Wellcare By Meridian (MI)

Provider Manual

2026

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Internal Approved 02022026

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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REVISION TABLE

Revision Date	Section Title	Sub-Section	Revised Information
1/2/2026	Section 1: General Information	Key Contact Information	Updated hours of operation and the Evolent phone number to 1-866-510-6450
1/2/2026	Section 4: Utilization Management	Prior Approval Requirements/Precertification Evolent	Updated fax number for Medicare Part B to 1-844-235-5090 Updated the Evolent phone number to 1-866-510-6450
1/2/2026	Section 5: Billing and Claims Payment	Clearinghouses	Corrected Payer ID to 68069

SECTION 1: GENERAL INFORMATION

Welcome to the Wellcare By Meridian Provider Manual. This manual serves as a comprehensive guide for healthcare providers participating in our Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP), managed by Centene Corporation. Our HIDE SNP product is designed to deliver seamless, coordinated care to individuals eligible for both Medicare and Medicaid, ensuring they receive the full spectrum of services they need. Through this manual, providers will find essential information on policies, procedures, and best practices to enhance patient care and optimize health outcomes. We are committed to supporting our providers in delivering high-quality, integrated care to our members.

BACKGROUND

In May 2022, the Centers for Medicare & Medicaid Services (CMS) finalized regulatory requirements mandating that states participating in the Medicare-Medicaid Financial Alignment Initiative conclude their demonstration programs no later than December 31, 2025, or transition to an integrated Dual Eligible Special Needs Plan (D-SNP) model.

In response, the Michigan Department of Health and Human Services (MDHHS) submitted a letter of intent to CMS confirming its plan to transition the MI Health Link (MHL) demonstration to an integrated D-SNP effective January 1, 2026.

To comply with updated CMS guidance, MDHHS will convert the existing MHL program into a Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP). A HIDE-SNP is a type of Medicare Advantage plan specifically designed to serve individuals who are dually eligible for both Medicare and Medicaid benefits.

Under the HIDE-SNP model:

- Contracted managed care organizations will deliver all Medicare-covered and most Medicaid-covered services to dual-eligible enrollees under capitated, D-SNP-only contracts.
- Long-Term Services and Supports (LTSS) will be integrated into the benefit structure.

Certain specialty Medicaid behavioral health services will remain carved out and will continue to be administered by the state's designated Prepaid Inpatient Health Plans (PIHPs).

Wellcare by Meridian is actively preparing for this transition to ensure continuity of care and full compliance with CMS and MDHHS requirements.

HIDE-SNP Program Commitment and Transition Pillars

Wellcare by Meridian, in collaboration with the Michigan Department of Health and Human Services (MDHHS), remains committed to improving 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 Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP), with a primary objective of ensuring continuity of program benefits and maintaining high standards for care delivery.

To support this transition, Wellcare by Meridian is adopting the Integrated Care Transition Pillars developed under the Michigan Coordinated Health (MICH) program framework. These pillars establish guiding principles for delivering high-quality, person-centered, and equitable care under the HIDE-SNP model.

Integrated Care Transition Pillars

- **Foster Integration and Continuity:** The HIDE-SNP program seeks to enhance access and quality by aligning Medicare and Medicaid services, thereby bridging existing gaps between physical health, behavioral health, and long-term care systems. Upon enrollment, enrollees must continue receiving the same providers and services — in terms of amount, scope, and duration — until a formal assessment is completed.
- **Reduce Racial and Ethnic Disparities:** MDHHS will employ a data-driven approach to identify and address the root causes of racial and ethnic health disparities. The goal is to reduce inequities in access to healthcare services and social determinants of health. Culturally competent care delivery will be emphasized for all enrollees, including individuals with limited English proficiency and those from diverse backgrounds. The HIDE-SNP program will incorporate policies and operational strategies that align with quality improvement, outcomes measurement, and health equity initiatives.
- **Improve Care Delivery:** Care within the HIDE-SNP framework will reflect a person-centered model that prioritizes the comprehensive needs of each enrollee. Coordination of services will be a central focus to ensure seamless, holistic care.
- **Promote Self-Determination:** MDHHS is committed to empowering enrollees with meaningful authority to direct their own long-term services and supports. Self-determination under the HIDE-SNP model ensures individuals have control over how, by whom, and for what purposes their care is delivered, shifting away from rigid service models to flexible, enrollee-directed care structures.
- **Build a Culture of Quality:** The HIDE-SNP program will embed continuous quality improvement practices throughout its operations. A robust, integrated, and data-informed approach will guide efforts to monitor performance, identify improvement opportunities, and ensure timely access to high-quality services. Through the advancement of MDHHS quality objectives — including effective care coordination, person-centered approaches, disparity reduction, and value-based payment reform — the program will pursue improved health outcomes for dual-eligible populations.

In alignment with 42 CFR §422.107, Wellcare by Meridian is preparing for the implementation of direct contracts with HIDE-SNPs to provide aligned Medicare and Medicaid services. While certain behavioral health services will remain carved out and continue to be administered by Prepaid Inpatient Health Plans (PIHPs), HIDE-SNPs will deliver most Medicaid benefits, including long-term services and supports (LTSS), under a capitated arrangement.

