NEW HAMPSHIRE Provider Orientation
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Dear Provider,

It is my pleasure to introduce you to Meridian Health Plan. As a licensed HMO in the State of New Hampshire, we know our success is based on the relationships we have with our providers. Meridian cultivates those relationships by offering several distinct services that differentiate it from others. We offer an elevated level of customer service to our contracted providers with an increased focus on the quality of care that our members receive.

Sincerely,

David B. Cotton, MD
President/CEO
Meridian Health Plan
Key Features

**Timely claims processing**
- Meridian pays 100% of the Medicaid Fee Screen
- Meridian pays clean claims within 10 business days
- Electronically billed claims are paid even faster
- Majority of claims processed in 2-5 days

**Simplified administration and authorization process**
- Secure, online Provider Portal allows providers to view member eligibility, enter authorizations, verify claims status, request direct assistance from Utilization Management and Member Services and review member health history, including previous utilization from other health plans
- Majority of routine outpatient surgeries are automatically approved online

**Incentive programs**
- Generous incentives based on HEDIS® measures ranging between $15 and $200 per service
- Paid over $18 million in quality bonuses to participating providers in 2012

**Hassle-free policies and procedures**
- Meridian will reimburse PCPs for well and sick visits provided during the same visit
- Meridian pays the medical co-pays so physicians do not have to collect them

**Additional Benefits**
- Provider offices will have an assigned local Provider Network Development Representative that will be able to respond to any issues that may arise
- Physician-owned and operated since 1997
- Provider support through care coordination:
  - Case management
  - Disease management
  - Population management
Director of Provider Network Development:

Mark Simpson 603-263-3882

Provider Network Development Representatives:

Kaitlyn Crandall 603-361-1834
Jodi Doody 603-321-3989

Revised: February 11, 2014
About Meridian

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

Our Vision
- To be the #1 Medicaid Health Plan based on quality, innovative technology and service to our members
- To be the premier service organization in healthcare

Corporate History
Meridian Health Plan was formed from the merger of two plans, Central Michigan Health Plan (CMHP) and American Preferred Provider Plan of Michigan (APPPM). In August 1997, Dr. David B. Cotton acquired a majority position in CMHP and assumed fiscal and administrative responsibility for the plan, which had approximately 1,400 members. CMHP acquired APPPM in January 1999 and ultimately became operational as Health Plan of Michigan (HPM) in May 1999.

Operating as a full service HMO since January 2000, HPM obtained NCQA accreditation in May 2002 and URAC accreditation in March 2011. On January 1, 2012, Health Plan of Michigan became Meridian Health Plan. The name change represents Meridian’s expanding horizons, yet the plan remains a physician-owned and physician-managed health plan.

Meridian has extensive experience in the Medicaid markets in Michigan, Illinois and Iowa. Meridian Health Plan is Michigan’s largest Medicaid HMO, developing one of the state’s best provider networks. Meridian’s Michigan plan holds URAC Full Health Plan Accreditation with Health Utilization Management.

In Illinois, Meridian began serving the Medicaid population in December 2008. In July 2013, Meridian will begin administering services in a mandatory enrollment program for the Seniors and Persons with Disabilities beneficiaries.

Meridian began serving Iowa in 2012, bringing its extensive experience in the Medicaid market. Meridian continually seeks to expand its service area throughout the State and increase its membership.

To learn more about Meridian Health Plan, please visit www.mhplan.com.

Service Description
Meridian Health Plan’s philosophy is to function as a care management and preventive care organization with an emphasis on disease management. Meridian provides Medicaid covered benefits to our members based on Medicaid benefit guidelines. These benefits include preventive care, physician office visits, diagnostic tests, home health care, inpatient hospital care, emergency room treatment and many other services to help our members stay healthy.
Population Management

Member Outreach
Each new member receives a welcome call within the first 30 days of enrollment to verify Primary Care Provider selection, explain Meridian’s managed care processes and perform a Health Risk Assessment (HRA). In addition, members receive periodic telephone calls to remind them of important preventive services such as well-child visits, immunizations, prenatal care and other screenings.

