

Wellcare With Meridian (MI)

Provider Manual

2027

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Internal Approved 09152026

Partners in Quality Care

Dear Provider Partner,

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

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

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

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

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

Thank you for being a trusted Wellcare provider partner.

Sincerely,

Wellcare

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2027 D-SNP(DUALS) PROVIDER MANUAL REVISION TABLE

Date	Section	Sub-Header	Comments
1/1/2027	2: Member Benefit Information	Member Eligibility and Enrollment Sample Member ID Card Special Supplemental Benefits for the Chronically Ill (SSBCI) Emergency Services Member Grievance	Updated list; Updated member ID card sample; Added section; Clarified language; Updated language
1/1/2027	3: Provider Functions and Responsibilities	Provider Credentialing/Re-Credentialing	Updated language
1/1/2027	4: Utilization Management	UM Decisions CMS Interoperability APIs — Provider Overview Care Coordination	Updated language; Added new section; Added training weblink
1/1/2027	5: Billing and Claims Payment	Retroactive Adjustments	Added new section
1/1/2027	6: Reporting Requirements	Critical Incidents Reporting	Updated language
1/1/2027	7: Compliance and Regulatory Requirements	FRAUD, WASTE & ABUSE (FWA) Program	Updated language

SECTION 1: GENERAL INFORMATION

Welcome to the Wellcare With Meridian Provider Manual. This manual 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 converted 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).

HIDE-SNP PROGRAM COMMITMENT AND TRANSITION PILLARS

Wellcare With 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 With Meridian adopted 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 employs 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 incorporates policies and operational strategies that align with quality improvement, outcomes measurement, and health equity initiatives.
- Improve Care Delivery: Care within the HIDE-SNP framework reflects 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 embeds 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.

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 launched 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, 2028.

Wellcare With 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 With 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 With Meridian website at wellcare.mimeridian.com.

Updates and Revisions

The Provider Manual is a dynamic resource that will continue to evolve in alignment with Wellcare With 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 With Meridian website at wellcare.mimeridian.com.

KEY CONTACT INFORMATION

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

Please refer to the table below for the most commonly used contact information:

wellcare With meridian	Wellcare With Meridian P.O. Box 10050 Van Nuys, CA 91410-0050 Hours of Operation: Monday-Friday, 8am-8pm EST wellcare.mimeridian.com	
Department	**Phone Number**	**Website**
Provider Services	1-855-445-3571	N/A
Member Services	1-844-536-2168	N/A
Centene Pharmacy Services	1-855-445-3571	www.centenepharmacy.com

wellcare With meridian	Wellcare With Meridian P.O. Box 10050 Van Nuys, CA 91410-0050 Hours of Operation: Monday-Friday, 8am-8pm EST wellcare.mimeridian.com	
Department	**Phone Number**	**Website**
Express Scripts, Inc. (ESI) Pharmacy Helpdesk	1-833-750-1800	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	1-800-345-1642	N/A

SECTION 2: MEMBER BENEFIT INFORMATION

MEMBER ELIGIBILITY AND ENROLLMENT

Members who wish to enroll in Wellcare With 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 With 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 prior to enrollment with Wellcare With Meridian; individuals who elect to receive hospice services while enrolled with Wellcare With Meridian may remain enrolled.
- Individuals who are incarcerated
- Individuals who have Presumptive Eligibility

NON-DISCRIMINATION STATEMENT

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

- Members may request and receive information about the health plan, including:
- Member rights and responsibilities
- Participating providers and their qualifications
- Grievance and appeal procedures
- Covered benefits and services
- Provider information – such as location, qualifications, and availability – is accessible via the online provider directory or by contacting the Customer Experience (CE) Department
- Members may request information about the plan's structure, operations, benefits, and the quality program, and can expect responses to reasonable inquiries.
- Plan rules, benefits, and available options may be explained to Members, with interpreter services made available when needed.
- Members have the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.

