Dear Meridian Health Plan Provider,

Meridian Health Plan (Meridian) would like to welcome you to the Meridian network of providers! Our Provider Manual was designed to assist you with understanding plan policies, procedures, and other protocols, as well as to be used a reference tool for you and your staff.

The Provider Manual is a dynamic tool and will evolve with Meridian Health Plan. Minor updates and revisions will be communicated to you via Provider Bulletins, which serve to replace the information found within this Provider Manual. Major updates and revisions will be communicated to you via a revised edition of the Provider Manual, which will be provided to you. The revised edition will replace older versions of the Provider Manual.

The current Provider Manual is always available on our website at www.mhplan.com.

Please contact your local Provider Network Development Representative or our Provider Services department at 866-606-3700 with any questions or concerns.

Thank you for your participation.

Meridian Health Plan
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Section 1: General Information

Our Mission, Vision and Philosophy

Mission
To continuously improve the quality of care in a low resource environment

Vision
• To be the #1 health organization based on quality, innovative technology and service to our members
• To be the premier service organization in healthcare

Philosophy
To function as a care management and preventive care organization with an emphasis on disease management

About Meridian Health Plan
Meridian Health Plan originated in Michigan in late 1996. Meridian Health Plan is the largest Medicaid health plan in the State of Michigan, providing health care to over 290,000 Medicaid members in 67 counties. In 2008, the Illinois Department of Healthcare and Family Services (HFS) partnered with Meridian specifically to increase quality outcomes of the Medicaid population. Meridian Health Plan of Illinois currently provides care to those beneficiaries enrolled in the AllKids, Family Care and Moms and Babies programs.

In 2011, MeridianRx, a Pharmacy Benefit Manager (PBM), was launched. At the same time, Meridian Advantage Plan of Michigan (HMO SNP) was established to provide Medicare benefits for the dual-eligible population in Michigan.

On March 1, 2012, Meridian began providing services to Medicaid members in eastern Iowa.

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

On July 1, 2013, Meridian will begin serving the Seniors and Persons with Disabilities (SPD) population in the central and metro east regions of Illinois.
Contact Information

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<tr>
<th>Contact and Service Function</th>
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<td><strong>Behavioral Health</strong></td>
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<td>• Inpatient Mental Health</td>
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<td>• Outpatient Mental Health</td>
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<td>• Substance Abuse Treatment</td>
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<td><strong>Illinois Client Enrollment Broker (ICEB)</strong></td>
<td>877-912-8880</td>
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<td>• Managed Care Enrollment Questions</td>
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<td><strong>Illinois Relay Services</strong></td>
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<td>• Interpretive Language Services</td>
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<td><strong>Member Services</strong></td>
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<tr>
<td>• General Information and Assistance</td>
<td>Medicare 855-827-1769</td>
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<td>• Verify Member Eligibility</td>
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<td>• Benefit Information</td>
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<td>• Status Claims</td>
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<td>• File Complaints/Grievances</td>
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<td>• Verify/Report Newborn Information</td>
<td>866-606-3700</td>
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<td>• Coordination of Benefits</td>
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<td><strong>MeridianRx (PBM)</strong></td>
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<td>• Pharmacy Questions and Concerns</td>
<td>Medicaid 855-580-1688</td>
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<td>• Formulary Information</td>
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<td>• Pharmacy-Utllization Management Information</td>
<td>Medicare 866-606-3700</td>
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<td>• Medication Therapy Management (MTM) Program Information</td>
<td>877-440-0175</td>
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<td><strong>Provider Services</strong></td>
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<td>• Fee Schedule Assistance</td>
<td>866-606-3700</td>
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<td>• Discuss Problems and Concerns</td>
<td>Ask for Provider Services</td>
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<td>• Contractual Issues</td>
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<td>• Primary Care Administration</td>
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<td>• Initiate Affiliation, Disaffiliation and Transfers</td>
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<td><strong>Quality Management</strong></td>
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<td>• Request Clinical Practice Guidelines</td>
<td>866-606-3700</td>
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<td>• Request Preventive Healthcare Guidelines</td>
<td>Ask for Quality Management</td>
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<td>• Quality Initiative Information</td>
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<td>• Quality Regulatory Requirements</td>
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<td>• Disease Management Program Information</td>
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<td><strong>Transportation – Medicaid Only</strong></td>
<td>866-796-1165</td>
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<tr>
<td>• Member Non-Emergent Transportation</td>
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<td><strong>Utilization Management</strong></td>
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<td>• Corporate Prior Authorizations</td>
<td>866-606-3700</td>
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<td>• Supporting Clinical Information</td>
<td>Ask for Utilization Management</td>
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<td>• Discharge Planning Information</td>
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<td>• Long Term Services and Supports</td>
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<td>• Care Coordination</td>
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Section 2: Member-Related Information

Member Services Department
Meridian’s Member Services department exists for the benefit of both our members and providers. Member Services is available to respond to any and all questions about Meridian Health Plan benefits, policies and procedures.

Member Services Representatives are available each business day from 8 a.m. to 8 p.m. and are able to assist with questions and resolve issues related to the following:

- Member eligibility
- Approval of non-emergency services
- PCP and site changes
- Women’s health care provider changes
- Complaints/grievances
- Disenrollment requests
- Claims payment
- Rights and responsibilities

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

**Member Rights and Responsibilities**

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

**Members Have the Right to:**

- Be treated with respect and dignity at all times;
- Be protected from discrimination and file or appeal any complaints of discrimination on the basis of race, color, national origin, age, or disability in the receipt of health services;
- Have their personal and health information kept private;
- Receive information from Meridian, Meridian providers and Meridian contractors in a manner they can understand;
- Receive all of the services that Meridian is required to provide;
- Have their questions about Meridian answered;
- Have access to doctors, other healthcare providers, specialists and hospitals;
- Learn about treatment choices in a manner they can understand and participate in treatment decisions, including the right to refuse treatment;
- Formulate advance directives;
- Receive emergency care when and where they need it;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Receive a decision about health care payment, coverage of services and prescription drug coverage;
- Request a review (appeal) of certain decisions about health care payment, coverage of services and prescription drug coverage;
- Request and receive a copy of their medical records, and request that their medical records be amended or corrected;
- Exercise their rights without fear of reprisal from Meridian or Meridian providers; and
• File complaints (grievances), including complaints related to the quality of the care they receive.

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

Eligibility Requirements

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

Eligible members will not have Third Party Liability (TPL), be part of the Spend Down Program, or have dual eligibility (Medicare and Medicaid eligibility).

Medicare Advantage
Meridian has an executed contract with the Centers for Medicare and Medicaid services (CMS) and a coordination agreement with HFS, to provide Medicare-covered benefits to eligible beneficiaries.

Eligible members must be entitled to Medicare Part A, enrolled in Medicare Part B, enrolled in Illinois Medicaid and reside in Meridian’s service area. In addition, prospective members with End Stage Renal Disease (ESRD) are generally prohibited from enrolling with Meridian.

Member Identification
All Meridian receive a Meridian Health Plan Member ID Card. The Meridian ID Card includes the following pieces of information:
• Member Name
• Medicaid ID Number
• Member Services Phone Number
• Medical Claims Processing Information
• Pharmacy Claims Processing Information
• Other Instructions and Important Information

Medicaid ID Card (Sample):
Eligibility Information

It is important to verify eligibility prior to rendering services to a Meridian member. To verify a member is currently eligible to receive services, request to see the member’s Meridian (and other health insurance ID cards if appropriate) ID Card at each encounter, and:

- Review your PCP monthly eligibility report or verify the member’s eligibility online through Meridian’s Provider Portal each time the member appears at the office for care or referrals; and/or
- Call our Member Services department at 866-606-3700 for assistance with eligibility determinations.

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

Medicaid

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

- Calling Meridian’s Eligibility Verification Line at 855-291-5228 and following the directions as prompted. The system will then verify if the member is eligible on the date of service indicated; and/or
- Utilizing the State of Illinois’ HFS MEDI website.
PCP Identification and Verification

To verify a Meridian member’s PCP, you may call the respective Member Services department or utilize Meridian’s online Provider Portal.

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<thead>
<tr>
<th>Medicaid</th>
<th>Medicare Advantage</th>
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<tbody>
<tr>
<td>866-606-3700</td>
<td>855-827-1769</td>
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PCP Changes

Meridian members can call their respective Member Services department at 866-606-3700 to request a PCP change, or request the change through Meridian’s Member Portal. PCPs are notified via fax of all PCP changes, as well as through changes identified on their monthly eligibility list.

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<tr>
<th>Medicaid</th>
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<td>866-606-3700</td>
<td>855-827-1769</td>
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Member Enrollment and Disenrollment

Medicaid

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

Medicare Advantage

Enrollment and disenrollment in Meridian Health Plan is processed by the Centers for Medicare and Medicaid Services (CMS). Prospective members are able to enroll in, and current members disenroll from Meridian at any time during the year. Meridian staff includes licensed agents able to process Medicare enrollments/disenrollments and respond to myriad questions from Medicare beneficiaries.

Notice of Privacy Practices

Pursuant to regulations under the Health Insurance Portability and Accountability Act (HIPAA), all providers must provide adequate notice of the provider’s privacy practices. Providers should have such notice available at their office upon request by any member, and should post the notice in a clear and prominent location. The following Notice of Privacy Practices may be used for this purpose and is compliant with HIPAA regulations. For specific requirements, see 45 C.F.R. 164.520.
Our Privacy Policy. We care about your privacy and we guard your information carefully whether it is in oral, written or electronic form. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and our privacy practices. We will provide you with notice if there is a breach in our privacy and security practices involving your personal information. We will not sell any information about you. Only people who have both the need and the legal right may see your information. Unless you give us a written authorization, we will only disclose your information for purposes of treatment, payment, business operations or when we are required by law or this Notice of Privacy Practices (Notice) to do so.

Treatment. We may disclose medical information about you for the purpose of coordinating your healthcare. For example, we may notify your personal doctor about treatment you receive in an emergency room.

Payment. We may use and disclose medical information about you so that the medical services you receive can be properly billed and paid for. For example, we may ask a hospital emergency department for details about your treatment before we pay the bill for your care.

Health Care Operations. We may use and disclose medical information about you in connection with our health care operations. For example, we may use medical information about you to review the quality of services you receive.

Required or Permitted by Law. We are permitted by law to use and disclose your personal information for the following enumerated, but not limited to, purposes:

- **Law Enforcement.** We will disclose your personal information to comply with local, state and federal investigations
- **National Security.** We will disclose your personal information to comply with federal intelligence and national security activities
- **Legal Proceedings.** We will use or disclose your personal information to comply with subpoenas or other court orders
- **Review by Government Agencies.** We will disclose your personal information to comply with all review of our activities by government agencies
- **Communicable Disease Reporting.** We may use or release your personal information to comply with federal and state requirements on reporting communicable disease
- **Emergencies.** We may use or disclose your personal information to avoid a serious threat to health or safety
• **Disaster Relief.** We may use or disclose your personal information to cooperate with disaster relief efforts.

• **Public Health Activities.** We may use or disclose your personal information to participate in federal, state or local public health activities and reporting.

• **Abuse/Neglect.** We may release your personal information to the proper government authority if we reasonably believe that you are a victim of abuse, neglect, or domestic violence.

• **Individuals.** We may disclose your personal information to a family member, relative, or close friend involved in your medical care. We will limit disclosure to the personal information directly relevant to the individual’s involvement in your health care, and you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

• **Parent/Guardian.** We may release your personal information to your parent or guardian, when not otherwise limited by law, if you are an un-emancipated minor.

• **Workers’ Compensation.** We may use or disclose your personal information to comply with workers’ compensation laws.

• **Business Associates.** We work with other companies called “business associates,” which help us to provide services to you. We may disclose your personal information to our business associates, but we will only disclose your personal information to the extent necessary for our business associates to carry out treatment, payment or healthcare operations. We will enter into contracts with all business associates to protect your personal information.

• **Coroner, Medical examiner, and Funeral directors.** We may disclose your personal information to coroners, medical examiners or funeral directors, but only to the extent necessary for them to carry out their duties.

• **Administrator/Executor.** We may disclose your personal information to the executor or administrator of your estate upon your death.

• **Research Studies.** We may disclose your personal information to researchers for use in a research study. We will only disclose your personal information if the study has been approved by a review board and the researchers have taken steps to ensure that your private information remains protected.

• **Organ and Tissue Donation.** We may disclose your personal information to those organizations involved in the process of organ or tissue transplantation.

• **Correctional Institution.** We may disclose your personal information to a correctional institution if you are or become an inmate of a correctional institution.

• **Military.** We may disclose your personal information to the military, if you are or become a member of the armed forces.

• **Other Disclosures Required by Law.** We will use or share your personal information when required by other federal, state, or local law to do so.
Authorizations. Other uses and disclosures of your personal information will be made only with your written authorization. For example, we must obtain your written authorization for the following uses and disclosures of your personal information:

- **Psychotherapy Notes.** Psychotherapy notes are notes taken by a mental health professional during a conversation with you. We will not use or disclose psychotherapy notes, except when we are permitted by law to do so.
- **Fundraising.** We may contact you with information on how to opt-out of fundraising communications if we choose to operate a fundraiser.
- **Marketing.** We will not market your personal information, except when we are permitted by law to do so.
- **Sale.** We will not sell your personal information.

If you give us a written authorization, you have the right to change your mind and revoke that authorization.

**Genetic Information.** We may receive genetic information about you if you have undergone genetic testing to identify and prevent certain illnesses. We will not use or disclose your genetic information to determine eligibility for benefits, premium or copayment amounts, pre-existing condition exclusions, or the creation, renewal or replacement of health insurance or benefits. We are prohibited from using or disclosing protected health information for underwriting purposes. However, we reserve the right to use your genetic information to determine whether treatment is medically necessary.

**Copies of this Notice.** You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy.

**Changes to this Notice.** We reserve the right to revise this Privacy Notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on our website and will be sent to you in writing at the next regularly scheduled Member Newsletter.

**Your Right to Inspect and Copy.** You may request, in writing, the right to inspect the information we have about you and to get copies of that information. You have the right to an electronic copy of the information we have about you if the information is maintained electronically. We can deny your request for certain limited reasons, but we must give you a written reason for our denial. We may charge a fee for copying your records.

**Your Right to Amend.** If you feel that the information we have about you is incorrect or incomplete, you can make a written request to us to amend that information. A written request must include the reason(s) supporting your amendment. We can deny your request for certain limited reasons, but we must give you a written reason for our denial.

**Your Right to a List of Disclosures.** Upon written request, you have a right to receive a list of our disclosures of your information during the six (6) years prior to your request, except: when you have authorized those disclosures; if the disclosures are made for treatment, payment or health care operations; when disclosures were made to you about your own information; incident to a use or disclosure as otherwise permitted or required under applicable law; as part of a limited data set for research or public health
activities; information released in the interest of national security or for intelligence purposes; to correctional institutions having custody of an inmate; or shared prior to April 14, 2003.

Your Right to Request Restrictions on Our Use or Disclosure of Information. If you do so in writing, you have the right to request restrictions on the information we may use or disclose about you. We are not required to agree to such requests. Where protected health information is disclosed to a health care provider for emergency treatment, we must request that the health care provider not further use or disclose the information.

Your Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. For example, you can ask that we only contact you at home or only at a certain address or only by mail.

How to Use Your Rights Under this Notice. If you want to use your rights under this notice, you may call us or write to us. If your request to us must be in writing, we will help you prepare your written request, if you wish.

Complaints to the Federal Government. If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may to: Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. Or visit their website at http://www.hhs.gov/ocr for specific filing instructions. You will not be penalized or retaliated against for filing a complaint with the federal government.

Complaints and Communications to Us. If you want to exercise your rights under this Notice or if you wish to communicate with us about privacy issues or if you wish to file a privacy related complaint, you can write to:

Chief Privacy Officer
Meridian Health Plan
333 South Wabash Avenue, Suite 2900
Chicago, IL 60604

You can also call us as at 866-606-3700. You will not be penalized or retaliated against for filing a complaint. You can view a copy of this notice on our web site at www.mhplan.com/il.

Member Satisfaction

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

HFS and the National Committee for Quality Assurance (NCQA) require that Meridian conduct annual surveys (e.g. CAHPS® and HOS) to determine current levels of member satisfaction with the health plan and to identify areas of potential health plan improvement. Providers and their office staff are expected to cooperate and assist Meridian with obtaining data necessary for these surveys. Providers will be notified in advance of their required participation and the time frames in which the surveys will be conducted annually.
**Member Grievances**

A grievance is an expression of dissatisfaction, including complaints, directed to Meridian about any matter other than an action (a denied, reduced, or terminated service) that can be appealed. For example:

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

For information regarding the Meridian grievance process, members should call the Meridian Member Services department at 866-606-3700.

