Wellcare By Meridian (IL)

Provider Manual

2026

For more than 20 years, Wellcare has offered a range of Medicare products, which offer affordable coverage beyond Original Medicare. Beginning Jan. 1, 2022, our affiliated Medicare product brands, including Allwell, Health Net, Fidelis Care, Trillium Advantage, and 'Ohana Health Plan transitioned to the newly refreshed Wellcare brand. If you have any questions, please contact Provider Relations.

By Allwell
By Fidelis Care
By Health Net
By 'Ohana Health Plan
By Trillium Advantage

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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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SECTION 1: GENERAL INFORMATION

Welcome to the Wellcare By 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) will transition its existing Medicare-Medicaid Alignment Initiative (MMAI) program in 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 - including long-term services and supports (LTSS) and behavioral health services – through a single managed care organization.

FIDE-SNP Program Commitment and Transition Pillars

Wellcare By 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.

To support a smooth and effective transition, Wellcare By 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 a 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 models 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.

Program Launch and Implementation

The FIDE-SNP program launches on January 1, 2026, with initial implementation in select Illinois regions, as confirmed by HFS. Full integration LTSS begins in 2027. During the early implementation phase, certain behavioral health services remain partially carved out, with coordination maintained between FIDE-SNP plans and state-contracted behavioral health providers to ensure continuity and alignment of care.

HOW TO USE THIS MANUAL

The Wellcare By 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.

To efficiently locate information:

- Start with the primary Table of Contents to identify the relevant section or topic.
- Note the corresponding Section Number.
- Navigate to that section and review its section-specific Table of Contents.
- Locate the page number for the topic you are seeking.

This manual is available digitally at go.wellcare.com/ILMeridian.

Updates and Revisions

The Wellcare By 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 By Meridian website at go.wellcare.com/ILMeridian.

KEY CONTACTS INFORMATION

To support providers in delivering high-quality care, Wellcare By 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 the most commonly used contact information:

wellcare By meridian	Wellcare By Meridian P.O. Box 10050 Van Nuys, CA 91410-0050 Phone: 1-844-536-2175 (TTY: 711) Hours of Operation: Monday-Friday, 8am-5pm CST go.wellcare.com/MeridianIL

Department	Phone or Fax Number	Website
Provider Services	1-844-536-2175	N/A
Pharmacy Prior Authorizations		
24 Nurse Advice Line	1-844-536-2180	
Member Services		
Centene Pharmacy Services	1-855-536-2175	www.centenepharmacy.com
Pharmacist	1-833-750-4200	N/A
Evolent	1-866-510-6340	www.radmd.com
Behavioral Health Services (Inpatient & Outpatient)	1-844-536-2175	N/A
CARES Hotline for Behavioral Health Crisis	1-800-345-9049	
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	

SECTION 2: MEMBER BENEFIT INFORMATION

MEMBER ELIGIBILITY AND ENROLLMENT

To enroll in a Wellcare By 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
- Permanently reside in the Wellcare By Meridian service areas
- Not be enrolled in hospice
- 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 residing in state psychiatric hospitals
- Individuals with commercial HMO coverage
- Individuals with elected hospice services
- Individuals who are incarcerated
- Individuals with presumptive Medicaid Eligibility
- Individuals disenrolled from Medicaid managed care due to special circumstances

NON-DISCRIMINATION STATEMENT

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

Access to Information

1. Members may request and receive information about the health 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 the Customer Experience (CE) Department
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 By Meridian's agreement with the state.
14. Members may have access to a network of providers, including primary care physicians, 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 outlines in plan policy.
23. Receive basic information about the plan, orally as well as in writing, upon request, about the organization of Wellcare By 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 By 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:

- Primar 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 (as covered by Illinois Medicaid)
- Vision services, including eye exams and eyeglasses
- Hearing services, including hearing aids (as covered by Medicaid)
- Durable Medical Equipment (DME) and medical supplies
- Home health care 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 (as covered by Medicaid)
- Transportation to medical appointments (non-emergency medical transportation)
- Care coordination and case management
- Second medical opinions, when requested
- Long-term services and supports (LTSS), including in-home and community-based services (phased in by 2027)

Additional Notes

- Members are not responsible for co-pays on Medicaid-covered services
- Prior authorization may be required for out-of-network services, except in the 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 By 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 beyond applicable copayments, coinsurance, or deductibles

