PROVIDER MANUAL
2023

Michigan Provider Manual
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Table of Contents

A. Using the Meridian Provider Manual

The Meridian Provider Manual is designed specifically for Meridian Medicaid providers. This manual will assist providers in understanding the specific policies, procedures, and protocols of the health maintenance organization (HMO) contracted with the State to deliver and manage health care for members.

How to Use this Manual

This Manual is designed to be a user-friendly informational tool. Meridian information is divided into sections, including a master Table of Contents and a separate Table of Contents for each section.

To access information quickly, please follow these steps:

- Locate the section or topic in the master Table of Contents
- Identify the Section Number
- Tab to the appropriate section's Table of Contents
- Find the page number in that section that is associated with the topic of interest

You may also access a copy of the Provider Manual on the Meridian website at **mimeridian.com**.

Updates and Revisions

The Provider Manual is a dynamic tool and will continue to evolve with Meridian's expansions and changes. Minor updates and revisions will be communicated to primary care providers (PCPs) via *Provider Bulletins*. Information delivered in *Provider Bulletins* replaces the information found in the body of the existing 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, replacing older versions of the Manual. The most current version of the Manual is always available on the Meridian website at: **mimeridian.com**.

B. Meridian Medicaid HMO Definition

Meridian is a health maintenance organization (HMO) contracted with the Michigan Department of Health and Human Services (MDHHS) to provide medical services to Medicaid members who are enrolled with Meridian.

Meridian is a health plan that provides, arranges for, and manages all Medicaid-covered services as defined by the Comprehensive Healthcare Program for Medicaid-eligible people.

C. Corporate Telephone Directory

The following table shows Meridian's key corporate contacts and their functions.

Contact and Service Function	Telephone Number
Utilization Management (UM) • Process authorization requests • 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 • Discuss Meridian's UM decisions with provider reviewer(s)	888-437-0606
Customer Service/Member Services • Primary Care Provider (PCP) changes • Verify member eligibility • Obtain member benefits • Obtain general information and assistance • Determine authorization request status • Record member personal data change • Obtain member benefit interpretation • File complaints and grievances • Verify/record newborn coverage • Third Party Liability questions • Dental Services	888-437-0606
Provider Services • Discuss recurring problems and concerns • Provider education assistance • Primary care administration • Update provider demographic information • Contact your direct Provider Representative	888-773-2647
Quality Improvement (QI) • Requests and questions about Clinical Practice Guidelines • Requests and questions about Preventive Healthcare Guidelines • Questions about QI initiatives • Questions about QI regulatory requirements	888-437-0606
Mental Health Outpatient Services • Member may contact Meridian directly for information regarding behavioral health services • No prior authorization is required • Meridian supports the coordination of care and sharing of treatment information between the PCP and the behavioral health provider	888-437-0606
Pharmacy Benefit Manager • Prior Authorizations	866-984-6462
Non-Emergent Transportation • **Coordinate Non-Emergent Transportation**	800-821-9369

D. Provider Roles and Responsibilities

This section describes the expectations for PCPs, specialists, hospitals, and ancillary providers who are contracted with Meridian.

PCP Roles and Responsibilities

Each Meridian Medicaid-eligible member selects a PCP who is responsible for coordinating the member's total health care. If the member does not select a PCP, one is assigned to him or her through the auto-assignment process. PCPs are required to work 20 hours per week per location. They must also be available 24 hours a day, 7 days a week. Please refer to *Section 8: Provider Functions and Responsibilities* for further details.

All covered health services are either delivered by the PCP or are referred/approved by the PCP and/or Meridian, except for required direct access benefits or self-referral services. There are certain services that also require prior authorization from Meridian. Please reference *Section 4: Utilization Management* for further details.

Specialty Care Provider Roles and Responsibilities

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

- Rendering services requested by the PCP
- Communicating with the PCP regarding medical findings in writing
- Obtaining prior authorization before rendering any services not specified on the original authorization
- Confirming member eligibility and benefit level prior to rendering services
- Providing a consultation report to the PCP within 60 days of the consult
- Providing the lab or radiology provider with:
    - The PCP and/or prior authorization number (when necessary)
    - The member's Medicaid ID number

Specialists may also contact Meridian to verify and request prior authorization for services. Please reference *Section 4: Utilization Management and Disease Management* for further details.

Hospital Roles and Responsibilities

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

- Coordination of discharge planning with Meridian Utilization Management staff
- Coordination of mental health/substance abuse care with the PCP, the health plan and the appropriate county agency or provider
- Obtaining the required prior authorization before rendering services
- Communication of all pertinent patient information to both Meridian and the member's PCP
- Communication of all emergent hospital admissions to the Meridian Utilization Management staff within one business day of admission

Ancillary/Organizational Provider Roles and Responsibilities

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

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

A. Meridian Member Services Department

The Meridian Member Services department exists for the benefit of our members and providers by responding to all questions about Meridian benefits, policies, and procedures.

Member Services Department
Toll-Free: 888-437-0606

Meridian phone lines are open Monday-Friday from 8 a.m. to 6:30 p.m. for the following types of issues: Eligibility for benefits, member requests for PCP changes, complaints or grievances, status authorization requests, nurse advice lines, hospital discharges, non-emergent medical transportation.

- Eligibility for benefits
- Non-emergent medical transportation
- Member requests for PCP or site changes
- Complaints or grievances
- Status authorization requests
- Nurse advice lines
- Hospital discharges

We have 24/7 availability to status claims and eligibility information through our IVR and provider portal.

B. Member Rights and Responsibilities

Meridian prides itself on the care and customer service it provides to its members. As a contracted Meridian provider, please familiarize yourself and your staff with the following member rights in order to provide the best possible care. Meridian and contracted providers must comply with all requirements concerning member rights. If there are any questions, please call Meridian Member Services at 888-437-0606.

Members Have the Right To:

- Receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities
- Be treated with respect and recognition of their dignity and right to privacy
- Participate with practitioners in making decisions about their health care
- A candid discussion of appropriate or medically necessary treatment options for their medical conditions, regardless of cost or benefit coverage
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the member rights and responsibilities policies

Members Have the Responsibility To:

- Supply information, to the extent possible, that the organization and its practitioners and providers need in order to provide care
- Follow plans and instructions for care that they have agreed on with their practitioners

- Understand their health problems and participate in developing mutually agreed upon treatment goals to the best degree possible
- Contribute toward their own health, including appropriate behavior

C. Member Identification

When a member joins Meridian, he or she will receive a member ID card sent by first class mail within ten business days. A separate card will be provided for each member of the family. The Meridian ID Card will include the following:

- Member Name
- Medicaid ID Number
- Member Services Phone Number
- Other Special Instructions

Members must bring their Meridian ID card with them every time they need to access medical services within the Meridian provider network. Members are not to share cards with anyone else. If there are any questions, please call Member Services at **888-437-0606**.

Lost ID Cards

If a Meridian ID card is lost, Meridian can send the member a new one. Ask the member to call Member Services at **888-437-0606**. A replacement card will be sent directly to the member within seven to 10 business days.

D. Eligibility Verification

Member eligibility changes frequently, so it is important to verify eligibility prior to rendering services to a member.

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

1. Request that the member present his/her Meridian ID card at each encounter
2. Request that the member present his/her green plastic MiHealth ID card, which is generated at the time of enrollment in the Medicaid program
3. Review your PCP monthly eligibility report
4. Verify online utilizing the Meridian Provider Portal each time the member appears at the office for care or referrals
5. Call Member Services at **888-437-0606** for assistance with eligibility determinations

If you find any discrepancies between a member's Medicaid ID card and/or your monthly eligibility report, please contact Member Services at **888-437-0606** for further assistance. You can also log into CHAMPS and verify a member's eligibility by visiting **https://milogintp.michigan.gov**.

E. PCP Identification

Call the Meridian Member Services department at **888-437-0606** or utilize the Meridian Provider Portal to identify a member's PCP location if the member is not listed on your monthly eligibility report.

To comply with Health Insurance Portability and Accountability Act (HIPAA) regulations, you must have the member's Medicaid ID number, full name and date of birth to obtain any member information.

F. How to Change a Member's PCP

The member must call the Meridian Member Services department at **888-437-0606** to request a PCP change. In most cases, the requested PCP change will take effect immediately. Meridian also has a PCP change form that is available for our providers. If you are interested in obtaining this form, please contact your local Provider Representative. If you do not know who your Provider Representative is, please visit Meridian's website to obtain this information at **mimeridian.com.**

G. Member Enrollment and Disenrollment

Enrollment in Medicaid health plans is coordinated by Michigan ENROLLS. Michigan ENROLLS is contracted with the State of Michigan to enroll clients into Medicaid health plans, offer provider participation information, and assist members with changing health plans. At the time of enrollment, the member is required to select a primary care provider (PCP) from Meridian's PCP network. At any time after the initial PCP assignment, the member may call Meridian to select a different PCP of his or her choice. The new member will be identified on their selected PCP's next monthly eligibility report and on each report thereafter as long as the member is still eligible for Medicaid services.

At times, members may temporarily lose eligibility. If they lose eligibility and regain eligibility within a two-month period of time, they will be re-assigned to Meridian and the prior PCP site unless they request otherwise. If the member wishes to disenroll from Meridian, he or she should contact Meridian Member Services at **888-437-0606** for more information.

H. New Meridian Member Information

The list below identifies some of the important information shared with new members when they join Meridian:

- Members may select a Meridian in-network primary care provider (PCP) of their choice for each eligible family member. Members may change their PCP by calling the Member Services department at **888-437-0606** and requesting a PCP change
- Members should contact their PCP to provide or arrange for all medical care. Members cannot go to specialists without a referral from their PCP, with the exception of self-referrals. If a member goes to another provider without an appropriate referral and prior authorization from the PCP, Meridian may not pay for services rendered
- If a member has been seeing a PCP that does not contract with Meridian, he or she will not be able to continue to see this provider unless the provider elects to join the Meridian provider network
- If an out-of-network provider is treating a member for a serious health condition or pregnancy, the member must contact the Member Services department immediately. Meridian will work with the member to assure that the member's health care is not disrupted while transferring to an in-network provider. Meridian will review the medical records for continuity of care to determine a specific time frame for approval of out-of-network care and the transfer to an in-network provider
- Members who have certain identified chronic illnesses may select a specialty provider from the Meridian network to act as their PCP
- If the member's Medicaid eligibility terminates, so does his or her Meridian coverage

Additional details surrounding Meridian coverage are described in the Meridian Member Handbook, which is mailed to each new member. Members are invited to call the Member Services department with any questions at **888-437-0606**.

I. Durable Power of Attorney

Michigan Notice to Patients

Required by the Patient Self-Determination Act: The State of Michigan has authorized the use of the Medical Durable Power of Attorney for health care. This allows you to choose another person to make decisions about your care, custody and medical treatment if you cannot make these decisions for yourself. This way, your desire to accept or refuse medical treatment is honored when you cannot participate in your medical treatment decisions.

J. Notice of Privacy Practices

Pursuant to regulations under the Health Insurance Portability and Accountability Act (HIPAA), all providers must provide adequate notice of the provider's privacy practices. Providers should have such notice available at their office upon request by any member and should post the notice in a clear and prominent location. The following *Notice of Privacy Practices* may be used for this purpose and is compliant with the *Health Insurance Portability and Accountability Act (HIPAA)* regulations. For specific requirements, see 45 C.F.R. 164.520.

Meridian
Notice of Privacy Practices (Combined Gramm Leach Bliley & HIPAA Notice)

Effective 5/5/2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
***PLEASE REVIEW IT CAREFULLY*.**

Covered Entity's Duties:

Meridian is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Meridian is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect, and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Meridian reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Meridian will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website or through a separate mailing.

Internal Protections of Oral, Written and Electronic PHI:

Meridian protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

Treatment - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.

Payment - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, and reviewing services for medical necessity.

Health Care Operations **-** We may use and disclose your PHI to perform our healthcare operations. These activities may include providing customer service, responding to complaints and appeals, and providing care management and care coordination.

In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals
- Care management and care coordination

- Detecting or preventing healthcare fraud and abuse

Group Health Plan/Plan Sponsor Disclosures - We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Underwriting Purposes*** – We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.

- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.

- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime

- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- ***Organ, Eye and Tissue Donation*** – We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of cadaveric organs, eyes, and tissues.

- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security concerns, intelligence activities, The Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.

- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization:

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

- ***Sale of PHI*** – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- ***Marketing*** – We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

- ***Psychotherapy Notes*** – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

Individuals Rights:

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

Right to Request Restrictions - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restrictions apply. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

Right to Request Confidential Communications - You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.

Right to Access and Receive a Copy of your PHI - You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.

Right to Amend your PHI - You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive an Accounting of Disclosures - You have the right to receive a list of instances within the last 6-year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

Right to File a Complaint - If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

200 Independence Avenue, S.W.,
Washington, D.C. 20201

or calling **1-800-368-1019**, (TTY: **1-800-537-7697**or visiting **ww.hhs.gov/ocr/privacy/hipaa/complaints**/.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

Right to Receive a Copy of this Notice - You may request a copy of our Notice at any time by using the contact information listed at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Questions about this Notice: If you have any questions about this notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone by using the contact information listed below.

