YouthCare
HealthChoice Illinois

Provider Manual

April 2024

We thank you for being part of YouthCare's network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare.

YouthCare works to accomplish this goal by partnering with the providers who oversee the healthcare of our members.

Table of Contents

YouthCare
HealthChoice Illinois

About Us

YouthCare is a specialized healthcare program of the Illinois Department of Healthcare and Family Services for current and former youth in care aged birth through 21. YouthCare provides medical, behavioral health, dental, vision, and pharmacy coverage, and is part of the Meridian family of brands. Meridian provides government-sponsored managed healthcare services to families, children, seniors, and individuals with complex medical needs.

Mission

YouthCare focuses on improving members' health status, encouraging successful outcomes, and striving for member and provider satisfaction in a coordinated care environment. YouthCare was designed to achieve the following goals:

- Ensure access to primary and preventive care services.
- Ensure care is delivered in the best setting to achieve an optimal outcome.
- Improve access to all necessary healthcare services.
- Encourage quality, continuity, and appropriateness of medical care.
- Provide medical coverage in a cost-effective manner.

How to Use This Manual

YouthCare is committed to working with our network of providers to deliver high quality health care services at the highest levels of member satisfaction. The Provider Manual contains a comprehensive overview of YouthCare operations, benefits, policies, and procedures.

Please note that some operational and regulatory processes (e.g., claims administration, fraud, waste and abuse) are administered by Meridian, our Medicaid plan. In these instances the Manual will reference Meridian and not YouthCare.

Please contact the Provider Services department at **844-289-2264** if you need further explanation on any topics covered in the Provider Manual.

Key Contacts

YouthCare
HealthChoice Illinois

The following chart contains contact information for YouthCare. When contacting any department, please have the following information on hand:

- National Provider Identifier (NPI);
- Tax ID Number (TIN); and
- If calling about a member-related issue, please know the member's ID Number.

Member and Provider Services	844-289-2264 (TTY: 711)
Website	ILYouthCare.com
Nurse Advice Line	844-289-2264
Transportation	844-289-2264
Rapid Response Team Contact for urgent operational matters such as access to care, member eligibility, provider contracting needs or pharmacy and payment issues.	844-289-2264, press * (TTY: 711)

YouthCare's hours of operation are Monday – Friday 8 a.m. to 6 p.m.

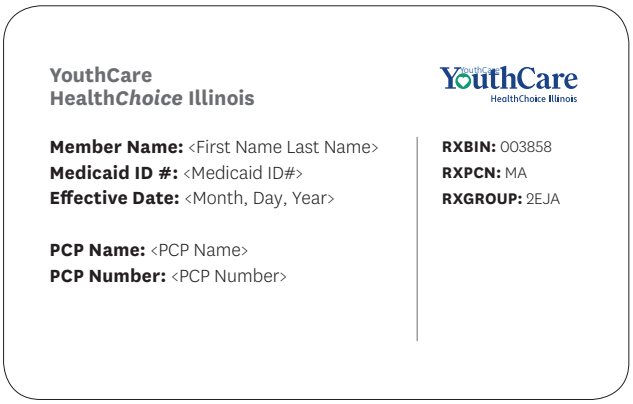
Member ID Card

All YouthCare members receive an ID card (see sample below). Members should present their ID card at the time of service, but an ID card in and of itself is not a guarantee of eligibility; therefore, **providers must verify a member's eligibility on each date of service**.

The member ID number, effective date, contact information for YouthCare, and PCP information are included on the ID card. If you are not familiar with the member seeking care, please ask to see photo identification for confirmation. **If you suspect fraud, please contact Provider Services immediately.**

YouthCare Health*Choice* Illinois ID card:

Front



Back

Verifying Eligibility

Use one of the following methods to verify a member's eligibility:

1 **Log on to the secure provider portal at Provider.ILYouthCare.com.**	Providers can search by date of service, plus member name and date of birth, or member ID number. You can submit multiple member ID numbers in a single request.
2 **Call our automated member eligibility Interactive Voice Response (IVR) system.**	Call Provider Services from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the member ID number, the member date of birth, and the month of service to check eligibility.
3 **Call Provider Services.**	If you cannot confirm a member's eligibility using the first two methods, call Provider Services. Follow the menu prompts to speak to a representative to verify eligibility before rendering services. Provider Services will need the member name, member ID number, and date of birth to verify eligibility.