Non-Covered Services

While Wellcare By 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 of 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

Behavioral Health and Other Services Managed Outside the Plan

Certain services may be administered outside of the FIDE-SNP benefit package by state-contracted providers or waiver programs. These services may include, but are not limited to:

- Certain behavioral health services, such as:
  - Inpatient psychiatric care
  - Substance use disorder treatment
  - Community-based mental health services for individuals with serious mental illness
- Waiver program services, such as:
  - Home and Community-Based Services (HCBS) for individuals with developmental disabilities or traumatic brain injuries
  - Services provided through the Department of Human Services (DHS) or Department on Aging (IDoA)

In these cases, Wellcare By Meridian providers are expected to assist members in obtaining referrals or coordinating care with the appropriate state agency or provider network.

Member ID Cards

Each Wellcare By 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)

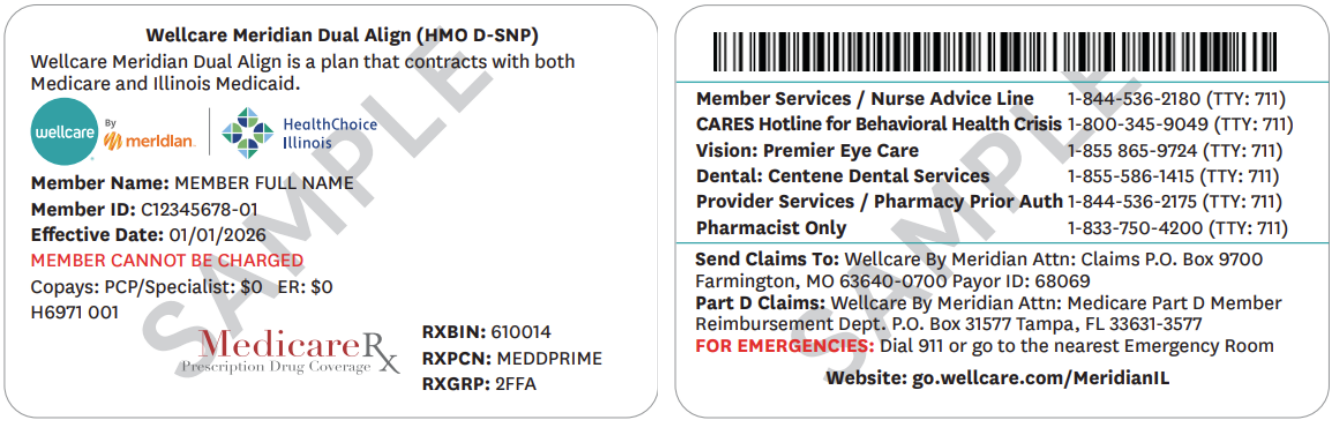
Provider Responsibilities

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.

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



Provider Support

Providers should contact Member Services at 1-844-536-2180 for assistance with:

- Referrals to state-administered services
- Clarification of benefit coverage
- Coordination with behavioral health or waiver program providers

PHARMACY BENEFIT MANAGEMENT

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

In accordance with the requirements set forth by IDHS, Wellcare By Meridian adopts the State's Health Plan Common formulary for Medicaid. The formulary is designed to cover the vast majority of 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 go.wellcare.com/MeridianIL and the Prescriber Portal. This formulary should be consulted when prescribing medications for Wellcare By 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 Prior Authorization (PA) are identified in the formulary with a PA designation.

Wellcare By 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 go.wellcare.com/MeridianIL or through covermymeds.com
2. The Pharmacy Services reviewer may request that the prescriber submit additional clinical information by fax in order 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 **1-844-536-2175** 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 delaying 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 By 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 By 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 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.

For more information on how to access non-emergent transportation services, members should consult their Member Handbook or contact Member Services at **1-844-536-2180**.

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 **1-866-796-1165** 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 By Meridian.