**Medicaid Grievances**

Meridian offers an Informal Grievance process to resolve complaints from members while they are at a provider’s office or when they call on the phone. In most cases, Meridian will work with the member to resolve their issue on their initial phone call.

If the member is not happy with the outcome of the Informal Grievance process they can file a Formal Grievance. This must be filed in writing within one year of the occurrence.

The address to file a Formal Grievance is:
**Meridian Health Plan**
**Grievance Coordinator**
**222 North LaSalle Street, Suite 930**
**Chicago, IL 60601**

Meridian will notify the member within three days of receipt of the Formal Grievance. The issue will then be reviewed by our Grievance Committee. Members have the right to present their grievance to the Grievance Committee, either in person or via telephone. They also have the right to bring a representative with them, including an attorney. Meridian will thoroughly investigate the grievance and the member will receive a response from the Grievance Committee within 30 days.

After exhausting Meridian’s internal grievance process, if the member is not satisfied with the determination of the Grievance Committee, they may request review by HFS. Members can write to HFS at the following address:

**HFS Bureau of Administrative Hearings**
**401 South Clinton, 6th Floor**
**Chicago, IL 60607**
**800-435-0774**
**(TTY) 877-734-7429**

The decision of HFS is final.
**Medicare Advantage Grievances**

Meridian members have sixty (60) days from the date of the precipitating event to file a grievance with Meridian. Grievances may be filed telephonically by calling the Meridian Member Services department, or in writing by writing to Meridian at the address identified above. Meridian responds to member grievances within thirty (30) calendar days.

If a member’s complaint is related to quality of care, the member can also file a complaint with the Quality Improvement Organization (QIO), IFMC-IL, telephonically by calling 630-928-5800 or by writing to IFMC-IL at the following address:

**IFMC-IL**
711 Jorie Boulevard
Suite 301
Oak Brook, Illinois 60523

In addition, members may file a quality of care related grievance by calling 800-MEDICARE, 24 hours a day, 7 days a week.

**Member Appeals**

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

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

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

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

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

**Meridian Health Plan**
Appeals Coordinator
222 North LaSalle Street, Suite 930
Chicago, IL 60601

Within three days of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. We will make a decision about the appeal within 15 days of receiving all required information. Members and their PCP, as well as any other providers
involved in the appeal, will be notified of the outcome of the appeal, orally and in writing, within five days of the decision.

**Medicaid Expedited Appeal**

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

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

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

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

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

**Meridian Health Plan**  
**Appeals Coordinator**  
**222 North LaSalle Street, Suite 930**  
**Chicago, IL 60601**

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

The reviewer will make a decision about the appeal within five days of receiving all required information.

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

If the member’s situation is clinically urgent, the member or a provider acting on the behalf of the member may call Meridian’s Member Services department at 866-606-3700 to file an urgent request for external independent review. Members will need confirmation from their provider to do this.
The reviewer will make a decision within 24 hours of receiving all required information. The member and their PCP, as well as any other provider involved in the case will be notified verbally of the outcome of the appeal. A written notification will follow.

After exhausting Meridian’s appeals process including, if applicable, the external independent review, if the Medicaid member is not satisfied with the determination of Meridian, they may request review by HFS. They can write to HFS at the following address:

**HFS Bureau of Administrative Hearings**
401 South Clinton, 6th Floor
Chicago, IL 60607
800-435-0774
(TTY) 877-734-7429

You may also contact the HFS electronically at [http://www.hfs.illinois.gov](http://www.hfs.illinois.gov). To obtain a complaint form or to receive help in completing the form, the Member may call HFS toll-free at 866-468-7543. TTY: 877-204-1012.

The decision of HFS is final.

**Medicare Advantage Expedited Appeal**

If a member or their provider thinks that they would be in danger of life or limb, they may call Member Services at 866-606-3700 to file an expedited appeal. Within 24 hours of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. We will make a decision about the appeal within 72 hours of receiving all required information.

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

**Medicare Advantage External Review of Appeals**

Appeals denied by Meridian will be automatically forwarded to the Independent Review Organization (IRO) for secondary review. The IRO will adhere to the same time frames that were followed by Meridian during the initial appeal.

**Medicare Advantage Appeal Levels 3, 4 and 5**

If the IRO upholds Meridian’s denial of the member’s appeal and the dollar value of the item or medical service in question meets certain minimum requirements established by CMS, the written decision from the IRO will contain the instructions for the member to file a Level 3 Appeal with an Administrative Law Judge (ALJ).

If the ALJ upholds Meridian’s denial of the member’s appeal and the dollar value of the item or medical service in question meets certain minimum requirements established by CMS, the written decision from the ALJ will contain the instructions for the member to file a Level 4 Appeal with the Medicare Appeals Council (MAC).

If the MAC upholds Meridian’s denial of the member’s appeal and the dollar value of the item or medical service in question meets certain minimum requirements established by CMS, the written decision from the MAC will contain the instructions for the member to file a Level 5 Appeal with the Federal District Court (FDC).
A provider with the same or like specialty as the treating provider will review the appeal. It will not be the same provider as the one who made the original decision to deny, reduce, or stop the medical service.

**Interpretive Services and Alternative Formats**

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

If the member is hearing or speech impaired, TTY/TDD services are available by calling the Illinois Relay Service at 711, 24 hours a day, 7 days a week. The Illinois Relay Service makes it possible for hearing-impaired and/or speech-impaired persons to call Meridian.

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

**New Technology**

Meridian wants to ensure our members have access to new technologies and procedures. We do research on new technology before approving it for our members. Information on new technology and/or procedures is received from medical research, professional groups and other sources of governmental and scientific groups. This information goes to a Meridian group comprised of doctors and other Meridian staff. Meridian may also use specialists to review the information. The decision to approve or not approve a new technology or procedure is then made. Both Medicare and Medicaid rules prevent the authorization of experimental technology.

**Provider Directory**

A list of participating providers in the Meridian network is available by viewing the on-line Provider Directory at [www.mhplan.com](http://www.mhplan.com). To receive a list of participating providers via hard-copy, contact Meridian and a Provider Directory will be mailed.
Section 3: Member Benefit Information

Member Benefits

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

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

- Alcohol and Substance Abuse Services
  - Medicaid TANF/SPD:
    - Inpatient rehabilitative services for alcohol and/or drug abuse are limited to 30 days per calendar year for adults
    - Detoxification services are limited to once every 60 days
- Chiropractic services
  - Medicaid TANF population: < 21 years
- Practice visits for Members with Special Needs (SPD only)
- Dental Services
  - Medicaid SPD Members receive coverage for Medically Necessary oral surgery services from an oral surgeon who is a Participating Provider, upon referral by a Participating Physician and authorized by Health Plan
- Diagnostic testing
- Durable medical equipment and supplies
- Emergency and urgent care
- Immunizations
- Inpatient hospital services
- Long Term Services and Supports/Home Community Based Services (for members eligible to receive Home Community Based Services)
- Mental Health services, including inpatient admission and outpatient services
- Outpatient hospital and provider services
- Pediatric Services
- Pharmacy
- Preventive services
- Primary care services
- Specialist services
- Surgery
- Therapy Services
  - Medicaid TANF/SPD:
    - Adult physical therapy services - Annual maximum of 20 services per year
    - Adult occupational therapy services - Annual maximum of 20 services per year
    - Adult speech, hearing and language therapy services – Annual maximum of 20 services per year
- Transplant services
- Vision Services
- Well Child & EPSDT Services (up to age 21)
• Women’s care

**Medicaid Benefits Not Covered by Meridian**

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

- Routine dental services for children under the age of 21

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

**Medicare Advantage Benefits Not Covered by Meridian**

The following service is not covered by Meridian, but is covered by Original Medicare (Medicare FFS). Members must use their Original Medicare ID card to access the following service:

- Hospice care

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

**Non-Covered Services**

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

**For any Meridian member:**

- Elective cosmetic surgery
- Elective abortions
- Infertility services
- Nursing Facility services beginning the 91st day (excluding SPD Members who are residents of a nursing facility)
- Services prohibited by State or Federal law
- Non-medically necessary services

**For Medicaid Only:**

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

**For Medicare Advantage Only:**

- Private duty nurses
- Convenience items
- Full-time in-home nursing care
- Homemaker services
• Elective or voluntary enhancement procedures
• Cosmetic surgery
• Routine chiropractic care
• RK and LASIK surgery
• Reversal of sterilization procedures
• Aqua therapy
• Non-prescription contraceptive supplies
• Acupuncture
• Naturopath services
• Services provided to veterans in Veterans Affairs (VA) facilities

Member Self Referrals

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

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

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

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

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

Children’s Health
A dependent minor may seek treatment from any in-network pediatrician without prior authorization if the dependent minor is assigned to a PCP who is not a pediatrician.
Pharmacy Benefit Management

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

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

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>855-580-1688</td>
<td>877-440-0175</td>
</tr>
</tbody>
</table>

All providers have access to the Meridian Pharmacy Drug Formulary for each Meridian Medicaid and Medicare Advantage plans. The drug formularies are available on our website at www.mhplan.com.

Drug formularies should be readily accessible and be referred to when prescribing medications for Meridian members.

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

Obtaining a Formulary Exception
If a medication that is required is not on the drug formulary, a “Formulary Exception Request Form” must be filled out. The form must include all required information to make a determination on the request. The form must then be faxed to the PBM at the fax numbers below. In emergency situations, please call the PBM at the number below.

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

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBM Phone</td>
<td>855-580-1688</td>
</tr>
<tr>
<td>PBM Fax</td>
<td>855-580-1695</td>
</tr>
</tbody>
</table>

Obtaining a Drug Prior Authorization
If a medication that is required has prior authorization criteria, a “Drug Prior Authorization Request Form” must be filled out. The form must include all required information to make a determination on the request. The form must then be faxed to the PBM at the fax numbers below. In emergency situations, please call the PBM at the number below.
Prior authorizations should be obtained **before** providing the member with a written prescription. If a prior authorization is not obtained in advance, the member will not be able to have the prescription filled at their pharmacy, causing a delay in the member's treatment.

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBM Phone</td>
<td>855-580-1688</td>
<td>877-440-0175</td>
</tr>
<tr>
<td>PBM Fax</td>
<td>855-580-1695</td>
<td>877-858-2437</td>
</tr>
</tbody>
</table>

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

**Non-Emergent Transportation**

**Medicaid**
Meridian ensures that non-emergency transportation and travel expenses, determined to be required for members to secure medically necessary medical examinations and treatment, are readily available and accessible. This non-emergency transportation is available for all medical and health services deemed medically necessary by the member’s PCP, including prenatal care, preventive services, mental health services, obtaining prescription medicine and DME supplies.

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

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

The non-emergent transportation vendor will transport the following individuals:
- Members
- Parents or legal guardians of minor or disabled members
- Other family members (such as siblings) to the appointment may be allowed

Transportation services must be scheduled at least two (2) days in advance. The transportation provider uses confidential eligibility information provided by Meridian to verify the member’s eligibility. Members are then assigned the most appropriate and cost effective means of transportation. Appointments can be scheduled twenty-four (24) hours a day, Monday through Friday. Members requiring transportation for next day appointments should contact the Member Services department at 866-606-3700 as soon as possible.

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

Members who must access non-emergent travel expenses outside of the Meridian geographical area for medically necessary care, and incur costs for such services, may contact Meridian Member Services at 866-606-3700 for assistance. Meridian will review the appropriateness of the request prior to the service being scheduled.

**Advance Directives**
Advance directives are legal documents that allow members to convey their decisions about end of life care ahead of time. They provide a way for members to communicate their wishes to family, friends and health care professionals. There are two types of advance directives.

**Living Will**
A living will tells how a person feels about care intended to sustain life. They can accept or refuse medical care. There are many issues to address, including:
- The use of dialysis and breathing machines
- Tube feeding
- Organ or tissue donation
- If a person wants doctors to try to save them if their breathing or heartbeat stops

**Durable Power of Attorney for Health Care**
This is a document that names another person to make decisions for the individual if they are not able to do so. This is called a health care proxy. The proxy should be given to someone that they trust to follow their wishes.

If there are any questions about Advance Directives or a Meridian member needs help finding an advance directive form, please call Member Services at:

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>866-606-3700</td>
<td>855-827-1769</td>
</tr>
</tbody>
</table>
Section 4: Utilization Management, Care Coordination and Disease Management

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

The function of utilization management is inclusive of the following tasks:
1. Pre-service, concurrent and post-service medical necessity review
2. Discharge planning for members who are not enrolled in the Care Coordination program or do not have complex post-discharge needs and/or conditions
3. Supporting transition of care between levels of care, facilities and/or providers

Referral Management

There are three easy ways to submit referrals to Care Coordination:

1. Electronically: Meridian’s Online Provider Portal
2. Fax: Refer to the Care Coordination department's fax numbers below. Please include pertinent clinical documentation with the request if indicated.

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>312-980-0444</td>
<td>866-606-3700</td>
</tr>
</tbody>
</table>

3. Phone: Urgent requests must always be submitted telephonically. Make sure you identify the request as “urgent” to expedite the pre-service review process.

The next table in this section provides Meridian’s referral requirements for the most commonly requested services. This list is not all inclusive and rarely requested services may require pre-service authorization. Should you have any questions please contact the Care Coordination department at the appropriate number listed above.

*You may access the most recent Authorization Overview at [http://www.mhplan.com/il/providers/pdf/tools/Prior_Auth_Overview.pdf](http://www.mhplan.com/il/providers/pdf/tools/Prior_Auth_Overview.pdf)
Referral Guide

Phone: 866-606-3700 Fax: 312-980-0444

Services that DO NOT require a referral include:
- Long Acting Reversible Contraception (LARCs)
- Office visits to Meridian-contracted (in-network) providers
- Referrals to Meridian-contracted (in-network) Specialists
- Behavioral health outpatient services (first 20 visits)
- Chiropractic services (for members under 21 years of age)
- All outpatient/ambulatory services not listed in Appendix A

<table>
<thead>
<tr>
<th>Service:</th>
<th>FHP/ACA</th>
<th>Meridian ICP</th>
<th>Meridian SNP</th>
<th>Meridian Complete</th>
<th>Meridian Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Admissions (Including Acute Rehab and LTAC)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Mental Health and Substance Abuse</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Intensive Outpatient Program</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Residential Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Electro Convulsive Treatment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Elective Inpatient Admissions</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavioral Health Outpatient Services &gt;20 visits</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Ambulance Transportation Non-emergent</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Prior Authorization Overview

<table>
<thead>
<tr>
<th>Service:</th>
<th>FHP/ACA</th>
<th>Meridian ICP</th>
<th>Meridian SNP</th>
<th>Meridian Complete</th>
<th>Meridian Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Cesarean Sections</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Dialysis</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
</tr>
<tr>
<td>Deliveries</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
</tr>
<tr>
<td>Dental Anesthesia in Facility &gt;6 years of age</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>DME</td>
<td>Yes, &gt;$1,000</td>
<td>Yes, &gt;$1,000</td>
<td>Yes, &gt;$1,000</td>
<td>Yes, &gt;$1,000</td>
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</tr>
<tr>
<td>Assistive and Augmentive Communication</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Enteral and Parenteral Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Experimental and Investigational Procedures</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sterilization Procedures</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Abortion</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Infusion</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Services by an Out of Network Provider/Facility with the exception of: Emergency</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Prior Authorization Overview

<table>
<thead>
<tr>
<th>Service:</th>
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<th>Meridian SNP</th>
<th>Meridian Complete</th>
<th>Meridian Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Women’s Health</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>• Family Planning &amp; Obstetrical Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>• Child &amp; Adolescent Health Center Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>• Local Health Department (LHD) services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>• Other services based on state requirements</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</table>

| Outpatient Surgeries/Procedures (Refer to Appendix A for select procedures) | Yes | Yes | Yes | Yes | Yes |
| Physical Therapy (excluding initial evaluation) | Yes | Yes | Yes | Yes | Yes |
| Speech Therapy (excluding initial evaluation) | Yes | Yes | Yes | Yes | Yes |
| Occupational Therapy (excluding initial evaluation) | Yes | Yes | Yes | Yes | Yes |
| Pulmonary and Cardiac Rehabilitation | Yes | Yes | Yes | Yes | Yes |
## Prior Authorization Overview