Meridian
Attn: Privacy Official
777 Woodward Ave., Suite 700
Detroit, MI 48226
888-437-0606
(TTY: 711)

K. Member Satisfaction

Meridian and its network providers are committed to providing and maintaining a consistently high level of member satisfaction. All primary care providers (PCP) and their office staff are expected to maintain a friendly and professional image and office environment for members, other providers and the general public. The survey asks members to rate their provider on how well they communicate and other items specific to the providers. It is important for PCPs and office staff to know of patient attitudes and improve the patient's experience with the PCP and office staff. If you need additional support in identifying areas for improvement, reach out to your Provider Representative. PCPs must maintain adequate levels of staff to provide for timely and effective services for Meridian members. Member Services functions are a requirement of the PCP initial orientation and ongoing network provider education.

Meridian conducts annual surveys to determine current levels of member satisfaction with the health plan, providers and specialists to identify areas of potential plan improvement. PCPs and their office staff are expected to cooperate and assist Meridian with obtaining data for these surveys. PCPs will be notified in advance of their required participation and the timeframes in which the annual surveys will be conducted.

L. Member Grievances and Appeals

Meridian monitors member grievances and appeals as another indicator of member satisfaction. The following is a summary of the grievance and appeal processes as written for Meridian members.

Member Grievance

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

- A member cannot get an appointment with his/her provider in a timely manner
- A member cannot get a referral from his/her provider in a timely manner
- A member has been denied any of his/her rights as a Meridian member
- Quality of care of services provided

If a member has a grievance or concern with their healthcare provider or Meridian, we want them to tell us about it. They may call Member Services at **888-437-0606** to file a grievance.

Meridian is required to respond to a Grievance in writing no later than 90 days from the filing date. Meridian will reach out directly to the provider/hospital system in attempt to obtain a response during an investigation within seven days. If the Grievance is clinically urgent, Meridian would expect a response from the provider/hospital system as soon as possible, or no later than 24 hours.

Meridian offers an Informal Grievance process to resolve member complaints while they are at a provider's office or when they call on the phone. In most cases, Meridian will work with them to resolve the issue in just one phone call.

If members are not happy with the outcome, they can file a Formal Grievance. Members must include a phone number where we can call them for more information.
The address to file a Formal Grievance is:

Meridian Michigan
Appeals Department
P.O. Box 10353
Van Nuys, CA 90410-0353

Meridian will notify the member and/or the authorized representative by sending a letter within five business days of receiving the grievance. A Grievance will be resolved within 90 calendar days. Meridian will send a response in writing to the member and/or the authorized representative.

Member Appeals

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

- An appeal of a denied service based upon medical necessity
- An appeal of a denied payment (in whole or part) for a service
- An appeal of a denied service, such as physical therapy, that was previously authorized

Non-Urgent Pre-Service Appeal

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

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

Members can appeal by writing to the Meridian Appeals Coordinator or by calling Member Services toll free at **888-437-0606**. If members write to us, they must include a phone number where they can be reached so we can let them know that their appeal has been received.

The address to file an appeal is:

Meridian Michigan
Appeals Department
P.O. Box 10353
Van Nuys, CA 90410-0353

Within three days of receiving the appeal, Meridian will notify the member of all the information that is needed to process the appeal. We will make a decision about within 30 days of receiving the member's repeal request. Members and their PCP, as well as any other provider involved in the appeal, will be notified of the outcome of the appeal in writing

A provider with the same or like specialty as the treating provider will review the appeal. It will not be the same provider as the one who made the original decision to deny, reduce, or stop the medical service.

Expedited Appeals

A member or their provider may call Member Services at **888-437-0606** to file an expedited appeal if they think that their situation is clinically urgent and reviewing the appeal in the standard timeframe could:

- Seriously jeopardize the life or health of the member or the member's ability to regain maximum function based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the member's medical condition
- Would subject the member to severe pain that cannot be adequately managed without the care or treatment

The member will need confirmation from their provider that the appeal is urgent. Within 24 hours of receiving the appeal, Meridian will notify the member of all the additional information that is needed to

process the appeal. We will make a decision about the appeal within 72 hours of receiving the expedited appeal request.

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

External Review of an Appeal (Expedited)

Members have the right to request a determination by the Insurance Director or his/her designee, or by an independent review organization under the Patient's Right to Independent Review Act.
An expedited external appeal may be submitted by the member and/or the member's authorized representative within 10 days after the member receives an adverse determination from the health plan only if the following are met:

- A provider must substantiate, either orally or in writing, that the standard time frame for review of the grievance/appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function; and
- The member has already filed a request for an expedited internal appeal with the health plan.

The request for external review should be submitted to the Director at the following address:

DIFS
Health Plans Division – Appeals Section
PO Box 30220
Lansing, MI 48909-7720
Phone: 877-999-6442
Fax: (517) 284-8838

External Review of an Appeal (Non-Expedited)

Members have the right to request a determination by the Director or his/her designee, or by an independent review organization under the Patient's Right to Independent Review Act. Enrollees must first exhaust the internal appeal process through the health plan before filing a request for an external review with Department of Insurance and Financial Services (DIFS).

A request for an external review of a grievance/appeal may be submitted by the member and/or the member's authorized representative within 127 days after the enrollee receives an adverse determination or final adverse determination from the health plan.

The request for external review should be submitted to the Director at the following address:

DIFS
Health Plans Division – Appeals Section
PO Box 30220
Lansing, MI 48909-7720
Phone: 877-999-6442
Fax: (517) 284-8838

State Fair Hearing

At any time, within -120 days of receipt of the adverse determination from the health plan, the member may request a Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) at the following address:

Michigan Office of Administrative Hearings and Rules
For the Department of Health and Human Services
PO Box 30763
Lansing, MI 48909-7695
Fax: (517) 763-0146

The member does need to exhaust the health plan's internal appeal process before requesting a Fair Hearing from MDHHS.

M. Interpretive Services and Alternative Formats

Meridian can arrange for an interpreter to speak to a member in most language, free of charge. Alternative formats of member communications are also available to members free of charge. Alternative formats help members with different reading skills, backgrounds, or disabilities understand Meridian materials. A member may call Member Services at **888-437-0606** to inquire about interpretive services or alternative formats.

If a member is hearing or speech impaired, TTY/TDD services are available by calling the Michigan Relay Service at **711**, 24 hours a day, seven days a week. The Michigan Relay Service makes it possible for hearing-impaired and/or speech-impaired persons to call Meridian. Meridian also operates a live chat program from Monday-Friday, 8 a.m. - 5 p.m., where members can interact with a Member Services Representative on our website at **mimeridian.com**.

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

N. New Technology

Meridian wants to ensure our members have access to new technologies and procedures. Meridian investigates all requests for new technology or a new application of existing technology. Information of new technology/procedures is received from medical information, professional groups, Medicare, Food and Drug Administration (FDA) releases, practitioners, members and other sources. This information goes to a Meridian group comprised of providers and Meridian staff. Meridian may also use specialists to review the information. The decision to approve or deny a new technology or procedure as a covered benefit is made after review by these practitioners.

O. Critical Incidents Reporting

Meridian requires participating program providers to report all Critical Incidents that occur in a home and community-based long-term services and supports delivery setting, including assisted-living facilities, community-based residential alternatives, adult day care centers, other HCBS provider sites, and a member's home, if the incident is related to the provision of HCBS. Providers will be provided with Critical Incident education materials and will have access to additional information via Meridian 's website. Providers must participate in trainings offered by Meridian to ensure accurate and timely

reporting all critical incidents. Trainings may be offered at webinars, online learning and regional meetings.

Critical incidents include but are not limited to:

- Unexpected death of a program member
- Any abuse, such as: physical, sexual, mental or emotional
- Theft or financial exploitation of a program member
- Severe injury sustained by a program member
- Medication error involving a program member
- Abuse and neglect and/or suspected abuse and neglect of a program member

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

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

- Providers must contact 911 if the incident can cause immediate/severe harm to the member
- Remove worker from the member's case (if incident includes allegation of improper behavior by that worker)
- Remove accused worker from servicing all Meridian program members until the investigation is complete. This may take up to 30 calendar days
- Order immediate drug screen or appropriate testing if allegation includes theft of drugs or use of substances including alcohol while on the job
- Interview involved employee(s) as soon as possible following the incident. Have the employee(s) submit a written account of events. Fax these written accounts to Meridian along with documentation to support completion of pre-employment screenings including background checks, drug screening, and a statement that the employee did not begin to perform services for Meridian program members until all required pre-employment screenings were completed and verified. Fax numbers can be obtained by calling Meridian

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

Michigan Department of Health & Human Services (MDHHS) website:
www.michigan.gov/mdhhs/0,5885,7-339-73971_7119---,00.html

Providers must notify MDHHS immediately if there is a member death related to alleged abuse, neglect, or exploitation.

Incident Involves	Contact	Timeframe	Special Instructions
Child (under 18), Adults (18 and older), and Adult Protective Services	Statewide 24-Hour Abuse Line **855-444-3911**	Immediately	
Adults, disabled, ages 18 or older with a mental illness or developmental disability	Michigan Protective Advocacy Services **800-288-5923**	Immediately	
Nursing Facility Residents	Bureau of Children and Adult Licensing (BCAL) **866-856-0126**	Immediately	
Criminal Abuse by Foster Home/Nursing Facility	Michigan Department of Consumer and Industry Services **800-882-6006**	Immediately	Must be reported to the Michigan Department of Consumer and Industry Services **800-882-6006**, the Michigan State Police and/or the local police or sheriff's department
Noncriminal Abuse/Neglect by Residential Facility	Michigan Department of Consumer and Industry Services **800-882-6006**	Immediately	Must be reported to facility administration AND to the Michigan Department of Consumer and Industry Services **800-882-6006**
Private Home Abuse, Neglect or Exploitation	Michigan Department of Human Services Statewide 24-Hour Abuse Line **855-444-3911**	Immediately	Must be reported to the Statewide Abuse Hotline (**855-444-3911**), County Protective Services or local law enforcement
Fraud	**855-643-7283**	Immediately	

A. Member Benefits and Services

Meridian has a comprehensive benefit package available to all Meridian members who are eligible for Medicaid. Services for members are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care.

The following is a list of medical services covered by Meridian:

- Access to Federally Qualified Health Centers (FQHC) & Tribal Health Centers (THC)
- Ambulance and other emergency medical transportation
- Lead testing in accordance with medical Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy
- Cardiac rehabilitation
- Certified midwife services
- Certified pediatric and family nurse practitioner services
- Child & Adolescent Health Center (CAHC) Program
- Chiropractic services for members, up to 18 visits in-network without prior authorization
- Dental services for all beneficiaries ages 19 and older, enrolled in Healthy Michigan Plan, as well as enrollees ages 21 and older, enrolled in Medicaid.For questions regarding dental coverage (D codes) please refer to our dental provider, DentaQuest at **855-898-1478**
- Diagnostic lab, x-ray and other imaging services
- Doula Services
- Durable Medical Equipment and supplies, including breast pump coverage
- Emergency services
- End Stage Renal Disease services
- Family Planning services
- Health education
- Hearing & speech services
- Hearing aids (MDHHS has approved reinstatement of hearing aids for members 21 years of age and older)
- Home health services
- Hospice services
- Immunizations
- Hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility) up to 45 days
- Restorative or rehabilitative services (in a place other than a nursing facility)
- Maternal Infant Health Program (MIHP)
- Medically necessary weight reduction services
- Behavioral health outpatient visits
- Out-of-state services authorized by Meridian
- Outreach services (including pregnancy and well-child related, providing preventive health information)
- Parenting and birthing classes
- Pharmacy services

- Preventive services required by the Patient Protection and Affordable Care Act as outlined by MDHHS.
- Podiatry services
- Provider office visits
- Prosthetics & orthotics
- Pulmonary rehabilitation
- School and sports physicals
- Surgeries (with prior authorization)
- Therapies, such as speech/language, physical or occupational therapy
- Tobacco cessation treatment
- Transplant services
- Transportation
- Treatment for sexually transmitted illnesses(STIs)
- Vision services
- Well-child/EPSDT for persons up to the age of 21

If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated or otherwise changed, Meridian will implement the changes consistent with the dates specified by MDHHS.

***Note that Meridian does not charge co-pays to its members for any Medicaid covered services unless the member is enrolled in the Healthy Michigan Plan.**

Meridian will reimburse for a second opinion from a qualified health professional within the provider network or arrange for the member to obtain a second opinion outside the network. Medical Management may be contacted to assist in the coordination of second opinions.