Language and Disability Services

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

Dignity, Privacy, and Nondiscrimination

- Members are to be treated with respect and dignity, with consideration for their right to privacy.
- 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.
- 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.
- Members may not be subjected to restraint or seclusion as a form of coercion, discipline, convenience, or retaliation.
- Members should be able to exercise their rights without fear of negative consequences from the plan, its providers, or the state.

Participation in Care

- Members are encouraged to participate in decisions about their healthcare, including the right to:
- Choose a plan and provider at any time in accordance with parameters defined in regulation, policy, and the Contract.
- Receive a health risk assessment (HRA) upon enrollment in a plan and to participate in the development and implementation of the individual care plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the member's goals, preferences, strengths and weaknesses, and a plan for managing and coordination of the member's care.
- Members, or authorized representative(s), also have the right to request a reassessment by the integrated care team (ICT) and be fully involved in any such reassessment.
- Receive complete and accurate information on their health and functional status by the ICT.
- Accept or refuse recommended treatment.
- Discuss treatment options with their providers, including potential risks, benefits, and alternatives.
- Members may receive healthcare services in accordance with applicable laws and Wellcare With Meridian's agreement with the state.
- Members may have access to a network of providers, including primary care providers, specialists, hospitals, and American Indian/Alaska Native providers when appropriate.
- Members may access emergency services when medically necessary, regardless of network status or prior authorization.
- Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
- Receive medical and non-medical care from a team that meets the member's needs, in a manner that is sensitive to the member's language and culture, and in an appropriate care setting, including the home and community.

Grievances, Appeals, and Involvement

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

Final Protections

- 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

- The plan and its contracted providers are expected to provide reasonable accommodations for Members with disabilities, as required by law.

- Members may be informed annually – and as needed- about their rights to accommodations via the member handbook.
- Providers are informed of these requirements through the provider manual.
- Members may request accommodations through their care coordinator, who can help assess needs and provide available options.
- The Utilization Management team reviews accommodation requests and determines whether they can be provided.
- Members may appeal decisions regarding accommodations through the appeals process outlines in plan policy.
- Receive basic information about the plan, orally as well as in writing, upon request, about the organization of Wellcare With Meridian including but not limited to Member rights and responsibilities, participating practitioners and providers, grievance and appeal procedures, and covered services. This information is made accessible to all Members including those with limited English proficiency or reading skills, with diverse cultural ethnic background, and with physical and mental disabilities.
- Have advance directives explained and to establish them, if the member so desires, in accordance with 42 CFR §§489.100, and 489.102.

MEMBER BENEFITS AND SERVICES

Wellcare With Meridian has a comprehensive benefit package available to all Wellcare With 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. Wellcare With Meridian's HIDE-SNP covers Medicare and Medicaid benefits as one integrated product. Medicare coverage rules apply first; Medicaid benefits are applied secondary, as defined by MDHHS.

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

- Access to Federally Qualified Health Centers (FQHC) & Tribal Health Centers (THC)
- Ambulance and other emergency medical transportation
- Cardiac rehabilitation
- Certified midwife services
- Certified family nurse practitioner services
- Chiropractic services
- Dental services. For questions regarding dental coverage (D codes) please refer to our dental provider, DentaQuest, at 1-844-870-3977.
- 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
- Home health services

- Hospice services
- Hospital services
- Immunizations
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility)
- Restorative or rehabilitative services (in a place other than a nursing facility)
- Maternal Infant Health Program (MIHP)
- Medically necessary weight reduction services
- Michigan Diabetes Prevention Program (MiDPP)
- Behavioral health outpatient visits for mild to moderate conditions
- Out-of-state services authorized by Wellcare With Meridian
- Outreach services (including pregnancy 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
- 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 wellcare.mimeridian.com 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 With 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 With Meridian does not charge co-pays to its members for any Medicaid-covered services.

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

Key Information on the Member ID Card

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

Provider Responsibilities

Providers are expected to:

- Verify member eligibility and benefits using the information on the ID card and the secure Provider Portal.
- Confirm the member's identity at the time of service.
- Use the Member ID number for all claims submissions and prior authorization requests.

