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Section 1: General Information

A. Using the Meridian Health Plan Provider Manual

The Meridian Health Plan (hereinafter “Meridian”) Provider Manual is designed specifically for Meridian Medicaid Providers. This manual will assist the provider in understanding the specific policies, procedures and protocols of the Managed Care Organization (MCO) contracted with the State of Iowa to deliver and manage health care for members.

How to Use This Manual

This manual is designed to be a user friendly informational tool. Meridian information is divided into sections. There is a master Table of Contents and a separate Table of Contents for each section.

To access information quickly, follow these simple steps:

- Locate the section or topic in the master Table of Contents
- Identify the Section Number
- Tab to the appropriate section’s Table of Contents
- Find the page number in that Section associated with the topic of interest

You may also access a copy of the Provider Manual on our website at http://mhplan.com/mi/providers/index.php?location=provider&page=home.

Updates and Revisions

The Provider Manual is a dynamic tool and will evolve with Meridian. Minor updates and revisions will be communicated to providers via Bulletins. Information delivered 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, in order to replace older versions of the manual. Providers will be notified when a revised version of the manual has been published to the website. The most current version of the Manual is always available at http://mhplan.com/mi/providers/index.php?location=provider&page=home.

B. Meridian Health Plan Medicaid MCO Definition

Meridian is a Managed Care Organization (MCO) contracted with the Iowa Department of Human Services (IDHS) to provide medical services to Medicaid members who are enrolled with Meridian.

Meridian is a plan that provides, arranges for, and manages all Medicaid covered services as defined by the Comprehensive Healthcare Program for Medicaid Eligible Persons.
C. Corporate Telephone Directory

The following table shows the key corporate contacts and their functions.

<table>
<thead>
<tr>
<th>Contact and Service Function</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Utilization Management</strong></td>
<td></td>
</tr>
<tr>
<td>• Process referrals</td>
<td></td>
</tr>
<tr>
<td>• Perform corporate pre-service review of select services</td>
<td>877-204-9072</td>
</tr>
<tr>
<td>• Collect supporting clinical information for select services</td>
<td></td>
</tr>
<tr>
<td>• Conduct inpatient review and discharge planning activities</td>
<td></td>
</tr>
<tr>
<td>• Coordinate case management services</td>
<td></td>
</tr>
<tr>
<td>• Request copy of clinical information</td>
<td></td>
</tr>
<tr>
<td>• Discuss UM decision with physician reviewer</td>
<td></td>
</tr>
<tr>
<td><strong>Customer Service/Members Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Verify member eligibility</td>
<td>877-204-9132</td>
</tr>
<tr>
<td>• Obtain member schedule of benefits</td>
<td></td>
</tr>
<tr>
<td>• Obtain general information and assistance</td>
<td></td>
</tr>
<tr>
<td>• Determine claims status</td>
<td></td>
</tr>
<tr>
<td>• Encounter inquiry</td>
<td></td>
</tr>
<tr>
<td>• Record member personal data change</td>
<td></td>
</tr>
<tr>
<td>• Obtain member benefit interpretation</td>
<td></td>
</tr>
<tr>
<td>• File complaints and grievances</td>
<td></td>
</tr>
<tr>
<td>• Verify/record newborn coverage</td>
<td></td>
</tr>
<tr>
<td>• Coordination of Benefit questions</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Services</strong></td>
<td>877-204-8977</td>
</tr>
<tr>
<td>• Fee schedule assistance</td>
<td></td>
</tr>
<tr>
<td>• Discuss recurring problems and concerns</td>
<td></td>
</tr>
<tr>
<td>• Contractual issues</td>
<td></td>
</tr>
<tr>
<td>• Provider education assistance</td>
<td></td>
</tr>
<tr>
<td>• Primary care administration</td>
<td></td>
</tr>
<tr>
<td>• Initiate physician affiliation, disaffiliation &amp; transfer</td>
<td></td>
</tr>
<tr>
<td><strong>Claims Department</strong></td>
<td>800-203-8206</td>
</tr>
<tr>
<td><strong>Quality Improvement</strong></td>
<td></td>
</tr>
<tr>
<td>• Requests and questions about Clinical Practice Guidelines</td>
<td>877-204-9132</td>
</tr>
<tr>
<td>• Requests and questions about Preventive Healthcare Guidelines</td>
<td>Ask for Quality Management</td>
</tr>
<tr>
<td>• Questions about Quality Initiatives</td>
<td></td>
</tr>
<tr>
<td>• Questions about QI Regulatory requirements</td>
<td></td>
</tr>
<tr>
<td>• Questions about Disease Management Programs</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>800-638-8820</td>
</tr>
<tr>
<td>• Member may contact Magellan Health Services of Iowa directly for services.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Emergent Transportation</strong></td>
<td>866-572-7662</td>
</tr>
<tr>
<td>• For non-emergent medical transportation services call TMS</td>
<td></td>
</tr>
</tbody>
</table>

D. Provider Roles and Responsibilities

This section describes the expectations for PCPs, Specialists, Hospitals and Ancillary providers who are contracted with Meridian.
Primary Care Physician (PCP) Roles and Responsibilities

Each Meridian Medicaid eligible member selects a PCP who is responsible for coordinating the member’s total health care. If the member does not select a PCP then one is assigned to them. PCPs are required to work 20 hours per week per location. They must also be available 24 hours a day, 7 days a week. Please refer to Section 8: Provider Functions and Responsibilities for more details.

All covered health services are either delivered by the PCP or are referred/approved by the PCP and/or Meridian, except for required direct access benefits or self-referral services. There are certain services that also require prior authorization from Meridian. Details are available in Section 4: Utilization Management and Disease Management.

Specialty Care Physician Roles and Responsibilities

Meridian recognizes that the specialty physician is a valuable team member in delivering care to our members. Meridian members do not need a PCP referral to seek care from a specialist. Some of the key specialty physician roles and responsibilities include:

- Communicating with the PCP regarding medical findings in writing
- Obtaining prior-authorization before rendering any services noted on the Corporate Prior Authorization Grid on page 23
- Confirming member eligibility and benefit level prior to rendering services
- Providing the lab or radiology provider with:
  - The PCP and/or prior authorization number (when necessary)
  - The member’s Medicaid ID number

Specialists may also contact Meridian to verify and request prior authorization for services. Details are available in Section 4: Utilization Management and Disease Management.

Hospital Roles and Responsibilities

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

- Coordination of discharge planning with Meridian Utilization Management staff
- Obtaining the required prior authorization before rendering services
- Communication of all pertinent patient information to Meridian and to the PCP
- Communication of all emergent hospital admissions to the Meridian Utilization Management staff within one business day of admission

Ancillary/Organizational Provider Roles and Responsibilities

Meridian recognizes that the ancillary provider is a valuable team member in delivering care to Meridian members. Some critical ancillary provider responsibilities include:

- Confirming member eligibility and benefit level prior to rendering services
- Being aware of any limitations, exceptions and/or benefit exclusions that are applicable to Meridian members
- Obtaining the required prior authorization before rendering services
- Communication of all pertinent patient information to Meridian and to the PCP
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Section 2: Member Related Information

A. Meridian Member Services Department

The Member Services department exists for the benefit of our members and providers, to respond to any and all questions about Meridian benefits, policies and procedures.

Member Services Department
Toll-Free: 877-204-9132

Full-time professional Member Services Representatives are available Monday through Friday, from 8 a.m. to 8 p.m. to assist with the following types of issues:

- Eligibility for benefits
- Approval of non-emergency services
- Member requests for PCP or site changes
- Complaints or Grievances

Members and providers are encouraged to call any time they have a question or concern.

B. Member Rights and Responsibilities

The following are the rights and responsibilities for persons enrolled in Meridian. If there are any questions, please call Member Services at 877-204-9132.

Members Have The Right To:

- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities
- Be treated with respect and recognition of their dignity and right to privacy
- Participate with practitioners in making decisions about their health care
- A candid discussion of appropriate or medically necessary treatment options for their medical conditions, regardless of cost or benefit coverage
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the member rights and responsibilities policies

Members Have The Responsibility To:

- Supply information, to the extent possible, that the organization and its practitioners and providers need in order to provide care
- Follow plans and instructions for care that they have agreed on with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Contribute toward their own health, including appropriate behavior

Meridian staff and contracted providers will comply with all requirements concerning member rights.
C. Member Identification

When a member joins Meridian, they will receive a member ID card sent by first class mail within five days. A separate card will be provided for each member of the family. The Meridian ID Card will include the following:

- Member Name
- Medicaid ID Number
- Member Services Phone Number
- Other Special Instructions

Members must bring their Meridian ID card with them every time they need to access medical services within the Meridian provider network. Members are not to share cards with anyone else. If there are any questions, please call Member Services at 877-204-9132.

Lost ID Cards

If a Meridian ID card is lost, Meridian can send the member a new one. Ask the member to call Member Services at 877-204-9132.

D. Eligibility Verification

Member eligibility changes frequently, so it is important to verify eligibility prior to rendering services to a member.

To verify if a member is currently eligible to receive services through Meridian, the following steps must be followed:

1. Request that the member present his/her Meridian ID card at each encounter
2. Request that the member present his/her IDHS ID card which is generated at the time of enrollment in the Medicaid program
3. Review your PCP monthly eligibility report or verify on-line utilizing the Meridian Provider Portal each time the member appears at the office for care or referrals
4. Call the Member Services department at 877-204-9132 for assistance with eligibility determinations

If you find any discrepancies between a member’s Medicaid ID card and/or your monthly eligibility report, please contact the Member Services department at 877-204-9132 for further assistance.

E. PCP Identification

Call the Member Services department at 877-204-9132 or utilize the Meridian Provider Portal to identify a member’s PCP location if the member is not listed on your monthly eligibility report.

To comply with HIPAA regulations, you must have a Medicaid ID number, Full Name and DOB to obtain any member information.

F. How to Change a Member’s PCP

The member must call the Member Services department at 877-204-9132 to request a PCP change. In most cases, the requested PCP change will take effect immediately. PCP monthly eligibility reports are available on the Meridian Provider Portal.
G. Member Enrollment and Disenrollment

Enrollment in Medicaid Health Plans is coordinated by the Iowa Medicaid Enterprise (IME). IME is contracted with the State of Iowa to enroll clients into Medicaid Health Plans, offer provider participation information and assist members in changing health plans. At the time of enrollment, the member is required to select a PCP from Meridian’s PCP Network. At any time after the initial PCP assignment, the member may call Meridian to choose a different PCP of his/her choice. The new member will be identified on their selected PCPs next monthly eligibility report and on each report thereafter as long as the member is still eligible for Medicaid services.

At times, members may temporarily lose eligibility. If they lose eligibility and then regain eligibility within a two month period of time, they will be re-assigned to Meridian and the prior PCP site unless they request otherwise. If the member wishes to disenroll from Meridian, he or she should contact Meridian Member Services at 877-204-9132 for more information.

H. New Meridian Member Information

The list below identifies some of the important information shared with new members when they join Meridian:

- Members may select a Meridian in-network doctor of their choice for each eligible family member. This doctor is called a PCP. Members may change their PCP by calling the Member Services department at 877-204-9132 and requesting a PCP change.

- If a member has been seeing a PCP that does not participate in Meridian, he/she may not be able to continue to see this doctor unless the doctor elects to join the Meridian provider network.

- Members who have certain identified chronic illnesses may select a specialty physician from the Meridian network to act as their PCP.

- If the member’s Medicaid eligibility ends, so does his or her Meridian coverage.

Additional details about Meridian coverage are described in the Meridian Member Handbook, which is mailed to each new member. Members are invited to call the Member Services department with any questions at 877-204-9132.