B. Non-Covered Meridian/Medicaid Services

The following are services prohibited or excluded under Medicaid:

- Elective abortions and related services
- Experimental or investigational drugs, procedures or equipment
- Elective cosmetic surgery
- Services for treatment of infertility and medication for erectile dysfunction

C. Medicaid Services Covered Outside Meridian Medicaid Benefit

- Services, including therapies (Speech, Language, Physical, Occupational) provided to persons with developmental disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School District
- Behavioral Health Services Coordinated and provided by Community Mental Health Service Program (CHMSP). These services include:
    - Inpatient Psychiatric Services
    - Partial Hospitalization
    - Substance Abuse Services
    - Electro Convulsive Treatment (ECT)
    - Intensive Outpatient and Community Based Programs

- Custodial care in a nursing facility
- Home and Community based waiver program services
- Personal care or home help services
- Transportation for services not covered in the CHCP Services
- Traumatic brain injury program services
- Any service that is not medically necessary
- Any service that is not approved by the PCP, excluding emergencies, well-woman care, maternity care, behavioral health treatment, services at local health departments, immunizations, family planning, FQHC visits, pediatrician visits, and vision services

Meridian providers are required to assist with and provide members with referrals for the above Medicaid covered services. Providers of the above Medicaid services will bill MDHHS directly for payment of their services under their State specific contracts.

Meridian providers should contact Member Services at 888-437-0606 for assistance with making the above referrals for members.

D. Pharmacy Benefit Management

Meridian utilizes a Pharmacy Benefit Manager (PBM) to manage member pharmacy benefits. The PBM provides Meridian with a pharmacy network, pharmacy claims management services, drug formulary and pharmacy claims adjudication. Prior to authorizing any drug benefit, each member's eligibility is determined.

The Pharmacy department provides provider support at **866-984-6462**. Meridian providers may also speak with a clinical pharmacist regarding any pharmaceutical, medication administration or prescribing issues.

Each PCP will receive a copy of the Meridian Pharmacy Drug Formulary. The drug formulary is available on our website at **mimeridian.com** and the Prescriber Portal. This drug formulary should be accessible and be referred to when prescribing medications for Meridian members. Medicaid members have both prescription and specific over-the-counter medication coverage.

The Meridian formulary is designed to cover the vast majority of therapeutic conditions; however, in the event a particular medication is required for a member, a medical necessity exceptions request is available through prior authorization (PA). Additionally, there are specialized medications on the drug formulary identified as requiring a PA.

Although we ask that you prescribe within the formulary, we are aware that certain situations arise when a formulary alternative may not exist. Drugs requiring Prior Authorization are identified in the formulary with a PA designation. Meridian requires that you follow the Prior Authorization procedures detailed below for obtaining medically necessary non-formulary/non-covered drug products.

1. In order to receive a non-formulary/non-covered medication, the prescriber must submit a prior authorization request at covermymeds.com.
2. The PBM may request that the prescriber submit additional clinical information by fax in order to process the request.
3. If the request is approved, the PBM will notify the provider via fax and enter the necessary authorization into the claims processing system for dispensing at a participating pharmacy network provider

4. The prescriber may contact the PBM by telephone at **866-984-6462** with any questions or concerns.

E. Member Self-Referrals

Family Planning

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

Treatment for infertility is not included under the family planning benefit.

All Meridian members have full freedom of choice of family planning providers, both in and out of the Meridian network. The PCP should work with the member in providing for family planning services or assisting them in selecting a provider, as requested.

Members may also contact Member Services at **888-437-0606** for additional assistance with family planning referrals or family planning information.

Women's Health

Members 16 years and older may self-refer to the network OB/GYN of her choice for routine annual exams and female preventive screens (Pap smear, chlamydia and mammogram). She may also refer to the in-network OB/GYN of her choice for prenatal/perinatal care.

Children's Health

Members 18 years and younger may seek treatment from the (in-network) pediatrician of his/her choice without prior authorization if the dependent minor is assigned to a PCP who is not a pediatrician.

F. Federally Qualified Health Centers (FQHC)

FQHCs are important community providers and all Meridian members have access to them if the member resides in a community where FQHC services are available. The Member Handbook outlines the member's rights to access a FQHC in their service area if they so desire.

For additional information and assistance in accessing a FQHC, members should be advised to contact Member Services at **888-437-0606**.

G. Non-Emergency Transportation

Meridian will assure that non-emergency transportation and travel expenses determined to be required for members to secure medically necessary medical examinations and treatment are readily available and accessible.

This non-emergent transportation is available for all medical and health services deemed medically necessary by the member's primary care provider, including End Stage Renal Disease services (hemodialysis), prenatal care, preventive services, mental health services, obtaining prescription medicine and DME supplies.

Meridian has contracted with a transportation agency that has a network capable of providing non-emergent transportation to the entire Meridian member geographic coverage area. Information on how and when members can access non-emergent transportation is available in the Member Handbook or by calling Member Services at **888-437-0606**.

Transportation Procedure

To arrange for these services, the member, PCP, or a Meridian representative should call for non-emergent transportation at **800-821-9369**. For out of state travel for members, please reach out to MTM at **1-844-299-6325** or Member Services at **888-437-0606**.

The Non-Emergent Transportation Vendor will transport the following individuals:

- Members: All Meridian members for all covered outpatient services
- Parents and Guardians: Parents or legal guardians of minor or incompetent members when they accompany the member to their appointment
- Others: Transportation of other family members, such as siblings, to the appointment may be allowed

Transportation will be to and from participating providers, or if explicitly directed by Meridian, to and from non-participating providers.

Appointment Scheduling Criteria/Process

Scheduling of transportation services requires a three (3) day notice to assure service. The transportation provider uses confidential eligibility information provided by Meridian to verify member eligibility. Members will be assigned to the most appropriate and cost-effective means of transportation in the network web. Routine appointments can be scheduled 8 a.m. to 6 p.m. seven days a week. Members who need transportation for next day appointments should contact the Member Services department at **888-437-0606** as soon as possible for scheduling assistance.

Member complaints and grievances regarding non-emergent transportation issues will be handled through the Meridian Complaints and Grievances Policy and Procedure as described under Section 2 Subsection L.

Non-emergent transportation service abuse will be reported to Meridian by the non-emergent transportation vendor and investigated by Meridian. Meridian reserves the right to withhold non-emergent transportation services from members found to be abusing the service.

Examples of abuse of the service include securing transportation for reasons outside of medical necessity and abusive behavior towards the transportation provider.

Members who must access non-emergent travel expenses outside of the Meridian geographical area for medically necessary care, and incur costs for such services, may contact Meridian Member Services at

888-437-0606 for assistance. Meridian will review the appropriateness of the request prior to the service being scheduled.

Reimbursement for reasonable and customary non-emergent transportation costs will be considered and made on an individual basis.

H. Advance Directives

Advance Directives are legal documents that allow members to convey their decisions about end of life care ahead of time. They provide a way for members to communicate their wishes to family, friends and healthcare professionals. This helps avoid confusion if a member becomes so sick that they are unable to express their wishes. There are two types of advance directives.

Living Will - A living will tells how a person feels about care intended to sustain life. They can accept or refuse medical care. There are many issues to address, including:

- The use of dialysis and breathing machines
- Tube feeding
- Organ or tissue donation
- If the person wants the providers to try to save them if breathing or heartbeat stops

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

Members must be sure to tell the PCP and Meridian if they have an Advance Directive. The PCP will keep a copy in the member's medical record. Members should also keep a copy at home in a safe place. If there are any questions about Advance Directives or a member needs help finding an Advance Directive form, please call Member Services at **888-437-0606**.

The objective of Meridian's Utilization Management program is to ensure that the medical services provided to members are medically necessary and/or appropriate, and are 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.

Access to the Utilization Management Staff

For Utilization Management inquiries, you may call during normal business hours Monday-Friday, 8 a.m. to 6:30 p.m. at 888-437-0606. The provider portal is available 24/7 to status authorization requests and submit new requests

UM Decisions

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

Utilization Management staff refer to plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by Meridian's medical directors. These guidelines include McKesson InterQual® criteria, Meridian Medical Review Criteria (developed by Meridian medical directors in conjunction with community providers), and applicable federal and state benefit guidelines.

Meridian's Medical Necessity Guidelines are based on current literature review, consultation with practicing providers and medical experts in their particular field, government agency policies, and standards adopted by national accreditation organizations. 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.

Copies of the criteria utilized in decision-making are available free of charge upon request by calling the Utilization Management department at **866-606-3700**. In certain circumstances, an external review of service requests is conducted by qualified, licensed providers with the appropriate clinical expertise. Utilization management decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the member's eligibility and benefits at the time the services are rendered.

Previously approved prior authorizations can be updated for changes in dates of service, CPT/HCPCS codes, or physician within 30 days of the original date of service prior to claim denial.

Classifying Your Prior Authorization Request:

Standard Organization Determination (Non-urgent Preservice Request): Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than 14 calendar days after Meridian receives the request for service.

Expedited Organization Determination (Urgent/Expedited Preservice Request): Expedited organization determinations are service requests are made when the member or the provider believes that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The service request will be made as expeditiously as the Member's health condition requires, but no later than 72 hours after Meridian receives the request for services.

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

Inpatient Review:

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

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

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

Providers must notify Meridian Health within one business day of admission.

Prior Approval Requirements/ Precertification:

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

1. **Online Submission-** The Meridian Online PA Form can be accessed by visiting the secure Provider Portal
2. **Fax Submission**- Refer to Utilization Management's referral type fax numbers. Please include pertinent clinical documentation with the request if indicated

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

- Member's name and date of birth
- Member's identification number
- Requesting Provider & NPI Number
- Servicing Provider & NPI Number
- Servicing Facility & NPI Number
- Place of Service
- Date(s) of service
- Procedure Code(s)
- ICD-10 Diagnosis Code(s)

Clinical Information

Clinical information should be provided at time of submission of the request. The provider or facility is responsible for ensuring services are authorized prior to service delivery authorization. Meridian provides a reference number on all authorizations. To ensure a timely decision, make sure all supporting clinical information is included with the initial request:

Clinical information includes relevant and current information regarding the members':

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

Services Requiring Prior Authorization

The list below provides Meridian's general Prior Authorization requirements. This list is not all inclusive and is subject to change. Providers will be given 60-day advance notice to additions to the Prior Authorization list. Please verify requirements at the time of the request.

Meridian Utilization Management verifies benefit eligibility and medical necessity for select services at the time of the request and is not a guarantee of coverage or payment. Payment is determined by the member's eligibility and benefits at the time of service.

Claims payment is also based on the appropriateness, accuracy, and presence of codes submitted on the claim as determined by Centers for Medicare and Medicaid Services (CMS) and the Michigan Medicaid Provider Manual (**www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html**)

You can check the requirements for any code on our website here: https://www.mimeridian.com/providers/preauth-check.html. Codes that are not listed on the applicable Medicaid fee schedule may not be payable by Meridian.

Inpatient

- All inpatient admissions (Emergent and Elective)
- Long-Term Acute Care (LTACH) admissions
- Acute Rehabilitation admissions
- Skilled nursing facilities (SNF) admissions

Durable Medical Equipment (DME)

This list is not all inclusive and is subject to change.

- DME items are covered according to MDHHS Medicaid Fee Schedule and applicable prior authorization requirements
- Insulin pumps for DM type 1

- Hearing aids

Certain Outpatient Services/Treatments/Procedures

- Chiropractic Services
- Nutritional Counseling
- Hyperbaric oxygen therapy
- Genetic Testing
- Home Health/Skilled Nursing Visits
- Back Surgeries
- Ambulance Transportation Non-Emergent
- Dental Anesthesia in Facility >6 years of age
- Hysterectomy
- Spinal Surgeries
- Varicose Vein Surgery
- Breast Reduction
- Septoplasty
- Rhinoplasty
- Experimental and Investigational procedures

A. Mental Health Outpatient Visits

You may contact our behavioral health staff at **888-437-0606** to assist with the following services:

- Locating a behavioral health provider
- Scheduling behavioral health appointments
- Locating community groups and self-help groups

B. Specialty Network Access to Care

Specialist referrals to the Hurley Hospital and Michigan State University may be utilized when an in-network specialist is not available, or to seek another opinion subsequent to consultation/treatment with an in-network specialist.

As a PCP, you may request a referral to one of the health care public entities via Meridian's Provider Portal at **provider.mimeridian.com,** fax or by calling Meridian at **888-437-0606**. Meridian's staff will forward the information and authorization to central referral office of the public entities. Meridian will fax you a copy of the approved referral notification form along with contact information to the public entity.

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

- Emergency services
- Post stabilization services
- Women's Health
- Family Planning & Obstetrical Services
- Child & Adolescent Health Center Services
- Local Health Department (LHD) services

- Long Acting Reversible Contraception (LARCs)
- School Dental Services
- Other services based on state requirements

You may access the most recent Authorization Requirements on the Online Prior Authorization form under the Prior Authorization Requirements link.