The program will launch on January 1, 2026, in the following Michigan regions:

- Region 8
- Region 10
- Region 12

Full implementation across the entire Lower Peninsula is scheduled for January 1, 2027.

Wellcare by Meridian will continue to work closely with MDHHS and CMS to support providers during the transition and ensure regulatory compliance, service continuity, and improved enrollee outcomes.

HOW TO USE THIS MANUAL

This Manual is intended to serve as a comprehensive and accessible informational resource. The Wellcare By Meridian information is organized into sections, each accompanied by a master Table of Contents and individual Table of Contents for each section.

To efficiently locate specific information, please adhere to the following steps:

- Refer to the master Table of Contents to identify the relevant section or topic.
- Note the corresponding Section Number.
- Navigate to the Table of Contents for the identified section.
- Locate the page number associated with the desired topic within that section.

You may also access a copy of the Provider Manual on the Wellcare By Meridian website at go.wellcare.com/MeridianMI.

Updates and Revisions

The Provider Manual is a dynamic resource that will continue to evolve in alignment with Wellcare By Meridian's expansions and modifications. Minor updates and revisions will be communicated to primary care providers (PCPs) through Provider Bulletins. Information disseminated via Provider Bulletins supersedes the content found in the existing Provider Manual.

Significant revisions to the Provider Manual will necessitate the publication of a revised edition, which will be distributed to all providers, thereby replacing previous versions of the Manual. The most current version of the Manual is always accessible on the Wellcare By Meridian website at go.wellcare.com/MeridianMI.

KEY CONTACT 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 P.O. Box 10050 Van Nuys, CA 91410-0050 Hours of Operation: Monday-Friday, 8am-9pm EST go.wellcare.com/MeridianMI	
Department	**Phone or Fax Number**	**Website**
Provider Services	1-855-445-3571	N/A
Member Services	1-844-536-2168	N/A
Centene Pharmacy Services	1-855-538-0454	www.centenepharmacy.com
Express Scripts, Inc. (ESI) Pharmacy Helpdesk	1-833-750-0408	N/A
Evolent	1-866-510-6450	www.radmd.com
Behavioral Health Services (Inpatient & Outpatient)	1-855-445-3571	N/A
Hearing		N/A
Vision		N/A
DentaQuest	1-800-233-1468	N/A
SafeRide© Non-Emergency Medical Transportation	1-855-955-7433	N/A
Interpreter Services	1-800-977-7522	N/A
Fraud, Waste, & Abuse	1-866-685-8664	N/A
Ethics & Compliance	1-800-345-164	N/A

SECTION 2: MEMBER BENEFIT INFORMATION

MEMBER ELIGIBILITY AND ENROLLMENT

Members who wish to enroll in Wellcare By Meridian **must** meet the following criteria:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Have full Medicaid benefits
- 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

The following populations are excluded from enrollment in the program:

- Individuals under the age of 21
- Individuals previously disenrolled due to Special Disenrollment from Medicaid managed care
- Individuals not living in a HIDE SNP Service Area
- Individuals who are eligible for partial Medicaid coverage through the following eligibility groups:
    - Additional Low Income Medicare Beneficiary (ALMB)
    - Qualified Individual (QI), Qualified Medicare Beneficiary (QMB)
    - Specified Low-Income Medicare Beneficiary (SLMB); or
    - Qualified Disabled and Working Individuals (QDWI)
- Individuals without full Medicaid coverage (spend-downs or deductibles)
- Individuals with Medicaid who reside in a state psychiatric hospital
- Individuals with commercial HMO coverage
- Individuals with elected hospice services
- Individuals who are incarcerated
- Individuals who have Presumptive Eligibility

Wellcare By Meridian will accept all members that meet the criteria outlined in this section at any time, without regard to 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

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

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

- Access to Federally Qualified Health Centers (FQHC) & Tribal Health Centers (THC)
- Ambulance and other emergency medical transportation
- Lead testing in accordance with medical Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy
- Cardiac rehabilitation
- Certified midwife services
- Certified pediatric and family nurse practitioner services
- Child & Adolescent Health Center (CAHC) Program
- Chiropractic services for members, up to 18 visits in-network without prior authorization
- Dental services for all beneficiaries ages 21 and older, enrolled in Medicaid. For questions regarding dental coverage (D codes) please refer to our dental provider, DentaQuest, at 1-833-206-6287
- Diagnostic lab, x-ray, and other imaging services
- Doula Services
- Durable Medical Equipment and supplies, including breast pump coverage
- Emergency services
- End Stage Renal Disease services
- Family Planning services
- Health education
- Hearing & speech services
- Hearing aids (MDHHS has approved reinstatement of hearing aids for members 21 years of age and older)
- Home health services
- Hospice services
- Hospital services
- Immunizations
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility) for up to 45 days
- Restorative or rehabilitative services (in a place other than a nursing facility)
- Maternal Infant Health Program (MIHP)
- Medically necessary weight reduction services
- Behavioral health outpatient visits for mild/to moderate conditions
- Out-of-state services authorized by Wellcare By Meridian
- Outreach services (including pregnancy and well-child related, providing preventive health information)
- Parenting and birthing classes
- Pharmacy services
- Preventive services required by the Patient Protection and Affordable Care Act as outlined by MDHHS.