EMERGENCY SERVICES

Wellcare By 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 By 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. Members will be screened and stabilized without prior authorization in accordance with the Emergency Medical Treatment and Labor Act (EMTALA), using the prudent layperson standard.
- Medicare-Covered Emergency Services: Wellcare By Meridian covers appropriate cost sharing for emergency services and medical screenings provided under Medicare, including:
    - Out-of-network or out-of-area emergency services delivered in a hospital emergency department
    - 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
- Post-Stabilization Care:
  Wellcare By 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 By 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 physician and the plan representative, and the physician cannot consult with a plan physician 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 physician 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 By 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 By Meridian physician assumes responsibility for the member's care
    - The member is transferred under the care of a plan-approved physician
    - An agreement is reached between the treating physician 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 for 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 the IDHS within 10 calendar days of treatment

Members **cannot** be held financially liable for any screening or treatment needed to diagnose or stabilize an emergency medical condition.

The attending emergency physician, 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

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 physician, 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 By Meridian's financial responsibility for post-stabilization care services ends when any of the following occurs:

- A Plan-affiliated physician with hospital privileges assumes responsibility for the Member's care;

- A Plan-affiliated physician 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 By 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 health care 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 By 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 By 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 By Meridian Member Services at 1-844-536-2180 to file a grievance.

Wellcare By Meridian offers both informal and formal grievance processes. Informal grievances are typically resolved during the initial interaction with Member Services. If not resolved to the member's satisfaction, a formal grievance may be filed in writing.

Formal grievances should be submitted to:

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

Upon receipt of a formal grievance, Wellcare By 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 By 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 By 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 By 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 60 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 By Meridian for an authorized representative to appeal on their behalf.

Members have the right to appeal and adverse benefit determination. Appeals may be submitted to the Wellcare By 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 By Meridian
Appeals Department
P.O. Box 10052
Van Nuys, CA 91410

Within three business days of receiving a member's appeal, Wellcare By Meridian will notify the member of all the information that is required to process the request. Appeals are reviewed and resolved within 30 calendar days from the date of receipt. For members enrolled in the Children's Special Health Care Service program, appeals will be resolved within 10 calendar days.

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 By 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 **1-844-536-2175** 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 By Meridian will notify the member within 24 hours if additional information is required. A decision will be rendered within 72 hours of receiving the expedited request.

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

Note: Wellcare By 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 health 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 health 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 health plan before filing a request for an external review with the Department of Insurance and Financial Services (DIFS).

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

PRIMARY CARE/MANAGED CARE PROGRAM

Wellcare By 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 health care. This may include, but is not limited to, ensuring that all medically necessary care is made available and delivered, facilitating the continuity of member health care, promoting, and delivering the highest quality health care per Wellcare By Meridian standards.

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

Primary Care Provider (PCP) Roles and Responsibilities

Each Wellcare By 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 health care 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 By 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.

Specialty Care Provider Roles and Responsibilities

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

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

Ancillary/Organization Provider Roles and Responsibilities

Wellcare By Meridian recognizes that the ancillary provider is another valuable team member in delivering care to Wellcare By Meridian Medicare 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 By Meridian Medicare members
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent member information to Wellcare By Meridian and to the PCP

Freedom of Provider Communications

Wellcare By 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 By 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 By 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	
Preventative/Routine Care	Within twenty-five (25) business days of request

Type of Care	Length of Wait Time
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	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
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
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

Type of Care	Length of Wait Time
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.	

Primary Care After Hours Requirements

Acceptable after-hours mechanisms include:

- Answering service
- On-call pager or cellular connection
- Call forwarding to the Provider's home and/or other location
- Published after-hours telephone number and recorded voice message directing members to a provider for urgent and non-life-threatening conditions

NOTE: The message **should not instruct members to obtain treatment at the emergency room for non-life-threatening emergencies** but must direct members in a medical emergency to call 911 or go to the nearest emergency room.

Additionally, voice message must contain one of the following:

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

NOTE: The message cannot direct members to the emergency room. The member must be able to leave a message for an on-call provider, speak with an on-call provider, or be forwarded to an on-call provider.

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
- Maintain such records and information in a manner that is accurate and timely
- Respect member rights to access, amend errors in, request confidentiality for, or an accounting of disclosures of the member's health information
- Identify when and to whom member information may be disclosed
- Safeguard the privacy of any information that identifies a particular member

- Secure information through robust controls designed to maintain the confidentiality, integrity, and availability of medical records and to protect against threats or hazards to the security or integrity of such information and any uses or disclosures of such information that could violate 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 health plan and all participating providers are each obligated to abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and member information. First tier and downstream providers must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, within requested time frames, and maintain records a minimum of 10 years.

