MERIDIAN ADVANTAGE PLAN
OF MICHIGAN

PROVIDER MANUAL
2014
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The Meridian Advantage Plan of Michigan Provider Manual is designed specifically for Meridian Advantage Plan of Michigan providers. This manual will assist the provider in understanding the specific policies, procedures and protocols of the Health Maintenance Organization (HMO) contracted with the State of Michigan and the Centers for Medicare and Medicaid Services (CMS) to deliver and manage health care for members.

**Updates and Revisions**

The Provider Manual is a dynamic tool that evolves with Meridian Advantage Plan of Michigan.

Minor updates and revisions will be communicated to the providers via *Bulletins*. Information given in *Bulletins* replaces information found in the body of the Provider Manual.

Major revisions of the information in the Provider Manual will result in publication of a revised edition that will be distributed to all providers in order to replace older versions of the manual.
## Corporate Telephone Directory

### CONTACT AND SERVICE FUNCTION | TELEPHONE NUMBER
--- | ---
**Utilization Management**  
- Process referrals  
- Perform corporate pre-service review of select services  
- Collect supporting clinical information for select services  
- Conduct inpatient review and discharge planning activities  
- Coordinate case management services  
  
Region 1: 888-322-8843  
Region 2: 800-845-8959  
Region 3: 888-322-8844

**Member Services**  
- Verify member eligibility  
- Obtain member schedule of benefits  
- Obtain general information and assistance  
- Determine claims status  
- Encounter inquiry  
- Record member personal data change  
- Obtain member benefit interpretation  
- File complaints and grievances  
- Verify / record newborn coverage  
- Coordination of Benefit questions  
  
877-902-6784

**Provider Services**  
- Fee schedule assistance  
- Discuss recurring problems and concerns  
- Contractual issues  
- Provider education assistance  
- Primary care administration  
- Initiate physician affiliation, disaffiliation & transfer  
  
888-773-2647

**Quality Management**  
- Requests and questions about Clinical Practice Guidelines  
- Requests and questions about Preventive Healthcare Guidelines  
- Questions about Quality Initiatives  
- Questions about QI Regulatory requirements  
- Questions about Disease Management Programs  
  
877-902-6784  
(Ask For QM)

### CONTRACTED PROVIDERS

**Managed Behavioral Health Provider**  
- Member may contact directly for services. No provider referral is necessary  
  
888-222-8041

**Pharmacy Benefit Manager**  
- Prior Authorize Non-Formulary Medications  
  
877-440-0175

**Non-Emergent Transportation**  
- Coordinate Non-Emergent Transportation  
  
866-569-1902
**Member Services Department**

The Meridian Advantage Plan of Michigan Member Services Department exists for the benefit of our members and providers, to respond to any and all questions about benefits, services, policies and procedures. Full-time professional Member Services Representatives (MSRs) are available each business day from 7:00 a.m. to 9:00 p.m. to be of assistance in any respect possible.

**Meridian Advantage Plan of Michigan**  
**Member Services Department**  
**Toll-Free: 877-902-6784**

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**MERIDIAN ADVANTAGE PLAN OF MICHIGAN MEMBERSHIP**

**Member Eligibility and Enrollment**

Members who wish to enroll in Meridian Advantage Plan of Michigan’s Medicare Advantage Prescription Drug (MAPD) Special Needs Plan for Dual Eligibles (D-SNP) must meet the following criteria:

- Be entitled to Medicare Part A;
- Be enrolled in Medicare Part B;
- Not be medically determined to have ESRD prior to completing the enrollment form (unless individual is an existing Medicaid Member);
- Permanently reside in the Meridian Advantage Plan of Michigan service area;
- Complete an enrollment election form completely and accurately;
- Be fully informed and agree to abide by the rules of Meridian Advantage Plan of Michigan;
- Be entitled to elect our Dual Eligibles Special Needs Plan (D-SNP) plan according to the election rules that apply to the beneficiary; and
- Be enrolled in Michigan Medicaid.

Further,
- We will accept all members that meet the above criteria at any time without reference to race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family status.

**Disenrollment**

Meridian Advantage Plan of Michigan staff may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare member to disenroll, except when the member has:

- Permanently moved outside the geographic service area;
- Committed fraud;
- Abused their Membership card;
- Displayed disruptive behavior;
- Lost Medicaid Eligibility;
- Lost Medicare Part A or B; or
- Deceased
When members permanently move out of the service area, or leave the service area for over six consecutive months, they must disenroll from our Special Needs Plan. There are a number of ways that we may be informed that the member has relocated:

- Out-of-area notification will be received from CMS on the daily Transaction Reply Report (TRR);
- The member may call to advise us that they have relocated; or
- Other means of notification can be made through the Claims Department, if out-of-area claims are received with a residential address other than the one on file

**Requested Disenrollment**

Meridian Advantage Plan of Michigan will request disenrollment of members from the health plan only as allowed by CMS regulations. We will request that a member be disenrolled under the following circumstances:

- The member requests to be disenrolled;
- The member provided fraudulent information on the election form; or
- The member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan’s ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Other reasons for the disenrollment may be one of the following:

- The member abuses the enrollment card by allowing others to use it to obtain fraudulent services;
- The member leaves the service area and directly notifies us of the permanent change of residence;
- The member has not permanently moved but has been out of the service area for 6 months or more, we will request that the member be disenrolled;
- The member loses entitlement to Medicare Part A or Part B benefits;
- The member dies;
- The member loses Medicaid eligibility;
- Meridian Advantage Plan of Michigan loses or terminates its contract with CMS. In the event of plan termination by CMS, we will send CMS approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely and before the termination of the plan; or
- Meridian Advantage Plan of Michigan discontinues offering services in specific service areas where the member resides

In all circumstances we will provide a written notice to the member or member’s estate with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.
**Member Rights and Responsibilities**

Members have a right to receive information about the managed care organization, its services, its practitioners and providers, and members’ rights and responsibilities.