Perinatal Care Coordination – Start Smart For Your Baby
The Start Smart for Your Baby program promotes education and care management techniques designed to reduce the risk of pregnancy complications, premature delivery, and infant disease, which may result from high-risk pregnancies. The program offers support for pregnant members and their babies by providing educational materials as well as incentives for going to prenatal, postpartum, and well-child visits. An experienced nurse will provide care management for newborns being discharged from the NICU unit and will follow them through the first year of life.

Providers must notify Meridian of all known pregnancies and should do so using the provider Notification of Pregnancy (NOP) form. Early identification of pregnant members and their risk factors is key to better health outcomes. If providers are unable to complete the provider NOP form, they should encourage all pregnant members to complete the member NOP form by calling Meridian at **1-888-437-0606**.
The provider can submit the NOP form via the provider portal or via fax:

- The provider NOP form can be found on the Provider Portal on **provider.mimeridian.com**.
    - The assessment name is "SSFB WEB ONLY Provider NOP V2."
- The form is also available under “Manuals, Forms, and Resources” on **mimeridian.com**.
    - The completed form can be faxed to **1-833-341-2052**
- Process Following the Notification of Pregnancy
- NOP forms are combined with claims data to calculate a risk score.
    - Each risk score will have an associated reason for the assigned risk level.
    - A primary care manager will be determined based on the member’s risk factors.
- Meridian’s Medical Management team will prioritize members for outreach via phone, home visits, and member mailings.

C. Denials, Reconsideration and Peer to Peer

Only a Meridian Medical Director can deny a request based on medical necessity. Once a request has been denied, Meridian contacts the requesting provider telephonically to inform them of the denial decision.

A written denial notification is faxed to the requesting provider and mailed to the member. The denial notification includes the following:

- Reason(s) for denial
- Reference to the benefit provision and/or clinical guideline on which the decision was based
- Instructions on how to request a free copy of the benefit provision and/or clinical guideline
- Instructions on how to request a peer-to-peer discussion
- A description of the appeal rights
- Instructions on how to request an appeal

Peer-to-Peer Discussion

Requesting providers have the opportunity to discuss a medical necessity denial with a Meridian Medical Director. Benefit and/or administrative determinations are excluded. The peer-to-peer request must be made within 10 days of the written denial notification. The requesting provider and the plan Medical Director will discuss the utilization review process, reason(s) for denial and criteria used in decision-making process. Following the peer-to-peer discussion, the provider will be notified verbally of the determination. If the decision is to uphold the initial denial, the provider may appeal the decision by following the appeal process outlined within the initial written denial notification. To schedule a peer-to-peer, please contact Meridian at**888-322-8844 x26155**.

D. Post-Service Provider Appeal

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

What Types of Issues Can Providers Appeal?

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

- **Post-Service Provider Appeal**: An appeal of services that were denied or reduced because they did not meet a specific criteria, policy or guideline and have a denied authorization on file. For example, the provider disagrees with a determination made by Meridian, such as combining two stays as a 15-day readmission. In this case, the provider should send additional information (such as medical records) that support the provider's position.
- **Administrative Appeal**: An appeal by a provider of a claim/service denied for failure to authorize services according to timeframe 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 a member being ineligible on the date of service or due to non-covered benefits.

How to File a Post-Service Provider Appeal

Providers may submit a post-service appeal one of two ways:

1. Login to the Provider Portal to submit an appeal. This is the preferred method for a quicker turnaround time.
2. Via mail by filling out this form and sending documentation to support your position, such as medical records to the following address:

Meridian
Attn: Appeals Department
PO Box 8080
Farmington, MO 63640-8080

Time Frame for Filing a Post-Service Provider Appeal

Provider Appeals must be submitted within 120 days from the EOP, provided the initial claim was submitted within 365 days of the date service, or unless otherwise specified within the provider contract.

Response to Post-Service Provider Appeals

Meridian typically responds to a Post-Service Provider Appeal within 30 calendar days from the date of receipt. Providers will receive a letter with Meridian's decision and rationale.

There is only one level of appeal available for Post-Service Provider Appeal reviews. All appeal determinations are final.

If a provider disagrees with Meridian's determination regarding an appeal the provider may pursue one of the following options depending on contract status:

Contracted Hospitals:

- Joint Operations Medical Sub-Committee (MM JOC): Providers may discuss specific circumstances related to Post-Service appeal requests. These meetings will be scheduled prospectively on a quarterly basis. The schedule of MM JOCs will be made available upon request. These should be scheduled through Meridian's Network Development upon request to the provider's respective Provider Representative. The Provider Representative will work with the Management team and Administrative Assistant for scheduling purposes. A case must be submitted at least two weeks prior to the MM JOC to be reviewed at the scheduled meeting. If it is submitted less than two weeks before a scheduled meeting it will be included in the next scheduled quarterly MM JOC meeting.
- Binding Arbitration: A provider may initiate arbitration by making a written demand for arbitration to Meridian. The Provider and Meridian agree to mutually select an arbitrator and the process for resolution.

Non-Contracted Hospitals:

- Non- Contracted Hospitals may utilize the dispute procedures outlined in the Hospital Access Agreement between signatory hospitals and MDHHS, provided the hospital is a signatory to that agreement. The dispute must first be submitted to an Accounts Receivable Reconciliation Group (ARRG) in accordance with the terms of the MDHHS Hospital Access Agreement included in MSA 01-28.

Provider must submit its request for Binding Arbitration or to use the procedures of the Access Agreement no later than 365 days from the date of service, or within 120 days of the last claim denial provided the initial claim was submitted within one year of the date of service. Providers will have no further recourse on any claim if they do not file their request for either of the above dispute resolution mechanisms within these timeframes.

E. Rapid Dispute Resolution Process

1. Hospitals and Health Plans agree to exhaust their efforts to achieve reconciliation solutions for outstanding accounts via internal means on a regular basis before pursuing the RAPID DISPUTE RESOLUTION PROCESS (RDRP) including the use of an Accounts Receivable Reconciliation Group (ARRG).
2. Where a disputed claim remains, either the Hospital or the Health Plan may submit a request to MDHHS for RDRP. Upon receipt of a request, MDHHS will contact the other party to obtain that party's agreement to pursue resolution of the disputed claim in this manner.

3. MDHHS will contact a mediator, selecting one at random from the list of available mediators that it has prepared. The Mediator will schedule the mediation session within fifteen (15) calendar days of contact by MDHHS. The Mediator will issue his/her decision within fifteen (15) calendar days of the mediation session.
4. Hospitals and Health Plan agree that, should this process be elected/agreed to by both parties, the outcome, including any monetary award will be binding. The party found to be liable will be assessed the cost of the arbitrator. If both parties area at fault, the cost of the arbitration will be apportioned.

If the Hospital's position is granted, the Health Plan agrees to make payment for the disputed claim within 30 days. If the Health Plan fails to make payment within the required timeframe, MDHHS will enforce the decision through a withhold of the disputed amount from the Health Plan's Capitation payment and direct payment to Hospital.

F. Mental Health Outpatient Visits

Meridian covers mental health outpatient services. You may contact our Behavioral Health staff at **888-222-8041** to assist with the following services:

- Locating a behavioral health provider
- Scheduling behavioral health appointments
- Locating community groups and self-help groups

G. Model of Care Overview

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

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

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

H. Care Coordination

The Meridian Care Coordination program provides patient-focused, individualized case management for those members with active disease processes, those who require extensive utilization of resources and

those at high risk for health complications. The following care coordination programs are available to personally support the healthcare needs of your members: asthma, diabetes, congestive heart failure, cardiovascular disease, complex/catastrophic illness, maternity, children with special needs and high emergency room use.

Our Care Coordinators will send you a report identifying the member's health status and identifying short-and-long term goals for care coordination.

Other reasons our Care Coordinators may contact you include:

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

You may refer a member for care coordination via the secure Meridian Provider Portal utilizing the "Notify CM" button or by calling Meridian at **888-437-0606**.

I. Prenatal/Postpartum Programs

Beginning the moment Meridian becomes aware a member is pregnant, Meridian will initiate interventions to lead to a healthy outcome for both mother and baby. The Meridian staff will assist the member in connecting with the healthcare system so the member can receive the appropriate treatment and care. This may be accomplished by helping the member find an OB/GYN provider, help making appointments, arranging transportation and/or connecting members to community resources. The member is also provided educational materials on numerous pregnancy related topics.

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

As a PCP or OB/GYN, Meridian helps you to promote and support these programs by encouraging your Meridian patients to take advantage of these services and potential member incentives. You can refer a member to any of these special programs by calling Member Services at 888-437-0606.

J. NIA

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Meridian Michigan is using National Imaging Associates (NIA) to provide prior authorization services and utilization management for advanced imaging and radiology services. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA,
- MRI/MRA, and
- PET.

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization;
- It is the responsibility of the ordering physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

To reach NIA and obtain authorization, please call 1-800-424-4926 and follow the prompt for radiology authorizations. NIA also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Meridian Michigan in collaboration with NIA, will launch a cardiac imaging program to promote health care quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, NIAaddresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

NIAhas developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. NIAalso includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed
- Quality assessment of imaging providers to ensure the highest technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography

- Stress Echocardiography

The following services do not require authorization through NIA:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach NIA and obtain authorization, please call 1-800-424-4926 and follow the prompt for radiology and cardiac authorizations. NIA also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

Physical Medicine Program

To help ensure that physical medicine services (physical and occupational therapy) provided to our members are consistent with nationally recognized clinical guidelines, Meridian Michigan has partnered with National Imaging Associates, Inc. (NIA) to implement a prior authorization program for physical medicine services. NIA provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Meridian Michigan members.

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by NIA's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through NIA. Home Health providers submitting claims using codes other than the designated initial evaluation CPT codes for the initial evaluation should request an authorization within the Meridian Michigan retro authorization guidelines. There is no need to send patient records in advance. NIA will contact the provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under terms of the agreement between Meridian Michigan and NIA, Meridian Michigan oversees the NIA Therapy Management program and continues to be responsible for claims adjudication. If NIA therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the patient will receive notice of the coverage decision.
Should you have questions, please contact Meridian Michigan Provider Services at 1-800-424-4926

Interventional Pain Management

NIA manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:
• Spinal Epidural Injections
• Paravertebral Facet Joint Injections or Blocks
• Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
• Sacroiliac Joint Injections
Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through NIA for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is

still required through Meridian Michigan. To obtain authorization through NIA, visit RadMD.com or call 1-800-424-4926.

A. Billing and Claims Payment

Claims Billing Requirements

- The standard CMS 1500 Claim Form or UB-04 Claim Form is required for Meridian billing
- Specialty provider claims should include a referral form or prior authorization number(s) for payment
- Providers must use industry standard HCPCS, CPT, Revenue and ICD-10 codes when billing Meridian
- In-network providers may also submit and check the status of claims electronically via the secure Meridian Provider Portal
- Claims must be the original; scanned or copied claims will not be accepted
- For mid-level providers, the supervising provider is required when billing for services
- Meridian ensures that current Medicaid rates are paid in the absence of a contract
- The taxonomy code for the rendering provider must be included on the claim
- Payment is based on medical necessity criteria being met and the codes being submitted and considered for review included on the Michigan Medicaid Fee Schedule found at http://www.michigan.gov/mdhhs under the Assistance Programs tab at the top, click Medicaid, then Providers, next Billing & Reimbursements, and lastly Provider Specific Information
- Providers have 365 days from the date of service to submit a claim. A claim can be resubmitted within 365 days from DOS or 120 days from last date of adjudication/remit – whichever is later.
- Any individual or entity that provides services to or orders, prescribes, refers, or certifies eligibility for services for individuals who are eligible for medical assistance under the Medicaid State Plan is required to be screened and enrolled in Medicaid. Providers must have their enrollment approved through the online MDHHS CHAMPS Provider Enrollment subsystem to be reimbursed for covered services rendered to eligible Medicaid beneficiaries. Enrollment in CHAMPS neither requires nor mandates those providers who are part of a managed care network to accept Medicaid fee-for-service beneficiaries. Please reference MSA 17-48 and the MDHHS website for additional information

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

Claims Mailing Requirements

Submit all initial claims for payment to:

Meridian
ATTN: Claims Department
PO Box 8080
Farmington, MO 63640-8080

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

B. Coordination of Benefits (COB)

It is important to remember that Meridian is a Medicaid plan and is always the final payer. Meridian is responsible only for the difference between what the primary insurance pays and the allowable Medicaid fee screen. Please submit claims that have other insurance payers to Meridian with an attached EOB payment or rejection.

C. Billing Procedure Code Requirements

Meridian requires that providers use the appropriate HCPCS, CPT, ICD-10 and revenue codes when billing Meridian.

D. Explanation of Payments (EOP)

Meridian sends its providers Remittance Vouchers as a method of explanation of payments.

Per the MDHHS Provider Manual, Section 11 – Billing Beneficiaries: When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for the difference between the provider's charge and the Medicaid payment for service.

E. Electronic Claims Submission

Meridian is currently accepting electronic claims from the following clearinghouses:

Providers are responsible for ensuring they receive a confirmation file for claims submitted via EDI.

