Agenda

- About Meridian Health Plan
- Meridian Health Plan (MHP) website
- Provider Portal
- Billing Instructions
- Claims Adjudication
- Reimbursement Methodology
- Care Coordination
- Discharge Planning
- Utilization Review
- Provider Claims Disputes
- Issue Escalation
MeridianHealth

Our Mission

To continuously improve the quality of care in a low resource environment

Our Vision

To be the premier service organization in government healthcare
To be the #1 health organization based on quality, innovative technology and service to our Meridian Family
About Us

- MeridianHealth operates in several states
  - **Michigan since 1997**
    - Largest Medicaid plan
    - Highest quality plan in Michigan, NCQA #9 in the country*
  - **Illinois since 2008**
    - Fastest growing plan in 2014
    - Highest quality plan in Illinois, NCQA #10 in the country*

- Lines of Business
  - **Government Programs**
    - Medicaid
    - Medicare
      - D-SNP
      - MAPD
    - Complete
    - Health Insurance Marketplace
  - **Pharmacy Benefit Manager**
    - MeridianRx

*According to NCQA’s Health Insurance Plan Rankings 2014-2015*
Meridian Programs

**MeridianHealth**: Meridian has an executed contract with the Illinois Department of Healthcare and Family Services (HFS) to provide Medicaid covered benefits to the beneficiaries of AllKids, Family Care, Moms and Babies Participants and the Seniors and Persons with Disabilities as well as Managed Long-Term Supports and Services. Eligible members will not have Third Party Liability or be part of the Spend Down Program.

**MeridianComplete**: (MMAI) integrates managed care for individuals who are eligible for both Medicaid and Medicare Parts A&B into Managed Care Organizations that are responsible for all services covered by both Medicare and Medicaid. This initiative is designed to provide better care coordination and improve health outcomes for individuals who have historically been left on their own to navigate two separate health care systems.

**MeridianCare (HMO)**: A Medicare Advantage Prescription Drug Plan (MAPD) in Michigan and Illinois. MAPDs are a type of Medicare health plan that provide Part A, Part B and Part D prescription drug benefits and include additional benefits that are not covered by Original Medicare.
Meridian Website

• Available Online at www.mhplan.com
  – Provider Manual
  – Provider Portal
  – Provider Directory
    • Online Search Tool

Member Services Representatives are available each business day from 8 a.m. to 8 p.m. and are able to assist with questions and resolve issues related to the following:

• Member eligibility
• Approval of non-emergency services
• PCP and site changes
• Women’s health care provider changes

• Complaints/grievances
• Disenrollment requests
• Claims payment
• Rights and Responsibilities

Questions outside the purview of Member Services will be routed to the appropriate Meridian department for investigation and follow-up.
Provider Manual

https://www.mhplan.com/

*Please check the website for policy changes and key updates monthly

Provider Manual


Tools & Resources

- Provider Search
- Documents & Forms
- FAQs
- Provider Portal
- Provider Manual
- Quality Improvement Program
- Billing & Payments
- Fraud Waste & Abuse
- Provider Quick Reference Call Guide
Provider Portal

MeridianHealth’s Provider Portal can be accessed at www.mhplan.com

To Enroll – Go to: www.mhplan.com
and Select Login>Provider Portal

Meridian’s Provider portal is free of charge and available to all contracted providers.
Provider Portal

Tools and Resources Available in Provider Portal:

• Eligibility Verification
• Authorization – submit request for authorization
  – Coming in November – ability to submit electronic requests with medical records
• Member Demographics
  – View Authorizations and completed Immunizations
  – Coordination of Benefit information
  – Claims Status
  – Refer to Disease Management/Care Management programs
• Provider Demographics
  – Enrollment and HEDIS (Gap) Reports
  – View claim Status by Provider
  – View hospital reports
• Member Postcards for notification of Care Gaps Due
• Ability to bill Professional or Facility Claims
• Ability to print remittance advices or create an electronic 835 file
• Sign up for Web Portal Training
Provider Portal

Eligibility Screen

Eligibility Inquiry

PCP - Please click the "Provider" menu on the left and select the "Enrollment" tab to view the enrollment list of the selected provider.