OBLIGATIONS OF RECIPIENTS OF FEDERAL FUNDS

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

At minimum, Wellcare By Meridian can check the MDHHS health professions website monthly for excluded providers. At minimum, Wellcare By 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 MDHHS Medicaid Program, Medicare, or another state's Medicaid program, or is the subject of a state or federal licensing action, the Integrated Community Organizations (ICO) shall terminate, suspend, or decline a provider from its Provider Network as appropriate.

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

Wellcare By 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 Wellcare By Meridian 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 By Meridian providers can be found at www.sam.gov.
- The Preclusion List can be found at cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html.

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
- MIOSHA poster (#2010)

PROVIDER CREDENTIALING, RE-CREDENTIALING, AND IMPACT ENROLLMENT

Providers applying for participation with Wellcare By 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 By 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 By Meridian.

Wellcare By Meridian Credentialing Process

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

Practitioners have the following rights during the credentialing process: All information received during the credentialing process that is not peer protected can be forwarded to the applicant upon written request to the credentialing department. If there are any substantial discrepancies noted during the credentialing process the applicant will be notified in writing or verbally by the credentialing department within 30 days and will have 30 days to respond in writing regarding the discrepancies and correct any erroneous information. Wellcare By 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 By Meridian will notify providers within 30 days of identifying any material discrepancies between credentialing verification data and the information submitted by the provider during the credentialing process. Providers will be granted 30 calendar days from the date of notification to respond in writing to the Credentialing Coordinator to address and resolve the identified discrepancies.

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

Wellcare By 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 the Illinois Medicaid State Plan must be screened and 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 By Meridian maintains a formal appeal process for any provider or applicant who is denied participation in the provider network.

1. When an Initial Applicant receives a non-approval notice, the affected practitioner has 30 calendar days from receipt of the notice to file a written request for a 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 By 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.**

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

2. When a practitioner's current participation status is being suspended, restricted or terminated based on issue of quality of care or service, Plan offers and informs the practitioner of the appeal process in the notification and the request for appeal hearing must be submitted in writing within thirty (30) days from 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.

3. 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, at least one who is in the same specialty as the practitioner under review. The Plan must not select Appeals Committee members who:

   a. Are in direct economic competition with the practitioner,
   b. Are in business with the practitioner, or
   c. Have previously made a recommendation or decision regarding the practitioner's network participation

4. When the Appeals Committee is appointed and hearing is scheduled, Plan provides a written hearing notice stating:
5. The time, location, and date of the hearing, which will not be less than thirty (30) days after the date of the notice,
6. A list of witnesses and consultants, if any, expected to be called by Plan at the hearing
7. The composition of the Appeals Committee; and
8. A statement that the practitioner has fourteen (14) days from receipt of the notice of hearing to notify the Credentialing Committee in writing if the practitioner believes that any member of the Appeals Committee does not meet the criteria set forth in Section C above
9. The Appeals Committee and the practitioner under review may be afforded the opportunity to examine Plan's exhibits before the hearing. However, failure on the part of Plan to distribute an exhibit before the hearing does not render such exhibit inadmissible at the hearing
10. The plan provides the Appeals Committee with a copy of the letter sent to the practitioner notifying him or her of the recommended action and a copy of the practitioner's written response, if any
11. The hearing holds to the following evidentiary standards
12. The evidence must relate to the specific issues or matters involved in the recommended action.
13. The Appeals Committee has the right to refuse to consider evidence that it deems irrelevant or otherwise unnecessary to consider.
14. The rules of evidence applicable in a court of law are not applicable at any hearing.
15. A party who objects to the presentation of any evidence must state the grounds for the objection and the Appeals Committee will determine whether the evidence will be admitted
16. The Appeals Committee determines the relative weight to be given to various items of evidence submitted
17. The hearing abides by the following format:
    a. **Representation:** The practitioner and Plan may be represented by counsel or other person of their choice. The practitioner must inform Plan at least ten (10) days prior to the hearing of counsel or witnesses appearing on his/her behalf at the hearing.
    b. **Record:** Plan creates a record of the hearing. Plan may take summary minutes, arrange for a court reporter to provide a record of the hearing, or make an audio recording of the hearing, in its sole discretion. If a court reporter is present, she/he names the parties present and, as necessary, identifies their representatives. The reporter swears in all witnesses, records all oral testimony, and marks and maintains the documents submitted as exhibits. Following the hearing, the reporter provides a copy of the written transcript to each of the parties and the Appeals Committee. Plan pays the court reporter's fees, except that the practitioner is responsible for the cost of his or her copy of the transcript. If an audio recording is made of the hearing, copies of this record are made available to the practitioner upon payment of a reasonable charge.
    c. **Quorum:** The presence of at least one-half of the voting members of the Appeals Committee, plus one additional voting member, constitutes a quorum for purposes of the conduct of the hearing. Any action taken by the Appeals Committee as a result of the hearing will be by the majority of the members present at a meeting at which a quorum is present.

