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Wellcare With Meridian (IL)

Provider Manual

2027

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Internal Approved 09152026

Partners in Quality Care

Dear Provider Partner,

At Wellcare, we deeply value your commitment to delivering compassionate, high-quality care to our members — your patients. Your role is essential in helping us serve individuals who rely on both Medicare and Medicaid, many of whom face complex health and social challenges.

Together, we ensure our members receive the coordinated care they need to live healthier, more fulfilling lives.

We are committed to quality — and that means supporting you with the tools, resources, and programs that help remove barriers to care. Whether it's identifying care gaps, navigating benefits, or addressing social needs, we're here to work alongside you and your team.

As part of our partnership, we also recognize and reward your efforts to close care gaps and improve outcomes. Your dedication makes a meaningful difference.

The enclosed D-SNP Provider Manual is your guide to working with Wellcare. We encourage you to explore the highlighted sections, which reflect our shared goal of delivering integrated, person-centered care.

Thank you for being a trusted Wellcare provider partner.

Sincerely,

Wellcare

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2027 D-SNP(DUALS) PROVIDER MANUAL REVISION TABLE

Date	Section	Sub-Header	Comments
1/1/2027	2: Member Benefit Information	Exclusions from Enrollment Sample Member ID Card Emergency Services Plan Coverage and Financial Responsibility Special Supplemental Benefits for the Chronically Ill (SSBCI):	Updated list; Updated member ID card sample; Clarified authorization language; Updated language; Added section
1/1/2027	3: Provider Functions and Responsibilities	Provider Credentialing/Re-Credentialing	Updated language
1/1/2027	4: Utilization Management	CMS Interoperability APIs — Provider Overview	Added new section
1/1/2027	5: Billing and Claims Payment	Retroactive Adjustments	Added new section
1/1/2027	7: Compliance and Regulatory Requirements	FRAUD, WASTE & ABUSE (FWA) Program	Updated language

SECTION 1: GENERAL INFORMATION

Welcome to the Wellcare With Meridian Provider Manual. This manual is a comprehensive resource for healthcare providers participating in our Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), administrated by Centene Corporation. Our FIDE-SNP product is designed to deliver seamless, coordinated care to individuals eligible for both Medicare and Medicaid, ensuring access to the full spectrum of covered services.

Within this manual, providers will find essential information on policies, procedures, and best practices that support high-quality, integrated care. Our goal is to empower providers with the tools and guidance needed to improve health outcomes and enhance the members' experience. We value our partnership with you and remain committed to supporting your efforts in delivering exceptional care to our members.

BACKGROUND

In May 2022, the Centers for Medicare & Medicaid Services (CMS) finalized regulatory requirements directing states participating in the Medicare-Medicaid Financial Alignment Initiative to end their demonstration programs by December 31, 2025, or transition to an integrated Dual Eligible Special Needs Plan (D-SNP) model.

In response to this guidance, the Illinois Department of Healthcare and Family Services (HFS) transitioned its existing Medicare-Medicaid Alignment Initiative (MMAI) program to a FIDE-SNP model effective January 1, 2026. A FIDE-SNP is a type of Medicare Advantage plan specifically designed to serve individuals who are dually eligible for both Medicare and Medicaid. It offers coordinated delivery of Medicare and Medicaid benefits through a single managed care organization.

FIDE-SNP Program Commitment and Transition Pillars

Wellcare With Meridian, in partnership with HFS, is committed to enhancing care delivery for low-income seniors and individuals with disabilities who are dually eligible for Medicare and Medicaid. This commitment will be upheld through the implementation of a FIDE-SNP, with the primary goal of ensuring continuity of benefits and maintaining high standards of care.

Wellcare With Meridian has adopted guiding principles aligned with the CMS Medicare-Medicaid Coordination Office (MMCO) and supported by the Resources for Integrated Care (RIC) initiative. These pillars promote high-quality, person-centered, and equitable care under the FIDE-SNP model:

- **Foster Integration and Continuity:** Illinois' FIDE-SNP program fully integrates Medicare and Medicaid services, bridging gaps between physical health, behavioral health, and long-term services and supports (LTSS). Members retain access to existing providers and services during the transition.
- **Reduce Racial and Ethnic Disparities:** HFS will use data-driven strategies to identify and address health disparities, ensuring culturally and linguistically appropriate services for diverse populations.
- **Improve Care Delivery:** FIDE-SNPs will implement a person-centered care model supported by interdisciplinary teams and robust care coordination.

- **Promote Self-Determination:** Members will be empowered to direct their care, especially in LTSS, with flexible models that honor individual preferences and goals.
- **Build a Culture of Quality:** Continuous quality improvement will be driven by integrated data systems, focusing on care coordination, health equity, and value-based payment reform.

HOW TO USE THIS MANUAL

The Wellcare With Meridian Provider Manual is a digital resource designed to provide comprehensive, easy-to-navigate guidance for participating providers. The manual is organized into clearly defined sections, each supported by a master Table of Contents and section-specific Tables of Contents for more precise navigation.

This manual is available digitally at wellcare.ILmeridian.com/for-providers.html.

Updates and Revisions

The Wellcare With Meridian Provider Manual is a living document, updated regularly to reflect changes in policies, procedures, and program requirements. Minor revisions may be communicated to providers through routine outreach or informational updates.

In the event of significant changes, a revised version of the manual will be issued and will replace previous editions. Providers are encouraged to reference the most current version, which is always available on the Wellcare With Meridian website at wellcare.ILmeridian.com/for-providers.html.

KEY CONTACTS INFORMATION

To support providers in delivering high-quality care, Wellcare With Meridian offers dedicated resources for assistance with clinical, administrative, and operational needs. The following contacts are available to help with questions related to claims, authorizations, pharmacy, and more.

Please refer to the table below for contact information:

wellcare With meridian	Wellcare With Meridian P.O. Box 10050 Van Nuys, CA 91410-0050 Phone: 1-844-536-2175 (TTY: 711) Hours of Operation: Monday-Friday, 8am-8pm CST wellcare.ILmeridian.com	
Department	**Phone**	**Website**
Provider Services	1-844-536-2175	N/A
Prior Authorizations		

wellcare With meridian	Wellcare With Meridian P.O. Box 10050 Van Nuys, CA 91410-0050 Phone: 1-844-536-2175 (TTY: 711) Hours of Operation: Monday-Friday, 8am-8pm CST wellcare.ILmeridian.com	
Department	**Phone**	**Website**
24 Nurse Advice Line	1-844-536-2180	
Member Services		
Care Management		
Pharmacy	1-800-867-6564	
Pharmacist	1-833-750-4200	N/A
Evolent	1-866-510-6340	www.radmd.com
CARES Hotline for Behavioral Health Crisis	1-800-345-9049	N/A
Vision: Premier Eye Care	1-855-865-9724	
Dental: Centene Dental Services	1-855-586-1415	
Interpreter Services	1-800-977-7522	
Fraud, Waste, & Abuse	1-866-685-8664	
Ethics & Compliance	1-800-345-1642	
Non-Emergent Transportation	1-844-299-6238	N/A

SECTION 2: MEMBER BENEFIT INFORMATION

MEMBER ELIGIBILITY AND ENROLLMENT

To enroll in a Wellcare With Meridian, individuals **must:**

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Have full Medicaid benefits (not partial duals)
- Be 21 years of age or older
- Not be enrolled in hospice
- Permanently reside in the Wellcare With Meridian service areas
- Be a U.S. citizen or lawfully present in the United States

EXCLUSIONS FROM ENROLLMENT

The following populations are excluded from enrollment in the program:

- Individuals under the age of 21
- Individuals with partial Medicaid eligibility (e.g., QMB, SLMB, QI, ALMB, QDWI)
- Individuals without full Medicaid coverage (e.g., spend-down status)
- Individuals who participate in the Home and Community-Based Services (HCBS) waiver for Adults with Developmental Disabilities
- Individuals receiving developmental disability institutional services
- Individuals enrolled in the Illinois Medicaid Breast and Cervical Cancer program
- Individuals residing in state psychiatric hospitals
- Individuals with Comprehensive Third-Party insurance (e.g., commercial HMO coverage)
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE)
- Individuals who are incarcerated

NON-DISCRIMINATION STATEMENT

Wellcare With Meridian will accept all eligible members regardless of:

- Race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family status.
- Furthermore, we will not limit, or condition coverage of plan benefits based on any factor that is related to the member's health status, including but not limited to:
  - Medical condition
  - Claims history
  - Receipt of healthcare
  - Medical history
  - Genetic information

- Evidence of insurability or disability

MEMBER RIGHTS AND RESPONSIBILITIES

Members of Wellcare With Meridian may have the following rights and responsibilities, in accordance with applicable federal and state laws, regulations, and the terms of the plan contract:

Access to Information

1. Members may request and receive information about the plan, including:
    a. Member rights and responsibilities
    b. Participating providers and their qualifications
    c. Grievance and appeal procedures
    d. Covered benefits and services
2. Provider information – such as location, qualifications, and availability – is accessible via the online provider directory or by contacting Member Services.
3. Members may request information about the plan's structure, operations, and benefits, and can expect responses to reasonable inquiries.
4. Plan rules, benefits, and available options may be explained to Members, with interpreter services made available when needed.

Language and Disability Services

5. Members may access, at no cost:
    a. Language assistance services, including qualified interpreters and translated written materials
    b. Auxiliary aids for effective communication, such as large print documents, audio materials, or accessible electronic formats
6. When available and upon request, the plan may assist in identifying providers who speak the Member's preferred language.

Dignity, Privacy, and Nondiscrimination

7. Members are to be treated with respect and dignity, with consideration for their right to privacy.
8. The plan is expected to comply with applicable laws regarding the confidentiality of personal health information. Members have the right to authorize or decline the release of their personal health information, consistent with those laws.
9. Members are protected from discrimination based on race, color, national origin, religion, sex, age, marital status, disability, sexual orientation, genetic information, source of payment, and other classifications protected by law.
10. Members may not be subjected to restraint or seclusion as a form of coercion, discipline, convenience, or retaliation.
11. Members should be able to exercise their rights without fear of negative consequences from the plan, its providers, or the state.

Participation in Care

12. Members are encouraged to participate in decisions about their healthcare, including the right to:
    a. Accept or refuse recommended treatment
    b. Discuss treatment options with their providers, including potential risks, benefits, and alternatives
13. Members may receive healthcare services in accordance with applicable laws and Wellcare With Meridian's agreement with the state.
14. Members may have access to a network of providers, including primary care providers, specialists, hospitals, and American Indian/Alaska Native providers when appropriate.
15. Members may access emergency services when medically necessary, regardless of network status or prior authorization.

Grievances, Appeals, and Involvement

16. Members may voice concerns or submit grievances and appeals regarding their care or plan services.
17. Members may request and review their medical records and request corrections as permitted by law.
18. Members may receive decisions related to service authorization, benefit coverage, and prescription drugs, including notification of appeal rights.
19. Members may recommend improvements to the plan's policies and procedures.
20. Members may participate in plan governance and operations, consistent with applicable rules and program structure.

Final Protections

21. Members are generally not responsible for bills, cost-sharing, or copayments for services covered by the plan, including those provided by American Indian/Alaska Native providers, when consistent with applicable program guidelines.

Reasonable Accommodations

22. The plan and its contracted providers are expected to provide reasonable accommodations for Members with disabilities, as required by law.
    a. Members may be informed annually – and as needed – about their rights to accommodations via the member handbook.
    b. Providers are informed of these requirements through the provider manual.
    c. Members may request accommodations through their care coordinator, who can help assess needs and provide available options.
    d. The Utilization Management team reviews accommodation requests and determines whether they can be provided.
    e. Members may appeal decisions regarding accommodations through the appeals process outlined in the plan policy.
23. Receive basic information about the plan, orally as well as in writing, upon request, about the organization of Wellcare With Meridian including but not limited to Member rights and responsibilities, participating practitioners and providers, grievance and appeal procedures, and covered services.

This information is made accessible to all Members including those with limited English proficiency or reading skills, with diverse cultural ethnic background, and with physical and mental disabilities.