- Podiatry services
- Provider office visits
- Prosthetics & orthotics
- Pulmonary rehabilitation
- School and sports physicals
- Surgeries (with prior authorization)
- Therapies, such as speech/language, physical or occupational therapy
- Tobacco cessation treatment
- Transplant services
- Transportation
- Treatment for sexually transmitted illnesses (STIs)
- Vision services

For Out-of-Network providers, certain services require prior authorization. Please refer to go.wellcare.com/MeridianMI for a complete list of authorization requirements.

If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise modified, Wellcare By Meridian will implement the changes in accordance with the dates specified by the Michigan Department of Health and Human Services (MDHHS).

*Please note that Wellcare By Meridian does not charge co-pays to its members for any Medicaid-covered services.

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

Non-Covered Services

The following services are prohibited or excluded under Medicaid:

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

Services Covered Outside Wellcare By Meridian Benefit

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

- Electro Convulsive Treatment (ECT)
- Intensive Outpatient and Community Based Programs
- Outpatient Services for Severe Mental Illness Conditions as defined by the State

- Traumatic brain injury program services
- Any service that is not medically necessary

Wellcare By Meridian providers are required to assist members in obtaining referrals for the Medicaid-covered services listed above. The providers delivering these services will bill MDHHS directly for payment for reimbursement under their State specific contracts.

Wellcare By Meridian providers should contact Member Services at 1-844-536-2168 for assistance with making the above referrals for members.

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

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 Michigan Department of Health and Human Services (MDHHS), 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/MeridianMI 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 are identified in the formulary with a PA designation.

Wellcare By Meridian requires adherence to the following Prior Authorization 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/MeridianMI 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 1-833-750-1800 with any questions or concerns

MEMBER SELF-REFERRALS

Family Planning

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

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

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

Members may also contact Member Services at 1-844-536-2168 for additional assistance with family planning referrals or family planning information.

Women's Health

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

Children's Health

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

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

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

For additional information and assistance in accessing a FQHC, members should be advised to contact Member Services at 1-844-536-2168.

NON-EMERGENCY TRANSPORTATION

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

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

Wellcare By Meridian has contracted with a transportation agency that has a network capable of providing non-emergent transportation to the entire Wellcare By Meridian member geographic coverage area. Information on how and when members can access non-emergent transportation is available in the Member Handbook or by calling Member Services at 1-844-536-2168.

Transportation Procedure

To arrange for these services, the member, PCP, or a Wellcare By Meridian representative should call for non-emergent transportation at 1-800-821-9369 or Member Services at 1-844-536-2168.

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

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

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

EMERGENCY SERVICES

When Michigan Medicaid covers emergency services not covered by Medicare or covers a needed service in a greater amount, duration, or scope than Medicare, Wellcare By Meridian will provide these services through Medicaid in accordance with this Contract.

- Wellcare By Meridian will cover appropriate cost sharing for Medicare covered emergency services and medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 USC 1395dd(a)). Members will be screened and stabilized without prior authorization.
- Wellcare By Meridian will ensure Emergency Services are available 24 hours per day and 7 days per week.
    - Wellcare By Meridian will cover appropriate cost sharing for Medicare-covered out of network or out-of-area Emergency Services and medical screening and stabilization services provided in an emergency department of a hospital consistent with the legal obligation of the emergency department to provide such services.

- Wellcare By Meridian will cover appropriate cost sharing for Medicare-covered Emergency Services regardless of whether the emergency department provider or hospital notified the Member's PCP or Wellcare By Meridian of the Member's services in the emergency department.
- Unless a representative of Wellcare By Meridian or the Member's PCP instructed the Member to seek Emergency Services, Wellcare By Meridian will not be responsible for paying for or covering cost-sharing for non-emergency treatment services that are not authorized by Wellcare By Meridian .
- Wellcare By Meridian will cover appropriate cost sharing for Medicare-covered emergency transportation and professional services needed to evaluate or stabilize an Emergency Medical Condition found to exist using a prudent layperson standard.

- Hospitals offering Emergency Services are required to perform a medical screening examination on emergency room clients leading to a clinical determination by the examining physician that an Emergency Medical Condition does or does not exist.
- If an Emergency Medical Condition is found to exist, the examining physician must provide whatever treatment is necessary to stabilize that condition of the Member.
- Wellcare By Meridian must ensure that Emergency Services continue until the Member is stabilized and can be safely discharged or transferred.
- If any services are not covered by Medicare but covered by Medicaid, Wellcare By Meridian will cover such services.
- Wellcare By Meridian must cover (consistent with 42 CFR 422.214) appropriate cost sharing for Medicare-covered post-stabilization care services obtained within or outside Wellcare By Meridian 's network that are pre-approved by a Wellcare By Meridian Provider or other Wellcare By Meridian representative.
- Wellcare By Meridian must cover appropriate cost sharing for Medicare-covered post-stabilization care services, regardless of whether the services were provided in Wellcare By Meridian 's network. Even if these services were not pre-approved by Wellcare By Meridian , Provider, or other Wellcare By Meridian representative but administered to maintain the Member's stabilized condition within one (1) hour of a request to Wellcare By Meridian for preapproval of further post-stabilization care services.
- If a Member requires hospitalization or other health care services that arise out of the screening assessment provided by the emergency department, then Wellcare By Meridian may require prior authorization for such services. Such services must be deemed prior authorized, and Wellcare By Meridian must cover appropriate cost sharing under any of the following conditions:
  - If Wellcare By Meridian does not respond within the timeframe established under 42 CFR 438.114 and 42 CFR 422.113 (one hour) to a request for authorization made by the emergency department.
  - If Wellcare By Meridian is not available when the request for post-stabilization services occurs.
  - If a Wellcare By Meridian representative and the treating physician cannot reach an agreement concerning the Member's care and a Wellcare By Meridian physician is not available for consultation. In this situation, Wellcare By Meridian must give the treating physician the opportunity to consult with a Wellcare By Meridian physician and the treating