Member Benefits and Limitations

YouthCare HealthChoice Illinois

YouthCare offers a comprehensive set of medical benefits and services. All services must be medically necessary and some services require prior authorization. See page 34 for information regarding the prior authorization process.

Please note we will NOT authorize services for out of network or non-participating providers, unless the services are necessary for continuity of care reasons. We may also authorize services for out of network providers at our discretion if the services are not available through our in-network providers.

For specific benefit information not covered in this Manual, please contact Provider Services. Providers can also reference ILYouthCare.com for the most recent benefit updates.

Covered Services

Note: Some services require prior authorization. Always check if services need prior authorization before completing. See page 34 for information regarding the prior authorization process.

- Abortion services
- Advanced Practice Nurse services
- Ambulatory Surgical Treatment Center services
- Assisted living
- Audiology services
- Behavioral health outpatient services
- Community case services
- Crisis services
- Inpatient psychiatric services
- Intensive outpatient services
- Partial hospitalization services
- Residential rehabilitation services
- Chiropractic services
- Clinic services
- Dental services
- Durable medical equipment
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to members under the age of 21
- Family Planning services and supplies
- Home Health Agency visits

- Hospital ambulatory (outpatient) services
- Hospital inpatient services
- Hospital emergency department services
- Imaging services
- Laboratory services
- Medical supplies, equipment, prostheses, and orthoses
- Pharmacy services
- Physician services
- Podiatric services
- Renal dialysis services
- Sub-acute alcohol and substance abuse services
- Transportation to secure covered medical services
  - Members can schedule transportation to and from a medical visit. Call Member Services 3 calendar days in advance and ask for a transportation specialist, and they will arrange appropriate transportation.

General Preventive Care Services

- Eye exams. We cover an eye exam once a year (more if member's eyesight changes a lot). We cover refractions to determine a prescription for glasses.
- Health education programs including: diabetes education, heart health education, nutritional education, etc.
- Child and youth immunizations.
  - Immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), and the United States Preventive Services Task Force recommendations.
- Periodic check-ups. A complete history and physical exam every one to three years.
- Cancer screening for cervical, breast, and skin.

Pregnancy and Maternity Services

- Outpatient services including routine prenatal care before and after delivery for problems or complications resulting from pregnancy or childbirth.
- Inpatient hospital services in participating hospitals and out-of-network emergency labor and delivery services.
- Comprehensive perinatal care, including a prenatal visit consisting of a medical/obstetrical, nutritional, psychosocial, and health education assessment, appointments during each trimester, and a postpartum appointment.
- The newborn child's healthcare for the month of delivery and the month after delivery. By that time, the newborn should be enrolled separately.

Voluntary Contraception Services

YouthCare covers the cost of contraceptives, including the birth control device, and fitting or inserting the device (such as diaphragms, IUDs, Norplant). Members can get services from any qualified family planning provider. He/she does not have to be a participating provider.

Our members do not need a referral from a PCP and do not require permission from YouthCare to get these services.

Well-Child Care

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is Medicaid's federally mandated comprehensive and preventive health program for individuals younger than 21 years old, which focuses on early prevention and treatment. Requirements include periodic screening, vision, dental and hearing services.

Additional Benefits

No Copays	No copays for medical visits or prescriptions.
Prescriptions	Option for 90-day supply mailed to member's home.
Dental Services	Services provided in school dental programs or dental offices.
Practice Visits	"Practice visits" are used for youth so they can learn about dental services.
My Health Pays™	Rewards program that provides prepaid debit card with funds added when members utilize certain screenings and preventive care.
SafeLink	Cell phones provided to eligible members who don't have access to a phone to call providers, 911, or care coordinators.
Vision Services	• $100 credit for eyeglass frames or an $80 credit for contact lenses. • Replacement Glasses: Eyeglasses may be replaced as needed, without pre-authorization
Nurse Advice Line	Members can call a nurse for advice 24 hours a day, 7 days a week.