Health Risk Assessment (HRA)
Members are contacted via phone and are interviewed regarding their medical history. Based on the results of the HRA, members are assigned to Disease Management programs or Case Management services, as appropriate. Members not acute enough to require case management are screened for required preventive services. They are contacted through Meridian’s health outreach program and are actively encouraged to obtain the necessary care.

All of the data gathered through these activities is captured in Meridian’s state-of-the-art Managed Care System (MCS). This data collection supports a comprehensive approach to preventive care and health management for our members and providers.

Care Coordination
Meridian Care Coordination integrates the behavioral and physical needs of the member and coordinates referrals to maximize treatment success and outpatient care services. The Meridian Care Coordination model seeks to accomplish this by:

- Focusing attention on the individual needs of members
- Promoting and assuring service accessibility
- Maintaining communication with the member/caregiver, providers and community
- Identifying and removing barriers through collaboration with the PCP, specialists, member and family to develop a plan of care
- Integrating behavioral health and specialty care into care delivery
- Educating members on condition management, appropriate use of services and self-care techniques

Members enrolled in Care Coordination are stratified based on claims, historical and HRA data and are assigned to an acuity level of one through three, with three being the most complex. Target populations include:

- Pregnant members at all acuity levels
- Adults and children with special needs
- High-risk and high-cost populations with multiple health and social needs
- Members requiring post-hospitalization assessment and follow up
- High ER utilizers requiring education and communications with PCP
- Members with level three chronic conditions or more than one chronic diagnosis, regardless of risk stratification
- Members with medical needs who are also suffering from psychosocial and behavioral health risk factors

Providers may refer members to Care Coordination by clicking the “Notify Health Plan” button within our Provider Portal, or by calling Meridian at 855-827-1766.

Revised: February 11, 2014
Complex Case Management
Meridian members who are considered high-risk due to multiple chronic conditions, physical or developmental disabilities, serious mental illness, severe injuries and other needs are enrolled in Complex Case Management. These members require treatment and interventions across a variety of care domains including medical, social and mental health. These members typically see multiple providers at multiple locations and require assistance in coordinating their complex care. Members have the option to accept or decline Complex Case Management for their care; it is not a requirement. This program is provided to members free of charge. Providers may refer members to Complex Case Management by clicking the “Notify MHP” button within our Provider Portal, or by calling Meridian at 855-827-1766.

Eligibility
All Meridian Health Plan members are issued an ID card upon becoming eligible and are requested to present this card at each appointment. You may verify eligibility through the Meridian Provider Portal or by calling Meridian Member Services department at 855-291-5221. PCPs will also receive monthly enrollment via fax by the first of every month.

Preferred Laboratories
Meridian Health Plan has entered into Preferred Provider Agreements with Quest Diagnostics for laboratory services. Meridian has partnered with Quest Diagnostics in this Preferred Provider relationship to capture laboratory results to support HEDIS and other quality initiatives.

Meridian does not require prior authorization for routine laboratory tests for in or out-of-network providers.

Quest Diagnostics: **866-MYQUEST (866-697-8378)**
Non-Bureau of Behavioral Health (BBH) eligible members have a maximum benefit amount on behavioral health services of $1800. The fiscal service limit is calculated from July 1 to June 30 of the following year.

Some substance abuse services can be provided through a member’s psychotherapy and community mental health benefit when applicable.

Prior authorization is required for all inpatient, day hospital and intensive outpatient programs for behavioral health.

At intake/admission to all treatment, all Providers must explain the purpose and benefits of communication to all other relevant Providers with the member. All providers must have the member sign Consent to Release Information Form and fax to Meridian Health Plan. If unable to obtain sign consent Provider must notify Meridian by faxing refusal to sign with the reason why.

PCP and BH providers are expected to communicate all relevant medical/health/behavioral status within three (3) business days of service. Notification of treatment may be by fax or mail.

Please contact Meridian’s Behavioral and Mental Health Services at 855-291-5218. Behavioral/Mental Health and Substance Abuse referrals can be faxed to 603-263-3447.

### Diabetic Supplies

All Meridian members with diabetes will receive a new Advocate Redi-Code Meter through our exclusive diabetic supply company, Healthy Living Medical Supply.