physician may continue with care of the patient until a Wellcare By Meridian physician is reached or one of the criteria specified below is met.

- Wellcare By Meridian 's monetary responsibility for Medicaid coverage or Medicare cost sharing for post-stabilization care services not preapproved ends when any of the following conditions are reached:
  - Wellcare By Meridian physician with privileges at the treating hospital assumes responsibility for the Member's care.
  - Wellcare By Meridian physician assumes responsibility for the Member's care through transfer.
  - Wellcare By Meridian representative and the treating physician reach an agreement concerning the Member's care.
  - The Member is discharged.

Emergency and Post-stabilization Care

Wellcare By Meridian (the "Plan") complies with all applicable federal and state requirements regarding emergency medical conditions, emergency services, and post-stabilization care. Providers must follow the standards outlined below to ensure timely and appropriate access to care for Members experiencing emergency situations.

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 Michigan Department of Health and Human Services (MDHHS) 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 generally 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.

Cost Sharing

Members may not be charged more for post-stabilization services than they would have paid had the services been obtained through a contracted provider. For the purposes of cost-sharing, post-stabilization services begin upon inpatient admission.

End of Plan Financial Responsibility

The Plan'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.

MEMBER GRIEVANCES AND APPEALS

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

Member Grievance

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

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

If a member has a grievance or concern with their healthcare provider or Wellcare By Meridian , we want them to tell us about it. They may call Member Services at 1-844-536-2168 to file a grievance.

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

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

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

The address to file a Formal Grievance is:

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

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

Member Appeals

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

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

Non-Urgent Pre-Service Appeal

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

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

Members can appeal by writing to the Wellcare By Meridian Appeals Coordinator or by calling Member Services toll free at 1-844-536-2168. If members write to us, they must include a phone number where they can be reached so we can let them know that their appeal has been received.

The address to file an appeal is:

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

Within three days of receiving the appeal, Wellcare By Meridian will notify the member of all the information that is needed to process the appeal. We will decide within 30 days of receiving the member's appeal request. We will decide within 10 calendar days for members enrolled in the Children's Special Health Care Service program. Members and their PCP, as well as any other provider involved in the appeal, will be notified of the outcome of the appeal in writing

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

Expedited Appeals

A member or their provider may call Member Services at 1-844-536-2168 to file an expedited appeal if they think that their situation is clinically urgent and reviewing the appeal in the standard timeframe could:

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

The member will need confirmation from their provider that the appeal is urgent. Within 24 hours of receiving the appeal, Wellcare By Meridian will notify the member of all the additional information that is needed to process the appeal. We will decide about the appeal within 72 hours of receiving the expedited appeal request.

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

Note: Wellcare By Meridian ensures that punitive action is not taken 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 Director at the following address:

DIFS
Health Plans Division – Appeals Section
PO Box 30220
Lansing, MI 48909-7720
Phone: 877-999-6442
Fax: (517) 284-8853

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 Director at the following address:

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

SECTION 3: PROVIDER FUNCTIONS AND RESPONSIBILITIES

PRIMARY CARE/MANAGED CARE PROGRAM

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

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

Hospital Roles and Responsibilities

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

- 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 patient 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. Some critical ancillary provider responsibilities include:

- 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 patient information to Wellcare By Meridian and to the PCP

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 Appointment	Access Standard
Preventive Care	
Adult Preventive Care	Within 30 days
Preventive care for children ⍰18 months old	Within 2 weeks
Preventive care for children ⍰ 18 months old	Within 4 weeks
Prenatal Care – Initial Prenatal Appointment	
First or Second Trimester	Within 7 business days of the member being identified as pregnant
Third Trimester	Within 3 business days of the member being identified as pregnant
High Risk (regardless of trimester)	Within 3 business days
Specialty Care	