Non-Covered Services

YouthCare does not cover:

- Services that are experimental or investigational in nature
- Services that are provided by an out-of-network provider and not authorized by YouthCare
- Services that are provided without a required referral or required prior authorization
- Elective cosmetic surgery
- Infertility care
- Any service that is not medically necessary
- Services provided through local education agencies

Our Approach

YouthCare
HealthChoice Illinois

YouthCare strives to work with the provider community to ensure members' individual needs are met leveraging our care coordination approach. This approach includes:

- Focus on early identification before condition worsens
- Facilitate communication and coordination of services across medical and behavioral health specialties
- Identify and engage high-risk consumers
- Identify barriers to adherence with current treatment plans and goals
- Coordinate with consumer, their support system, and physicians to customize a plan of care
- Holistic model: Care coordination can link to local community resources such as shelter/housing, clothing, utilities assistance, and domestic violence agencies

To reach the Medical Director or Vice President of Medical Management for additional information on our approach, please contact:

Clinical Management
YouthCare Health*Choice* Illinois: **844-289-2264**

Model of Care

Model of Care defines the management, procedures and operational systems that provide access, coordination and structure needed to provide services and care to YouthCare members.

YouthCare's Model of Care includes the following elements:

- Measurable goals
- Staff structure and care management roles
- Interdisciplinary care team
- Provider network having special expertise and use of clinical practice guidelines
- Model of care training
- Health risk assessment
- Individualized Care Plan
- Communication network
- Care Management
- Performance and health outcome measurements

YouthCare ensures all of our members have:

- Access to essential available services such as medical, behavioral and social services
- Access to affordable care
- Care coordination through an identified point of contact
- Seamless transitions of care
- Improved access to preventive health services
- Appropriate utilization of healthcare services
- Overall improved health outcomes

Health Risk Screening

Completed by all new members within 60 days of enrollment to identify those with unmet or ongoing needs. The HRS allows us to assess:

- Functional abilities
- Social drivers of health
- Physical and behavioral health conditions
- Social, environmental, and cultural issues
- Exposure to trauma
- Developmental delays
- Medications
- Review HEDIS care gaps
- Other needs that form the basis of our care plans

For high risk members, a more comprehensive Health Risk Assessment (HRA) will be conducted, either in-person or over the phone, and an individualized plan of care will be developed within 60 days.

Member Outreach

- Explain benefits, provide health education, including how to access care (i.e., appropriate Emergency Room utilization).
- Participate in community events and establish partnerships with local community agencies, churches, and high volume provider offices to promote healthy living and preventive care.
- Influence consumers' beliefs and behaviors because they are hired from within the community.
- Identify and engage high-risk consumers.
- Facilitate communication across medical and behavioral health specialties.

YouthCare encourages our members to undergo routine preventive screenings to diagnose and treat conditions in a timely fashion. Below is an overview of the preventive screenings covered by YouthCare.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's comprehensive and preventive child health program for individuals under the age of 21, which is mandated by state and federal law.

YouthCare provides coverage for the full range of EPSDT services in accordance with HFS policies and procedures. These services include periodic health screenings and appropriate up-to-date immunizations using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics (AAP) periodicity schedule for pediatric preventative care.

The following services are included in the EPSDT benefit:

- Comprehensive health history
- Developmental history – including assessment of both physical and mental health development
- Comprehensive physical exam (with clothes off when clinically appropriate)
- Laboratory tests (including blood lead level assessment)
- Health education.
- Vision screening and necessary follow-up services
- Dental screening and necessary follow-up services
- Hearing screening and necessary follow-up services
- Other necessary healthcare, diagnostic services, treatment, and other measures to ameliorate defects, physical, and mental illnesses and conditions identified. PCPs should provide inter-periodic screenings, which are Medically Necessary to determine the existence of suspected physical or mental illnesses or conditions. This includes at a minimum vision and hearing screening services. An inter-periodic visit may be performed only for vision or hearing screening services.
- Appropriate children's immunizations

All components of the EPSDT exam must be clearly documented in the PCP's medical record for each member. Minimum record requirements are as stated in the Illinois Handbook for Providers of Healthy Kids Services and must include the following:

- Problem list
- Medication list
- Personal health, social history and family history
- Periodic examination records
- Growth charts
- Objective developmental screening tools or risk assessment screening tools, as applicable
- Health education and anticipatory guidance
- Nutritional assessment, including documentation and interpretation of BMI for children starting at 2 years of age
- Relevant history of current illness or injury, if any, and physical findings
- Immunization records
- Reports of procedures, tests, and results, including findings and clinical impression from screening or assessments
- Allergy history
- Diagnostic and therapeutic orders, including medication lists
- Clinical observations, including results of treatment
- Diagnostic impressions
- Hospital admissions and discharges, if any
- Referral information and specialty consultation reports, if any

YouthCare requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Illinois citizens, and to actively participate in the increase of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. YouthCare will cooperate and assist providers to identify all members that are not up-to-date with their immunizations.