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

Sample Member ID Card



SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)

Overview

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

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

Provider Attestation Process

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

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

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

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

SSBCI Eligibility Requirements

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

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

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

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

Provider Instructions for Submitting an Attestation

Providers should follow these steps to submit an SSBCI attestation:

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

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

Determination Process & Member Notification

Once an attestation is submitted:

- The attestation will be reviewed as part of the SSBCI eligibility determination process
- The member will receive written notification of the determination within 10 business days
- Members determined eligible will receive information regarding available SSBCI benefits and how to access those benefits

- Members not meeting eligibility requirements will receive notification explaining the determination and appeal rights

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

PHARMACY BENEFIT MANAGEMENT

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

In accordance with the requirements set forth by Michigan Department of Health and Human Services (MDHHS), Wellcare With 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 wellcare.mimeridian.com and the Prescriber Portal. This formulary should be consulted when prescribing medications for Wellcare With Meridian members. Wellcare With Meridian 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 With 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 wellcare.mimeridian.com 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 With Meridian members have full freedom of choice of family planning providers, both in and out of the Wellcare With 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 With 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 With 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 With Meridian has contracted with a transportation agency that has a network capable of providing non-emergent transportation to the entire Wellcare With 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 With 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 With 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 With 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 With Meridian will provide these services through Medicaid in accordance with this Contract.

- Wellcare With 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 With Meridian will ensure Emergency Services are available 24 hours per day and 7 days per week.
    - Wellcare With 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 With 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 With Meridian of the Member's services in the emergency department.
- Unless a representative of Wellcare With Meridian or the Member's PCP instructed the Member to seek Emergency Services, Wellcare With Meridian will not be responsible for paying for or covering cost-sharing for non-emergency treatment services that are not authorized by Wellcare With Meridian.
- Wellcare With 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 provider that an Emergency Medical Condition does or does not exist.
- If an Emergency Medical Condition is found to exist, the examining provider must provide whatever treatment is necessary to stabilize that condition of the Member.
- Wellcare With 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 With Meridian will cover such services.
- Wellcare With Meridian must cover (consistent with 42 CFR 422.214) appropriate cost sharing for Medicare-covered post-stabilization care services obtained within or outside Wellcare With Meridian's network that are pre-approved by a Wellcare With Meridian Provider or other Wellcare With Meridian representative.
- Wellcare With Meridian must cover appropriate cost sharing for Medicare-covered post-stabilization care services, regardless of whether the services were provided in Wellcare With Meridian's network. Even if these services were not pre-approved by Wellcare With Meridian, Provider, or other Wellcare With Meridian representative but administered to maintain the Member's stabilized condition within one (1) hour of a request to Wellcare With 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 With Meridian may require prior authorization for such services. Such services must be deemed prior authorized, and Wellcare With Meridian must cover appropriate cost sharing under any of the following conditions:
    - If Wellcare With 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 With Meridian is not available when the request for post-stabilization services occurs.
    - If a Wellcare With Meridian representative and the treating provider cannot reach an agreement concerning the Member's care and a Wellcare With Meridian provider is not available for consultation. In this situation, Wellcare With Meridian must give the treating provider the opportunity to consult with a Wellcare With Meridian provider and the treating provider may continue with care of the patient until a Wellcare With Meridian provider is reached or one of the criteria specified below is met.
    - Wellcare With 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 With Meridian provider with privileges at the treating hospital assumes responsibility for the Member's care.
        - Wellcare With Meridian provider assumes responsibility for the Member's care through transfer.
        - Wellcare With Meridian representative and the treating provider reach an agreement concerning the Member's care.

- The Member is discharged.

Emergency and Post-stabilization Care

Wellcare With 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 provider, or the provider treating the Member, is solely responsible for determining when the Member is stabilized for discharge or transfer. This determination is binding on the Plan if:

- It adheres to 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 provider, and care may proceed until such consultation occurs or until one of the criteria outlined in 42 CFR §422.113(c)(3) is met.

