MERIDIANCOMPLETE MEDICARE-MEDICAID PLAN PROVIDER MANUAL

2024

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USING THE MERIDIANCOMPLETE PROVIDER MANUAL

The MeridianComplete Medicare-Medicaid Provider Manual is designed specifically for MeridianComplete providers. This manual will assist the provider in understanding the specific policies, procedures, and protocols of the Health Maintenance Organization (HMO) contracted with the State and the Centers for Medicare and Medicaid Services (CMS) to deliver and manage healthcare for members.

Updates and Revisions

The Provider Manual is a dynamic tool that evolves with MeridianComplete.

Minor updates and revisions are communicated to providers via *Bulletins*. Information given in *Bulletins* replaces information found in the body of the Provider Manual.

Major revisions of the information in the Provider Manual will result in publication of a revised edition that will be distributed to all providers.

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MERIDIANCOMPLETE CONTACT INFORMATION

CONTACT AND SERVICE FUNCTION	MeridianComplete
Utilization Management	
• 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	MI: **1-855-323-4578**
Member Services	
• Verify member eligibility • Obtain member Summary of benefits • Obtain general information and assistance • Obtain claims status • Encounter inquiry • Record member personal data change • Obtain member benefit interpretation • File complaints and grievances • Coordination of benefits questions	MI: **1-855-323-4578**
Provider Services	
• Fee schedule assistance • Discuss recurring problems and concerns • Contractual issues • Provider education assistance • Primary care administration • Initiate provider affiliation, disaffiliation and transfer	MI: **1-855-323-4578**
Quality Improvement (QI)	

• Requests and questions about Clinical Practice Guidelines (CPGs)
  • Find the CPGs on our website at
  • **mmp.mimeridian.com.** Located under Training and Education or through the Provider Portal
• Requests and questions about Preventive Healthcare Guidelines
• Questions about QI initiatives
• Questions about QI regulatory requirements
• Questions about Disease Management Programs
	MI: **1-855-323-4578**

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Pharmacy Benefit Manager	
• Prior authorize non-formulary medications	MI: **1-800-867-6564** **Fax: 1-877-941-0480**
• Hours of Operation	5 a.m. to 6 p.m. PST Monday - Friday

Member Services Department

The MeridianComplete Member Services team exists for the benefit of our members and providers, to respond to all questions about benefits, services, policies, and procedures. Hours are 8 a.m. to 8 p.m., seven days a week. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. Call toll-free at **1-855-323-4578, Monday – Sunday, 8 a.m. to 8 p.m.,** if you need:

- More information about your benefits
- Help locating a Primary Care Provider (PCP)
- To change your PCP
- To get basic plan information
- A new MeridianComplete ID card or handbook
- To change your address or phone number
- To file a complaint

Alternative technologies are used outside of business hours for Utilization Management inquiries and requests.

MeridianComplete Member Services Department - Michigan
Toll-Free: 1-855-323-4578

MERIDIANCOMPLETE MEDICARE-MEDICAID MEMBERSHIP

Member Eligibility and Enrollment

Beneficiaries who wish to enroll in MeridianComplete's Medicare-Medicaid plans should reach out to their local Department of Health and Human Services office**. MeridianComplete does not actively submit enrollment or disenrollment for Medicare-Medicaid plans (MMP) to the State or to CMS.** Members who wish to enroll in MeridianComplete MMPs must meet the following criteria:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Have full Medicaid benefits
- Are ages 21 or older
- Permanently reside in the MeridianComplete Medicare-Medicaid service areas
- Not enrolled in hospice
- The individual is a U.S. citizen or lawfully present in the United States

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The following populations will be excluded from enrollment in the demonstration:

- Individuals under the age of 21
- Individuals previously disenrolled due to Special Disenrollment from Medicaid managed care
- Individuals not living in a Demonstration region
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI)
- Individuals without full Medicaid coverage (spend-downs or deductibles)
- Individuals with Medicaid who reside in a state psychiatric hospital
- Individuals with commercial HMO coverage
- Individuals with elected hospice services
- Individuals who are incarcerated
- Individuals who have Children's Special Health Care Services (CSHCS)
- Individuals who are in the MI Care Team Demonstration
- Individuals who have Presumptive Eligibility

MeridianComplete will accept all members that meet the criteria in this section at any time without reference to race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family status. Additionally, we will not limit, or condition coverage of plan benefits based on any factor that is related to the member's health status, including but not limited to medical condition, claims history, receipt of healthcare, medical history, genetic information, and evidence of insurability or disability.

Disenrollment

MeridianComplete Medicare staff may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare member to disenroll, except when the member:

- Permanently moved outside the geographic service area
- Committed fraud
- Abused their membership card
- Displayed disruptive behavior
- Lost Medicaid eligibility (for plans requiring Medicaid eligibility)
- Lost Medicare Parts A or B or
- Is deceased

When members permanently move out of the service area, they are encouraged to notify Medicare-Medicaid, the Social Security Administration, and the local Department of Health and Human Services office as soon as possible to update their address information. Members will be submitted for disenrollment once confirmation of relocation outside of the service area is confirmed. If a member leaves the service area for over six consecutive months, they are involuntarily disenrolled from our plan. There are several ways that we may be informed that the member has relocated:

- Out-of-area notification will be received from CMS on the daily Transaction Reply Report (TRR)
- Other means of notification can be made through the Claims department, if out-of-area claims are received with a residential address other than the one on file

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- Provider notification to the plan
- Directly from member or member responsible party

Members may request disenrollment from MeridianComplete. Members should call Michigan ENROLLS to request disenrollment, but may request disenrollment directly by calling **1-800-MEDICARE** or by enrolling directly in a new Medicare Advantage, MMP, or Medicare prescription drug plan. The effective date for all voluntary disenrollments is the first day of the month following the State's receipt of the disenrollment request.

Medicare-Medicaid plans, such as MeridianComplete, may not accept enrollment, disenrollment, or opt-out requests directly from members and process such requests themselves. Instead, MeridianComplete must refer members or prospective members to Michigan ENROLLS.

Requested Disenrollment
MeridianComplete will request disenrollment of members from the plan only as allowed by CMS and state regulations. We will place requests to the state that a member be disenrolled under the following circumstances:

- The member provided fraudulent information
- The member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment

Other reasons the plan may submit for disenrollment request to the state for a member's disenrollment may be:

- The member abuses the enrollment card by allowing others to use it to obtain services fraudulently
- The member leaves the service area and directly notifies us of the permanent change of residence
- The member has not informed the plan of a permanent move, but has been out of the service area for six months or more
- The member loses entitlement to Medicare Part A or Part B benefits
- The member is deceased
- MeridianComplete loses or terminates its contract with CMS. In the event of plan termination by CMS, we will send CMS-approved notices to the member and a description of alternatives for obtaining benefits. The notice will be sent in accordance with CMS regulations, prior to the termination of the plan
- MeridianComplete discontinues offering services in specific service areas where the member resides

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In all circumstances, we will provide a written notice to the member or member's estate with an explanation of the reason for the disenrollment. All notices will comply with CMS rules and regulations.