I. Durable Power of Attorney

**IOWA NOTICE TO PATIENTS**

*Required by the Patient Self-Determination Act:* The State of Iowa has authorized the use of the Medical Durable Power of Attorney for health care. This allows you to choose another person to make decisions about your care, custody and medical treatment if you cannot make these decisions for yourself. This way your desire to accept or refuse medical treatment is honored when you cannot participate in your medical treatment decisions.

J. Notice of Privacy Practices
Pursuant to regulations under the Health Insurance Portability and Accountability Act (HIPAA), all providers must provide adequate notice of the provider’s privacy practices. Providers should have such notice available at their office upon request by any member, and should post the notice in a clear and prominent location. The following Notice of Privacy Practices may be used for this purpose and is compliant with HIPAA regulations. For specific requirements, see 45 C.F.R. 164.520.

MERIDIAN HEALTH PLAN

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 will 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; information released in the interest of national security or for intelligence purposes; to correctional institutions having custody of an inmate; or shared prior to April 14, 2003.

**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, 601 East 12th Street – Room 248; Kansas City, MO 64106. 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 Health Plan  
666 Grand Avenue, 14th Floor  
Des Moines, IA 50309

You can also call us as at 877-204-9132. 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.mhplan.com/ia.

**K. Member Satisfaction**

Meridian and its network providers are committed to providing and maintaining a consistently high level of member satisfaction. All PCPs and their office staff are expected to maintain a friendly and professional image and office environment for members, other physicians and the general public. PCPs must maintain adequate levels of staff to provide for timely and effective services for Meridian members. Member Services functions are a requirement of the PCP initial orientation and on-going network provider education.

Meridian conducts annual surveys to determine current levels of member satisfaction with the health plan, providers and specialists to identify areas of potential Plan improvement. PCPs and their office staff are expected to cooperate and assist Meridian with obtaining data for these surveys. PCPs will be notified in advance of their required participation and the time frames in which the surveys will be conducted annually.

**L. Member Grievances and Appeals**

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 Meridian members.

**Member Grievance**

A grievance is an expression of dissatisfaction, including complaints, directed to Meridian about any matter of an action (denied, reduced or terminated service) that can be appealed. Examples of members’ grievances include the following:

- Access to Care (inability to get an appointment with the doctor in a timely manner)
• Attitude and Service (provider, office staff, plan staff)
• Quality of Practitioner Office Site (waiting room, exam room)
• Quality of Care services provided
• Billing and Financial Concerns

If you have a grievance or concern with your health care provider or Meridian, we want you to tell us about it. Please call Member Services at 877-204-9132 and ask for the Grievance Coordinator. You may also file your grievance in writing. Your physician or a designated representative may file a grievance for you in writing. Please include a phone number where we can reach you. The address to file a grievance is:

**Meridian Health Plan**  
**Grievance Coordinator**  
**666 Grand Avenue, 14th Floor**  
**Des Moines, IA 50309**

We will acknowledge your grievance by sending you or your representative a letter within five business days of receiving the grievance. Your grievance will be resolved within 15 calendar days. We will call you with the results and also send a response in writing.

You or your representative can appear in person or by phone before the Grievance Committee. You can also submit additional written information for the Grievance Committee to review. You or your representative will be notified of the resolution within three business days of the Committee’s decision. We will call you with the results and also send a response in writing.

**External Review of Grievances**

If you are unhappy with Meridian’s resolution, you or your representative can submit a request for external review in writing to the Iowa Insurance Division. You can write to them at the following address:

Send your request for external review to:

**Iowa Insurance Division**  
**330 Maple Street**  
**Des Moines, IA 50319**

At any time within 90 days of the date of the denial letter, you have the right to request a Fair Hearing by the State of Iowa within 90 days of the denial letter from Meridian. You can file a Fair Hearing by the State of Iowa at the following address:

**Department of Human Services**  
**Appeals Section**  
**1305 E Walnut Street, 5th Floor**  
**Des Moines, IA 50319**

**Member Appeals**

If you are not happy with a decision made by Meridian, you may file an appeal with us. An appeal is a request to change a decision about a denied, reduced or terminated service or a member’s relationship with Meridian. A few examples of things you can appeal are:
The reduction, suspension or termination of a previously authorized service
The denial, in whole or in part, of payment for an authorized and covered service
When a request for services, medical supplies or prescriptions is denied

Your request for an appeal must be made between 30 and 90 days of the date of the determination. You can have someone else, such as a family member or a physician, file the appeal for you. You must put in writing that you want the person to appeal for you. You must also give this person access to your health information. You/your authorized representative have the right to submit written comments, documents, medical records or other information related to the appeal.

To start an appeal, write a letter about the problem or use Meridian’s Internal Appeal form that is included with the initial denial letter. Send the appeal request to:

Meridian Health Plan
Appeals Coordinator
666 Grand Avenue, 14th Floor
Des Moines, IA 50309
Phone: 877-204-9132

If you need help writing your appeal, the Meridian Appeals Coordinator will help you. Call us at 877-204-9132. Please send all paperwork and any other items related to the appeal to the address listed above. Please include a number where you can be reached so we can let you know that your appeal has been received.

Meridian Internal Grievance/Appeal Process

A doctor with the same or like specialty as your treating doctor will review your appeal. It will not be the same doctor who made the original decision.

Meridian will send you a letter notifying you of the decision:

- Within 14 calendar days if you are waiting to get the medical services
- Within 30 calendar days if you already received the medical services

Meridian may need to take up to 14 more calendar days if we are waiting for information from your provider. If this happens we will send you a letter. You also have the right to request up to 14 more calendar days if Meridian does not completely approve your request during the internal review, the letter will describe your further appeal rights.

Expedited Appeal Review

Your problem may be so urgent that you need a decision about your care very quickly. If the usual time frame for appeal would cause serious harm to your life or health, you or your representative can ask for an expedited appeal. Your doctor must support this request. No punitive action will be taken against a doctor who requests and/or supports an expedited appeal. You can ask for an expedited appeal 24 hours a day, 7 days a week. Meridian will make a decision about your care within 72 hours. Call the Appeals Coordinator at 877-204-9132 during normal business hours of Monday through Friday from 8 a.m. to 5 p.m.

Fair Hearing by the State of Iowa
If you or your authorized representative is unhappy with Meridian’s final decision, you have the right to request a Fair Hearing by the State of Iowa within 30 days of the denial letter from Meridian. You can file a Fair Hearing by the State of Iowa at the following address:

**Department of Human Services**
**Appeals Section**
**1305 E Walnut Street, 5th Floor**
**Des Moines, IA 50319**

You can also call the Iowa Department of Community Health at 515-256-4606.

A physician or other representative of the member such as family member, friend or attorney, may appeal on the member’s behalf with the member’s written permission. Meridian must receive a copy of the member’s written permission prior to an appeal being processed.

### I. Interpretive Services

Meridian can arrange for an interpreter to speak to a member in any language, free of charge. A member may call Member Services at 877-204-9132 and we can help. If a member is hearing or speech impaired, TTY/TDD services are available by calling 877-204-9132. Many doctors in Meridian’s network speak multiple languages. A member can find out if a provider speaks their preferred language by referring to the Provider Directory, available online at [www.mhplan.com/ia](http://www.mhplan.com/ia).

The Iowa Relay Center makes it possible for hearing-impaired and/or speech-impaired persons to call Meridian. They can be reached 24 hours a day, 7 days a week at 800-735-2942.

### J. New Technology

Meridian wants to make sure our members have quality access to new technologies and procedures. The plan investigates all requests for new technology or a new application of existing technology. Information of new technology/procedures is received from medical information, professional groups, Medicare, Food and Drug Administration (FDA) releases, practitioners, members and other sources. This information goes to a Meridian group made up of doctors and Meridian staff. Meridian may also use specialists to review the information. The decision to approve or not approve a new technology or procedure as a covered benefit is made after review by these practitioners.
Section 3: Member Benefit Information

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Section 3: Member Benefit Information

A. Member Benefits and Services

Meridian has a comprehensive benefits package available to all Meridian members that are Medicaid eligible members. Services for members are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care. Meridian Health Plan and Meridian Wellness Plan follow the benefit packages as outlined by IME.

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

- **Children’s Care**
  - Certified Pediatric and Family Nurse Practitioner services
  - Chiropractic services
  - Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) services (Care for Kids)
  - Health education
  - Hearing aids
  - Immunizations and vaccines
  - Lead screening
  - Newborn care
  - Provider visits (well-child, routine, sick visits, school physicals)

- **Emergency and Urgent Care/Inpatient Hospital Services**
  - Ambulance and other emergency medical transportation
  - Emergency services
  - Medical inpatient care (hospitals, acute inpatient rehabilitation centers)
  - Post-stabilization care (inpatient hospitals)
  - Urgent care center visits

- **Home Health Services**

- **Hospice Care**

- **Outpatient Care**
  - Cardiac and pulmonary rehabilitation
  - Primary care office visits (routine physical exams, routine care, sick visits)
  - Rehabilitative therapy (physical, occupational, speech, language therapy)
  - Specialty care
  - Testing and diagnostic procedures

- **Surgery**
  - Inpatient, ambulatory outpatient, emergency and reconstructive surgeries
  - Organ transplant services

- **Vision Services**
- Eye exams
- Eyeglass frames
- Eyeglass lenses

*Wellness Plan members ages 19 & 20 are still covered by the EPSDT program and therefore related vision services are covered.

- **Women’s Care**
  - Abortion (only in specific situations)
  - Certified midwife services
  - Enhanced services for high-risk pregnant women (care coordination, health education, social services, nutrition education, postpartum home visit)
  - Obstetric and maternity care services (prenatal, delivery, postpartum care)
  - Well care for women (mammograms, Pap tests, family planning)

- **Additional Services**
  - Access to Federally Qualified Health Centers (FQHC) and Rural Health Clinics
  - Asthma care
  - Case management
  - Certified pediatric and family nurse practitioner services
  - Chiropractic services
  - Diabetes care
  - Disease management
  - Durable Medical Equipment and supplies
  - End Stage Renal Disease services
  - Family planning services/sexually transmitted infections (STIs)
    - Sterilization services
    - Treatment for STIs
  - Hearing aids
  - Nutritional class/counseling and weight management programs
    - Medically necessary weight reduction services
    - Services/counseling by a licensed dietician
    - Weight management programs
  - Podiatry and Orthopedic care
  - Tobacco cessation treatment

If new services are added to the Iowa Medicaid Program, or if services are expanded, eliminated or otherwise changed, Meridian will implement the changes consistent with the dates specified by the Iowa Department of Human Services.

*Note that Meridian does not charge co-pays to its members for any Medicaid covered services.*

**B. Medicaid/Federally Funded Services Covered Outside of Meridian Benefits**

- Behavioral Health Intervention Services (BHIS) (mental health, substance abuse, institutional psychiatric)
- Dental services
- Habilitation services – Home and Community Based Services (HCBS)
• Health Insurance Premium Payment (HIPP)
• Home and Community-Based Waiver services
• Intermediate Care Facilities for Persons with Mental Retardation and Related Conditions (ICF/MR)
• Maternal and Child Health Program (MCHP)
• Non-emergent medical transportation
• Program for All-Inclusive Care for the Elderly (PACE)
• Pharmacy
• Skilled nursing facilities
• Services by Area Educational Agencies (AEA)
• Women, Infants & Children (WIC)

Meridian providers are required to assist with and provide members with referrals for the above Medicaid covered services. Providers should contact Member Services at 877-204-9132 for assistance with making the above member referrals.

C. Non-Covered Meridian/Medicaid Services

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

D. 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 Meridian members have full freedom of choice of family planning providers, both in and out of the Meridian network. The PCP should work with the member in providing for family planning services or assisting them in selecting a provider, as requested.

Members may also contact Member Services at 877-204-9132 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 preventative 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 21 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.

E. Federally Qualified Health Centers (FQHC)

FQHCs are important community providers and all 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 877-204-9132.

F. Non-Emergency Transportation

Any member that cannot access non-emergent transportation services through their own resources, family or friends, may contact TMS at 866-572-7662.