The Advocate Redi-Code meter offers:

- Small blood sample size (0.6 microliter)
- No Coding of test strips
- 6 second test time, with a 450-test memory
- Talking meter providing results in both English & Spanish
- Alternate site testing

Healthy Living Medical Supply should be utilized for any Meridian member who is newly diagnosed or needs a new glucometer. Please contact Healthy Living Medical Supply at 866-779-8512 for coordination.

If a Meridian member has questions or needs assistance using the new Advocate Redi-Code meter, please instruct the member to contact Healthy Living Medical Supply. Meridian will not reimburse for any other glucometer or testing supplies provided from any other Durable Medical Equipment Vendor.
Diabetic Supply Prescription

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<table>
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<tr>
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Insurance

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<th>Group:</th>
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</table>

**DURATION of need:**

Duration of need: ☐ Lifetime ☐ Other: ________________

(The maximum allowed duration is 12 months. The duration will default to this unless specified otherwise.)

Diagnosis Code:

☐ 250.00 ☐ 250.01 ☐ 250.02 ☐ 250.03 ☐ 648._______

Estimated Due Date:

☐ Pre Existing ☐ New (please check one)

Is patient treated with insulin? ☐ Yes ☐ No

I have seen this patient within the last six (6) months to evaluate their diabetes control and have noted the reason(s) for a testing frequency of more than 6x a day.

Recommended Testing frequency:

☐ 1 time a day ☐ 4 times a day
☐ 2 times a day ☐ 5 times a day
☐ 3 times a day ☐ 6 times a day
☐ Other: ______ times a day Reason: ________________

Diabetes Testing Supplies:

☐ Glucose Monitor ☐ Alcohol Wipes
☐ Battery ☐ Lancing Device
☐ Control Solution ☐ Other: ________________

Insulin Pump: ☐ Yes / No

HEDIS Data: Please fill in the result within the Last 6 months for the following tests:

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<tr>
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<th>Date of Test</th>
<th>Score/Result</th>
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<tbody>
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<td>LDL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c</td>
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<td></td>
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<tr>
<td>Blood Pressure</td>
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<th>Score/Result</th>
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<tbody>
<tr>
<td>Dilated Eye Exam</td>
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<tr>
<td>Micro albumin</td>
<td></td>
<td></td>
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<td>BM1</td>
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<th>Date:</th>
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<tr>
<th>Phone#:</th>
<th>Fax#:</th>
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</table>
Meridian Health Plan has contracted with MeridianRx to administer all pharmacy benefits. The formulary is available on our website (www.mhplan.com) and through Epocrates. We also have a relationship with Surescripts, giving our providers the opportunity to ePrescribe for Meridian members while integrating our policies and procedures.

In order to enjoy the benefits of ePrescribe, a provider must have an appropriate Electronic Medical Record System (EMR) or ePrescribing system.

If you are currently using an EMR or ePrescribe software, chances are that your software is already currently certified by Surescripts. To find out if your software is certified, or to find out more about e-Prescribing, we invite you to view the Surescripts website at www.surescripts.com.

e-Prescribing allows providers to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point of care. This is an important element in improving the quality of patient care. Electronic prescribing has been instrumental in reducing medication errors.

MeridianRx Support:
855-291-5217

MeridianRx Fax:
603-263-3455
**Request for Medication Prior Authorization**

**Phone** 855-291-5217 / Fax 877-355-8070

**Only one medication request per form**
**All fields must be complete and legible for review**
**Prior Authorizations cannot be completed over the phone**

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### Patient Information

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<tr>
<th>Patient Name:</th>
<th>Prescriber Name and Specialty:</th>
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<tr>
<td>Member ID#:</td>
<td>NPI#:</td>
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<tr>
<td>Sex (circle): Male</td>
<td>Female</td>
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<tr>
<td>Date of Birth:</td>
<td>Office Fax: (     ) -</td>
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<td>Patient Phone:</td>
<td>Contact Person:</td>
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### Diagnosis and Medical Information