- Members have a right to privacy and to be treated with respect and dignity
- Members have a right to participate with practitioners in decision-making regarding their healthcare
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Members have a right to voice complaints or appeals about the managed care organization or the care provided
- Members have a right to make recommendations regarding the organization’s members’ rights and responsibilities policies
- Members have a responsibility to provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible

**Meridian Advantage Plan of Michigan staff and contracted providers comply with all requirements concerning member rights.**
**Member Identification**
Meridian Advantage Plan of Michigan members receive a Meridian Advantage Plan of Michigan Membership Card that has both the health plan’s Member Services phone number and pharmacy contact information on it. If there are any questions about the member’s Meridian Advantage Plan of Michigan Member Identification Card, call the Meridian Advantage Plan of Michigan Member Services Department at 877-902-6784.

**Eligibility Verification**

**How to Identify a Member’s Eligibility**
It is important to verify member eligibility prior to rendering services to a member.

To verify if a member is currently eligible to receive services as a Meridian Advantage Plan of Michigan member, the following steps must be followed:

1. Request that the member present his/her Meridian Advantage Plan of Michigan card at each encounter
2. Review your PCP monthly eligibility report each time the member presents at your office for care or referrals
3. Call the Member Services Department at 877-902-6784 for assistance with eligibility determinations
4. Utilize the Meridian Advantage Plan of Michigan online Managed Care System (MCS)

   If you find any discrepancies between a member’s ID Card, an Eligibility Verification System and/or your monthly eligibility report, please contact the Member Services Department for further assistance.
Notice of Privacy Practices

The following notice of Privacy Practices was written specifically for members. Meridian Advantage Plan of Michigan PCPs must post the following information in their offices for members to read:

Meridian Advantage Plan of Michigan

NOTICE OF PRIVACY PRACTICES
(Combined Gramm Leach Bliley & HIPAA Notice)

Effective April 14, 2003
Revised September 2013

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

Our Privacy Policy. We care about your privacy and we guard your information carefully whether it is in oral, written or electronic form. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and our privacy practices. We will provide you with notice if there is a breach in our privacy and security practices involving your personal information. We will not sell any information about you. Only people who have both the need and the legal right may see your information. Unless you give us a written authorization, we will only disclose your information for purposes of treatment, payment, business operations or when we are required by law or this Notice of Privacy Practices (Notice) to do so.

Treatment. We may disclose medical information about you for the purpose of coordinating your healthcare. For example, we may notify your personal doctor about treatment you receive in an emergency room.

Payment. We may use and disclose medical information about you so that the medical services you receive can be properly billed and paid for. For example, we may ask a hospital emergency department for details about your treatment before we pay the bill for your care.

Health Care Operations. We may use and disclose medical information about you in connection with our health care operations. For example, we may use medical information about you to review the quality of services you receive.

Required or Permitted by Law. We are permitted by law to use and disclose your personal information for the following enumerated, but not limited to, purposes:

- Law Enforcement. We will disclose your personal information to comply with local, state and federal investigations
- National Security. We will disclose your personal information to comply with federal intelligence and national security activities
- Legal Proceedings. We will use or disclose your personal information to comply with subpoenas or other court orders
• **Review by Government Agencies.** We will disclose your personal information to comply with all review of our activities by government agencies.

• **Communicable Disease Reporting.** We may use or release your personal information to comply with federal and state requirements on reporting communicable disease.

• **Emergencies.** We may use or disclose your personal information to avoid a serious threat to health or safety.

• **Disaster Relief.** We may use or disclose your personal information to cooperate with disaster relief efforts.

• **Public Health Activities.** We may use or disclose your personal information to participate in federal, state or local public health activities and reporting.

• **Abuse/Neglect.** We may release your personal information to the proper government authority if we reasonably believe that you are a victim of abuse, neglect, or domestic violence.

• **Individuals.** We may disclose your personal information to a family member, relative, or close friend involved in your medical care. We will limit disclosure to the personal information directly relevant to the individual’s involvement in your health care, and you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

• **Parent/Guardian.** We may release your personal information to your parent or guardian, when not otherwise limited by law, if you are an un-emancipated minor.

• **Workers’ Compensation.** We may use or disclose your personal information to comply with workers’ compensation laws.

• **Business Associates.** We work with other companies called “business associates,” which help us to provide services to you. We may disclose your personal information to our business associates, but we will only disclose your personal information to the extent necessary for our business associates to carry out treatment, payment or healthcare operations. We will enter into contracts with all business associates to protect your personal information.

• **Coroner, Medical examiner, and Funeral directors.** We may disclose your personal information to coroners, medical examiners or funeral directors, but only to the extent necessary for them to carry out their duties.

• **Administrator/Executor.** We may disclose your personal information to the executor or administrator of your estate upon your death.

• **Research Studies.** We may disclose your personal information to researchers for use in a research study. We will only disclose your personal information if the study has been approved by a review board and the researchers have taken steps to ensure that your private information remains protected.

• **Organ and Tissue Donation.** We may disclose your personal information to those organizations involved in the process of organ or tissue transplantation.

• **Correctional Institution.** We may disclose your personal information to a correctional institution if you are or become an inmate of a correctional institution.

• **Military.** We may disclose your personal information to the military, if you are or become a member of the armed forces.