MeridianComplete MMPs will not directly submit requests for enrollment or disenrollment to the State or to CMS per the three-way contract agreement. MeridianComplete can initiate requests to the State, but enrollment and disenrollment processing is handled solely by Michigan ENROLLS.

Member Rights and Responsibilities

- Members have a right to receive information about the Medicare-Medicaid managed care organization (MCO), its services, its providers, and members' rights and responsibilities

1. Members have a right to privacy and to be treated with respect and dignity
2. Members have a right to participate with providers in decision-making regarding their healthcare
3. Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
4. Members have a right to file complaints or appeals about the managed care organization (MCO) or the care provided
5. Members have a right to make recommendations regarding the organization's members' rights and responsibilities policies
6. Members have a right to change their Primary Care Provider (PCP) at any time. Changes that occur on or before the tenth of the month will be effective for the current month. Changes that occur after the tenth of the month will be effective on the first of the following month
7. Members have a responsibility to provide, to the extent possible, information that the MCO and its providers need in order to care for them
8. Members have a responsibility to follow the plans and instructions for care that they have agreed on with their providers, including referral and authorization rules
9. Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible
10. Members have the right to receive information in a way that works for them. MeridianComplete provides member materials in alternate formats, languages other than English and provides a language line for members who speak languages other than English
11. Members have the right to get timely access to covered services
12. Members have the right to directly access through self-referral: screening mammography, influenza vaccine, and pneumococcal vaccine through contracted providers at no cost
13. Members have the right to adequate access to plan providers, and as such MeridianComplete will maintain and monitor a network of providers including but not limited to: primary care providers, specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics and other providers. Furthermore, MeridianComplete will ensure that members have access to network providers that can furnish all plan benefits, including supplemental benefits. If a network provider cannot perform a medically necessary service for a member, then MeridianComplete will arrange for an out-of-network provider to furnish the service
14. Members have the right to direct access to an in-network women's health specialist without

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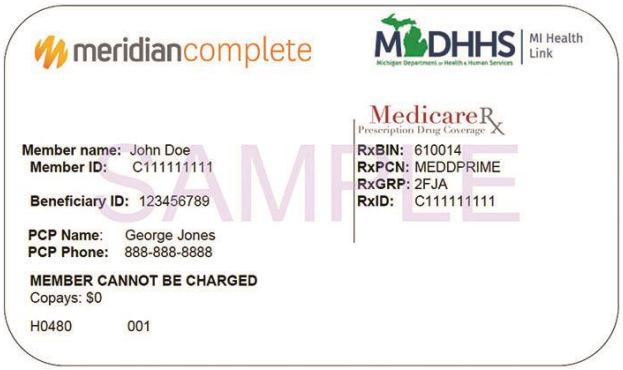
having to obtain a referral from their PCP or plan authorization

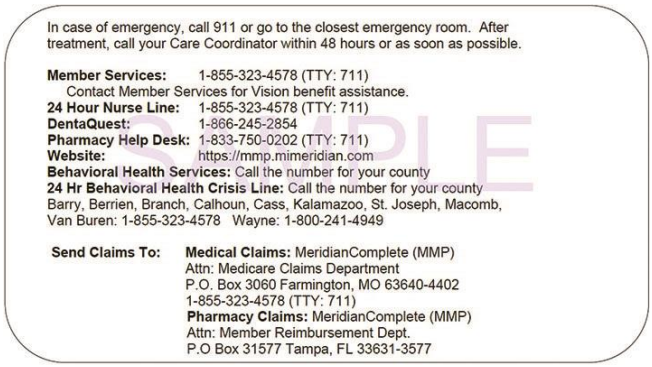
15. Members have the right to out-of-network specialty care if network providers are unavailable or inadequate to meet a member's medical needs
16. Members have the right to a continuation of benefits for the contract period the plan has with CMS. Furthermore, if the member is hospitalized on the date the plan's contract ends with CMS, the plan will still be responsible for furnishing a continuation of benefits per MeridianComplete's contractual obligation with CMS
17. Meridian maintains policies to protect enrollees from incurring liability (for example, as a result of organizational insolvency or other financial difficulties) for payment or fees for covered services/benefits through the member's enrollment period with the plan. Per contractual agreements, providers may not hold members liable for covered services
18. Members have the right to receive upon enrollment and annually thereafter an evidence of coverage that explains all plan benefits, rights, and responsibilities of the plan and rights and responsibilities of the member, including but not limited to appeal rights, cost sharing and plan premium responsibilities and how to locate and select providers in MeridianComplete's network. Members can also call Member Services if they have questions about their rights and responsibilities, think they are being treated unfairly, or want more information about the plan
19. Members have the right to be notified in writing at least 30 days in advance before a provider that they are currently receiving care from is terminated. MeridianComplete will assist the member in finding a new provider prior to the termination date of their current one

MeridianComplete Medicare staff and contracted providers must comply with all requirements concerning member rights.

Member Identification

All members receive an ID card at the time of enrollment that has Meridian's Member Services phone number and pharmacy contact information on it. Below is an example of a MeridianComplete Member Identification Card. **Sample ID Card below:**





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Eligibility Verification

How to Identify a Member's Eligibility

Providers must verify member eligibility prior to rendering services to a member.

To verify if a member is currently eligible to receive services as a MeridianComplete member, the following steps must be followed:

- Request that the member present his/her Member Identification Card at each encounter
- Review your PCP monthly eligibility report each time the member presents at your office for care or referrals
- Call the Member Services department at the number listed on the member's ID card for assistance with eligibility determinations
- Utilize the Meridian Managed Care System (MCS)
- Verify eligibility through state Medicaid enrollment systems (e.g., CHAMPS — MI Medicaid system)
- Members will have access to a Member portal starting 1/1/21 and can access the portal via the public website.

If you find any discrepancies between a member's ID card, an Eligibility Verification System, and/or your monthly eligibility report, please contact the Member Services department for further assistance.

Members have a right to change their PCP at any time. Changes that occur on or before the tenth of the month will be effective for the current month; changes that occur after the tenth of the month will be effective on the first of the following month.

Notice of Privacy Practices

Meridian is regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules. In accordance with these regulations, Meridian provides a Notice of Privacy Practices on our website that describes member rights and responsibilities to safeguard protected health information.

While providers must have their own Notice of Privacy Practices per the HIPAA Privacy Rule, a copy of our Privacy Practices may be accessed on our website:
MeridianComplete: **mmp.mimeridian.com/provider.html.**

You may contact Meridian's Privacy Officer with any questions or concerns regarding member privacy or if you wish to file a privacy-related complaint.

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Privacy Officer
Meridian
777 Woodward, Suite 700
Detroit, MI 48226

Email: privacy.mi@mhplan.com
Phone: 1-855-323-4578 (TTY 711)

ADVANCE DIRECTIVES

MeridianComplete providers are responsible for maintaining written policies and procedures regarding Advance Directives, educating members regarding Advance Directives, providing members with Advance Directive forms, and obtaining forms from members for attachment to the member's medical record. Providers must have written information available to members explaining their rights while describing the provider's role and limitations in implementing the advance directive. All completed Advance Directive forms must be maintained in the front of each member's health record.

MEDICARE OVERVIEW

Medicare Program

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers 55 million Americans. Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home healthcare, and hospice care. Part B helps pay provider bills, outpatient hospital care and other medical services not covered by Part A.