Availity
Customer Support: **800-282-4548**
Claim Types: Professional/Facility
Payer ID: MHPMI

In-network providers may submit claims through Meridian's Provider Portal at **provider.mimeridian.com**.

Providers using electronic submission shall submit all claims to Meridian or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic

format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the provider's NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim.

Section 6: Quality Improvement Program

A. Introduction

The primary objective of Meridian's Quality Improvement Program (QIP) is centered on the corporate mission to help those eligible for government-sponsored healthcare plans live better, healthier lives. The QIP objectively and systematically monitors and evaluates the quality, appropriateness, and outcomes of care and services, and the processes by which they are delivered. Direct improvement in individual and aggregate member health status is measured using the applicable HEDIS® quality measures, state of Michigan mandated performance indicators, internal performance improvement projects, and health outcomes data. Indirect improvement in individual and aggregate member health status is measured using critical operational metrics designed to monitor accessibility and availability of care.

B. QIP Goals and Objectives

Meridian's primary goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered. Performance measures are aligned to specific priorities and goals used to drive quality improvement and operational excellence.

Meridian's Quality Program priorities and goals support the Centene Corporation purpose of *Transforming the Health of the Community, One Person at a Time* and the mission of *Better Health Outcomes at Lower Costs* employing the three core brand pillars: a focus on the individual; an innovative, whole-health, well-coordinated system of care; and active local and community involvement. The mission, core pillars and health priorities are outlined in the table below:

Transforming the Health of the Community, One Person at a Time		
Better Health Outcomes at Lower Costs		
Focus on Individuals	**Whole Health**	**Active Local Involvement**
Priorities	**Priorities**	**Priorities**
• Well-Coordinated, Timely, Accessible Care Delivery • Member Healthy Decisions • Home and Community Connection • Right Care, Right Place, Right Time • Member Engagement • Provider Engagement • High Value Care • Member Satisfaction with Provider and Health Plan	• Meaningful Use of Data • Prevent and Manage Top Chronic Illnesses • Manage Co-morbid Physical and Behavioral Health Diagnosis • Manage Episodic Illnesses • Manage Rare Chronic Conditions • Screen for Unmet Needs • Remove Barriers to Care; Make It Simple to Get Well/Stay Well/Be Well • Coordination of Care Across the Health Care Continuum • Behavioral Health Integration • LTSS Quality of Life	• Local Partnerships • Population Health Improvement • Preventive Health and Wellness • Maternal-Child Health Care • Prevent and Manage Obesity • Tobacco Cessation • Opioid Misuse Prevention and Treatment • Address Social Determinants of Health • Health Equity/Disparity Reduction • Multi-Cultural Health

C. Pay for Performance Program

Meridian offers a HEDIS Provider Incentive Program that rewards providers for assisting members in completing necessary procedures. An overview of this program is depicted below.

In 2023, the Medicaid P4P program will follow a threshold model in which the incentive amount per hit will be paid to in-network Medicaid primary care providers (PCP) after their assigned membership reaches set completion rates. We believe that our new incentive structure will better support you and your healthcare team in caring for our members. The grids below outline the benchmarks to meet for the 25th, 50th, and 75th percentile and applicable incentive amounts for each measure included in the 2023 program. Each measure will be calculated and rewarded individually. Additional details on the measures included in the program can be found starting on page 4.

HEDIS® Measure	25th Percentile	50th Percentile	75th Percentile
Adults' Access to Preventative Ambulatory Health Services (20-44 years)	$ 5.00	$ 10.00	$ 15.00
Adults' Access to Preventative Ambulatory Health Services (45-64 years)	$ 5.00	$ 10.00	$ 15.00
Asthma Medication Ratio	$ 25.00	$ 30.00	$ 40.00
Breast Cancer Screening	$ 25.00	$ 30.00	$ 40.00
Controlling High Blood Pressure	$ 30.00	$ 40.00	$ 50.00
Cervical Cancer Screening	$ 40.00	$ 55.00	$ 70.00
Blood Pressure Control for Patients with Diabetes	$ 30.00	$ 40.00	$ 50.00
Eye Exam for Patients with Diabetes	$ 40.00	$ 55.00	$ 70.00
Hemoglobin A1c Control for Patients with Diabetes	$ 30.00	$ 40.00	$ 50.00
Chlamydia Screening in Women (16-20 years)	$ 40.00	$ 55.00	$ 70.00
Chlamydia Screening in Women (21-24 years)	$ 40.00	$ 55.00	$ 70.00
Childhood Immunizations - Combo 10	$ 40.00	$ 55.00	$ 70.00
Healthy Michigan Plan Health Risk Assessment Annual Completion	$ 25.00	$ 30.00	$ 40.00
Immunizations for Adolescents - Combo 2	$ 25.00	$ 30.00	$ 40.00
Lead Screening in Children	$ 25.00	$ 30.00	$ 40.00
Prenatal and Postpartum Care - Postpartum Care	$ 100.00	$ 150.00	$ 200.00
Prenatal and Postpartum Care - Timeliness of Prenatal Care	$ 100.00	$ 150.00	$ 200.00
Well-Child Visits in the First 30 Months of Life - 6+ visits in the first 15 months of life	$ 40.00	$ 55.00	$ 70.00
Well-Child Visits in the First 30 Months of Life - 2 visits from 15-30 months of life	$ 25.00	$ 30.00	$ 40.00
Child and Adolescent Well-Care Visits	$ 25.00	$ 30.00	$ 40.00
Kidney Health Evaluation for Patients with Diabetes	$ 5.00	$ 10.00	$ 15.00

Medicaid Incentive Amounts

Medicaid Target Compliance Percentage

HEDIS® Measure	25th Percentile	50th Percentile	75th Percentile
Adults' Access to Preventative Ambulatory Health Services (20-44 years)	67.30%	73.61%	77.97%
Adults' Access to Preventative Ambulatory Health Services (45-64 years)	76.90%	82.30%	85.72%
Asthma Medication Ratio	59.94%	64.26%	69.67%
Breast Cancer Screening	45.23%	50.95%	56.52%
Controlling High Blood Pressure	54.50%	59.85%	65.10%
Cervical Cancer Screening	52.39%	57.64%	62.53%
Blood Pressure Control for Patients with Diabetes	55.47%	60.83%	67.40%
Eye Exam for Patients with Diabetes	45.01%	51.09%	56.51%
Hemoglobin A1c Control for Patients with Diabetes	43.80%	50.12%	54.26%
Chlamydia Screening in Women (16-20 years)	44.53%	50.14%	59.61%
Chlamydia Screening in Women (21-24 years)	55.96%	61.34%	66.59%
Childhood Immunizations - Combo 10	28.95%	34.79%	42.09%
Healthy Michigan Plan Health Risk Assessment Annual Completion	8.00%	10.00%	12.00%
Immunizations for Adolescents - Combo 2	30.41%	35.04%	41.12%
Lead Screening in Children	53.28%	63.99%	72.67%
Prenatal and Postpartum Care - Postpartum Care	72.87%	77.37%	81.27%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	81.27%	85.40%	88.86%
Well-Child Visits in the First 30 Months of Life - 6+ visits in the first 15 months of life	49.88%	55.72%	61.19%
Well-Child Visits in the First 30 Months of Life - 2 visits from 15-30 months of life	60.53%	65.83%	72.24%
Child and Adolescent Well-Care Visits	43.50%	48.93%	57.44%
Kidney Health Evaluation for Patients with Diabetes	45.01%	51.09%	56.51%

Comprehensive Child and Adolescent Care		
Service	Procedure	Performance Criteria*
Childhood Immunizations Status – Combination 10	4 Diphtheria, Tetanus and Acellular Pertussis (DTaP)	Children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
	3 Polio (IPV/OPV)	
	1 Measles, Mumps and Rubella (MMR)	
	3 Haemophilus Influenza Type B (HiB)	
	3 Hepatitis B (HepB)	
	1 Chicken Pox (VZV)	
	4 Pneumococcal Conjugate (PCV)	
	1 Hepatitis A (HepA)	
	2 or 3 Rotavirus (RV)	
	2 Influenza (Flu)	
Immunizations for Adolescents – Combination 2	1 Meningococcal	Adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their thirteenth birthday.
	1 Tetanus, Diphtheria Toxoids and Acellular Pertussis (Tdap)	
	Human Papillomavirus Series (HPV)	
Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits in the First 15 Months of Life	Children who turned 15 months old during the measurement year and had six or more well-child visits with a primary care provider (PCP) during their first 15 months of life.
Well Child Visits for Age 15-30 Months	Two or More Well-Child Visits between 15-30 Months of Life	Children who turned 30 months old during the measurement year and had two or more well-child visits with a PCP between their 15-month birthday and 30-month birthday.

Comprehensive Child and Adolescent Care		
Service	Procedure	Performance Criteria*
Child and Adolescent Well-Care Visits	Well-Care Visit	Members 3 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Lead Screening in Children	Lead Capillary or Venous Blood Test	Children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Prevention and Screening		
Service	Procedure	Performance Criteria*
Breast Cancer Screening (Electronic Only)	Mammogram	Women 50 – 74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
Cervical Cancer Screening	Cervical Cytology/Testing	Women 21 – 64 years of age who were screened for cervical cancer using either of the following criteria: • Women 21 – 64 years of age who had cervical cytology performed within the last three years • Women 30 – 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years • Women 30 – 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years
Chlamydia Screening in Women Ages 16-20 Years Old	Screening for Chlamydia	Women 16 – 20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Chlamydia Screening in Women 21-24 Years Old	Screening for Chlamydia	Women 21 - 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Adults' Access to Preventive/Ambulatory Health Services 20-44 Years Old	Ambulatory or Preventive Care Visit	Members 20 – 44 years of age who had an ambulatory or preventive care visit during the measurement year.
Adults' Access to Preventive/Ambulatory Health Services 45-64 Years Old	Ambulatory or Preventive Care Visit	Members 45-64 years of age who had an ambulatory or preventive care visit during the measurement year.
Controlling High Blood Pressure	Screening for High Blood Pressure**	Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year
Asthma Medication Ratio	Ratio of controller medications to total asthma medications**	Members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Comprehensive Diabetes		
Service	Procedure	Performance Criteria*
Comprehensive Diabetes Care	Eye Exam	Members 18 – 75 years of age with diabetes (type 1 and type 2) that had a retinal eye exam performed during the measurement year.
	Blood Pressure Control (<140/90 mm Hg)**	Members 18 – 75 years of age with diabetes (type 1 and type 2) that had a controlled blood pressure (<140/90 mm Hg) as of the latest reading of the measurement year.
	HbA1c Good Control (<8.0%)**	Members 18 – 75 years of age with diabetes (type 1 and type 2) that had a controlled HbA1c level (<8.0%) during the measurement year.

Obstetrical Care		
Service	Procedure	Performance Criteria*
Prenatal and Postpartum Care	Timeliness of Prenatal Care Visit	Women who delivered that received a prenatal care visit in the first trimester (280 – 176 days prior to delivery or estimated date of delivery) or within 42 days of enrollment in the organization.
	Postpartum Care Visit	Women who had a postpartum visit on or between seven and 84 days after delivery.

Program Information:
Results may be faxed to **833-667-1532 or sent to our secure email MIHEDIS@mhplan.com**. All procedures must be completed within strict HEDIS® and Michigan Department of Health and Human Services (MDHHS) guidelines. For a complete list of covered CPT codes for these measures or to view the Drug Formulary for a list of covered drugs, visit **mimeridian.com**. For more information, contact your local Provider Network Management Representative or the Provider Services department at **888-773-2647**.

† Plan Definitions:

Medicaid	Meridian Medicaid members
Healthy Michigan Plan	Meridian Medicaid Expansion members

* Incentive is paid upon completion of all qualifying services in compliance with HEDIS® measurement year 2022 guidelines. Unless otherwise noted, one incentive is paid per member, per year. Incentives will begin being paid in 2022. Incentive is paid to the assigned PCP at the time of payment.

** Incentive is paid if the member is adherent to their medications or blood pressure or HbA1c level is controlled as of 12/31/2022.

Meridian maintains the right to modify or discontinue the P4P Program at any time. Meridian will notify providers of any changes or incentive program alterations.

Performance Improvement Projects

Meridian engages in performance improvement projects (PIP) as mandated by the State of Michigan for Medicaid health plans, external quality reviews or internal identification for improvement. The purpose of the PIP(s) is to improve the quality of care members receive, while improving health outcomes, lowering cost, and improving the member experience.

For more information on current PIP, please contact the quality improvement department.

D. QIP Processes and Outcomes

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

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

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

Meridian's QIP focuses on both clinical and operational outcomes such as patient experience, provider satisfaction, utilization management, and complaint and grievance resolutions.
Outcomes of the QIP are tracked, analyzed, and reported to the QIC and Board of Directors annually.

E. Provider Opportunities in QIP Activities

Provider involvement is integral to a successful QIP. By ensuring accessibility and delivering high quality care, providers contribute to the goals and objectives of the Meridian QIP. Providers also have the opportunity to contribute administratively by becoming active participants in Meridian Committees. To express interest in joining any of the following committees, or to request more information, please contact Quality Improvement at **313-324-3700**.