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

24 HOUR NURSE ADVICE LINE

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

The Nurse Advice Line offers:

- General health information
- Guidance on appropriate levels of care
- Assistance understanding 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 With 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 With Meridian members.

Member Grievance

A grievance is an expression of dissatisfaction, including complaints, directed to Wellcare With 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 With Meridian member
- Quality of care of services provided

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

Wellcare With Meridian is required to respond to a standard integrated Grievance in writing no later than 30 days from the filing date, and expedited grievances within 24 hours. days from the filing date. Wellcare With 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 With Meridian would expect a response from the provider/hospital system as soon as possible, or no later than 24 hours.

Wellcare With 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 With Meridian will work with them to resolve the issue in just one phone call.

The address to file a Formal Grievance is:

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

Wellcare With 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 With 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 With 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 65 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.

An authorized representative of the member such as family member, friend, provider or attorney may file an appeal on the member's behalf with the member's written permission. The member must submit written permission to Wellcare With Meridian for an authorized representative to appeal on their behalf. Members can appeal by writing to the Wellcare With 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 With Meridian
Appeals Department
P.O. Box 10052
Van Nuys, CA 91410

Within three days of receiving the appeal, Wellcare With 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 With 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 With 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:

Michigan Office of Administrative Hearings and Rules Michigan Department of Health and Human Services
PO Box 30763
Lansing, MI 48909

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 Michigan Office of Administrative Hearings and Rules Michigan Department of Health and Human Services.

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:

Michigan Office of Administrative Hearings and Rules Michigan Department of Health and Human Services
PO Box 30763
Lansing, MI 48909

SECTION 3: PROVIDER FUNCTIONS AND RESPONSIBILITIES

PRIMARY CARE/MANAGED CARE PROGRAM

Wellcare With 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 With Meridian standards.

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

Primary Care Provider (PCP) Roles and Responsibilities

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

Female members will have direct access to women's health specialists to provide women's routine and preventative 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 With Meridian.

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

Specialty Care Provider Roles and Responsibilities

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

- Coordination of discharge planning with Wellcare With Meridian Medicare Utilization Management staff
- Coordination of mental health/substance abuse care with the appropriate state agency or provider
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent patient information to Wellcare With Meridian and to the PCP
- Communication of all hospital admissions to the Wellcare With 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 With Meridian recognizes that the ancillary provider is another valuable team member in delivering care to Wellcare With 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 With Meridian Medicare members
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent patient information to Wellcare With Meridian and to the PCP

APPOINTMENT STANDARDS

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

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

Type of 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)
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
- 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 With 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 With Meridian can check the MDHHS health professions website monthly for excluded providers. At minimum, Wellcare With Meridian can check the OIG List of Excluded Individual Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)] for its providers at least monthly, before contracting with the provider, and at the time of a provider's credentialing and recredentialing. If a provider is terminated or suspended from the 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 With 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 With 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 With Meridian is prohibited from issuing payment to a provider or entity that appears in the List of Excluded Individuals/Entities as published by the Department of Health and Human Services Office of the Inspector General or in the List of Debarred Wellcare With Meridian as published by the General Services Administration (with the possible exception of payment for emergency services under certain circumstances).

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

OSHA TRAINING

Employee training and annual in-service education must include:

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

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

Necessary equipment must be provided for the administration of mouth-to-mouth resuscitation.

Documents to be posted in the facility are:

- Pharmacy Drug Control license issued by the State of 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's credentialing and re-credentialing processes require that all providers keep the Wellcare With Meridian's Provider Services department is updated with changes in credentials. In conjunction with this, providers should respond promptly to any requests to update information so that all credentialing files can be maintained appropriately.

Practitioners have the following rights during the credentialing process: All information received during the credentialing process that is not peer-protected can be forwarded to the applicant upon written request to the Credentialing Department. Wellcare With Meridian is not required to reveal the source of the information if the information is not obtained to meet the credentialing verification requirements or if disclosure is prohibited by law. Upon written request to the Credentialing Department, any practitioner has the right to be informed in writing or verbally of their credentialing status.