Part A

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible or spouse has worked at least 10 years in Medicare-covered employment, is age 65 or older, and a citizen or permanent resident of the United States. Certain younger disabled people and kidney dialysis and transplant patients qualify for premium-free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80 percent of the approved cost for wheelchairs, hospital beds and other durable medical equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

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Part B

Medicare Part B pays for many medical services and supplies, including coverage for provider's bills. Medically necessary services of a provider are covered no matter where received — at home, in the provider's office, in a clinic, in a nursing home or in a hospital. The Medicare member pays a monthly premium for Part B coverage. The amount of premium is set annually by CMS. Part B also covers:

- Outpatient hospital services
- X-rays and laboratory tests
- Diagnostic services and tests
- Certain ambulance services
- Durable medical equipment
- Services of certain specially qualified practitioners who are not providers
- Physical and occupational therapy
- Speech/language pathology services
- Partial hospitalization for mental healthcare
- Defined outpatient mental health services including treatment for substance abuse
- Colorectal cancer screening, mammograms, and pap smears
- Home healthcare if a member does not have Part A

Part C

The Balanced Budget Act of 1997 (BBA) established Medicare Part C, also referred to as **Medicare Advantage**. Prior to Jan. 1, 1999, Medicare HMOs existed as Medicare Risk or Medicare Cost plans. The BBA was intended to increase the range of alternatives to the traditional fee-for-service program for Medicare beneficiaries. The options included HMOs and Preferred Provider Organizations (PPOs).

Under the Medicare Modernization Act of 2003 (MMA), Congress created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. **Special Needs Plans (SNPs)** are allowed to target enrollment to one or more types of special needs individuals identified by Congress as: 1) institutionalized, 2) dually eligible, and/or 3) individuals with severe or disabling chronic conditions.

SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. Dual eligible SNPs also offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from higher risk to lower risk on the care continuum. Meridian offers Medicare plans that target **special needs individuals** who are dually eligible for both Medicare and Medicaid.

Medicare Star Ratings

The Centers for Medicare and Medicaid Services (CMS) created the Medicare star rating system to provide quality and performance information to members when choosing a health and drug plan. CMS grades all Medicare Advantage and prescription drug plans on the care that is provided. The score is

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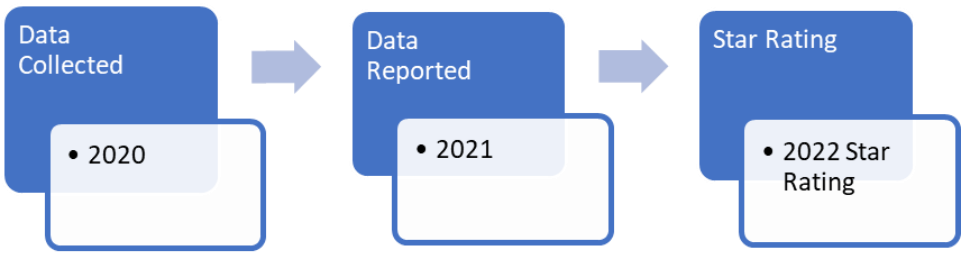
based on performance from Healthcare Effectiveness Data and Information Set (HEDIS®) quality scores and member satisfaction reported through the Health Outcome Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The purpose of the star rating system is to help members, family members and caregivers compare the quality of Medicare plans in their area.

The grade is publicly available, influences member perception and is tied to large financial incentives. The grading scale is a five Star scale with five being the best, one being poor and a score of four stars or higher making the plan eligible for quality bonus payments from CMS. These bonus payments are used to provide better benefits to members; this includes lower copays and premiums for members.

The overall rating is broken up by Part C and Part D ratings, which are based on 40 combined measures. Examples of these measures are breast cancer screenings, improving mental health, all-cause readmissions, and appeals. The measures fall under nine domains, including Staying Healthy (screening, preventive services), Managing Chronic Conditions (diabetes, hypertension), Member Experience, Member Complaints, Drug Safety, and Customer Service.

Star Rating Timeline

Meridian's Star rating is based on data from two years prior. The timeline below shows the development of the 2022 Star rating. The data from 2020 is collected and reported in 2021, which comprises the 2022 Star rating. The Star rating for 2022 is released in October 2021, in order for prospective members to evaluate the plan before the next year begins.



The Provider Impact

More than half of the star rating measures are influenced by the providers. Each provider has the opportunity to impact the success of a plan's star rating by influencing the patient's experience. On average, providers have a higher impact on keeping the member satisfied than the Medicare Advantage plan.

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Medicare-Medicaid plans (MMPs) do not gain a star rating. However, there are currently two member surveys sent out each year: Health Outcome Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The HOS measures member-reported physical and mental health status. It also asks members about physical activity, improving bladder control and fall risk management. The CAHPS survey measures patient satisfaction with their healthcare experience. The patient experience could include communication with providers, if medications were reviewed clearly and if the provider showed respect for what the patient said.

Our partnership goals with our providers are to:

1) Increase member engagement at provider offices through tailored member outreach
2) Improve member outcomes by addressing open care gaps at every visit

PROVIDER PARTICIPATION IN MERIDIANCOMPLETE

Provider Credentialing and Recredentialing

Meridian has written policies and procedures for the selection and evaluation of providers. There is a documented process with respect to providers and suppliers who have signed contracts or participation agreements.

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

The provider credentialing and recredentialing processes require that all providers keep Meridian Credentialing Specialists updated with changes in credentials. Providers should also respond promptly to any requests to update information so that all credentialing files can be maintained appropriately.

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 Specialist 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 his or her intent to correct any erroneous information.

Meridian recredentials each provider in the network at least every three years. Approximately six months prior to the provider's three-year anniversary date, the provider will be notified of the intent to recredential. All necessary forms will be sent for completion. In certain instances, a site visit will also be scheduled.

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Additionally, the provider recredentialing process includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data, and member transfer rates.

Appeals Process

There is a formal method of appeal for a provider/applicant who is denied participation within the Meridian Medicare Network. The request for reconsideration or appeal must be submitted to the Credentialing Manager in the Credentialing department, who will submit it to the Credentialing Committee.

1. The provider/applicant who is denied participation in the Meridian Medicare Network may submit a request for reconsideration within 21 days of the date of his or her participation denial with additional supportive information or evidence of his or her professional qualifications or abilities to meet the accepted credentialing criteria.
2. The request for reconsideration and the additional information will be submitted to the Credentialing Committee at the next scheduled meeting date.
3. The Credentialing Committee will review the appeal request and additional information and will make a final determination of the appeal.
4. The appealing provider/applicant will be notified of the appeal determination by the Credentialing Committee, through the Medical Director, by certified letter, within five working days of the Credentialing Committee meeting.
5. If the denial is overturned, the applicant will continue with the new participation notification process outlined in this policy.
6. Denied applications are maintained confidentially in a Denied Participation file and are maintained for a period of four years from the date of denial. Denials of participation are kept confidential except where reportable by Meridian under federal or state regulation.

Member Access and Availability Guidelines

Meridian contracted providers are responsible and accountable to Meridian members/patients 24 hours a day, seven days a week. Providers will be expected to abide by state and federal standards of timeliness of access to care and services based on the urgency of member's needs and when medically necessary.