d. **Chairperson's Statement of the Procedure:** Before evidence or testimony is presented in an in-person or telephonic hearing, the Chairperson of the Appeals Committee announces the purpose of the hearing and the procedure to be followed for the presentation of evidence as determined by the Appeals Committee.
e. **Presentation of Evidence by Plan:** Plan may present any oral testimony or written evidence collected by Plan staff relevant to the proposed action. The practitioner will have the opportunity to cross-examine any witness testifying on behalf of Plan.
f. **Presentation of Evidence by practitioner:** After Plan submits its evidence, the practitioner may present evidence to rebut or explain the situation or events described by Plan. Plan will have the opportunity to cross-examine any witness testifying on behalf of the practitioner.
g. **Plan Rebuttal:** Plan may present additional witnesses or written evidence to rebut the practitioner's evidence. The practitioner will have the opportunity to cross-examine any additional witnesses testifying on Plan's behalf.
h. **Summary Statements:** After the parties have submitted their evidence, first the Plan and then the practitioner may have the opportunity to make a brief closing statement. In addition, the parties may have the opportunity to submit written statements to the Appeals Committee. The Appeals Committee establishes a reasonable timeframe, but not less than thirty (30) days, for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.
i. **Examination by Appeals Committee:** Throughout the hearing, the Appeals Committee may question any witness who testifies.

18. The Appeals Committee decision is rendered utilizing the following decision-making guidelines:
    a. Standard of Review: Plan has the initial obligation to present evidence in support of its recommendation. The practitioner requesting the hearing has the burden of persuading the Appeals Committee that the Plan's recommendation lacks substantial factual basis or is unreasonable, arbitrary, or capricious.
        i. Review of Evidence and Vote: After the hearing and receipt of summary written statements, the Appeals Committee convenes and privately discusses the Credentialing Committee's recommendation. The Appeals Committee may uphold, reject, or modify the recommendation. The Appeals Committee's decision is based upon the evidence admitted at the hearing and by the affirmative vote of the majority of the members of the Appeals Committee.
19. Notification of the action of the Appeals Committee, and any change in the practitioner's participation status, is communicated as follows:
        i. Written notice of the decision is given to the practitioner in an expeditious and appropriate manner and no more than sixty (60) days following the determination, and includes a statement, containing specific reasons, of the basis of the decision.
        ii. If the practitioner is a Primary Care Physician or Primary OB/GYN whose network participation is terminated, Plan notifies the members who regularly obtain health

services from, or who are assigned to such practitioner, that such practitioner is no longer participating in the Plan network.

iii. The Credentialing Committee Chair or his or her designee provides written notice of a final adverse determination or action materially affecting a practitioner to such managed care organizations, health plans, and similar entities as required by contract or state or federal law. It is the responsibility of the Plan to fulfill any obligation to report the adverse determination or action to the State licensure board and the NPDB as may be required under the provisions of the HCQIA, as amended from time to time.

iv. The action of the Appeals Committee regarding any restriction, suspension, or termination matter is final.

20. Denied applications are maintained in a confidential manner in the Denied Participation file and are maintained for a period of four years from the date of denial. Denials of participation are kept confidential except where reportable by Wellcare By Meridian under federal or state regulation

SECTION 4: UTILIZATION MANAGEMENT

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

Access to the Utilization Management Staff

For Utilization Management inquiries, you may call during normal business hours Monday-Friday, 8 a.m. to 5 p.m. at **1-855-580-1689**. The provider portal is available 24/7 to status authorization requests and submit new requests

UM DECISIONS

Utilization decisions are based on appropriateness of care and service, as well as the member's eligibility. Wellcare By 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 Meridian Medicare 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).