MEMBER BENEFITS AND SERVICES

Wellcare With Meridian offers a comprehensive benefit package to members who are eligible for Medicare and full Medicaid benefits. Covered services are based on medical necessity and must meet professionally accepted standards of care. The plan integrates Medicare and Medicaid benefits, including LTSS, behavioral health, and preventive care.

Covered services may include:

- Primary and specialty care provider visits
- Hospital inpatient and outpatient services
- Emergency and urgent care services
- Ambulance and emergency medical transportation
- Behavioral health services, including outpatient therapy and psychiatric care
- Prescription drugs (Medicare Part D and Medicaid-covered medications)
- Dental services
- Vision services, including eye exams and eyeglasses
- Hearing services, including hearing aids
- Durable Medical Equipment (DME) and medical supplies
- Home healthcare and personal care services
- Skilled nursing facility care
- Rehabilitative therapies (physical, occupational, and speech therapy)
- Preventive services, including immunizations and screenings
- Family planning and reproductive health services
- Podiatry and chiropractic care
- Transportation to medical appointments (non-emergency medical transportation)
- Care coordination and case management
- Second medical opinions, when requested
- LTSS, including in-home and community-based services

Additional Notes

- Members do not have co-pays
- Prior authorization may be required for out-of-network services, except in case of emergencies
- Members have the right to receive care from Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Interpreter services and materials in alternative formats (e.g., large print, braille, or audio) are available at no cost to members

- Wellcare With Meridian will implement any changes to covered services as directed by the Illinois Department of Healthcare and Family Services (HFS), in alignment with updates to the Illinois Medicaid program
- Members should not be balance billed for covered services Non-Covered Services

While Wellcare With Meridian provides a wide range of integrated Medicare and Medicaid benefits, certain services are excluded from coverage under Illinois Medicaid and/or Medicare. These services are not reimbursable and will not be covered by the plan unless required by law or authorized under special circumstances.

Services not covered by the plan include:

- Elective abortions, except in case of rape, incest, or when the life of the pregnant person is endangered
- Experimental or investigational treatments, drugs, or equipment not approved by CMS or HFS
- Cosmetic surgery or procedures performed solely for aesthetic purposes
- Infertility treatments and related medications
- Erectile dysfunction medications (unless medically necessary and covered under Medicare Part D)
- Services not deemed medically necessary by the plan or state guidelines

Member ID Cards

Each Wellcare With Meridian member receives a personalized Member ID card upon enrollment. This card serves as proof of coverage and contains essential information that providers should verify prior to delivering services.

Key Information on the Member ID Card

- Member name and identification number
- Plan name and coverage type
- Effective date of coverage
- Contact information for Member Services
- Pharmacy, Vision, and Dental benefit details (if applicable)

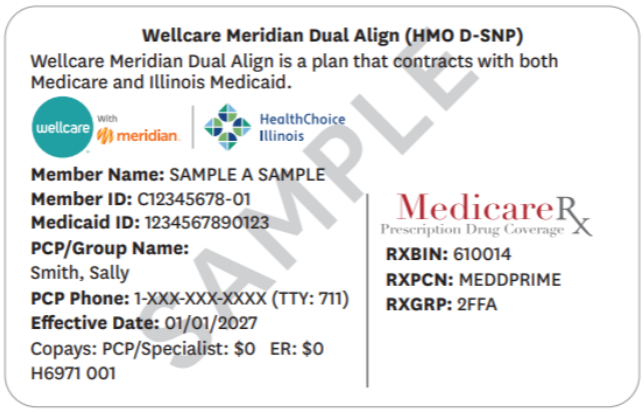
Provider Responsibilities

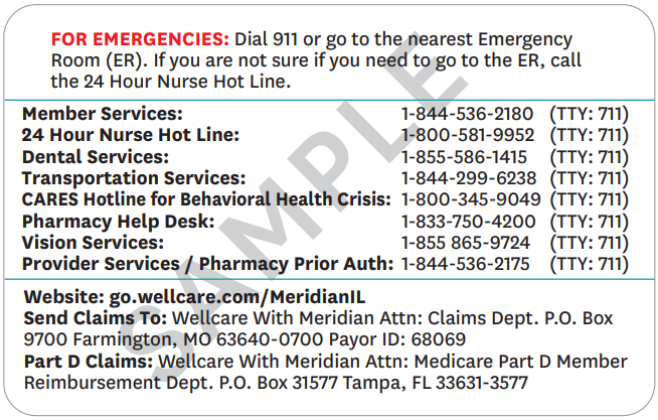
Providers are expected to:

- Verify member eligibility and benefits using the information on the ID card and the secure Provider Portal.
- Confirm the member's identity at the time of service.
- Use the Member ID number for all claims submissions and prior authorization requests.
- Contact the CARES line at **1-800-345-9049** if someone is experiencing a mental health crisis or you have concerns for their immediate safety, that they may harm themselves or worry that they may require inpatient psychiatric treatment.
- Contact Member Services at **1-844-536-2180** for clarification of benefit coverage.

Note: Possession of a Member ID card does not guarantee eligibility. Always verify current coverage through the Provider Portal or by contacting Provider Services.

Sample Member ID Card





Special Supplemental Benefits for the Chronically Ill (SSBCI)

Overview

Special Supplemental Benefits for the Chronically Ill (SSBCI) are supplemental benefits available to eligible members enrolled in a Wellcare With Meridian plan that offers SSBCI and who meet CMS-defined eligibility requirements.

Members are continuously reviewed through Wellcare With Meridian's automatic eligibility process using available claims, medical records, clinical assessments, and other approved clinical information. This automated process is the primary pathway used to determine SSBCI eligibility.

Provider Attestation Process

Provider attestation is an alternative qualification pathway for SSBCI benefits primarily intended for newly enrolled members when sufficient claims or clinical data may not yet be available to determine eligibility through the automatic eligibility process.

Members should schedule an in-person office visit or contact their healthcare provider to request that an attestation be submitted. A healthcare provider who is familiar with the member's medical history may attest whether the member meets all required SSBCI eligibility criteria.

Providers should visit the Wellcare With Meridian SSBCI Provider Attestation Portal to complete the online attestation. Providers with questions regarding the attestation process or who may require additional support with submitting an attestation should contact Provider Services using the phone number listed in the applicable Provider Manual or the phone number listed on the back of the member's ID card.

Please note: Provider attestation is for provider use only. Members cannot self-attest for SSBCI eligibility.

SSBCI Eligibility Requirements

To qualify for SSBCI benefits, members must meet **all three** CMS-defined eligibility criteria:

- Has one or more qualifying chronic conditions that is life threatening or significantly limits overall health or function
- Has a high risk of hospitalization or other adverse health outcomes
- Requires intensive care coordination

A diagnosis of a qualifying chronic condition alone does not qualify a member for SSBCI benefits. In addition to having one or more qualifying chronic conditions, eligibility for SSBCI may be demonstrated through one or more of the following:

- History of hospitalization or emergency department visits, and/or
- Frequent use of outpatient services or specialty care, and/or
- Evidence of poor disease control or medication adherence, and/or
- Non-medical social needs that impact health outcomes

Provider Instructions for Submitting an Attestation

Providers should follow these steps to submit an SSBCI attestation:

1. Access the Wellcare With Meridian SSBCI Provider Attestation portal at wellcare.ssbci.rrd.com
2. Review the eligibility criteria and evaluate whether the member meets all required SSBCI eligibility criteria
3. Complete and submit the electronic provider attestation
4. If applicable, submit a claim including the appropriate diagnosis coding consistent with the member's documented chronic condition(s) and services provided

Providers should complete the attestation based on their clinical judgment and evaluation of the member, certifying whether the member meets all required SSBCI eligibility criteria.

Determination Process & Member Notification

Once an attestation is submitted:

- The attestation will be reviewed as part of the SSBCI eligibility determination process
- The member will receive written notification of the determination within 10 business days
- Members determined eligible will receive information regarding available SSBCI benefits and how to access those benefits
- Members not meeting eligibility requirements will receive notification explaining the determination and appeal rights

Submission of a provider attestation does not guarantee approval. Eligibility determinations are based on the member meeting all applicable SSBCI eligibility requirements.

PHARMACY BENEFIT MANAGEMENT

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

In accordance with the requirements set forth by Illinois Department of Healthcare and Family Services (HFS), Wellcare With Meridian adopts the State's Health Plan Preferred Drug List for Medicaid. The formulary is designed to cover most therapeutic conditions. However, should a specific medication not listed on the formulary be deemed medically necessary for a member, a medical necessity exception may be requested through the prior authorization (PA) process. Additionally, certain specialized medications on the drug formulary require a PA before they can be dispensed.

The drug formulary is accessible on our website at wellcare.ILmeridian.com/drug-pharmacy/formulary.html. This formulary should be consulted when prescribing medications for Wellcare With Meridian members. Medicaid members have coverage for both prescription and specific over-the-counter medication.

While we encourage prescribing within the formulary, we recognize that situations arise where a formulary alternative is not available. Drugs requiring PA are identified in the formulary with a PA designation.

Wellcare With Meridian requires adherence to the following PA procedures for obtaining medically necessary non-formulary/non-covered drug products:

1. To receive a non-formulary/non-preferred medication, the prescriber must submit a prior authorization request using the form on our website located at wellcare.ILmeridian.com/drug-pharmacy/formulary.html or through covermymeds.com
2. The Pharmacy Services reviewer may request that the prescriber submit additional clinical information by fax to process the request
3. If the request is approved, pharmacy services 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 Pharmacy Services by telephone at **1-800-867-6564** with any questions or concerns

MEMBER SELF-REFERRALS

Family Planning

Family planning services include any medically approved method – such as diagnostic evaluation, medications, supplies, devices, and related counseling – used to voluntarily prevent or delay pregnancy, or to detect and treat sexually transmitted diseases (STDs). These services must be provided confidentially to individuals of childbearing age, including sexually active minors, who choose to avoid pregnancy or wish to manage the number and timing of their children.

Infertility treatment is not covered under the family planning benefit.

All Wellcare With Meridian members have the right to choose any qualified family planning provider, whether in-network or out-of-network. Primary Care Providers (PCPs) should support members by providing family planning services or assisting them in locating and selecting a family planning provider, as requested.

Members seeking additional information or assistance with family planning referrals may contact Member Services at 1-844-536-2180.

Women's Health

Female members may self-refer to any in-network OB/GYN for routine annual examinations and preventive screenings, including Pap smears, chlamydia testing, and mammograms. Members may also self-refer to an in-network OB/GYN of their choice for prenatal and perinatal care.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

FQHCs are essential community-based providers that deliver comprehensive healthcare services. All Wellcare With Meridian members have access to FQHCs when these services are available within their community. The Member Handbook outlines each member's right to seek care from an FQHC within their service area.

For more information or assistance accessing an FQHC, members may contact Member Services at 1-844-536-2180.

NON-EMERGENCY TRANSPORTATION

Meridian ensures that non-emergency transportation and travel expenses are readily available and accessible for members requiring medically necessary care. This service supports access to medical appointments, examinations, and treatments as determined necessary by the member's primary care provider.

Non-emergency transportation is available to support members' access to necessary care. Covered services include, but are not limited to:

- End Stage Renal Disease treatment (hemodialysis)
- Prenatal and preventive care
- Mental health services
- Prescription pickup
- Durable Medical Equipment (DME) supplies

Meridian partners with a transportation agency that maintains a provider network capable of servicing the entire geographic area in which members reside.

Accessing Non-Emergent Transportation Services

To schedule non-emergent transportation, the member, their primary care provider (PCP), or a Meridian representative may call the transportation vendor at 1-844-299-6238 or contact Member Services at 1-844-536-2180 for assistance.

The non-emergent transportation vendor will provide services for the following individuals:

- Members: All Meridian members for covered outpatient services
- Parents or Legal Guardians: May accompany minor or legally incapacitated members to appointments
- Other Family Members: Transportation for additional individuals (e.g., siblings) may be permitted, depending on circumstances and vendor policies but will need health plan approval

Transportation is provided to and from participating providers. If medically necessary services are only available through a non-participating provider, transportation may be arranged as directed by Wellcare With Meridian.

EMERGENCY SERVICES

Wellcare With Meridian provides coverage for emergency services in accordance with applicable Medicare and Medicaid requirements. When Illinois Medicaid covers emergency services not included under Medicare – or covers them at a greater amount, duration, or scope – Wellcare With Meridian will provide those services through Medicaid as outlined in our contract.