Quality Improvement Committee

The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered, and to continuously enhance and improve the quality of care and services provided to members through a comprehensive, health plan-wide system of ongoing, objective, and systematic monitoring of activities and outcomes using the quality process.

The responsibilities of the committee include:

- Oversight of the quality activities of the health plan to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the National Committee for Quality Assurance (NCQA)
- Annual development of the Quality Program Description and Work Plan incorporating applicable supporting department goals as indicated
- Development of quality and performance improvement studies and activities, and reporting of findings to the Board of Directors
- Annual review and approval or acceptance of the Credentialing, Pharmacy, Utilization Management, Care Management, and Population Health Management Program Descriptions and Work Plans as developed by the appointed subcommittees to facilitate alliance with the strategic vision and goals
- Evaluation of the effectiveness of each departments' activities to include analysis and recommendations of policy decisions based on identified trends, barrier analysis, and interventions required to improve the quality of care and/or service to members. Implements corrective actions as appropriate, and acts as a communication channel to the Board of Directors

- Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities
- Review and establishment of benchmarks and performance goals for each quality improvement initiative and service indicator
- Review and approval of due diligence information for any potential delegated entity and the annual oversight audit outcomes for delegated entities
- Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care
- Monitoring of clinical quality indicators (such as HEDIS, adverse events, sentinel events, peer review outcomes, quality of care tracking, etc.) to identify deviation from standards of medical care, and supporting the formulation of corrective actions, as appropriate
- Ongoing evaluation of the appropriateness and effectiveness of pay-for-performance and value-based contracting initiatives and support in designing and modifying the program as warranted

Credentialing Committee

The purpose of the Credentialing Committee is to provide oversight of the development and annual review/approval of credentialing policies. The Credentialing Committee has final authority for credentialing and recredentialing licensed medical and behavioral health practitioners, other licensed healthcare professionals, and organizational providers who have an independent relationship with the health plan. The Committee oversees the credentialing process to ensure compliance with regulatory and accreditation requirements and ensure network practitioners and organizational providers are qualified, properly credentialed, and available for access by health plan members.
The responsibilities of the committee include:

- Provide guidance to organization staff on the overall direction of the Credentialing Program
- Review and approve credentialing and recredentialing policies and procedures
- Review and recommend credentialing and recredentialing criteria
- Final authority to approve or disapprove applications by practitioners and organization providers for network participation status and recredentialing
- Provide clinical peer input to address standards of care for a particular type of practitioner
- Review oversight audits of delegates Credentialing Program performance
- Evaluate and report to management on the effectiveness of the Credentialing Program
- Review potential QOC events and adverse events, including any corrective action plans from peer review committee, for recredentialing decisions

Physician Advisory Committee

The purpose of the Physician Advisory Committee is to provide input on the health plan provider profiling and incentive programs, and other administrative practices, and supports development of the provider scorecard indicators, useful analyses of the data, and effective means of helping providers improve their performance.

The responsibilities of the committee include:

- Provide the health plan with feedback regarding programs and processes from a community provider-based perspective
- Allow providers to make recommendations related to the programs and processes

- Assist the health plan to identify key issues related to programs that may affect community providers

F. Contractual Arrangements

Non-Delegated

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

- Abide by the policies and procedures of the Meridian QIP
- Participate in Peer Review activity
- Provide credentialing and re-credentialing information in accordance with Meridian standards every three years
- Serve on the QIC or other subcommittee, as necessary
- Allow Meridian to collect data and information for quality improvement purposes
- Cooperate with the utilization management, care coordination and disease management programs as applicable, including, but not limited to:
    - Clinical data submission with the initial corporate prior authorization request
    - Timely response to outreach requests for information or to discuss member's plans of care
    - Participate in care coordination conferences, as necessary
    - Resolve appeals, complaints and grievances

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

Delegated

Meridian does not sub-delegate any administrative, clinical, operational, or quality improvement functions.

Integrated Care Program

Meridian integrates the functions of utilization management, care coordination and population health management into its QIP to provide total coordination across the full continuum of care and facilitate timely, ongoing communications with the member's primary care provider.

The Integrated Care Program begins with the performance of a health risk assessment (HRA) which is performed by a specially trained Member Services Representative, Quality Specialist or Quality Coordinator to:

- Assess the member's overall health status
- Identify current conditions and impairments, including screening for depression

- Identify the member's current medications and treatments, including therapeutic and personal assistance services provided by ancillary agencies
- Assess the member's past medical and family medical histories
- Assess the member's social history
- Assess the member's use of assistive devices, i.e., ambulation, alternative communication, etc.
- Assess the member's living situation and level of independence
- Identify the member's immediate care and treatment needs

Health Risk Assessment

The HRS Adult (Age18-64) Mini Screener is a specially designed questionnaire for Meridian members that can be performed telephonically, or in the home as necessary, to assess a member's degree of stratified risk in the following areas: medical, behavioral health, and substance abuse, psychosocial and functional. HRS Adult (Age18-64) Mini Screener are completed within the first 30 days for the Temporary Assistance for Needy Families (TANF) population using an electronic questionnaire that links to the member's profile in the TruCare system and interfaces with all other operational modules including care, utilization, and quality.

The information collected through the HRS Adult (Age18-64) Mini Screener process is documented under the member profile section of TruCare. Members identified as having one or more of the following are automatically referred for care coordination assessment

- One or more chronic conditions or impairments
- History of chronic pain or receiving services through a pain management clinic
- History of behavioral illness or substance abuse
- An acute condition currently receiving active care and treatment
- Self-reported
- Identified as being part of the ABAD sub-population through the eligibility identifier
- Child with special health care needs
- Poor overall health status
- Poor endurance
- Poor nutritional status
- Unsteady gait or difficulty with walking or standing
- Difficulty performing activities of daily living independently or rely on others to perform on their behalf
- Receiving HCBS waiver services
- Are near the end of life

Utilization Management

The function of utilization management is inclusive of the following tasks:

- Pre-service, concurrent and post-service medical necessity review
- Discharge planning for members who are not enrolled in the care coordination program or do not have complex post-discharge needs and/or conditions
- Supporting transition of care between levels of care, facilities and/or providers

Initial medical necessity review of corporate prior authorization requests requiring approval of the health plan and concurrent review of admissions for medical conditions are performed by Utilization Management Coordinators who are State of Michigan active Licensed Registered or Practical Nurses. Medical necessity determinations for medical conditions are made in accordance with InterQual® Guidelines, Meridian Medical Policy or CMS National or Local Coverage Determinations, as appropriate.

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

Utilization Management Coordinators and Behavioral Health Care Managers may make approval determinations in accordance with applicable medical necessity review criteria, Meridian Medical Policy or CMS National or Local Coverage Determinations. Utilization Management Coordinators and Behavioral Health Care Managers are not permitted to render medical necessity adverse determinations (denials).

Only Medical Directors who have an active and unrestricted license in the State of Michigan are permitted to render an adverse determination once a medical necessity review of the clinical information is completed. When feasible, the Medical Director will make at least one outreach attempt to discuss the request or case prior to an adverse determination decision being rendered.

Utilization Management Coordinators perform routine discharge planning and coordinate routine transitions between levels of care, facilities and/or providers in collaboration with the member, the facility's designated contact and the member's primary care provider.

Utilization management determinations are made and communicated within the following timeframes:

- *Non-Urgent, Pre-Service Determinations*
  - Made within 14 calendar days of receipt of the request
  - Verbally communicated to the requesting provider via telephone on the same day the determination is made
  - Adverse determinations are communicated in writing within three calendar days of the verbal communication to the provider and member
- *Urgent, Pre-Service Determinations*
  - Made within 72 hours of receipt of the request
  - Verbally communicated to the requesting provider via telephone on the same day the determination is made
  - Adverse determinations are communicated in writing within three calendar days of the verbal communication to the provider and member
- *Urgent, Concurrent Determinations*
  - Made within 72 hours of receipt of the request
  - Verbally communicated to the requesting provider via telephone on the same day the determination is made

    - Adverse determinations are communicated in writing within three calendar days of the verbal communication to the provider and member

- *Urgent, Pre-Service Admission – Out-of-Network Hospital*
    - Within 1 hour of receipt of the request
    - Verbally communicated to the requesting provider via telephone on the same day the determination is made
        - Adverse determinations are communicated in writing within the 72 hours from when the appeal is initiated

Providers and members may appeal adverse determinations to Meridian within 60 days of receipt of the written denial notification. Appeals are adjudicated in accordance with the following timelines:

- *Standard Member Appeals*
    - Within 30 days of receipt of the appeal request
    - Member appeal determinations are communicated in writing to the member, PCP and any provider involved in the appeal *Expedited Member Appeals*
    - Within 72 hours of receipt of the appeal request
    - Verbally communicated to the requesting provider via telephone on the same day the determination is made
- Member appeal determinations are communicated in writing within three calendar days of the verbal communication to the provider and member

- Members, or their representatives, may also file an appeal with the Michigan Department of Health and Human Services

- Meridian considers all appeal determination decisions to be final and abides by the determination decision rendered

Care Coordination

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

- Focusing attention on the individual needs of the member
- Promoting and assuring service accessibility
- Maintaining communication with the member/caregiver, providers and community
- Identifying and removing barriers to access 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 member on condition management, appropriate use of services and self-care techniques
- Reducing social barriers that negatively impact a member's behavioral and physical health

Meridian's Care Coordination team determines whether or not a member is eligible for Care Coordination. The member is then assigned to a risk stratification level and a plan of care is developed.

The risk stratification level is determined by results of the members HRS Adult Mini Screener and reassessments, claims history, or by predictive model.

Care Coordinators

Care Coordinators are Meridian team members responsible for identifying health goals for each member. They coordinate services and providers to help members achieve these goals by:

- Working with members to create individualized care plans
- Identifying and removing barriers to accessing care
- Linking members with community resources to facilitate referrals and respond to social service needs
- Educating members on condition management, appropriate use of services, and self-care techniques
- Referring members to appropriate community resources to address medical, social, and financial needs and following up to ensure fulfillment
- Updating the care plan at least annually and whenever members experience a change in condition

Target Population

- High risk pregnancies
- 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-ED utilizers requiring education and communication with PCP
- Members with level 3 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

"Integrated Team" Approach

Our Care Coordination program operates as an integrated team comprised of Care Coordinators, Care Coordination Nurses, Community Health Workers (CHW) and consultant staff for behavioral health and pharmacy needs. Led by a Meridian Medical Director, the teams meet regularly for continuous eduction and care review.

Teams are specialized in:

- Medical
- Children's Special Health Care Services (CSHCS)
- Maternity
- NICU
- High-ED
- Behavioral Health
- Sickle Cell Disease
- Hepatitis C

- Complex Case Management

Available Health Coaching Consultations:

- Weight Management
- Stress Management
- Tobacco Cessation
- Asthma
- American Therapy Centers
- Cardiac Health

Care Coordination teams will regularly reach out to providers to keep everyone involved with the member's plan of care. The following forms of communication will be used: letters, faxes and phone calls.

Referring a Member to the Care Coordination Program

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

- Notifying Meridian through the Provider Portal
    - Log in to the Provider Portal at **provider.mimeridian.com**
    - Select "Member" on the left menu
    - Enter the Member ID number
    - Click "Notify Health Plan" at the bottom of the "Demographics" screen
    - Select "Case Management" (middle tab) and fill out the reason for referral
- Completing the "Care Coordination Referral Form" and faxing it to Meridian. To get the form:
    - Go to **mimeridian.com/providers.html**
    - Go to "Provider Resources" on the left side
        - Click on Manuals, Forms, and Resources
        - Select Medical Referrals, Authorizations, and Notification
        - Select "Care Coordination/Complex Case Management Referral Form - (PDF)"
    - Fax the completed form to **833-337-0596**
- You can also request a Care Coordination Referral Form from your local Provider Network Development Representative

Outcomes Measurement

HEDIS® measures are utilized on an annual basis to assess clinical outcomes including:

- Annual monitoring of patients on persistent medications
- Condition specific HEDIS® measures
- Children, adolescents and adults access to preventive care
- Annual influenza vaccination
- Pneumonia vaccination

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

Member satisfaction with choice and quality of care received and member reassessment of self-reported improvements in status are measured, analyzed and evaluated annually using mailed and telephonic survey tools by the Quality & Utilization Management departments.

Outcomes are reported, reviewed, analyzed, and evaluated by the QIC quarterly and annually. The QIC makes recommendations for improvement to the Care Coordination program based upon these outcome reports.