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

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

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

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

Appeals Process

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

When an Applicant receives a non-approval notice, the affected practitioner has 30 calendar days from receipt of the notice to file a written request for reconsideration. The request must include additional supporting documentation in favor of the applicant's consideration for network participation and should be directed to the Wellcare With Meridian Quality Medical Director via Provider Services. To submit a reconsideration request or obtain further instructions, please contact Provider Services at **1-855-445-3571.**

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

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

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

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

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

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

SECTION 4: UTILIZATION MANAGEMENT

The objective of Wellcare With Meridian's Utilization Management 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 With Meridian does not specifically reward our providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

Utilization management clinical staff uses plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by 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 in Medicare manuals, Wellcare With Meridian may utilize current literature review, Optum, Inc.'s InterQual criteria, and input from practicing providers and medical experts in the relevant field. The organization also considers government agency policies, standards adopted by national accreditation organizations, and its own Medical Management policies for clinical decision making. Additionally, Wellcare With Meridian may adopt coverage policies from other MA Organizations within its service area to guide its determinations.

Wellcare With Meridian's Medical Necessity Guidelines are based on current literature review, consultation with practicing providers and medical experts in their particular field, government agency policies, and standards adopted by national accreditation organizations. It is the responsibility of the attending provider to make all clinical decisions regarding medical treatment. These decisions should be made 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 provider 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 With 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 With 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 With Meridian's nurse reviewers assess the care and services provided in an inpatient setting and the member's response to the care by applying InterQual® criteria and Centene Short Stay policy. Together, with the facility's staff, Utilization Management's clinical staff coordinates the members' discharge needs.

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

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

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

Prior Approval Requirements/Precertification

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

1. **Authorization Requirements:** Refer to the Prior Authorization check tool to confirm PA necessity.
2. **Online Submission:** The Wellcare With Meridian Online PA Form can be accessed by visiting the secure Provider Portal
3. **Fax Submission**: Refer to Utilization Management's referral type fax numbers. Please include pertinent clinical documentation with the request if indicated
4. **Phone Submission**: Many authorizations cannot be processed via phone, as clinical review and supporting documentation are required. Requests should only be submitted via the phone for services related to pending hospital discharges or expedited pre-certification requests.

Wellcare With Meridian	
Type of Request	Fax Number
Inpatient Admissions	1-844-930-4390
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

CMS INTEROPERABILITY APIS — PROVIDER OVERVIEW

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

Prior Authorization API

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

Provider Access API

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

Additional Interoperability APIs

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

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

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

Clinical information includes relevant and current information regarding the members:

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

Clinical Practice Guidelines

Wellcare With Meridian encourages the use of evidence-based Clinical Practice Guidelines (CPGs) by our providers. The ones that have been adopted can be found under the Provider section on our website wellcare.mimeridian.com. 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 With 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 With Meridian Utilization Management verifies benefit eligibility and medical necessity for select services at the time of the request and is not a guarantee of coverage or payment. Payment is determined by the members' eligibility and benefits at the time of service.

Claims payment is also based on the appropriateness, accuracy, and presence of codes submitted on the claim as determined by Centers for Medicare. You can check the requirements for any code on our website at wellcare.mimeridian.com. Codes that are not listed on the applicable Medicaid fee schedule may not be payable by Wellcare With 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 With 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.

As a PCP, you may request a referral to one of the health care public entities via Wellcare With Meridian's Provider Portal at wellcare.mimeridian.com, fax or by calling Wellcare With Meridian at 1-855-445-3571. Wellcare With Meridian's staff will forward the information and authorization to the central referral office of the public entities. Wellcare With 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

Once a request has been denied, Wellcare With 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 With 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 With Meridian's 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 Wellcare With Meridian's Medical Director will discuss the utilization review process, reason(s) for denial and criteria used in decision-making process. 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 With Meridian at 1-833-456-8216.

MODEL OF CARE OVERVIEW

Wellcare With Meridian's Model of Care is specifically designed to serve a complex population with diverse social structures and varying health care needs. Wellcare With 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 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 With Meridian's dedication to quality improvement is recognized on National and State levels.