National Coverage Determinations (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.

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

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

policies for clinical decision making. Meridian may also adopt the coverage policies of other MA Organizations in its service area.

Wellcare By 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 Utilization Management 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 physician within 30 days of the original date of service prior to claim denial.

Classifying Your Prior Authorization Request

Standard Organization Determination (Non-urgent Preservice Request): Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than 7 calendar days after Wellcare By Meridian receives the request for service.

Expedited Organization Determination (Urgent/Expedited Preservice Request): Expedited organization determinations are service requests are made when the member or the provider believes that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the Member's health condition requires, but no later than 72 hours After receiving the Member's or Provider's request. An extension may be granted for an additional 14 calendar days if the Member requests an extension or if Wellcare By 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 By 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 By Meridian 's nurse reviewers' interface with the hospital/facility discharge planners to:

- Obtain the member's discharge planning needs
- Identify the members' discharge planning needs

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

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

Prior Approval Requirements/ Precertification

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

1. **Online Submission -** The Wellcare By Meridian Online PA Form can be accessed by visiting the secure Provider Portal
2. **Fax Submission** - Refer to Utilization Management's referral type fax numbers. Please include pertinent clinical documentation with the request if indicated
3. **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 By 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 Inpatient Admissions*	1-844-930-4395
Behavioral Health Outpatient Services*	1-833-728-0124

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 7 days of receipt of the request	Within 7 days of receipt of the request	Within 7 days of receipt of the request
Pre-Service Urgent	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request
Urgent Concurrent	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 72 hours of the decision

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 authorization. Wellcare By Meridian provides a reference number on all authorizations. To ensure a timely decision, make sure all supporting clinical information is included with the initial request:

Clinical information includes relevant and current information regarding the members:

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

Clinical Practice Guidelines

Wellcare By 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: go.wellcare.com/MeridianIL.

Whenever possible, Wellcare By 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 By 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 By 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. You can check the requirements for any code on our website at go.wellcare.com/MeridianIL. Codes that are not listed on the applicable Medicaid fee schedule may not be payable by Wellcare By 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

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

- 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

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

Wellcare By Meridian covers mental health outpatient services for members with mild to moderate behavioral health conditions. Members with severe mental illness conditions as defined by the state, receive mental health outpatient services through the PIHPs. You may contact our Behavioral Health staff at **1-833-728-0124** 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 health care public entities via Wellcare By Meridian's Provider Portal at go.wellcare.com/member, fax or by calling Wellcare By Meridian at **1-844-536-2175**. Wellcare By Meridian 's staff will forward the information and authorization to the central referral office of the public entities. Wellcare By Meridian will fax you a copy of the approved referral notification form along with contact information to the public entity.

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

- Emergency services

- Post stabilization services
- Women's Health
- Family Planning & Obstetrical Services
- Child & Adolescent Health Center Services
- Local Health Department (LHD) services
- Long-Acting Reversible Contraception (LARCs)
- School Dental Services
- Other services based on state requirements

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

DENIALS AND RECONSIDERATIONS

Denials based on medical necessity may only be issued by a Wellcare By 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

MODEL OF CARE OVERVIEW

Wellcare By Meridian's Model of Care is designed to support a complex population with diverse medical, behavioral, and social needs. The Care Coordination model integrates medical, hospital, behavioral health, and long-term services and supports (LTSS), along with community-based resources, to promote independent and healthy living.

This whole-person approach emphasizes not only the management of chronic conditions but also recovery, wellness, and member autonomy. Central to this model is the Interdisciplinary Care Team (ICT), which may include the member, their chosen supports, primary care provider (PCP), care manager, LTSS coordinator, and other clinical or social service specialists, as appropriate.

The provider network reflects this integrated philosophy, consisting of medical professionals, behavioral health specialists, LTSS providers, and community-based organizations committed to evidence-based, collaborative, and person-centered care.

Wellcare By Meridian continuously refines its Model of Care through quality improvement initiatives, incorporating data-driven insights and member feedback to ensure it meets the evolving needs of the dual-eligible population. These efforts have been recognized at both the state and national levels.