The following guidelines will be continuously monitored to ensure compliance to these standards within the network.

1) PCPs and specialists must be available to address member/patient medical needs 24 hours a day, seven days a week. The PCP may delegate this responsibility to another Meridian provider on a contractual basis for after-hours, holiday, and vacation coverage. Voicemail alone is not acceptable.

2) If the PCP or specialist site uses 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

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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 providers 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 provider is added to a PCP's practice to ensure that all providers are credentialed to Meridian standards. PCPs may employ licensed/certified Physician's Assistants (PAs) or Registered Nurse Practitioners (RNPs) to assist in the care and management of their patient practice. If PAs or RNPs are utilized, the PCP or the designated and credentialed provider 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) Nonprofessional healthcare staff shall perform their functions under the direction of the licensed PCP, credentialed provider, or other appropriate healthcare professionals such as a licensed PA or RNP.

REMINDER: 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

Type of Care/Appointment	Length of Wait Time
Emergency Services	Immediately 24 hours/day 7 Days per week
Urgent Care	Within 48 hours
Routine Care	Within thirty (30) Business Days of request
Non-urgent Symptomatic Care	Within seven (7) Business Days of request
Specialty Care	Within six (6) weeks of request
Acute Specialty Care	Within five (5) Business Days of request

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Behavioral Health Office Visit Appointments

- Life-threatening emergency appointments are scheduled immediately
- Non-life-threatening emergency/urgent visits are scheduled within six hours
- Urgent visits are scheduled within 24 hours
- Initial routine office visits are scheduled within 10 business days
- Follow-up routine visits are scheduled within 14 business days

Office Waiting Time

To ensure 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 30 minutes to be seen by a provider with no more than six scheduled appointments made for a provider per hour.** Supervising providers may routinely account for more than six 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 provider 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 and 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.

OSHA Training

Employee training and annual in-service education must include:

1. Universal precautions
2. Proper handling of blood spills
3. HBV and HIV transmission and prevention protocol
4. Needle stick exposure and management protocol
5. Bloodborne pathogen training
6. Sharps handling
7. Proper disposal of contaminated materials
8. Information concerning each employee's at-risk status

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At-risk employees must be offered hepatitis B vaccination free of charge. Each employee file of an at-risk employee must contain informed consent or informed refusals for hepatitis B vaccines. Personal protective equipment must be provided to each at-risk employee. Necessary equipment must be provided for the administration of mouth-to-mouth resuscitation.

Documents to be posted in the facility are:

- Pharmacy Drug Control license issued by the State if dispensing drugs other than samples
- Section 17757a from the Board of Pharmacy (if dispensing drugs other than samples)
- Controlled Substances License from State of Michigan and the Drug Enforcement Administration (DEA)
- CLIA certificate or waiver
- Medical Waste Management certificate
- X-ray equipment registration
- R-H 100 notice
- Radiology protection rules
- OSHA poster (#2010)

Provider Roles and Responsibilities

CMS requires providers to provide care to members in a culturally competent manner, being sensitive to language, cultural, and reading comprehension capabilities. Meridian offers a language service to members speaking a non-English language. There is no charge to members for this service. To access this service for Meridian members in your practice, please contact Member Services at the numbers listed in the contact information section of this booklet and ask for language services.

Providers must ensure that their hours of operation are convenient for the aged, disabled, chronically ill, and low-income populations that they serve. Providers must provide all plan benefits covered by Medicare and by Meridian in a manner consistent with professionally recognized standards of healthcare. Providers must also ensure continuity of care and develop procedures that ensure that members are informed of their healthcare needs that require follow-up visits or provide training in self-care as necessary.

Providers must provide to Meridian, upon request, member's medical records, both to support complete and accurate risk adjustment data and for the validation of risk adjustment data for auditing purposes.

Providers shall not distribute any marketing materials that mention Meridian or include Meridian's logos without first obtaining approval from both Meridian and CMS. Providers must comply with all CMS marketing requirements in Chapter 3 of the Medicare Managed Care Manual.

Providers must make a good faith effort to provide 60 calendar days' notice prior to effective date to plan regarding contract changes and terminations. Providers must make a good faith effort to provide written notice of request to terminate or contract changes to MeridianComplete at least 30 calendar

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days before the termination or change effective date, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care provider MeridianComplete will notify all enrollees who are patients of that primary care provider. Provider shall also make a good faith effort to provide appropriate notification to members.

Primary Care Provider (PCP) Roles and Responsibilities
Each Meridian member selects a PCP who is responsible for coordinating the member's total healthcare. PCPs are required to work 20 hours per week per location, and be available 24 hours a day, seven days a week.

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

Specialty Care Provider Roles and Responsibilities
Meridian recognizes that the specialty provider is a valuable team member in delivering care to Meridian Medicare members. Some key specialty provider roles and responsibilities include:

- Rendering services requested by the PCP by referral
- Communicating with the PCP regarding the findings in writing
- Obtaining prior authorization from the PCP and plan 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
- Providing the lab or radiology provider with:
    - The PCP and/or corporate prior authorization number
    - The member's ID number

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

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

Ancillary/Organization Provider Roles and Responsibilities
Meridian recognizes that the ancillary provider is another valuable team member in delivering care to Meridian Medicare members. Some critical ancillary provider responsibilities include:

- Confirming member eligibility and benefit level before rendering services

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

Confidentiality and Accuracy of Member Records

Medical records and other health and enrollment information of a member 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
- Respect member rights to access, amend errors in, request confidentiality for, or an accounting of disclosures of the member's health information
- Identify when and to whom member information may be disclosed
- Safeguard the privacy of any information that identifies a particular member
- Secure information through robust controls designed to maintain the confidentiality, integrity, and availability of medical records and to protect against threats or hazards to the security or integrity of such information and any uses or disclosures of such information that could violate law
- Maintain such records and information in a manner that is accurate and timely, ensure timely access by enrollees to the records and information that pertain to them for what purpose(s) the information will be used within the organization, and identify when and to whom member information may be disclosed

In addition to the obligation to safeguard the privacy and security of any information that identifies a particular member, the health plan and all participating providers are each 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 (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, within requested time frames, and maintain records a minimum of 10 years.

Obligations of Recipients of Federal Funds

Providers participating in Meridian Medicare plans are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including but not limited to Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act, the Anti-Kickback Statute, and HIPAA laws.

At minimum, Meridian can check the MDHHS health professions website monthly for excluded providers. At minimum, Meridian can check the OIG List of Excluded Individual Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)] for its providers at least monthly, before contracting with the provider, and at the time of a provider's credentialing and recredentialing. If a provider is terminated

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or suspended from the MDHHS Medicaid Program, Medicare, or another state's Medicaid program, or is the subject of a state or federal licensing action, the Integrated Community Organizations (ICO) shall terminate, suspend, or decline a provider from its Provider Network as appropriate.

Upon notice from MDHHS or CMS, Meridian cannot authorize any providers who are terminated or suspended from participation in the Michigan Medicaid Program, Medicare, or from another state's Medicaid program, to treat enrollees and shall deny payment to such providers for services provided.