All PCPs should ensure that appropriate immunizations are available for child members. Vaccines are available at no charge to public and private providers for eligible children ages newborn through 18 years through the federal Vaccine for Children (VFC) program. To enroll in the VFC program or receive more information, visit the Illinois Department of Public Health website.

YouthCare providers shall participate in the Vaccines for Children (VFC) program. Vaccines from VFC should be billed with the specific antigen codes for reimbursement of administration of the vaccine. No payment will be made on the administration codes alone.

Preventive Care

The below guides are the recommended preventive care schedules for youth. Members should consult with their PCP to determine which screenings are right for them and when to undergo each screening.

Wellness Visits

Age	Frequency
Under age 21	Annually

Wellness visits include:

- Complete health history
- Comprehensive physical exam
- Preventive screenings (as needed)

Recommended Preventive Screenings

Screening	Recommendation
Alcohol misuse: screening and counseling	Members aged 13 and older.
Bacteriuria screening	Youth 12–16 weeks pregnant.
Blood pressure screening	Annually for members age 18 and older.
BRCA risk assessment and genetic counseling/testing	Youth with family members with breast, ovarian, tubal, or peritoneal cancer.
Breast cancer preventive medications	Youth at an increased risk for breast cancer.
Breastfeeding interventions	Youth during pregnancy and after birth.
Chlamydia screening	Sexually active youth age 21 or younger.
Depression screening	General population, including pregnant and postpartum women.
Folic acid supplementation	Youth who are planning or capable of pregnancy.
Gestational diabetes screening	Asymptomatic pregnant youth after 24 weeks of gestation.
Healthy diet and physical activity counseling to prevent cardiovascular disease (CVD)	Members who are overweight or obese and have additional CVD risk factors.
Hepatitis B screening	Persons at high risk for infection. Pregnant youth at first prenatal visit.
Hepatitis C screening	Members at high risk for infection.
HIV screening	Adolescents and adults 15–21 years old. Pregnant youth.

Recommended Preventive Screenings (continued)

Screening	Recommendation
Intimate partner violence screening	Youth of childbearing age.
Obesity screening and counseling	All members.
Preeclampsia prevention: aspirin	Pregnant youth at high risk for preeclampsia after 12 weeks of gestation.
Preeclampsia screening	Pregnant youth.
Rh incompatibility screening	Pregnant youth at first prenatal visit. Repeated test at 24–28 weeks for unsensitized Rh(D)-negative pregnant youth.
Sexually transmitted infections counseling	Sexually active adolescents. Youth with an increased risk for infection.
Skin cancer counseling	Children, adolescents, and young adults age 10–21 with fair skin.
Tobacco use counseling and interventions	All members. All pregnant youth.
Syphilis screening	Members at increased risk for infection. All pregnant youth.

Pharmacy

YouthCare HealthChoice Illinois

YouthCare is committed to providing appropriate, high quality and cost-effective drug therapy to all members. YouthCare works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. Prescription drugs and certain over-the-counter (OTC) drugs are covered when ordered by a YouthCare physician/clinician.

The pharmacy program does not cover all medications. Some medications require prior authorization or have limitations on age, dosage and/or maximum quantities. Visit our pharmacy web page at ILYouthCare.com/providers/pharmacy.html.

Pharmacy Benefit Manager

YouthCare works with Express Scripts® to administer pharmacy benefits. Certain drugs require prior authorization to be approved for payment by YouthCare.

These include:

- All medications not listed on the PDL
- Medications in the "Preferred with PA" and "Non-Preferred" tiers

Follow these steps for efficient processing of your prior authorization requests:

1) Visit account.covermymeds.com OR
2) Complete the Medication Prior Authorization Request Form.
   - Fax form to Pharmacy Services at **844-205-3384**.
   - Once approved, Pharmacy Services notifies the prescriber by fax and the member by mail.
3) If the clinical information provided does not explain the reason for the requested prior authorization medication, Pharmacy Services responds to the prescriber by fax, offering PDL alternatives.

For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the pharmacist help desk at **833-750-4409**.

All prior authorization requests should be submitted to Pharmacy Services.

Pharmacy Services

Prior Authorization Fax: **844-205-3384**

Pharmacy Services PA Department
5 River Park Place East, Suite 210
Fresno, CA 93720

Please submit all clinically relevant information, including, but not limited to the patient information available: member ID number, complete diagnosis, medication history, and current medications.