• **Other Disclosures Required by Law.** We will use or share your personal information when required by other federal, state, or local law to do so.

**Authorizations.** Other uses and disclosures of your personal information will be made only with your written authorization. For example, we must obtain your written authorization for the following uses and disclosures of your personal information:
• **Psychotherapy Notes.** Psychotherapy notes are notes taken by a mental health professional during a conversation with you. We will not use or disclose psychotherapy notes, except when we are permitted by law to do so.

• **Fundraising.** We may contact you with information on how to opt-out of fundraising communications if we choose to operate a fundraiser.

• **Marketing.** We will not market your personal information, except when we are permitted by law to do so.

• **Sale.** We will not sell your personal information.

If you give us a written authorization, you have the right to change your mind and revoke that authorization.

**Genetic Information.** We may receive genetic information about you if you have undergone genetic testing to identify and prevent certain illnesses. We will not use or disclose your genetic information to determine eligibility for benefits, premium or copayment amounts, pre-existing condition exclusions, or the creation, renewal or replacement of health insurance or benefits. We are prohibited from using or disclosing protected health information for underwriting purposes. However, we reserve the right to use your genetic information to determine whether treatment is medically necessary.

**Copies of this Notice.** You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy.

**Changes to this Notice.** We reserve the right to revise this Privacy Notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on our website and will be sent to you in writing at the next regularly scheduled Member Newsletter.

**Your Right to Inspect and Copy.** You may request, in writing, the right to inspect the information we have about you and to get copies of that information. You have the right to an electronic copy of the information we have about you if the information is maintained electronically. We can deny your request for certain limited reasons, but we must give you a written reason for our denial. We may charge a fee for copying your records.

**Your Right to Amend.** If you feel that the information we have about you is incorrect or incomplete, you can make a written request to us to amend that information. A written request must include the reason(s) supporting your amendment. We can deny your request for certain limited reasons, but we must give you a written reason for our denial.

**Your Right to a List of Disclosures.** Upon written request, you have a right to receive a list of our disclosures of your information during the six (6) years prior to your request, except: when you have authorized those disclosures; if the disclosures are made for treatment, payment or health care operations; when disclosures were made to you about your own information; incident to a use or disclosure as otherwise permitted or required under applicable law; as part of a limited data set for research or public health activities;
Your Right to Request Restrictions on Our Use or Disclosure of Information. If you do so in writing, you have the right to request restrictions on the information we may use or disclose about you. We are not required to agree to such requests. Where protected health information is disclosed to a health care provider for emergency treatment, we must request that the health care provider not further use or disclose the information.

Your Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. For example, you can ask that we only contact you at home or only at a certain address or only by mail.

How to Use Your Rights Under this Notice. If you want to use your rights under this notice, you may call us or write to us. If your request to us must be in writing, we will help you prepare your written request, if you wish.

Complaints to the Federal Government. If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may to: Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. Or visit their website at [http://www.hhs.gov/ocr](http://www.hhs.gov/ocr) for specific filing instructions. You will not be penalized or retaliated against for filing a complaint with the federal government.

Complaints and Communications to Us. If you want to exercise your rights under this Notice or if you wish to communicate with us about privacy issues or if you wish to file a privacy related complaint, you can write to:

Chief Privacy Officer  
Meridian Advantage Plan of Michigan (HMO SNP)  
777 Woodward Avenue, Suite 600  
Detroit, MI 48226

You can also call us as at 877-902-6784 (TTY users should call 711) Monday – Friday from 8 a.m. to 8 p.m. You will not be penalized or retaliated against for filing a complaint. You can view a copy of this notice on our web site at [www.medicaremeridian.com](http://www.medicaremeridian.com).

**Advance Directives**

Meridian Advantage Plan of Michigan providers are responsible for educating members regarding Advanced Directives, providing members with Advance Directive forms and obtaining forms from members for the patient chart. All completed Advance Directive forms must be maintained in the front of each member’s health record.
MEDICARE OVERVIEW

Medicare Program
The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers 43 million Americans. Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care and hospice care. Part B helps pay doctor bills, outpatient hospital care and other medical services not covered by Part A.

Part A
Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible or spouse has worked at least 10 years in a Medicare-covered employment, is age 65, and a citizen or permanent resident of the United States. Certain younger disabled persons and kidney dialysis and transplant patients qualify for premium free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80 percent of the approved cost for wheelchairs, hospital beds and other durable medical equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

Part B
Medicare Part B pays for many medical services and supplies, including coverage for doctor’s bills. Medically necessary services of a doctor are covered no matter where received - at home, in the doctor’s office, in a clinic, in a nursing home or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage. The amount of premium is set annually by CMS. Part B also covers:

- Outpatient hospital services
- X-rays and laboratory tests
- Certain ambulance services
- Durable Medical Equipment
- Services of certain specially qualified practitioners who are not physicians
- Physical and Occupational therapy
- Speech/language pathology services
- Partial hospitalization for mental health care
- Mammograms and Pap smears
- Home Health care if a beneficiary does not have Part A
Part C
The Balanced Budget Act of 1997 (BBA) established Medicare Part C also referred to as Medicare Advantage. Prior to Jan. 1, 1999, Medicare HMO’s existed as Medicare Risk or Medicare Cost plans. The Balanced Budget Act of 1997 was intended to increase the range of alternatives to the traditional fee for service program for Medicare beneficiaries. The options included Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Under the Medicare Modernization Act of 2003 (MMA) Congress created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. **Special Needs Plans (SNPs)** are allowed to target enrollment to one or more types of special needs individuals identified by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.

SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. Dual eligible SNPs also offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. The Meridian Advantage Plan of Michigan program targets **special needs individuals** who are dually eligible for both Medicare and Medicaid.
Provider Credentialing and Recredentialing

Meridian Advantage Plan of Michigan has written policies and procedures for the selection and evaluation of providers. There is a documented process with respect to providers and suppliers who have signed contracts or participation agreements.

For physician group practices, PHOs, IPAs, etc. CMS requires copies of the arrangements/contracts between the contracting entity and the providers covered under the Medicare Advantage agreement with Meridian Advantage Plan of Michigan. CMS requires copies of each of these downstream contracts as part of the application to apply for a Medicare Advantage contract with CMS.

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

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

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

Meridian Advantage Plan of Michigan re-credentials each provider in the network at least every three (3) years. Approximately six (6) months prior to the provider’s three (3) 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

There is a formal method of appeal for a provider / applicant who is denied participation within the Meridian Advantage Plan of Michigan Network. The request for reconsideration or appeal must be submitted to the credentialing coordinator in the Quality Improvement Department, who will submit it to the Credentialing Committee.

A. The provider / applicant who is denied participation in the Meridian Advantage Plan of Michigan Network may submit a request for reconsideration, within 21 days of the date of their participation denial, with additional supportive information or evidence of his/her professional qualifications or abilities to meet the accepted credentialing criteria.
B. The request for reconsideration and the additional information will be submitted to the Credentialing Committee at the next scheduled meeting date.

C. The Credentialing Committee will review the appeal request and additional information and will make a final determination of the appeal.

D. The appealing provider / applicant will be notified of the appeal determination by the Credentialing Committee, through the Medical Director, by certified letter, within 5 working days of the Credentialing Committee meeting.

E. If the denial is overturned, the applicant will continue with the new participation notification process outlined in this policy.

F. Denied applications are maintained in a confidential manner in a Denied Participation file and are maintained for a period of four (4) years from the date of denial. Denials of participation are kept confidential except where reportable by Meridian Advantage Plan of Michigan under federal or state regulation.

Facility Site Reviews

As part of the Meridian Advantage Plan of Michigan annual monitoring audits, a sampling of provider office facilities will be evaluated against Meridian Advantage Plan of Michigan site review and medical record keeping requirements.

Guidelines for Facility Site Reviews

<table>
<thead>
<tr>
<th>GUIDELINES FOR FACILITY SITE REVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESS TO SERVICE</strong></td>
</tr>
<tr>
<td>- Is the next Adult Preventive Care appointment available within 30-45 days</td>
</tr>
<tr>
<td>- Is the next Child (&lt; 18 months old) Preventive Care appointment available within 2 weeks</td>
</tr>
<tr>
<td>- Is the next Child (&gt; 18 months old) Preventive Care appointment available within 4 weeks</td>
</tr>
<tr>
<td>- Is the next non-urgent sick visit available within two weeks</td>
</tr>
<tr>
<td>- Is the next urgent care appointment available within 24 hours</td>
</tr>
<tr>
<td>- Is each PCP available 20 hours per week</td>
</tr>
<tr>
<td>- Is the physician available 24 hrs/7 days a week</td>
</tr>
<tr>
<td>- Does the practitioner have mechanisms in place to meet Meridian Advantage Plan of Michigan after-hours access standards</td>
</tr>
<tr>
<td><strong>PROVISIONS FOR PERSONS WITH DISABILITIES</strong></td>
</tr>
<tr>
<td>- Are there designated handicap parking spaces close to building entrance</td>
</tr>
<tr>
<td>- Is the building entrance accessible by wheelchair, walker, etc.</td>
</tr>
<tr>
<td>- Are office hallways, doorways and bathrooms accessible to wheelchairs, walkers, etc. (all hallways should have a minimum of 42 inches clearance)</td>
</tr>
<tr>
<td>- Are doors able to be operated by persons with physical limitations</td>
</tr>
<tr>
<td>- Are there accommodations for sight or hearing impaired patients</td>
</tr>
<tr>
<td><strong>GENERAL OFFICE APPEARANCE</strong></td>
</tr>
<tr>
<td>- Are NO SMOKING signs &amp; Patient’s Rights posted</td>
</tr>
<tr>
<td>- Is business conducted at the registration desk in a confidential manner (discussion, sign-in sheet, etc.)</td>
</tr>
<tr>
<td>- Staff is aware of the confidentiality policy of office</td>
</tr>
<tr>
<td>- Are restroom facilities available for waiting patients</td>
</tr>
<tr>
<td>- Are hours of operation posted</td>
</tr>
<tr>
<td>- Are all public and patient care areas clean, orderly and ample enough to accommodate patients</td>
</tr>
</tbody>
</table>
## GUIDELINES FOR FACILITY SITE REVIEWS

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

### DOCUMENTS
- Current CLIA License
- Written Medical Waste Plan reviewed yearly
- Current Radiology Registration
- Written Emergency Preparedness and Disaster Plan with disaster drill documentation
- Copies of appropriate MSDS sheets for the office
- Blood borne Pathogen Exposure Control Plan
- Manifests from Material Waste Processing Company
- Documented Quality Improvement Efforts
- Documentation of Well Water Safety if appropriate
- Documentation of Septic System Maintenance if appropriate
- Documentation of quarterly fire drills and yearly disaster drill

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

### MEDICATIONS
- All stock and sample medications stored in a secure area away from patient access and in an appropriate location (shelf, refrigerator.)
- No oral and injectable medications stored together
### GUIDELINES FOR FACILITY SITE REVIEWS