Care Coordination

Wellcare By Meridian's Care Coordination program offers personalized case management for members with complex or high-risk conditions. The program is designed to improve health outcomes through proactive care planning and service coordination.

Eligible members include those with:

- Asthma
- Diabetes
- Congestive heart failure
- Cardiovascular disease
- Complex or catastrophic illness
- High emergency room utilization
- Maternity care needs

Care Coordinators may contact providers to:

- Participate in the members' ICT meeting
- Coordinate or update a member's plan of care
- Confirm diagnoses or test results
- Identify care gaps or non-compliance issues
- Address behavioral health needs or social determinants of health

Referrals to Care Coordination may be submitted via the secure Wellcare By Meridian Provider Portal using the "Notify CM" button, or by calling **1-844-536-2180**.

Provider Action: Integrated Care Team (ICT)

Providers identified as part of a member's ICT are encouraged to actively participate in the care planning process. The ICT collaborates with the member and their supports to ensure care is coordinated, person-centered, and aligned with the member's unique goals, preferences, and needs.

EVOLENT

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Wellcare By Meridian is using 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 physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

To reach 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 our Provider Services department.

Cardiac Solutions

Wellcare By Meridian in collaboration with Evolent, will launch a cardiac imaging program to promote health care quality for members with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a 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

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

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

The following services do not require authorization through 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 and occupational therapy) provided to our members are consistent with nationally recognized clinical guidelines, Wellcare By 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 By 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 By 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 By Meridian and Evolent, Wellcare By 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, you and the member will receive notice of the coverage decision.

Should you have questions, please contact Wellcare By 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 physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through 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 By 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. The decision to implement this latest program is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Under the terms of this agreement:

- We will oversee the MSK program and continue to be responsible for claims adjudication and medical policies.
- Evolent will manage IPM services*, and inpatient and outpatient MSK surgeries through the existing contractual relationships with us.

It is the responsibility of the ordering physician 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 physician 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 By Meridian FIDE-SNP line of business.

SECTION 5: BILLING AND CLAIMS PAYMENT

OVERVIEW

Wellcare By Meridian's Claims Department is structured to ensure accurate and timely processing of provider claims. A dedicated toll-free telephone number, **1-844-536-2175**, is available for providers to contact a representative with claims-related inquiries.

CLEAN CLAIM SUBMISSION

Wellcare By 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 By 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, SLP, 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 By Meridian Medical Policies
7. Is a claim for which the provider has verified the member's eligibility and enrollment in Wellcare By Meridian before the claim was submitted
8. Is not a duplicate of a claim

9. Is submitted in compliance with all of Wellcare By Meridian's prior authorization and claims submission guidelines and procedures
10. For Medicaid only services, ss a claim for which the provider has exhausted all known other insurance resources for the Medicaid line of business (Medicaid is the payer of last resort)

Providers may submit and check the status of claims electronically via the secure Wellcare By Meridian Provider Portal. To gain access to the Provider Portal, please register with the link provided below.

Submit claims through the Provider Portal at go.wellcare.com/member.

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

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

Wellcare By 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 By 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 go.wellcare.com/member.

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 By Meridian currently accepts electronic through the following clearinghouse:

Availity

- **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 By 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. It is the providers' responsibility to ensure receipt of a confirmation file for all claims submitted via EDI.

Availity Essentials

Wellcare By 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 By 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 Essentials account is the first step toward working with Wellcare By Meridian on Availity. Your provider organization's designated Availity administrator is the person responsible for registering your organization in 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 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 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. 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 By 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 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, Meridian will not provide prior written notice of a recovery. In that case, Meridian will recover the overpayment by issuing an invoice or performing a take-back. Full details of this recovery will be provided in either the invoice or the remittance advice. No time limit applies to the initiation of overpayment recovery efforts required by a state or federal program or where there is suspected fraud or intentional misconduct involved

To report possible FWA: Contact 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

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 By Meridian to the Provider. Providers may not bill Wellcare By Meridian DSNP members for covered services, also known as "balance billing," regardless of whether they believe the amount they were paid or will be paid by Wellcare By 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 Nursing Facility.

PAYSPAN® ELECTRONIC PAYMENTS & REMITTANCE

Overview

PaySpan® is Wellcare By 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 (To be tailored per market if needed.)