- If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific member to receive this specific drug and information will be sent to the clinician and member.
- If the request is denied, information about the denial and appeal rights will be provided to the clinician and member.

Clinicians are requested to utilize the PDL when prescribing medication for those patients covered by the YouthCare pharmacy program. If a pharmacist receives a prescription for a drug that requires a prior authorization request, the pharmacist should attempt to contact the clinician to request a change to a product included in the YouthCare PDL.

Specialty Pharmacy Provider

YouthCare works with AcariaHealth Specialty Pharmacy to review and dispense these products, Providers can request that AcariaHealth deliver the specialty drug to the office or member. For more information, call AcariaHealth at **855-535-1815**.

Psychotropic Medications

YouthCare works with the UIC Centralized Consent Unit (CCU) to review all psychotropic medication requests that require consent, pursuant to DCFS Rule 325. To request consent, prescribers should fax the completed DCFS Psychotropic Medication Request Form (CFS 431-A) to **312-814-7015**.

Psychotropic medications prescribed without prior consent approval from the CCU will be rejected at the point of sale.

Medications may have separate age limits, quantity limits, and/or prior authorization requirements established in partnership with the Illinois Department of Healthcare and Family Services (HFS). For an updated list of drugs and requirements, please see the YouthCare PDL, located at ILYouthCare.com/providers/pharmacy.html.

Maintenance Medications

YouthCare offers a 90-day supply (3-month supply) of maintenance medications at most retail pharmacies or through YouthCare's mail order pharmacy, Express Scripts Pharmacy. There is no cost to members for utilizing the maintenance program. To call in a new prescription for mail order you may call Express Scripts at **833-750-4409**.

Pharmacy & Therapeutics Review

The YouthCare Quality Improvement and Utilization Management Committee (QIUMC) continually evaluates the therapeutic classes included in the PDL. The committee is composed of both

internal and external clinicians, including several community-based primary care physicians and specialists. The primary purpose of the QIUMC is to assist in developing and monitoring the YouthCare PDL and to establish programs and procedures that promote the appropriate and cost-effective use of medications.

The QIUMC schedules meetings at least quarterly during the year and coordinates therapeutic class reviews with our national Utilization Review Committee.

Preferred Drug List

The YouthCare Preferred Drug List (PDL) describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the program. The PDL is created in conjunction with the Illinois Department of Healthcare and Family Services (HFS). The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the independent professional judgment of the physician/clinician or pharmacist; or,
- Relieve the physician/clinician or pharmacist of any obligation to the patient or others.

YouthCare's QIUMC has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring prior authorization. If a patient requires medication that does not appear on the PDL, the clinician can submit a prior authorization request for a nonpreferred medication. The PDL can be found at ILYouthCare.com/providers/pharmacy.html.

Specific Exclusions

The following drug categories are not covered by YouthCare:

- Drugs manufactured by companies that have not signed a rebate agreement with the federal government
- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Experimental or investigational drugs
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Oral vitamins and minerals (except those listed in the PDL)
- Drugs and other agents used for cosmetic purposes
- Drugs dispensed after the termination date included on the quarterly drug tape provided by the federal Centers for Medicare and Medicaid Services (CMS)
- Over-the-Counter (OTC) Medications (except those listed in the PDL)

The YouthCare pharmacy program covers a variety of OTC medications. All covered OTC medications appear in the PDL. All OTC medications must be written on a valid prescription, by a licensed provider.

Step Therapy

Medications requiring Step Therapy are listed with an "ST" notation throughout the preferred drug list. The pharmacy claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member's profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a prior authorization is required.

Quantity Limitations

Quantity limitations have been implemented on certain medications to ensure the safe and appropriate use of the medications. Quantity limitations are approved by the YouthCare QIUMC and noted throughout the PDL.

Age Limits

Some medications on the YouthCare PDL may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of pharmaceuticals.

Unapproved Use of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by YouthCare. Experimental drugs, investigational drugs and drugs used for cosmetic purposes are excluded from coverage.

Generic Substitutions

YouthCare requires that generic substitution be made when a generic equivalent is available, except where branded products are preferred on the YouthCare Health*Choice* PDL. All branded products that have an A-rated generic equivalent will be reimbursed at the maximum allowable cost (MAC).

Exception Requests

In the event that a clinician or member disagrees with the decision regarding coverage of a medication, the clinician may request an appeal by submitting additional information to YouthCare. The additional information may be provided verbally or in writing. A decision will be rendered and the clinician will be notified with a faxed response. If the request is denied, the clinician will be notified of the appeals process at that time.