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

### DIAGNOSTIC MEDICAL EQUIPMENT

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

### SAFETY

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

### LABORATORY

- Quality checks are done and documented on each Waived Lab Test each day used
- No food, drink or medication is ingested near or stored with collected lab specimens (lab reagents may be stored with them in a separate container)
### GUIDELINES FOR FACILITY SITE REVIEWS

- No lab reagent is kept or used beyond its expiration date (Proper Disposal)
- All specimens are discarded in the proper manner after use
- All specimens should be labeled with the patient's name or ID# when multiple specimens are being tested

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

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

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

### MEDICAL RECORDS
- The Medical Record is retrievable for review for ten years
- Patient information is kept confidential. Files are maintained away from accessibility of other patients, as are fax machines. Desktops do not have identifiable information in sight of other patients. Sign in sheet is not left in view of others
GUIDELINES FOR FACILITY SITE REVIEWS

- There is organization of the medical record, with dividers by type of service, i.e., Lab, X-ray, Consultations, discharge summaries, preventive services, progress notes, durable power of attorney/advance directives, informed consent, etc.
- All diagnostic and therapeutic services for which the practitioner referred the member are documented in the chart (Home Health Nursing Reports, Consults, Hospital discharges, Physical Therapy)
- There is a Problem List of significant illnesses and medical conditions with date of onset.
- Medication allergies and adverse reactions or NKDA as appropriate are prominently displayed in the medical record.
- A Past Medical History for patients seen more than three times that is easily identified and includes serious accidents, operations and illnesses. For children 18 and under, past medical history relates to prenatal care, birth, operations and childhood illnesses.
- The medical record is a unit record
- There is an appropriately signed and dated Release of Information in the medical record.
- The entries in the Medical Record are legible
- The entries in the Medical Record are signed and dated by the author
- There is acknowledgement of receipt of privacy notice in record. (If not in individual records, there is a central file with acknowledgement of receipt of notice)

OSHA Training

Employee training and annual in-service education must include:

1. Universal precautions;
2. Proper handling of blood spills;
3. HBV and HIV transmission and prevention protocol;
4. Needle stick exposure and management protocol;
5. Blood borne pathogen training;
6. Sharps handling;
7. Proper disposal of contaminated materials; and
8. Information concerning each employee’s at-risk status

At-risk employees must be offered 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:

1. Pharmacy Drug Control license issued by the State of Michigan, if dispensing drugs other than samples;
2. Section 17757a from the Board of Pharmacy (if dispensing drugs other than samples);
3. Controlled Substances License from State of Michigan and the Federal DEA;
4. CLIA certificate or waiver;
5. Medical Waste Management certificate;
6. X-ray equipment registration;
7. R-H 100 notice;
8. Radiology protection rules; and  
9. MIOSHA poster (#2010).

**Provider Roles and Responsibilities**

CMS requires providers to provide care to Medicare Advantage members in a culturally competent manner, being sensitive to language, cultural and reading comprehension capabilities. Meridian Advantage Plan of Michigan offers a language service to anyone speaking a non-English language. There is no charge to members for this service. To access this service for any health plan Medicare Advantage members in your practice, please follow these steps.

**Primary Care Provider (PCP) Roles and Responsibilities**

Each Meridian Advantage Plan of Michigan Medicare Advantage member selects a PCP who is responsible for coordinating the member’s total health care. Primary Care Providers are required to work 20 hours per week per location, and be available 24 hours a day/seven days a week.

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 Meridian Advantage Plan of Michigan.

**Specialty Care Physician Roles and Responsibilities**

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

- Rendering services requested by the PCP
- Communicating with the PCP regarding the findings in writing
- Obtaining prior-authorization from the PCP 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**

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

- Coordination of discharge planning with Meridian Advantage Plan of Michigan Utilization Management staff;
- Coordination of mental health/substance abuse care with the appropriate state agency or provider;
- Obtaining the required prior-authorization before rendering services;
- Communication of all pertinent patient information to Meridian Advantage Plan of Michigan and to the PCP;
- Communication of all hospital admissions to the Meridian Advantage Plan of Michigan utilization management staff within one business day of admission; and
- Issuing all appropriate service denial letters to identified members

Ancillary / Organization Provider Roles and Responsibilities
Meridian Advantage Plan of Michigan recognizes that the ancillary provider is another valuable team member in delivering care to Meridian Advantage Plan of Michigan 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 Meridian Advantage Plan of Michigan members;
- Obtaining the required prior-authorization before rendering services; and
- Communication of all pertinent patient information to Meridian Advantage Plan of Michigan and to the PCP

Confidentiality and Accuracy of Member Records
Medical records and other health and enrollment information of a member must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular member;
- Maintain such records and information in a manner that is accurate and timely; and
- Identify when and to whom member information may be disclosed

In addition to the obligation to safeguard the privacy of any information that identifies a particular member, the health plan, including its participating providers, is 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, CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, provide information as requested and maintain records a minimum of 10 years.

Obligations of Recipients of Federal Funds
Providers participating in Meridian Advantage Plan of Michigan are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the

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

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at oig.hhs.gov/fraud/exclusions/database.html.

- The General Services Administration List of Debarred Contractors can be found at epls.arnet.gov.
BILLING AND CLAIMS PAYMENTS

When billing for services rendered to Meridian Advantage Plan of Michigan members, providers must use the most current Medicare approved coding (ICD-9/ICD-10, CPT, HCPCS, etc.) available.

