include the following:

- Rationale
- Reference to the benefit provision, clinical guidelines and/or clinical policy used, and directions on how to obtain a copy
- Opportunity to discuss the determination with a medical director
- Appeal rights

Peer-to-Peer Discussion

A 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 or a request for further documentation 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 an adverse benefit determination may result in an overturn. The request must be submitted **within ten (10) calendar days** of the initial denial notification. Meridian will work with the treating physician to schedule the peer-to-peer review **within three (3) business days** of receipt of the request.

Medical directors may verbally notify the provider of their decision during or after the peer-to-peer discussion. All providers will be notified of Meridian's decision in writing **within 24 hours** of the peer-to-peer review.

Administrative Days

Administrative Days may be requested once the facility receives notification that medical necessity criteria are no longer met and a denial has been issued. Administrative Days provide reimbursement, at a reduced rate, when a member no longer meets medical necessity criteria for the current level of care and there are barriers to discharge. Please note, if Administrative Days are approved, providers waive their appeal rights and may not appeal the medical necessity denial.

Administrative Days Request Procedure and Criteria

Request Administrative Days by faxing supporting documentation to the appropriate number listed below. Label your submission "Administrative Days Request."

- Standard/Urgent Requests Fax: **833-544-0590**
- Behavioral Health Requests Fax: **833-544-1827**

Criteria for Administrative Days consideration include:

- Member is covered by Medicaid.
- Initial admission diagnosis required an acute inpatient level of care.
  - Initial admission was authorized by Meridian.
  - Notification requirements were met, and the date and time of the admission and notification should be included with the request.
- A discharge plan to a lower level of care is documented and submitted with the request.
  - Barriers to the discharge plan beyond the control of the provider, facility, and/or health plan are documented.
  - The facility has notified Meridian as soon as they believe post-discharge placement will be difficult and has made reasonable efforts to engage the health plan in discharge planning (date of notification, Meridian point of contact, and other pertinent details should be included with the request).

Medical Necessity Appeals

Pre-service medical necessity appeals must be filed as outlined in the ***Standard & Expedited Member Appeals section*** of the manual. Members or their authorized representatives have 60 days from the date of the Adverse Benefit Determination letter to file an appeal verbally or in writing.

Post-service medical necessity appeals must be filed as outlined in the ***Provider Appeals and Claim Dispute Process section*** of the manual. Providers have 90 days to file a post-service appeal in writing from the date of the Explanation of Payment (EOP).

SECTION 7:

Care Coordination and Disease Management

Care Coordination Program

The purpose of Meridian's Care Coordination program is to link members to 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, specialists, substance use, mental health, and community supports.

Care coordination ensures members receive the most appropriate services, in the most appropriate setting, at the appropriate time and uses a holistic approach to connect members to services and community resources that help improve health and overall well-being. The program focuses on coordination and collaboration between behavioral health, medical care, and the member, which ensures an emphasis on member education, coaching, and knowledge.

Care coordination goals:

- Complete health risk assessments
- 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

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.

To refer a member to care coordination:

1. Notify Meridian through the **secure provider portal**
   a. Log in to the secure provider portal
   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. Complete the **Provider Referral to Care Coordination & Complex Case Management [PDF]** form at **ILmeridian.com** and fax it to **833-969-3812**.

Care Coordination – Provider's Role

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

Health Risk Screenings or Assessments

Meridian members may complete 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 complete the HRS or HRA.

Develop and implement an Individual Plan of Care (IPoC)

Upon completion of the health risk assessment, members enrolled into the Care Coordination program 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 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 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 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 experience effective 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 their 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 and ensure the member has a visit scheduled with you or the appropriate specialist after discharge.

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 to improve the health of pregnant birthing parents and their newborns.

The key driver of the SSFB program is 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, Meridian observes several important improvements to outcomes, such as:

1. Preterm delivery rate
2. C-Section rate
3. Low birth weight rate
4. Admission rates to neonatal intensive care units

Notification of Pregnancy

All pregnant members should have a completed Notification of Pregnancy (NOP) [PDF] form, which directs them to individualized resources, including SSFB. The NOP form alerts and engages the plan about a member's pregnancy and is preferred over claims-based awareness.