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

Care Coordination

The Wellcare With 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 With Meridian Provider Portal utilizing the "Notify CM" button or by calling Wellcare With 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. Model of care training is available at the following link https://www.wellcare.com/en/providers/model-of-care-training

EVOLENT

Advanced Diagnostic Imaging

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

To reach Evolent and obtain authorization, please call **1-866-510-6450** 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 With 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 With 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 With 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 With 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 With Meridian Michigan and Evolent, Wellcare With 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 With 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 provider to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

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

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

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

Radiation Oncology

Wellcare By Meridian Michigan has partnered with Evolent to administer the Radiation Therapy Utilization Management Program. This program is designed to ensure that selected radiation therapy services are clinically appropriate, evidence-based, and delivered in accordance with nationally recognized guidelines and medical necessity criteria.

Coverage and authorization requirements may vary by product and market. Services subject to prior authorization are identified in the Health Plan's current Prior Authorization List and applicable medical policies, which are updated periodically.

Providers are required to submit all applicable prior authorization requests through the https://www.evolent.com/provider-portal. The portal is used for submission of clinical documentation, authorization determination, and related inquiries.

How the Program Works

Radiation Oncology Services: Prior authorization will be required for outpatient settings:

Radiation Oncology

- **Treatment planning and simulation**
- **Conventional external beam radiation therapy (EBRT)**
- **Intensity-Modulated Radiation Therapy (IMRT)**
- **Stereotactic Body Radiation Therapy (SBRT)**
- **Stereotactic Radiosurgery (SRS)** (brain and spine-focused treatments)
- **Image-Guided Radiation Therapy (IGRT)**
- **Brachytherapy** (internal radiation in certain cases)

- **Specialized radiation treatment planning services** and physics/technical components tied to treatment delivery

Program functions

- Review of dose, frequency, and treatment duration
- Validation against oncology clinical pathways and guidelines
- Monitoring for appropriate sequencing of therapies (especially multi-line treatment)

Cardiology Surgical Procedures

Wellcare By Meridian Michigan has partnered with Evolent to launch an innovative Cardiac Surgical Quality and Safety Management Program. The program is designed to work collaboratively with providers to promote patient safety through the practice of high quality and cost-effective care for Wellcare By Meridian Michigan members undergoing cardiac surgical procedures.

How the Program Works

Cardiology surgical procedures: Prior authorization will be required for the following non-emergent inpatient and outpatient surgeries:

CARDIAC SURGERIES & PROCEDURES

Including all associated partial, total, and revision surgeries

- Coronary Angioplasty/Stenting
- Internal Cardiac Monitoring
- Implantable Cardioverter Defibrillator
- Leadless Pacemaker
- ICD Revision or Removal
- Left Atrial Appendage (LAA) Occluders
- Non-Coronary Angioplasty/Stenting
- Pacemaker
- Pacemaker Revision or Removal
- Peripheral Revascularization
- Percutaneous Transcatheter Closure
- WCD - Wearable Cardiac Defibrillator
- Cardiac Ablation

- Coronary Artery Bypass Grafting

KEY PROVISIONS:

- Emergency related procedures do not require authorization
- It is the responsibility of the ordering provider to obtain authorization
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.

To submit authorizations, please visit www.RadMD.com.

SECTION 5: BILLING AND CLAIMS PAYMENT

OVERVIEW

Wellcare With 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 With Meridian only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) Claim Forms whether filing on paper or electronically. Other claim form types will be 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 With Meridian does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10- or 12- point Times New Roman font and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten forms and nonstandard will be 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 providers 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 With 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 With 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 providers 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. Enter provider's billing NPI number in box 33A, must be group NPI or individual if sole proprietor for CMS 1500
5. Ensure an authorization number is listed on the claim for services that require prior authorization by Wellcare With 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 180 days for non-contracted providers,365 days for contracted providers from the date the service was performed
4. Identifies the patient (Member ID assigned by Wellcare With 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 With Meridian
8. Includes additional documentation based upon services rendered as reasonably required by Wellcare With Meridian Medical Policies at wellcare.mimeridian.com
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 With 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 With 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 With Meridian Provider Portal.