- Emergency Care Access: Emergency services are available to members 24 hours a day, 7 days a week. Emergency services do not require prior authorization under any circumstances in accordance with the Emergency Medical Treatment and Labor Act (EMTALA), using the prudent layperson standard.
- Medicare-Covered Emergency Services: Wellcare With Meridian covers appropriate cost sharing for emergency services and medical screenings provided under Medicare, including:
    - Emergency services are covered both within and outside the service area, including when a member is temporarily
    - Emergency care received without prior notice to the PCP or plan
    - Emergency transportation and professional services necessary to evaluate or stabilize an emergency medical condition
- Mobile Crisis Response: Members experiencing a behavioral health crisis have access to the CARES line.
    - It operates 24/7, 365 days a year.
    - It is accessed by calling 1-800-345-9049
    - CARES can dispatch a Mobile Crisis Response (MCR) team within 2 hours.
- Post-Stabilization Care:
  Wellcare With Meridian ensures coverage for post-stabilization services in alignment with 42 CFR §422.214 and §422.113. Cost-sharing coverage is provided under the following conditions:
    - Services are pre-approved by a plan provider or representative

- Services are delivered within one hour of a pre-approval request to maintain the members' stabilized condition without explicit prior approval
- Wellcare With Meridian fails to respond within the regulatory timeframe (1 hour) to a request for authorization
- No plan representative is available at the time of the authorization request
- A disagreement occurs between the treating provider and the plan representative, and the provider cannot consult with a plan provider in a timely manner

- Medical Screening and Stabilization:
  Hospitals providing emergency services must conduct a medical screening exam to determine if an emergency condition exists. If one is found, the provider must stabilize the member before discharge or transfer. Emergency services must continue until the member is clinically stabilized.
- Medicaid Coverage:
  For services not covered under Medicare but included under Medicaid, Wellcare With Meridian will ensure those services are provided as part of the member's benefits.
- Authorization Requirements After Stabilization:
  If additional care (e.g., hospitalization or specialty services) is needed following an emergency room visit, prior authorization may be required unless the circumstances meet any of the above exceptions.
- Coverage Ends When:
  - A Wellcare With Meridian provider assumes responsibility for the member's care
  - The member is transferred under the care of a plan-approved provider
  - An agreement is reached between the treating provider and the plan
  - The member is discharged

Definitions

Emergency Medical Condition

An emergency medical condition is defined as a medical condition manifesting acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in one or more of the following:

- Placing the health of the individual (or a pregnant woman and her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part
- Emergency Services

Emergency services are defined as covered inpatient and outpatient services that:

- Are provided by a qualified provider in accordance with federal requirements under Title 42, and

- Are necessary to evaluate or stabilize an emergency medical condition
- Post-stabilization care services

Post-stabilization care services are defined as medically necessary services provided after a Member has been stabilized, and are intended to:

- Maintain the stabilized condition; or
- Improve or resolve the Member's condition, consistent with 42 CFR §438.114(e)

Plan Coverage and Financial Responsibility

The plan covers and reimburses emergency services regardless of whether the provider is contracted with the plan.

The plan will not deny coverage for emergency services under the following circumstances:

- The Member experienced an emergency medical condition, even if the absence of immediate medical attention would not have led to the outcomes described above, or
- A plan representative directed the Member to seek emergency care

The plan does not:

- Restrict what qualifies as an emergency condition based solely on diagnosis or symptom lists,
- Deny emergency service claims due to lack of notification to the Member's Primary Care Provider, the plan, or DHS within 10 calendar days of treatment

Members will not be held financially liable for emergency services, including any balance billing beyond the plan's payment amount.

The attending emergency provider, or the provider treating the Member, is solely responsible for determining when the Member is stabilized for discharge or transfer. This determination is binding on the plan if:

- It adheres to accepted medical standards; and
- The services are covered under the plan's contract.

Post-stabilization Authorization and Coverage

Post-stabilization services do not require prior authorization when regulatory conditions apply. The plan is financially responsible for post-stabilization services provided by contracted or non-contracted providers when:

- Services are pre-approved by a plan provider or representative,
- Services are initiated within one hour of a request for pre-authorization, even if pre-approval is not yet obtained,
- The plan fails to respond within one hour, cannot be reached, or if the plan and the treating provider cannot reach agreement on care and no plan provider is available for consultation.

In such cases, the treating provider must be given the opportunity to consult with a plan provider, and care may proceed until such consultation occurs or until one of the criteria outlined in 42 CFR §422.113(c)(3) is met.

End of Plan Financial Responsibility

Wellcare With Meridian's financial responsibility for post-stabilization care services ends when any of the following occurs:

- A plan-affiliated provider with hospital privileges assumes responsibility for the Member's care;
- A plan-affiliated provider assumes care through transfer;
- The plan and the treating provider reach agreement on care; or
- The Member is discharged.

24 HOUR NURSE ADVICE LINE

Wellcare With Meridian offers a 24-Hour Nurse Advice Line as a resource to support members in making informed healthcare decisions. This service is intended to supplement, not replace, the care and guidance of the members' Primary Care Provider (PCP).

The Nurse Advice Line offers:

- General health information
- Guidance on appropriate levels of care
- Assistance understanding healthcare benefits
- Information on treatment options and available resources

This service is available at no cost to members, 24 hours a day, 7 days a week, 365 days a year.

Nurse Advice Line Phone Number: 1-855-323-4578 (TTY: 711)

Providers should encourage members to utilize the Nurse Advice Line for non-emergency medical questions or concerns, especially outside of regular office hours.

Wellcare With Meridian monitors member grievances and appeals as part of its quality oversight and compliance responsibilities. The grievance and appeal processes outlined below are in accordance with state and federal regulations and apply to all Wellcare With Meridian members.

MEMBER GRIEVANCE

A grievance is defined as any expression of dissatisfaction about matters other than an "action" (i.e., a denial, reduction, or termination of a service), which would be subject to the appeal process. Examples of grievances may include:

- Delays in obtaining timely appointments or referrals
- Concerns regarding provider or staff behavior
- Alleged violations of member rights
- Issues related to the quality of care or services received

Grievances may be submitted by the member, their authorized representative, or a provider acting on the member's behalf. Members may contact Wellcare With Meridian Member Services at 1-844-536-2180 to file a grievance.

Wellcare With Meridian offers both informal and formal grievance processes. Informal grievances are typically resolved during the initial interaction with Member Services.

Formal grievances should be submitted to:

Wellcare With Meridian
Appeals Department
P.O. Box 10052
Van Nuys, CA 91410

Upon receipt of a formal grievance, Wellcare With Meridian will send written acknowledgment within five (5) business days and issue a resolution within 30 calendar days of receipt. In cases involving clinical urgency, Wellcare With Meridian will request a response from the provider or facility within 24 hours. For standard grievances, provider responses are expected within seven (7) calendar days to support timely resolution.

Providers are expected to cooperate fully with Wellcare With Meridian in the investigation and resolution of member grievances, including responding to information requests within designated timeframes. Failure to respond may impact the resolution process or be escalated for contractual review.

Members will receive written notification of the grievance outcome, which will include the resolution determination and any next steps, if applicable.

Member Appeals

An appeal is a formal request from the member, their authorized representative, or provider to review a decision made by Wellcare With Meridian to deny, reduce, delay, or terminate a requested service or payment. Examples include:

- Denial of a service based on medical necessity
- Denial of payment for a service already received
- Termination or reduction of a previously authorized service

Non-Urgent Pre-Service Appeal

Members have 65 calendar 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, delay, 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 Wellcare With Meridian for an authorized representative to appeal on their behalf.

Members have the right to appeal an adverse benefit determination. Appeals may be submitted to the Wellcare With Meridian Appeals Department or by phone through Member Services at **1-844-536-2180**. If submitted in writing, the appeal should include a valid phone number for follow-up and confirmation of receipt.

Appeals should be mailed to:

Wellcare With Meridian
Appeals Department
P.O. Box 10052
Van Nuys, CA 91410

Within five business days of receiving a member's appeal, Wellcare With Meridian will notify the member of all the information that is required to process the request. Appeals are reviewed and resolved within 14 calendar days from the date of receipt.

Appeals are reviewed by a qualified clinical peer reviewer holding the same or similar specialty as the treating provider. The reviewer will not be the same individual who made the initial determination to deny, reduce, or terminate services.

Wellcare With Meridian will provide written notification of the appeal decision to the member, the Primary Care Provider (PCP), and any other provider directly involved in the appeal.

Expedited Appeals

A member or their provider may call Member Services at **1-844-536-2180** 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

If an appeal is deemed urgent, the member must obtain written confirmation from their provider who attests that the standard appeal timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function.

Upon receipt of the expedited appeal, Wellcare With Meridian will notify the member within 24 hours if additional information is required. A decision will be rendered within 24 hours of receiving the expedited request.

The outcome will be communicated verbally to the member, their PCP, and any other provider involved in the appeal, followed by written notification.

Note: Wellcare With Meridian prohibits any punitive action against a provider who requests an expedited resolution or supports a member's appeal.

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 plan only if the following are met:

- A provider must substantiate, either orally or in writing, that the standard timeframe 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 plan.

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

Illinois HFS
Bureau of Administrative Hearings
401 South Clinton Street, 6th Floor
Chicago, IL 60607
Phone: 1-855-418-4421
Fax: 1 (312) 793-2005

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. Members must first exhaust the internal appeal process through the plan before filing a request for an external review with the IL Department of Insurance (IDOI).

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 Member receives an adverse determination or final adverse determination from the plan.

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

Illinois HFS
Bureau of Administrative Hearings
401 South Clinton Street, 6th Floor
Chicago, IL 60607
Phone: 1-855-418-4421
Fax: 1 (312) 793-2005

SECTION 3: PROVIDER FUNCTIONS AND RESPONSIBILITIES

PRIMARY CARE/MANAGED CARE PROGRAM

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

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

Primary Care Provider (PCP) Roles and Responsibilities

Each Wellcare With Meridian member selects a PCP who is responsible for coordinating the member's total healthcare. PCPs are required to work 20 hours per week per location, and be available 24 hours a day, seven days a week.

Female members will have direct access to women's health specialists to provide women's routine and preventative healthcare services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

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

All providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members.

Behavioral Health Provider Roles and Responsibilities

Behavioral Health (BH) Providers play a critical role in supporting the safety, stability, and recovery of Wellcare With Meridian Members. Behavioral Health Providers are expected to deliver clinically appropriate, person-centered care and to collaborate with the Plan, Care Management, and community-based crisis resources to ensure members receive timely and effective services across the continuum of care.

Behavioral Health Provider responsibilities include, but are not limited to, the following:

Access to Covered Behavioral Health Services

- Provide behavioral health services in accordance with the Member's benefits, medical necessity criteria, and applicable state and federal regulations.
- Verify eligibility and benefit coverage prior to service delivery.
- Obtain prior authorization as required for services subject to utilization management requirements.

Care Coordination and Communication

- Collaborate with Primary Care Providers (PCPs), Care Managers, hospitals, and other treating providers to support integrated, whole-person care.
- Participate in care planning activities, including Interdisciplinary Care Team (ICT) meetings, when requested.
- Communicate changes in clinical status, treatment needs, or risk factors to the Plan or designated Care Manager in a timely manner.

Crisis Identification and Response

- When able to assess members for acute behavioral health needs, including risk of harm to self or others, worsening psychiatric symptoms, or loss of functional stability.
- Utilize least restrictive, community-based interventions whenever clinically appropriate.

Education and Member/Caregiver Awareness of CARES

Behavioral Health Providers are responsible for **educating members and, when appropriate, their families and caregivers** about available behavioral health crisis resources, including the Illinois Crisis Assistance Response and Engagement Services (CARES) line.