Claims must be submitted using the proper claim form/format, e.g., for paper claims, submit a CMS1500 or UB04 and for an electronically submitted claim, submit in approved ANSI/HIPAA format. It is recommended that claims be submitted as if they are being billed to Medicare fee-for-service. With D- SNP members, Meridian Advantage Plan of Michigan will apply the Medicare benefits first and then apply Medicaid benefits as secondary.

Providers need only submit one claim for Meridian Advantage Plan of Michigan members. Meridian Advantage Plan of Michigan will apply both Medicare and Medicaid benefits as appropriate.

Billing Requirements

- The standard CMS 1500 Claim Form or UB 04 Claim Form is required for Meridian Advantage Plan of Michigan billing
- Specialty physician claims should include a referral form or prior-authorization number(s) for payment
- Providers must use industry standard HCPCS, CPT, Revenue, and ICD-9/ICD-10 codes when billing Meridian Advantage Plan of Michigan

Claims Mailing Requirements

Submit all initial claims for payment to:

Attention: Claims Department
Meridian Advantage Plan of Michigan
1001 Woodward Ave. Suite 510
Detroit, MI 48226

If you are re-submitting a claim for a status or a correction, please indicate STATUS or CLAIMS CORRECTION on the claim.

Billing Procedure Code Requirements

Meridian Advantage Plan of Michigan requires that providers use HCPCS, CPT, ICD-9/ICD-10, and revenue codes when billing Meridian Advantage Plan of Michigan.

Explanation of Payments (EOP)


Electronic Claims Submission

Meridian Advantage Plan of Michigan is currently accepting electronic claims from the following clearinghouses:
Provider Grievance & Appeals Process for Denied Claims

Contracted providers can request an appeal from Meridian Advantage Plan of Michigan when acting strictly on their own behalf and the member is not at financial risk, such as for an unapproved inpatient admission. The Meridian Advantage Plan of Michigan appeal process for these cases is independent of Medicare regulations and mirrors the non-Medicare provider appeal process.

Meridian Advantage Plan of Michigan offers a post-service claim appeal process for disputes related to denial of payment for services rendered to Meridian Advantage Plan of Michigan 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:

1. The provider disagrees with a determination made by Meridian Advantage Plan of Michigan, such as combining two stays as a 15-day readmission. In this case, the provider should send additional information (such as medical records) that support the provider’s position.

2. The provider is requesting an exception to an Meridian Advantage Plan of Michigan policy, such as prior authorization requirements. In this case, the provider must give an explanation of the circumstances and why the provider feels an exception is warranted in that specific case.

The Meridian Advantage Plan of Michigan physician reviewer is available for a discussion with the treating physician or your physician reviewer prior to a post-service appeal decision. The physician may call for a peer to-peer discussion by calling 888-322-8843. If a specific time frame for the call is desired, a facility representative acting on behalf of the physician may call to schedule a peer-to-peer discussion.
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 member ineligibility on the date of service or non-covered benefits.

**How to File a Post-Service Claim Appeal**

1. Please send a letter explaining the nature of your appeal and any special circumstances that you would like Meridian Advantage Plan of Michigan to consider.

2. Attach a copy of the claim and documentation to support your position, such as medical records.

3. Send the appeal to the following address:
   
   Attention: Claims Appeals Department
   Meridian Advantage Plan of Michigan
   1001 Woodward Avenue, Suite 510
   Detroit, MI 48226

**Timeframe for Filing a Post Service Appeal**

Appeals must be filed within one year from the date of service. The Claims Appeals Department will allow an additional 120-day grace period from the date of the last claim denial, provided that the claim was submitted within one year of the date of service. Appeals submitted after the time frame has expired will not be reviewed.

**Response to Post Service Claims Appeals**

The Claims Appeals Department typically responds to a post-service claim appeal within 30 days from the date of receipt. If additional information is needed, such as medical records, then the Claims Appeals Department will respond within 30 days of receiving the necessary information. Providers will receive a letter with the Claims Appeals Department decision and rationale.

There is only one level of claims appeal available. All appeal determinations are final. If a provider disagrees with the Claims Appeals Department determination regarding an appeal, the in or out-of-network provider may pursue the following option:

- If the decision is not favorable to the appellant, the appeal case is sent to the IRE within 60 calendar days of receipt of the appeal, and written notice is sent to the appellant. If the IRE reverse’s the Meridian Advantage Plan of Michigan decision to not pay the claim, Meridian Advantage Plan of Michigan pays for the service within 30 calendar days of receipt of the IRE notice of reversal.

- The appellant will receive information about further review if the IRE does not reverse the Meridian Advantage Plan of Michigan decision. In the case that a reversal of the Meridian Advantage Plan of Michigan decision comes from a higher level review entity, Meridian Advantage Plan of Michigan pays for the service within 60 calendar days of receipt of notice of such reversal.

If you have any questions about the post-service claim appeal process, please call Meridian Advantage Plan of Michigan Provider Services at 888-773-2647 for more information.
The objective of the Meridian Advantage Plan of Michigan Utilization Management program is to ensure that medical services provided to members are medically necessary and/or appropriate, as well as in conformance with the benefits of the Plan. The program functions on consistently applied systematic evaluation of appropriateness criteria and by considering circumstances unique to the member.

**Referral Management**
Referral processing is the primary activity performed by our care management specialist staff. The specialists are assigned in teams by provider group and region. If you have a referral request or question, contact a member of your team at 877-902-6784 for all referrals. They will be glad to help you.