Providers have two options for submitting an NOP on a member's behalf:

1. **Secure provider portal** — the preferred and quickest method
   - When logged into the portal, access the **Member Overview page** and navigate to the "**Assessments**" tab
   - Find the "SSFB Provider Notification of Pregnancy" and select "Fill Out Now"
   - Complete and submit the NOP

2. Provider fax

- Complete the fillable **NOP form [PDF]**, accessible from the **Manuals, Forms and Resources page** for providers
- Fax it to **833-544-1629**

Disease Management

The goal of Meridian's Disease Management programs is to improve member outcomes and well-being by supporting the provider/patient relationship and care plan by combining current information and resources for providers with self-management education and outreach strategies for members.

The Disease Management and Lifestyle programs are developed to assist members in gaining a better understanding of their condition, update them on new information about their disease, and provide them with assistance to help manage their disease. The programs are designed to reinforce your treatment plans.

Enrollment is voluntary for Meridian members who meet qualifying criteria for a specific chronic condition. Eligible members may be identified for enrollment through claims or encounter data (e.g., medical, behavioral, pharmacy, etc.), health appraisal results, referrals from the health plan (e.g., UM, Care Management) or physician, or a current or previous program participant.

Meridian will:

- Outreach to targeted members with program information, inform members about the health coaching programs, and offer to enroll them
- Establish telephonic behavior change health coaching with a licensed primary health coach with clinical experience matched to the participant's needs
- Educate members on the importance of medication adherence, self-management of conditions, and communication with providers
- Promote collaboration among providers and the health plan for comprehensive care plans

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 members to take advantage of this service.

If you would like to enroll a Meridian member in a health coaching program, contact the Meridian Disease Management department by phone at **833-796-0683**. If at any time a member wishes to stop participating in the program, they can call **833-796-0683** to disenroll.

Smoking Cessation Program

We ask that providers talk to members about their smoking habits at every visit, and if the member is a smoker, 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 on our **Pharmacy page** or call the Pharmacy team at **855-580-1688**.

SECTION 8:

Quality Improvement (QI)

Quality Improvement Program (QIP) Introduction

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

QIP Goals and Objectives

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

Meridian demonstrates its commitment to quality through the implementation of the QIP and through participation in various State of Illinois committees, sub-committees, and partnerships. QIP 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 use, 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
- Timely and accurate reporting of HEDIS, CAHPS, and HCBS waiver performance measures

- 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

QIP 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, contractually required clinical performance measures, and Illinois Performance Improvement Projects 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 has identified key areas for performance improvement and developed interventions to address them.

Key areas:

- 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

Provider Opportunities in QIP Activities

Provider involvement is integral to a successful QIP. By ensuring accessibility and delivering high-quality care, providers contribute to the goals and objectives of the Meridian QIP. Meridian also offers the opportunity to partner on wellness days, which are dates/times reserved specifically to schedule Meridian members to close specific care gaps.

Provider Quality Education webinars are held monthly to offer education and resources to providers, who may contribute by becoming active participants in Meridian committees. To join any of the following committees or to learn more, contact Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m.

Medicaid Performance Improvement Projects

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

Transportation Overview

The Transportation PIP was established by a directive from 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 and Utilization Management Committee

The Quality Improvement and Utilization Management Committee (QIUMC) continuously monitors the medical necessity, medical appropriateness, accessibility, and availability and use of medical, behavioral health, and substance use healthcare resources. The QIUMC, which meets quarterly, is chaired by the corporate chief medical officer and is comprised of members including the medical director, vice president of quality improvement, director of quality improvement, director of utilization management, and a minimum of one community-based physician representative.

The QIUMC Committee is responsible for the following:

- Report QIP status (including recommendations) to the Board of Directors 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 QIUMC 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 QIUMC 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

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 CMS regulatory requirements. The Committee is chaired by a medical director and comprises committee members including a minimum of three community-based physicians. The Physician Advisory Committee meets at a minimum on a quarterly basis.

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 QIUMC
- Facilitate development of Meridian medical policies and evidence-based clinical practice guidelines
- Review and approve Meridian medical policies
- Recommend adoption of Meridian medical policies and evidence-based clinical practice guidelines to the QIUMC
- 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

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

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

Contractual Arrangements

Non-Delegated

By signing a contractual agreement with Meridian to be part of our 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 (PA) request
  - Timely response to outreach requests for information or to discuss members' plans of care
  - Participation in care coordination conferences as necessary
  - Resolution of 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.