Type of Appointment	Access Standard
Routine specialty care (e.g., vision, hearing)	Within 6 weeks of request
Acute specialty care (e.g., vision, hearing)	Within 5 business days of request
Dental Services	
Emergency dental services	Available immediately, 24 hours/day, 7 days/week
Urgent dental care	Within 48 hours
Routine dental care	Within 21 business days of request
Preventive dental services	Within 6 weeks of request
Initial dental appointment	Within 8 weeks of request
Durable Medical Equipment (DME)	
Adaptive/enhanced DME and supplies	• 21 calendar days (large metro, metro, micro areas) • 28 calendar days (rural/extreme access areas)
Assistive Technology Devices	• 21 calendar days (large metro, metro, micro areas) • 28 calendar days (rural/extreme access areas)
Home and Community-Based Services (HCBS)	
Chore services	• 14 calendar days (large metro, metro, micro areas) • 21 calendar days (rural/extreme access areas)
Community living supports	• 7 calendar days (large metro, metro, micro areas) • 14 calendar days (rural/extreme access areas)
Home-delivered meals	• 14 calendar days (large metro, metro, micro areas) • 21 calendar days (rural/extreme access areas)
Personal care services (non-waiver)	• 7 calendar days (large metro, metro, micro areas) • 14 calendar days (rural/extreme access areas)
Personal emergency response systems	• 30 calendar days (all geographic areas)
Preventive nursing services (agency and non-agency)	• 7 calendar days (large metro, metro, micro areas) • 14 calendar days (rural/extreme access areas)
Private duty nursing services (agency and non-agency)	• 7 calendar days (large metro, metro, micro areas) • 14 calendar days (rural/extreme access areas)
Respite services	• 7 calendar days (large metro, metro, micro areas) • 14 calendar days (rural/extreme access areas)
Respite services – non-waiver (in-home)	• 7 calendar days (large metro, metro, micro areas) • 14 calendar days (rural/extreme access areas)

Type of Appointment	Access Standard
Vehicle modifications	• 90 calendar days (large metro, metro, micro areas) • 120 calendar days (rural/extreme access areas)
Non-Emergency Medical Transportation (NEMT)	
Regularly scheduled services	48–72 hours advance notice required
Urgent services	Same-day or next-day availability
NEMT wait and transport times	• Pickup must not occur more than 15 minutes after scheduled time • Drivers must wait 15 minutes before leaving • Members must not arrive >1 hour early - Drop-off must not occur before facility opens unless requested • Pickup after appointment must occur within 1 hour of notice if no prearranged time • Pickup must not occur >15 minutes after facility closes unless requested

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

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

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 s 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 http://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 Michigan if dispensing drugs other than samples
- Section 17757a from the Board of Pharmacy (if dispensing drugs other than samples)
- Controlled Substances License from State of Michigan and the Federal DEA
- CLIA certificate or waiver
- Medical Waste Management certificate
- X-ray equipment registration
- R-H 100 notice
- Radiology protection rules
- MIOSHA poster (#2010)

PROVIDER CREDENTIALING/RE-CREDENTIALING

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

Practitioners have the following rights during the credentialing process: All information received during the credentialing process that is not peer protected can be forwarded to the applicant upon written request to the credentialing department. If there are any substantial discrepancies noted during the credentialing process the applicant will be notified in writing or verbally by the credentialing department within 30 days and will have 30 days to respond in writing regarding the discrepancies and correct any erroneous information. 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.

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

All providers will be given 30 days to correct any erroneous information obtained by 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.

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

Reconsiderations Process

Providers who are denied participation in the Wellcare By Meridian network, or whose participation status is suspended, restricted, or terminated, may request a reconsideration. This process is not an appeal and does not involve a formal hearing or review by an Appeals Committee.

Request Submission

Providers must submit a written request for reconsideration within 30 calendar days of receiving a non-approval or termination notice. The request must include supporting documentation that demonstrates the provider's qualifications and ability to meet Wellcare By Meridian's participation criteria.

Review and Determination

A Medical Director will review the reconsideration request and all submitted documentation within 60 calendar days. The Medical Director may uphold the original decision and close the file, or approve the provider for network participation if minimum criteria are met. A written notification of the decision will be sent to the provider within 30 calendar days of the determination.

Evidence Consideration

Providers may submit relevant documentation to support their reconsideration. The Medical Director will determine the relevance and weight of all submitted materials. Only documentation directly related to the reconsideration request will be considered.

Representation

Providers may be represented by a third party in preparing their reconsideration request. No formal hearing, cross-examination, or oral testimony is permitted.

Final Determination

All decisions made by the Medical Director are final. There is no further review or appeal process available to providers.

Notification of Network Changes

If a provider's participation is terminated, Wellcare By Meridian will notify affected members who regularly receive care from that provider. Wellcare By Meridian will also notify applicable managed care organizations, health plans, and regulatory entities of any final adverse determination, as required by law. Reporting obligations to state licensure boards and the National Practitioner Data Bank (NPDB) will be fulfilled in accordance with applicable federal and state regulations.

Confidentiality and Recordkeeping

Denied applications are maintained in a confidential manner in the Denied Participation file for a period of four years from the date of denial. Denials are kept confidential unless disclosure is required under federal or state regulations.

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 6:30 p.m. at 1-855-323-4578. 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).

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

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 consistent 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 1-855-323-4578. 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.