An expedited appeal may be requested at any time the provider believes the adverse determination might seriously jeopardize the life or health of a patient. Call the YouthCare complaint and grievance coordinator. A response will be rendered within 24 hours of receipt of complete information.

YouthCare offers our members access to all covered, medically necessary behavioral health (BH) services.

YouthCare members seeking mental health or substance abuse services may self-refer to a network provider. For assistance in identifying a behavioral health provider or for prior authorization for inpatient or outpatient services, please call Member Services.

In the event that the physician or practitioner is unable to provide timely access for a member, YouthCare will assist in securing authorization to a physician or practitioner to meet the member's needs in a timely manner.

For information regarding behavioral health services, locating providers, or for assistance in coordinating services for the member, contact Member Services.

Continuity of Care

When members are newly enrolled and have been previously receiving behavioral health services, YouthCare will make best efforts to maximize the transition of members' care through providing for the transfer of pending prior authorization information; and work with the member's provider to honor those existing prior authorizations.

BH Providers and PCP Coordination

YouthCare encourages PCPs to consult with their members' mental health and substance use treatment practitioners. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required. We encourage all service providers to coordinate care with a member's entire treatment team, including but not limited to PCPs and mental health and/or substance use treatment practitioners. Additionally, YouthCare will offer trainings to PCPs and mental health and/or substance use treatment practitioners focused on the concepts of integrated care; cross training in medical, behavioral and substance use disorder; and screening tools.

BH providers should communicate and coordinate with the member's PCP and with any other behavioral health service providers whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered to the member. Examples of some of the items to be communicated include:

- Prescription medication.
- Results of health risk screenings.

- If the member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment.
- If the member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse).
- If the member's progress toward meeting their goals was established in their treatment plan.

BH providers can identify the name and contact information for a member's PCP by performing an eligibility inquiry on the secure provider portal or by contacting Provider Services. Practitioners should screen for the existence of co-occurring mental health and substance use conditions and make appropriate referrals. Practitioners should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment.

We also offer provider training on screening tools that can be used to identify possible behavioral health and substance use disorders. Resources and training will include referral processes for providers to assist members in accessing supports.

YouthCare requires that practitioners report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the practitioner's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment;
- Written notification of member's noncompliance with treatment plan (if applicable);
- Member's completion of treatment;
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order; and
- The results of functional assessments.

Covered Services and Prior Authorization

Please see the benefit grid online at ILYouthCare.com/providers/preauth-check.html for the most up-to-date authorization requirements and a comprehensive list of covered benefits.

BH Services including substance use disorder

- Inpatient Psychiatric
- Partial Hospitalization
- Intensive Outpatient Therapy
- Psychological Testing
- Neuropsychological Testing

- Electroconvulsive Therapy (ECT)
- Individual, Family, and Group Therapy

Substance Use Disorder and Prevention (SUPR) Services

- Substance Use Disorder Treatment/Rehabilitation
- Detoxification
- Residential Rehabilitation
- Day Treatment

Community Mental Health Clinic Services, including crisis services

See the IAMHP Comprehensive Billing Guide at IAMHP.net/providers for information about billing YouthCare for behavioral health services.

Children's Mental Health and Mobile Crisis Response Services

YouthCare's Health*Choice* Illinois plan includes working with Mobile Crisis Response Program providers to administer crisis intervention services for members who require behavioral health services. Mobile Crisis Response Program providers must be appropriately credentialed and approved by HFS and are responsible for the following:

- Performing a face-to-face crisis screening within ninety (90) minutes of notification that a member is experiencing a behavioral health crisis, which will include, at a minimum, the completion of the IM CAT and the Crisis Stabilization Plan
- Providing immediate care and stabilization services when a member in crisis can be stabilized in the most appropriate setting;
- Providing the member's family with contact information that may be used at any time, twenty four (24) hours a day, to contact Mobile Crisis Response system in moments of crisis
- Establishing a Crisis Safety Plan unique for members who present in behavioral health crisis and to provide families of members with physical copies of the Crisis Safety Plan consistent with the following timelines:
  - Prior to the completion of the crisis screening event for any member stabilized in the community; and
  - Prior to member discharging from an inpatient psychiatric hospital
- The Crisis Safety Plan must be done in collaboration with and reviewed with the member and member's family
  - Mobile Crisis Response providers must educate and orient the member's family to the components of the Crisis Safety plan
  - Ensure the plan is reviewed with the family regularly, and detail how the plan is updated as necessary