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

Existing PaySpan providers will be required to add the Wellcare By 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 the applicable Provider Services phone number on the member's ID card.

PROVIDER COMPLAINTS, APPEALS AND DISPUTES

Wellcare By 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., Z016MCW00046) for reference and

follow-up.

Provider 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 By 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 Managed Care Provider Resolution Portal 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 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 By Meridian allows appeals of authorization denials. Requests for a contracted provider claim review related to authorization denials must be received by Wellcare By Meridian within 90 days from the date of this 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 By 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-and-grievances/mmcag/downloads/model-waiver-of-liability_feb2019v508.zip.

Wellcare By 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 this EOP. A copy of the EOP and all supporting documentation (such as medical records when applicable) must be submitted with an appeal request. Requests should be submitted to the following address:

Wellcare By 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 By 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

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 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 Meridian. All dispute determinations are final. If a provider disagrees with Meridian's determination regarding a dispute, the in or out-of-network provider may pursue other options as outlined below.

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

MEDICAL RECORDS

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

Medical records should be provided to Wellcare By 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 By Meridian to assist in extracting medical records for this request. Electronic access to medical records should be arranged wherever possible.

Procedure

All practitioners in the network must comply with the following:

1. Medical record documentation must include at least the following elements:
    a. All services provided directly by the practitioner
    b. All ancillary services and diagnostic tests ordered by the practitioner
    c. All diagnostic and therapeutic services for which the member was referred 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 By 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.

CRITICAL INCIDENTS REPORTING

Wellcare By Meridian requires participating program providers to report all Critical Incidents that occur in home and community-based long-term services and supports (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 will receive Critical Incident education materials and can access additional information on Wellcare By Meridian's website. Providers must participate in trainings offered by Wellcare By 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 By 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 By 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 By 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 Wellcare By Meridian or 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

[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 (only Medicare

For more information, please complete the Critical Incident Training on Wellcare By Meridian's website at go.Wellcare.com/MeridianIL.

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 By 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 health plan. The State will determine the minimum data elements of the encounter reporting. A format consistent with the formats and coding conventions of the CMS 1500 and UB-04 will be used initially. PCPs will submit their encounter data monthly to Wellcare By Meridian , who must then submit it to the MDHHS via an electronic tape. Both Wellcare By 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 By Meridian 's contract with providers, it is required that Provider Preventable Conditions (PPCs) associated with claims be reported to Wellcare By 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 is the EVV system being 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 health care services that require an in-home visit. CMS defines personal care services as help with: Activities of Daily Living (ADLs), such as bathing, dressing, toileting, mobility, and grooming. Instrumental Activities of Daily Living (IADLs), such as meal preparation, shopping, laundry, and housekeeping. If you receive Medicaid-funded personal care or home health care services such as assistance with ambulation, bathing, dressing, grooming, personal hygiene, meals, and homemaker services through any of the five programs listed below, then your caregiver must validate those services through an EVV system. In order to complete the HHAX onboarding process, receive credentials to access the EVV system, and have their portals set up, the provider must have an NPI and be enrolled in CHAMPS.

FRAUD, WASTE, AND ABUSE

Healthcare fraud, waste, and abuse affect every one of us. It is estimated to account for between 3% and 10% of the annual expenditures for health care in the U.S. Healthcare fraud is both a state and federal offense.

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

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

Waste is the overutilization of services or practices that result in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return.

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

Here are some examples of Fraud, Waste and Abuse:

Fraud and Waste

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

Abuse

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

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

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

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

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

To report possible Fraud, Waste, or Abuse:

Contact Meridian's Corporate Compliance Officer toll free at **1-800-345-1642** or the Fraud, Waste, and Abuse Hotline at **1-866-685-8664**. You can also send an email to Special_Investigations_Unit@centene.com.

Mail to: Providers may also report potential Fraud, Waste, and Abuse to Meridian anonymously at the following address:

Wellcare By Meridian
Attn: Compliance Officer
1333 Burr Ridge Parkway, Ste 100
Burr Ridge, IL 60527

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

Illinois Department of Health
Office of Inspector General
401 South Clinton Street, 6th Floor
Chicago, IL 60607
1-844-453-7283
https://hfs.illinois.gov/oig

go.wellcare.com/MeridianIL