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

Inpatient Review

Our nurse reviewers are assigned to follow members at specific acute care facilities to promote collaboration with the facility's review staff and management of the member across the continuum of care. 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 and Centene Short Stay policy. 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	1-844-930-4390
Post-Acute Admissions	1-844-930-4390
Pre-Service Standard Requests	1-844-930-4389
Pre-Service Expedited Requests (Toll Free)	1-855-323-4578
Medicare Part B	1-844-235-5090
Medicare 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 Prior Authorization request, please include the following information:

- Member's name and date of birth
- Member's identification number
- Requesting Provider & NPI Number
- Servicing Provider & NPI Number
- Servicing Facility & NPI Number
- Place of Service

- Date(s) of service
- Procedure Code(s)
- ICD-10 Diagnosis Code(s)

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 our providers. The ones that have been adopted can be found under the Provider section on our website go.wellcare.com/MeridianMI. Whenever possible, Meridian adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field.

These guidelines are reviewed by clinicians with the MI Complete Health (MICH) population in mind – topics such as home and community-based services and chronic conditions that frequently impact our HIDE-SNP members can be found within these guidelines.

SERVICES REQUIRING PRIOR AUTHORIZATION

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

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/MeridianMI. Codes that are not listed on the applicable Medicaid fee schedule may not be payable by Wellcare By Meridian.

Inpatient

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

Durable Medical Equipment (DME)

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

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

Certain Outpatient Services/Treatments/Procedures

- Chiropractic Services
- Nutritional Counseling
- Hyperbaric oxygen therapy
- Genetic Testing
- Home Health/Skilled Nursing Visits
- Back Surgeries
- Ambulance Transportation Non-Emergent
- Dental Anesthesia in Facility >6 years of age
- Hysterectomy

- Spinal Surgeries
- Varicose Vein Surgery
- Breast Reduction
- Septoplasty
- Rhinoplasty
- Experimental and Investigational procedures

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 1-855-323-4578 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/MeridianMI, fax or by calling Wellcare By Meridian at 1-855-445-3571. 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 Prior Authorization form under the Prior Authorization Requirements link.

DENIALS, RECONSIDERATION AND PEER TO PEER

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

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

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

Note: Once a determination has been issued, the sole recourse available is through the appeals process. Prior to issuing a denial, Wellcare By Meridian will make reasonable efforts to consult with the requesting provider to conduct a peer-to-peer discussion.

Peer-to-Peer Discussion

Requesting providers have the opportunity to discuss a medical necessity denial with a Wellcare By Meridian Medical Director. Benefit and/or administrative determinations are excluded. The peer-to-peer request must be made within 10 days of the written denial notification. The requesting provider and the Meridian's Medical Director will discuss the utilization review process, reason(s) for denial and criteria used in decision-making process. Following the peer-to-peer discussion, the provider will be notified verbally of the determination. If the decision is to uphold the initial denial, the provider may appeal the decision by following the appeal process outlined within the initial written denial notification. To schedule a peer-to-peer, please contact Wellcare By Meridian at 1-833-456-8216.

MODEL OF CARE OVERVIEW

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

behavioral health specialists, LTSS and other community resources with a shared commitment to evidence-based treatment, robust communication, teamwork, and a culture of "going the extra mile."

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

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

Care Coordination

The Wellcare By Meridian Care Coordination program provides patient-focused, individualized case management for all members. Generally, these members include individuals who have complex healthcare needs and are more fragile and vulnerable than the general population. This includes but is not limited to members with active disease processes, those who require extensive utilization of resources and those at substantial risk for health complications. The following care coordination programs are available to personally support the healthcare needs of your members: asthma, diabetes, congestive heart failure, cardiovascular disease, complex/catastrophic illness, maternity, and high emergency room use.

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

Other reasons our Care Coordinators may contact you include:

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

You may refer a member for care coordination via the secure Wellcare By Meridian Provider Portal utilizing the "Notify CM" button or by calling Wellcare By Meridian at 1-855-445-3571.

Provider Action: Integrated Care Team (ICT) — Providers identified as a participant in a member's Integrated Care Team (ICT) are encouraged to participate in the ICT meetings. The role of ICT is to work collaboratively with the member and other ICT team members. The member's ICT team includes the member, the member's chosen allies or legal representative, PCP, Meridian Care Manager, LTSS Coordinator or PIHP Supports Coordinator (as applicable) and others as needed.

EVOLENT

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Wellcare By Meridian Michigan 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 1-866-510-6450 and follow the prompt for radiology authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

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

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

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

Program Components

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

How the Program Works

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

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

The following services **do not** require authorization through Evolent:

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

To reach Evolent and obtain authorization, please call 1-866-510-6450 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 www.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 Michigan has partnered with Evolent (formerly NIA) 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 Michigan 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 Michigan retro authorization guidelines. There is no need to send patient 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 Michigan and Evolent, Wellcare By Meridian Michigan 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 patient will receive notice of the coverage decision.

Should you have questions, please contact Wellcare By Meridian Michigan Provider Services at 1-855-445-3571.

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 Michigan. To obtain authorization through Evolent, visit www.RadMD.com or call 1-866-510-6450.

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 (HIDE SNP) line of business.

SECTION 5: BILLING AND CLAIMS PAYMENT

OVERVIEW

Wellcare by Meridian's Claims department is organized to precisely process claims in a timely manner. Meridian has established a toll-free telephone number. 1-855-445-3571, for providers to access a representative should you need to contact the plan for claims related questions.

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 upfront 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 upfront rejected 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.