Appointment Scheduling Criteria/Process

Scheduling of transportation services usually requires a three day notice to assure service. The transportation provider uses confidential eligibility information provided by Meridian to verify member eligibility. Members will be assigned to the most appropriate and cost effective means of transportation in the network web. Appointments will be scheduled during business hours between 8 a.m. and 8 p.m. Monday – Friday.

Members who need transportation for next day appointments should contact the Member Services department at 877-204-9132 as soon as possible.

Member complaints and grievances regarding non-emergent transportation issues will be handled through the Meridian Complaints and Grievances Policy and Procedure as described under Section 2 Subsection L.

Non-emergent transportation service abuse will be reported to Meridian by the non-emergent transportation vendor and investigated by Meridian. Meridian reserves the right to withhold non-emergent transportation services from members found to be abusing the service.

Examples of abuse of the service would include securing transportation for reasons outside of medical necessity and abusive behavior towards the transportation provider.

Members who must access non-emergent travel expenses outside of the Meridian geographical area for medically necessary care, and incur costs for such services, may contact Meridian Member Services at 877-204-9132 for assistance. Meridian will review the appropriateness of the request prior to the service being scheduled.

Reimbursement for reasonable and customary non-emergent transportation costs will be considered and made on an individual basis.

G. Advance Directives
Advance Directives are legal documents that allow members to convey their decisions about end of life care ahead of time. They provide a way for members to communicate their wishes to family, friends and health care professionals. This will hopefully avoid confusion if a member becomes so sick that they are unable to express their wishes. There are two types of advance directives.

**Living Will** - A living will tells how a person feels about care intended to sustain life. They can accept or refuse medical care. There are many issues to address, including:

- The use of dialysis and breathing machines
- Tube feeding
- Organ or tissue donation
- If the person wants the doctors to try to save them if breathing or heartbeat stops

**Durable Power of Attorney for Health Care** - This is a document that names another person to make decisions for the individual if they are not able to do so. This is called a health care proxy. The proxy should be given to someone that they trust to follow their wishes.

Members must be sure to tell the PCP and Meridian if they have an Advance Directive. The PCP will keep a copy in the Member’s medical record. Members should also keep a copy at home in a safe place. If there are any questions about Advance Directives or a member needs help finding an Advance Directive form, please call Member Services at 877-204-9132.
Section 4: Utilization Management, Care Coordination and Disease Management

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I. Care Coordination Maternity Program ...................................................................................... 31
Section 4: Utilization Management, Care Coordination and Disease Management

The objective of Meridian’s Utilization Management program is to ensure that the medical services provided to members are medically necessary and/or appropriate, as well as in conformance with the plan benefits. The program functions on a consistently applied systematic evaluation of appropriateness criteria and by considering circumstances unique to the member.

A. Referral Management

Referral processing is the primary activity performed by our utilization management specialist staff. If you have a referral request or question, contact Utilization Management at 877-204-9072. They will be glad to help you.

Three easy ways to submit referrals:

1. **Electronically** – Meridian Provider Portal
2. **Fax** – Refer to utilization 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 your regional team. Make sure you identify the request as “urgent” to expedite the pre-service review process.

The next table in this section provides Meridian’s referral requirements for the most commonly requested services. This list is not all inclusive and rarely requested services may require pre-service authorization. Should you have any questions please, contact the utilization management team.

If the service you are requesting requires a referral/authorization, contracted providers can complete the request electronically through the Provider Portal for more expeditious review. Requests can also be submitted by all providers by completing the Iowa referral form and faxing it back to Meridian. Referral authorization request forms can be found on the Meridian Health Plan website ([www.mhplan.com/ia/providers](http://www.mhplan.com/ia/providers)). For pregnant members, please complete the Global Authorization form. The Global Authorization form can also be found on the Meridian website and Provider Portal.
## MERIDIAN HEALTH PLAN
### PRIOR AUTHORIZATION PROCEDURES OVERVIEW - IOWA

You may forward your request to Meridian via fax: 515-802-3560 or by phone: 877-204-9072
In-network providers may request and view authorizations online at [www.mhplan.com/ia/mcs](http://www.mhplan.com/ia/mcs)

<table>
<thead>
<tr>
<th>No Prior Authorization</th>
<th>PCP/Specialist Notification to Meridian</th>
<th>Corporate Prior Authorization (May Require Clinical Information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing</td>
<td><strong>Meridian requests notification to communicate services with all providers involved, provide additional reporting services and support efforts.</strong></td>
<td>Ambulance Transportation (Non-Emergent)</td>
</tr>
<tr>
<td>Annual Mammogram and Pap Test</td>
<td></td>
<td>Anesthesia when performed with Radiology Testing</td>
</tr>
<tr>
<td>Audiology Services and Testing (excluding hearing aids)</td>
<td>Complex Outpatient Treatment • Chemotherapy • Dialysis • Outpatient Radiation Therapy</td>
<td>Bariatric Surgery</td>
</tr>
<tr>
<td>Barium Enema</td>
<td>Maternity care/Maternal support services • Notification is needed for OB referrals and for OB delivery</td>
<td>Cardiac/Pulmonary Rehab</td>
</tr>
<tr>
<td>Bone Densitometry Studies</td>
<td>Family Planning Services • Sterilization</td>
<td>Chiropractic Services (over 12 visits)</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td></td>
<td>Cosmetic, Reconstructive or Plastic Surgery</td>
</tr>
<tr>
<td>Cardiac Stress Test</td>
<td>First PCP/Specialist Notification is not necessary for claims payment. In-network or out-of-network practitioners will be reimbursed for consultations, evaluations and treatments provided within their offices, when the member is eligible and the service provided is a covered benefit under Iowa Medicaid and the Medicaid MCO Contract. *Must be in compliance with 30 days federal notification requirement</td>
<td>Durable Medical Equipment, Prosthetic Devices and Medical Supplies &gt; $1,000 (e.g., augmentative enteral feeding device, enteral pump, communication devices)</td>
</tr>
<tr>
<td>Cardiograph</td>
<td></td>
<td>Elective Hospital Outpatient Surgery (Please refer to Appendix A for select procedures)</td>
</tr>
<tr>
<td>Chiropractic Services (up to 12 visits)</td>
<td></td>
<td>Elective Inpatient Admissions/Surgeries</td>
</tr>
<tr>
<td>Colposcopy after an abnormal Pap</td>
<td></td>
<td>Genetic testing</td>
</tr>
<tr>
<td>Durable Medical Equipment, Prosthetic Devices and Medical Supplies &lt; $1,000 (e.g., enteral feeding device, enteral pump, communication devices) – in network only</td>
<td></td>
<td>Hearing Aids</td>
</tr>
<tr>
<td>Electrocardiogram (EKG)</td>
<td></td>
<td>Home Health Care/Hospice/Infusion Therapy Services</td>
</tr>
<tr>
<td>Evaluation for Physical, Occupational and Speech Therapy</td>
<td></td>
<td>Pain Management</td>
</tr>
<tr>
<td>Gastroenterology Diagnostics</td>
<td></td>
<td>Pregnancy termination</td>
</tr>
<tr>
<td>Intravenous Pyelography (IVP)</td>
<td></td>
<td>Specialty Drugs (covered under medical benefit) – e.g. Rituxun and Remicade (view a complete list at <a href="http://www.mhplan.com">www.mhplan.com</a>)</td>
</tr>
<tr>
<td>Life-Threatening Emergencies – ER Screening</td>
<td></td>
<td>Speech, Occupational and Physical Therapy for ages 0-20 and ages 21+ over 24 visits</td>
</tr>
<tr>
<td>Myoview Stress Test</td>
<td></td>
<td>Weight Management (prior to Bariatric Surgery)</td>
</tr>
<tr>
<td>Neurology/neuromuscular diagnostic testing video, including EEGs, 24-hour video EEGs and EMGs</td>
<td></td>
<td>Emergency inpatient admissions require authorization from Meridian. In-network hospitals must notify Meridian within the first 24 hours or the following business day.</td>
</tr>
<tr>
<td>Non-Invasive Vascular Diagnostic Studies</td>
<td></td>
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<tr>
<td>Obstetrical Observations</td>
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<tr>
<td>Routine Lab</td>
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<tr>
<td>Routine X-Ray including CT Scan, MRI, MRA, PET Scan, DEXA, HIDA Scans, Bone Density</td>
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<td></td>
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<tr>
<td>Sigmoidoscopy or Colonoscopy</td>
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<tr>
<td>Sleep Studies (facility only)</td>
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<td></td>
</tr>
<tr>
<td>Speech, Occupational and Physical Therapy age 21+ (up to 24 visits) – in network only</td>
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<tr>
<td>SPECT Pulmonary Diagnostic Testing</td>
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<tr>
<td>Ultrasounds</td>
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<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
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<tr>
<td>Voiding Cysto-Urethrogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision - 1 exam/yr; Lenses 4x/yr for ages 1-3, 1x/yr for ages 3-7, 1x/2 yrs for ages 8+</td>
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</tbody>
</table>

All services performed by out-of-network providers must receive prior authorization before the services may be performed for Medicaid members. Prior authorization does not apply for services required by EMTALA or for family planning related services. Out-of-network hospitals must notify Meridian at the time of stabilization and request authorization for all post-stabilization services.

### NON-COVERED BENEFITS

The following services are not covered benefits by Meridian but may be reimbursed by the Iowa Medicaid Program: Dental services, non-emergent medical transportation, services by area educational agencies, mental health/substance abuse/psychiatric services, and pharmacy benefits.

For non-emergent medical transportation services, call TMS at 866-572-7662. You can also visit their website at [www.tmsmanagementgroup.com](http://www.tmsmanagementgroup.com) and click on “Iowa Medicaid”.

By requesting prior authorization, the provider is representing that the services to be provided are medically necessary. As a condition of authorization of those services, the servicing provider agrees to accept no more than 100% of Iowa Medicaid rates. At no time will Meridian pay more than 100% of Iowa Medicaid rates for any services. In the event that these services are deemed not to be medically necessary, Meridian will not reimburse the provider for those services.

[www.mhplan.com](http://www.mhplan.com)
PRIOR AUTHORIZATION APPENDIX A: Outpatient Surgeries Requiring Prior Authorization

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominoplasty</td>
<td>Hysterectomy</td>
</tr>
<tr>
<td>Abortion/Pregnancy Termination</td>
<td>Hysterectomy Sterilization</td>
</tr>
<tr>
<td>Back/Neck Surgery</td>
<td>Implant Neuroelectrodes</td>
</tr>
<tr>
<td>Bariatric Surgery/Gastric Bypass</td>
<td>Implantation of Neurostimulator</td>
</tr>
<tr>
<td>Blepharoplasty</td>
<td>Lap Band Gastric Adjustment</td>
</tr>
<tr>
<td>Breast Reduction</td>
<td>Laparoscopy Fundoscopy</td>
</tr>
<tr>
<td>Cardiac Implant Recorder/Loop Recorder</td>
<td>Laparoscopy Paraesophageal Hernia Repair</td>
</tr>
<tr>
<td>Cochlear Implant/Device</td>
<td>Laparoscopy, Tubal Cautery Block</td>
</tr>
<tr>
<td>Dental General Anesthesia (&gt;6 years old)</td>
<td>Mastectomy for Gynecomastia</td>
</tr>
<tr>
<td>Dermabrasion</td>
<td>Multifetal Pregnancy Reduction</td>
</tr>
<tr>
<td>Division of Fallopian Tube</td>
<td>Orthognathic Surgery</td>
</tr>
<tr>
<td>Dual Chamber Pacemaker Insertion</td>
<td>Penile Implant/Prosthesis</td>
</tr>
<tr>
<td>Ectopic Pregnancy</td>
<td>Photo Chemotherapy for Psoriasis</td>
</tr>
<tr>
<td>Esophagus Surgery Procedure</td>
<td>Scar Excision/Revision</td>
</tr>
<tr>
<td>Fertility Tests</td>
<td>Septoplasty/Rhinoplasty</td>
</tr>
<tr>
<td>Gastric Neurostimulator</td>
<td>Varicose Vein Treatment/Surgery</td>
</tr>
<tr>
<td>Hair Plugs</td>
<td>Vasectomy Removal/Ligation of Sperm duct</td>
</tr>
<tr>
<td>Hip Arthroplasty</td>
<td>Ventral Hernia Repairs</td>
</tr>
<tr>
<td>Hyperbaric Oxygen Therapy</td>
<td>Video EEG</td>
</tr>
</tbody>
</table>

If you have any questions or would like additional information, contact your local Provider Network Development Representative or the Provider Services department at 877-204-8977.