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<th>Strength and Route of Administration:</th>
<th>Frequency:</th>
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<tbody>
<tr>
<td>Height and Weight:</td>
<td>Expected Length of Therapy:</td>
<td>Quantity:</td>
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<td>BMI:</td>
<td>Date Calculated:</td>
<td>Diagnosis Related to Medication Request:</td>
</tr>
<tr>
<td>Blood Pressure:</td>
<td>Taken on:</td>
<td>Drug Allergies:</td>
</tr>
</tbody>
</table>

### Rationale for Prior Authorization

- History of a medical condition, allergies or other pertinent information requiring the use of this medication:
  
  ______________________________________________________
  ______________________________________________________
  ______________________________________________________

- Previous use of non-authorized and prior authorized medications tried and failed for this condition:
  - Name of Medication: ____________________________
  - Reason for Failure: ____________________________
  - Date of failure: ____________________________
  
  ______________________________________________________
  ______________________________________________________

- Relevant laboratory tests or procedures. Please attach most recent info to ensure a complete PA review:
  - Test: ____________________________
  - Results: ____________________________
  - Date of test: ____________________________
  
  ______________________________________________________
  ______________________________________________________

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**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents. **Revised 12/19/11**
Meridian Health Plan offers a HEDIS Bonus Program for all contracted Primary Care Providers. The yearly bonus period will cover all HEDIS services provided between January 1 to December 31 of the calendar year. Providers may also submit HEDIS service information through Meridian's secure web portal.

To qualify for a bonus payment, the service must be delivered in strict accordance with HEDIS guidelines. Services which are delivered, but do not meet strict HEDIS guidelines will not be eligible for a bonus. HEDIS guidelines are attached for the bonus measures. Timeframes and enrollment criteria for each measure must be met.

Bonuses will be paid in four installments. In the current calendar year, the first payment will be made at the end of April, followed by a payment at the end of July and the end of October. The final payment will be made during March of the next calendar year. Meridian will provide each PCP with a monthly HEDIS report either electronically through the Meridian Provider Portal or in a hard copy. The report will list all members who require HEDIS services. Specifically, a child member needing immunizations will remain on the list until all immunizations are received, or the second birthday passes. Childhood members requiring well-child visits will remain on the list until all 6 visits are received, or until the 15-month birthday passes. If members change PCPs but are still enrolled with Meridian, they will show on the new PCP lists.

In addition, Provider Network Development Representatives will meet with each practice to answer questions and assist in developing a plan to ensure Meridian members receive these very important services.

Meridian is committed to ensuring that our members receive quality preventive health care.
Outreach

Meridian Health Plan wants to make sure that all of our members receive the preventive care they need. In order to demonstrate our commitment, Meridian has dedicated significant resources to its member outreach programs.

All of these efforts result in higher HEDIS® scores and help our providers obtain their incentive bonuses.

This summary of Meridian’s outreach efforts demonstrates our commitment to quality:

- Meridian’s Member Outreach Team places phone calls to Meridian households to remind them of important preventive services, including:
  - Well-Child and Adolescent Visits
  - Child and Adolescent Immunizations
  - Blood Lead Testing
  - Breast and Cervical Cancer Screenings
  - Diabetes Testing (HbA1c, LDL, Eye Exams)

- All of these outreach phone calls are provided by a live person, not a pre-recorded voice message
- On every call, the Member Outreach Specialists verify the member’s demographic information and PCP selection in addition to providing outreach reminders
- Approximately 30% of members have a HEDIS® hit with a date of service after receiving a Meridian outreach call
- Meridian mails outreach postcards to members reminding them of important preventive services
- Incentives are distributed to members for obtaining preventive health services (gift cards)
- Meridian sponsors and participates in community events, including health fairs and lead screening fairs

The Meridian Provider Services department can work with PCP offices to design a targeted mail outreach program especially for your patients. Your assigned Provider Network Development Representative will be happy to coordinate these outreach efforts with your office.
Avoid Missed Opportunities

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 3-6 years and adolescents between the ages of 12-21 years need one well-child visit every year. A well-child visit includes:

- Health and developmental history (physical and mental)
- Physical exam
- Health education/anticipatory guidance

What is a Missed Opportunity?
Meridian Health Plan wants providers to avoid missed opportunities. Take advantage of every office visit to provide the preventive health services our members need, including well-child visits, immunizations and lead testing. Here are some tips to maximize those visits:

Turn a Sick Visit into a Well-Child Visit
Meridian will reimburse providers for a well-child visit and a sick visit performed on the same day. Simply add a modifier 25 to the sick visit and bill for the appropriate well visit.