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 With 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 With 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 With 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 With 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 With Meridian Medicare primary: bills on a UB and is paid at CMS federal encounter rate or fee schedule, based on the services provided
- Wellcare With Meridian Medicaid primary: bills on a UB and is paid from the provider fee schedule
- Dual Population: Wellcare With Meridian processes the Medicare claim and Medicaid picks up the coinsurance

ELECTRONIC CLAIMS SUBMISSION

Providers using electronic submission shall submit all claims to Wellcare With Meridian or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the provider's NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim.

In-network providers may submit claims through Wellcare With 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 With 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 Essentials

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

Wellcare With 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.

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 180 days for PAR providers, 365 for non-par providers and 120 days from last date of adjudication for both.

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 ending in 7 or 8. If you are replacing or voiding/cancelling a CMS 1500 claim, please complete box 22. For replacement or corrected claim, enter resubmission code 7 on the left side of item 22 and enter the original claim number of the claim you are replacing on 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 With Meridian upon identification of any overpayment. Identified overpayments must be returned to the Plan within sixty (60) calendar days, accompanied by written documentation detailing the reason for the overpayment.

RETROACTIVE ADJUSTMENTS

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

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

REIMBURSEMENT GUIDELINES, PAYMENT POLICES AND CODING GUIDANCE

Member Billing

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

Post-Service Provider Appeals

Wellcare With Meridian offers a Post-Service claim appeal process for disputes related to denial of payment for services rendered to Wellcare With 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 With Meridian, such as combining two stays as a 30-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 the following 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 With 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 65 calendar days from date of denial for non-participating providers and 90 days from date of the denial for participating provides (unless specified otherwise within the provider contract).

Response to Post-Service Provider Appeals

Wellcare With 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 With 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 With Meridian's determination regarding an appeal the provider may pursue one of the following options depending on contract status:

Contracted Hospitals:

- Joint Operations Medical Sub-Committee (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 With 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 With Meridian. The Provider and Wellcare With 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 With Meridian are to be provided at no cost from the Provider. This includes administrative fees, copying fees, paper fees, and fees delegated from a third-party vendor.

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

Procedure

All practitioners in the network must comply with the following:

1. Medical record documentation must include at least the following elements:
    a. All services provided directly by the practitioner
    b. All ancillary services and diagnostic tests ordered by the practitioner
    c. All diagnostic and therapeutic services for which the member was referred to by the practitioner (e.g., home health nursing reports, specialty provider reports, hospital discharge reports and physical therapy reports)
2. The essential documentation elements for the medical record include:
    a. History and physicals
    b. Allergies and adverse reactions, or NKDA, are prominently noted
    c. Problem lists of significant illnesses and medical conditions, with date of onset

d. Medications (current medications, changes, discontinuation, and reported reactions)

e. Working diagnoses are consistent with findings

f. Treatment plans are consistent with diagnoses

g. Preventive services/risk screenings

h. There is no evidence that the 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 With Meridian. In addition, an individual practitioner medical record review may be performed, when the apparent lack of compliance with the above standards is discovered during a utilization management or QI activity.

SECTION 6: REPORTING REQUIREMENTS

CRITICAL INCIDENTS REPORTING

Wellcare With Meridian requires participating program providers to report all Critical Incidents that occur in any setting, including home and community-based long-term services and supports (HCBS) delivery. Examples of HCBS settings are 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 With Meridian's website. Providers must participate in trainings offered by Wellcare With Meridian to ensure accurate and timely reporting of all critical incidents. These trainings may be offered through webinars, online learning, and regional meetings.