QIP Activities

Monitoring Quality Performance Indicators – Clinical and Operational

The purpose of the 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 **Availity Essentials**. The data is aggregated, stored, and analyzed using a HEDIS software program 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
- Provider network access and availability are adequate to meet members' care needs in a timely manner
- Meridian makes initial PA 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 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**, available at **ILmeridian.com**, to help you increase your practice's HEDIS rates and address care gap opportunities for your patients.

For more information, visit **www.ncqa.org**.

Note that recommendations and guidelines are subject to change. Providers can contact Member and Provider Services at **866-606-3700 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m., with 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 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 to continue improvement. Based on these survey results, the QI Committee can ensure 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 through the Annual Provider Survey. Results from this survey help Meridian identify areas of provider dissatisfaction for corrective action, identify areas of satisfaction 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 providers in balance with those that are most beneficial and meaningful to the member population.

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 that 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 it is determined 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 relevant to the populations served. The medical policies are complementary to local, regional, and national standards of medical practice and are in accordance with the Illinois Medicaid Program benefit coverage rules and CMS national and local coverage determinations as applicable. Meridian has adopted evidence-based clinical practice guidelines from regional and nationally recognized external sources. The clinical practice guidelines are reviewed and approved at least annually, and as necessary, by Meridian's Physician Advisory Committee and Quality Improvement and Utilization Management Committee. Providers are educated about **Meridian Medical Policies** and **Clinical Practice Guidelines** through **ILmeridian.com**, provider newsletters, and this provider manual.

Providers 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.

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 Relations 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 reassessment 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 that 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 Department visit within seven (7) 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)
- Monitoring 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 as permitted or required by law
- HIPAA privacy and security policies and procedures developed and implemented by Meridian's privacy and security officers; adherence is monitored by the HIPAA Privacy and Security Committee through quarterly meetings 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 operational functions and meet the legal obligations of the health plan
- Corporate policies restricting access to member and provider information to only employees who need access to perform each employee's job and controlled by 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, code of conduct, and corporate policies prohibit 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 supplied with **Critical Incident education materials** and 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
- Medication error involving a member
- Abuse and neglect and/or suspected abuse and neglect of a member
- Suicide attempt

A **Critical Incident and Significant Event Intake Form [PDF]** must be submitted to Meridian by email to **criticalincidents@mhplan.com** no later than 24 hours following the discovery of the incident. Providers must cooperate fully in the investigation of reported Critical Incidents, including submitting all requested documentation. If the incident involves an employee or HCBS provider, the provider must also submit a written report of the incident including actions taken within 20 calendar days of the incident. To protect the safety of members, 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.

The **Critical Incident and Significant Event Intake Form [PDF]** can be found on the **Manuals, Forms and Resources page** for providers.

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

Use the table on the following page to properly direct incidents.

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 DCFS **CANTS 5 Form** needs to be completed and sent to the external agency immediately
All adults (**including those with disabilities**), ages 18–59, living in an **institutional setting** • Cases of suicidal ideation for members with developmental disabilities (DD) or mental health concerns residing in an institutional setting	Illinois Department of Human Services Office of the Inspector General Hotline: **800-368-1463** (Voice and TTY)	Immediately	
Adults with disabilities, ages 18–59, living in a **community setting** • Older adults (60 years of age and older) regardless of residence	Adult Protective Services Hotline: **866-800-1409** **800-206-1327**	Immediately	
All adults, ages 18–59, living in a **community setting**	Local Police Department	Immediately	
Nursing facility resident	Department of Public Health's Registry Hotline*: **800-252-4343**	Immediately	
Supportive Living Facility resident	Department of Healthcare and Family Services' SLF Complaint Hotline: **844-528-8444**	Immediately	

* The hotline also investigates allegations of actual or potential harm to patients, patients' 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 9:

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.

The following are 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 Manual, which can be found online at **iamhp.org/providers**
- PA, if required, must be obtained prior to submitting claims. PA requirements may be checked via the **Prior Auth Check tool**.
- Providers may submit and check the status of claims electronically through **Availity Essentials**
- The standard timely filing submission of Medicaid claims must be within 180 days from 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: **hfs.illinois.gov/medicalproviders/medicaidreimbursement**

To receive reimbursement in a timely manner, 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 (TIN) 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 Medicaid 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 ***Medicaid Covered Services section*** of the 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 PA 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 – Corrected claims must be submitted per the guidelines outlined in the manual below
- Is submitted in compliance with all of Meridian's PA and claims submission guidelines and procedures
- Is a claim for which the provider has exhausted all other insurance resources
- Is submitted electronically if the provider can 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 registered in **IMPACT** and rendered on the submitted claim. Information on appropriate taxonomy and category of service can be found at the following link: **hfs.illinois.gov/medicalproviders/handbooks/5010**.