- Inform members and caregivers that **CARES is available 24 hours a day, 7 days a week, 365 days a year** for behavioral health crisis support.
- Educate members that **anyone may call CARES**, including the member, family members, caregivers, or providers, when a behavioral health crisis occurs.
- Reinforce that calling CARES can result in **telephonic crisis screening, referral, and dispatch of a Mobile Crisis Response (MCR) team**, typically within two (2) hours.
- Explain that CARES and MCR services are designed to help stabilize crises in the **least restrictive setting** and may help divert unnecessary emergency department visits or inpatient admissions.
- Encourage Members and caregivers to keep the CARES phone number readily available: **CARES: 1-800-345-9049**

Referral to CARES and Mobile Crisis Response

- Utilize the CARES line when Members experience behavioral health crises that require immediate assessment, de-escalation, or on-site intervention.
- Coordinate with CARES and Mobile Crisis Response teams, as needed, to support crisis stabilization and follow-up care.
- Cooperate with post-crisis coordination efforts to ensure linkage to outpatient services, medication management, and ongoing supports.

Post-Crisis Follow-Up

- Engage in follow-up care following a CARES or Mobile Crisis Response intervention to support continued stabilization.
- Coordinate with Wellcare With Meridian Care Management to address ongoing behavioral health needs, social determinants of health, and access to services.
- Participate in transition planning, including referrals to appropriate outpatient or community-based services.

For additional information on Behavioral Health resources please visit
ILmeridian.com/providers/resources/behavioral-health-provider-resources.html

Specialty Care Provider Roles and Responsibilities

Wellcare With Meridian recognizes that the specialty provider is a valuable team member in delivering care to Wellcare With Meridian Medicare members. Key specialty provider roles and responsibilities include, but are not limited to:

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

Hospital Roles and Responsibilities

Wellcare With Meridian recognizes that the hospital is a valuable team member in delivering care to Wellcare With Meridian members. Essential hospital responsibilities include, but are not limited to:

- Coordination of discharge planning with Wellcare With Meridian Utilization Management staff
- Coordination of mental health/substance use disorder care with the appropriate state agency or provider
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent member information to Wellcare With Meridian and to the PCP
- Communication of all hospital admissions to the Wellcare With Meridian Utilization Management staff within one business day of admission
- Issuing all appropriate service denial letters to identified members
- **Behavioral Health Crisis Coordination:** Utilize Illinois Crisis Assistance Response and Engagement Services (CARES) for members experiencing behavioral health crises when clinically appropriate, to stabilize members in the least restrictive setting and to support diversion from unnecessary inpatient psychiatric admissions when appropriate.
- CARES Hotline: **1-800-345-9049** (24/7/365).

Ancillary/Organization Provider Roles and Responsibilities

Wellcare With Meridian recognizes that the ancillary provider is a valuable team member in delivering care to Wellcare With Meridian members. Critical ancillary provider responsibilities include, but are not limited to:

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

Freedom of Provider Communications

Wellcare With Meridian does not impose any limitations or restrictions on a provider's ability to communicate openly and honestly with Members regarding their health status, treatment options, or plan of care. Providers may freely discuss all available medical services or treatment alternatives, regardless of benefit coverage, consistent with their professional judgement and ethical standards.

APPOINTMENT STANDARDS

All participating providers are required to comply with Wellcare With Meridian's standards for appointment availability and in-office wait times. These standards are established to ensure that Members receive timely access to medically necessary services based on the urgency of their clinical needs.

Wellcare With Meridian continuously monitors provider adherence to these standards through various oversight mechanisms. Providers found to be out of compliance may be subject to corrective action plans, up to and including contract review.

Type of Care	Length of Wait Time
Primary Care Appointments	
Preventive/Routine Care	Within twenty-five (25) business days of request
Urgent/Non-Emergent (Medically Necessary) Care	Within one (1) business day of request
Non-Urgent/Non-Emergent Conditions (Medically Necessary)	Within seven (7) business days of request
Non-Urgent/Non-Emergent Conditions (Not Medically Necessary)	Within three (3) weeks of request
Initial Prenatal w/o Problems (First Trimester)	Within two (2) weeks of request
Prenatal (Second Trimester)	Within one (1) week of request
Prenatal (Third Trimester)	Within three (3) calendar days of request
Office Wait Time	Within thirty (30) minutes

Type of Care	Length of Wait Time
NOTE: Hours must be the same for all members regardless of member's health plan.	
Behavioral Health Appointments	
Type of Care/Appointment	**Length of Wait Time**
Life-Threatening Emergency	Immediate admittance or referred to the Emergency Room
Non-Life-Threatening Emergency	Within six (6) hours of request
Urgent Care Visit	Within forty-eight (48) hours of request
Initial Visit for Routine Care	Within ten (10) business days of request
Follow-Up Visit for Routine Care	Within twenty (20) business days of request
Office Wait Time	Within thirty (30) minutes
NOTE: Hours must be the same for all members regardless of member's health plan.	
Specialty Care Appointments	
Type of Care/Appointment	**Length of Wait Time**
Preventive/Routine Care (Adult)	Within twenty-five (25) business days of request
Urgent/Non-Emergent (Medically Necessary) Care	Within one (1) business day of request
Non-Urgent/Non-Emergent Conditions (Medically Necessary)	Within seven (7) business days of request
Non-Urgent/Non-Emergent Conditions (Not Medically Necessary)	Within three (3) weeks of request
Office Wait Time	Within thirty (30) minutes
NOTE: Hours must be the same for all members regardless of member's health plan.	

Medical coverage 24 hours a day, 7 days a week

Primary Care and Behavioral Health After Hours Requirements

All participating provider agreements with PCPs, specialists, and behavioral health providers require physicians to provide members with access to care 24 hours a day, seven days a week.

Acceptable after-hours access mechanisms include:

- Answering service
- On-call pager/cellular connection
- Call forwarding to practitioner's home/other location

- Published after-hours telephone number and recorded voice message directing patients to a practitioner for urgent and non-life-threatening conditions.

Acceptable after-hours answering machine instructions include:

Primary Care (PCP)	Behavioral Health (BH)*
Answering system with option to page physician	Answering system provides a direct transfer or paging option to a Behavioral Health practitioner or on-call clinician
Provides number to access physician live or answering service	Answering system directs or directly connects callers to 24-hour crisis services
Nurse with access to a physician	Advice Nurse with access to physician
Pages provides once message is left	Pages provider once message is left
Please hold or Press # for Physician Exchange	Please hold or Press # for an answering service

**New NCQA standard, effective July 2026*

Note that the following options are **NOT** acceptable for after-hours instructions:

- An answering machine that only takes a message
- Message providers a phone number, page, email, text, or voicemail without direct connection
- Recommending that members call during business hours
- Recommending member go to an urgent care center or Emergency Room

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

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

After-Hours Voice Message MUST contain ONE of the following:

- Message forwards to on-call practitioner
- Message forwards to an answering service
- Message gives the on-call practitioner's number
- Message gives the on-call practitioner's pager number
- Message refers patient to another office, practitioner, or on-call service

CONFIDENTIALITY AND ACCURACY OF MEMBER RECORDS

Medical records and other health and enrollment information of a member must be managed under established procedures that:

- Safeguard the privacy of any information that identifies a particular member

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

In addition to the obligation to safeguard the privacy and security of any information that identifies a particular member, the plan and all participating providers are each obligated to abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and member information. First tier and downstream providers must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)) and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, within requested time frames, and maintain records a minimum of 10 years.

OBLIGATIONS OF RECIPIENTS OF FEDERAL FUNDS

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

At minimum, Wellcare With Meridian can check the HFS health professions website monthly for excluded providers. At minimum, Wellcare With Meridian can check the OIG List of Excluded Individual Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)] for its providers at least monthly, before contracting with the provider, and at the time of a provider's credentialing and recredentialing. If a provider is terminated or suspended from the HFS Medicaid Program, Medicare, or another state's Medicaid program, or is the subject of a state or federal licensing action, the plan shall terminate, suspend, or decline a provider from its Provider Network as appropriate.

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

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

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

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at exclusions.oig.hhs.gov.
- The General Services Administration List of Debarred Wellcare With Meridian providers can be found at www.sam.gov.
- More information on the Preclusion List can be found at Preclusion List | CMS.

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 Illinois 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 Illinois and the Federal DEA
- CLIA certificate or waiver
- Medical Waste Management certificate
- X-ray equipment registration
- R-H 100 notice
- Radiology protection rules

PROVIDER CREDENTIALING, RE-CREDENTIALING, AND IMPACT ENROLLMENT

Providers applying for participation with Wellcare With Meridian must be credentialed. In most instances, participating providers should be enrolled with Illinois Medicaid through the Illinois Medicaid Program

Advanced Cloud Technology (IMPACT). For providers enrolled in IMPACT, Meridian will accept the HFS credentialed status.

In the case providers are not registered with IMPACT, Wellcare With Meridian requires credentialing to be completed with us prior to participation. Please note, providers of Medicaid only services must be IMPACT enrolled for participation in Wellcare With Meridian.

Wellcare With Meridian Credentialing Process

For providers who are not enrolled in IMPACT and require direct credentialing by Wellcare With Meridian, the process outlined below will apply.

The provider's credentialing and re-credentialing processes require that all providers keep the Wellcare With Meridian's Provider Services department 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. Wellcare With 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.

Wellcare With Meridian will notify providers of any material discrepancies between credentialing verification data and the information submitted by the provider during the credentialing process, giving them the opportunity to correct erroneous information. Notification will include the time frame for making the correction and includes the contact information for submitting the correction/explanation which must be submitted in writing before the due date stated on the notification.

The provider must inform Wellcare With Meridian in writing of their intent to correct any erroneous information.

Wellcare With 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.

All individuals or entities that furnish services to, or order, refer, or certify the need for services provided to individuals eligible under Illinois Medicaid must be enrolled in the Illinois Medicaid program. To receive reimbursement for Medicaid-covered services rendered to eligible beneficiaries, providers must complete the enrollment process and obtain approval through the Illinois Medicaid Management Information System (IMPACT).

Note: Enrollment in IMPACT is required for participation in a managed care network but does not obligate providers to accept Medicaid fee-for-service beneficiaries. For additional information regarding enrollment

requirements, providers are encouraged to consult relevant guidance issued by the Illinois Department of Healthcare and Family Services (HFS) and review applicable policy communications.

Appeals Process

Wellcare With Meridian maintains a formal appeal process for any provider or applicant who is denied new or continued participation in the provider network.

When an Applicant receives a non-approval notice, the affected practitioner has 30 calendar days from receipt of the notice to file a written request for reconsideration. The request must include additional supporting documentation in favor of the applicant's consideration for network participation and should be directed to the Wellcare With Meridian Quality Medical Director via Provider Services. To submit a reconsideration request or obtain further instructions, please contact Provider Services at **1-844-536-2175.**

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

The request is presented to the Credentialing Committee at the next regularly scheduled meeting but in no case later than sixty (60) calendar days from the receipt of additional information. The Committee may recommend:

- Support of the original denial recommendation by the Credentialing Committee and closure of the file; OR
- Support of the applicant's ability to meet the plan minimum participation criteria and approval of the applicant for inclusion in the plan practitioner network.

The Medical Director/Credentialing Committee Chair, or designee, notifies the applicant in writing within thirty (30) calendar days of the Credentialing Committee decision.

When a practitioner's current participation status is being suspended, restricted or terminated based on issue of quality of care or service, the plan offers and informs the practitioner of their right to a formal appeal hearing. Information about the appeal process and where to submit the request is included within the notification letter. The request for the appeal hearing must be submitted in writing to the Credentialing contact listed on the notification letter within thirty (30) calendar days of the date of the notice. Failure to deliver the request within 30 calendar days constitutes a waiver of hearing rights and the Credentialing Committee's proposed decision becomes final.

In the event a practitioner requests a hearing pursuant to this Policy and Procedure, the plan appoints an Appeals Committee on an ad hoc basis. The Appeals Committee conducts hearings regarding proposed decisions from the Credentialing Committee to suspend, restrict or terminate the network participation of practitioners. The Appeals Committee is comprised of a minimum of three (3) network practitioners, including at least one who is in the same specialty as the practitioner under review.

SECTION 4: UTILIZATION MANAGEMENT

The objective of Wellcare With Meridian 's Utilization Management (UM) 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. Unlike traditional HMOs, where prior authorization is needed for most services, DSNP operations require a referral from the PCP and, when appropriate, an authorization as outlined below.