B. Corporate Pre-Service Review

Meridian must review and approve select 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.

Utilization management clinical staff use 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’s medical directors. These guidelines include McKesson InterQual® criteria, Meridian Medical Review Criteria (developed by Meridian medical directors in conjunction with community physicians), Hayes Directory, and applicable Medicaid benefits and guidelines. Copies of the criteria utilized in decision-making are available upon request by calling the Utilization Management department. In certain circumstances, an external review of service requests are conducted by qualified, licensed physicians with the appropriate clinical expertise.

Meridian’s 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. 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 the Meridian Provider Portal. Providers may also submit a fax with the necessary information to Meridian’s Utilization Management department. If clinical information is not received with the
request, Meridian’s 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 when possible. The facility is responsible for ensuring authorization. Meridian provides a reference number on all referrals. Utilization decisions are based only on appropriateness of care and service, as well as the member’s eligibility. 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 a denial of care or service.

**Turn Around Times for Referral Processing**

<table>
<thead>
<tr>
<th></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. Meridian believes there are very few situations that justify requesting retrospective authorization and most often will be denied.</td>
<td>N/A</td>
<td>Within 30 days of receipt of the request.</td>
</tr>
</tbody>
</table>

**C. Access to the Utilization Management Staff**

Meridian has processes in place to ensure that our Utilization Management staff is available to receive or initiate calls to members or providers to discuss Utilization Management decisions or practices. You may call during normal business hours Monday through Friday, 8 a.m. to 5 p.m. After normal business hours or holidays, you may contact Meridian at 877-204-9132 for assistance.

**D. 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. 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 Meridian’s Observation policy. Together, with the facility's staff, Utilization 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. Call the appropriate regional Utilization Management team, enter the authorization request in Meridian’s Managed Care System or fax the request to the appropriate Utilization Management Team. Be sure to include documentation of medical necessity to facilitate the earliest possible turnaround time. The facility is responsible for ensuring authorization. Meridian provides a reference number on all referrals.

E. Denials & Provider Appeals

All denial determinations are rendered by a physician reviewer. A nurse reviewer contacts the provider telephonically to inform them of the denial decision, reason for the denial and contact information to discuss the denial with Meridian’s Medical Director.

Written denial notification and appeal rights are sent via fax to the PCP and requesting provider/physician 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 877-204-9702 between 8 a.m. and 5 p.m. Monday thru Friday. After business hours you may call Meridian at 877-204-9132.

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 877-204-9072 to request a copy of Meridian’s 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.

An expedited appeal may be requested by the member, member’s authorized representative or the member’s treating provider. 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 Provider Appeal (Separate and Distinct from the Member/Authorized Representative Appeal Process)

Providers may request an appeal of denial in advance of the member obtaining care or services. Meridian will provide acknowledgement of your 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 Section 5: Billing and Payment for directions on Post-Service Appeals.
Reconsideration of an Adverse Determination

In addition to the appeals process, providers may request a reconsideration of a denial determination within 10 calendar days of the date of the initial notification of denial. The request for reconsideration may be requested verbally, faxed or sent to the same address and/or fax number as listed for appeals. The reconsideration will be reviewed by Meridian’s Medical Director. The provider will be notified verbally at the time of the determination of the denial reconsideration. If the decision is to overturn the denial, Meridian will notify the provider in writing no later than 10 business days following Meridian’s receipt of the request. If the decision is to uphold the initial denial, the provider may appeal the decision by following the appeal process provided with the initial written denial notice.

Turn Around Times for Processing Provider Appeals

<table>
<thead>
<tr>
<th></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.</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>
<td>Within 14 calendar days of receipt of the appeal.</td>
</tr>
</tbody>
</table>

F. Care Coordination

Care Coordination integrates behavioral and physical health needs of the member and coordinates referrals to maximize treatment success and outpatient care services. Meridian’s Care Coordination model seeks to accomplish this by:

- Focusing attention on the individual needs of the members
- Promoting and assuring service accessibility
- Maintaining communication with the member/caregiver, providers and community
- Identifying and removing barriers to access through collaboration with the PCP, specialists, member and family to develop a plan of care
- Integrating behavioral health and specialty care into care delivery
- Educating members on condition management, appropriate use of services and self-care techniques

The Care Coordinator determines whether or not a member is eligible for Care Coordination, assigns the member’s risk stratification level and develops a plan of care. The results of the member’s Health Risk Assessment (HRA) and reassessments determine their risk stratification level.

G. Care Coordinators

Care Coordinators are Meridian team members responsible for identifying health goals for each member. They coordinate services and providers to help members achieve these goals by:

- Working with members to create individualized care plans
- Identifying and removing barriers to accessing care
• Linking members with community resources to facilitate referrals and respond to social service needs
• Educating members on condition management, appropriate use of services, and self-care techniques
• Referring members to appropriate community resources to address medical, social and financial needs and following up to ensure fulfillment
• Updating the care plan at least annually and whenever members experience a change in condition

Target Population

• Pregnant members at all risk levels
• Adults and children with special needs
• High-risk and high-cost populations with multiple health and social needs
• Members requiring post-hospitalization assessment and follow up
• High-ED utilizers requiring education and communication with PCP
• Members with level 3 chronic conditions or more than one chronic diagnosis, regardless of risk stratification
• Members with medical needs who are also suffering from psychosocial and behavioral health risk factors

“Integrated Team” Approach

Our Care Coordination program operates as an integrated team comprised of Care Coordinators, a Care Coordination Nurse Team Lead and assigned consultant staff from Behavioral Health, Pharmacy and Nutrition. Led by a Meridian Medical Director, the teams meet daily for continuous education and case review.

Teams are specialized in:

- Medical
- Children’s Special Health Care Services (CSHCS)
- Maternity
- Medicare
- High-ED
- Behavioral Health
- Weight Management
- Complex Case Management

Care Coordination teams will regularly reach out to providers to keep everyone involved with the members plan of care. The following forms of communication will be used: letters, faxes and phone calls.

Referring a Member to the Care Coordination Program

Providers can refer any Meridian member to the Care Coordination program by:

1. Notifying Meridian through the Provider Portal
   A. Log in to the Provider Portal (www.mhplan.com/ia/mcs)
   B. Select “Member” on the left menu
C. Enter the Member ID number
D. Click “Notify Health Plan” at the bottom of the “Demographics” screen
E. Select “Case Management” (middle tab) and fill out the reason for referral

2. Completing the “Care Coordination Referral Form” and faxing it to Meridian. To get the form:
   A. Go to www.mhplan.com/ia/providers
   B. Click on “Documents & Forms” on the left side
   C. Fax the completed form to 313-202-5787

3. You can also request a Care Coordination Referral Form from your local Provider Network Development Representative

If you have any questions regarding Meridian’s Care Coordination program, call the Utilization Management department at 877-204-9072.

H. Disease Management

Meridian offers disease management (DM) programs to assist your patients to better understand their condition, update them on new information about their disease and provide them with assistance from our staff to help them manage their disease. The programs are designed to reinforce your treatment plans for the patient.

Members of Meridian do not have to enroll; they are automatically enrolled when we identify them with the diseases through claims, the UM/CM program, pharmacy information or Health Risk Assessments (HRA). The programs your patients are enrolled in are listed on your member eligibility list.

If you would like to enroll a Meridian member who is not in the program, please contact the Meridian Care Coordination department by phone at 877-204-9132 x2072, fax 515-802-3566 or via the Provider Portal “Notify” button.

Disease Management programs provide the following services:

- Support from Meridian nurses and other health care staff to ensure that your patients can understand how to best manage their condition and periodically evaluate their health status
- Periodic newsletters to keep the patients informed of general information regarding their disease and the ways to self-manage
- Educational and informational materials that can assist your patients in understanding and managing the medications you prescribe, how to effectively plan for visits to see you and reminders as to when those visits should occur

Meridian also provides you with updates on the results of tests or other information that we collect on your patients. Enrollment in these Meridian disease management programs is voluntary. If at any time your patients wish to stop participating in the program, they can call the Care Coordination department at the number listed above.

I. Care Coordination Maternity Program
Beginning the moment Meridian becomes aware a member is pregnant; Meridian will initiate interventions to lead to a healthy outcome for both mother and baby. Meridian staff will assist the member to connect with the health care system whereby the member can receive the appropriate treatment and care. This may be accomplished by assisting the member find an OB/GYN provider, help make appointments and/or arrange transportation. The member is also provided educational materials on numerous pregnancy related topics.

Members are followed throughout the course of their pregnancy to provide support and assistance as needed and to ensure the member follows through with their postpartum visit. Members are also screened for possible postpartum depression and referred to appropriate behavioral health providers, as necessary. Educational materials related to postpartum and infant care are provided to the new mother. These materials encourage well-care visits and promote important preventive health care services, such as immunizations and lead testing. Meridian also offers High-risk Case Management services to members identified as meeting the high risk criteria through our prenatal screening tool.

Meridian hopes you promote and support these programs by encouraging your Meridian patients to take advantage of these services. You can refer a member to any of these special programs by calling Member Services at 877-204-9132.
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Section 5: Billing and Payment

A. Billing and Claims Payment

Claims Billing Requirements

- The standard CMS 1500 Claim Form or UB 04 Claim Form is required for Meridian billing
- Services which require prior authorization should include a referral form or prior authorization number(s) on the claim for payment
- Providers must use industry standard HCPCS, CPT, Revenue and ICD-9 codes when billing Meridian
- Providers may also submit and check the status of claims electronically via Provider Portal

Claims Mailing Requirements

Submit all initial claims for payment to:

Meridian Health Plan
1001 Woodward Avenue
Suite 530
Detroit, MI 48226
Attn: Claims Department

If you are replacing or voiding/cancelling a UB-04 claim, please use appropriate bill type of 137 or 138. If you are replacing or voiding/cancelling a CMS 1500 claim, please complete box 22. For replacement or corrected claim enter resubmission code 7 in the left side of item 22 and enter the original claim number of the claim you are replacing 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/canceling on the right side of item 22.

B. Coordination of Benefits (COB)

It is important to remember that Meridian is a Medicaid plan and is always the final payer. Meridian is responsible only for the difference between what the primary insurance pays and the allowable Medicaid fee screen. Please submit claims that have other insurance payers to Meridian with an attached EOB payment or rejection.

C. Billing Procedure Code Requirements

Meridian requires that providers use the appropriate HCPCS, CPT, ICD-9 and revenue codes when billing Meridian.

D. Explanation of Payments (EOP)

Meridian sends its providers Remittance Vouchers as a method of explanation of benefits. Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) are also available. For more information regarding EFT or ERA services please contact Provider Services at 877-204-8977.
E. Grievance and Appeal Process for Denied Claims

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.