IMPORTANT STEPS TO SUCCESSFUL SUBMISSION OF CLAIMS

The following information must be included on every claim, paper or electronic:

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for physicians or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard, and handwritten claim forms will be rejected back to the provider.
3. Enter the provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
4. Providers must include their taxonomy code (e.g., 207Q00000X for Family Practice) and corresponding ID qualifier in this section for correct processing of claims.
5. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Locations (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
6. Ensure all Diagnosis and Procedure Codes are appropriate for the age and sex of the member.
7. Ensure all Diagnosis Codes are coded to their highest number of digits available.
8. Ensure member is eligible for services during the time which services are provided.
9. Ensure provider receives authorization to provide services to the eligible member, when appropriate.
10. Ensure an authorization is given for services that require prior authorization by Wellcare By Meridian.

If electronic Claim submission is not possible, all hard copy (CMS-1500, CMS-1450 {UB-04}) claims must be submitted by mail to the address listed below.

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

When submitting paper Claims:

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for physicians or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard, and handwritten claim forms will be rejected back to the provider.
3. Ensure provider receives authorization to provide services to the eligible member, when appropriate.
4. Ensure an authorization number is listed on the claim for services that require prior authorization by Wellcare By Meridian.

CLAIMS BILLING REQUIREMENT

Sample forms for the CMS 1500 and the UB-04 forms are provided at the back of the manual. 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. If the facility is Medicaid-enrolled ASC, bill using the ASC X12 837 5010 professional claim format when submitting electronic claims. Paper claims must be billed on CMS 1500 paper form.
3. It is submitted within 365 days of the date the service was performed
4. Identifies the patient (Member ID assigned by Wellcare By Meridian, address, and date of birth)
5. Identify the plan (plan name and/or member ID number)
6. Lists the date (mm/dd/yyyy) and place of service
7. If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by Wellcare By Meridian
8. Includes additional documentation based upon services rendered as reasonably required by Wellcare By Meridian Medical Policies at go.wellcare.com/MeridianMI.

9. Is certified by provider that claim: o Is true, accurate, prepared with the knowledge and consent of provider o Does not contain untrue, misleading, or deceptive information o Identifies each attending, referring, or prescribing provider, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim
10. Is a claim for which the provider has verified the member's eligibility and enrollment in Wellcare By Meridian before the claim was submitted
11. Is not a duplicate of a claim submitted within 45 days of the previous submission
12. Is submitted in compliance with all of Wellcare By Meridian's prior authorization and claims submission guidelines and procedures
13. Is 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)
14. Is submitted electronically if the provider has the ability to submit claims electronically

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 via the Provider Portal:
https://provider.mimeridian.com/careconnect/login

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

Submit all initial claims for payment to:

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

TAXONOMY CODES

Taxonomy Codes are designed to categorize the type, classification, and/or specialization of healthcare providers. Wellcare By Meridian requires all claims, both paper and electronic, to include the taxonomy code of the rendering provider. The taxonomy code included on the claim must also match the taxonomy code Wellcare By Meridian has on file for the rendering provider. To submit or update this information, please complete the provider enrollment form located on our website.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)/FREESTANDING RURAL HEALTH CLINIC (RHC)/ENCOUNTER RATE CLINIC (ERC)

FQHCs are important community providers and all Wellcare By Meridian members have access to them if the member resides in a community where FQHC services are available. The Member Handbook outlines the member's rights to access a FQHC in their service area. Billing requirements for FQHC/RHC for Medicaid is fee-for-service.

FQHC/RHC/ERC Billing Requirements:

- FQHC, RHC, and ERC claims must bill with the group National Provider Identifier (NPI)
- FQHC, RHC, and ERC behavioral health (BH) claims must include a BH modifier
- FQHC, RHC and ERC claims must be billed on a UB FQHC Specific:
- Wellcare By Meridian Medicare primary: bills on a UB and is paid at CMS federal encounter rate or fee schedule, based on the services provided
- Wellcare By Meridian Medicaid primary: bills on a UB and is paid from the provider fee schedule
- Dual Population: Wellcare By Meridian processes the Medicare claim and Medicaid picks up the coinsurance

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 Wellcare By Meridian's Provider Portal at https://provider.mimeridian.com/careconnect/login.

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 is currently accepting electronic claims from the following clearinghouses: *Providers are responsible for ensuring they receive a confirmation file for claims submitted via EDI.

Availity

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

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

Wellcare By Meridian may add new clearinghouses from time to time. Contact Provider Services at 1-855-445-3571 to see if your clearinghouse partner is on the list. Providers are responsible for ensuring that they receive a confirmation file for claims submitted via electronic data interchange (EDI).

PAPER CLAIMS SUBMISSION

To facilitate processing and to minimize chances for rejection or error in payment, it is required that paper claims be typewritten or computer printed. The recommended font to use for computer generated claims is 12-point Times New Roman font. Do not print in italics, bold or script. Handwritten claims and photocopied claims are not accepted. Paper claims information must be submitted within the confines of each item box.