Three easy ways to submit referrals:

1. **Electronically**
   - The Meridian Advantage Plan of Michigan Managed Care System (MCS)
2. **Fax**
   - Refer to care management’s regional team fax numbers. Please include pertinent clinical documentation with the request if indicated
3. **Phone**
   - Urgent requests must always be submitted by calling a member of your regional team. Make sure you identify the request as “urgent” to expedite the pre-service review process

**Types of Referrals**
Meridian Advantage Plan of Michigan must review and approve all services before they are provided. The primary reasons for clinical review are to determine whether the service is clinically appropriate, is performed in the appropriate setting and is a benefit. Clinical information is necessary for all services that require clinical review for medical necessity.

Care 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 Advantage Plan of Michigan medical directors. In certain circumstances, external review of service requests are conducted by qualified, licensed physicians with the appropriate clinical expertise.

The Meridian Advantage Plan of Michigan Medical Necessity Guidelines are based on current literature review, consultation with practicing physicians and medical experts in their particular field, government agency policies and standards adopted by national accreditation organizations. It is the responsibility of the attending physician to make all clinical decisions regarding medical treatment. These decisions should be made consistent with generally accepted principles of professional medical practice and in consultation with the member.

Clinical information is required for all clinical review requests to ensure timely decisions by Meridian Advantage Plan of Michigan. The decision time frame is based on the date
we receive the supporting clinical information. To ensure a timely decision, make sure all supporting clinical information is included with the initial request. The preferred method of clinical review submission is via fax to your regional team. If clinical information is not received with the request the Meridian Advantage Plan of Michigan Utilization Management staff will send a fax request for the information and/or contact the physician or specialist verbally to collect the necessary documentation.

Clinical information includes relevant information regarding the member’s:

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

Clinical information should be provided at least 14 days prior to the service. The facility is responsible for ensuring authorization. Meridian Advantage Plan of Michigan provides a reference number on all referrals.

**Turn Around Time for Referral Processing**

<table>
<thead>
<tr>
<th>Referral</th>
<th>Makes Decision</th>
<th>Fax/Phone Notification</th>
<th>Written Notification (Denials)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Urgent Pre-Service Review</td>
<td>Within 14 days of receipt of the request</td>
<td>Within 14 days of receipt of the request</td>
<td>Within 14 days of receipt of the request</td>
</tr>
<tr>
<td>Urgent Pre-Service Review</td>
<td>Within 72 hours of receipt of the request</td>
<td>Within 72 hours of the request</td>
<td>Within 72 hours of the request</td>
</tr>
<tr>
<td>Urgent Concurrent</td>
<td>Within 24 hours of receipt of the request. 48 hours if clinical is not included</td>
<td>Within 24 hours of receipt of the request. 48 hours if clinical not included</td>
<td>Within 72 hours of the decision</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Within 30 days of receipt of the request. N/A for members</td>
<td>N/A</td>
<td>Within 30 days of receipt of the request</td>
</tr>
</tbody>
</table>

**Inpatient Review**

Our nurse reviewers are assigned to members at specific acute care facilities to promote collaboration with the facility’s review staff and management of the member across the continuum of care. Meridian Advantage Plan of Michigan nurse reviewers assess the care and services provided in inpatient settings and the member’s response to the care by applying InterQual® criteria and the Meridian Advantage Plan of Michigan
Observation policy. Together with the facility’s staff, care management’s clinical staff coordinates the member’s discharge needs.

All elective hospital admissions initiated by the PCP or specialist requires Corporate Pre-Service review. You may call 877-902-6784, enter the authorization request in the Meridian Advantage Plan of Michigan Managed Care System, or fax requests to us. Be sure to include documentation of medical necessity to facilitate the earliest possible turnaround time. The facility is responsible for ensuring authorization. Meridian Advantage Plan of Michigan provides a reference number on all referrals.

**Denials and Appeals**

All denial determinations are rendered by physicians. A nurse reviewer contacts the provider by phone to inform them of the denial decision, reason for the denial and contact information to discuss the denial with the Meridian Advantage Plan of Michigan medical director. Written denial notification is sent via fax and mailed to the member. Treating physicians who would like to discuss a utilization review determination with the decision-making medical director may contact the Utilization Management Department at 888-322-8843.

The written denial notification will include the reason for the denial, the reference to the benefit provision and/or clinical guideline on which the denial decision was based, and directions on how to obtain a copy of the reference. You may contact the Utilization Management Department any time at 888-322-8843 to request a copy of the Meridian Advantage Plan of Michigan medical necessity guidelines.

**Expedited Appeal**

An expedited appeal is a request to change a denial decision for urgent care. Urgent care is any request for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations 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.

Inpatient services that are denied while a member is in the process of receiving the services are considered an urgent concurrent request and is therefore eligible for an expedited appeal.

**Non-Urgent Pre-service Appeal**

Providers, acting on behalf of a member, may request an appeal of denial in advance of the member obtaining care or services. Meridian Advantage Plan of Michigan will provide acknowledgement of the appeal within three days of receipt of the request. No physician will be involved in an appeal for which he/she made the original Adverse Determination. No physician will render an appeal decision who is a subordinate of the physician making the original decision to deny.

Refer to the Billing and Payment section for directions on Post-Service Appeals.
### Turn Around Time for Provider Appeal Processing

<table>
<thead>
<tr>
<th>Appeal Type</th>
<th>Makes Decision</th>
<th>Fax/Phone Notification</th>
<th>Written Notification (Denials)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited Appeal</td>
<td>Completed as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of an expedited grievance. Inpatient admissions are eligible if the member is receiving services at the time of the denial</td>
<td>Within 24 hours of the decision</td>
<td>Within 72 hours of receipt of the request</td>
</tr>
<tr>
<td>Pre-Service Appeals</td>
<td>Within 14 calendar days of receipt of the appeal</td>
<td>Within 14 calendar days of receipt of the appeal</td>
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### Case Management
The Meridian Advantage Plan of Michigan Case Management Program provides patient-focused, individualized case management for every member. The following case management programs are available to personally support the health care needs of members: asthma, diabetes, congestive heart failure, cardiovascular disease, complex/catastrophic illness, and high emergency room use.