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, 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 a Meridian 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

Meridian’s 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 877-204-9132. 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 a member being ineligible 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 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:

   Meridian Health Plan
   1001 Woodward Avenue
   Suite 530
   Detroit, MI 48226
   Attn: Claims Department

Time Frame for Filing a Post-Service Appeal

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

Meridian 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 Meridian will respond within 30 days of receiving the necessary information. Providers will receive a letter with Meridian’s decision and rationale.
There is only one level of appeal available within Meridian. All appeal determinations are final. If a provider disagrees with Meridian’s determination regarding an appeal, the contracted provider may pursue:

- Binding Arbitration - A provider may initiate arbitration by making a written demand for arbitration to Meridian. The Provider and Meridian agree to mutually select an arbitrator and the process for resolution.

If you have any questions about the post-service claim appeal process, please contact your local Provider Network Development Representative or Meridian Provider Services at 877-204-9132 for more information.

F. Electronic Claims Submission

Meridian is currently accepting electronic claims from the following clearinghouses:

**Availity**
Customer Support: 800-Availity
Claim Types: Professional/Facility
[www.availity.com](http://www.availity.com)

**Emdeon**
Customer Support: 800-845-6592
Claim Types: Professional/Facility
[www.emdeon.com](http://www.emdeon.com)

**Netwerkes**
Customer Support: 866-521-8547
Claim Types: Professional/Facility
[www.netwerkes.com](http://www.netwerkes.com)

**PayerPath**
Customer Support: 877-623-5706
Claim Types: Professional
[www.payerpath.com](http://www.payerpath.com)

**Relay Health**
Customer Support: 800-527-8133
Claim Types: Professional/Facility
[www.relayhealth.com](http://www.relayhealth.com)

**SSI Group**
Customer Support: 800-880-3032
Claim Types: Professional/Facility
[www.thesigroup.com](http://www.thesigroup.com)

*Providers are responsible for ensuring that they receive a confirmation file for claims submitted via EDI.*
Section 6: Quality Improvement Program

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Section 6: Quality Improvement Program

A. Introduction

The primary objective of Meridian’s Quality Improvement Program (QIP) is to continuously improve the delivery of health care services in a low resource environment to enhance the overall health status of its members. The QIP objectively and systematically monitors and evaluates the quality, appropriateness, and outcomes of care and services, and the processes by which they are delivered. Direct improvement in individual and aggregate member health status is measured using the applicable HEDIS® quality measures, State of Iowa mandated performance indicators, internal performance improvement projects, and health outcomes data. Indirect improvement in individual and aggregate member health status is measured using critical operational metrics designed to monitor accessibility and availability of care.

B. QIP Goals & Objectives

To ensure that Meridian members receive high quality, medically appropriate and cost-effective health care, the QIP is integrated within clinical and non-clinical and operational services provided to Meridian members. The program encompasses services rendered in ambulatory, inpatient and transitional care settings and is designed to resolve identified areas of concern on an individual and system-wide basis. The QIP reflects the population serviced by Meridian in terms of age, gender, ethnicity, culture, disease or disability categories and level or risk stratification.

The primary goals of the Meridian QIP are to:

- Ensure member access to medically appropriate care
- Assure accessibility and availability of quality medical care
- Develop and implement programs to increase preventive care delivery rates
- Identify members for participation in disease management program(s), as appropriate
- Coordinate care for members with acute, chronic and complex medical, and co-morbid conditions
- Improve coordination and transition across care settings and among ancillary providers
- Improve communication with the member’s primary care physician
- Monitor adherence to Meridian-approved evidence-based clinical practice guidelines
- Ensure member and provider satisfaction
- Improve CAHPS/Patient Experience Survey outcomes
- Develop and maintain collaborative relationships with the State agencies, providers and other health plans
- Continue educating internal staff and contracted providers to address the health care needs of culturally and linguistically diverse member sub-populations to identify and address health care disparities, reduce barriers to care and improve compliance with treatment and outcomes

C. QIP Processes & Outcomes
Meridian uses the Plan Do Check Act (PDCA) methodology for its quality improvement activities, initiatives and performance improvement projects. Integrated into the PDCA methodology are the following components: identification, performance goals and benchmarks, data sources, data collection, establishment of baseline measurements, analysis and evaluation, trending, intervention development and implementation, remeasurement, additional analysis, evaluation and trending and revision, addition, modification or discontinuation of intervention development and implementation as indicated.

Clinical and operational performance indicators provide a structured, organized framework of standardized metrics to consistently:

- Measure, monitor and re-measure performance and outcomes at prescribed intervals
- Assess and evaluate outcomes against predefined performance goals and benchmarks
- Identify and address potential barriers
- Promote early identification and remediation of potential quality issues to mitigate risk
- Recommend revision, addition, modification or discontinuation of a quality improvement activity or initiative
- Re-measure, reassess and re-evaluate the impact of quality activities and improvement initiatives

Meridian’s QIP focuses on both clinical and operational outcomes such as patient experience, provider satisfaction, utilization management, and complaint and grievance resolutions.

Outcomes of the QIP are tracked, analyzed, and reported to the QIC and Board of Directors annually.

**D. Provider Opportunities in QIP Activities**

Provider involvement is integral to a successful QIP. By ensuring accessibility and delivering high quality care, providers contribute to the goals and objectives of the Meridian QIP. Providers also have the opportunity to contribute administratively by becoming active participants in Meridian Committees. To express interest in joining any of the following committees, or to request more information, please contact Quality Improvement at 515-802-3500.

**Quality Improvement Committee**

The Quality Improvement Committee (QIC) continuously monitors the medical necessity, medical appropriateness, accessibility and availability and use of medical resources. The QIC, which meets quarterly, is chaired by the corporate Chief Medical Officer and is comprised of members including the Medical Director; Chief Operating Officer; Director of Quality Improvement; Director of Utilization Management; and representative member of the Meridian Board of Directors (BOD).

The committee is responsible for the following:

a. Report QIP Status, including recommendations, to the BOD quarterly and annually
b. Review and approval of all Meridian Corporate and Departmental Policies & Procedures
c. Review and adoption of all Meridian Medical Necessity Review Criteria, Medical Policies and Clinical Practice Guidelines
d. Provides direction to and ensures coordination among the QIC subcommittees
e. Review and approve the annual QIP, Work Plan and previous year’s evaluation
f. Identify opportunities for improvement
g. Establish performance goals and benchmarks
h. Review, approve and prioritize all quality improvement activities, programs and initiatives, including satisfaction
i. Ensure all quality improvement activities, programs and initiatives are fully implemented as approved
j. Analyze and evaluate quarterly and annual QIP performance metrics
k. Monitor urgent and routine determination decision timeframes
l. Implement use of approved Medical Necessity Review Criteria, Meridian Medical Policies and Clinical Practice Guidelines to monitor the medical appropriateness of care
m. Identify and report aberrant or substandard care practices, including sentinel events and near misses, to the Physician Advisory Committee and QIC for further investigation and corrective action as necessary
n. Monitor determination decision-making appropriateness and inter-rater reliability testing
o. Monitor approval and denial rates
p. Monitor appeal and overturn rates
q. Analyze and evaluate utilization resource trends
r. Identify barriers and facilitate resolution
s. Identify and remediate instances of over- and under-utilization
t. Evaluation of new technology
u. Monitor satisfaction with all Utilization Management processes including Utilization Review, Case Management, Care Coordination and Disease Management

**Credentialing Committee**

The Credentialing Committee continuously ensures the Meridian provider network is comprised of practitioners and providers that deliver quality health care services in a safe and sanitary environment, and use medical record practices that are consistent with the applicable standards set forth by Meridian in accordance with the NCQA accreditation, the State of Iowa and the Centers for Medicare and Medicaid (CMS) regulatory requirements. The Subcommittee is chaired by the Medical Director, and is comprised of members including a minimum of three community-based physicians.

The Credentialing Committee is responsible for the following:

1. Review and recommend approval, pend or denial of applicants for initial credentialing or recredentialing and inclusion in the Meridian network
2. Perform peer review of practitioner or provider-specific quality of care or service issues and recommend remedial corrective action as necessary
3. Ensure and monitor impact of remedial corrective action recommendations by contracted physicians
4. Review performance indicators of all Meridian contracted providers at least every three years

The Credentialing Committee meets at a minimum on a monthly basis.

**Physician Advisory Committee**

The Physician Advisory Committee (PAC) works to promote quality of health care delivery through compliance with the standards put forth by Meridian in accordance with the NCQA accreditation, the State of Iowa and the Centers for Medicare and Medicaid (CMS) regulatory requirements. The Subcommittee is chaired by a Medical Director and is comprised of members including a minimum of three community-based physicians.

The Physician Advisory Committee:

- Reviews and approves all Medical Necessity Review Criteria
- Makes recommendations for adoption of Medical Necessity Review Criteria to the QIC
- Facilitates development, reviews and approves Meridian Medical Policies and evidence-based Clinical Practice Guidelines and submits to the QIC for approval
- Facilitates implementation and monitors adherence to Meridian Medical Necessity Review Criteria, Medical Policies and Clinical Practice Guidelines
- Educates internal staff and external peers on Meridian Medical Necessity, Medical Policy and Clinical Practice Guideline requirements
- Makes provider appeal determinations
- Reviews and resolves provider complaints and grievances

The Physician Advisory Committee meets at a minimum quarterly.

**Appeals, Complaints and Grievances Committee**

The Appeals, Complaints and Grievances Committee continuously identify opportunities for quality improvement and corrective actions through the review, analysis and evaluation of provider and member appeals, complaints and grievances. The Subcommittee is chaired by the Director of Quality Improvement, and is comprised of members including the Chief Operating Officer, Medical Director, and a minimum of one community-based physician, as appropriate.

The Appeals, Complaints, and Grievances Committee is responsible for the following:

1. Adjudicate first-level provider and member appeals
2. Review provider and member complaints and grievances
3. Analyze and evaluate appeal, complaint and grievance data
4. Propose complaint and grievance resolution
5. Identify areas and make recommendations to the QIC for quality improvement initiatives and/or corrective action

The Appeals, Complaints, and Grievances meet in accordance with the following schedule as applicable:

1. Ad-hoc basis in the absence of appeals, complaints and grievances
2. Within 7 calendar days for a non-urgent member or provider appeal
3. Within 1 calendar day for an expedited member appeal

E. Contractual Arrangements

Non-Delegated

By signing a contractual agreement with Meridian to be part of its provider network, the practitioner, provider, facility or ancillary service agrees to:

- Abide by the policies and procedures of the Meridian QIP
- Participate in Peer Review activity
- Provide credentialing and recredentialing information in accordance with Meridian standards every three years
- Serve on the QIC or other subcommittee, as necessary
- Allow Meridian to collect data and information for quality improvement purposes
- Cooperate with the utilization management, case management and disease management programs as applicable, including, but not limited to:
  - Clinical data submission with the initial corporate prior authorization request
  - Timely response to outreach requests for information or to discuss member’s plans of care
  - Participate in care coordination conferences, as necessary
  - Resolve appeals, complaints and grievances

Delegated

Meridian does not sub-delegate any administrative, clinical, operational or quality improvement functions.

Integrated Care Program

Meridian integrates the functions of utilization management, case management and disease management into its QIP to provide total coordination across the full continuum of care and facilitate timely, ongoing communications with the member’s primary care provider.

The Integrated Care Program begins with the performance of a Health Risk Assessment (HRA) which is performed by a specially trained Member Services Representative, Quality Specialist or Quality Coordinator to:

- Assess the member’s overall health status
- Identify current conditions and impairments, including screening for depression
- Identify the member’s current medications and treatments, including therapeutic and personal assistance services provided by ancillary agencies
- Assess the member’s past medical and family medical histories
- Assess the member’s social history
- Assess the member’s use of assistive devices, i.e., ambulation, alternative communication, etc.
- Assess the member’s living situation and level of independence
- Identify the member’s immediate care and treatment needs

Health Risk Assessment (HRA)
The HRA is a specially designed questionnaire that can be performed telephonically, or in the home as necessary, to assess a member’s degree of stratified risk in the following areas: medical, behavioral health and substance abuse, psychosocial and functional. HRAs are completed within the first 30 days using an electronic questionnaire that links to the member’s profile in the MCS system and interfaces with the all other operational modules including care and case management and quality.