Meridian must notify CMS and MDHHS on a quarterly basis when a provider fails credentialing or recredentialing because of a program integrity reason, or Adverse Action reason, or, effective no sooner than January 1, 2018, an Adverse Benefit Determination reason, and shall provide related and relevant information to CMS and MDHHS as required by CMS, MDHHS, or state or federal laws, rules, or regulations.

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

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at **exclusions.oig.hhs.gov/**.
- The General Services Administration List of Debarred Contractors can be found at **www.sam.gov.**
- The Preclusion List can be found at **cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html**

Disclosures to CMS and Beneficiary

Meridian must disclose to CMS and MDHHS information on ownership and control, business transactions, and people convicted of crimes. Meridian must obtain federally required disclosures from all network providers and applicants – and including, but not limited to, obtaining such information through providers enrollment forms and credentialing and recredentialing packages. Meridian is required to obtain such disclosed information in a manner that can be periodically searched for exclusions and provided by MDHHS and CMS.

Meridian is required to provide the necessary information to enable CMS to provide to current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage. This must happen annually and in a format that uses standard terminology that may be specified by CMS.

Meridian is required to provide to CMS all information that is necessary for CMS to administer and evaluate the program. Meridian is also required to provide information to CMS that would allow CMS to establish and facilitate a process for current and prospective enrollees to exercise choice in obtaining their Medicare services. This information includes, but is not limited to:

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- Benefits covered under a Medicare Advantage (MA) plan
- MA monthly basic member premium and MA monthly supplemental member premium, if any, for Meridian
- Service area and continuation area, if any, of each plan and the enrollment capacity of each plan
- Information about member appeals and their disposition
- Information regarding all formal actions, reviews, findings, or other similar actions by states, other regulatory bodies, or any other certifying or accrediting organization
- Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program

As a contracted provider with Meridian, you are required to comply with Meridian's request for information to meet disclosure obligations to CMS. Types of disclosures to CMS by Meridian include, but are not limited to: plan disenrollment rates for the previous two years, enrollee satisfaction results, health outcome information, recent compliance record of the plan, and any other information that may be necessary for CMS to assist beneficiaries in making an informed health plan choice.

In meeting these requirements, the provider must cooperate with Meridian and assist in complying when applicable.

Partnership for Quality Program — what is it?
Meridian offers the Partnership for Quality (P4Q) program, a performance-based compensation program, to encourage providers to support our goal of providing accessible, high-quality care.

The goals of the P4Q program are to improve health outcomes for members, reducing costs associated with chronic conditions and to link health quality and provider performance in a manner that is equitable for payers and providers.

The program's measurements are carefully considered. The metrics selected for inclusion are intended to meet HEDIS specifications.

Measures that are calculated into the Medicare star ratings receive a high priority for inclusion in the program. The measurements selected target health screening and prevention in all populations. Data used to determine compensation are gathered from a variety of sources, including administrative claims, laboratory results and pharmacy use.

BILLING AND CLAIMS PAYMENTS

When billing for services rendered to MeridianComplete members, providers must use the most current Medicare-approved coding (e.g., ICD-10, CPT, HCPCS) available.

Claims must be submitted using the proper claim form/format, e.g., for paper claims, submit a CMS1500 or UB04 and for an electronically submitted claim, submit in approved ANSI/HIPAA format.

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It is recommended that claims be submitted as if they are being billed to Medicare fee-for-service. **Providers need only submit one claim for MeridianComplete members. Meridian will apply Medicare benefits and, when applicable, Medicaid benefits.**

Billing Requirements

1. Providers must use a standard CMS 1500 Claim Form or UB-04 Claim Form for submission of claims to Meridian
2. Specialty provider claims should include a PCP referral form and/or a corporate prior authorization number for payment
3. Claim must be original, using national or state form types as applicable. Photo or scanned copies are not accepted. The claim information must be typed, with no handwritten information other than applicable signatures
4. Taxonomy code must be included on all claims
5. Participating providers have 180 days to submit a clean claim to the Health Plan. Non-participating providers have 365 days to submit a claim. Please note that your participating agreement can state otherwise, so please ensure you are checking your agreement for your timely filing guidelines. This guidance is in accordance with CMS's expectations concerning timely submission of claims/encounter data by MMPs.

Claims Mailing Requirements
Submit all initial claims for payment to:

MeridianComplete
Attn: Meridian Claims Department
P.O. Box 3060
Farmington, MO 63640-3822

If you are resubmitting a claim for a status or a correction, please use the corrected/resubmission claim process as outlined in the provider billing manual.

Billing Procedure Code Requirements
Meridian requires that providers use HCPCS, CPT, ICD-10, and revenue codes when billing Meridian.

Explanation of Payments (EOP)
Meridian sends its providers remittance vouchers as a method of explanation of benefits.

Balance Billing Prohibited for Medicare Eligibles

You may not balance bill for services and supplies furnished to MeridianComplete members. Any difference between what you bill and what Meridian pays cannot be billed to the member.

Additionally, you may not bill for services and supplies furnished to Qualified Medicare Beneficiaries (QMBs); for them, Medicaid is responsible for premiums, deductibles, coinsurance and copayment amounts for Medicare Part A and B covered services. Federal law prohibits Medicare providers from

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collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program that exempts individuals from Medicare cost-sharing liability. Billing prohibitions may also apply to other dual eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing. Note that the prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B. Low Income Subsidy copayments still apply for Part D benefits. (Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter; 42 C.F.R. §422.504(g)(1)(iii)). For more information, see **www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf**.

Note: QMBs are sometimes called "dual eligibles." They are entitled to Medicare Part A, eligible for Medicare Part B, have income below 100% of the Federal Poverty Level, and have been determined to be eligible for QMB status by the State Medicaid Office.

Electronic Claims Submission

Electronic Claim Submission (EDI) Vendors

Date of Service	Health Plan Name	Transaction Type (CH/RP)	Clearing House Payer ID	Paper Claim Submissions
On or after Jan. 1, 2021	MeridianComplete	Fee-for-service BHT06 = RP	68069	MeridianComplete Attn: Claims Dept. P.O. Box 3060 Farmington, MO 63640

Please Note: For fastest, most accurate processing, EDI is the preferred method.

REAL-TIME CONNECTIVITY

Vendor Partner	Health Plan	Phone Numbers
Availity*	Meridian	**1-800-282-4548**

These services improve data interchanges, provide an innovative solution to provider requests, and implement other HIPAA-compliant transactions in the future:

- Real-time eligibility and claim status information – no waiting on the phone
- Low or no cost to the provider community
- Increased office productivity

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- One-stop shopping – view eligibility and claim status information for all participating health insurance companies from a single website with a single login

Payment to Noncontracted Providers

Meridian will make timely and reasonable payment on behalf of or to the member for the following services if obtained by an out-of-network provider in accordance with 422.100(b):

- Ambulance services dispatched through 911 or its local equivalent
- Emergency and urgently needed services
- Maintenance and post-stabilization care services
- Renal dialysis services provided while the member was temporarily outside the plan's service area
- Services for which coverage has been denied by Meridian and found (upon appeal) to be services the member was entitled to have furnished, or paid for, by Meridian

Provider Grievance and Appeals Process for Denied Claims

Contracted providers can request an appeal from Meridian when acting strictly on their own behalf and the member is not at financial risk, such as for an unapproved inpatient admission.