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 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 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.

Meridian Clearinghouse – Availity: **800-282-4548**

Payer ID: MHPIL*

* Providers utilizing Change Healthcare as their clearinghouse must submit with Payor ID MCCIL. Reach out to **Change Healthcare** with any questions.

Paper Claims

Mail to: **Meridian Claims Department**
PO Box 4020
Farmington, MO 63640-4402

Defining Claim Rejections and Claim Denials

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; there will be no explanation or record of the claim in our system. A rejection is defined as an unclean 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 a paper claim was submitted or a rejection report if the claim was submitted electronically. In these instances, the claim will need to be corrected and resubmitted 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 be denied. 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 180 days from the last date of the correspondence/EOP, not to exceed one year from the date of service.

- 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. This process is only 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 **Availity Essentials** to submit corrected claims. While it is not necessary to attach the original Explanation of Payment or a claim adjustment request form when submitting through the web, you may include attachments if you choose.

Medical Claim Refunds/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 send a refund for a claim overpayment, mail a check and requested documentation to:

Meridian Refunds
PO Box 856407
Minneapolis, MN 55585-6407

Refer to the **IAMHP Comprehensive Billing Manual** for more information.

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 (TPL)-related delays: These claims must be accompanied by a 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 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.

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, which must then submit it to HFS. Both Meridian and the 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 that links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service

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

Meridian's 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 [PDF]** with supporting documentation must be completed if the provider does not agree with the denial decision or adjustment request.

Coordination of Benefits (COB)

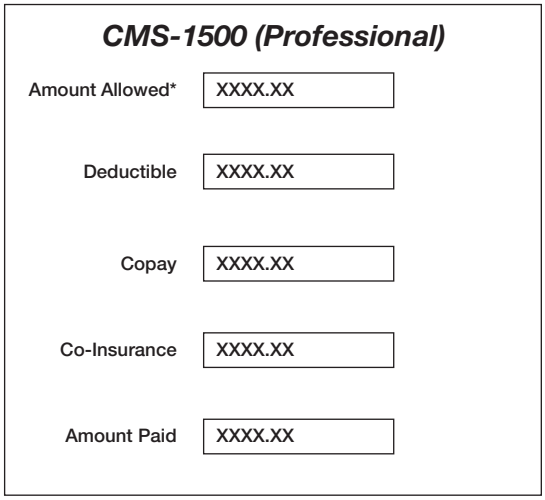
Meridian appreciates your assistance and cooperation in notifying us when any other coverage exists, such as, but not limited to, other healthcare plans and workers' compensation benefits. If Meridian is not the only insurance coverage for the member, Meridian should be billed as the secondary payer 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 through the **secure provider portal**.