Access to the Utilization Management Staff

For Utilization Management inquiries, you may call Provider Services during normal business hours Monday-Friday, 8 a.m. to 5 p.m. at **1-844-536-2175**. The provider portal is available 24/7 to check the 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. Wellcare With 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 clinical staff uses plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by Wellcare With Meridian medical directors. In certain circumstances, external review of service requests is conducted by qualified, licensed providers with the appropriate clinical expertise.

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

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

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

In situations where neither NCDs nor LCDs, nor guidance in Medicare manuals exist, Wellcare With Meridian may reference current literature reviews and Optum, Inc.'s InterQual criteria to inform coverage decisions. When appropriate, Wellcare With Meridian consults with practicing providers and medical experts within the relevant field. Additionally, Wellcare With Meridian considers government agency policies, standards set by nationally recognized accreditation organizations, and Wellcare With Meridian Medical Management policies in its clinical decision-making process. Wellcare With Meridian may also align its coverage policies with those of other Medicare-Advantage (MA) Organizations within its service area when applicable.

Wellcare With 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 consistently with 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 Provider Services department at 1-844-536-2175. 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 provider within 30 days of the original date of service prior to claim denial.

CARE MANAGEMENT PROGRAM

Wellcare With Meridian offers a comprehensive, member centered Care Management program designed to support Members with physical health, behavioral health and social determinant of health needs. The program promotes care coordination, education, advocacy, and connection to resources that support improved health outcomes and access to appropriate healthcare services across the continuum of care.

Providers play an integral role in partnering with the Care Management team to ensure Members receive timely, appropriate, coordinated, and cost-effective healthcare services. Providers are encouraged to collaborate with Care Coordinators to identify and address barriers to care, support adherence to treatment plans, and facilitate access to needed services and resources.

Care Coordinators may contact providers to:

- Participate in the Member's Interdisciplinary Care Team (ICT) meetings.
- Coordinate or update a Member's Individualized Care Plan (ICP).
- Confirm diagnoses, treatment plans, or test results.
- Identify gaps in care or adherence concerns.
- Address behavioral health needs and social determinants of health.
- Coordinate transitions of care and follow-up services.

Disease Management (DM) and Behavioral Health (BH) Management are embedded within the Care Management Program and delivered through an integrated, multidisciplinary model of care. Members and caregivers receive education, support, care coordination, and health coaching designed to encourage self-management, healthy behavior changes, and improved quality of life. The program takes a whole-person approach by addressing physical health, behavioral health, and social support needs in a coordinated manner. Behavioral health goals and interventions are incorporated into the overall Care Management

Program, and interdisciplinary case consultations involving Care Coordinators and Medical Directors from both physical and behavioral health disciplines occur as needed to support coordinated, member-centered care.

Program components may include:

- Care coordination across healthcare settings and providers.
- Management of care transitions following hospitalization, emergency department visits, or stays in other institutional settings.
- Symptom and chronic disease management.
- Medication reconciliation and medication management.
- Coordination of preventive and acute care services.
- Identification of and referral for community-based resources and social support services.
- Support for Members experiencing exacerbations of chronic conditions.

Wellcare With Meridian's Care Management Program utilizes an integrated multidisciplinary team of clinical and non-clinical professionals, including Care Coordinators and support staff. Care Coordinators assess Members' clinical and social needs, identify risk factors, develop individualized care plans, establish health goals, monitor progress, and update care plans as needed to reflect changing circumstances.

Care Coordinators collaborate closely with Primary Care Providers (PCPs), specialists, behavioral health providers, community organizations, and other members of the healthcare team to facilitate access to services and support the delivery of person-centered care. They also serve as a resource to providers by helping connect Members with medical, behavioral health, residential, community-based, and social support services when appropriate.

Providers may request additional Care Management support for any Member and are encouraged to partner with the Care Management team whenever coordination needs are identified.

Member Identification and Risk Stratification

Because all Members are automatically enrolled in Care Management upon enrollment in the health plan, Wellcare With Meridian uses Member-specific data, health information, and predictive modeling to stratify Members according to their level of risk and care coordination needs. Members are assigned a low, moderate, or high-risk designation to help prioritize outreach and care coordination activities.

While all Members are eligible for Care Management services, the frequency and intensity of outreach, care planning, interventions, and Care Coordinator involvement may vary based on the Member's assessed needs and risk level.

Members may be identified for enhanced Care Management interventions through various sources, including:

- Health Risk Assessments (HRAs).
- Referrals from PCPs or specialists.

- Member self-referrals.
- Family or caregiver referrals.
- Internal department referrals.
- Claims, utilization, and predictive modeling data.
- Hospitalization, emergency department utilization, or other transition of care events.

Key Elements of Care Management

Wellcare With Meridian views Care Management as a critical component of delivering coordinated, high-quality care to Members. Key elements of the Care Management process include:

Clinical Assessment and Evaluation

A comprehensive assessment is conducted to evaluate the Member's physical, behavioral, social, and functional needs, support systems, and available resources.

Care Planning

Care Coordinators collaborate with the Member, caregivers, PCPs, specialists, and other members of the healthcare team to develop and maintain an individualized care plan that addresses identified needs, goals, barriers, and interventions. Individualized Care Plans are shared in accordance with the Model of Care and applicable regulatory requirements.

Service Facilitation and Coordination

Care Coordinators work with providers, caregivers, and community resources to facilitate adherence to care plans and access to necessary services, supports, and benefits.

Member Advocacy

Care Coordinators assist Members in navigating the healthcare system, advocating for needed services, and addressing barriers that may affect health outcomes and access to care.

INTEGRATED CARE TEAM (ICT)

Providers identified as part of a Member's Interdisciplinary Care Team (ICT) are encouraged to actively participate in the care planning process. The ICT works collaboratively with the Member and their support system to ensure care is coordinated, person-centered, and aligned with the Member's goals, preferences, and healthcare needs.

Accessing Care Management Services

All Wellcare With Meridian Members are assigned a Care Coordinator. Providers may contact a Member's Care Coordinator through the secure Provider Portal using the Notify CM function or by calling Member Services at 1-844-536-2180.

MODEL OF CARE OVERVIEW

The Model of Care (MOC) provides the basic framework under which Wellcare With Meridian will meet the needs of our Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) Members. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each Member are identified and addressed through the plan's Care Management practices.

Wellcare With Meridian identifies, supports, and engages our most vulnerable Members at any point in their healthcare continuum to help them achieve an improved health status. Wellcare With Meridian provides services in a Member-centric fashion. Wellcare With Meridian's objectives for serving Members with complex and special needs include, but are not limited to:

- Conducting population assessments during Model of Care renewal cycles to identify the needs of the population and subpopulations, so Care Management processes and resources can be updated to address Member needs.
- Promoting preventive health services and the management of chronic diseases through Care Management programs that encourage the use of services to decrease future morbidity and mortality in Members.
- Conducting comprehensive health assessments that identify Member needs and barriers to care.
- Coordinating transitions of care for Members with complex and special needs to assist in navigating the complex healthcare system and accessing Provider, public and private community-based resources.
- Improving access to primary and specialty care for Members with complex health conditions so they receive appropriate services.
- Consulting with appropriate specialized healthcare personnel when needed such as Medical Directors, pharmacists, social workers and behavioral health professionals, etc.
- Ensuring that Members' socioeconomic barriers are addressed.

Effectiveness of the Model of Care Program is evaluated through the identification of objective, measurable, and population-specific quality indicators. Indicator data is collected on a routine and ad hoc basis, outcomes are analyzed, opportunities are identified, interventions are implemented for goal attainment, and reports are generated for ongoing monitoring. Data collection follows protocols established in approved policies and/or program designs. Data sources include administrative data such as claims, survey data, medical record documentation, or a combination of sources. There is a documented systematic step sequence for administrative data collection. Standardized tools are developed for utilization with any manual data collection such as extraction of data from medical records. Statistically valid sampling techniques are used as appropriate.

Wellcare With Meridian has established performance outcomes for SNP plans to evaluate and measure the quality of care, quality outcomes, service, and access for Members. For each metric, benchmarks have been established based on evidenced-based medicine found in current literature, standards, and guidelines. Root cause analysis is conducted, and interventions identified for each indicator that falls below the desired value. The analysis, process improvement plan, implementation of interventions, and improvements are reported to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) for review, feedback, and approval.

Model of Care Training

Applicable to participating and non-participating Providers that treat FIDE SNP Members, Wellcare With Meridian reviews and updates, as needed, the Model of Care (MOC) training annually at the beginning of each year. Wellcare With Meridian offers a printable self-study training guide which can be found at Model of Care Program | Wellcare. If Providers would like to request a copy mailed, they can contact Provider Services at 1-844-536-2175.

CRISIS AND REFERRAL ENTRY SERVICES (CARES)/ MOBILE CRISIS RESPONSE

All DSNP members have access to the State of Illinois Behavioral Health Crisis line, known as CARES. This service is available 24/7, 365 days a year, and provides immediate telephonic crisis screening and referral support for Enrollees, their family members, and other concerned parties seeking behavioral health crisis assistance.

CARES is staffed by clinicians capable of addressing behavioral health crises upon direct answer and can facilitate connection to Mobile Crisis Response services when appropriate. This resource is designed to ensure timely support and improved access to behavioral health interventions for our DSNP population.

The role of CARES / Mobile Crisis response team is:

Core Supports and Services Offered

- Face-to-face evaluation of emotional, psychiatric, and behavioral health needs.
- Use of standardized tools through the Illinois Medicaid Crisis Assessment Tool (IM-CAT).

De-escalation and Immediate Stabilization

- Therapeutic interventions to reduce distress and agitation.
- Verbal de-escalation, grounding techniques, and emotional support.
- Focus on trauma-informed, recovery-oriented care, prioritizing safety and dignity.

Crisis Safety Planning

- Development of a personalized Crisis Safety Plan including the identification of:
    - Warning signs and triggers
    - Coping strategies
    - Support persons
    - Emergency contacts
- Plans are designed to prevent escalation and future crises.

Coordination to Ongoing Services

- Assistance when need with psychiatric hospitalization
- Diversion of emergency room visits
- Support around locating the least restrictive level of care including:
    - Outpatient therapy and psychiatry
    - Medication management

- Community mental health programs
- Substance use treatment

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 5 calendar days after Wellcare With Meridian receives the request for service.

Expedited Organization Determination (Urgent/Expedited Preservice Request): Expedited organization determinations are service requests 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 determination will be made as expeditiously as the Member's health condition requires, but no later than 48 hours after receiving the Member's or Provider's request. An extension may be granted for an additional 5 calendar days if the Member requests an extension or if Wellcare With Meridian justifies a need for additional information and documents how the delay is in the interest of the Member.

Requests for expedited review will require provider attestation confirming the clinical 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. Wellcare With Meridian's nurse reviewers assess the care and services provided in an inpatient setting and the member's response to the care by applying InterQual® criteria. Together with the facility's staff, Utilization Management's clinical staff coordinates the members' discharge needs.

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

- Obtain and 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 facilitate the authorization of post discharge services, such as DME, home health services, and outpatient services

Providers must notify Wellcare With Meridian within one business day of admission.

Prior Approval Requirements/ Precertification

Wellcare With Meridian offers multiple methods to submit authorization requests. For the most efficient and timely service—use of Wellcare With Meridian 's online Prior Authorization (PA) Form is the preferred method of submitting requests. For additional information regarding PA refer to the Service Authorization Program webpage.

1. **Authorization requirements –** Refer to the Prior Authorization Check tool to confirm PA necessity
2. **Online Submission –** The Wellcare With Meridian Online PA Form can be accessed by visiting the secure Provider Portal

3. **Fax Submission –** Refer to Utilization Management's referral type fax numbers. Please include pertinent clinical documentation with the request if indicated
4. **Phone Submission –** Many authorizations cannot be processed via phone, as clinical review and supporting documentation are required. Requests should only be submitted via the phone for services related to pending hospital discharges or expedited pre-certification requests.