G. Confidentiality and Conflict of Interest

1. Confidentiality

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

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

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

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

2. Conflict of Interest

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

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

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

H. Member Safety

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

- The development and implementation of clinical practice guidelines based on national standards
- Provider and member newsletters that convey new, revised, and/or updated initiatives and provide safety related information
- The development and delivery of effective and on-going fraud and abuse education and training for employees, members and providers through various methods (i.e. member and provider websites, newsletters, member handbook, provider manual, Network Development Provider Representative visits with providers, and on-site training for all employees)
- The inclusion of provider office safety evaluations in the site visits for Quality

Incorporated into the QIP is a strong emphasis on member safety. The program ensures that individual practice sites have implemented appropriate safety practices before being considered for participation in the Meridian Network.

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

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

- The development, implementation, review and evaluation of internal and external audits and other proactive risk management tools intended to monitor compliance and assist in the identification of problem areas

A. Primary Care/Managed Care Program

Meridian utilizes a *Primary Care Provider (PCP) Patient-Centered Medical Home* system. In this system, the PCP is responsible for the comprehensive management of each member's health care. This may include, but is not limited to, ensuring that all medically necessary care is made available and delivered, facilitating the continuity of member health care, promoting and delivering the highest quality health care per Meridian standards.

Meridian providers are responsible for knowing and complying with all Meridian network policies and procedures. Implementation of Meridian policies will facilitate the Plan's periodic reporting of HMO data to MDHHS, the State and the Federal agencies.

B. PCP Prior Authorization and Referral Procedures

PCPs are responsible for initiating all necessary medical referrals for their assigned members. Details on the procedures for prior authorizations are located in Section 4 of this manual.

C. Corporate Reporting Requirements

Member encounter information should be reported on submitted claims forms (CMS 1500; UB-04) by stamping or clearly designating on the claims form "ENCOUNTER."

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

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

D. Encounter Reporting Requirements

In order to assess the quality of care, determine utilization patterns and access to care for various healthcare services, qualified health plans are required to submit encounter data containing detail for each patient encounter reflecting all services provided by the providers of the health plan. The State will determine the minimum data elements of the encounter reporting. A format consistent with the formats and coding conventions of the CMS 1500 and UB-04 will be used initially. PCPs will submit their encounter data monthly to Meridian, who must then submit it to the MDHHS via an electronic tape. Both Meridian and provider agree that all information related to payment, treatment, or operations will be shared between both parties and all medical information relating to individual Members will be held confidential.

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

E. Provider Intent to Discharge Member from Care

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

F. Medical Care Access Standards

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 Visit Appointments

- Emergency: Immediately
- Urgent care: Appointments are scheduled within 48 hours with an available clinician
- Non-urgent symptomatic care: Appointments are scheduled within seven days with an available clinician
- Preventive care:
    - For Adult Preventive Care appointments, schedule within 30 days
    - For Children <18 months old, preventive care appointments are available within 2 weeks
    - For Children >18 months old, preventive care appointments are available within 4 weeks

After Hours Access Standards

Meridian has established acceptable mechanisms for use by Primary Care Providers, Specialists, and Behavioral Health providers to ensure telephone access and service for members 24 hours a day.

All Primary Care Provider, Specialist, and Behavioral Health provider contracts require providers to provide members with access to care 24 hours a day, seven days a week.

Acceptable after-hours access mechanisms include:

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

There must be a method to talk to a provider 24 hours a day, 7 days a week regarding after-hours care for urgent or non-life threatening conditions as well as instructions to call 911 or go to the emergency department in the event of a life-threatening condition or serious trauma.

This message should not instruct members to obtain treatment at the emergency department for non-life-threatening emergencies.

Hours of Operation Parity

All Network Providers must offer hours of operation that are no less than the hours of operation offered to commercial members.

G. 24-Hour PCP Member Responsibility/Accountability

Through the Meridian practitioner agreements, Meridian primary care providers (PCPs) have 24-hours a day, seven days a week responsibility and accountability to their Meridian members/patients.

Guidelines:

1. PCPs must be available to address member/patient medical needs on a 24-hours a day, seven days a week basis. The PCP may delegate this responsibility to another Meridian provider or provider on a contractual basis for AFTER-HOURS, HOLIDAY and VACATION COVERAGE.
2. If the PCP site utilizes a different contact phone number for an on-call or after-hours service, the PCP site must provide Meridian with the coverage information and the contact phone or beeper number. Please notify the 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 assure that all provider providers are credentialed to Meridian standards. PCPs may employ licensed/certified Physician Assistant (PA) or Registered Nurse Practitioners (RNP) 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. Non-professional healthcare staff shall perform their functions under the direction of the licensed PCP, credentialed provider, or other appropriate health care professionals such as a licensed PA or a 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.

H. Office Waiting Time

In order to assure that members have *timely access to patient care and services*, Meridian providers are expected to monitor waiting room times on a continual basis. PCP offices may be surveyed periodically regarding this process. Member waiting room times should be less than 30 minutes. 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.

I. Access and Availability Remediation Process

At least annually, the Quality Improvement (QI) department evaluates the ease that enrollees have in obtaining health care services from Meridian primary care, specialty care, and behavioral health providers. The standards for the Meridian product are outlined above.

Providers are audited twice a year on the standards. If a provider fails they must complete a corrective action plan to avoid any further disciplinary action as listed below.

Year 1		
	Pass	**Fail**
Round 1 Audit (Q2)	N/A	Provider must complete and submit CAP form to Plan
Round 2 Audit (Q4)	N/A	Provider removed from online directory
Year 2		
	Pass	**Fail**
Round 1 Audit (Q2)	N/A	Provider must complete and submit CAP form to Plan
Round 2 Audit (Q4)	N/A	PCPs' panels closed, BH and Specialist Providers removed from the online directory
Year 3		
	Pass	**Fail**
Round 1 Audit (Q2)	N/A	Provider must complete and submit CAP form to Plan
Round 2 Audit (Q4)	N/A	Provider terminated from Plan

J. Site Visits

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

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

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

K. Substance Abuse Referrals

Meridian members receive their mental health services and substance abuse services through State-contracted vendors. MDHHS has contracted with local Community Mental Health (CMH) providers for these services. Members may access these services directly or through provider referrals. These providers will communicate directly with the PCPs with regard to the member's diagnoses, dispositions, and other medical needs. PCPs must refer members to CMH and other community providers, as necessary.

L. Maternal Support Services/Infant Support Services

Meridian has coordination agreements with MIHP (Maternal Infant Health Program) service providers within its provider network. MIHPs provide preventive health services of a non-medical nature. Specifically these services are:

- Childbirth/parenting education
- Psychosocial and nutritional related assessments
- Psychosocial and nutritional related counseling
- Transportation

These preventive services are designed to be supportive to the woman/infant in coping with the pregnancy and supportive to the basic prenatal care provider in the care of the woman during the course of her pregnancy and needed services for the infant. These services are not meant to replace medical care or to replace the PCPs or OB/GYN's role. Meridian will identify and refer each pregnant member to a MIHP provider to determine if the member qualifies for the MIHP Program.

Visit **www.michigan.gov/mihp** for more information.

M. Fraud, Waste, and Abuse

Healthcare fraud, waste, and abuse affect 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. Healthcare fraud is both a state and federal offense.

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 him or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

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

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

Here are some examples of Fraud, Waste and Abuse:

Fraud and Waste

- 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
- Providers performing inappropriate or unnecessary services
- The misuse of a Medicaid card to receive medical or pharmacy services
- Altering a prescription written by a provider
- Making false statements to receive medical or pharmacy services

Abuse

- Going to the Emergency Department for non-emergent medical services
- Threatening or abusive behavior in a provider's office, hospital or pharmacy

Overpayment and Recovery
Meridian handles recovery of overpayments ("take-backs") according to the situation that created the overpayment and the timeframe between when the payment was made and when the overpayment was identified. Below are examples of overpayment and recovery situations:

- Inaccurate payment: This includes duplicate payment, system set-up error, claim processing error and claims paid to wrong provider. Adjustment/notification date for recovery will be limited to 12 months from date of payment
- Identified through a medical record audit: Adjustment/notification date for recovery will be limited to 12 months from date of payment. In the event that the audit reveals fraud, waste or abuse, the 12 month look back period will no longer apply
- Fraud and abuse: Adjustment/notification date for recovery time period will be the statute of limitations or the time limit stated in the Provider Agreement

In the event it is determined that an inaccurate payment was made, Meridian will not provide prior written notice of a recovery. In that case, Meridian will recover the overpayment by issuing an invoice or performing a take-back. Full details of this recovery will be provided in either the invoice or the remittance advice.

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.

To report possible Fraud, Waste or Abuse:

Contact Meridian's Corporate Compliance Officer toll free at **800-345-1642**or the Fraud, Waste, and Abuse Hotline at **866-685-8664**. You can also send an email to**Special_Investigations_Unit@centene.com**. Providers may also report potential Fraud, Waste and Abuse to Meridian anonymously at the following address:

Meridian
Attn: Compliance Officer
777 Woodward Ave., Suite 700
Detroit, MI 48226

Providers may also choose to report anonymously to the State of Michigan:

Michigan Department of Health and Human Services
Office of Inspector General
PO Box 30062
Lansing, MI 48909
1-855-MI-FRAUD (643-7283)
www.michigan.gov/fraud

N. Non-Discrimination

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

O. Provider Credentialing/Re-Credentialing

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

Practitioners have the following rights during the credentialing process: All information received during the credentialing process that is not peer protected can be forwarded to the applicant upon written request to the credentialing department. If there are any substantial discrepancies noted during the credentialing process the applicant will be notified in writing or verbally by the credentialing department within 30 days and will have 30 days to respond in writing regarding the discrepancies and correct any erroneous information. Meridian is not required to reveal the source of the information if the information is not obtained to meet the credentialing verification requirements or if disclosure is prohibited by law. Upon written request to the credentialing department, any practitioner has the right to be informed in writing or verbally of their credentialing status.

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

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

Meridian re-credentials 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 re-credential. All necessary forms will be sent for completion. In certain instances, a site visit will also be scheduled.

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

Please also note that any individual or entity that provides services to or orders, prescribes, refers, or certifies eligibility for services for individuals who are eligible for medical assistance under the Medicaid State Plan is required to be screened and enrolled in Medicaid. Providers must have their enrollment approved through the online MDHHS CHAMPS Provider Enrollment subsystem to be reimbursed for covered services rendered to eligible Medicaid beneficiaries. Enrollment in CHAMPS neither requires nor mandates those providers who are part of a managed care network to accept Medicaid fee-for-service beneficiaries. Please reference MSA 17-48 and the MDHHS website for additional information.

Appeals Process

There is a formal method of appeal for a provider/applicant who is denied participation within the Meridian Network.

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

Meridian
Credentialing Department
777 Woodward Ave., Suite 700
Detroit, MI 48226

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

2. *Level One Hearing:*
    a. Level One Hearings are conducted at the Meridian corporate headquarters
    b. The Meridian Credentialing department or designee will notify the affected applicant of the date, time and place of the hearing by Special Notice at least seven calendar days prior to the hearing date
    c. The hearing date will not be more than 45 calendar days from receipt of request for the hearing
    d. The Hearing Committee shall consist of at least two provider members of the Credentialing Committee who are not in direct economic competition with the practitioner applicant and one additional member appointed by the Quality Medical Director. This member will be one of the following:
        i. Meridian Medical Director
        ii. Meridian Associate Medical Director
        iii. Meridian Director of Utilization Management
        iv. Meridian Director of Quality Improvement
        v. A Meridian participating practitioner who is not in direct economic competition with the provider applicant and of similar scope of practice
        vi. A member of the Meridian Board of Directors
    e. If the practitioner applicant scope of practice is not within the two appointed practitioner members' scope of practice, it is required to include a Meridian participating practitioner with a similar scope of practice
    f. Previous participation in the credentialing decision does not disqualify a practitioner from serving on the Hearing Committee
    g. All members of the Hearing Committee are required to consider and decide the case with good faith objectivity
    h. The affected practitioner has the right to be represented by a person of his or her own choice, which may be an attorney, at the Hearing Committee
    i. The presiding officer for the hearing is appointed by the Meridian Quality Medical Director and determines the order of proceedings
    j. During the hearing, both the affected practitioner and the person appointed to represent the Meridian position have an opportunity to have their positions fairly heard and considered
    k. Both Meridian and the affected practitioner may submit to the hearing for consideration:
        i. Written statements, letters and documents relevant to the subject matter of the hearing, including relevant portions of the credentialing file
        ii. Oral statements
    l. Only the presiding officer may, at his/her discretion, authorize the appearance of witnesses

m. The affected practitioner has the burden of proof and must demonstrate that the non-approval is:
    i. Inconsistent with Meridian policies and procedures
    ii. Based on inaccurate or insufficient information through no fault of the affected practitioner
    iii. Not in the best interest of Meridian and/or its members
n. A recording secretary selected by Meridian takes minutes of the hearing. The affected practitioner may request a copy of the minutes at his/her own cost
o. The decision of the Hearing Committee will be issued within 30 calendar days of completion of the hearing and the affected practitioner will be notified by Special Notice
p. The notice to the affected practitioner informs him/her of the right to appeal a non-approval decision to the Meridian Medical Director
q. The affected practitioner may request a Level Two appeal within 30 calendar days of receipt of the notification
r. Failure to request a Level Two appeal within 30 calendar days constitutes waiver of final appeal rights

3. Level Two:

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

4. Final Decision:

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

5. Denied applications are maintained in a confidential manner in the 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

P. Medical Care Access Standards

As part of Meridian's annual monitoring audits, provider office facilities may be evaluated against Meridian's site review and medical record keeping requirements.