Meridian offers a post-service claim appeal process for disputes related to denial of payment for services rendered to Meridian Medicare members.

What Types of Issues Can Providers Appeal?

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

- The provider disagrees with a determination made by Meridian, such as combining two stays as a 15- or 30-day readmission. In this case, the provider should send additional information (such as medical records) that support the provider's position.
- The provider is requesting an exception to a Meridian Medicare 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.

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 member ineligibility 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:

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MeridianComplete
ATTN: Claims
P.O. Box 3060
Farmington, MO 63640

Time Frame for Filing a Post-Service Appeal
Provider Appeals must be submitted within 120 days from the EOP, provided the initial claim was submitted within the timely guidelines.

Response to Post-Service Claims Appeals
The Claims Appeals department typically responds to a post-service claim appeal within 60 days from the date of receipt. Providers will receive a remittance with the Claims Appeals department decision and denial reason.

There is only one level of claims appeal available. All appeal determinations are final.

If you have any questions about the post-service claim appeal process, please call Member Services at the numbers listed in the contact information section of this manual.

UTILIZATION MANAGEMENT

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

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

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

Requesting Prior Authorization/Precertification For all authorization questions, please contact us at the numbers listed in the contact information section of this manual.

Meridian offers multiple methods to submit authorization requests. For the most efficient and timely service, **Meridian's Online Prior Authorization (PA) Form is the preferred method.**

1. **Online Electronic System —** The Meridian Online PA Form can be accessed in two ways:
   - Secure Provider Portal

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- Meridian website at **mmp.mimeridian.com** Click on "Prior Auth Form" at bottom of the page

2. **Fax Submission —** Please include pertinent clinical documentation with the request.

Michigan Medicare	
Type of Request	**Fax Number**
Inpatient Admissions	**1-844-930-4390**
Post-Acute Admissions	**1-844-930-4390**
Pre-Service Standard Requests	**1-844-930-4389**
Pre-Service Expedited Requests	**Phone Number 1-855-323-4578**
Part B Drug	**1-844-930-4394**
Behavioral Health Inpatient Admissions*	**1-844-930-4395**
Behavioral Health Outpatient Services*	**1-833-728-0124**

**Only for members residing in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, & Van Buren. For members residing in Wayne county, please direct all Behavioral Health service requests to the PIHP.*

3. **Phone Submission**

Michigan MeridianComplete: **1-855-323-4578**

*Please note: Many authorizations cannot be processed via phone, as clinical review and supporting documentation are required. Requests should only be submitted via the phone for services related to pending hospital discharges or expedited pre-certification requests.

When submitting a Prior Authorization request, please include the following information:

- Member's name
- Member's identification number
- Member's date of birth
- Date(s) of service
- Facility where services are to be rendered
- Diagnosis/Procedure code(s), as applicable

UM Decision Clinical Review Criteria

Meridian must review and approve all services before they are provided. The primary reasons for clinical review are to determine whether the service is clinically appropriate, is performed in the

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appropriate setting and is a covered benefit. Clinical information is necessary for all services that require clinical review for medical necessity.

Utilization management clinical staff uses 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 Medicare medical directors. In certain circumstances, external review of service requests are conducted by qualified, licensed providers with the appropriate clinical expertise.

Providers should refer directly to Medicare coverage policies for information on Medicare coverage policies and determinations. The two most common types of Medicare coverage policies are National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

As a Medicare Advantage plan, we must cover all services and benefits covered by Original Medicare.

National Coverage Determinations (NCDs)
The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals.

Local Coverage Determinations (LCDs)
LCDs provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

In coverage situations where there are no NCDs, LCDs or guidance on coverage in Medicare manuals, Meridian may use current literature review, along with consulting with practicing providers and medical experts in their particular field. Meridian also uses government agency policies and relies on standards adopted by a national accreditation organization and Meridian Medical Management policies for clinical decision making. Meridian may also adopt the coverage policies of other MA Organizations in its service area.

It is the responsibility of the attending provider 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.

To ensure timely decisions are rendered, Meridian requires completed and legible clinical information with each request. The preferred method of clinical review submission is via Meridian's Online Prior Authorization (PA) Form. If clinical information is not received with the request, the Meridian Medicare Utilization Management staff will send a fax request for the information and/or contact the provider or specialist verbally to collect the necessary documentation.

Clinical information includes relevant information regarding the member's:

- History of presenting problem

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- Physical assessment
- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Response to treatment
- Discharge disposition

Clinical information should be provided at the time of the request. Meridian provides a referral number on all authorizations.

Inpatient Review

Nurses review care for members in acute care facilities to promote collaboration with the facility's review staff and management of the member across their continuum of care. Meridian Medicare nurse reviewers assess the care and services provided in inpatient settings and the member's response to the care by applying InterQual® criteria. Together with the facility's staff, nurse reviewers coordinate the member's discharge needs.

All elective hospital admissions initiated by the PCP, or specialist, require a prior authorization. A provider may initiate a prior authorization request by calling Member Services, entering the authorization request via the provider portal form or by submitting the request via fax. Be sure to include clear and concise documentation to support medically necessity, which will facilitate a quick determination.

Turnaround Time for Referral Processing

Review Type	Makes Decision	Written/Verbal Notification	Written Notification (Denials)
Pre-Service Nonurgent	Within 14 days of receipt of the request	Within 14 days of receipt of the request	Within 14 days of receipt of the request
Pre-Service Urgent	Within 72 hours of receipt of the request	Within 72 hours of the request	Within 72 hours of the request
Urgent Concurrent	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 24 hours of receipt of the request, 72 hours if clinical not included with initial request	Within 72 hours of the decision

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Required Notification to Members for Observation Services

In compliance with the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), contracted hospitals and Critical Access Hospitals (CAHs) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including an MA enrollee) who receives observation services as an outpatient for more than 24 hours. See the final at: **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON#:~:text=Hospitals%20and%20CAHs%20are%20required,critical%20access%20hospital%20(CAH).**

Care Management

The Meridian Medicare Care Management Program provides patient-centered, individualized care management for all MeridianComplete members. Generally, these members include individuals who have complex healthcare needs and are more fragile and vulnerable than the general population. It is the goal of Meridian to provide access to quality healthcare services for these special members through care coordination.

As a part of our Care Coordination Program, our Care Managers will send you an Individual Integrated Care and Supports Plan, which is a plan of care developed by the member, the member's care manager and any other individuals identified as a part of the member's Integrated Care Team (ICT). The care plan will contain a prioritized list of the member's goals, objectives, barriers, and strengths and a plan for addressing the member's concerns or goals.

Our care managers may contact you for other reasons such as:

1. To participate in a member's Integrated Care Team (ICT) meeting
2. To coordinate a plan of care
3. To confirm a diagnosis
4. To verify appropriate follow-up such as cholesterol/LDL-C screening or HbA1c testing
5. To identify compliance issues
6. To discuss other problems and issues that may affect outcomes of care
7. To inform you of a member's potential need for behavioral health follow up

Provider Action:

Integrated Care Team (ICT) — Providers identified as a participant in a member's Integrated Care Team (ICT) are encouraged to participate in the ICT meetings. The role of ICT is to work collaboratively with the member and other ICT team members.