<table>
<thead>
<tr>
<th>Service:</th>
<th>FHP/ACA</th>
<th>Meridian ICP</th>
<th>Meridian SNP</th>
<th>Meridian Complete</th>
<th>Meridian Prime</th>
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</thead>
<tbody>
<tr>
<td><strong>Pain Management</strong></td>
<td>PA Required?</td>
<td>PA Required?</td>
<td>PA Required?</td>
<td>PA Required?</td>
<td>PA Required?</td>
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<tr>
<td><strong>Specialty Pharmacy</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(including chemotherapy and biologicals)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>MeridianRx is the PBM for all lines of business. Phone: 855-580-1688 Fax: 855-580-1695</td>
<td>Yes; click here to review PA requirements</td>
<td>Yes; click here to review PA requirements</td>
<td>Yes; click here to review PA requirements</td>
<td>Yes; click here to review PA requirements</td>
<td>Yes; click here to review PA requirements</td>
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<tr>
<td><strong>Radiation Therapy</strong></td>
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<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
<td>Notify Plan</td>
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<tr>
<td><strong>Transplants</strong> (including evaluation)</td>
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<td><strong>Weight Management</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>(prior to bariatric surgery)</td>
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<td><strong>Nutritional Counseling</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td><strong>Wound Vac</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td><strong>Long Term Supports and Services, if waiver eligible (Refer to Appendix B)</strong></td>
<td>N/A</td>
<td>Yes</td>
<td>N/A</td>
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<td>N/A</td>
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Diabetic Testing Supplies: J&B Medical Supplies is the preferred provider and can be contacted at 800-737-0045
Behavioral Health Services: Please call 866-796-1167 or fax to 312-980-0443

### APPENDIX A: SELECT OUTPATIENT SURGERY/PROCEDURES

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure</td>
<td>Code</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
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<tr>
<td>Abdominoplasty (and removal of excess skin and fat from other areas),</td>
<td>15819, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833,</td>
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<tr>
<td>Panniculectomy, Suction Liposuction, Lipoabdominoplasty &amp; Ventral Hernia</td>
<td>15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878,</td>
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<td></td>
<td>15879, 17999</td>
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<tr>
<td>Hair Plugs</td>
<td>15778, 15775</td>
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<td>Abortion/pregnancy termination</td>
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<td></td>
<td>S0190, S2260, S2265, S2266, S2267, S0191, S0199-</td>
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<tr>
<td></td>
<td>Medication to induce abortions</td>
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<td>Back/neck surgery</td>
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<td>22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633,</td>
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<td>22634, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819,</td>
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<td>63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102,</td>
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<td>63103, 63170, 63172, 63173, 63075, 63076, 63077, 63078, 63180,</td>
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<td>63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280,</td>
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<td>63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295, 63300,</td>
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<td>63301, 63302, 63303, 63304, 63305, 63306, 63307, 63308, 63600,</td>
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<td>63610, 63615, 63620, 63621, 63650, 63655, 63661, 63662, 63663,</td>
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<td></td>
<td>63664, 63685, 63688, 63710</td>
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<tr>
<td>Back/neck surgery Osteotomy of Spine including discectomy:</td>
<td>22220, 22222, 22224, 22226, 20930, 20931</td>
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<tr>
<td>Bariatric surgery/gastric bypass</td>
<td>43644, 43645, 43647, 43648, 43770, 43771, 43772, 43773, 43774,</td>
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<td>43842, 43843, 43845, 43846, 48847, 43775, 43848, 43886, 43887,</td>
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<td>43888, 43999</td>
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<tr>
<td>Lap Band Gastric Adjustment</td>
<td>S2083</td>
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<tr>
<td>Blepharoplasty (and repair of blepharoptosis)</td>
<td>11950, 11951, 11952, 11954, 15820, 15821, 15822, 15823, 67900,</td>
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<td>67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67999</td>
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<tr>
<td>Breast reconstruction (including, but not limited to: mammoplasty</td>
<td>11920, 11921, 11922, 11970, 11971, 19316, 19318, 19324, 19325,</td>
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<tr>
<td>augmentation, breast implants)</td>
<td>19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364,</td>
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<td>19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396, 19499,</td>
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<td>L8020, L8039, L8600, S2066, S2067, S2068</td>
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<tr>
<td>Breast reduction</td>
<td>19316, 19318, 19300, 19304</td>
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<tr>
<td>Cochlear implantation/device</td>
<td>69714, 69715, 69717, 69718, 69799, 69930, 92640, S2235, L8614, L8615,</td>
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<tr>
<td></td>
<td>L8616, L8617, L8618, L8619, L8621, L8622, L8623, L8624, L8627,</td>
</tr>
<tr>
<td></td>
<td>L8628, L8629, 61785 (Neuro-stimulator), 69930 (L8614 is included with</td>
</tr>
<tr>
<td></td>
<td>this procedure code and needs to be reported when submitting</td>
</tr>
<tr>
<td></td>
<td>claims)</td>
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<tr>
<td>Dermabrasion</td>
<td>15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792,</td>
</tr>
<tr>
<td></td>
<td>15793, 17340, 17360, 17999 (Unlisted skin procedure)</td>
</tr>
<tr>
<td>Division of Fallopian Tube</td>
<td>58600, 58605, 58611, 58615</td>
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</tbody>
</table>
### APPENDIX A: SELECT OUTPATIENT SURGERY/PROCEDURES

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
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<tbody>
<tr>
<td>Dual Chamber pacemaker insertion</td>
<td>33208, 33202, 33203, 33206, 33207, 33213, 33214, 33215, 33216, 33218, 33220, 33221, 33222, 33223, 33224, 33225, 33226, 33227, 33228, 33229, 33231, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33217, 33249, 33230, 33263, 33264, 33222, 33223, 33224, 33225, 33226, 33227, 33228, 33229, 33231, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33217, 33249, 33230, 33263, 33264, 33282</td>
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<tr>
<td>Ectopic pregnancy</td>
<td>59135, 59136, 59150, 59151</td>
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<tr>
<td>Gastric neurostimulator</td>
<td>64590, 64595, 43647, 43648, 43881, 43882, 43999, 95980, 95981, 95982</td>
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<tr>
<td>Hysterectomy</td>
<td>51925, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58275, 58290, 58291, 58292, 58293, 58294, 58267, 58270, 58280, 58285, 58541, 58542, 58543, 58544, 58548, 58549, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58578, 58952, 58953, 58954, 58958, 59135, 59525</td>
</tr>
<tr>
<td>Hysteroscopy, sterilization</td>
<td>58565</td>
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<tr>
<td>Implantation of neurostimulator (SPINE ONLY)</td>
<td>63650, 63655, 63661, 63662, 63663, 63664, 63685, 63685, 64581</td>
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<tr>
<td>Laparoscopy, tubal cautery/block</td>
<td>58670, 58671, 58679</td>
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<tr>
<td>Mastectomy for gynecostasia</td>
<td>19300</td>
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<td>Multifetal pregnancy reduction</td>
<td>59866</td>
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<tr>
<td>Orthognathic surgery</td>
<td>21085, 21110, 21120, 21121, 21122, 21123, 21124, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208, 21209, 21210, 21215, 21230, 21235, 58262, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7995</td>
</tr>
<tr>
<td>Penile Implant/Prosthesis</td>
<td>54360, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417</td>
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<tr>
<td>Septoplasty/ Rhinoplasty</td>
<td>30400, 30410, 30420, 30430, 30435, 30450, 30620, 30520</td>
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<tr>
<td>Scar excision/revision</td>
<td>15766, 15787, 31830</td>
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<tr>
<td>Varicose vein treatment/surgery</td>
<td>36468, 36469, 36470, 36471, 36475, 36476, 36478, 36479, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, 37799, S2202</td>
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<tr>
<td>Vasectomy, removal/ligation of sperm duct(s)</td>
<td>55250, 55450</td>
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<tr>
<td>Laparoscopy fundoplasty</td>
<td>43280, 43279</td>
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<tr>
<td>Laparoscopy para-esophageal hernia repair</td>
<td>43281</td>
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<tr>
<td>Esophagus surgery procedure</td>
<td>43499</td>
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<tr>
<td>Hip arthroplasty</td>
<td>27125, 27130, 27132, 27134, 27137, 27138</td>
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<tr>
<td>Hyperbaric Oxygen Therapy</td>
<td>99183</td>
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<tr>
<td>Video EEG</td>
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<td>Fertility tests</td>
<td>58340, 74740, 58345, 55350, 58350</td>
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<tr>
<td>Implant Neuroelectrodes</td>
<td>64553, 64555, 64566, 64566, 64565, 64569, 64570, 64575, 64580, 64581, 64585, 61870, 64875, 61880, 61885, 61888, 61888, 64586</td>
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<tr>
<td>Ventral Hernia Repairs</td>
<td>49652, 49653, 49560, 49561, 49565, 49566, 49568</td>
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<tr>
<td>Photo chemotherapy for Psoriasis</td>
<td>96910, 96912, 96913, 96920, 96921, 96922, 96999</td>
</tr>
<tr>
<td>Cardiac Implant Recorder/ Loop Recorder</td>
<td>33282, 33284</td>
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### APPENDIX B: LONG TERM SUPPORTS AND SERVICES: FHP/ACA, ICP & MMAI POPULATIONS

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<th>Waiver</th>
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32
Meridian_PSM01 IL Combined FHP/ACA-SPD-MAP_4/2015
<table>
<thead>
<tr>
<th>Services*</th>
<th>Persons with Brain Injury</th>
<th>Persons with Disabilities</th>
<th>Persons who are Elderly</th>
<th>Persons with HIV/AIDS</th>
<th>Supportive Living Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hour response/security staff</td>
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<td></td>
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<td>X</td>
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<tr>
<td>Adult day care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Ancillary (transportation to group/community activities, shopping, arranging outside services)</td>
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<td>X</td>
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<tr>
<td>Behavioral services</td>
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<tr>
<td>Day habilitation</td>
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<tr>
<td>Environmental accessibility adaptations</td>
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<tr>
<td>Health promotion and exercise</td>
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<tr>
<td>Home delivered meals</td>
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<td>Homemaker</td>
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<td>Housekeeping</td>
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<td>Intermittent nursing</td>
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<tr>
<td>Laundry</td>
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<td>Maintenance</td>
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<td>Medication oversight and assistance with self-administration</td>
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<td>Personal care (personal assistant)</td>
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<td>Personal emergency response system</td>
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<td>Physical, occupational and speech therapy</td>
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<td>Prevocational services</td>
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<td>Respite</td>
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<td>Skilled nursing and home health aide</td>
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<tr>
<td>Social/recreational programming</td>
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<td>Supported employment services</td>
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<tr>
<td>Transportation for employment</td>
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*All services require prior authorization. Existing care plan service will not require authorization for first 180 days.
Model of Care Overview

Meridian’s Model of Care is specifically designed to serve a complex population with diverse social structures and varying health care needs. Meridian’s innovative Care Coordination model promotes independent, healthy living through integration of traditional medical and hospital benefits with a focus on supporting members in the community through the use of an Interdisciplinary Care Team (ICT), coordination with community resources, and provision of long term services and supports (LTSS), depending upon the population served. Our model emphasizes recovery through treating the whole person across the spectrum of their care needs, not simple maintenance of stable but diminished health and well-being. Our provider network partnerships are built with this goal in mind, consisting of traditional health care providers, behavioral health specialists, LTSS and other community resources with a shared commitment to evidence-based treatment, robust communication, teamwork and a culture of “going the extra mile.”

In recognition of the often complex and unique needs of members, specifically dual eligible individuals, the Model of Care is continuously updated and expanded through ongoing quality improvement initiatives. The success of Meridian’s dedication to quality improvement is recognized on national and State levels.

By applying the scientific knowledge Meridian has gained through the study of its members, the Meridian Model of Care will optimize their overall health, well-being, and independence.

Care Coordination Program

The purpose of Meridian’s Care Coordination program is to link the member’s needed services and resources in a coordinated effort, achieve better access to needed care, navigate the member through the complex health care system, and to increase self-management and self-advocacy skills. The program is designed to ensure the coordination of services across various domains, such as primary care, substance abuse, mental health and community supports. It is also designed to connect providers through the exchange of relevant information so that treatment for any one of the member’s needs includes recognition of their full set of needs. The goal of the program is to maximize the member’s potential and provide them with optimal care.

The tenets of Meridian’s Care Coordination program include:

- Develop person-centered plan of care
- Monitor progress towards goals
- Assess risk regularly
- Connection to services: Primary Care, Specialty Care, Behavioral Health, Substance Abuse, Long-Term Services and Supports, Acute Care, Post-Acute Care, and Transitional Care
- Establish a consistent medical home
- Link members with community resources to facilitate referrals and respond to social service needs
- Guide transition of care
- Medication Reconciliation
- Maintain regular contact with member/caregiver
- Dedicated team-based care management
- Chronic disease self-management education
**Target Population**

- Members of certain special healthcare populations are automatically identified and referred to Care Coordination at the time of enrollment. These special health care populations include:
  - Pregnant members
  - Members served in our Medicare Dual eligible Special Needs Plans (SNP)
  - Seniors and Persons with Disabilities (SPD)
  - Members receiving Long-Term Services and Supports
  - Institutionalized members
  - Members with a developmental disability
  - High risk and high cost populations with multiple health and social needs

**“Integrated Team” Approach**

The Meridian Care Coordination program operates as an integrated team comprised of Care Coordinators, a Care Coordination Nurse Team Lead and assigned consultant staff from Behavioral Health, Pharmacy and Nutrition and Community Health Outreach Worker. Led by a Meridian Medical Director, the teams meet daily for continuous education and case review.

Care Coordinators will send a member’s providers a report identifying the member’s health status and identifying short-and-long term goals for Care Coordination. Care Coordinators may contact providers for other reasons, such as:

- To coordinate a plan of care;
- To confirm a diagnosis;
- To verify appropriate follow-up such as cholesterol/LDL-C screening or HbA1c testing;
- To identify compliance issues;
- To discuss other problems and issues that may affect outcomes of care; or
- To inform you of a member’s potential need for behavioral health follow-up.

The Care Coordination program is available to all members currently enrolled with Meridian. Potential members eligible for Care Coordination are identified through a variety of referral sources. It is the goal of Meridian to ensure each member receives appropriate and individualized care that meets their health needs. Meridian uses predictive modeling, disease management programs, claims analysis, the hospital discharge review and planning process, screening assessment tools, and direct physician and/or member referrals. Meridian Care Coordinators contact the member and their family to collaborate with them and their healthcare team to ensure full care coordination and to improve self-management skills.

**Complex Case Management**

Meridian’s Complex Case Management Program supports members with a condition and/or medical fragility that is persistent and substantially disabling or life threatening. Members enrolled in Complex Case Management may require treatment and services across a variety of settings to ensure the best possible outcome for each member's need. The criteria for a Complex Case Management referral is based on the severity of illness, degree of impairment or disability, and the presence of multiple providers and level of need for comprehensive Care Coordination.
**Behavioral Health Care Coordination**

Meridian offers a comprehensive Behavioral Health (BH) benefit, including Care Coordination services. Members who have encountered inpatient admissions or outpatient care associated with behavioral healthcare or chemical/substance abuse are eligible for BH Care Coordination. Meridian is able to support this population and provide medical – behavioral health coordination of care. Members have the opportunity to self-refer and providers can directly refer members for BH Care Coordination services. Psychosocial assessments and information about available resources within the community provide for comprehensive care planning for these members. See page 40 for more information.

**Maternity Care Coordination**

Meridian provides support for all pregnant women through Care Coordination services. This program includes proactive identification and outreach based on results of prenatal screening assessments. Maternity Care Coordinators provide support for pregnant members through coordination of care, educational materials, assistance in referrals and appointment scheduling to ensure consistent and ongoing prenatal care. High-risk pregnant members will receive their care coordination from a High-Risk Maternity Nurse.

Meridian will coordinate with the Family Case Management (FCM) Program, which will include, but is not limited to:

- Coordinating services and sharing information with existing FCM providers for its members;
- Developing internal policies, procedures and protocols for the organization and its provider network for use with FCM providers serving members; and
- Conducting periodic meetings with FCM providers performing problem resolution and handling of grievances and issues, including policy review and technical assistance.