Wellcare With Meridian	
Type of Request	Fax Number
Inpatient Admissions	1-855-581-2251
Post-Acute Admissions	1-844-409-5557
Pre-Service Standard Requests	1-844-409-5557
Pre-Service Expedited Requests (Phone)	1-855-581-2251
Part B	1-844-409-5557
Part D (prescription drugs)	1-866-388-1767
Behavioral Health	1-833-419-0129

When submitting a PA 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)

Decision Timeframes – Prior Authorizations			
Review Type	Make Decision	Written/Verbal Notification	Written Notification (Denials)
Pre-Service Non-urgent	Within 5 days of receipt of the request	Within 5 days of receipt of the request	Within 5 days of receipt of the request
Pre-Service Urgent	Within 48 hours of receipt of the request	Within 48 hours of receipt of the request	Within 48 hours of receipt of the request
Urgent Concurrent	Within 24 hours of receipt of the request, 48 hours if clinical is not included with initial request	Within 24 hours of receipt of the request, 48 hours if clinical is not included with initial request	Within 48 hours of the decision

CMS INTEROPERABILITY APIS — PROVIDER OVERVIEW

In support of federal CMS interoperability requirements, Wellcare With offers a set of standardized application programming interfaces (APIs) that support improved data sharing between providers, health plans, and members. Two of these - the **Prior Authorization API** and the **Provider Access API** - are designed specifically to reduce administrative burden, streamline clinical workflows, and strengthen care coordination through the secure, electronic exchange of information within participating EHR/EMR systems.

Prior Authorization API

Providers whose EHR/EMR vendor has connected to the Prior Authorization API may be able to check authorization requirements, identify required documentation, submit prior authorization requests, and receive status updates and decisions electronically within their existing clinical workflow. These capabilities bring greater transparency to the process and support more efficient prior authorization processing for medical items and services.

Provider Access API

Providers whose EHR/EMR vendor has connected to the Provider Access API may be able to retrieve eligible patient claims, clinical, and prior authorization information to support treatment and care coordination. Access is generally limited to providers with an active treatment relationship and remains subject to applicable member consent and privacy requirements.

Additional Interoperability APIs

CMS interoperability requirements also include the **Patient Access API**, which allows members to share their health information with third-party applications; the **Payer-to-Payer API**, which supports electronic data exchange when members change plans or are covered by more than one health plan; and the **Provider Directory API**, which makes provider directory information available to third-party applications.

For detailed educational materials, implementation guidance, a list of connected EHR/EMR vendors, and frequently asked questions, providers are encouraged to visit the **wellcare.ILmeridian.com/for-providers.html**.

CLINICAL INFORMATION

Clinical information should be provided at the time of submission of the request. The provider or facility is responsible for ensuring services are authorized prior to service delivery. Wellcare With 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 member's:

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

Clinical Practice Guidelines

Wellcare With Meridian encourages the use of evidence-based Clinical Practice Guidelines (CPGs) by all participating providers. These guidelines are available under the Provider section of our website: **wellcare.ILmeridian.com/for-providers.html**.

Whenever possible, Wellcare With Meridian adopts preventive and clinical practice guidelines that are:

- Published by nationally recognized organizations (e.g., CDC, USPSTF, AHRQ),
- Endorsed by government institutions, or
- Developed through statewide collaboratives or consensus among healthcare professionals in the relevant field.

These guidelines are reviewed and selected with the needs of the Illinois FIDE-SNP population in mind. This includes individuals who are dually eligible for Medicare and Medicaid, and who may require:

- Home and community-based services (HCBS),
- Behavioral health support, and
- Management of chronic and complex conditions.

The goal is to support whole-person, integrated care that improves health outcomes, promotes independence, and aligns with the principles of the Model of Care for FIDE-SNPs.

SERVICES REQUIRING PRIOR AUTHORIZATION

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

Wellcare With 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 members' 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). You can check the requirements for any code on our website at **wellcare.ILmeridian.com/for-providers.html** Codes that are not listed on the applicable Medicaid fee schedule may not be payable by Wellcare With Meridian.

Inpatient Services

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

Durable Medical Equipment (DME)[1]

- DME items are covered according to the Illinois Department of Healthcare and Family Services (HFS) Medicaid Fee Schedule and are subject to 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
- Hysterectomy
- Spinal Surgeries
- Varicose Vein Surgery
- Breast Reduction
- Septoplasty
- Rhinoplasty
- Experimental and Investigational procedures

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 authorization requirements using the Prior Authorization Check tool.

[1] *This list is not all inclusive and is subject to change.*

MENTAL HEALTH OUTPATIENT VISITS FOR MEMBERS WITH MILD-TO-MODERATE BEHAVIORAL HEALTHCARE NEEDS

Wellcare With Meridian covers mental health outpatient services for members with mild to moderate behavioral health conditions. You may contact our Behavioral Health staff at 1-844-536-2175 to assist a member with the following services:

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

SPECIALTY NETWORK ACCESS TO CARE

Referrals to Specialists may be considered when an appropriate in-network specialist is not available, or when a second opinion is requested following consultation or treatment by an in-network specialist. Specialist referrals 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 healthcare public entities via Wellcare With Meridian's Provider Portal at www.ilmeridian.com/providers/login.html, fax or by calling Wellcare With Meridian at 1-844-536-2175. Wellcare With Meridian's staff will forward the information and authorization to Provider Services. Wellcare With Meridian will fax you a copy of the approved referral notification form along with contact information to the public entity.

DENIALS AND RECONSIDERATIONS

Denials based on medical necessity may only be issued by a Wellcare With Meridian Medical Director. When a denial occurs, the requesting provider will be notified via phone to discuss the decision.

In addition to verbal communication, a written denial notice is:

- Faxed to the requesting provider, and
- Mailed to the member

The denial notice includes the following:

- The specific reason(s) for the denial,
- A reference to the applicable benefit provision and/or clinical guideline used to make the decision,
- Instructions on how to request a free copy of the benefit provision and/or guideline,
- A clear description of the members' appeal rights, and
- Step-by-step instructions for submitting an appeal.

EVOLENT

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Wellcare With Meridian uses Evolent to provide prior authorization services and utilization management for advanced imaging and radiology services. Evolent 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
- PET

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization;
- It is the responsibility of the ordering provider 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 Evolent and obtain authorization, please call **1-866-510-4470 (TTY: 711)** and follow the prompt for radiology authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call Provider Services.

Cardiac Solutions

Wellcare With Meridian in collaboration with Evolent, offers a cardiac imaging program to promote healthcare quality for members with possible cardiac disease.

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

Evolent has 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. Evolent also 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 the members' 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 members' 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 member
- 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

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 Evolent:

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

To reach Evolent and obtain authorization, please call **1-866-510-4470 (TTY: 711)** and follow the prompt for radiology and cardiac authorizations. Evolent 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, speech, and occupational therapy) provided to our members are consistent with nationally recognized clinical guidelines, Wellcare With Meridian has partnered with Evolent to implement a prior authorization program for physical medicine services. Evolent provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Wellcare With Meridian members.

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by Evolent'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 Evolent. 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 Wellcare With Meridian retro authorization guidelines. There is no need to send member records in advance. Evolent 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 the agreement between Wellcare With Meridian and Evolent, Wellcare With Meridian oversees the Evolent Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, the provider and the member will receive notice of the coverage decision.

For questions, please contact Wellcare With Meridian Provider Services at **1-844-536-2175 (TTY: 711)**.

Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering provider 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 is required for each procedure ordered. Prior authorization is not required through Evolent 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 Wellcare With Meridian. To obtain authorization through Evolent, visit RadMD.com or call **1-866-510-4470 (TTY: 711)**.

Musculoskeletal (MSK) Management Program

The MSK program currently requires prior authorization for non-emergent outpatient, interventional spine pain management services (IPM), and will be expanded to include spinal cord stimulators, and inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries for our members.

It is the responsibility of the ordering provider to obtain prior authorization for all IPM procedures and MSK surgeries managed by Evolent. Evolent does not manage prior authorization for emergency MSK surgery cases that are admitted through the emergency room or for MSK surgery procedures outside of those procedures listed above. The ordering provider must obtain prior authorization with Evolent prior to performing the surgery/procedure. Facility admissions do not require a separate prior authorization. However, the facility should ensure that an Evolent prior authorization has been obtained prior to scheduling the surgery/procedure.

MSK surgeries other than those outlined above will continue to follow prior authorization requirements for hospital admissions and elective surgeries as outlined for the Wellcare With Meridian FIDE-SNP line of business.

SECTION 5: BILLING AND CLAIMS PAYMENT

OVERVIEW

Wellcare With Meridian's Claims Department is structured to ensure accurate and timely processing of provider claims. Provider Services can be reached toll-free at **1-844-536-2175** for claims-related inquiries.

CLEAN CLAIM SUBMISSION

Wellcare With Meridian only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) Claim Forms whether filing on paper or electronically. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Wellcare With Meridian does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10- or 12- point Times New Roman font and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten forms and nonstandard will be rejected upfront and returned to the provider. To reduce document handling time, do not use highlights, italics, bold text, or staples for multiple page submissions. If you have questions regarding what type of forms to complete, contact Provider Services.

CLAIMS BILLING REQUIREMENT

All services that are dually covered should be billed under Medicare billing guidelines utilizing the Medicare required codes and appropriate claim forms. Medicaid only services, such as HCBS waiver services, CMHC, CCBHC, certain Hospice services, SUPR, SLF, SMHRF and custodial care nursing facility services should follow Medicaid billing guidelines.

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

1. Uses the data elements of UB-04 (UB-04 Version 050) or CMS 1500 as appropriate http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf
2. It is submitted within 180 days of the date the service was performed
3. Identifies the member (Medicare member ID, address, and date of birth)
4. Identify the plan (plan name and/or member ID number)
5. Lists the date (mm/dd/yyyy) and place of service
6. Includes additional documentation based upon services rendered as reasonably required by Wellcare With Meridian Medical Policies
7. Is a claim for which the provider has verified the member's eligibility and enrollment in Wellcare With Meridian before the claim was submitted
8. Is not a duplicate of a claim
9. Is submitted in compliance with all of Wellcare With Meridian's prior authorization and claims submission guidelines and procedures

10. For Medicaid only services, a claim for which the provider has exhausted all known other insurance resources (Medicaid is the payer of last resort)

Providers may submit and check the status of claims electronically via Availity Essentials.

Note: For fastest, most accurate processing, electronic submission is preferred.

Paper claims must be submitted on a red and white claim form. Submit all paper claims to:

Wellcare With Meridian
ATTN: Claims Department
P.O. Box 9700
Farmington, MO 63640-0700

ELECTRONIC CLAIMS SUBMISSION

Providers using electronic submission shall submit all claims to Wellcare With 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.

In-network providers may submit claims through the secure provider portal at www.ilmeridian.com/providers/login.html.

Clearinghouses

The preferred method for submitting claims is electronically. This can be done through clearinghouses or via the online Provider Portal.

If you are re-submitting a claim for a status or a correction, please indicate "Status" or "Claims Correction" on the claim.

Wellcare With Meridian currently accepts electronic claims through the following clearinghouse:

Availity Essentials

- **Customer Support: 1-800-282-4548**
- **Claim Types:** Professional/Facility
- **Payer ID:** 68069

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

Wellcare With Meridian may add new clearinghouses partners periodically. Providers should contact Provider Services at **1-844-536-2175** to verify whether their current clearinghouse is included in the approved list.

Availity Essentials

Wellcare With Meridian has chosen Availity Essentials as its new, secure provider portal. Providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access Wellcare With Meridian payer resources via Availity Essentials. Our current secure portal will still be available for other functions you may use today.

If you are new to Availity Essentials, getting your Availity Essentials account is the first step toward working with Wellcare With Meridian on Availity Essentials. Your provider organization's designated Availity Essentials administrator is the person responsible for registering your organization in Availity Essentials and managing user accounts. This person should have legal authority to sign agreements for your organization. If you are the administrator, you can register and get started with Availity Essentials. If you need additional assistance with your registration, please call Availity Essentials Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday, 8 a.m. – 8 p.m. ET. For general questions, please reach out to your Provider Engagement Representative.

TIMELY FILING OF CLAIMS

A claim must be submitted within 180 calendar days from the date of service.

CORRECTED CLAIMS

Providers must submit a corrected claim when changes are needed to a previously submitted initial claim.