Medical Care Access Standards

Type of Care/Appointment	Length of Time
Emergency Services	Immediately 24 hours/day, 7 days per week
Urgent Care	Within 48 hours
Routine Care	Within 30 business days of request
Non-urgent Symptomatic Care	Within 7 business days of request
Specialty Care	Within 6 weeks of request
Acute Specialty Care	Within 5 business days of request
Behavioral Health*	Routine care within 10 business days of request

	Non-life-threatening emergency within s6 hours of request
	Urgent Care within 48 hours of request

**Behavioral Health is limited to Covered Services*

Dental Appointment and Timely Access to Care Standards	
Type of Care	**Length of Time**
Emergency Dental Service	Immediately 24 hours/day, 7 days per week
Urgent Care	Within 48 hours
Routine Care	Within 21 business days of request
Preventive Services	Within 6 weeks of request
Initial Appointment	Within 8 weeks of request

Provisions for Persons with Disabilities

- Are there designated handicap parking spaces close to building entrance?
- Is the building entrance accessible by wheelchair, walker, etc.?
- Are office hallways, doorways and bathrooms accessible to wheelchairs, walkers, etc. (all hallways should have a minimum of 42 inches clearance)?
- Are doors able to be operated by persons with physical limitations?
- Are there accommodations for sight or hearing-impaired patients?

General Office Appearance

- Are NO SMOKING signs and Patient's Rights posted?
- Is business conducted at the registration desk in a confidential manner (discussion, sign-in sheet, etc.)?
- Is staff aware of the confidentiality policy of office?
- Are restroom facilities available for waiting patients?
- Are hours of operation posted?
- Are all public and patient care areas clean, orderly and ample enough to accommodate patients?
- Is teaching literature available for the patient?

Staff Competency

- Personnel file for each employee contains a copy of their current licensure, if applicable, or documentation of their formal training or certification
- Each personnel file contains documentation of orientation to the facility, duties of their position, office medical equipment and procedures
- Each personnel file contains documentation of regular evaluations
- There is documentation of on-going education for all staff (Office in-services, staff meeting, conferences, etc.)
- There is documentation of annual OSHA training for bloodborne pathogens/hazardous materials
- Job descriptions are available for each position
- Staff has current CPR training
- There is documentation of acceptance or denial of Hepatitis B Immunization

Documents

- Current CLIA License
- Written Medical Waste Plan reviewed yearly
- Current Radiology Registration

- Written Emergency Preparedness and Disaster Plan with disaster drill documentation
- Copies of appropriate material safety data sheets (MSDS) for the office
- Bloodborne Pathogen Exposure Control Plan
- Manifests from Material Waste Processing Company
- Documented Quality Improvement Efforts
- Documentation of Well Water Safety if appropriate
- Documentation of Septic System Maintenance if appropriate
- Documentation of quarterly fire drills and yearly disaster drill

Policies

- Confidentiality (including all medical information relating to individual members)
- Conflict Resolution
- Staff Competency & Orientation
- Medication storage and administration (include Narcotics and method to dispose of expired medication)
- Infection Control
- Radiology (pregnancy, safety apparel, maintenance of equipment, use of dosimeters, verification of proper technique, etc.)
- Maintenance of medical equipment (plan for broken equipment and routine maintenance and calibration – include Emergency Box if appropriate)
- Staffing plan (to include call-in vacation coverage and delegation of responsibilities)
- Purging and storing of records
- Sterilization/High Level Disinfectant
- Advance Directives
- Abuse and Neglect
- Policy for reporting communicable diseases to the state
- Sentinel Events
- Documentation of “no show” follow up and phone contacts

Medications

- All stock and sample medications stored in a secure area away from patient access and in an appropriate manner (shelf, refrigerator)
- No oral and injectable medications stored together
- Documentation of regular review of all medicines for expiration dates
- A log is kept of all sample medications that are dispensed (to include patient name, drug, lot #, and name of person giving the medication)
- Multi dose vials are marked with the initials of the person opening the vial and the date opened
- Medications and laboratory specimens stored in separate refrigerators
- All narcotics are stored under double lock system and the key is secure
- A narcotic log is maintained each working day (to include current number of each item, name of drug and dosage given, name of patient given medication, date, medication given, and number remaining). All wastage should also be documented. Any count should be accomplished using two staff persons
- No medication identified for an individual is stored with stock medication
- Medication is not stored in a refrigerator with food or drink and a temperature log for the fridge is maintained (staff should be aware of the proper temperature to be maintained)
- The office participates in the Vaccines for Children Program and submits data to the MICR database

Diagnostic Medical Equipment

- Thermometers
- Pulse Oximetry
- EKG Machine
- Glucometer
- Treadmill
- Oxygen Tanks
- Aerosol Machines
- Cryocautery Machine
- Colposcopy Equipment
- Ultrasound Machine
- Peak Flow Meter
- Autoclave
- Other
- Equipment manuals are available for all medical equipment

Safety

- All Emergency exits are indicated. Emergency lights and electric exit signs are in working order
- Universal Precautions are always observed
- Fire Extinguishers are inspected at least yearly and have current markings
- Staff is aware of the location of fire pulls and fire extinguishers
- All fire exits are free of obstruction on both sides of the door (open all doors to check)
- Staff has been educated regarding the use and accessibility of MSDS
- Appropriate staff has received annual Bloodborne Pathogen Training and is aware of the Exposure control plan
- Appropriate Protective Apparel is provided (gowns, masks, gloves, face shields, etc.)
- All gases are stored in an appropriate manner (intact tanks, upright & secured position). Staff is aware of the process for determining volume
- Sharps containers are used and discarded when ¾ full (disposed of with biohazard material) and not within reach of children

Laboratory

- Quality checks are done and documented on each Waived Lab Test each day used
- No food, drink or medication is ingested near or stored with collected lab specimens (lab reagents may be stored with them in a separate container)
- No lab reagent is kept or used beyond its expiration date (Proper Disposal)
- All specimens are discarded in the proper manner after use
- All specimens should be labeled with the patient's name or ID# when multiple specimens are being tested

X-Ray

- Pregnancy Precautions for X-ray are posted
- Protective apparel is available and maintained including dosimeters
- Written plan for disposal of old films and developing agents
- X-ray room is identified with a system to protect other staff from exposure

Sterilization High/Level Disinfectant

- All items to be sterilized or disinfected are first cleaned with an enzymatic detergent, dried, and then processed maintaining a soiled to clean workflow

- Sterilized items are packaged appropriately, marked with a chemical test strip, the date processed, an expiration date, and then stored in the appropriate manner
- A log documenting each run and the chemical test strip is maintained, including the date and the signature of the person processing the run
- A monthly spore check is done and documented
- All containers holding chemical solutions are marked with the name of the solution, date of expiration, and the date solution was mixed
- Solution strength documentation exists for each day the solution is used
- The staff is aware of when sterilization with autoclave vs. high-level disinfectant should be done
- Glass thermometers are cleaned with alcohol and disposable probe covers are used for electronic thermometers
- Work surfaces soiled with biohazard materials are wiped down with commercial disinfectant material or a 10% bleach solution after the completion of testing
- There are sinks with soap and paper towels available in-patient care areas (bar soap on the sink is not acceptable). Liquid hand disinfectants may be used in instances where the activity has taken place in an area not supplied with a sink and then hands are washed as soon as a sink is available
- Hand washing is an expected practice before and after each patient encounter
- No food or beverage is consumed in any work area
- All equipment and surfaces are cleaned appropriately after patient use
- The staff is aware of the process for reporting communicable diseases to the state
- Staff has been educated for the instance of TB and the screening process

Exam Rooms

- Each room assures patient privacy
- No medications, needles or syringes are stored in exam rooms unless in a locked cabinet
- Exam room is childproofed as appropriate (electrical outlet covers, no harmful solutions within reach, etc.)
- Area is clean and organized with opaque bags in wastebaskets
- No patient care supplies or cardboard boxes stored on the floor or under the sinks
- There is an 18-inch clearance for sprinkler heads
- Clean laundry is covered
- No outdated material is stored

Medical Records

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

Medical records should be provided to Meridian within 10 business days of request, unless otherwise agreed. To help ease the burden on providers, accommodations can be arranged for individuals designated by Meridian to assist in extracting medical records for this request. Electronic access to medical records should be arranged wherever possible.

Procedure

All practitioners in the network must comply with the following:

1. Medical record documentation must include at least the following elements:
    a. All services provided directly by the practitioner
    b. All ancillary services and diagnostic tests ordered by the practitioner

c. All diagnostic and therapeutic services for which the member was referred by the practitioner (e.g. home health nursing reports, specialty provider reports, hospital discharge reports and physical therapy reports)

2. The essential documentation elements for the medical record include:
   a. History and physicals
   b. Allergies and adverse reactions, or NKDA, are prominently noted
   c. Problem lists of significant illnesses and medical conditions, with date of onset
   d. Medications (current medications, changes, discontinuation, and reported reactions)
   e. Working diagnoses are consistent with findings
   f. Treatment plans are consistent with diagnoses
   g. Preventive services/risk screenings
   h. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure

3. The Medical Record Keeping standard checks for the following:
   a. Presence of an organized medical record system (i.e. dividers by type of service such as lab reports/test, consults, etc.)
   b. The medical record is a unit record (bound and organized)
   c. Entries in the medical record are legible, signed and dated
   d. The medical record is available to the practitioner (attending and covering) at every visit and retrievable for review for ten years
   e. Patient information is kept confidential by ensuring that the records are stored securely and only authorized personnel have access to the records. Fax machines should be in an area that is not accessible by other patients to ensure confidentiality
   f. Acknowledgement of receipt of privacy notice in record (If not in individual records, there is a central file with acknowledgement of receipt of notice)

Note: Corrective action plans are requested of all providers whose compliance falls below stated levels (80%). Reassessment is subsequently completed within 6 months to verify improved performance and compliance.

A focused medical record review is performed annually as part of the continuous quality improvement activities of Meridian. In addition, an individual practitioner medical record review may be performed, when the apparent lack of compliance with the above standards is discovered during a utilization management or QI activity.

OSHA Training

Employee training and annual in-service education must include:
- Universal precautions
- Proper handling of blood spills
- HBV and HIV transmission and prevention protocol
- Needle stick exposure and management protocol
- Bloodborne pathogen training
- Sharps handling
- Proper disposal of contaminated materials
- Information concerning each employee's at-risk status

At-risk employees must be offered the 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 of Michigan, 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 Federal DEA
- CLIA certificate or waiver
- Medical Waste Management certificate
- X-ray equipment registration
- R-H 100 notice
- Radiology protection rules
- MIOSHA poster (#2010)

Q. Provider/Staff Education and Training

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

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

If you would like to request a training session, please call your Provider Network Development Representative or the Provider Services department at **888-773-2647**.

R. Language Services

In accordance with Title VI of the Civil Rights Act, Prohibition Against National Origin Discriminations, the President's Executive Order 131166, Section 1557 of the Patient Protection and Affordable Care Act, the Health Plan and its providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Language services are available at no cost to Meridian members and providers without unreasonable delay at all medical points of contact. The member has the right to file a grievance if cultural and linguistic needs are not met.

Language services include:

- Telephonic interpretation
- Oral translation (reading of English material in a member's preferred language)
- Face-to-face non-English interpretation
- American Sign Language
- Auxiliary aids, including alternate formats such as large print and braille
- Written translations for materials that are critical for obtaining health insurance coverage and access to health care services in non-English prevalent languages

Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the material is required by law or regulation to provide the document to an individual.

To obtain language services for a member, contact Meridian Provider Services. Face-to-face and American Sign Language services should be requested as soon as possible, or at least 5 business days before the appointment. All providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our Provider Customer Contact Center at: **888-773-2647** (TTY 711). You may also call the toll-free number on the back of our member's ID card.

Restrictions Related to Interpretation or Facilitation of Communication

- Providers may not request or require an individual with limited English proficiency to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
- Providers may not use an accompanying adult or minor child to interpreter or facilitate communication
- Exceptions to these expectations include:
    - In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
    - Accompanying adults (minors are excluded) where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs.

- Providers are encouraged to document in the member's medical record any member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

For more information, call Provider Services toll-free at **888-773-2647** (TDD/TTY: 711).

A. Clinical Practice Guidelines

Meridian has adopted evidence-based clinical practice guidelines (CPG) from regional and national external sources. The clinical practice guidelines are reviewed and approved every other year and, as necessary, by Meridian's Physician Advisory Committee and Quality Improvement Committee. Clinical practice guidelines can be viewed on the Meridian website at **mimeridian.com** under Training & Education Resources.