FCM is a key community resource for high-risk maternity cases. FCM is a community based resource that locally manages members healthcare needs and provides the necessary assistance for a healthy pregnancy. Meridian will refer to FCM when appropriate and encourage providers to refer high-risk pregnant members as well. In addition, Meridian works with providers to identify high-risk prenatal or neonatal complications. Members requiring high-risk or specialty care should be referred to an appropriate specialist or transferred to a level III perinatal facility; Meridian can provide assistance in this referral process if necessary.

**Assessment**

Members referred to the Care Coordination program are assessed by one of the following based upon their type of underlying condition:

A. Case Managers who are actively licensed registered nurses for medical conditions

B. Behavioral Health Care Managers who are Master’s level-prepared social workers, professional counselors or psychologists for behavioral health or substance abuse conditions

C. An integrated team consisting of a Case Manager and Behavioral Health Care Manager for complex co-morbid conditions

The Case Manager assesses the member’s care needs and preferences to ensure the member has access to the right type of care applicable to their condition at the right time from the right provider and for the right reason. Care Coordination assessments are conducted telephonically.
or on-site, as necessary, to collect additional medical, behavioral health, substance abuse, psychosocial, functional, living situation and life planning information.

The results of these assessments are used to a) determine whether or not the member is eligible for Care Coordination, b) assign the member’s risk stratification level and c) begin the development of the plan of care.

**Individualized Plans of Care**

Based upon the member’s stratified level of risk and additional assessment results, the results are reviewed, analyzed and transformed into an individualized, integrated plan of care in accordance with nationally recognized, evidence-based Care Coordination guidelines.

The Case Manager develops the plan of care in collaboration with the member, the member’s PCP and other providers, as applicable, to identify problems, set goals and select the interventions to be used. The plan of care includes milestones, short-term and long-term goals. The goals are prioritized in accordance to the member’s medical and/or behavioral health needs, stability, preferences and readiness to participate in the selected intervention.

Interventions are tailored to meet individual member needs and set the member up for success in attaining the ultimate goal of the Care Coordination program which is to empower the member to assume responsibility for taking care of his or her health in partnership with his or her PCP.

Interventions include, but are not limited to:

- Member, or family/caregiver, self-management education and coaching
- Coordination of care and treatment services
- Psychosocial support
- Behavioral health support
- Referral to ancillary or community-based agencies as appropriate

**Communication**

The initial plan of care is communicated orally via telephone or in writing via USPS mail or facsimile, according to the preferences of the member, the PCP and other providers, as applicable. Once agreement on the plan of care’s goals and interventions is mutually agreed upon by all parties, the plan is implemented.

Status updates, plan of care revision and reassessment information is communicated in accordance with the frequency required by the member’s condition and in a format requested by the member, the PCP and other providers, as appropriate.

**Monitoring and Evaluation**

The Case Manager closely monitors the member’s responses to interventions, progress toward achieving milestones and goals and barrier resolution as appropriate to the level stratified risk. The Case Manager documents the plan of care and its outcomes in MCS in the member’s profile under the Care Coordination module.
Reassessment

Members are reassessed:

- Semi-annually;
- Whenever there is a marked change in condition
- Onset of a new co-morbidity or complication
- Upon emergency room or inpatient utilization

The plan of care is updated in response to the results of the reassessments. Revisions to the plan of care are developed in collaboration among and implemented upon mutual agreement from the member, the member’s PCP and other providers, as appropriate, and occur on a regular basis as outlined in plan policies. The revised plan of care is then communicated orally by telephone or in writing via USPS mail or facsimile in accordance with member, PCP and provider preference.

Outcomes Measurement

HEDIS® measures are utilized on an annual basis to assess clinical outcomes including:
- Annual monitoring of patients on persistent medications
- Condition-specific HEDIS® measures
- Children, adolescents and adults access to preventive care
- Annually influenza vaccination
- Pneumonia vaccination

Utilization data from claims are measured, analyzed and evaluated quarterly by the Quality Improvement and Utilization Management departments. Data review includes inpatient admission and readmission, planned or unplanned transitions in care and emergency department use.

Member satisfaction with choice and quality of care received and member reassessment of self-reported improvements in status are measured, analyzed and evaluated annually using mailed and telephonic survey tools by the Quality Improvement department. Outcomes are reported, reviewed, analyzed and evaluated by the QIC quarterly and annually. The QIC makes recommendations for improvement to the Care Coordination program based upon these outcome reports.

Providers can refer any Meridian member to the Care Coordination program by:

A. Notifying Meridian through the Provider Portal
   1. Log in to the Provider Portal (www.mhplan.com/il/mcs)
   2. Select “Member” on the left menu
   3. Enter the Member ID number
   4. Click “Notify Health Plan” at the bottom of the “Demographics” screen
   5. Select “Case Management” (middle tab) and fill out the reason for referral

B. Completing the “Care Coordination Referral Form” and faxing it to Meridian. To get the form:
   A. Go to www.mhplan.com/il/providers
   B. Click on “Documents and Forms” on the left side
C. Fax the completed form to 313-202-5787

C. You can also request a Care Coordination Referral Form from your local Provider Network Development Representative

**Medicaid Primary Care Providers (PCP) Open Access**

Medicaid PCPs do not need an authorization to provide services to a Meridian member that is not assigned to their panel. PCPs can provide Medicaid covered benefits to any Meridian member that is eligible at the time of service.

**Medicaid Specialty Network Access to Care**

Out-of-network, in-state specialist referrals may be utilized without an authorization from if the specialist is contracted with the State of Illinois and have an HFS number. Meridian requests notification to communicate services with all providers involved, provide additional reporting services and support Care Coordination and Disease Management efforts.

PCP/Specialist notification is not necessary for claims payment. In-network or out-of-network providers will be reimbursed for consultations, evaluations and treatments provided within their offices, when the member is eligible and the service provided is a covered benefit under Illinois Medicaid and the Medicaid Managed Care Organization (MCO) contract.

As a PCP, you may request a referral via Meridian’s Provider Portal, by fax or by calling Meridian’s Utilization Management department at 866-606-3700.

**Corporate Pre-Service Review**

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

Care Coordination clinical staff use plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by Meridian’s medical directors. These guidelines include McKesson InterQual® criteria, Meridian Medical Review Criteria (developed by Meridian medical directors in conjunction with community physicians), and applicable federal and state benefit guidelines. Copies of the criteria utilized in decision-making are available free of charge upon request by calling the Utilization Management department at 866-606-3700. In certain circumstances, an external review of service requests are conducted by qualified, licensed physicians with the appropriate clinical expertise.

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

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. The preferred method of clinical review submission is via fax to the Care Coordination department. If clinical information is not received with the request, Meridian’s Care Coordination staff will send a fax request for the information and/or contact the physician or specialist verbally to collect the necessary documentation.

Clinical information includes relevant information regarding the member’s:

- History of presenting problem
- Physical assessment
- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Member’s response to treatment

Clinical information should be provided at least 14 days prior to the service. The facility is responsible for ensuring authorization. Meridian provides a reference number on all referrals.

Utilization decisions are based on appropriateness of care and service, as well as the member’s eligibility. Meridian does not specifically 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.

**Turnaround Times for Referral Processing**

<table>
<thead>
<tr>
<th>Type of Authorization</th>
<th>Decision Timeframe</th>
<th>Fax/Phone Notification</th>
<th>Written Notification (Denials)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Urgent pre-service review</td>
<td>Within 14 days of receipt of the request.</td>
<td>Within 14 days of receipt of the request.</td>
<td>Within 14 days of receipt of the request.</td>
</tr>
<tr>
<td>Urgent pre-service review</td>
<td>Within 72 hours of the request.</td>
<td>Within 72 hours of the request.</td>
<td>Within 72 hours of the request.</td>
</tr>
<tr>
<td>Urgent/Concurrent</td>
<td>Within 24 hours of receipt of the request.</td>
<td>Must be telephonic.</td>
<td>Within 72 hours of the decision.</td>
</tr>
<tr>
<td></td>
<td>48 hours if clinical information is incomplete or is not included.</td>
<td>Within 24 hours of receipt of the request. 48 hours if clinical information is incomplete or not included.</td>
<td>Within 72 hours of the decision.</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Within 30 days of receipt of the provider’s request. N/A for members.</td>
<td>N/A</td>
<td>Within 30 days of receipt of the request.</td>
</tr>
</tbody>
</table>
very few situations that justify requesting retrospective authorization and most often will be denied.

Inpatient Review

Our nurse reviewers are assigned to members at specific acute care facilities to promote collaboration with the facility’s review staff and management of the member across the continuum of care. Meridian’s nurse reviewers assess the care and services provided in an inpatient setting and the member’s response to the care by applying InterQual® criteria. Together with the facility’s staff, Care Coordination’s clinical staff coordinates the member’s discharge needs.

All elective hospital admissions initiated by the PCP or specialist require Corporate Pre-Service review. To initiate review, call the Care Coordination department, enter the authorization request through Meridian’s Provider Portal or fax the request to the Care Coordination Team. Be sure to include documentation of medical necessity to facilitate the earliest possible turnaround time. The facility is responsible for ensuring authorization. Meridian provides a reference number on all referrals.

Initial medical necessity review of corporate prior authorization requests that require approval of the health plan and concurrent review of admissions for behavioral health and substance abuse conditions are performed by Utilization Management Coordinators who are active licensed registered nurses with the State of Illinois or Behavioral Health Care Coordinators who are master’s level prepared social workers, professional counselors or psychologists. Medical necessity review determinations for behavioral health care and substance abuse are made in accordance with The Mihalik Group’s Medical Necessity Manual for Behavioral Health, Level of Care Utilization System (LOCUS), Meridian Medical Policy, or CMS National or Local Coverage Determinations, as appropriate.

Utilization Care Coordinators or Behavioral Health Care Coordinators perform routine discharge planning and coordinate transitions between levels of care, facilities and/or providers in collaboration with the member, the facility’s designated contact and the member’s PCP.

Denials and Provider Appeals

All denial determinations are rendered by a physician reviewer. A nurse reviewer contacts the provider telephonically to provide them with the denial decision, reason for the denial and contact information to discuss the denial with Meridian’s Medical Director.

Written denial notification and appeal rights are sent via fax to the PCP and requesting provider/physician and mailed to the member. Treating physicians who would like to discuss a utilization review determination with the decision-making Medical Director may contact the Care Coordination department at 866-606-3700 between 8:00 a.m. and 5:00 p.m. Monday through Friday. After business hours, you may call Meridian at 866-606-3700.

The written denial notification will include the reason for the denial, the reference to the benefit provision and/or clinical guideline on which the denial decision was based and directions on how
to obtain a copy of the reference. You may contact the Care Coordination department at 866-606-3700 to request a copy of Meridian’s medical necessity guidelines.

**Expedited Appeal**

An expedited appeal is a request to change a denial decision for urgent care. Urgent care is any request for medical care or treatment to which the time period for making non-urgent care determinations could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function based on a prudent layperson’s judgment.

An expedited appeal may be requested by the member, the member’s authorized representative or the member’s treating provider. Inpatient services that are denied while a member is in the process of receiving the services are considered an urgent concurrent request and are therefore eligible for an expedited appeal.

**Non-Urgent Pre-Service Provider Appeal** (Separate and Distinct from the Member/Authorized Representative Appeal Process)

Providers may request an appeal of denial in advance of the member obtaining care or services. Meridian will provide acknowledgement of your appeal within three days of receipt of the request.

**Reconsideration of an Adverse Determination**

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

**Turn Around Times for Processing Provider Appeals**

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Decision Timeframe</th>
<th>Fax/Phone Notification</th>
<th>Written Notification (Denials)</th>
</tr>
</thead>
</table>

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Meridian_PSM01 IL Combined FHP/ACA-SPD-MAP_4/2015
Expedited Appeal

Completed as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of an expedited grievance.

Inpatient admissions are eligible if the member is receiving services at the time of the denial.

Within 24 hours of the decision.

Within 72 hours of receipt of the request.

Pre-service Review

Within 14 calendar days of receipt of the appeal.

Within 14 calendar days of receipt of the appeal.

Within 14 calendar days of receipt of the appeal.

Second Opinion

Members wishing to obtain a second opinion on the care they receive for covered healthcare services may do so from a qualified in-network or an in-state out-of-network provider at no cost. Members may self-refer for the second opinion or contact the Member Services department for assistance and coordination.

Long-Term Services and Supports Program

For Meridian Medicaid Plans

Meridian Health Plan has a Community Care Coordination Program designed for members eligible for the State Medicaid long-term delivery system which fully integrates traditional Long-Term Services and Supports (LTSS) and nursing facility based services, with home and community based services (HCBS). This fully integrated approach improves member access and ensures a full continuum of services for Medicaid members through a Managed Care Organization (MCO).

The goal of Meridian’s LTSS Program is to provide the appropriate HCBS that will enable people with disabilities to live in their own homes and other community settings, and to lead satisfying and productive lives.

These goals can be accomplished through the systematic process of assessment, planning, coordinating, implementing and evaluating of a member’s care by person-centered care coordination. Fully integrated, person-centered, Community Care Coordination ensures that the member’s acute/chronic physical healthcare, behavioral healthcare, and LTSS/HCBS community supports and services are provided in a seamless, cohesive and collaborative manner, improving quality and increasing outcomes, reducing waste, duplication and redundancy in services. Community Care Coordination not only provides the member with a coordinator to facilitate scheduling and service access; it also provides the member with an advocate that assists in gaining needed knowledge of services and alternatives to make the most informed decision related to community supports and services, healthcare and custodial services.

Waivers Served

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

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

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

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

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

- Persons residing in Supported Living Facilities (SLF) Waiver
  Operated by the Medicaid agency, HFS. Persons age 65 or older or persons with disabilities (as determined by the Social Security Administration) age 22 and older, screened by HFS and found to be in need of nursing facility level of care and SLF is appropriate to meet the needs of the individual. These persons can be without a primary or secondary diagnosis of a developmental disability or serious and persistent mental illness

Home and Community Based Services include the following:

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

Person Centered Plan of Care and Comprehensive Assessment

Members who are referred to the program and meet the program’s level of care guidelines will receive a face to face person-centered plan of care (POC) which includes a comprehensive and risk assessment component at the member’s location of choice, from a designated community care coordinator. The comprehensive and risk assessment section of the POC will include the evaluation of existing HCBS services with recommended changes if necessary. The POC is reviewed by an interdisciplinary team who makes recommendations for appropriateness of care.
Ongoing services are provided by the Community Care Coordination team, which includes the Community Care Coordinator, interdisciplinary and community support team members. The assigned Community Care Coordinator (CCC) and/or team members will work with the member on an ongoing basis, as recommended and authorized within the service summary to assure that their needs are met safely and effectively in the least restrictive environment and in accordance with Meridian established benefit limits.

**Care Planning Process**

An individualized person-centered Plan of Care (POC) is established for each program member that specifically includes the amount, frequency, duration and scope of each service needed to support the member in the least restrictive level of care possible. When developing the person-centered Plan of Care, the CCC considers needs identified during the face to face visit and ensures the POC addresses those needs, facilitates plans and advocates for the member.

**Community Care Coordination**

Members and/or their representatives play a critical role in the LTSS program and are invited to participate actively in the assessment and care planning process. CCCs include members in their healthcare decisions and encourage members to participate to the extent of their ability and willingness to do so. Meridian’s focus on self-management requires an assessment and understanding of the member’s needs, values, health beliefs and cultural influences and how these influences drive healthcare behavior and decisions. The CCC works closely with the member and their family or representative to develop a POC using the results of the health and functional assessment. This process, combined with medical record and utilization claims review, helps to develop the member’s clinical treatment goals.

Meridian’s community care coordination:

- Is based on person-centered planning that assures member choice, member desired outcomes and member self-directed options
- Integrates primary, acute, behavioral services and LTSS into one consumer-driven, seamless system of care
- Provides members with timely, medically necessary healthcare services in the least restrictive and most appropriate setting
- Focuses on preventive, primary and secondary care that slows illness progression and disability
- Involves members, caregivers, physicians, and other providers in the care planning process
- Works in collaboration with providers, caregivers, and others who are involved in the care of the member

Each member will be assigned a CCC who assists in planning and coordinating his or her care.