The member's ICT team includes the member, the member's chosen allies or legal representative, PCP, Meridian Care Manager, LTSS Coordinator or PIHP Supports Coordinator (as applicable) and others as needed.

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MEMBER APPEALS AND GRIEVANCES

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two types of complaints members can make. All contracted providers must cooperate with the Medicare Advantage appeals and grievances process.

Definitions

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the healthcare services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and, if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Grievance: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides healthcare services, regardless of whether any remedial action can be taken. A member or their representative may make a complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination, or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

Appeals

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 in which the application of the time period for making nonurgent 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.

Inpatient services that are denied while a member is in the process of receiving the services are considered urgent concurrent requests and are therefore eligible for an expedited appeal.

Pre-service Nonurgent Appeal

Providers, acting on behalf of a member, may request an appeal of denial in advance of the member obtaining care or services. Meridian will provide acknowledgement of the appeal within three days of receipt of the request. No provider will be involved in an appeal for which he/she made the original Adverse Determination. No provider will render an appeal decision who is a subordinate of the provider making the original decision to deny.

Refer to the Billing and Payment section for directions on Post-Service Appeals.

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Levels of the Appeals Process

The levels of the appeals process are listed below. If an appeal is not resolved at one level, it can proceed to the next.

- Meridian standard or expedited appeals process
- Review by an Independent Review Entity (IRE)
- Review by an Administrative Law Judge (ALJ)
- Review by a Medicare Appeals Council (MAC)
- Review by a Federal District Court Judge

For a **Michigan Medicaid**-only service, the member can file an external appeal him or herself, following Meridian's internal appeal process. There are two ways to make an External Appeal: (1) Michigan Medicaid Fair Hearing with the Michigan Office of Administrative Hearing and Rules (MOAHR) and/or (2) External Review with the Department of Insurance and Financial Services (DIFS).

For a service that could be covered by **both Medicare and Michigan Medicaid**, the case is automatically sent to the Medicare IRE for an External Appeal. The enrollee can also ask for a Michigan Medicaid Fair Hearing with MAHS and/or and External Review with DIFS.

Members can appeal a medical decision within 60 calendar days of receiving Meridian's letter denying the initial request for services or payment on their own behalf. They can also designate a representative, including a relative, friend, advocate, provider or other person, to act for them. The member and the representative must sign and date a statement giving the representative legal permission to act on the member's behalf.

This statement must be sent to MeridianComplete at:

MeridianComplete
Attn: Appeals & Grievances, Medicare Operations
7700 Forsyth Blvd
St. Louis, MO 63105

Fax: 1-844-273-2671

The member can call our Member Services department at the numbers listed in the contact information section of this manual to learn how to name an authorized representative.

Appeals and Grievances

A member may appeal an adverse initial decision by Meridian or a participating provider concerning authorization for, or termination of coverage of a healthcare service. A member may also appeal an adverse initial decision by Meridian concerning payment for a healthcare service. A member's appeal of a decision about authorizing healthcare or terminating coverage of a service must generally be resolved by Meridian within 30 calendar days if the member's health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

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Participating providers must also cooperate with Meridian and members in providing necessary information to resolve the appeals within the required time frames. Participating providers must provide the pertinent medical records and any other relevant information to Meridian. In some instances, participating providers must provide the records and information very quickly in order to allow Meridian to make an expedited decision.

If the normal time period for an appeal could result in serious harm to the member's health or ability to function, the member or the member's provider can request an expedited appeal. Such an appeal is generally resolved within 72 hours unless it is in the member's interest to extend this time period. If a provider requests the expedited appeal and indicates that the normal time period for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

A special type of appeal applies only to hospital discharges. Hospitals are required to notify all Meridian Medicare members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue *Important Message from Medicare About Your Rights (IM),* a statutorily required notice, up to seven days before admission or within two calendar days of admission, obtain the signature of the member or of his or her representative, and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of the discharge as possible, but not less than two calendar days before discharge.

If the member thinks their hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization that is contracted with CMS. However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that Meridian's coverage of the stay is ending. If the member misses this deadline, the member can request an expedited appeal from Meridian.

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Medicare regulations require the provider to deliver the standard *Notice of Medicare Non-Coverage* (*NOMNC)* to all members when covered services are ending, whether the member agrees with the plan to end services or not. Providers must distribute the NOMNC at least two days prior to enrollee's CORF or HHA services ending and two days prior to termination of SNF services. If the member thinks his or her coverage is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization. If the member gets the notice two days before coverage ends, the member must request an appeal to the Quality Improvement Organization no later than noon of the day after the member gets the notice. If the member gets the notice more than two days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to a quality improvement organization, the member can request an expedited appeal from Meridian.

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If a member has a grievance about his or her plan, a provider or any other issue, the member should call Member Services or submit a complaint in writing by mail or fax. The address to file the grievance is:

MeridianComplete
Attn: Appeals & Grievances, Medicare Operations
7700 Forsyth Blvd
St. Louis, MO 63105

Fax: 1-844-273-2671

We will resolve the grievance as quickly as the case requires based on the member's health status, but no later than 30 calendar days after receiving the complaint. We may extend the time frame by up to 14 days if the member requests the extension, or if we justify a need for additional information and the delay is in the member's best interest.

Meridian's Quality Improvement Program (QIP) is designed to ensure members receive high quality, medically appropriate, and cost-effective healthcare.

- The objectives of Meridian's QIP include:
    - Ensure enrollee access to care
    - Provide accessibility and availability of quality medical and behavioral healthcare
    - Develop programs to increase and improve preventive healthcare
    - Monitor and expand Disease Management Programs for prevalent disease states
    - Manage members with complex healthcare needs
    - Coordinate care for members with acute and chronic care needs
    - Improve coordination and transition of care across healthcare settings
    - Monitor adherence to evidence-based and established Clinical Practice Guidelines
    - Improve member and provider satisfaction
    - Design member and provider health education materials that include a call to action
    - Improve HEDIS and CAHPS performance
    - Develop and maintain collaborative relationships with providers and State agencies
    - Develop program for serving culturally and linguistically diverse membership through analysis of significant healthcare disparities in clinical areas
    - Identify specific healthcare disparities to reduce and implement targeted activities to address barriers and improve health outcomes

Medical Policy, Quality Improvement, and Medical Management

Meridian encourages the use of evidence-based Clinical Practice Guidelines (CPGs) by contracted providers. Meridian's Quality Improvement Committee approves and adopts CPGs for prevention, diagnosis, and management of medical and behavioral health conditions. The nationally-recognized National Committee for Quality Assurance (NCQA) developed these guidelines for NCQA, Michigan Quality Improvement Consortium (MQIC), and other CPG developers to develop clinical strategies to monitor and evaluate the quality of care provided to Medicare members.

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Meridian promotes the implementation of these CPGs via dissemination among providers and uses numerous performance measures to provide feedback to achieve consistent and high-quality health outcomes for our members. The CPGs are reviewed at least every two years and updated as necessary by the MeridianHealth Physician Advisory Committee (PAC), and approved by Meridian's Quality Improvement Committee and Board of Directors. See page 5 for information on requests and questions about CPGs.