Critical incidents include but are not limited to:

- Exploitation
- Illegal Activity in the Home
- Neglect
- Physical Abuse
- Use of restraints, seclusions, or restrictive interventions
- Provider no-shows
- Sexual Abuse
- Theft
- Verbal Abuse
- Working Consuming Drugs or Alcohol on the Job
- Suspicious or Unexpected Death, Including Suicide
- Suicide Attempt
- Medication Errors

Providers are trained to report critical incidents to the appropriate State Agency. If Wellcare With Meridian needs to assist in resolving a critical incident, please email PatientSafety@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 With Meridian program members until the investigation is complete, which may take up to 30 calendar days.
- Ordering an immediate drug screen or appropriate testing if the allegation involves theft of drugs or substance use, including alcohol, while on the job.

- Interviewing the involved employee(s) as soon as possible following the incident and having them submit a written account of events.

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.

Adult Protective Services (APS) Centralized Intake:

- 855-444-3911
- Reports can be made 24 hours a day 7 days a week

Licensing and Regulatory Affairs (LARA):

- Report to LARA if an incident occurred in a Nursing Facility, Adult Foster Care or Home for the Aged
- 1-800-882-6006
- https://www.michigan.gov/lara

911 or local law enforcement (life threatening or possible crime)

For more information, please complete the Critical Incident Training on Wellcare With Meridian's website at https://www.mimeridian.com/providers/provider-training/annual-training.html.

CORPORATE REPORTING REQUIREMENTS

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

Practices will be monitored for accurate and complete encounter reporting. The data that Wellcare With Meridian submits to the State of 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 With Meridian, who must then submit it to the MDHHS via an electronic tape. Both Wellcare With Meridian and provider agree that all information related to payment, treatment, or operations will be shared between both parties and all medical information relating to individual Members will be held confidential.

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

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

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

ELECTRONIC VISIT VERIFICATION

What is Electronic Visit Verification (EVV)?

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

- The type of service performed
- Beneficiary, client, or participant receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

Why was the EVV system implemented?

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

What services require EVV?

Per CMS, EVV must be used to record all personal care services and all home 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. To complete the HHAeXchange (contracted with

MDHHS for EVV) 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.

SECTION 7: COMPLIANCE AND REGULATORY REQUIREMENTS

FRAUD, WASTE & ABUSE (FWA) PROGRAM

PURPOSE AND COMMITMENT

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

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

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

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

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

DEFINITIONS (42 CFR §455.2 AND HHS DEFINITIONS)

For purposes of this manual:

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

EXAMPLES OF FWA AND IMPROPER BILLING PRACTICES

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

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

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

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

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

PROVIDER RESPONSIBILITIES AND COOPERATION REQUIREMENTS

Reporting

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

Cooperation with Audits and Investigations

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

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

Documentation Standards

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

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

SPECIAL INVESTIGATIONS UNIT (SIU)

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

FWA DETECTION AND MONITORING

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

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

Reviews may incorporate, as applicable:

- CMS guidelines
- Federal and state regulations/guidance

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

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

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

Overview

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

Medical Record Requests and Timeframes

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

- Medical records will be requested for a defined review period.
- Providers must submit requested records within the timeframe stated in the request.
- If no response is received, an overpayment letter will be send and an offset of future claims will be initiated.
- Records must be received within the timeframe specified in the second request.

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

Failure to Submit Records / Insufficient Documentation

If a provider:

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

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

Findings Communication, Overpayments, and Recovery

Findings Results Letter

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

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

Overpayment Methodology

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

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

Appeal of Overpayment

Providers may contest the findings, the amount of the overpayment, or the methodology used to identify the overpayment by filing an appeal within 60 calendar days of the date of receipt of the PAL with supporting documentation.

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

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

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

Required FWA Training and Screening Requirements

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

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

Exclusion / Preclusion Screening (Medicare Networks)

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

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

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

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

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

Reporting Suspected Fraud, Waste, or Abuse

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

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

All reports are reviewed and investigated as appropriate.

False Claims Act (Overview)

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

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

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

To report possible Fraud, Waste, or Abuse:

Contact Wellcare With 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 Wellcare With Meridian anonymously at the following address:

Wellcare With 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



wellcare.mimeridian.com