**LTSS Provider Responsibility**

1. Service Requirements for HCBS providers:
   - HCBS will provide services in accordance with the person-centered POC including the amount, frequency, duration and scope of each service in accordance with the member’s service schedule
   - HCBS providers will complete and forward all requested documentation verifying both the services provided, in accordance with the POC service authorizations and goal
outcome documentation on a monthly basis, or as requested by the Meridian Community Care Coordinator. Documentation will include the information listed in the above bullet as well as the member’s signature approving and verifying provision of services

- HCBS providers are prohibited from soliciting members to receive services including:
  - Referring an individual for screening and intake with the expectation that should program enrollment occur, the provider will be selected by the member as the service provider
  - Communicating with existing program members via telephone, face-to-face, or written communication for the purpose of petitioning the member to change providers

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

HCBS providers must accept and agree to start services for Money Follows the Person (MFP) eligible members with a faxed authorization. HCBS providers must comply with critical incident reporting and management requirements; see the “Provider Critical Incident Reporting” section on page 60.

**Behavioral Health**

Meridian is dedicated to providing care that is culturally sensitive, community-based and family-centered and focused on recovery and resiliency for all individuals. Meridian’s Integrated Behavioral Healthcare Management Program is based on Meridian’s overarching commitment to the well-being of all members through the provision of high quality healthcare services in a low resource environment. The main goal of this program is to ensure that the “whole person” is considered and treated at every visit through the integration of physical and behavioral health care.

Meridian focuses on prevention, early detection and the elimination of fragmentation. This focus allows us to provide the right care, at the right time, in the right setting. Thus, members show higher rates of recovery, improved health and wellness and are more likely to live self-directed lives to reach their fullest potential. Our Integrated Behavioral Healthcare Management Program focuses on care coordination and collaboration between behavioral health, medical care and the members themselves to ensure coordinated care with a strong emphasis on patient education, coaching and knowledge.

**Program Goals:**

- Improve health outcomes for persons diagnosed with a serious mental illness by reducing complications of common co-occurring physical illnesses through improved access to and integration of behavioral health and primary care services
- Ensure that member/caregivers are aware of the services available to them
- Encourage the member/caregiver’s active participation in needed services
- Provide adequate support to the severely mentally ill in their recovery efforts
- Promote community tenure
- Encourage positive functional outcomes
- Reduce symptoms of mental illnesses
- Reward providers based upon outcomes and quality of services provided

Central to this program are a wide array of services, including but not limited to:

- Nutritional education
- Weight management programs
- Behavioral and physical care coordination and collaboration
- Discharge planning
- Depression screening
- Follow-up after hospitalization to prevent readmissions
- Outreach services
- Educational material distribution
- Prenatal depression screening
- Postpartum depression screening
- Smoking cessation program
- Referring members to local peer support agencies

In recognition of the complex and unique needs of members requiring behavioral health assistance, this program is continuously updated and enhanced through ongoing quality improvement initiatives.

Referrals for Behavioral Health Services
Prior authorization is not required for the first 20 behavioral health outpatient services, but notification from the behavioral health provider is requested by completion of the 3rd visit.

The behavioral health provider is asked to complete the “Continued Outpatient Treatment Notification Form,” including the DSM-IV diagnosis, reason for continued treatment and the status of PCP notification.

A copy of the Continued Outpatient Treatment Notification Form can be found at www.mhplan.com in the Provider section under Documents and Forms.

You may contact our behavioral health staff at 866-796-1167 for assistance with the following services:
- Locating a behavioral health provider
- Scheduling behavioral health appointments
- Locating community groups and self-help groups

If a member requires additional outpatient care for behavioral health services, a corporate authorization is required.

All substance abuse services require prior authorization regardless of inpatient or outpatient services. All inpatient, day hospital, and intensive outpatient programs for behavioral health also require prior authorization.

For acute behavioral health and substance abuse services including inpatient, partial hospitalization, intensive outpatient and residential treatment, Meridian Health Plan requires the completion of the Transition of Care Form located on our website. The form should be completed in full and faxed to the number identified on the form prior to the member’s discharge.

Behavioral health and substance abuse referrals may be faxed to 312-980-0443.

**Smoking Cessation Program**

Meridian offers a free counseling program and other resources to help members quit smoking. In addition, we ask that our providers take the time to ask patients about their smoking habits.
at every visit and if the patient is a smoker, please advise them to quit. Providers should also discuss smoking cessation strategies. Medications as part of nicotine replacement therapy are available through each plan’s pharmacy benefit:

**Medicaid Covered Nicotine Replacement Therapy Medications:**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Coverage Specifications</th>
</tr>
</thead>
</table>
| Nicotine Patches Over-the-Counter Generic | • Covered with a prescription from a physician  
• Only 1 patch per day is covered  
• Limited to 6 months of therapy per 365 days |
| Nicotine Gum Over-the-Counter Generic    | • Covered with a prescription from a physician  
• Only 336 pieces of gum per month are covered  
• Limited to 6 months of therapy per 365 days |
| Nicotine Lozenges Over-the-Counter Generic | • Covered with a prescription from a physician  
• Only 360 pieces/lozenges per month are covered  
• Limited to 6 months of therapy per 365 days |
| Zyban (Bupropion) 150Mg SR Tablets       | • Only 2 tablets per day are covered  
• Limited to 90 days of therapy per rolling 365 days |
| Chantix                                  | • Before this drug is covered, member must have documentation that  
all other smoking cessation medications covered by Meridian Medicaid  
have failed to work  
• Limited to 90 days of therapy per rolling 365 days |

**Medicare Advantage Covered Nicotine Replacement Therapy Medications:**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Coverage Specifications</th>
</tr>
</thead>
</table>
| Zyban (Bupropion) 150Mg SR Tablets       | • Covered  
• Before this drug is covered, member must have documentation that  
all other smoking cessation medications covered by Meridian Medicaid  
have failed to work  
• Limited to 180 tablets as a 90 day supply |
| Chantix                                  | • Before this drug is covered, member must have documentation that he/she has tried Zyban (three consecutive fills  
within the past 90 days)  
• Limited to 180 tablets as a 90 day supply |
| Nicotrol Nasal Spray                     | • Before this drug is covered, member must have documentation that all other smoking cessation medications covered  
by Meridian Medicare Advantage have failed to work  
• Limited to one bottle per month |

**Disease Management**

The goal of Meridian’s Disease Management is to improve member outcomes and well-being by supporting the practitioner/patient relationship and plan of care. We do this by combining up-to-date information and resources for our providers with self-management education and outreach strategies for members. The disease management programs were developed to assist your patients in better understanding of their condition, to update them on new information about their disease and to provide them with assistance from our staff to help them manage their disease. The programs are designed to reinforce your treatment plans for the patient.
The targeted populations within are identified through data produced from HRAs, medical claims, encounter data and pharmacy claims. Interventions are created for members in targeted populations that relate to specific diseases. The goal of these interventions is to improve health outcomes.

**The clinical topics of our Disease Management programs include:**

- Asthma
- Diabetes
- CVD (hypertension, hyperlipidemia, hypercholesterolemia, acute myocardial infarction, ischemic vascular disease or post cardiac event such as CABG or percutaneous coronary interventions (PCI))
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)

Members of Meridian do not have to enroll; they are automatically enrolled when we identify them as members with one or more of the above diseases through claims, the UM/CC program, pharmacy information or Health Risk Assessments (HRA). The programs your patients are enrolled in are listed on your monthly member eligibility list.

Once a member is identified on our stratification list, his or her claims history is used to determine the appropriate intervention level. Meridian then performs outreach based on the member's level of need, which includes the following:

- Support from Meridian nurses and other health care staff to ensure that your patients can understand how to best manage their condition and periodically evaluate their health status
- Periodic newsletters to keep the patients informed of general information regarding their disease and ways to self-manage
- Educational and informational materials that can assist your patients in understanding and managing the medications you prescribe, how to effectively plan for visits to see you and reminders as to when those visits should occur
- Reminders for annual tests/labs

Providers play an important role in the Disease Management programs. Meridian will assist its PCPs in developing chronic care action plans for our members. These action plans will help the PCP and the member set goals for managing the member’s condition. These action plans should be maintained in the medical record. Meridian also provides you with updates on the results of tests or other information that we collect on your patients.

Meridian hopes our PCPs and providers will support these programs and encourage your patients to take advantage of this service.

If you would like to enroll a Meridian member who is not in the program, please contact the Meridian Disease Management Department by phone at 866-606-3700, fax 312-980-0444 or via the Provider Portal “Notify” button.

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

**Prenatal/Postpartum Program**

Meridian has a special program for pregnant women. Beginning the moment Meridian becomes aware a member is pregnant; Meridian will initiate interventions to lead to a healthy outcome for both mother and baby. The Meridian staff will assist the member with connecting with the health
care system whereby the member can receive the appropriate treatment and care. This may be accomplished by assisting the member to find an OB/GYN provider, helping make appointments and/or arranging transportation. The member is also provided educational materials on numerous pregnancy related topics.

Members are followed throughout the course of their pregnancy to provide support and assistance as needed and to ensure that they follow through with their postpartum visit. Members are also screened for possible postpartum depression and referred to appropriate behavioral health providers, as necessary. Educational materials related to postpartum and infant care are provided to the new mother. These materials encourage well-care visits and promote important preventive health care services, such as immunizations and lead testing. Meridian also offers High-Risk Maternity Care Coordination services to members identified as meeting the high risk criteria through our prenatal screening tool.

As a PCP, Meridian hopes you promote and support these programs by encouraging your Meridian patients to take advantage of these services. You can refer a member to any of these special programs by calling Member Services at 866-606-3700.
Section 5: Billing and Payment

Claims Billing Requirements

When billing for services rendered to Meridian members, providers must use the most current Medicare-approved coding format (ICD-9/ICD-10, CPT, HCPCS, etc.) and/or state Medicaid guidelines for claims payment.

Please follow these guidelines for claims submission to Meridian:

- Providers must use a standard CMS 1500 Claim Form, UB-04 Claim, or IL HFS 2360* Form for submission of claims to Meridian Health Plan
- Providers must use industry standard procedure and diagnosis codes such as CPT, Revenue, HCPCS and ICD-9 when billing Meridian Health Plan
- Specialty physician claims should include a PCP referral form and/or a corporate prior authorization number for payment
- Providers may also submit and check the status of claims electronically via Meridian Health Plan's Provider Portal

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

- Is submitted within 45 days of service for Medicare primary claims, or 365 days of service for Medicaid primary claims;
- Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service and includes a matching provider ID number assigned by the Plan;
- Identifies the patient (Member ID number assigned by the Plan, address, and date of birth);
- Identifies the Plan (Plan name and/or ID number);
- Lists the date (mm/dd/yyyy) and place of service;
- Is for covered service- See Section 3 of Provider Manual. (Services must be described using uniform billing coding and instructions (ANSI X12 837) and ICD-9 or ICD 10CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered clean claims);
- If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by Health Plan;
- Includes additional documentation based upon services rendered as reasonably required by Plan Policies;
- Is certified by provider that the claim is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information, that identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim;
- Is a claim for which the provider has verified the Member’s eligibility and enrollment in the Plan before the claim was submitted;
- Is not a duplicate of a claim submitted within 45 days of the previous submission;
- Is submitted in compliance with all of Health Plan’s prior authorization and claims submission guidelines and procedures;
- Is a claim for which provider has exhausted all known other insurance resources;
- Is submitted electronically if the provider has the ability to submit claims electronically;
- Uses the data elements of UB04 (UB04 Version 050) or CMS 1500 as appropriate
*Meridian accepts claims billed on both a CMS 1500 and IL HFS 2360, but prefers the submission of the CMS 1500

** All laboratory charges should be submitted to Meridian on a CMS 1500 or IL HFS 2360

Submit all initial claims for payment to:
Meridian Health Plan
Attn: Claims Department
1001 Woodward Avenue, Suite 520
Detroit, MI 48226

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

**Coordination of Benefits (COB)**

**Medicaid Members**

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

**Claims Guidelines for Dually-Eligible Members**

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

- Submit one authorization request – Meridian will coordinate authorization requirements, benefits and services between the two products
- Submit one claim to Meridian - There is no need to submit two claims. Claims processing information will be reported on two Remittance Advice (RA) forms:
  - The 1st RA will come from Meridian Medicare indicating how the claim was processed and informing you that the claim was forwarded to Meridian Medicaid for secondary processing
  - The 2nd RA will show how the claim was processed for Meridian Medicaid

**Explanation of Benefits (EOB)**

Meridian sends its providers Remittance Vouchers as a method of explanation of benefits.
Balance billing: When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for the difference between the provider’s charge and the Medicaid payment for service.

**FQHC and RHC Billing Guidelines**

Meridian requires that FQHC and RHC providers submit claims on a CMS 1500 (or IL HFS 2360) Form using the appropriate HCPCS Code T1015 for medical services for behavioral health services. All services provided during the encounter need to be line item listed on the claim using the appropriate E/M CPT Code(s).

**Electronic Claims Submission**

Meridian is currently accepting electronic claims from the following clearinghouses:

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<thead>
<tr>
<th>The SSI Group</th>
<th>WebMD (Emdeon)</th>
<th>PayerPath</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-880-3032</td>
<td>800-845-6592</td>
<td>877-623-5706</td>
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<table>
<thead>
<tr>
<th>Availity</th>
<th>Netwerkes</th>
<th>RelayHealth</th>
</tr>
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<tbody>
<tr>
<td>800-282-4548</td>
<td>800-435-4048</td>
<td>800-895-6700</td>
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for the above contracted vendors is: 13189

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

**Appeals Process for Denied Claims**

Meridian offers a post-service claim appeal process for disputes related to denial of payment for services rendered to Meridian members. This process is available to all providers, regardless of whether they are in- or out-of-network.

**What Types of Issues Can Providers Appeal?**

The appeals process is in place for two main types of issues:

1. The provider disagrees with a determination made by Meridian. In this case, the provider should send additional information (such as medical records) that support the provider’s position.

2. The provider is requesting an exception to a Meridian policy, such as prior authorization requirements. In this case, the provider must give an explanation of the circumstances and why the provider feels an exception is warranted in that specific case.

Meridian’s physician reviewer is available for a discussion with the treating physician or your physician reviewer prior to a post-service appeal decision. The physician may call for a peer to peer discussion by calling:

- Meridian Medicare Advantage members: 855-827-1769
- Meridian Medicaid members: 866-606-3700
If a specific time frame for the call is desired, a facility representative acting on behalf of the physician may call to schedule a peer-to-peer discussion.

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

**How to File a Post-Service Claim Appeal**

1. Please send a letter explaining the nature of your appeal and any special circumstances that you would like Meridian to consider.

2. Attach a copy of the claim and documentation to support your position, such as medical records.

3. Send the appeal to the following address:

   **Meridian Health Plan**
   **Attn: Claims Appeals Department**
   **1001 Woodward Avenue, Suite 520**
   **Detroit, MI 48226**

**Time Frame for Filing a Post Service Appeal**

Appeals must be filed within one year from the date of service. Meridian will allow an additional 120-day grace period from the date of the last claim denial, provided that the claim was submitted within one year of the date of service. Appeals submitted after the time frame has expired will not be reviewed.

**Response to Post Service Claims Appeals**

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

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

**Medicare Advantage-Specific Guidelines:**

- If the decision is not favorable to the appellant, the appeal case is sent to the IRE within 60 calendar days of receipt of the appeal, and written notice is sent to the appellant.
- If the IRE reverse’s the Meridian decision to not pay the claim, Meridian pays for the service within 30 calendar days of receipt of the IRE notice of reversal.

The appellant will receive information about further review if the IRE does not reverse the Meridian decision. In the case that a reversal of the Meridian decision comes from a higher level
review entity, Meridian pays for the service within 60 calendar days of receipt of notice of such reversal.

If you have any questions about Meridian post-service claim appeal process, please call 855-827-1769 for more information.

**Medicaid-Specific Guidelines**

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

If you have any questions about the Meridian Medicaid post-service claim appeal process, please call 866-606-3700 for more information.
Section 7: Quality Improvement (QI)

QI Introduction

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

QIP Goals and Objectives

To ensure that Meridian members receive high quality, medically appropriate, and cost-effective health care, the QIP is integrated within clinical and 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 or risk stratification.

Meridian demonstrates its commitment to quality through the implementation of the QIP and through participation on various State of Illinois committees, sub-committees and collaboratives, including but not limited to the following:

- Medical Home and Primary Care
- Behavioral Health
- Long-Term Care
- Disease Management.