Claims must be legibly signed and dated in ink by the provider or his or her authorized representative. Any claim that is not properly signed or that has the certification statement altered will be rejected. A rubber signature stamp or other substitute is not acceptable. An authorized representative may only be a trusted employee over whom the provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the provider. Such a representative must be designated specifically and must sign the provider's name and his or her own initials on each certification statement. This responsibility cannot be delegated to a billing service. It is mandatory that claims for services be submitted only on original billing forms. Photocopies or other facsimile copies cannot be accepted for payment purposes.

TIMELY FILING OF CLAIMS

A claim can be resubmitted within 365 days from DOS or 120 days from last date of adjudication/remit – whichever is later.

CORRECTED CLAIMS

A corrected claim should be submitted when a provider needs to change information on a previously submitted initial claim. All requests for corrected claims or reconsiderations/claim disputes must be received within 90 days from the date of the original explanation of payment or denial.

If you are replacing or voiding/cancelling a UB-04 claim, please use appropriate bill type of 137 or 138. If you are replacing or voiding/cancelling a CMS 1500 claim, please complete box 22. For replacement or corrected claim, enter resubmission code 7 in the left side of item 22 and enter the original claim number of the claim you are replacing in the right side of item 22. If submitting a void/cancel claim, enter resubmission code 8 on the left side of item 22 and enter the original claim number of the paid claim you are voiding/cancelling on the right side of item 22. If you do not follow these corrected claim form submission processes the claim will deny for a duplicate claim submission.

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.

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.

Post-Service Provider Appeals

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

What Types of Issues Can Providers Appeal?

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

- Post-Service Provider Appeal: An appeal of services that were denied or reduced because they did not meet a specific criteria, policy or guideline and have a denied authorization on file. For example, the provider disagrees with a determination made by Wellcare By Meridian , such as combining two stays as a 15-day readmission. In this case, the provider should send additional information (such as medical records) that support the provider's position.
- Administrative Appeal: An appeal by a provider of a claim/service denied for failure to authorize services according to timeframe requirements. In this case, the provider must explain the circumstances and why the provider feels an exception is warranted in that specific case.

A provider's lack of knowledge of a member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to a member being ineligible on the date of service or due to non-covered benefits.

How to File a Post-Service Provider Appeal

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

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

Wellcare By Meridian
Attn: Appeals Department

P.O. Box 9700
Farmington, MO. 63640-0700

Timeframe for Filing a Post-Service Provider Appeal

Provider appeals must be submitted within 365 days from the date of service or 120 days from the EOP, whichever is later, provided the initial claim was submitted timely (unless specified otherwise within the provider contract).

Response to Post-Service Provider Appeals

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

There is only one (1) level of appeal available for Post-Service Provider Appeal reviews. All appeal determinations are final.

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

Contracted Hospitals:

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

Non-Contracted Hospitals:

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

The provider must submit its request for Binding Arbitration or to use the procedures of the Access Agreement no later than 365 days from the date of service, or within 120 days of the last claim denial provided the initial claim was submitted within one year of the date of service. Providers will have no further recourse on any

claim if they do not file their request for either of the above dispute resolution mechanisms within these timeframes.

Rapid Dispute Resolution Process

1. Hospitals and Health Plans agree to exhaust their efforts to achieve reconciliation solutions for outstanding accounts via internal means on a regular basis before pursuing the RAPID DISPUTE RESOLUTION PROCESS (RDRP) including the use of an Accounts Receivable Reconciliation Group (ARRG).
2. Where a disputed claim remains, either the Hospital or the Health Plan may submit a request to MDHHS for RDRP. Upon receipt of a request, MDHHS will contact the other party to obtain that party's agreement to pursue resolution of the disputed claim in this manner.
3. MDHHS will contact a mediator, selecting one at random from the list of available mediators that it has prepared. The Mediator will schedule the mediation session within fifteen (15) calendar days of contact by MDHHS. The Mediator will issue his/her decision within fifteen (15) calendar days of the mediation session.
4. Hospitals and Health Plan agree that, should this process be elected/agreed to by both parties, the outcome, including any monetary award will be binding. The party found to be liable will assess the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

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

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

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

A focused medical record review is performed annually as part of the continuous quality improvement activities of 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.

SECTION 6: REPORTING REQUIREMENTS

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:

- Exploitation
- Neglect
- Abuse
- Use of restraints, seclusions, or restrictive interventions
- Provider no-shows
- Theft

Providers are trained to report critical incidents to the appropriate State Agency. If Wellcare By Meridian needs to assist in resolving a critical incident, please email OutreachQuality@mimeridian.com.

Providers must fully cooperate in the investigation of critical incidents reported, including submitting all requested documentation. To protect the safety of the member, immediate actions may include:

- Contacting 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.

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.

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

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 Michigan requires your compliance with this requirement.

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

ENCOUNTER REPORTING REQUIREMENTS

In order to assess the quality of care, determine utilization patterns and access to care for various healthcare services, qualified health plans are required to submit encounter data containing detail for each patient encounter reflecting all services provided by the providers of the health plan. The State will determine the minimum data elements of the encounter reporting. A format consistent with the formats and coding conventions of the CMS 1500 and UB-04 will be used initially. PCPs will submit their encounter data monthly to 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 -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 mimeridian.com Meridian Medicaid Provider Manual

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
777 Woodward Ave., Suite 700
Detroit, MI 48226

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

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

go.wellcare.com/MeridianMI