- Mobile Crisis Response providers must share the Crisis Safety Plan with all necessary medical professionals, including YouthCare Care Coordinator staff as consistent with the authorizations established by consent or release
- Must be available 365 days a year, 24 hours a day
- For members that experience a Crisis event, YouthCare shall convene an Interdisciplinary Care Team (ICT) meeting for the member
  - within fourteen (14) days after the event if the member is stabilized within the community
  - within fourteen (14) days post discharge if the member is hospitalized
- YouthCare will ensure that the member has a scheduled appointment with Behavioral Health Provider and the member's PCP or psychiatric resource within thirty (30) days after the member discharges from hospitalization
- If member has been identified by DCFS as a Youth at Risk, YouthCare will involve DCFS on the members ICT
- Providers are to facilitate the member's admission to an appropriate inpatient treatment setting when the member cannot be stabilized in the community, including education to the member's parents, guardian, caregivers, or residential staff to select an appropriate inpatient treatment setting and network providers

YouthCare will closely follow the process and procedures of the Illinois Crisis and Referral Entry Services (CARES) program. CARES, in addition to YouthCare's Mobile Crisis Response Services, can authorize and dispatch Mobile Crisis Services. In the event that CARES is unable to locate a provider within the YouthCare Mobile Crisis Response Service to provide a face-to-face screening for a member experiencing a behavioral health crisis, CARES will contact the Mobile Crisis Response program to ensure crisis response to the member.

Care Coordination

YouthCare HealthChoice Illinois

YouthCare's care coordination model consists of a team of registered nurses, licensed mental health professionals, social workers, and non-clinical staff. The model is designed to help YouthCare members obtain needed services and assist them in coordination of their healthcare needs whether they are covered within the YouthCare array of covered services, from the community, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice, large multi-specialty group setting, or a home and community-based service setting.

The program is based upon a coordinated care model that uses a multi-disciplinary care coordination team in recognition that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and the member's PCP to achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for early identification of members, completion of their needs assessment tools, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. The PCP is included in the creation of the Care Plan as appropriate to assure that the plan incorporates considerations related to the medical treatment plan and other observations made by the provider. The Care Plan is made available to the provider in writing or verbally. Our care coordination team will integrate covered and non-covered services and provide a holistic approach to a member's medical and behavioral healthcare, as well as functional, social, and other needs. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A care coordination team is available to help all providers improve the health of YouthCare members. Contact us to refer a member for care coordination.

Care Coordination Department
YouthCare Health*Choice* Illinois:
844-289-2264

Integrated Care Teams

Care Coordinators are familiar with evidence-based resources and best practice standards specific to conditions common among YouthCare members. These teams are led by clinical licensed care coordinators with experience working with people with physical and/or mental health conditions. In addition, a team will be specifically dedicated to assisting members with developmental disabilities. The teams have experience with the member population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services.

YouthCare uses a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices.

Care Plans

YouthCare members with moderate, high, or complex acuities have an identified Interdisciplinary Care Team and a Care Plan. The Care Plan is developed in conjunction with the member, their family, their caregiver, as well as individuals in the member's care team. The member will agree to the developed Care Plan, and the Care Plan is distributed to members of the interdisciplinary care team.

Waiver Services

For members receiving waiver services, the Care Plan will include services such as home health, home delivered meals, personal emergency response systems, adult day service, home modification, and adaptive equipment. Based on each member's plan, YouthCare care coordinators will work directly with home and community-based services providers in order to execute the Care Plan. This includes securing the service with the provider and authorizing the number of hours/ units approved. The care coordinator will give an authorization number to the provider. The provider is then able to render the service that has been authorized.

YouthCare's care coordination team will guide members through the process of obtaining covered services. Each member is assigned to a care coordinator. Care coordinator responsibilities include:

- Help members obtain services.
- Visit members in their residence to assess health status, needs, and develop a Care Plan.
- Communicate with providers on services that are authorized according to the Care Plan.
- Discharge planning.
- Support quality of life for members.

Please contact the care coordination department for changes in a member's status, questions regarding services, or other member issues.

Transition of Care

Once the appropriate state agency determines eligibility, YouthCare will be responsible for all care coordination for YouthCare members. YouthCare has processes and procedures in place to ensure smooth transitions to and from YouthCare's care coordination to other plans/agencies such as another Managed Care Organization, the Department of Rehabilitative Services and the Department of Healthcare and Family Services.