The information collected through the HRA process is documented under the member profile section of the MCS systems. Members identified as having one or more of the following are automatically referred for case management assessment through the assignment of a task and general alert to the case management to-do in-box in the MCS system:

1. One or more chronic conditions or impairments
2. History of chronic pain or are receiving services through a pain management clinic
3. An acute condition currently receiving active care and treatment
4. Self-reported:
   a. Special healthcare needs
   b. Poor overall health status
   c. Poor endurance
   d. Poor nutritional status
   e. Unsteady gait or difficulty with walking or standing
   f. Difficulty performing activities of daily living independently or rely on others to perform on their behalf
   g. Are near the end of life

Members identified as having one or more chronic conditions are automatically referred for disease management assessment through the assignment of a task and general alert to the disease management to-do in-box in the MCS system:

When members are identified for disease management for conditions identified by the State of Iowa, the case manager will reach out to the primary care provider (PCP) and obtain the PCP’s agreement with the Disease Management program for the member prior to the member being contacted.

**Utilization Management**

The function of utilization management is inclusive of the following tasks:

1. Pre-service, concurrent and post-service medical necessity review
2. Discharge planning for members who are not enrolled in the case management program or do not have complex post-discharge needs and/or conditions
3. Supporting transition of care between levels of care, facilities and/or providers

Initial medical necessity review of corporate prior authorization requests requiring approval of the health plan and concurrent review of admissions for medical conditions are performed by Utilization Management Coordinators who are State of Iowa active Licensed Registered or Practical Nurses. Medical necessity determinations for medical conditions are made in accordance with InterQual Guidelines, Meridian Medical Policy or CMS National or Local Coverage Determinations, as appropriate.
Utilization Management Coordinators may make approval determinations in accordance with applicable medical necessity review criteria, Meridian Medical Policy or CMS National or Local Coverage Determinations. Utilization Management Coordinators are not permitted to render medical necessity adverse determinations (denials).

Only Medical Directors who have an active and unrestricted license in the State of Iowa are permitted to render an adverse determination once a medical necessity review of the clinical information is completed. When feasible, the Medical Director will make at least one outreach attempt to discuss the request or case prior to an adverse determination decision being rendered.

Utilization Management Coordinators perform routine discharge planning and coordinate routine transitions between levels of care, facilities and/or providers in collaboration with the member, the facility’s designated contact and the member’s Primary Care Provider.

Utilization management determinations are made and communicated within the following timeframes:

1. **Non-Urgent, Pre-Service Determinations**
   a. Made within 14 calendar days of receipt of the request
   b. Verbally communicated to the requesting provider via telephone on the same day the determination is made
   c. Adverse determinations are communicated in writing within three calendar days of the verbal communication to the provider and member

2. **Urgent, Pre-Service Determinations**
   a. Made within 72 hours of receipt of the request
   b. Verbally communicated to the requesting provider via telephone on the same day the determination is made
   c. Adverse determinations are communicated in writing within three calendar days of the verbal communication to the provider and member

3. **Urgent, Concurrent Determinations**
   a. Made within 24 hours of receipt of the request
   b. Verbally communicated to the requesting provider via telephone on the same day the determination is made
   c. Adverse determinations are communicated in writing within three calendar days of the verbal communication to the provider and member

4. **Urgent, Pre-Service Admission – Out-of-Network Hospital**
   a. Within 1 hour of receipt of the request
   b. Verbally communicated to the requesting provider via telephone on the same day the determination is made
   c. Adverse determinations are communicated in writing within three calendar days of the verbal communication to the provider and member

Providers and members may appeal adverse determinations to Meridian within 180 days of receipt of the written denial notification. Appeals are adjudicated in accordance with the following timelines:

1. **Provider Appeals**
   a. Within 30 days of receipt of the appeal request
b. Verbally communicated to the requesting provider via telephone on the same day the determination is made
c. Provider determinations are communicated in writing within three calendar days of the verbal communication to the provider and member.

2. **Standard Member Appeals**
   a. Within 30 days of receipt of the appeal request
   b. Verbally communicated to the requesting provider via telephone on the same day the determination is made
   c. Member appeal determinations are communicated in writing within three calendar days of the verbal communication to the provider and member

3. **Expedited Member Appeals**
   a. Within 72 hours of receipt of the appeal request
   b. Verbally communicated to the requesting provider via telephone on the same day the determination is made
   c. Member appeal determinations are communicated in writing within three calendar days of the verbal communication to the provider and member

Members, or their representatives, may also file an appeal with the Iowa Department of Health and Human Services.

Meridian considers all appeal determination decisions to be final and abides by the determination decision rendered.

**Case Management**
The function of case management is inclusive of the following functions:

- Coordination of complex medical care
- Self-management teaching and confidence building
- Plan of Care compliance assessment
- Barrier identification and resolution
- Communication coordination among the member, the Primary Care Provider (PCP) and other providers, as applicable
- Follow-up care compliance assessment, including follow-up appointments

Members referred to the case management program are assigned to Case Managers who are State of Iowa actively licensed registered nurses.

The case manager determines whether or not the member is eligible for case management, assigns the member’s risk stratification level and develops a plan of care. The results of the member’s HRA and reassessments determine their risk stratification level:

**Level I**

- Members with uncomplicated, non-debilitating conditions requiring occasional care coordination or episodic management
- Members with one or more chronic conditions who are stable and without emergency room or inpatient utilization for the past six months
- Members with debilitating conditions who are stable, well-managed in their environment of care, without emergency room or inpatient utilization for six months and require HEDIS preventive and maintenance utilization management
**Level II**
- Members with one or more chronic condition(s) and are pregnant
- Members newly diagnosed with asthma, diabetes or cardiovascular disease who require self-management education and training including plan of care adherence monitoring including medications, diet and exercise
- Members with co-morbid medical conditions who are stable and in recovery without emergency room or inpatient utilization and relapse for the past six months
- Members with chronic condition(s) and new on-set of co-morbidities who require additional self-management education and training including plan of care adherence monitoring including medications, diet and exercise

**Level III**
- Members with high risk pregnancies
- Members with one or more chronic illnesses and inpatient utilization in the past six months
- Members with degree of fragility or impairment that affects their ability to function at their optimum health level
- Members with disabling chronic conditions including conditions associated with cognitive impairment
- Members with condition resulting in near of end of life
- Members with conditions requiring high cost treatment
- Members with chronic or debilitation conditions and are at risk for multiple coordination of care issues

**Level IV**
- Members with medically complex conditions and emergency room or inpatient utilization within the past 6 months
- Members with co-morbid medical conditions and emergency room or inpatient utilization and/or relapse within the past six months
- Members with severe mental illness (SMI) who had emergency room or inpatient utilization within the past six months
- Members with co-morbid or medically complex chronic conditions that require coordination of all care and treatment services
- Members with co-morbid, medical complex or chronic conditions that are of advanced or end stage and near end of life
- Members with multiple co-morbidities who are medically frail, have significant degrees of physical or cognitive impairment or unstable and require complete coordination of all care and treatment services
- Members with catastrophic illness or post-trauma and require intensive or complete coordination of all care and treatment services
- Members with chronic complex, co-morbid and lack consistent caregiver services
- Members whose cost of ongoing care is identified as being in the top 1% high cost tier
- Members identified at risk for multiple sources of care

**Assessment**
The case manager assesses the member’s care needs and preferences to ensure the member has access to the right type of care applicable to their condition at the right time from the right provider and for the right reason.

Case management assessments are conducted telephonically to collect additional medical, behavioral health, substance abuse, psychosocial, functional, living situation and life planning information.

**Individualized Plans of Care**

Based on the member’s stratified level of risk and additional assessment results, the results are reviewed, analyzed and transformed into individualized, integrated plans of care in accordance with nationally recognized, evidence-based case management guidelines.

The case manager develops the plan of care in collaboration with the member, the member’s primary care physician and other providers, as applicable, to identify problems, set goals and select the interventions to be used. The plan of care includes milestones, short-term and long-term goals. The goals are prioritized in accordance to the member’s medical needs, stability, preferences and readiness to participate in the selected intervention.

Interventions are tailored to meet individual member needs and set the member up for success in attaining the ultimate goal of the case management program which is to empower the member to assume responsibility for taking care of his or her health in partnership with his or her primary care physician.

Interventions include, but are not limited to:

A. Member, or family/caregiver, self-management education and coaching  
B. Coordination of care and treatment services  
C. Psychosocial support  
D. Referral to Magellan for behavioral health support  
E. Referral to ancillary or community-based agencies as appropriate

**Communication**

The initial plan of care is communicated orally via telephone or in writing via USPS mail or facsimile, according to the preferences of the member, the primary care physician and other providers, as applicable. Once agreement on the plan of care’s goals and interventions is mutually agreed upon by all parties, the plan is implemented.

Status updates, plan of care revision and reassessment information is communicated in accordance with the frequency required by the member’s condition and in a format requested by the member, the primary care physician and other providers, as appropriate.

**Monitoring and Evaluation**

The case manager closely monitors the member’s responses to interventions, progress toward achieving milestones and goals and barrier resolution as appropriate to the level stratified risk. The case manager documents the plan of care and its outcomes in the MCS system in the member’s profile under the case management module.
Members are reassessed:
  A. Semi-annually
  B. Whenever there is a marked change in condition
  C. Onset of a new co-morbidity or complication
  D. Upon emergency room or inpatient utilization

The plan of care is updated in response to the results of the reassessments. Revisions to the plan of care are developed in collaboration among and implemented upon mutual agreement from the member, the member’s primary care physician and other providers, as appropriate. The revised plan of care is then communicated orally by telephone or in writing via USPS mail or facsimile in accordance with member, primary care physician and provider preference.

Outcomes Measurement
HEDIS measures are utilized on an annual basis to assess clinical outcomes including:
  a. Annual monitoring of patients on persistent medications
  b. Condition specific HEDIS measures
  c. Children, adolescents and adults access to preventive care
  d. Annually influenza vaccination
  e. Pneumonia vaccination

Utilization data from claims are measured, analyzed and evaluated quarterly by the Quality & Utilization Management department. Data review includes inpatient admission and readmission, planned or unplanned transitions in care and emergency department use.

Member satisfaction with choice and quality of care received and member reassessment of self-reported improvements in status are measured, analyzed and evaluated annually using mailed and telephonic survey tools by the Quality & Utilization Management department.

Outcomes are reported, reviewed, analyzed and evaluated by the QIC quarterly and annually. The QIC makes recommendations for improvement to the case management program based upon these outcome reports.