Turn a Sports Physical into a Well-Child Visit
Many children request sports physical annually to participate in school and community activities. Just add anticipatory guidance to the sports physical's medical history and physical exam, and you can turn it into a well-child visit.

Make Every New Patient Visit a Well-Child Visit
New patients usually require a health and developmental history and a physical exam. Add some health education, and you have provided a well-child visit. Include the V20.2 diagnosis code to your claim, along with the appropriate CPT code for the new patient visit.

Don’t Wait a Year for the Next Well-Child Visit
Meridian pays for one well-child visit per calendar year - the visits do not have to be 12 months apart, or coincide with the child’s birthday. For example, if you provided a well-child visit in October 2010 and the child is back in your office in June 2011, you can provide a well-child visit and Meridian will reimburse you.

Meridian Offers a Quality Incentive Bonus for Well-Child Visits
For every well-child visit performed on an assigned member in accordance with HEDIS specifications, providers will receive a bonus payment.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>CPT Codes</th>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>0-15 Months</td>
<td>99381, 99382, 99391, 99392, 99432</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
<tr>
<td>3-6 Years</td>
<td>99382, 99383, 99392, 99393</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
<tr>
<td>12-21 Years</td>
<td>99383, 99384, 99385, 99393, 99394, 99395</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
</tbody>
</table>
Meridian Website

The Meridian Health Plan website has been updated with the following features:

- Provider manual
- Provider directory
- Formulary
- Bulletins
- Forms
- Useful links and information
- Live online chat services
- Plus much more

Meridian Provider Portal

The Meridian Provider Portal is available FREE for contracted providers with the following features:

- Verify Medicaid eligibility for Meridian members
- Authorizations
- Claims status and submission/correction
- Meridian member information & reports
- Enrollment lists
- HEDIS Bonus information
- HEDIS self-reporting
- Plus much more

An Meridian-supplied user name is required for access. To sign up, please visit our website at www.mhplan.com/nh/mcs. If you have any questions, please contact your Provider Network Development Representative.
Referral Pre-Service Clinical Review Program

Referrals
Referral processing is the primary activity performed by our Utilization Management Specialist staff. The Specialists are assigned in teams by provider group and region. If you have a referral request or question, please contact a member of your team. They will be glad to help you.

Meridian offers three easy ways to submit referrals:

1. Electronically through Meridian's secure Provider Portal

2. By fax, 603-263-3449, to the Utilization Management department. Please include pertinent clinical documentation with the request if indicated.

3. By phone for urgent requests. Please call the Meridian Utilization Management department at 855-827-1766. Make sure to identify the request as "urgent" to expedite the pre-service review process.

Pre-Service Clinical Review Program
Meridian clinical staff must review select services before they are provided. Clinical review assists in determining whether the service is clinically appropriate, is performed in the appropriate setting, and is a covered benefit. Please forward the pertinent clinical information with your request via fax or the secure Meridian Provider Portal services to expedite a response.

Refer to the next page for the services that require clinical review.

Utilization Management 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. In certain circumstances, external reviews of service requests are conducted by qualified, licensed physicians with the appropriate clinical expertise.

Provider Appeal
Providers may appeal a denial either before or after a service is rendered. In the instance of a pre-service denial, Meridian’s nurse reviewer contacts the provider office by phone to inform them of the denial decision and the reason for the denial. The nurse reviewer also provides contact information to discuss the denial with an Meridian Medical Director.

Written denial notification is sent via fax and mailed to the member. Treating providers who would like to discuss a utilization review determination with the decision-making Medical Director may contact the Utilization Management department at 855-827-1766. 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 Utilization Management department at 855-827-1766 to request a copy of Meridian’s medical necessity guidelines.