The primary goals of the Meridian QIP are to:

- Ensure member access to medically appropriate care;
- Assure accessibility and availability of quality medical, behavioral health, substance abuse and home-based community services (HBCS) waiver care;
- Develop and implement programs to increase preventive care delivery rates;
- Identify members for participation in disease management program(s), as appropriate;
- Develop and implement a depression disease management program;
- Coordinate care for members with acute, chronic and complex medical, behavioral health, substance abuse and co-morbid conditions;
- Improve coordination and transition across care settings and among ancillary providers;
- Improve communication with the member’s primary care physician;
- Monitor adherence to Meridian -approved evidence-based clinical practice guidelines;
- Ensure member and provider satisfaction;
- Improve CAHPS®/Patient Experience Survey outcomes;
- Develop and maintain collaborative relationships with the State agencies, providers and other health plans; and
- Continue educating internal staff and contracted providers to address the health care needs of culturally and linguistically diverse member sub-populations to identify and
address health care disparities, reduce barriers to care and improve compliance with
treatment and outcomes.

**Medicaid Performance Improvement Projects**

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

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Perinatal Care

**EPSDT PIP**

The purpose of this PIP is to ensure that all members aged 0 to 3 years receive comprehensive
and preventive health services. EPSDT is key to ensuring that children receive appropriate
preventive, dental, mental health, and developmental, and specialty services. An EPSDT exam
includes the following services:

- Comprehensive physical examination
- Comprehensive health and developmental history
- Vision screening
- Hearing screening
- Dental services
- Age-appropriate immunizations (according to the Advisory Committee on
  Immunization Practices)
- Laboratory tests (including Lead Screen Testing)
- Health education (anticipatory Guidance including child development, healthy
  lifestyles, and accident and disease prevention)
- Referrals for medically necessary health and mental health treatment as documented
  in the chart

**Perinatal Care PIP**

The purpose of this PIP is to ensure that all pregnant members receive the following perinatal
services:

- Initiation of prenatal care within the first trimester or within the first 42-days
  of enrollment with the plan
- The frequency of ongoing prenatal care as measured by the total number of
  American College of Obstetrics and Gynecology (ACOG) recommended
  prenatal visits based on the month/trimester of pregnancy the member
  enrolled with the plan
- A prenatal depression screening with the results faxed to the member’s OB
  physician for further evaluation and treatment, as necessary
- Postpartum visit between days 21-56 after delivery
- Postpartum depression screening with the results faxed to the member’s
  OB physician for further evaluation and treatment, as necessary

**Medicare Advantage Star Ratings**

The Medicare Five-Star Rating System was implemented by CMS. It was put in place to
educate consumers on quality and make quality more transparent. The Stars Rating consists of
51 unique-measures from the following data sources:

- **HEDIS®**: Healthcare Effectiveness Data and Information Set
- **CAHPS®**: Consumer Assessment of Healthcare Provider Systems
• Administrative Reviews: Conducted by CMS
• HOS: Health Outcomes Survey
• IRE: Independent Review Entity

There are six unique-categories that determine a Plan’s Star Rating, including:
- **Staying healthy** – Evaluates how often members receive screening tests, vaccines, checkups and other preventive services
- **Managing chronic conditions** – Evaluates how effectively health plans help members manage long-term conditions
- **Member satisfaction** – Evaluates member satisfaction with their health plan and how they feel about the quality of care they receive from the health plan and providers
- **Customer service** – Evaluates the health plan’s customer service based on responsiveness, helpfulness and accuracy of information given to members
- **Complaint rate** – Evaluates member complaints against the health plan
- **Pharmacy benefits** – Evaluates medication pricing, patient safety and member experience

Meridian works closely with providers and members to improve our Star Ratings in order to better the health of current members and attract new members. Meridian has many quality improvement initiatives focused around the Star Ratings categories and values support from providers to improve quality and service for our members.

**QIP Processes and Outcomes**

Meridian uses the Plan Do Check Act (PDCA) methodology for its quality improvement activities, initiatives and performance improvement projects. Integrated into the PDCA methodology are the following components: identification, performance goals and benchmarks, data sources, data collection, establishment of baseline measurements, analysis and evaluation, trending, intervention development and implementation, re-measurement, additional analysis, evaluation and trending and revision, 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; and
- Re-measure, reassess and re-evaluate the impact of quality activities and improvement initiatives.

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

Meridian is proud to have achieved and exceeded NCQA HEDIS® performance benchmarks for the third consecutive year in key State of Illinois quality measures.

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Meridian_PSM01 IL Combined FHP/ACA-SPD-MAP_4/2015
Outcomes of the QIP are tracked, analyzed, and reported to the QIC and Board of Directors annually. Meridian identified three key areas for performance improvement in SFY 2013-2014 and developed interventions to address. The key areas are:

- HEDIS® measures performing at or below the 50th percentile;
- Ensuring appointment access and office wait time less than 30 minutes for all members; and
- Implementation of a depression program that is focused on our current disease management conditions.

**Provider Opportunities in QIP Activities**

Provider involvement is integral to a successful QIP. By ensuring accessibility and delivering high quality care, providers contribute to the goals and objectives of the Meridian QIP. Providers also have the opportunity to contribute administratively by becoming active participants in Meridian Committees. To express interest in joining any of the following committees, or to request more information, please contact Quality Management at 312-980-0432.

**Quality Improvement Committee**

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

The QIC is responsible for the following:

- Report QIP Status, including recommendations, to the BOD quarterly and annually;
- Review and approval of all Meridian Corporate and Departmental Policies and Procedures;
- Review and adoption of all Meridian Medical Necessity Review Criteria, Medical Policies and Clinical Practice Guidelines;
- Provides direction to and ensures coordination among the QIC subcommittees;
- Review and approve the annual QIP, Work Plan and previous year’s evaluation;
- Identify opportunities for improvement;
- Establish performance goals and benchmarks;
- Review, approve and prioritize all quality improvement activities, programs and initiatives, including satisfaction;
- Ensure all quality improvement activities, programs and initiatives are fully implemented as approved;
- Analyze and evaluate quarterly and annual QIP performance metrics;
- Monitor urgent and routine determination decision timeframes;
- Implement use of approved Medical Necessity Review Criteria, Meridian Medical Policies and Clinical Practice Guidelines to monitor the medical appropriateness of care;
- Identify and report aberrant or substandard care practices, including sentinel events and near misses, to the Physician Advisory Committee and QIC for further investigation and corrective action as necessary;
- Monitor determination decision-making appropriateness and inter-rater reliability testing;
- Monitor approval and denial rates;
- Monitor appeal and overturn rates;
- Analyze and evaluate utilization resource trends;
- Identify barriers and facilitate resolution;
- Identify and remediate instances of over- and under-utilization;
- Evaluation of new technology; and
- Monitor satisfaction with all Care Coordination processes including Utilization Review, Care Coordination, and Disease Management.

**Credentialing Committee**

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

**The Credentialing Committee is responsible for the following:**
- Review and recommend approval, pend or denial of applicants for initial credentialing or re-credentialing and inclusion in the Meridian network;
- Perform peer review of practitioner or provider-specific quality of care or service issues and recommend remedial corrective action as necessary;
- Ensure and monitor impact of remedial corrective action recommendations by contracted physicians; and
- Review performance indicators of all Meridian contracted providers at least every three years

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

**Physician Advisory Committee**

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

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

The Physician Advisory Committee meets at a minimum quarterly.
**Grievance Committee**

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

**The Grievance Committee is responsible for:**
- Analyzing and evaluating complaints and grievances;
- Proposing complaint and grievance resolutions; and
- Identifying areas for quality improvement initiatives and/or corrective action.

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

**Contractual Arrangements**

**Non-Delegated**

By signing a contractual agreement with Meridian to be part of its provider network, the practitioner, provider, facility or ancillary service agrees to:
- Abide by the policies and procedures of the Meridian QIP
- Participate in Peer Review activity
- Provide credentialing and re-credentialing information in accordance with Meridian standards every three years
- Serve on the QIC or other subcommittee, as necessary
- Allow Meridian to collect data and information for quality improvement purposes
- Cooperate with the utilization management, Care Coordination and disease management programs as applicable, including, but not limited to:
  - Clinical data submission with the initial corporate prior authorization request
  - Timely response to outreach requests for information or to discuss member’s plans of care
  - Participate in Care Coordination conferences, as necessary
  - Resolve appeals, complaints and grievances

**Delegated**

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

**Quality Improvement Program Activities**
Monitoring Quality Performance Indicators – Clinical and Operational

The purpose of HEDIS® is to ensure that health plans collect, analyze, evaluate and report quality, utilization, cost and outcome data using a standardized, consistent methodology so that accreditors, regulators, providers and the plan itself can compare its 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 health care 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 in MCS by departmental staff and providers through the provider portal. The data is aggregated, stored and analyzed using a proprietary, in-house developed HEDIS® software program that is certified by the Health Services Advisory Group (HSAG) and Healthcare Data Company annually. Meridian conducts additional analysis, evaluation and monitoring continuously at the departmental, committee and organizational levels to:

- Ensure members have timely access to and availability of necessary preventive and maintenance health care 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 its member population

The purpose of the operational metrics is to ensure:

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

Monitoring Quality Performance Indicators – Surveys

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

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

**Meridian Medical Policies and Clinical Practice Guidelines**

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

**Monthly Provider HEDIS® Education**

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

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

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

**Management of Quality of Care Complaints**

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

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

**Patient Safety**

Patient safety needs are addressed through the following activities:

- Review of appeals, complaints and grievances and determination of quality of care impact
- Review of initial Health Risk Assessments and periodic re-assessment by clinical staff
- Review in initial and periodic reassessment of the member’s level of risk stratification
- Care Coordination and Disease Management programs targeted at educating members and their families on:
  - The member’s condition including subtle changes which may warrant acute intervention
  - Medication use, safety and interaction prevention
  - Self-management instructions including diet and exercise
  - Coordination of multiple or complex health care services
  - HEDIS® measure care reminders
- Notification to members and providers of medications recalled by the FDA
- Notification to the Quality and Care Coordination Department of any potential quality or safety cases:
  - Re-admissions within 15 or 30 days of discharge
  - Emergency room visit within 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

**Confidentiality and Conflict of Interest**
Confidentiality

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

- Corporate policy prohibiting any employee from voluntarily disclosing any peer review information except to persons authorized to receive member information
- Meridian HIPAA Privacy and Security policies and procedures developed and implemented by the Chief HIPAA Privacy Officer and Chief HIPAA Security Officer and adherence monitored by the HIPAA Privacy and Security Committee through quarterly meeting and reports
- Corporate policy prohibiting any employee from voluntarily disclosing any member identifiable health information (IHI) or protected health information (PHI) except to persons authorized to perform payment, treatment or operations on behalf of Meridian, required by law exempted under the HIPAA Privacy Rules or by written member consent explicitly authorizing such disclosure
- Corporate policy mandating the minimum necessary amount of member and provider information is used only to perform the payment, treatment and operations functions and meet the legal obligations of the health plan
- Corporate policy restricting access to member and provider information to the minimum necessary to perform one’s job and controlled through the use of individual user identification and passwords

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

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

Conflict of Interest

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

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

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

Member Safety

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

- The development and implementation of Clinical Practice Guidelines based on national standards.
- Provider and member newsletters that convey new, revised, and/or updated initiatives and provide safety related information
• The development and delivery of effective and on-going fraud and abuse education and training for employees, members and providers through various methods (i.e. member and provider websites, newsletters, Member Handbook, Provider Manual, Provider Network Development Representative visits with providers, and on-site training for all employees)
• The inclusion of provider office safety evaluations in the annual site visits for quality
• A safety action plan continued in 2013 - 2014 to ensure safety measures are assessed and incorporated in day-to-day operations

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

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

Provider Critical Incident Reporting

Meridian requires participating program providers to report all Critical Incidents that occur in a home and community-based long term services and supports delivery setting, including assisted-living facilities, community-based residential alternatives, adult day care centers, other HCBS provider sites, and a member’s home, if the incident is related to the provision of HCBS. Providers must participate in trainings offered by Meridian to ensure accurate and timely reporting all critical incidents. Trainings may be offered at webinars, online learning and regional meetings. To obtain training information regarding critical incidents, please contact Meridian.

Critical incidents include but are not limited to:
• Unexpected death of a program member
• Suspected physical or mental abuse of a program member
• Theft or financial exploitation of a program member
• Severe injury sustained by a program member
• Medication error involving a program member
• Sexual abuse and/or suspected sexual abuse of a program member
• Abuse and neglect and/or suspected abuse and neglect of a program member
Providers must contact Meridian’s Community Care Coordination department with a verbal report of the incident within 24 hours. The verbal report, at a minimum, must include member name, date of birth, date and time of incident, a brief description of the incident, member’s current condition, and actions taken to mitigate risk to the member.

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

- 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. This may take up to 30 calendar days
- Order immediate drug screen or appropriate testing if allegation includes theft of drugs or use of substances including alcohol while on the job
- Interview involved employee(s) as soon as possible following the incident. Have the employee(s) submit a written account of events. Fax these written accounts to Meridian along with documentation to support completion of pre-employment screenings including background checks, drug screening, and a statement that the employee did not begin to perform services for Meridian program members until all required pre-employment screenings were completed and verified

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

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

<table>
<thead>
<tr>
<th>Population</th>
<th>Responsible Department</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children under the age of 18</td>
<td>Department of Children and Family Services</td>
<td>800-25-ABUSE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>800-358-5117 (TTY)</td>
</tr>
<tr>
<td>Persons age 18 through 59</td>
<td>Department of Human Services Office of the Inspector General</td>
<td>800-368-1463 (voice and TTY)</td>
</tr>
<tr>
<td>Persons age 60 or older</td>
<td>Department on Aging</td>
<td>866-800-1409 (voice)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>800-206-1327 (TTY)</td>
</tr>
<tr>
<td>Persons in Nursing Facilities</td>
<td>Department of Public Health</td>
<td>800-252-4343</td>
</tr>
<tr>
<td>Persons in Supportive Living Facilities</td>
<td>Department of Healthcare and Family Services</td>
<td>800-226-0768</td>
</tr>
</tbody>
</table>
Section 9: Provider Functions and Responsibilities

Provider Roles and Responsibilities

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

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

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

Provider/Staff Education and Training

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

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

If you would like to request a training session, please call your Provider Network Development Representative, or the Provider Services department at 866-606-3700.
Primary Care Providers/ Medical Homes

Meridian utilizes a Primary Care Provider (PCP) Patient Centered Medical Home system. In this system the PCP is responsible for the comprehensive management of each member’s health care. This may include, but may not be limited to, ensuring that all medically necessary care is made available and delivered, facilitating the continuity of member health care, and promoting and delivering the highest quality health care per Meridian standards. Meridian providers are responsible for knowing and complying with all Meridian network policies and procedures. Implementation of Meridian policies will facilitate the plan’s periodic reporting of data to HFS, the state and the federal agencies.

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

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

Identification of Medical Homes

The Director of Network Development, in collaboration with Provider Network Development Representatives (PNDRs), identifies primary care offices that serve as Medical Homes, which may include:

- Federally Qualified Health Centers (FQHCs)
- Community Mental Health Centers (CMHCs)
- PCP-centered medical groups
- Private PCP offices
- Nurse Practitioner-led clinics

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

Assessment and Support of Medical Homes

A. Assessment

Meridian provides Medical Homes with a self-assessment tool, in order to facilitate advancement towards PCMH certification. The tool, which utilizes NCQA’s PCMH standards to provide a roadmap for certification readiness, will allow Medical Homes to self-assess readiness for certification, as well as provide Meridian with scoring criteria for incentives. The tool allows Medical Homes the ability to self-assess their organizational capacity; chronic health condition management approaches; coordination and continuity of care processes; community outreach knowledge and connections; data management; and quality improvement/change. The tool will be reviewed by Quality Improvement to ensure validity and thoroughness of supporting documentation.
B. Support

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

**Medical Home Development Advisory Council**

Meridian’s Medical Home Development Advisory Council serves as a partnership with key community stakeholders to develop a plan to promote PCMH principles and the transformation and adoption of the PCMH model within the provider community. The Council is co-chaired by the Medical Director and the Director of Quality Improvement, and includes Medical Homes and community stakeholders. The Council is responsible for establishing a mission, purpose, and Council Charter. The Council meets no less than biannually.

**Specialty Care Providers**

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

- Rendering services requested by the PCP;
- Communicating with the PCP regarding findings in writing;
- Obtaining prior authorization from the PCP before rendering any additional services not specified on the original referral form;
- Confirming member eligibility and benefit level prior to rendering services;
- Providing a consultation report to the PCP within 60 days of the consult; and
• Providing the lab or radiology provider with:
  o The PCP and/or corporate prior-authorization number; and
  o The member’s ID number.