Specialist - Please click the "Member" menu on the left and enter the member's ID number to view the member status.

You may also utilize the Illinois HFS ME system at the following website: https://www.hfs.illinois.gov/Edi/MedicalProviders/EDI/medPages/default.aspx

Providers may also contact Meridian Health Plan at 1-866-606-3700 to verify a Member's eligibility or for further support.

Inquiry by Member ID

Member ID:

Coordinating Care Messages (0 Unread)

Notifications (875 Unread)
IMPACT Registration

• All providers must be registered in IMPACT to receive payment from Meridian Health Plan
• To enroll please go to the following website:

https://www.illinois.gov/hfs/impact/Pages/ProviderEnrollment.aspx
Billing Instructions

Meridian Health Plan is a member of IAMHP and adheres to the billing guidelines as set by HFS and published by IAMHP, including:

• APL/non-APL services
• E.D. and observation services
• Therapy services

Please see for guidelines: http://iamhp.net/billing-guidance
Billing Instructions cont.

• Our PNDRs hold monthly or quarterly joint operations committee (JOC) meetings with our in-network hospital partners and bring any updates to the hospital regarding new or revised Medicaid FFS billing instructions
Claims Submission

- Claims may be filed one of three ways:
  1. Paper
  2. Provider Portal
  3. Electronic

- Corrected claims/reconsideration of payment request/appeal filing deadline:
  - 120 days from the date of service

- Submit paper claims, corrected claims, requests for payment reconsideration and appeals to:
  
  Meridian Health Plan
  Claims Department
  1 Campus Martius
  Suite 720
  Detroit, Michigan 48226
Timely Filing

- **In-network providers** have 365 days from the date of service to submit an initial claim, and
- 120 days from the last remittance date to resubmit the claim if the claim is initially received within one year timeframe.
- There are two exceptions to the timely filing guideline, which include:
  - Retroactive eligibility: These claims must be accompanied by a Notice of Decision and received within 365 days of the notice date and reimbursed under a retrospective payment system
  - Third-party related delays: These claims must be accompanied by a third-party liability (TPL) explanation of benefits and also received within 365 days of the TPL process date
- **Out-of-network providers** have 180 days from the date of service to submit an initial claim.

*All information on this slide is also available in our Claims Billing Submission Manual on our website.*
Reimbursement Methodology

• MHP follows the HFS EAPG and APR-DRG reimbursement methodology.

• Communication flow for updates:

  HFS
  ↓
  MHP Operations Director
  ↓
  Payment Integrity Team
  ↓
  Claims Team
Communication

• Our MHP team members will communicate known system issues affecting claims processing via the Provider Network Development Representative assigned to your hospital.
Care Coordination

• Integrates the physical and behavioral health needs of the member and coordinates referrals to maximize treatment success

• Goal is to assist members with their healthcare, create a natural support team, ensure members are receiving the right level of care at the right time in their life

• Collaboration
  – Community partners
  – Pharmacy
  – Primary care and specialists
  – Facilities
Facility Collaboration

• Daily census
• Care coordination assignment
• Collaboration begins at admission
• Close collaboration with utilization management as well as hospital staff
• Assist with transition back home
• Case discussion with a multidisciplinary team
• Post discharge follow up from care coordination to assist with appt
Care Coordination Process

- Health Risk Screening
- Predictive Modeling
- Risk Stratification
- Assign to Care Coordinator
- In-depth Health Assessment
- Develop Care Plan
- Interdisciplinary Team
- Community Resources
Waivers

- IL HCBS Waiver Programs- Funding programs that give members the opportunity to expand their health care services. There are 5 programs:
  
  1) Persons with Disabilities
  2) Persons with Brain Injuries (BI)
  3) Persons with HIV or Aids
  4) Persons who are Elderly
  5) Supportive Living Facilities (SLF)

- Members require assessments based upon their waiver status
  - Non-waiver required the HRS within 60 days of enrollment
  - Waiver members- assessments within 60 days of enrollment

- Person Centered Plans of Care are developed for all members by the 90th day of enrollment
Utilization Care Coordinators or Behavioral Health Care Coordinators support and facilitate routine discharge planning and coordination of transitions between levels of care, facilities and/or providers in collaboration with the member, the facility’s designated contact and the member’s PCP.