If a claim was denied or partially paid due to an error in the original submission, the provider must revise the relevant section and resubmit the corrected claim within 180 calendar days from EOP date for Medicare covered services. However, corrected claims must not be submitted later than one year from the date of service (DOS).

Submission Requirements

- **CMS-1500 Claims:** Include the appropriate resubmission code (value 7) in Field 22, along with the original claim number.
- **EDI 837P Claims:** Submit using the 2300 Loop, segment CLM05 (value 7), and include the original claim number in segment REF*F8*.
- **UB-04 Claims:** Use the resubmission code (value 7) in the third digit of the bill type and enter the original claim number in Field 64.
- **EDI 837I Claims:** Submit using the 2300 Loop, segment CLM05 (value 7), and include the original claim number in segment REF*F8*.

Important: Claims submitted without the required resubmission indicators and original claim number will be treated as new submissions and may be denied as duplicates.

This process applies only to denied or incorrectly processed claims. It does not apply to rejected claims, which must be corrected and resubmitted as new claims.

Providers are encouraged to submit corrected claims electronically using the appropriate EDI format. Alternatively, submissions may be made through the secure Provider Portal or Availity Essentials. While

attaching the original EOP or a claim adjustment request form is optional when submitting online, providers may include them for reference if desired.

OVERPAYMENTS

Providers are required to promptly notify Wellcare With Meridian upon identification of any overpayment. Identified overpayments must be returned to the plan within sixty (60) calendar days, accompanied by written documentation detailing the reason for the overpayment.

Overpayment and Recovery

Wellcare With 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 setup error, claim processing error, and claims paid to the wrong provider. Notification date for recovery will be limited to 12 months from date of payment.
- Identified through a medical record audit: Notification date for recovery will be limited to 12 months from the date of payment. If the audit reveals fraud, waste, or abuse, the 12-month look-back period will no longer apply.
- Fraud and abuse: Adjustment/notification date for the recovery 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, Wellcare With Meridian will not provide prior written notice of a recovery. Wellcare With 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 FWA: Contact Wellcare With Meridian through the FWA Hotline at **1-866-685-8664**. All reporting of possible FWA may be done anonymously through this hotline. The Special Investigations Unit can be contacted by email at: Special_Investigations_Unit@centene.com, or by mail at:

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

RETROACTIVE ADJUSTMENTS

Should CMS Risk Adjustment activity retroactively increase or decrease payments, including Risk Adjustment Data Validation (RADV), and for adjustments made by CMS to Health Plan's monthly payments based upon changes in eligibility, capitation payments to Providers shall be retroactively adjusted on a proportional basis.

Wellcare may contract with a vendor to conduct premium enhancing activities. Any fees resulting from premium enhancing activities conducted by Wellcare's vendor will be charged back to Provider during the period when the premium changes are realized. The vendor will sign a HIPAA compliant Business Associate Agreement with Wellcare that allows it to collect PHI on our behalf.

REIMBURSEMENT GUIDELINES

Member Billing

Pursuant to Law, Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payor is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Wellcare With Meridian to the Provider. Providers may not bill Wellcare With Meridian DSNP members for covered services, also known as "balance billing," regardless of whether they believe the amount paid or will be paid by Wellcare With Meridian is appropriate or sufficient. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable patient liability towards covered Medicaid services such as custodial nursing facility care.

PAYSPAN® ELECTRONIC PAYMENTS & REMITTANCE

Overview

PaySpan® is Wellcare With Meridian's preferred secure electronic payment solution that allows providers to receive claim payments and remittance information electronically. Through PaySpan, providers can access payment details quickly, streamline reimbursement processes, and reduce administrative burden associated with paper checks and mailed EOBs.

Benefits to Providers

- **Faster Payments:** Receive claim payments via EFT (Electronic Funds Transfer), reducing delays associated with paper checks.
- **Convenient Online Access:** View remittance information (835s/EOBs) online, download reports, and reconcile payments in real time.
- **Customizable Preferences:** Choose how and when payments are received, including grouping, notification settings, and reporting formats.
- **Enhanced Security:** EFT reduces risk of lost, stolen, or misdirected checks.
- **Improved Administrative Efficiency:** Streamlined payment workflows allow billing teams to reduce manual posting and improve cash flow management.

Enrollment

Providers who have not yet enrolled in PaySpan must complete the online registration process. During enrollment, providers will:

- Verify TIN/NPI credentials
- Provide banking information for EFT
- Set up user accounts and security preferences

Providers should have their most recent payment or provider information available to complete registration.

Existing PaySpan providers will be required to add the Wellcare With Meridian's line of business to their existing account using their TIN. Failure to register the new line of business may result in providers receiving paper checks.

How to Access PaySpan

Providers may log in to PaySpan's secure portal at www.payspanhealth.com.

Support & Assistance

For enrollment assistance, password resets, or technical questions, providers may contact PaySpan Customer Service:

- **PaySpan Support: 1-877-331-7154**
- **Email:** providersupport@payspanhealth.com
- **Hours:** Monday–Friday, 8 a.m. to 8 p.m. EST

For questions related to claim payment amounts or adjudication decisions (not system access), providers should contact Provider Services at **1-844-536-2175**.

PROVIDER COMPLAINTS, APPEALS AND DISPUTES

Wellcare With Meridian is committed to maintaining open communication and ensuring timely resolution of provider concerns. An internal complaint and resolution process is available to both in-network and out-of-network providers. This process includes:

- A claim dispute process for contesting payment decisions after a claim has been adjudicated
- A service authorization dispute process for contesting authorization denials or changes to previously approved services (e.g., reductions, suspensions, or terminations)
- A standardized tracking system, as designed by the Illinois Department of Healthcare and Family Services (HFS), which records the date a complaint is filed and the date of resolution, if applicable
- A resolution process that aims to provide a substantive response within 30 calendar days of receiving the complaint

All provider's complaints will be assigned a tracking number (e.g., Z016CCW00046) for reference and follow-up.

Providers should follow the appropriate process outlined in this manual to submit complaints based on the nature of the issue (e.g., claim disputes, authorization denials). If a provider is unable to resolve a concern through the standard process, they may contact the Provider Engagement team for additional support.

Wellcare With Meridian is dedicated to fostering collaborative relationships with providers and resolving concerns through transparent and timely communication.

If all internal resolution efforts have been exhausted, providers may also utilize the HFS Managed Care Provider Resolution Portal, available at hfs.illinois.gov.

Provider Appeals and Claim Dispute Process

- **Provider Appeals (Post-Service Authorization Appeals):** Provider appeals are related to authorizations that were denied in whole or in part for medical necessity. Providers' appeals are submitted post-service. An authorization denial will result in a denied claim.
- **Provider Claim Disputes:** Provider claim disputes are related to claim payment denials, including claims denied for authorization when the provider failed to obtain the required authorization, and claim processing and/or payment discrepancies.

Wellcare With Meridian's provider appeal and claim dispute process is available to all providers, regardless of whether they are in or out of network.

Provider Appeal Rights for Authorizations Decisions for Medicare Covered Services

Contracted providers: In accordance with Medicare managed care regulations, CMS does not govern Medicare appeal rights for claims submitted by contracted providers which are denied for authorization reasons. However, Wellcare With Meridian allows appeals of authorization denials. Requests for a contracted provider claim review related to authorization denials must be received by Wellcare With Meridian within 90 days from the date of the EOP. A copy of this EOP and supporting justification or documentation (such as medical records) must be submitted with the review request.

Non-contracted providers: In accordance with Medicare managed care regulations, non-contracted providers have Medicare appeal rights. Medicare appeal rights apply to any claim for which Wellcare With Meridian has denied payment for authorization reasons. All requests for payment appeals must include a completed and signed "Waiver of Liability" (WOL) statement. The WOL document is available at: https://www.cms.gov/medicare/appeals-grievances/managed-care/notices-forms

Wellcare With Meridian cannot begin the appeals process until a completed and signed WOL is received. Requests for appeals that do not include a WOL will be issued a Notice of Dismissal of Appeal request. Requests for payment appeals must be filed within 65 calendar days of the EOP for non-contracted providers.

Appeal requests for contacted and non-contracted providers should include a copy of the EOP and all supporting documentation (such as medical records when applicable) and be submitted to the following address:

Wellcare With Meridian
Attn: Appeals
P.O. Box 9700
Farmington, MO 63640-0700

Provider Appeal Rights for Authorization Decisions For Medicaid only services: Please refer to the Meridian Provider Manual located at ILmeridian.com/providers/resources/forms-resources.html for appeals timelines. Appeals should be sent to

Wellcare With Meridian
Attn: Appeals
P.O. Box 9700
Farmington, MO 63640-0700

Claim Disputes

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

If the original determination is upheld, the provider will be notified within 30 days of receipt of the dispute. If additional information is needed, such as medical records, then Wellcare With Meridian will respond within 30 days of receiving the necessary information. The written determination will include a detailed explanation of the determination. If the original determination is overturned, the provider will see payment details on the EOP.

There is only one level of dispute available within Wellcare With Meridian. All dispute determinations are final. If a provider disagrees with Wellcare With Meridian's determination regarding a dispute, the in or out-of-network provider may pursue other options as outlined below.

Disputes may be filed via the provider portal. This method allows the quickest and easiest method of disputing claims payment. The provider portal also allows attachment to be included with the dispute.

If a paper dispute is needed, please send to:

Wellcare With Meridian
Attn: Provider Claim Disputes
P.O. Box 9700
Farmington, MO 63640-0700

MEDICAL RECORDS

All medical records requested by Wellcare With 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 Wellcare With 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 Wellcare With 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 to 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 member 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. Member 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 members 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 Wellcare With 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.

SECTION 6: REPORTING REQUIREMENTS

CRITICAL INCIDENTS REPORTING

Wellcare With Meridian requires participating program providers to report all Critical Incidents that occur in HCBS delivery settings. These settings include 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 receive Critical Incident education materials and can access additional information on Wellcare With Meridian's website. Providers must participate in trainings offered by Wellcare With Meridian to ensure accurate and timely reporting of all critical incidents. These trainings may be offered through webinars, online learning, and regional meetings.

Critical incidents include but are not limited to:

- Unanticipated death of a member
- Any abuse, such as physical, sexual, mental, or emotional
- Theft or financial exploitation of a member
- Severe injury sustained by a member
- Medication error involving a member
- Neglect and/or suspected neglect of a member
- Suicide ideation/suicide attempt

A Critical Incident Report must be submitted to Wellcare With Meridian by email to criticalincidents@mhplan.com no later than 24 hours following the discovery of the incident. Providers must cooperate fully in the investigation of reported Critical Incidents, including submitting all requested documentation. If the incident involves an employee or HCBS provider, the provider must also submit a written report of the incident including actions taken within 20 calendar days of the incident. To protect the safety of the member, actions that can be taken immediately include (but are not limited to) the following:

- Contact 911 if the incident poses immediate/severe harm to the member.
- Removing the worker from the member's case if the incident involves allegations of improper behavior by that worker.
- Removing the accused worker from servicing all Wellcare With Meridian program members until the investigation is complete, which may take up to 30 calendar days.
- Ordering an immediate drug screen or appropriate testing if the allegation involves theft of drugs or substance use, including alcohol, while on the job.
- Interviewing the involved employee(s) as soon as possible following the incident and having them submit a written account of events. Email these written accounts to criticalincidents@mhplan.com along with documentation to support completion of pre-employment screenings including background checks, drug screening, and a statement that the employee did not begin to perform

services for Wellcare With Meridian program members until all required pre-employment screenings were completed and verified.

Based on the severity of the incident, any identified trends, or failure on the part of the provider to cooperate with the investigation, the provider may be required to submit a written plan of correction to address and rectify any issues related to the critical incident.

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, they must report the incident to the appropriate State agency. Use the following phone numbers to report suspicions of abuse, neglect, or exploitation.