**Hospital Providers**

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

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

**Ancillary Providers**

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

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

**Medicaid-Specific Roles and Responsibilities**

Providers wishing to participate with Meridian must be enrolled with the Illinois Medical Assistance Program (MAP). If you are already enrolled with MAP, simply contact Meridian at 866-606-3700 to obtain a contract for participation. Interested providers can also visit www.mhplan.com to obtain detailed instructions on how to enroll in the MAP, access links to the appropriate paperwork and directions on where to send the completed forms.

Providers who have not submitted a claim to the State for reimbursement within 18 months may reach “non-par” status. The provider must then call the Provider Participation Unit (PPU) at 217-782-0538 or write to the following location to verify their address.

**Illinois Department of Healthcare and Family Services**

Provider Participation Unit
P.O. Box 19114
Springfield, IL 62794-9114

Should too much time elapse before contacting the PPU the Provider could become inactive with MAP. If this happens, the provider would have to re-enroll with MAP prior to seeing a Meridian member.

All providers meeting the above affiliation requirements may submit for inclusion into the Meridian provider network. Meridian will not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, nor will Meridian

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discriminate against any provider acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

**Member Access and Availability Guidelines**

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

**Guidelines:**

1. PCPs must be available to address member/patient medical needs on a 24-hours/day, seven (7) day a week basis. The PCP may delegate this responsibility to another Meridian physician or provider on a contractual basis for AFTER-HOURS, HOLIDAY and VACATION COVERAGE.

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

3. PCPs 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 PCP to notify Meridian each time a new physician is added to a PCP’s practice to assure that all physician providers are credentialed to Meridian standards. PCPs may employ licensed/certified Physician’s Assistants (PAs) or Registered Nurse Practitioners (RNP)s to assist in the care and management of their patient practice. If PAs or RNP s are utilized, the PCP or the designated and credentialed physician must be readily available for consultation via telephone or beeper, within a 15-minute call back time. They must also be able to reach the site where the PA or RNP is within 30 minutes.

4. Non-professional health care staff shall perform their functions under the direction of the licensed PCP, credentialed physician, or other appropriate health care professionals such as a licensed Physician’s Assistant (PA) or a Registered Nurse Practitioner (RNP).

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

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

- Urgent care:
  - Scheduled within 24 hours with an available clinician
- Non-urgent symptomatic care:
  - Scheduled within three weeks with an available clinician
- Preventive care:
  - Adult preventive care appointments are scheduled within five weeks
  - Children <6 months old, preventive care appointments are available within two weeks
- Initial prenatal visits:
  - Members in 1st trimester are available within two weeks
  - Members in 2nd trimester are available within one week
  - Members in 3rd trimester are available within three days

Behavioral Health Office Visit Appointments:

- Life threatening emergency: Immediately
- Non-life threatening emergency: Within 6 hours
- Urgent visit: Within 48 hours
- Routine office visit: Within 10 working days

Office Waiting Time

In order to assure that members have timely access to patient care and services, Meridian providers are expected to monitor waiting room times on a continual basis. PCP offices will be surveyed periodically regarding this process. **Member waiting room times should be less than 60 minutes to be seen by a provider with no more than six (6) scheduled appointments made for a provider per hour.** Supervising Providers may routinely account for more than six (6) visits. If a longer wait is anticipated, office staff members should explain the reason for the delay and offer to book the patient for another appointment.

After Hours Access Standards

Meridian has established acceptable mechanisms for use by PCPs, specialists, and behavioral health providers to ensure telephone access and service for members 24 hours a day. All practitioner agreements require providers to supply members with access to care 24 hours a day, seven days a week.

Acceptable after-hours access mechanisms include:

- Answering service
- On-call beeper
- Call forwarded to provider’s home or other location
- Recorded telephone message with instructions for urgent or non-life threatening conditions as well as instructions to call 911 or go to the emergency room in the event of a life-threatening condition or serious trauma

This message should not instruct members to obtain treatment at the emergency room for non-life-threatening emergencies.
**Encounter Reporting Requirements**

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

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

In order to assess the quality of care, determine utilization patterns and access to care for various health care 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 UB04 will be used initially. PCPs will submit their encounter data monthly to the Meridian, who must then submit it to HFS via an electronic tape. Both Meridian and provider agree that all information related to payment, treatment or operations will be shared between both parties and all medical information relating to individual members will be held confidential.

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

**Physician Intent to Discharge Member from Care**

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

**Site Visits**

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

- When a member complaint/grievance is received about the quality of a practitioner’s office (physical accessibility, physical appearance or the adequacy of waiting or examining room) within 6 months
- Member satisfaction results indicate an office site may not meet Meridian standards
- Other data is required for quality improvement purposes and cannot be reasonably collected using other methods
- Other circumstances as deemed necessary

A Meridian staff member or designated representative with the appropriate training will perform the site visit once the determination is made that a site visit is warranted.
Confidentiality and Accuracy of Member Records

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; and
- 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(j)(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 Medicare Advantage are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including the:

- Title VI of the Civil Rights Act of 1964;
- Rehabilitation Act of 1973;
- Age Discrimination Act of 1975; and

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 as defined by CMS).

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

The General Services Administration List of Debarred Contractors can be found at epls.arnet.gov

Fraud, Waste and Abuse

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

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

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

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

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

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

To report possible fraud, waste or abuse cases, please contact the Meridian Corporate Compliance Officer via the FWA hotline at 877-218-7949, or email directly at fraud@mhplan.com. Providers may also report potential fraud, waste or abuse to Meridian anonymously at the following address:

**Meridian Health Plan**
**Compliance Officer**
**777 Woodward Ave.**
**Suite 700**
**Detroit, MI 48226**

**Non-Discrimination**

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

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

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

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

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

The initial credentialing process includes verification of credentials by Meridian Credentialing staff. Re-credentialing occurs every three (3) years for contracted providers. Additionally, the provider re-credentialing process includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data and member transfer rates.

Provider Credentialing Rights and Responsibilities

Providers have the following rights during the credentialing process:

- All information received during the credentialing process that is not peer protected can be forwarded to the applicant upon written request to the Credentialing department.

- If there are any substantial discrepancies noted during the credentialing process, the applicant is notified in writing or verbally by the Credentialing department within 30 calendar days. The applicant then has 30 calendar days to respond in writing regarding the discrepancies and correct any erroneous information. Meridian is not required to reveal the source of the information if the information is not obtained to meet the credentialing verification requirements or if disclosure is prohibited by law.

- Upon written request to the Credentialing department, the provider has the right to be informed in writing or verbally of their credentialing status. When a practitioner contacts the Credentialing department, a Credentialing Specialist or Manager will either speak with the practitioner directly or send a Missing Information Letter with the purposes of informing the practitioner of the credentialing criteria that has been met or what information is still needed in order to continue the credentialing process.

- Upon written request to the Credentialing department, an applicant may obtain all Meridian policies and procedures related to the credentialing process.

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

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Means of Validation</th>
<th>Frequency of Validation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current State License to Practice and Controlled Substance License (if applicable)</td>
<td>Verification with State Licensing Boards</td>
<td>Initial credentialing, every three years at re-credentialing</td>
</tr>
<tr>
<td>Current Federal Drug Enforcement Agency License (DEA) (if applicable)</td>
<td>Visual inspection of license and/or verification with DEA (NTIS) registration file</td>
<td>Initial credentialing and every three years at re-credentialing</td>
</tr>
<tr>
<td>Completion of Appropriate Medical Education and Post-Graduation Training (internship and/or residency program)</td>
<td>Primary source verification with certifying entity AMA/AOA, ECFMG for all foreign graduates or verification from professional school and hospital</td>
<td>Initial credentialing</td>
</tr>
<tr>
<td>Board Certification (if applicable)</td>
<td>Primary source verification with certifying entity ABMS, AMA/AOA</td>
<td>Initial credentialing, every three years at re-credentialing and on an ongoing basis</td>
</tr>
<tr>
<td>Current Malpractice Coverage as Required by Meridian Health Plan with Minimum Coverage of $100,000/$300,000</td>
<td>Visual inspection of the malpractice image facesheet</td>
<td>Initial credentialing and every three years at re-credentialing</td>
</tr>
<tr>
<td>Acceptable Malpractice Claims History</td>
<td>NPDB/HIPDB and information from malpractice carrier, application information</td>
<td>Initial credentialing and every three years at re-credentialing</td>
</tr>
<tr>
<td>Privileges at Hospital(s) (if applicable)</td>
<td>Application information unless there are reports from NPDB/HIPDB reports then Primary Source Verification is required</td>
<td>Initial credentialing and every three years at re-credentialing</td>
</tr>
<tr>
<td>Criteria</td>
<td>Means of Validation</td>
<td>Frequency of Validation</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Appropriate Work History of Professional Activity</td>
<td>Information submitted on credentialing application and/or Curriculum Vitae</td>
<td>Initial credentialing</td>
</tr>
<tr>
<td>Free of Any Sanctions and/or Restrictions Through State, Federal, and Local Authorities</td>
<td>Disclosure information on credentialing application, NPDB/HIPDB information; verification with State Licensing Board, OIG, SAM’s</td>
<td>Initial credentialing and every three years at re-credentialing and on an ongoing basis</td>
</tr>
<tr>
<td>System for Award Management (SAM’s)</td>
<td>Primary source verification via SAM’s website</td>
<td>Initial credentialing, every three years at re-credentialing and on an ongoing basis</td>
</tr>
<tr>
<td>Office of Inspector General (OIG)</td>
<td>Primary source verification via OIG website</td>
<td>Initial credentialing, every three years at re-credentialing and on an ongoing basis</td>
</tr>
<tr>
<td>Medicare Opt Out</td>
<td>Primary source verification via appropriate state website</td>
<td>Initial credentialing and every three years at re-credentialing</td>
</tr>
</tbody>
</table>

**Corporate Credentialing Committee**

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

- Reviewing and approving the Meridian Health Plan credentialing plan
- Reviewing completed and verified files, done by the Quality Medical Director. Applicant files that meet established Meridian criteria for “clean files” may be reviewed and signed by a Medical Director or Associate Medical Director. The signature date becomes the committee decision date. All other applicant files are reviewed by the Quality Medical Director and brought forward to the Corporate Credentialing Committee for review and recommendation
- The Quality Medical Director submits the applicant’s verified file for individual review to the Corporate Credentialing Committee if there are any malpractice claims under ten years, adverse actions, State license or DEA actions, exclusion or debarment actions, government administrative actions, clinical, judgments, convictions, health plan or professional society actions at the next scheduled meeting date for final acceptance or denial of practitioner participation. The Corporate Credentialing Committee has the right to pend any request for participation while it obtains additional information or verification it deems necessary based on the information within the applicant’s file. If the Corporate Credentialing Committee decides to accept the provider into the Meridian network, the Quality Medical Director or the Associate Medical Director will sign off on the file. The signature date becomes the committee decision date
• Reviewing provider performance data and individual instances of quality of care and recommending corrective action as necessary

• Making recommendations for acceptance or denial (Meridian Health Plan reserves the right to accept, reject or sanction providers and other providers at its sole discretion).

**Credentialing Committee members include:**

- Meridian Health Plan Chief Medical Officer
- Meridian Health Plan Quality Medical Director.
- Meridian Health Plan Medical Directors.
- Meridian Health Plan participating providers with a wide range of specialties
- Quality Management representatives

**Peer Review**

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

**Appeals Process**

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

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

**Meridian Health Plan**  
**Credentialing Department**  
**777 Woodward Ave., Ste.600**  
**Detroit, MI 48226**

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

1. **Level One Hearing:**
   - Level One Hearings are conducted at the Meridian corporate headquarters
   - The Meridian Credentialing Department or designee will notify the affected applicant of the date, time and place of the hearing by Special Notice at least seven (7) calendar days prior to the hearing date
   - The hearing date will not be more than 45 calendar days from receipt of request for the hearing
• The Hearing Committee shall consist of at least two physician members of the Credentialing Committee who are not in direct economic competition with the provider applicant and one additional member appointed by the Quality Medical Director. This member will be one of the following:
  o Meridian Medical Director
  o Meridian Associate Medical Director
  o Meridian Director of Utilization Management
  o Meridian Director of Quality Management
  o A Meridian participating provider who is not in direct economic competition with the provider applicant and of similar scope of practice
  o A member of the Meridian Board of Directors
• If the provider applicant scope of practice is not within the two appointed practitioner members’ scope of practice, it is required to include a Meridian participating providers with a similar scope of practice
• Previous participation in the credentialing decision does not disqualify a practitioner from serving on the Hearing Committee
• All members of the Hearing Committee are required to consider and decide the case with good faith objectivity
• The Affected Practitioner represents him/herself at the Hearing Committee
• The presiding officer for the hearing is appointed by the Meridian Quality Medical Director and determines the order of proceedings
• During the hearing, both the Affected Practitioner and the person appointed to represent the Meridian position have an opportunity to have their positions fairly heard and considered
• Both Meridian and the Affected Practitioner may submit to the hearing for consideration:
  o Written statements, letters and documents relevant to the subject matter of the hearing, including relevant portions of the credentialing file
  o Oral statements
• Only the presiding officer may, at his/her discretion, authorize the appearance of witnesses
• The Affected Practitioner has the burden of proof and must demonstrate that the non-approval is:
  o Inconsistent with Meridian policies and procedures
  o Based on inaccurate or insufficient information through no fault of the affected practitioner
  o Not in the best interests of Meridian and/or its members
• A recording secretary selected by Meridian takes minutes of the hearing. The Affected Practitioner may request a copy of the minutes at his/her own cost
• The decision of the Hearing Committee will be issued within 30 calendar days of completion of the hearing and the Affected Practitioner will be notified by Special Notice
• The notice to the Affected Practitioner informs him/her of the right to appeal a non-approval decision to the Meridian Medical Director
• The Affected Practitioner may request a Level Two appeal within 30 calendar days of receipt of the notification
Failure to request a Level Two appeal within 30 calendar days constitutes waiver of final appeal rights

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

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

Denied applications are maintained in a confidential manner in a Denied Participation file and are maintained for a period of seven (7) years from the date of denial. Denials of participation are kept confidential except where reportable by Meridian under Federal or State regulation.

**Facility Criteria**

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

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

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

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

**Delegated Credentialing**

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

**Delegated Credentialing Requirements**

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

1. Current Credentialing Dates
2. TIN Associated with Group
3. General Information Regarding the Provider:
   - Full Name
   - Social Security Number
   - NPI Number
   - Gender
   - Date of Birth
   - Provider Type (MD, DO, etc.)
   - Provider’s specialty and Category (PCP, Spec, etc.)
4. School History (Highest Degree Earned):
   - Name of School
   - Address of School
   - Degree Earned
5. Office Location Information:
   - Name of Office
   - Office Address
   - Office Phone and Fax Number
   - Accepting New Members at Location or Not
   - Listed in Meridian’s Provider Directory or Not
   - Any Age Limitations or None, if so
   - The Provider’s Hours at Specific Offices
6. Licensing Information:
   - Medical License
   - DEA License
   - Controlled Substance License (if applicable)
   - Medicare ID Number (if applicable)
   - Medicaid ID Number (if applicable)
   - UPIN (if applicable)
   - ECFMG Number (if applicable)
7. Liability Insurance:
   - Carrier Name
   - Expiration Date
8. Other Information – If Any/Not Required:
   - Covering Colleagues
   - Foreign Languages Spoken by the Provider
   - Current Hospital Affiliations
   - References
9. Copy of W-9 if Pay-To Address is New
Additional State Requirements

Medicaid

- Meridian must obtain re-credentialing data on a healthcare professional according to the single credentialing cycle except:
  - When a healthcare professional submits initial credentials data to Meridian;
  - When a healthcare professional’s credentials data changes substantively;
  - When Meridian requires re-credentialing as a result of patient or quality assurance issues (410 ILCS 517/20; 77 Ill. Adm. Code 965.300). This is based on the last digit of each healthcare professional’s Social Security number; which provides for a one month notification to those providers and a two month collection period of re-credentialing data. Once this cycle has begun, Meridian can continue to request data from a healthcare professional outside of the published single credentialing cycle if it is not submitted by the deadline data.

- This re-credentialing cycle reflects a six month “open” period when Meridian cannot collect data from a healthcare professional, except as noted above, unless Meridian receives a waiver from the single credentialing cycle. The re-credentialing process includes the addition of physician/provider profiling data, including performance data and utilization data (which are evaluated for quality), utilization and accessibility. Profiling and performance data includes member complaints/grievances, results of quality reviews, utilization management and member satisfaction surveys.