- Specialized Transitional Case Managers
- Pharmacy Discharge Coordinators

*Please submit discharge instructions so we can assist in readmission prevention and assure the member is receiving everything necessary for a successful discharge.
Authorizations

No prior authorization needed for:

- In-Network Specialist referrals
- In-Network MRI, CT, MRA scans
- In-Office Services

Prior Authorization and Referral Guide can be obtained at www.mhplan.com

Note: BH Providers: Phone-866-796-1167; Fax 312-508-7200
LTC Providers: Email: umcommunity@mhplan.com; FAX-855-898-1485

For more information – refer to the Prior Authorization and Referral Guide at www.mhplan.com. Click Provider Auth Form under Provider Tools
Prior Authorization Submission

Can be submitted via mhplan.com via:

- Fax
- EMR
- Electronic - COMING SOON!

Prior Authorization Instructions

The New Pre-Service Medical Authorization Form is LIVE! Meridian has created a universal form to improve efficiencies for the authorization process. The form is user friendly, and provides faster decision making and turnaround time. Learn how to submit an authorization by reading or downloading the forms below.

- Standard Fax Submission (Last Updated: 6/2/2017)
- Electronic Fax Submission EMR (Last Updated: 6/2/2017)
- Electronic Fax Submission Non-EMR (Last Updated: 6/2/2017)
Utilization Review

- Emergent admissions/Concurrent review
  - Notification of admission required within 24 hours
  - If submitted with clinical information will receive response in 24 hours

- Clinical information needed:
  - Demographic information
  - Diagnosis
  - Procedure requested (if applicable)
  - ER notes
  - History and physical
  - Imaging studies
  - Presenting Signs and symptoms
  - Vital Signs from the first 24 hours
  - Pertinent laboratory tests from the first 24 hours
Utilization Review

- Observation does not require prior authorization
- Interqual criteria used as well as medical policy. Recommend use of observation first if appropriate.

- Documents can be uploaded to our electronic fax form on the portal.
- Peer to peer conversations allowed at any point in review process.
- Post denial, there are 2 opportunities for decision to be reviewed again.
  - Peer to peer conversation
  - Reconsideration (which is triggered by submission of additional clinical information not presented upon first review.)

- IP review nurses will follow up for progress of patient and to assist in discharge planning at a frequency determined IQ criteria, by the acuity of the care as well as anticipated length of stay

*submission of thorough clinical information as early as possible will result in the most success.*
Claim and P.A. Disputes

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

Appeals must be filed within one year from the date of service.

**Types of issues eligible for appeal:**
- Provider disagrees with MHP determination
- Provider is requesting an exception to MHP policy

Additional information on filing an appeal can be found in the provider manual.
Claim and P.A. Disputes

How to File a Post-Service Claim Appeal

1. Send a letter explaining the nature of your appeal and any special circumstances that you would like Meridian 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:

   MeridianHealth
   ATTN: Appeals Department
   P.O. Box 44287
   Detroit, MI 48244

Meridian typically responds to a post-service claim appeal within 30 days from date of receipt. Providers will receive a letter with Meridian’s decision and rationale.

Provider Services: (866)606-3700
Issue Escalation

Meridian Health Plan has multiple departments who can escalate issues to our Network Development team. For example:

- Member Services
- Claims Department
- Care Coordination
- Utilization Management
Contact Information/References

- **Member Services**
  - Phone: 866-606-3700
  - Fax: 312-980-0445

- **Provider Services**
  - Phone: 866-606-3700
  - Fax: 313-202-0008
  - Email: providerhelp.il@mhplan.com

- **Meridian Website**

- **Illinois HFS Website:**
  http://www.illinois.gov/hfs/Pages/