Our case managers will send you a report identifying the member’s health status and short- and long-term goals for case management.

Our case managers may contact you for other reasons:
- 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

### Dual Eligible Special Needs Plan Model of Care
The focus of Meridian Advantage Plan of Michigan is on individuals who are eligible for both Medicare and Medicaid. Generally, these members include individuals who have complex health care needs and are more fragile and vulnerable than the general population. It is the goal of Meridian Advantage Plan of Michigan to provide access to quality health care services for these special members through care coordination. The care coordination for special needs members who are dual eligible is based on a comprehensive model of care.
MEMBER APPEALS & GRIEVANCES

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two types of complaints members can make. All contracted providers must cooperate with the Medicare Advantage appeals and grievances process.

Definitions

**Appeal**: Any of the procedures that deal with the review of adverse organization determinations on the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

**Grievances**: Any compliant or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member or their representative may make a compliant or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

Levels of Appeal/Grievance

The levels of the appeals process are listed below. If an appeal is not resolved at one level, it can proceed to the next.

1. Meridian Advantage Plan of Michigan standard or expedited appeals process
2. Review by an Independent Review Entity (IRE)
3. Review by an Administrative Law Judge (ALJ)
4. Review by a Medicare Appeals Council (MAC)
5. Review by a Federal District Court Judge

Members can appeal a medical decision within 60 calendar days of receiving Meridian Advantage Plan of Michigan’s letter denying the initial request for services or payment on their own behalf. They can also designate a representative, including a relative, friend, advocate, doctor or other person, to act for them. The member and the representative must sign and date a statement giving the representative legal permission to act on the member’s behalf. This statement must be sent to Meridian Advantage Plan of Michigan at:
Attention: Care Management Appeals Coordinator
Meridian Advantage Plan of Michigan
777 Woodward Ave. Suite 600
Detroit, MI 48226

The member can call us at 877-902-6784 to learn how to name an authorized representative.

**Appeals and Grievances**

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two different types of complaints they can make. All Participating Providers must cooperate in the Medicare Appeals and Grievances process.

A member may appeal an adverse initial decision by Meridian Advantage Plan of Michigan or a participating provider concerning authorization for, or termination of coverage of a health care service. A member may also appeal an adverse initial decision by Meridian Advantage Plan of Michigan concerning payment for a health care service. A member’s appeal of a decision about authorizing health care or terminating coverage of a service must generally be resolved by Meridian Advantage Plan of Michigan within 30 calendar days or sooner, if the member’s health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

Participating providers must also cooperate with Meridian Advantage Plan of Michigan and members in providing necessary information to resolve the appeals within the required time frames. Participating Providers must provide the pertinent medical records and any other relevant information to Meridian Advantage Plan of Michigan. In some instances, participating providers must provide the records and information very quickly in order to allow Meridian Advantage Plan of Michigan to make an expedited decision.

If the normal time period for an appeal could result in serious harm to the member’s health or ability to function, the member or the member’s physician can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member’s interest to extend this time period. If a physician requests the expedited appeal and indicates that the normal time period for an appeal could result in serious harm to the member’s health or ability to function, we will automatically expedite the appeal.

**A special type of appeal applies only to hospital discharges.** Hospitals are required to notify all Meridian Advantage Plan of Michigan members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue the standard CMS Notice of Medical Non-Coverage (NOMC) within two calendar days of admission, obtain the signature of the member or of his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of the discharge as possible, but not less than two calendar days before discharge.

If the member thinks Meridian Advantage Plan of Michigan coverage of a hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization which is contracted with CMS. However, such an appeal
must be requested no later than noon on the first working day after the day the member gets notice that Meridian Advantage Plan of Michigan coverage of the stay is ending. If the member misses this deadline, the member can request an expedited appeal from Meridian Advantage Plan of Michigan.

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). Medicare regulations require the provider to deliver the standard NOMNC to all members when covered services are ending, whether the member agrees with the plan to end services or not. If the member thinks his/her coverage is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization. If the member gets the notice two days before coverage ends, the member must request an appeal to Quality Improvement Organization no later than noon of the day after the member gets the notice. If the member gets the notice more than two days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to Quality Review Organization, the member can request an expedited appeal from Meridian Advantage Plan of Michigan.

If a member has a grievance about Meridian Advantage Plan of Michigan, a provider or any other issue, the member can contact us at 877-902-6784 and ask for the Grievance Coordinator. The address to file the grievance is:

Attention: Grievance Coordinator  
Meridian Advantage Plan of Michigan  
777 Woodward Ave. Suite 600  
Detroit, Michigan 48226

Meridian Advantage Plan of Michigan will send an acknowledgement letter within five days of receiving a grievance request. An final decision will be made as quickly as the case requires based on the member’s health status, but no later than 15 calendar days after receiving the complaint. We may extend the timeframe by up to 14 days if the member requests the extension, or if we justify a need for additional information and the delay is in the member’s best interest.

**Further Appeal Rights**

If Meridian Advantage Plan of Michigan denies the member’s appeal in whole or in part, it will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not part of Meridian Advantage Plan of Michigan. This organization will review the appeal and, if the appeal involves authorization for health care service, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ’s decision, the member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the member may be able to appeal to a Federal District Court of the United States.