SPD

- As an additional validation check, the Illinois AHS Provider Data Extract Report is run on a weekly basis to verify the accuracy of the data entered into the MCS system. All files needing corrections are sent back to the Credentialing Manager who oversees the necessary changes, verifies the information and resubmits the file to the Medical Director.

- Providers that chose to provide Home and Community Based Services (HCBS) shall maintain certification as a Community Care Provider following the 89 Illinois Admin. Code 240, Subpart P, as applicable. All providers will have to show proof of this certification to Meridian prior to the performance of any HCBS services. These providers will have to maintain the requirements of the Community Care Program to perform these services.

Credentialing FAQs

Becoming Credentialed

Credentialing is the process by which an organization obtains and verifies specific professional and personal background data on physicians and other healthcare professionals. Meridian then determines whether that individual meets the specified criteria to serve as a contracted provider of services to Meridian members. A provider must be credentialed before becoming a part of the Meridian network and is re-credentialed every three (3) years thereafter. Meridian Health Plan’s credentialing standards align with the requirements designated by the NCQA and URAC. To become credentialed with Meridian, a practitioner or healthcare provider should utilize CAQH to
house all of their application information and should attest that the information is current at least once every 120 days.

**Timeframe of the Credentialing Process**

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

**Checking the Status of a Credentialing Application**

Providers can check on the status of their credentialing application by contacting the Meridian Provider Services Department at 888-773-2647.

**CAQH**

The Council for Affordable Quality Healthcare (CAQH) is a centralized online system used by Meridian Health Plan, along with many other insurance companies, to gather credentialing and re-credentialing data from practitioners and healthcare professionals. The use of this system streamlines the process of applying for participation with a health plan for a practitioner and ultimately provides a more efficient credentialing process.

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

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

To set up a CAQH ID, a provider can call Meridian Health Plan at 888-773-2647 and speak to a representative in the Provider Services Department. This representative will gather basic information and begin the set-up of your CAQH application. The CAQH ID number will be given to the provider at the end of the phone call and the provider can access their application anytime to complete it at [http://www.caqh.org/access-upd.php](http://www.caqh.org/access-upd.php).

*If a provider already has a CAQH ID number but wishes to become a new provider in the Meridian network, please contact the Meridian Provider Services Department to notify them of this and visit [www.caqh.org/cred](http://www.caqh.org/cred) to authorize Meridian Health Plan to access your data.*

CAQH will send out automatic reminders to a practitioner to review and attest to the accuracy of their information online. The standard timeframe for doing so is once every four (4) months or 120 days. Meridian Health Plan re-credentials practitioners every three (3) years after initial credentialing and will notify the practitioner in writing at the start of the re-credentialing process.

To re-attest:

1. Go online to [caqh.org/oas](http://caqh.org/oas) at least every four months
2. Log in
3. At “Start Page,” select “Re-attest”
Section 10: Clinical Guidelines and Recommendations

Immunizations

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

<table>
<thead>
<tr>
<th>Immunization</th>
<th>When It is Needed</th>
<th>Why Children Need This Shot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (Hep B)</td>
<td>A total of 3 shots before age 2: Birth, 1-2 months and 6-18 months.</td>
<td>These shots protect children from a type of hepatitis.</td>
</tr>
<tr>
<td>Rotavirus (RV)</td>
<td>A total of 2 shots of a 2 dose vaccine: 2 months and 4 months OR One shot of the 2 dose vaccine and 2 shots of the 3 dose vaccine: 2 months, 4 months and 6 months OR A Total of 3 shots of a 3 dose vaccine: 2 months, 4 months and 6 months</td>
<td>These shots protect children from rotavirus.</td>
</tr>
<tr>
<td>Diphtheria, Tetanus and Pertussis (DTaP)</td>
<td>At least 4 shots on different dates of service on or before children’s 2nd birthday: 2 months, 4 months, 6 months and 15-18 months.</td>
<td>These shots protect children from diphtheria, tetanus and pertussis (whooping cough).</td>
</tr>
<tr>
<td>Haemophilus Influenzae (HiB)</td>
<td>At least 3 shots on different dates of service on or before children’s 2nd birthday: 2 months, 4 months, 6 months and 15-18 months.</td>
<td>These shots protect children from Haemophilus Influenzae (HiB).</td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>At least four shots with different dates of service before children’s 2nd birthday: 2 months, 4 months, 6 months and 15-18 months.</td>
<td>These shots protect children from pneumonia.</td>
</tr>
<tr>
<td>Polio (IPV)</td>
<td>At least 3 shots with different dates of service on or before children’s 2nd birthday: 2 months, 4 months, 6-18 months and again at age 4-6 years.</td>
<td>These shots protect children from polio.</td>
</tr>
<tr>
<td>Influenza (Flu)</td>
<td>A total of 2 shots before children’s 2nd birthday: 6-12 months, 13-24 months and then yearly thereafter.</td>
<td>These shots protect children from seasonal flu.</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella (MMR)</td>
<td>At least 1 shot before children’s 2nd birthday: 12-15 months and again at age 4-6 years.</td>
<td>These shots protect children from Measles, Mumps and Rubella (German Measles).</td>
</tr>
<tr>
<td>Varicella (VZV)</td>
<td>At least 1 shot before children’s 2nd birthday: 12-15 months and again at age 4-6 years.</td>
<td>These shots protect children from Varicella (German Measles).</td>
</tr>
</tbody>
</table>

4. Run the audit
5. Review and update data as needed
6. Click on “Attest”
12-15 months and again at age 4-6 years.

### Hepatitis A (Hep A)
- A total of 2 shots on different dates of service before children's 2nd birthday: 12-24 months.
- These shots protect children from a type of hepatitis.

### Tdap or Td
- A total of 1 shot between children’s 10th and 13th birthdays.
- This shot protects children from diphtheria, tetanus and pertussis (whooping cough) Tdap or tetanus (Td).

### Meningococcal
- A total of one shot between children’s 11th and 13th birthday.
- This shot protects children from a type of brain infection called meningitis.

### Combination Meningococcal and Tdap or Meningococcal and Td.
- A total of one shot between children’s 10th and 13th birthdays.
- This shot protects children from diphtheria, tetanus and pertussis (whooping cough) Tdap or tetanus (Td) and a brain infection called meningitis.

Providers should note that immunization guidelines are subject to change. There are several resources for up to date information on immunizations, including the American Academy for Pediatrics and the Centers for Disease Control.

If you have any questions about immunizations, please contact the Quality Management Department at 866-606-3700.

### Well-Child Visits
According to the National Committee for Quality Assurance and HEDIS® specifications, infants need at least six Well-Child Visits between the ages of 0 and 15 months. Children between the ages of 3 and 6 years need one Well-Child Visit every year.

<table>
<thead>
<tr>
<th>Infants Age 0-15 Months</th>
<th>Children Age 2-12 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 Days</td>
<td>Children ages 2 through 12 should be seen for a well-child exam every year, not just when they are sick.</td>
</tr>
<tr>
<td>2 Weeks</td>
<td></td>
</tr>
<tr>
<td>1 Month</td>
<td></td>
</tr>
<tr>
<td>2 Months</td>
<td></td>
</tr>
<tr>
<td>4 Months</td>
<td></td>
</tr>
<tr>
<td>6 Months</td>
<td></td>
</tr>
<tr>
<td>9 Months</td>
<td></td>
</tr>
<tr>
<td>12 Months</td>
<td></td>
</tr>
<tr>
<td>15 Months</td>
<td></td>
</tr>
</tbody>
</table>

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

A Well-Child Visit includes the following three components:

- Health and Developmental History (Physical and Mental)
- Physical Exam
- Health Education/Anticipatory Guidance (Nutrition, childhood development, physical activity, injury and poison prevention, second hand smoke exposure)
The first time you see a new patient, it is likely that you will need to perform a health and developmental history and a physical exam. Make sure you incorporate some health education and you have provided a Well-Child Visit. Just add the V20.2 diagnosis code to your claim, along with the appropriate CPT code for the new patient visit.

**Adolescent Well-Care Visits**

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

<table>
<thead>
<tr>
<th>Physical Exam</th>
<th>Immunizations</th>
<th>History and Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Tdap (Age 10-13)</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Weight</td>
<td>Meningococcal (Age 11-13)</td>
<td>Exercise</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>MMR (If second dose was missed, given at age 12)</td>
<td>Injury Prevention - Use of seatbelts and proper sporting equipment</td>
</tr>
<tr>
<td></td>
<td>Varicella (If missed and no history of chickenpox - given at any age over 1 year)</td>
<td>Dental Health</td>
</tr>
<tr>
<td></td>
<td>HepB (If childhood series was missed, 3 doses as recommended)</td>
<td>Tobacco, Alcohol, Drug Use</td>
</tr>
<tr>
<td></td>
<td>HPV (3 doses, Ages 9-26) Females only</td>
<td>Developmental assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Safe Sexual Practices - Including abstinence and birth control methods, Chlamydia screening if sexually active</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sun exposure, skin lesions, use of sun block to prevent skin cancer</td>
</tr>
</tbody>
</table>

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

**Pregnancy Care**

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

<table>
<thead>
<tr>
<th>Stage of Pregnancy</th>
<th>How Often to See the Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 13 Weeks (Or as soon as you think you may be pregnant.)</td>
<td>See the doctor for the first Prenatal Visit as soon as possible.</td>
</tr>
<tr>
<td>Between 13 and 28 Weeks Pregnant</td>
<td>See the doctor every 4 weeks.</td>
</tr>
<tr>
<td>Between 29 and 36 Weeks Pregnant</td>
<td>See the doctor every 2 weeks.</td>
</tr>
<tr>
<td>Between 37 and 40 Weeks Pregnant</td>
<td>See the doctor every week.</td>
</tr>
<tr>
<td>After you have delivered your Baby</td>
<td>Get a postpartum checkup between 21 days and 56 days after delivery.</td>
</tr>
</tbody>
</table>

* It is very important to have a postpartum checkup within 21-56 days after delivery.
If you have a patient who is pregnant and needs assistance, please call Meridian Member Services at 866-606-3700 as soon as possible! We can assist the member in making appointments and provide free transportation. The Women and Children’s staff will be in touch with the member throughout her pregnancy.

**Family Planning Services**

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

**Preventive Health Recommendations for Adults**

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

The following table shows the recommendations for Men:

<table>
<thead>
<tr>
<th>Men 20-39 Years Old</th>
<th>Men 40-59 Years Old</th>
<th>Men 60 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every 3-5 Years:</td>
<td>Every Year:</td>
<td>Every Year:</td>
</tr>
<tr>
<td>- Health Maintenance Exam</td>
<td>- Fecal Occult Blood Test starting at age 50</td>
<td>- Health Maintenance Exam</td>
</tr>
<tr>
<td>- Clinical testicular exam with self-exam instructions</td>
<td>- Health Maintenance Exam</td>
<td>- Clinical testicular exam with self-exam instructions</td>
</tr>
<tr>
<td>- Cholesterol every 5 years starting at 35 years</td>
<td>- Clinical testicular exam with self-exam instructions</td>
<td>- Prostate Screening</td>
</tr>
<tr>
<td>Discuss with Doctor:</td>
<td>Every 5 Years:</td>
<td>Every 5 Years:</td>
</tr>
<tr>
<td>- Prostate Screening</td>
<td>- Cholesterol Screening</td>
<td>- Cholesterol Screening</td>
</tr>
<tr>
<td>- Fecal Occult Blood Test</td>
<td>Colon Cancer Screening (after age 50)</td>
<td>Colon Cancer Screening (after age 50)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Women 20-39 Years Old</th>
<th>Women 40-59 Years Old</th>
<th>Women 60 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every Year:</td>
<td>Every Year:</td>
<td>Every Year:</td>
</tr>
<tr>
<td>- Health Maintenance Exam</td>
<td>- Health Maintenance Exam</td>
<td>- Health Maintenance Exam</td>
</tr>
</tbody>
</table>

The following table shows the recommendations for Women:
- Pelvic exam with Pap test
- Chlamydia Testing (Ages 20-25)
- Clinical breast exam with self-breast exam instructions

Discuss with Doctor:
- Baseline Mammogram (Ages 35-39)
- Cholesterol Screening

- Pelvic exam with Pap test
- Clinical breast exam with self-breast exam instructions
- Mammogram

Every 5 Years:
- Cholesterol Screening
- Colon Cancer Screening (after age 50)
- Fecal Occult Blood Test OR Sigmoidoscopy every 5 years OR Colonoscopy every 10 years

- Pelvic exam with Pap test
- Clinical breast exam with self-breast exam instructions
- Mammogram

Every 5 Years:
- Cholesterol Screening
- Colon Cancer Screening (after age 50)
- Fecal Occult Blood Test OR Sigmoidoscopy every 5 years OR Colonoscopy every 10 years

- Pelvic exam with Pap test
- Clinical breast exam with self-breast exam instructions
- Mammogram

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

<table>
<thead>
<tr>
<th>19 - 49 Years</th>
<th>50 - 64 Years</th>
<th>65 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Tetanus (Td) every 10 Years (One dose of Tdap can be substituted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Pneumococcal Vaccine - Talk with your PCP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Flu – every year if high risk. Talk to your doctor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Tetanus (Td) every 10 Years (One dose of Tdap can be substituted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Pneumococcal and Flu Vaccine - Talk with your PCP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Influenza (Flu) every year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Tetanus (Td) every 10 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Pneumococcal - At Age 65 (A booster may be needed every 5 years.)</td>
<td></td>
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</tr>
</tbody>
</table>

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

**Clinical Practice Guidelines**

Meridian Health Plan is accountable for adopting and disseminating practice guidelines for the provision of acute and chronic care services that are relevant to its enrolled membership. Meridian involves appropriately board-certified practitioners in the adoption of clinical practice guidelines. See below for current Clinical Practice Guidelines, They are also available on the Meridian Health Plan website.

- [Acute Pharyngitis in Children](#)
- [ADHD](#)
- [Adult Preventive Services Ages 18-49](#)
- [Adult Preventive Services Ages 50-65+](#)
- [Adults with Systolic Heart Failure](#)
- [Advance Care Planning](#)
- **Asthma, Diagnosis and Management**
- **Asthma, Management in Children 0-4 years**
- **Asthma, Management in Children 5-11 years**
- **Asthma, Management in Ages 12 and older**
- **COPD**
- **Diabetes Mellitus**
- **Diagnosis and Management of Adults with Chronic Kidney Disease**
- **Diagnosis and Management of Adults with Depression**
- **Hypercholesterolemia**
- **Hypertension, Medical Management of Adults**
- **Management of Acute Low Back Pain**
- **Management of Uncomplicated Acute Bronchitis in Adults**
- **Management of Adults with Osteoarthritis**
- **Management of Overweight and Obesity in Adults**
- **Office-based Surgery Guidelines**
- **Outpatient Management of Uncomplicated DVTs**
- **Prevention and Identification of Childhood Overweight and Obesity**
- **Prevention of Pregnancy in Adolescents Ages 12-17 years**
- **Prevention of Unintended Pregnancy in Adults 18 years and older**
- **Routine Prenatal and Postpartum Care**
- **Routine Preventive Services for Infants and Children (Birth - 24 Months)**
- **Routine Preventive Services for Children and Adolescents (Ages 2-21)**
- **Treatment of Childhood Overweight and Obesity**
- **Tobacco Control**
- **Screening, Diagnosis and Referral for Substance Use Disorders**
I attest, as a credentialed Meridian Health Plan provider, for the following lines of business for which I am contracted, that I and all staff in my office/site have reviewed this manual regarding Meridian Health Plan’s policies and procedures and have successfully completed any required training for:

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>□ FWA</th>
<th>□ Model of Care</th>
<th>□ Cultural Competency/ADA</th>
<th>□ Medical Home</th>
<th>□ Abuse, Neglect, Exploitation</th>
<th>□ Critical Incidents</th>
<th>□ Model of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
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<tr>
<td>ICP</td>
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<td></td>
<td>□ Cultural Competency/ADA</td>
<td>□ Medical Home</td>
<td>□ Abuse, Neglect, Exploitation</td>
<td>□ Critical Incidents</td>
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<tr>
<td>MMAI</td>
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</tr>
</tbody>
</table>

Signed: __________________________________________

Printed Name: __________________________________________ Date: __________

Please check, sign and date the above form. To submit this form, please fax to 312-980-2381 for processing. Please disregard the submission of this form if you have already attested to the completion of training for your office. If you have any questions regarding this attestation, please call Provider Services at 866-606-3700.

You can find this attestation form online at www.mhplan.com.