Revised: February 11, 2014
Authorization Overview

**MERIDIAN HEALTH PLAN AUTHORIZATION OVERVIEW – NEW HAMPSHIRE**

**You may contact Meridian Health Plan by Phone: 855-827-1766**

Most outpatient services are auto approved via the secure Meridian Health Plan Provider Portal at www.mhplan.com/nh/mcs

<table>
<thead>
<tr>
<th>No Prior Authorization Required (in or out-of-network)</th>
<th>PCP/Specialist Notification to Meridian (in or out-of-network)</th>
<th>Corporate Prior Authorization (may require clinical information)</th>
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</thead>
<tbody>
<tr>
<td>• Allergy Testing</td>
<td>Speech, Occupational and Physical Therapy (up to eighty (80) 15-minute units)</td>
<td>• High-Tech Imaging – CT Scan, MRI, MRA, PET, Nuclear Cardiology</td>
</tr>
<tr>
<td>• Audiology Services and Testing (excluding hearing aids)</td>
<td>Complex Outpatient Treatment</td>
<td>• Elective and emergent inpatient admissions</td>
</tr>
<tr>
<td>• Cardiac Stress Test</td>
<td>• Dialysis</td>
<td>• Home Health Care services including home infusion, skilled nursing and therapy</td>
</tr>
<tr>
<td>• Colposcopy after an abnormal Pap (excluding family planning)</td>
<td>• Outpatient Radiation Therapy</td>
<td>&gt; Home Health Services</td>
</tr>
<tr>
<td>• Durable Medical Equipment, Prosthetic Devices, and Medical Supplies &lt; $500 (e.g., enteral feeding device, enteral pump, communication devices)</td>
<td>Maternity Care/Maternal Support Services</td>
<td>&gt; Private Duty Nursing</td>
</tr>
<tr>
<td>• Electrocardiography</td>
<td>• Notification is needed for OB referrals and for OB delivery</td>
<td>&gt; Hospice</td>
</tr>
<tr>
<td>• Endoscopy</td>
<td>Specialist office visits/consults by only NH Medicaid contracted providers</td>
<td>&gt; Furnished medical supplies and DME</td>
</tr>
<tr>
<td>• Hearing Aid Evaluation/Consultation</td>
<td>• Evaluate &amp; treat in office</td>
<td>• Hospital outpatient services/surgery</td>
</tr>
<tr>
<td>• Obstetrical Observations</td>
<td></td>
<td>• Elective inpatient surgery</td>
</tr>
<tr>
<td>• Podiatry (up to the 4 visit limit)</td>
<td></td>
<td>• Ambulance transportation (non-emergent)</td>
</tr>
<tr>
<td>• Routine Lab</td>
<td></td>
<td>• Speciality Drugs and Chemotherapy may require review under the medical or pharmacy benefit</td>
</tr>
<tr>
<td>• Sleep Studies (facility only)</td>
<td></td>
<td>• Infusions</td>
</tr>
<tr>
<td>• Urgent Care</td>
<td></td>
<td>• Weight Management (prior to Bariatric Surgery)</td>
</tr>
<tr>
<td>• Vision – 1 exam per year, with the exception of diabetics</td>
<td></td>
<td>• Prosthetics and Orthotics &gt;$500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Speech, Occupational and Physical Therapy that exceed 80, 15-min units</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Podiatry services that exceed 4 visits per year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnostic X-rays that exceed 15 X-rays</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Genetic Testing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Large DME (wheelchairs, hospital beds, etc.) &gt;$500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vision services that exceed service limits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transplants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Potential cosmetic services, including, but not limited to; breast reduction, blepharoplasty, panniculctomy, septoplasty and rhinoplasty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical Weight Loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adult medical day care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Personal care attendants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-State service request (except those from NH Medicaid contracted providers)</td>
</tr>
</tbody>
</table>

All emergency inpatient admissions, surgeries and out-of-network 23 hour observations require corporate authorization.

For emergency authorizations, Meridian must be notified within the first 24 hours or the following business day.

Out-of-network hospitals must notify Meridian at the time of stabilization and request authorization for all post-stabilization services.