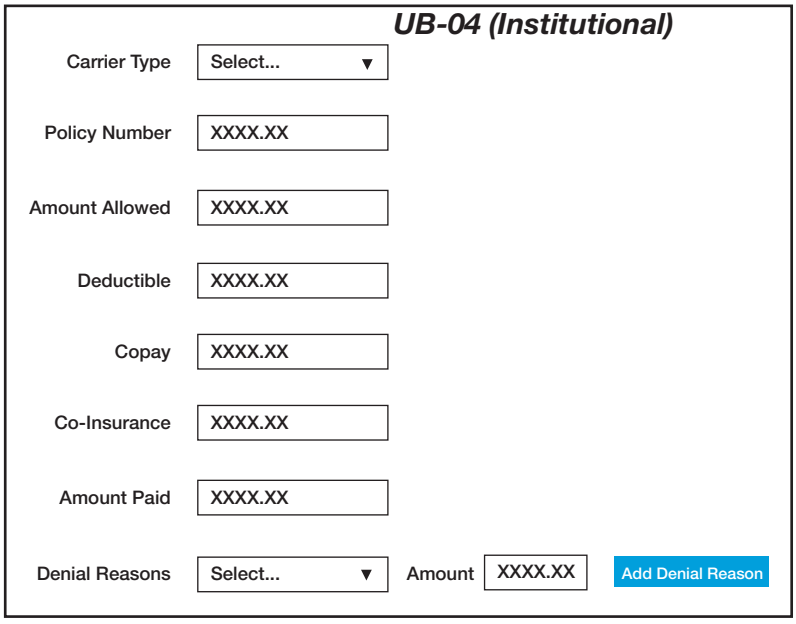
Third Party Coverage

Topic	Description
Identification of Third-Party Resources	Providers must always identify third-party resources and report third-party payments on the claim. Third-party resources must be identified even when the payer does not cover the services.
Commercial Insurance Payments	If payments are made by commercial insurance, the Explanation of Benefits (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 paper CMS-1500 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 not 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 paper CMS-1500 Claim Form.

Secure 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 Meridian's **secure provider portal**. When using the portal, input your COB information directly into the data fields. The data fields used to populate COB information are outlined below:





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, contact your clearinghouse.

COB Field Name From the primary payer's Explanation of Payment	**8371 – 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 Field Name From the primary payer's Explanation of Payment	8371 – Institutional EDI Segment and Loop	837P – Professional EDI Segment and Loop
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 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.

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 investing 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 Benefits to Providers

- **Free service** – Providers are not charged any fees to use the service
- **Eliminate re-keying of remittance data** – ERAs can be imported directly into practice management or patient accounting systems, eliminating the need for manual keying of paper remittance 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 remittance advices quickly** – Providers can associate electronic payments with ERAs 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 to settle claims

With PaySpan, you have several options for viewing and receiving remittance details. PaySpan 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 Payspan Inc. 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. Provider 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 are 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 related to medical necessity determinations (authorization denial). Medical necessity appeals must be filed by one of the following: the member, the member's authorized representative, the member's provider of record, or a healthcare practitioner with knowledge of the member's medical condition acting on the member's behalf. They may be filed pre-service on the member's behalf with permission, or post-service on the provider's behalf. Medical necessity appeals may be for the following:

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

Pre-service medical necessity appeals must be filed as outlined in the ***Standard & Expedited Member Appeals section*** of the manual.

Providers have 90 days to file a **post-service appeal** in writing from the date of the Adverse Benefit Determination letter. (Do not use this option if you fail to get an authorization. See ***Provider Claim Disputes*** in the following section.) Post-service medical necessity appeals must be filed in writing as outlined below.

For Non-Behavioral Health Services:	For Behavioral Health Services:
Submit via the **secure provider portal**	BH Fax: **866-714-7991**
Fax: **833-383-1503**	
Mail: **Meridian** **ATTN: Provider Appeals** PO Box 4020 Farmington, MO 63640-4402	Mail: **Centene Advanced Behavioral Health (CABH)** **Appeals Dept.** P.O. Box 10378 Van Nuys, CA 91410-0378

Claim Disputes

If a provider is not satisfied with the claims disposition, a claim dispute can be submitted via the **secure provider portal** (preferred). A completed **Provider Claim Dispute [PDF] form** can also be mailed to the address listed on the form. Attach or enclose the necessary documents and an explanation of what should be reconsidered.

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

Providers electing to dispute the disposition or reimbursement level of a claim may do so via the **secure provider portal** (preferred):

- Select the claim and provide appropriate reason for the dispute
- Attach supporting documents (i.e., medical records)

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 time frame and prior authorization requirements.	Two ways to submit: 1. **Secure provider portal (preferred)** 2. Via mail: **Meridian** **ATTN: Provider Appeals** PO Box 4020 Farmington, MO 63640-4402

Type	Where to Submit
Provider Claim Dispute Disputes **related to claims processing** are handled separately from Administrative Denial Disputes. Claim disputes are disputes regarding the following: • Inaccurate Payment or Denial • Coding Edits (Correct Coding Initiative (CCI) edits) • Claims Denied as a Duplicate • Untimely Filing	Two ways to submit: 1. **Secure provider portal (preferred)** 2. Via mail: **Meridian** **ATTN: Provider Claim Disputes** PO Box 4020 Farmington, MO 63640-4402

Binding Arbitration

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

If you have questions about the Meridian Medicaid post-service claim appeal/dispute process, contact Member and Provider services at **866-606-3700 (TTY: 711)** for more information.

1333 Burr Ridge Parkway, Suite 500 | Burr Ridge, IL 60527 | 866-606-3700
ILMeridian.com

Published online January 30, 2026