Incident Reporting

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

Incident Involves	Contact	Timeframe
All adults (including those with disabilities), ages 18–59, living in an institutional setting Cases of suicidal ideation for members with developmental disabilities (DD) or mental health concerns residing in an institutional setting	Illinois Department of Human Services Office of the Inspector General Hotline: **1-800-368-1463** (Voice and TTY)	Immediately
Adults with disabilities, ages 18-59, living in a community setting Older adults (60 years of age and older) regardless of residence	Adult Protective Services Hotline: **1-866-800-1409** **1-800-206-1327**	Immediately
All adults, ages 18–59, living in a community setting	Local Police Department	Immediately
Nursing facility resident	Department of Public Health's Registry Hotline[2]: **1-800-252-4343**	Immediately
Supportive Living Facility resident	Department of Healthcare and Family Services' SLF Complaint Hotline: **1-844-528-8444**	Immediately

For more information, please complete the Critical Incident Training on Wellcare With Meridian's website at **wellcare.ILmeridian.com/for-providers.html**.

[2] The hotline also investigates allegations of actual or potential harm to patients, patients' rights, infection control, and medication errors. Complaints submitted are limited to hospitals, nursing homes, home health agencies, hospices, end-stage renal dialysis units, ambulatory surgical treatment centers, rural health clinics, critical access hospitals, clinical laboratories (CLIA), outpatient physical therapy, portable X-ray services, community mental health centers, accredited mental health centers (Medicare only)

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 Wellcare With Meridian submits to the State of Illinois requires your compliance with this requirement.

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

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 member encounter reflecting all services provided by the providers of the plan. The State will determine the minimum data elements of the encounter reporting. The submission format is the ANSI X12 837 standard this format is consistent with the formats and coding conventions of the CMS 1500 and UB-04. PCPs will submit their 837 Encounter data monthly to Wellcare With Meridian, who must then submit it to the HFS via the state's SFTP. Both Wellcare With 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 Wellcare With Meridian's contract with providers, it is required that Provider Preventable Conditions (PPCs) associated with claims be reported to Wellcare With 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 been prevented through the application of evidence-based guidelines.

Medicare requires all delegated vendors, delegated Providers, and capitated Providers to submit encounter data to Centene, even if they are reimbursed through a capitated arrangement.

This section is intended to give Providers necessary information to allow them to submit encounter data to Centene. If the encounter data does not meet the requirements set forth in Centene's government contracts for timeliness of submission, completeness or accuracy, federal and state agencies (for example, CMS) have the ability to impose significant financial sanctions on Centene.

ELECTRONIC VISIT VERIFICATION

What is Electronic Visit Verification (EVV)?

Electronic Visit Verification (EVV) is a validation of the date, time, location, type of Personal Care Services (PCS) or Home Health (HH) Care Services provided, and the individual(s) providing and receiving services. The EVV system will electronically capture:

- The type of service performed
- Beneficiary, client, or participant receiving the service

- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

Why was the EVV system implemented?

The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use Electronic Visit Verification (EVV) for Personal Care Services (PCS) and Home Health Care Services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan.

What services require EVV?

Per CMS, EVV must be used to record all personal care services and all home healthcare services that require an in-home visit.

CMS defines personal care services as help with:

1. Activities of Daily Living (ADLs), such as bathing, dressing, toileting, mobility, and grooming.
2. Instrumental Activities of Daily Living (IADLs), such as meal preparation, shopping, laundry, and housekeeping.

For additional information pertaining to EVV, please visit Illinois' Electronic Visit Verification (EVV) | HFS

SECTION 7: COMPLIANCE AND REGULATORY REQUIREMENTS

FRAUD, WASTE & ABUSE (FWA) PROGRAM

Purpose and Commitment

Wellcare With Meridian is committed to the prevention, detection, investigation, and reporting of suspected **fraud, waste, and abuse (FWA)** in accordance with applicable **federal and state laws, regulations, and contractual requirements**. FWA impacts the healthcare system broadly and may result in significant and unnecessary costs to publicly funded programs.

Wellcare With Meridian has developed an aggressive, proactive fraud waste and abuse ("FWA") program designed to collect, analyze and evaluate data to identify suspected fraud, waste and abuse.

Detection tools have been developed to identify patterns of healthcare service use, including over utilization, unbundling, up-coding, misuse of modifiers, services not rendered and other common schemes

Through its parent company, **Centene Corporation (Centene)**, Wellcare With Meridian maintains a dedicated **Special Investigations Unit (SIU)** and an established FWA program designed to:

- Collect, analyze, and evaluate data to identify potential FWA patterns
- Conduct audits and investigations to assess billing and documentation compliance
- Implement corrective actions, recover overpayments when appropriate, and refer matters to regulatory or law enforcement agencies as required

DEFINITIONS (42 CFR §455.2 AND HHS DEFINITIONS)

For purposes of this manual:

- **Fraud**: An intentional deception or misrepresentation made with knowledge that the deception could result in an unauthorized benefit to the individual or another party. This includes any act that constitutes fraud under applicable federal or state law.
- **Waste**: The overutilization of services or practices that result in unnecessary costs, including consumption or expenditures without adequate return.
- **Abuse**: Provider practices inconsistent with sound fiscal, business, or medical practices that result in unnecessary costs to Medicare and/or Medicaid, reimbursement for services not medically necessary, or services that fail to meet professionally recognized standards of care. Abuse also includes member practices that result in unnecessary program costs.

EXAMPLES OF FWA AND IMPROPER BILLING PRACTICES

Common FWA and improper billing practices may include, but are not limited to:

- Billing for services **not rendered**
- **Duplicate billing** (billing the same service more than once)
- **Unbundling** or fragmenting codes
- **Upcoding** services
- Billing **add-on codes without required primary CPT codes**
- Use of **exclusion codes**
- Misuse of modifiers
- Diagnosis and/or procedure codes **inconsistent with the member's age**
- **Excessive units** or frequency
- **Overutilization** or medically unnecessary services
- Misuse of benefits (including inappropriate use of identification cards)

Providers are cautioned that unbundling, upcoding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD-CM), Providers' Current Procedural Terminology (CPT) Health Care Common Procedure Coding System, (HCPCS) and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be maintained consistent with contractual and regulatory obligations.

Federal and state regulatory agencies, law enforcement and Wellcare With Meridian vigorously investigate incidents of suspected FWA. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure and/or civil and/or criminal prosecution, fines and other penalties.

PROVIDER RESPONSIBILITIES AND COOPERATION REQUIREMENTS

Reporting

Providers, including Provider employees and /or Provider sub-contractors, must report to Wellcare With Meridian any suspected fraud, waste or abuse, misconduct or criminal acts by any Provider, including Provider employees and/or Provider sub-contractors, or by Wellcare With Meridian Members. If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from Wellcare With Meridian, with appropriate state and regulatory approval.

Cooperation with Audits and Investigations

Participating providers are obligated to cooperate fully with Centene SIU, and applicable oversight agencies. This includes, as required:

- Producing requested medical records and related documentation timely
- Making staff and/or subcontractor personnel available for interviews and consultation
- Making offices and facilities available for onsite visits
- Cooperating with investigative processes, including hearings, trials, and other proceedings when applicable

Documentation Standards

Quality care and appropriate payment depend on **accurate, complete, and legible medical record documentation**. Documentation must support:

- The service(s) billed
- The level of service reported
- Medical necessity, where applicable
- Compliance with all relevant CMS, state, contractual and Wellcare With Meridian documentation and billing requirements

SPECIAL INVESTIGATIONS UNIT (SIU)

Our Special Investigations Unit (SIU) proactively monitors for potential FWA and investigates allegations of fraud, waste, and abuse. Staff includes full-time investigators, clinical investigators, data analysts, management support, administrative staff, and legal personnel.

FWA DETECTION AND MONITORING

Wellcare With Meridian uses multiple methods to identify potential billing irregularities, including:

- Claims analytics and code editing tools during claims processing
- Pattern recognition for potential overutilization, unbundling, upcoding, and modifier misuse
- Retrospective audits and investigations
- Prepayment Reviews

Reviews may incorporate, as applicable:

- CMS guidelines
- Federal and state regulations/guidance

- Local Coverage Determinations (LCDs)
- National Coverage Determinations (NCDs)
- Specialty-specific billing and coding guidance
- Wellcare With Meridian clinical and billing policies
- Contractual requirements

When clinically appropriate, review may include assessment by a clinician of like specialty.

Post-Payment (Post-Processing) Claims Audits/Investigations

Overview

A post-payment audit/investigation is a review of clinical documentation for claims previously submitted. Reviews are conducted to ensure payment is supported by proper documentation, consistent with the services rendered.

Medical Record Requests and Timeframes

Wellcare With Meridian will request medical, behavioral health, dental, vision, or pharmacy records to initiate an investigation:

- Medical records will be requested for a defined review period.
- Providers must submit requested records within the timeframe stated in the request.
- If no response is received, a **second and final request** may be issued.
- Records must be received within the timeframe specified in the second request.

As a reminder, HIPAA permits the use or disclosure of protected health information (PHI) for treatment, payment, and healthcare operations (TPO) without the member's or patient's consent or authorization. See 45 C.F.R. § 164.506.

Failure to Submit Records / Insufficient Documentation

If a provider:

- Fails to respond to the second and final request, **or**
- Submits records that do not document the services billed,

Consistent with applicable law, regulation, and provider agreement terms, Wellcare With Meridian may recover all amounts paid for the services in question.

Findings Communication, Overpayments, and Recovery

Findings Results Letter

Upon completion of an investigation, Wellcare With Meridian may issue a Proposed Action Letter (PAL) that includes:

- A summary of the review findings and outcome.
- A complete list of the claims reviewed, including the determination for each claim line.
- Documentation of the sources used to make claim-line determinations.
- Any applicable recovery amount and the basis for it.
- Notice of appeal rights

Overpayment Methodology

If documentation does not support the payment, Wellcare With Meridian will seek recovery of identified claim payments. Depending on the scope of review, overpayments may be calculated using:

- **Claim-by-claim** review, and/or
- **Extrapolation methodology** may be used to estimate overpayment amounts through statistical sampling, consistent with program integrity methods used in Medicare and Medicaid oversight.

Appeal of Overpayment

Providers may contest the findings, the amount of the overpayment, or the methodology used to identify the overpayment by filing an appeal within 120 calendar days of the date of receipt of the PAL with supporting documentation.

Instructions for filing an appeal are provided in the initial PAL and include:

- A complete and accurate explanation of the issues being refuted. Supporting materials, medical records, or other documentation to challenge the findings.
- An appeal letter as necessary outlining any contractual, regulatory, factual or other basis of disagreement with the findings and/or overpayment amount.

If the provider does not contest the overpayment, repay the amount due, or contact Wellcare With Meridian within thirty calendar days of receiving the PAL to arrange payment, Wellcare With Meridian will offset the overpayment against future claims submitted for by the provider.

Required FWA Training and Screening Requirements

Providers and their employees/contractors must comply with applicable CMS rules and regulations related to compliance training and education, including FWA training requirements. Providers and their employees must complete FWA training:

- Within 90 days of contracting, and
- Annually thereafter, as applicable (e.g., consistent with requirements referenced under § 423.504).

Exclusion / Preclusion Screening (Medicare Networks)

For Medicare lines of business, providers are required to check:

- OIG/GSA Exclusion lists, and
- The CMS Preclusion List

Prior to hiring/contracting and monthly thereafter for staff, volunteers, temporary employees, consultants, directors, and contractors who meet applicable requirements, consistent with references including:

- The Act §1862(e)(1)(B)
- 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6)
- 1001.1901

Medicare payment may not be made for items or services furnished or prescribed by a precluded or excluded provider/entity.

Reporting Suspected Fraud, Waste, or Abuse

Wellcare With Meridian encourages prompt reporting of suspected FWA. Reports may be made anonymously and are treated as confidential to the extent permitted by law.

Fraud, Waste, and Abuse Hotline: **1-866-685-8664**
Corporate Compliance/Ethics Hotline (as applicable): **1-800-345-1642**
Email (if applicable): Special_Investigations_Unit@centene.com

All reports are reviewed and investigated as appropriate.

False Claims Act (Overview)

The False Claims Act establishes liability when a person or entity improperly receives or avoids payment to the federal government. Prohibited conduct includes, but is not limited to:

- Knowingly presenting (or causing to be presented) a false claim for payment or approval
- Knowingly making or using a false record or statement material to a false or fraudulent claim
- Conspiring to violate the False Claims Act
- Knowingly making or using false statements to avoid or decrease an obligation to pay the government

For additional information, providers may reference CMS resources (e.g., www.cms.hhs.gov).



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