Managed Care System (MCS) Description
All data collection, storage, retrieval, analysis, aggregation and report generation specific to the following functions is performed using Meridian’s internally developed, proprietary MCS electronic documentation system:
  - Quality, including HEDIS
  - Utilization Management
  - Disease Management
  - Member Services
  - Provider Services
  - Contracting
  - Operations

Data Collection
The member’s profile in MCS is used for:

1. Member data collection including enrollment
2. Member clinical data collection including:
   a. Initial and reassessment health risk assessments
   b. Behavioral health and substance abuse screening;
   c. Case management assessments
   d. HEDIS data
   e. Immunizations
   f. Laboratory results
3. Utilization management
   a. Corporate prior authorizations
   b. Concurrent reviews
   c. Discharge planning
   d. Transitions between levels of care, facilities and providers
   e. Appeals
   f. Complaints and grievances
4. Disease management, including initial and reassessment risk level stratification
5. Disease management including initial and reassessment risk level stratification
6. Quality including member surveys and post-ER visit follow-up assessments
7. Member Services inquiries
8. Provider Services credentialing/recredentialing and primary care physician history
9. Claims
10. Management of health plan and program specific mailed communications such as newsletters and educational materials

Data Validation
To ensure the data collected is accurate and complete, Meridian employs a variety of data control processes paired with appropriate MCS functions such as:

A. All claim transactions data/files are validated prior to being loaded into MCS
B. Standardized automated process rules and logic
C. Internal MCS system controls prevent member HRAs from being flagged as complete until all of the applicable questions are answered
D. Internal data quality audits are performed by the IS and Quality & Utilization Management department
E. Outgoing reports and member materials are reviewed and audited prior to distribution by the IS and appropriate responsible departments to ensure data accuracy and quality

Data Analysis & Reporting
Meridian maintains a wide range of reports for each of the above-mentioned functions. Reports are available on a scheduled and ad-hoc basis as needed. User access to data and reports is restricted to the minimum necessary required to perform one’s job role in accordance with the company’s HIPAA Privacy and Security policies and procedures.
The data is analyzed by the department requesting the specific report type. The data is reviewed to ensure accuracy and completeness through a series of standardized validation procedures and processes. Any discrepancies identified brought to the attention of and immediately rectified by the IS and Finance departments.
The reports are analyzed and evaluated against one or more of the following:

a. Meridian performance standards
b. National, state, regional and/or local benchmarks
c. Internal organizational, departmental or program goals

Evaluation outcomes are trended. Variations are analyzed and addressed. Reports generated, analyzed and evaluated by the Quality & Utilization Management department are reported to:

a. Senior leadership weekly
b. QIC quarterly and annually
c. BOD quarterly and annually

System Corrective Action/Modification

Modifications to the System and/or corrective action fixes are handled through a written help requests or work order justification submissions. All requests for system fixes or modifications are reviewed by the Director, IS and the Chief Security Officer to ensure such requests:

a. Are necessary
b. Meet the required need
c. Are in accordance with corporate objectives, policies and procedures
d. Are compliant with applicable HIPAA Privacy and Security Rules including data confidentiality, integrity and availability

F. Confidentiality & Conflict of Interest

Confidentiality

Meridian uses the following mechanisms to effectively govern confidentiality, integrity and availability of protected health information in written and electronic form:

a. Corporate policy prohibiting any employee from voluntarily disclosing any peer review information except to persons authorized to receive such information to conduct QIP activities
b. Meridian HIPAA Privacy and Security policies and procedures developed and implemented by the Chief HIPAA Privacy Officer and Chief HIPAA Security Officer and adherence monitored by the HIPAA Privacy and Security Committee through quarterly meeting and reports
c. Corporate policy prohibiting any employee from voluntarily disclosing any member identifiable health information (IIHI) or protected health information (PHI) except to persons authorized to perform payment, treatment or operations on behalf of Meridian, required by law exempted under the HIPAA Privacy Rules or by written member consent explicitly authorizing such disclosure
d. Corporate policy mandating the minimum necessary amount of member and provider information is used only to perform the payment, treatment and operations functions and meet the legal obligations of the Health Plan
e. Corporate policy restricting access to member and provider information to the minimum necessary to perform one’s job and controlled through the use of individual user identification and passwords
Each employee is required to sign a confidentiality statement and participate in HIPAA Privacy and Security training annually.

Each external committee participant must agree in writing to abide by these confidentiality policies and sign a Committee Member Confidentiality Statement.

Conflict of Interest

All Meridian employees who are directors or above and community-based physician advisors are required to sign conflict of interest statements annually.

Meridian corporate policy prohibits any Meridian employee or community-based physician advisor from performing utilization review or making medical necessity determinations on any member for which they are providing care for or from which he or she may directly or indirectly financially, or in kind, benefit personally or professionally other than standard remuneration from the company.

Meridian does not bonus, reward or financially incentivize any Medical Director or Physician Advisor based upon the number of adverse initial and appeal determinations made.

G. Member Safety

Meridian encourages and supports practitioners in creating a safe practice environment. Meridian demonstrates this support through:

1. The development and implementation of clinical practice guidelines based on national standards
2. Provider and member newsletters that convey new, revised, and/or updated initiatives and provide safety related information
3. The development and delivery of effective and on-going fraud and abuse education and training for employees, members and providers through various methods (i.e. member and provider websites, newsletters, member handbook, provider manual, MPH Network Development Specialist visits with providers and on-site training for all employees)
4. The inclusion of provider office safety evaluations in the annual site visits for Quality
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Section 7: Provider Functions and Responsibilities

A. Primary Care/Managed Care Program

Meridian utilizes a 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 Meridian standards.

Meridian providers are responsible for knowing and complying with all Meridian network policies and procedures. Implementation of Meridian policies will facilitate the Plan’s periodic reporting of MCO data to the Iowa Department of Human Services, the State and the Federal agencies.

B. PCP Prior Authorization and Referral Procedures

PCPs are responsible for initiating all necessary medical referrals for their assigned members. Details on the procedures for prior authorizations are located in Section 4 of this manual.

C. Corporate Reporting Requirements

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.

D. Encounter Reporting Requirements

In order to assess the quality of care, determine utilization patterns and access to care for various health care 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 UB04 will be used initially. PCPs will submit their encounter data monthly to Meridian, who must then submit it to the IDHS via an electronic format. Both 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.

E. Physician Intent to Discharge Member from Care

PCPs must give reasonable notice to a member of his/her intent to discharge the member from his/her care. Meridian considers reasonable notice to be at least a 30-day prior written notice. This notice must be given by certified mail. Meridian must also be notified of this process concurrently in writing. Failure to give reasonable notice may result in allegations of patient abandonment against the treating physician. PCP must provide 30 days of emergent care and referrals.

F. Medical Care Access Standards

Meridian recognizes that providing medical care is not always a predictable experience. Emergencies and episodic increases in the demand for services will challenge the ability of an office to meet the expectations for medical care access. However, in the normal course of
providing medical care, Meridian has established appointment standards for all primary care providers, OB/GYNs and high-volume Specialists.

These standards outline the maximum allowable waiting time for the following types of appointments:

<table>
<thead>
<tr>
<th>Appointment Types</th>
<th>Population</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive/Routine Care</td>
<td>Adult</td>
<td>30 Days</td>
</tr>
<tr>
<td></td>
<td>Child &lt; 18 months old</td>
<td>2 Weeks</td>
</tr>
<tr>
<td></td>
<td>Child &gt; 18 months</td>
<td>4 Weeks</td>
</tr>
<tr>
<td>Urgent, not serious</td>
<td>Child or Adult</td>
<td>2 Days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Child or Adult</td>
<td>24 Hours</td>
</tr>
<tr>
<td>Emergency</td>
<td>Child or Adult</td>
<td>Immediate</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>First Trimester</td>
<td>7 days</td>
</tr>
<tr>
<td></td>
<td>Second Trimester</td>
<td>7 days</td>
</tr>
<tr>
<td></td>
<td>Third Trimester</td>
<td>3 days</td>
</tr>
<tr>
<td></td>
<td>High Risk Pregnancy</td>
<td>3 days</td>
</tr>
<tr>
<td></td>
<td>Emergency</td>
<td>Immediate</td>
</tr>
<tr>
<td>Specialty Referrals</td>
<td>Type Of Referral</td>
<td>Standard</td>
</tr>
<tr>
<td></td>
<td>Urgent, Serious</td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td></td>
<td>Urgent, but not routine</td>
<td>Within 3 days of referral</td>
</tr>
<tr>
<td></td>
<td>Routine Care</td>
<td>Within 30 days of referral</td>
</tr>
</tbody>
</table>

The average length of time for Primary Care appointments shall not exceed one (1) hour from scheduled appointment time.

After Hours Access Standards

Meridian has established acceptable mechanisms for use by PCPs and OB/GYNs, to ensure telephone access and service for members 24 hours a day.

All PCP and Specialist contracts require physicians to provide members with access to care 24 hours a day, seven days a week.

Acceptable after-hours access mechanisms include:

- Answering service
- On-call beeper
- Call forwarded to physician’s home or other location
- Recorded telephone message with instructions for urgent or non-life threatening conditions. Message must direct members to a practitioner

There must be a method to talk to a physician 24 hours a day, seven days a week regarding after-hours care for urgent or non-life threatening condition as well as instructions to call 911 or go to the emergency room in the event of a life-threatening condition or serious trauma.

The message should not instruct members to obtain treatment at the emergency room for non-life threatening emergencies.
G. 24-Hour PCP Member Responsibility/Accountability

Through the Meridian practitioner agreements, Meridian PCPs have a 24 hours a day, seven days a week responsibility and accountability to their Meridian member/patients.

Guidelines:

1. PCPs must be available to address member/patient medical needs on a 24-hours a day, seven days a week basis. The PCP may delegate this responsibility to another Meridian physician or provider on a contractual basis for AFTER-HOURS, HOLIDAY and VACATION COVERAGE.
2. If the PCP site utilizes a different contact phone number for an on-call or after-hours service, the PCP site must provide Meridian with the coverage information and the contact phone or beeper number. Please notify the Provider Services department with any changes in PCP medical care coverage.
3. PCPs may employ other licensed physicians who meet the credentialing requirements of Meridian for patient coverage as required and necessary. It is the responsibility of the PCP to notify Meridian each time a new physician is added to a PCPs practice to assure that all physician providers are credentialed to Meridian standards. PCPs may employ licensed/certified Physician Assistant (PA) or Registered Nurse Practitioners (RNP) to assist in the care and management of their patient practice. If PAs or RNPs are utilized, the PCP or the designated and credentialed physician must be readily available for consultation via telephone or beeper, within a 15-minute call back time. They must also be able to reach the site where the PA or RNP is within 30 minutes.
4. Non-professional health care staff shall perform their functions under the direction of the licensed PCP, credentialed physician, or other appropriate health care professionals such as a licensed Physician’s Assistant (PA) or a Registered Nurse Practitioner (RNP).

REMEMBER: Failure to provide 24-hour medical coverage and/or make the appropriate arrangements for member/patient medical coverage constitutes a BREACH OF THE Meridian Practitioner Agreement, placing the Provider at risk of due consequences.

H. Office Waiting Time

In order to assure that members have timely access to patient care and services, Meridian providers are expected to monitor waiting room times on a continual basis. PCP offices will be surveyed periodically regarding this process. Member waiting room times should be less than 30 minutes. If a longer wait is anticipated, office staff members should explain the reason for the delay and offer to book the patient for another appointment.

I. Site Visits

Meridian may conduct provider site visits for any of the following reasons:

- When a member complaint/grievance is received about the quality of a practitioner’s office (physical accessibility, physical appearance or the adequacy of waiting or examining room) within 6 months
- Member satisfaction results indicate an office site may not meet Meridian standards
- Other data is required for QI purposes and cannot be reasonably collected using other methods
- Other circumstances as deemed necessary
A Meridian personnel or a designated representative with the appropriate training will perform the site visit once the determination is made that a site visit is warranted.

**J. Fraud, Waste and Abuse**

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

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

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

**Waste** involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by players with control over or access to government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

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

Here are some examples of Fraud, Waste and Abuse:

**Fraud and Waste**

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

**Abuse**

- Going to the Emergency Room for non-emergent medical services
- Threatening or abusive behavior in a doctor’s office, hospital or pharmacy

Meridian encourages members, providers and employees to report all cases of fraud, and abuse. If you know of any Medicaid members or providers, including doctors, hospitals and pharmacies, who have committed actions of fraud or abuse, you can report them using the process described below. You may report them anonymously if you choose.
To Report Potential Fraud, Waste and Abuse:

Contact Meridian’s Compliance Officer at Meridian’s fraud, waste and abuse hotline: **877-204-9086**. You can explain details of the possible fraud or abuse; Meridian will investigate and file a report with the appropriate government authorities, if necessary.

Meridian members, providers or employees can also report potential instances of fraud, waste and abuse directly to the State of Iowa:

**Medicaid Fraud Control Unit of Iowa**  
Department of Inspections and Appeals  
3rd Floor, Lucas State Office Building  
Des Moines, IA 50319  
Phone: 515-281-0506  
Fax: 515-725-1245

You can report anonymously if you choose.