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**BEHAVIORAL HEALTH SERVICES**

Phone: 855-291-5218 Fax: 603-263-3447

Please refer to BH authorization overview

Behavioral Health and Psychiatric services are covered by Meridian. If you are receiving services from a Community Mental Health Center (CMHC), please call Meridian’s Behavioral Health Department.

For more information about behavioral health authorizations, please call Meridian.

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**Dental Care (under 18 years old)**
The State of New Hampshire’s Medicaid program covers dental care for all Medicaid enrollees through the New Hampshire Smiles program. To find a dentist, call 800-852-3345 x 4344 or 603-271-4344.

*Meridian covers an oral exam and fluoride varnish for children age 6 months – 3 years during well child care up to twice a year.

**MeridianRx is the Meridian Pharmacy Benefit Manager.** If you have questions about formulary or pharmacy prior authorizations, please call 855-291-5217 or fax 603-263-3455.

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For non-emergent medical transportation services, call 855-291-5223.

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By requesting prior authorization, the provider is representing that the services to be provided are medically necessary.

As a condition of authorization of those services, the servicing provider agrees to accept no more than 100% of New Hampshire Medicaid rates.

At no time will Meridian pay more than 100% of New Hampshire Medicaid rates for any services. In the event that these services are deemed not to be medically necessary, Meridian will not reimburse the provider for those services. Providers must request prior authorization for any services that exceed the service benefit limit. A request must include clinical documentation that supports medical necessity for the requested additional services. This authorization is invalid if the practitioner is not contracted with New Hampshire Department of Health and Human Services (DHHS).
Claims Information

Claims Payments & Status
Meridian Health Plan is dedicated to processing your claims in under 10 days. You may status your claims several ways:

• Meridian’s secure Provider Portal: www.mhplan.com/nh/mcs
• By Phone: 888-773-2647
• By Fax: 313-202-0008
• By Mail
  Meridian Health Plan Claims Department
  1001 Woodward Ave, Suite 540
  Detroit, MI 48226

Claims Appeal Process
Meridian Health Plan makes every reasonable effort to partner with our providers. In cases where a claim has been denied, providers may submit an appeal in writing within 30 days of the denial. Please include the following:

• Patient name and ID#
• Reason for appeal
• Any relevant clinical information to support your appeal

The Health Plan Appeals Committee meets regularly to review these appeals. You will receive a response within 30 days.

Meridian is continually making efforts to improve the efficiency of its claims payment by increasing automation of its processes. The two measures of claims efficiency are electronic claims submission and auto-adjudication. These automated processes support timely claims payment. The following chart demonstrates the level of automation of Meridian's claims processing.

<table>
<thead>
<tr>
<th>Efficiency of Claims Processing</th>
<th>Automated</th>
<th>Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI Submission</td>
<td>89%</td>
<td>11%</td>
</tr>
<tr>
<td>Auto Adjudication</td>
<td>77%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Meridian consistently meets performance requirements for timely claims payment.

• Total Claims Processed in 2012 = 4,534,610
• Average Monthly Claims Volume = 377,884
• Average Claims Payment Time = 1.85 Days
• Claims Payment Accuracy Level = 99.21%
• % of Calls Answered within 30 Seconds = 99.9%
Billing Information

Meridian Health Plan follows the State of New Hampshire Medicaid billing guidelines unless otherwise noted.

Mail to:  
Meridian Health Plan  
1001 Woodward Avenue, Suite 540  
Detroit, MI 48226

**Meridian Electronic Claim Submission (EDI) Vendors**
The payer ID# for the following vendors is 13189.

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Customer Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI Group</td>
<td>800-880-3032</td>
</tr>
<tr>
<td>Availity</td>
<td>800-282-4548</td>
</tr>
<tr>
<td>PayerPath</td>
<td>877-623-5706</td>
</tr>
<tr>
<td>Relay Health</td>
<td>800-527-8133</td>
</tr>
<tr>
<td>WebMD (Emdeon)</td>
<td>800-845-6592</td>
</tr>
<tr>
<td>Netwerkes</td>
<td>866-521-8547</td>
</tr>
</tbody>
</table>
Health care fraud, waste and abuse affects every one of us. It is estimated to account for between 3% and 10% of the annual expenditures for health care in the U.S. Health Care fraud is both a state and federal offense. Based on the HIPAA regulations of 1996, a dishonest provider or member may be subject to fines or imprisonment of not more than 10 years, or both (18USC, Ch. 63, Sec 1347).