Further Appeal Rights

If Meridian denies the member's appeal in whole or in part, it will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not part of Meridian. This organization will review the appeal and, if the appeal involves authorization for healthcare services, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the member may be able to appeal to a Federal District Court of the United States.

Critical Incidents Reporting

Meridian requires participating program providers to report all Critical Incidents that occur in a home, community-based, or long-term services and supports delivery setting. This includes assisted living facilities, community-based residential alternatives, adult day care centers, other HCBS provider sites, and a member's home, if the incident is related to the provision of HCBS. Providers will be provided with Critical Incident education materials and have access to additional information via our website (**mmp.mimeridian.com**). Providers must participate in trainings offered by Meridian to ensure accurate and timely reporting of all critical incidents. Trainings may be offered as webinars, online learning, and regional meetings.

Critical incidents include but are not limited to:

- Unexpected death of a program member
- Any abuse or suspected abuse of a program member, such as physical, sexual, mental, or emotional abuse
- Theft or financial exploitation of a program member
- Severe injury sustained by a program member
- Medication error involving a program member
- Neglect and/or suspected neglect of a program member
- Provider no-shows, particularly when the enrollee is bedbound all day or there is a critical need

Providers must contact Meridian with a verbal report of the incident within 48 hours. The verbal report, at a minimum, must include:

- Member name
- Date of birth

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- Date and time of incident
- A brief description of the incident
- Member's current condition
- 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 24 hours following the discovery of the incident. Providers must cooperate fully in the investigation of reported critical incidents, including submitting all requested documentation.

The Critical Incident form must include:

- Member name
- Date of birth
- Date and time of incident
- Member's ID number
- When we received the information of the critical incident
- A brief description of the incident
- Member's current condition
- Actions taken to mitigate risk to the member

If the incident involves an employee or an HCBS provider, the provider must also submit a written report of the incident, including actions taken within 20 calendar days of the incident. To protect the safety of the member, actions that can be taken immediately include, but are not limited to the following:

- Providers must contact 911 if the incident can cause immediate/severe harm to the member
- APS needs to be contacted in cases of abuse, neglect, and/or exploitation
- Remove the accused worker from the member's case (if incident includes an allegation of improper behavior by that worker)
- Remove the accused worker from servicing all plan members until the investigation is complete. This may take up to 30 calendar days
- Order an immediate drug screen or appropriate testing if allegation includes theft of drugs or use of substances including alcohol while on the job
- Interview any 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 preemployment screenings, including background checks, drug screening, and a statement that the employee did not begin to perform services for plan members until all required preemployment screenings were completed and verified. Fax numbers can be obtained by calling Meridian

Depending upon the severity of the incident, any identified trend, or the failure by the provider to cooperate with any part of the investigation, the provider may be required to submit a written plan of

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correction to address and correct any problem or deficiency surrounding the critical incident. Required forms can be found on the Meridian website at **mmp.mimeridian.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.

Michigan Critical Incident Reporting Table
Michigan State Government website:
www.michigan.gov/mdhhs/adult-child-serv/abuse-neglect

Providers must notify MDHHS immediately if there is a member death related to alleged abuse, neglect, or exploitation. If there is immediate risk of serious injury or death, call the local police dispatch office.

Incident Involves	Contact	Timeframe	Special Instructions
A. Child (under 18) **B.** Adults (18 and older)	Statewide 24-Hour Abuse Line (855) 444-3911	Immediately	For any incident involving the abuse, neglect, or exploitation of a child, the **3200 form** needs to be completed and sent to the external agency immediately

You may need to make a report in addition to the report made to the Statewide Abuse Line depending on the circumstances. Please review the table below:

Incident Involves	Contact	Timeframe	Special Instructions
Adults (18 and older), disabled, with a mental illness or developmental disability	Disability Rights Michigan (800) 288-5923	Immediately	
Adult Foster Care, Homes for the Aged, Child Care Centers/Homes, Adult/Child Camps	Bureau of Community and Health Systems (866) 856-0126	Immediately	After-hours staff: When unable to submit a complaint by phone, go to the State of Michigan website and follow the instructions to submit a complaint form.
State licensed or federally certified health facility,	Bureau of Community and Health Systems (800) 882-6006	Immediately	After-hours staff: When unable to submit a complaint by phone, go to the State of

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including nursing home, hospitals, home health agencies, hospices, surgery centers, dialysis centers, and other providers			Michigan website and follow the instructions to submit a complaint form.
Fraud	Office of Inspector General (855) 643-7283	Immediately	
Suspicious death possibly linked to abuse or neglect	Local authorities/police	Immediately	

FRAUD, WASTE, AND ABUSE

Meridian Health is committed to preventing, identifying, and reporting all instances of suspected fraud, waste, and abuse to the proper authorities.

As an affiliate of Centene Corporation, Meridian Health uses Centene's anti-fraud programs to comply with state and federal laws. Centene created its anti-fraud program to provide mechanisms for the prevention, detection, investigation, and recovery of suspected or actual fraud, waste, and abuse activities. As such, Meridian Health partners with Centene's Special Investigations Unit (SIU) to conduct routine audits of provider billing and coding practices to comply with Meridian Health's state contract requirements and other state and federal regulations, to include those contained in the Affordable Care Act

Investigators will request records for a defined review period from a provider under an audit. If the records are not received, the Investigator will determine the overpayment, total amount paid within the audit period (which can be an extrapolated amount) and send a Proposed Action Letter outlining the overpayment. If payment is not received, the Investigator will move to an offset of future claims billed to Meridian Health.

Centene's SIU performs both prepayment and retrospective reviews that, in some cases, may result in taking actions against providers who commit waste, abuse, and/or potential fraud. These actions include, but are not limited to:

- Remedial education and training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Referral for civil and/or criminal prosecution
- Any other remedies available

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Investigators review claims data for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

Meridian investigators consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician may also review specific cases to determine if billing is appropriate. Investigators issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying unsupported records reviewed during the audit. If the investigator determines that clinical documentation does not support the claims payment in some or all circumstances, Meridian will seek recovery of all overpayments. Depending on the error rate of the review, Meridian may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

No time limit applies to the initiation of overpayment recovery efforts required by a state or federal program or where there is suspected fraud or intentional misconduct involved.

False Claims Act The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the federal government (tax fraud is suspected). The Act prohibits:

1. Knowingly presenting, or causing to be presented, a false claim for payment or approval;
2. Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. Conspiring to commit any violation of the False Claims Act;
4. Falsely certifying the type or amount of property to be used by the government;
5. Certifying receipt of property on a document without completely knowing that the information is true;
6. Knowingly buying government property from an unauthorized officer of the government, and;
7. Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the government.

For more information regarding the False Claims Act, please visit **www.cms.gov**.

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To report possible Fraud, Waste, and Abuse (FWA):
Contact Meridian through the Fraud, Waste and Abuse hotline at **1-866-685-8664**. All reporting of possible FWA may be done anonymously through this hotline. The Special Investigations Unit (SIU) can be contacted by email at **Special_Investigations_Unit@CENTENE.COM.**

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