**The False Claims Act**

The False Claims Act is aimed at establishing a law enforcement partnership between federal law enforcement officials and private citizens who learn of fraud against the Government. Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for up to three times the government’s damages plus civil monetary penalties. The False Claims Act explicitly excludes tax fraud.

The Act permits a person with knowledge of fraud against the United States Government to file a lawsuit on behalf of the Government against the person or business that committed the fraud. The lawsuit is known as a "qui tam" case, but it is more commonly referred to as a "whistleblower" case. If the lawsuit is successful, the qui tam plaintiff is rewarded with a percentage of the recovery, typically between 15 and 25%. Any person who files a qui tam lawsuit in good faith is protected by law from any threats, harassment, abuse, intimidation or coercion by his or her employer.

For more information on the False Claims Act, please contact the Meridian Compliance Officer at 877-204-8997.

**K. Non-Discrimination**

Providers shall not unlawfully discriminate in the acceptance or treatment of a Member because of the Member’s religion, race, color, national origin, age, sex, income level, health status, marital status, disability or such other categories of unlawful discrimination as are or may be defined by federal or state law

**L. Provider Credentialing/Re-Credentialing**

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

Practitioners have the following rights during the credentialing process: All information received during the credentialing process that is not peer protected can be forwarded to the applicant upon written request to the credentialing department. If there are any substantial discrepancies noted
during the credentialing process the applicant will be notified in writing or verbally by the credentialing department within 30 days and will have 30 days to respond in writing to the Credentialing Coordinator regarding the discrepancies and correct any erroneous information. Meridian is not required to reveal the source of the information if the information is not obtained to meet the credentialing verification requirements or if disclosure is prohibited by law. Upon written request to the credentialing department, any practitioner has the right to be informed in writing or verbally of their credentialing status.

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

Meridian 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 Network.

1. When an Initial Applicant receives a non-approval notice, the affected practitioner has 30 calendar days from receipt of the notice to file a written request for a hearing. The request must be in writing and delivered in person or by Special Notice to the Meridian Quality Medical Director:

   Meridian Health Plan
   Credentialing Department
   777 Woodward Ave., Ste.600
   Detroit, MI 48226

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

2. Level One Hearing:

   - Level One Hearings are conducted at the Meridian corporate headquarters
   - The Meridian Credentialing department or designee will notify the affected applicant of the date, time and place of the hearing by Special Notice at least 7 calendar days prior to the hearing date
   - The hearing date will not be more than 45 calendar days from receipt of request for the hearing
   - The Hearing Committee shall consist of at least two physician members of the Credentialing Committee who are not in direct economic competition with the practitioner applicant and one additional member appointed by the Quality Medical Director. This member will be one of the following:
     - Meridian Medical Director
     - Meridian Associate Medical Director
     - Meridian Director of Utilization Management
Meridian Director of Quality Improvement
A Meridian participating practitioner who is not in direct economic competition with the physician applicant and of similar scope of practice
A member of the Board of Directors of Meridian

- If the practitioner applicant scope of practice is not within the two appointed practitioner members’ scope of practice, it is required to include a Meridian participating practitioner with a similar scope of practice
- Previous participation in the credentialing decision does not disqualify a practitioner from serving on the Hearing Committee
- All members of the Hearing Committee are required to consider and decide the case with good faith objectivity
- The Affected Practitioner has the right to be represented by a person of his or her own choice, which may be an attorney, at the Hearing Committee
- The presiding officer for the hearing is appointed by the Meridian Quality Medical Director and determines the order of proceedings
- During the hearing, both the affected practitioner and the person appointed to represent the Meridian position have an opportunity to have their positions fairly heard and considered
- Both Meridian and the affected practitioner may submit to the hearing for consideration:
  - Written statements, letters and documents relevant to the subject matter of the hearing, including relevant portions of the credentialing file
  - Oral statements
- Only the presiding officer may, at his/her discretion, authorize the appearance of witnesses
- The affected practitioner has the burden of proof and must demonstrate that the non-approval is:
  - Inconsistent with Meridian policies and procedures
  - Based on inaccurate or insufficient information through no fault of the affected practitioner
  - Not in the best interests of Meridian and/or its members
- A recording secretary selected by Meridian takes minutes of the hearing. The affected practitioner may request a copy of the minutes at his/her own cost
- The decision of the Hearing Committee will be issued within 30 calendar days of completion of the hearing and the Affected Practitioner will be notified by Special Notice
- The notice to the Affected Practitioner informs him/her of the right to appeal a non-approval decision to the Meridian Quality Medical Director
- The Affected Practitioner may request a Level Two appeal within 30 calendar days of receipt of the notification
- Failure to request a Level Two appeal within 30 calendar days constitutes waiver of final appeal rights

3. Level Two:

Upon receipt of a written request from the Affected Practitioner, the Meridian Quality Medical Director determines if the hearing was conducted fairly and if the record reasonably supported the final recommendation. The Meridian Quality Medical Director reviews the decision of the Hearing Committee, the hearing record and any written statements or other documentation relevant to the matter.

4. Final Decision:

The decision of the Meridian Quality Medical Director is immediately effective and final and is not subject to further hearing or review. The Affected Applicant will be notified of the final decision by Special Notice within 30 calendar days of receipt of the request for a Level Two appeal.
5. Denied applications are maintained in a confidential manner in 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 under federal or state regulation.

M. Contractual Arrangements

- By signing a contractual agreement with Meridian to be part of its provider network, the practitioner, provider, facility or ancillary service agrees to:
  
  - Abide by the policies and procedures of the Meridian QIP
  - Participate in Peer Review activity
  - Provide credentialing and recredentialing information in accordance with Meridian standards every three years
  - Serve on the QIC or other subcommittee, as necessary
  - Allow Meridian to collect data and information for quality improvement purposes
  - Cooperate with the utilization management, case management and disease management programs as applicable, including, but not limited to:
    A. Clinical data submission with the initial corporate prior authorization request
    B. Timely response to outreach requests for information or to discuss member’s plans of care
    C. Participate in care coordination conferences, as necessary
    D. Resolve appeals, complaints and grievances

Meridian encourages practitioners to freely communicate with patients regarding treatment regimens including medication treatment options, regardless of benefit coverage limitations.

N. Facility Site Reviews

As part of Meridian’s annual monitoring audits, provider office facilities will be evaluated against Meridian’s site review and medical record keeping requirements.

Guidelines for Facility Site Reviews

Access to Service

- Is the next Adult Preventive Care appointment available within 30-45 days?
- Is the next Child (< 18 months old) Preventive Care appointment available within 2 weeks?
- Is the next Child (> 18 months old) Preventive Care appointment available within 4 weeks?
- Is the next non-urgent sick visit available within two weeks?
- Is the next urgent care appointment available within 24 hours?
- Is each PCP available 20 hours per week?
- Is the physician available 24 hours/7 days a week?
- Does the practitioner have mechanisms in place to meet Meridian after hour’s access standards?

Provisions for Persons with Disabilities

- Are there designated handicap parking spaces close to building entrance?
- Is the building entrance accessible by wheelchair, walker, etc.?
• Are office hallways, doorways, and bathrooms accessible to wheelchairs, walkers, etc. (all hallways should have a minimum of 42 inches clearance)?
• Are doors able to be operated by persons with physical limitations?
• Are there accommodations for sight or hearing impaired patients?

General Office Appearance

• Are NO SMOKING signs & Patient’s Rights posted?
• Is business conducted at the registration desk in a confidential manner (discussion, sign-in sheet, etc.)?
• Staff is aware of the confidentiality policy of office?
• Are restroom facilities available for waiting patients?
• Are hours of operation posted?
• Are all public and patient care areas clean, orderly and ample enough to accommodate patients?
• Teaching literature is available for the patient?

Staff Competency

• 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 Bloodborne 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
• Bloodborne Pathogen Exposure Control Plan
• Manifests from Material Waste Processing Company
• Documented QI 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 (including all medical information relating to individual Members)
• Conflict Resolution
• Staff Competency & Orientation
• Medication storage and administration (including 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 manner (shelf, refrigerator)
• No oral and injectable medications stored together
• Documentation of regular review of all medications 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

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 Bloodborne 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)
- 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 Disinfectants

- 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

Meridian requires providers to maintain complete and legible clinical records documenting that services are medically necessary, consistent with the member’s diagnosis and consistent with professionally recognized standards of care. Patient information must be kept confidential.

The documentation for each member encounter must include the following when appropriate:

- Identity of the member and personal data including age, sex, address, employer, home and work telephone numbers and marital status
- Date
- Identity of the provider
- Complaint and symptoms
- Medical history including any prior hospitalizations, any known allergies, immunization record of members age 12 and under, use of tobacco, alcohol or substance abuse for members age 12 and over
- Advance directives such as a living will or a durable power of attorney for health care decisions for members age 21 and over
- Examination findings
- Diagnostic test results with explicit notation of abnormal results
- Assessment
- Diagnosis
- Plan for care including consultations and referrals to Specialists and reports thereof (e.g., Home health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports)
- Procedure or treatment performed including emergency care
- Medications or other supplies
- Member progress, response to treatment and any revision of diagnosis
- Hospital discharge summary
Medical record documentation compliance review is performed annually as part of the continuous quality improvement activities of Meridian including the following:
  - During HEDIS® medical record reviews
  - During practitioner site visit reviews
  - As part of quality reviews

A score of 80% or better on the medical record review audit is required to pass this standard. Scores of less than 80% require corrective action plans. If the office is unable to implement the CAP within 90 days, a follow-up site visit and medical record review is completed 6 months after the initial review.

Aggregate results of medical record reviews are reported to the QIC for review and additional actions. Results of the reviews are also reported to the Credentialing Committee for inclusion in the provider file.

**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 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 Iowa, 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 Iowa and the Federal DEA
  - CLIA certificate or waiver
  - Medical Waste Management certificate
  - X-ray equipment registration
  - R-H 100 notice
  - Radiology protection rules
  - OSHA poster
Section 8: Clinical Practice Guidelines

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Section 8: Clinical Practice Guidelines

A. Clinical Practice Guidelines

Meridian has adopted clinical practice guidelines (CPG) from regional and national external sources. These clinical practice guidelines are reviewed and approved on an annual basis by Meridian’s Peer Review and Quality Improvement Committees and can be viewed at the Meridian website www.mhplan.com.

- Acute Pharyngitis in Children
- ADHD
- Adult Preventive Services Ages 18-49
- Adult Preventive Services Ages 50-65+
- Adults with Systolic Heart Failure
- Advance Care Planning
- Asthma, Diagnosis and Management
- Asthma, Management in Children 0-4 years
- Asthma, Management in Children 5-11 years
- Asthma, Management in Ages 12 and older
- COPD
- Diabetes Mellitus
- Diagnosis and Management of Adults with Chronic Kidney Disease
- Diagnosis and Management of Adults with Depression
- Hypercholesterolemia
- Hypertension, Medical Management of Adults
- Management of Acute Low Back Pain
- Management of Uncomplicated Acute Bronchitis in Adults
- Management of Adults with Osteoarthritis
- Management of Overweight and Obesity in Adults
- Office-based Surgery Guidelines
- Outpatient Management of Uncomplicated DVTs
- Prevention and Identification of Childhood Overweight and Obesity
- Prevention of Pregnancy in Adolescents Ages 12-17 years
- Prevention of Unintended Pregnancy in Adults 18 years and older
- Routine Prenatal and Postpartum Care
- Routine Preventive Services for Infants and Children (Birth - 24 Months)
- Routine Preventive Services for Children and Adolescents (Ages 2-21)
- Treatment of Childhood Overweight and Obesity
- Tobacco Control
- Screening, Diagnosis and Referral for Substance Use Disorders