The following are the official definitions of Fraud, Waste and Abuse: 42 CFR §455.2 Definitions.

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

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

Here are some examples of Fraud, Waste and Abuse:

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

**Waste & Abuse**
- Going to the Emergency Department for non-emergent medical services
- Threatening or abusive behavior in a doctor’s office, hospital or pharmacy
Fraud, Waste and Abuse

Meridian encourages members, providers and employees to report all cases of fraud, waste and abuse. If you know of any Medicaid members or providers, including doctors, hospitals and pharmacies, who have committed actions of fraud, waste or abuse, you can report them using the process described below. You may report them anonymously if you choose.

To Report Potential Fraud, Waste and Abuse:

Meridian members, providers or employees can also report potential instances of fraud, waste and abuse directly to the State of New Hampshire at the following address. You can report anonymously if you choose.

Office of the Attorney General
Medicaid/Healthcare Fraud Unit
33 Capitol Street
Concord, NH 03301

Or call: 603-271-1246
Or fax: 603-223-6274

Meridian members, providers or employees can also report potential fraud, waste or abuse anonymously in writing to Meridian Health Plan at the following address:

Compliance Officer
Meridian Health Plan
777 Woodward Avenue, Suite 600
Detroit, MI 48226
Phone: 877-218-7949
Fax: 313-202-0009

The False Claims Act

The False Claims Act is aimed at establishing a law enforcement partnership between federal law enforcement officials and private citizens who learn of fraud against the Government. Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for up to three times the government’s damages plus civil monetary penalties. The False Claims Act explicitly excludes tax fraud.

The Act permits a person with knowledge of fraud against the United States Government to file a lawsuit on behalf of the Government against the person or business that committed the fraud. The lawsuit is known as a “qui tam” case, but it is more commonly referred to as a “whistleblower” case. If the lawsuit is successful, the qui tam plaintiff is rewarded with a percentage of the recovery, typically between 15 and 25%. Any person who files a qui tam lawsuit in good faith is protected by law from any threats, harassment, abuse, intimidation or coercion by his or her employer. For more information on the False Claims Act, please contact the Meridian Corporate Compliance Officer at 877-218-7949.
Utilization Management
Phone: 855-827-1766  Fax: 603-263-3449
• Process referrals
• Perform corporate pre-service review of select services
• Collect supporting clinical information for select services
• Conduct inpatient review and discharge planning activities
• Coordinate case management services

Member Services
Phone: 855-291-5221  Fax: 603-263-3901
• Verify member eligibility
• Obtain member schedule of benefits
• Obtain general information and assistance
• Determine claims status
• Encounter inquiry
• Record member personal data change
• Obtain member benefit interpretation
• File complaints and grievances
• Verify / record newborn coverage
• Coordination of Benefit questions

Provider Services
Phone: 877-480-8250  Fax: 603-263-3453
• Fee schedule assistance
• Contractual issues
• Primary care administration
• Discuss recurring problems and concerns
• Provider education assistance
• Initiate physician affiliation, disaffiliation & transfer

Quality Management
Phone: 855-291-5221  Fax: 603-263-3451
• Requests and questions about Clinical Practice Guidelines
• Requests and questions about Preventive Healthcare Guidelines
• Questions about Quality Initiatives
• Questions about QI Regulatory requirements
• Questions about Disease Management Programs

Other Important Phone and Fax Numbers
Pharmacy Benefit Manager  855-291-5217  Main Fax  603-263-3445
Meridian Behavioral Health  855-291-5218  Behavioral Health Fax  603-263-3447
Meridian Claims  800-203-8206  Meridian Claims Fax  313-324-3642
Non-Emergent Transportation  855-291-5223

Revised: February 11, 2014