During transitions between entities, YouthCare will assure 180 days of continuity of services and will not adjust services without the member's consent during that time frame.

High Risk Pregnancy Program

YouthCare will place high risk pregnancy members in our Start Smart for Your Baby® program which incorporates case management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart for Your Baby is a unique prenatal program with a goal of improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing case management to high and moderate risk members through the postpartum period. A care coordinator will work with members at high risk of early delivery or who experience complications from pregnancy. The care coordinators have physicians advising them on overcoming obstacles, helping identify high risk members, and recommending interventions.

Transplants

A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the YouthCare medical management department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

24/7 Nurse Advice Line

When our members have questions about their health, their primary care provider, and/or access to emergency care, we are here for them. YouthCare offers a 24/7 Nurse Advice Line service at **844-289-2264** to encourage members to talk with their physician and to promote education and preventive care.

Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access. The staff often answers basic health questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use the Nurse Advice Line to request information about providers and services available in their community after hours, when the Member Services department is closed. The staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse on a daily basis. If you have any additional questions, please call Provider Services or the Nurse Advice Line.

Member Rewards Program

The goal of YouthCare's rewards program is to increase appropriate utilization of preventive services by rewarding members for healthy behaviors. The program encourages members to regularly access preventive services, and promotes personal responsibility for the member's own healthcare.

Health*Choice* Illinois Rewards Program – My Health Pays™ Rewards

My Health Pays™ rewards program is offered to members in the YouthCare Health*Choice* Illinois plan. My Health Pays™ rewards members with a pre-paid debit card to purchase healthcare items, such as over-the-counter medications that they might otherwise not be able to afford. Preventive services that may qualify for rewards through the program include completion of an initial health risk screening, primary care medical home visits within 90 days of enrollment, annual adult well visits, certain disease-specific screenings, and completion of prenatal and postpartum care.

YouthCare Community Health Services

YouthCare Community Health Services is a community-based outreach program designed to provide coaching and education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link YouthCare and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of YouthCare within the community. The program has various components that can be provided depending on the needs of the member.

YouthCare Community Health Services outreach employees are hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area.

These representatives are an integral part of our Integrated Care Team which benefits our members and increases our effectiveness. Representatives will make home visits to members we cannot reach by phone or that require a face-to-face approach.

They assist with member outreach, conduct member home visits, coordinate with social services, and attend community functions to provide health education and outreach.

YouthCare Community Health Services works with providers to organize healthy lifestyle events and works with other local organizations for health events. To refer a member, contact us:

YouthCare Health*Choice* Illinois: **844-289-2264**

SafeLink®

SafeLink® provides phones to high risk members who do not have safe, reliable phone access. Members who qualify receive a pre-programmed cell phone with limited use. Members may use this cell phone to call their case manager, PCP, specialty physician, the 24/7 Nurse Advice Line, 911, or other members of their healthcare team. In some cases, YouthCare may provide MP-3 players with preprogrammed educational programs for those with literacy issues or in need of additional education.

Disease Management/Health Coaching

YouthCare offers a specialized disease management/health coaching program in addition to Care Coordination services. The disease management programs target members with specific chronic diseases, including:

- Asthma
- Diabetes
- Hypertension
- Heart Failure

- Obesity
- Behavioral Health

Members are linked with the health coaching team which includes Registered Nurses, Registered Dieticians, and Licensed Behavioral Health Clinicians. The Health Coaching team works in collaboration with the primary Care Coordinator.

Our specialty pharmacy offers disease management services for YouthCare members with hemophilia.

To refer a member for disease management call:

Disease Management
YouthCare Health*Choice* Illinois: **844-289-2264**

Value-Added Benefits

Free Gym Membership

Eligible members age 16 years and up can receive a voucher to cover monthly membership fees at participating locations.

To quality for FREE Gym Memberships, members must:

1) Complete a Health Risk Screening
2) Go to the gym at least 4 times a month to maintain the program

Free After School Care

Eligible members ages 6-18 years can receive a voucher to assist with after school care at participating locations.

To quality for FREE After School Care, members must:

1) Complete a Health Risk Screening
2) Complete an Annual Well-Child Visit

Free School Uniforms

Eligible members in 1st-5th grade can receive three uniforms (shirt, pants and sweater) annually.

To qualify for FREE School Uniforms, members must:

1) Complete a Health Risk Screening
2) Complete an Annual Well-Child Visit
3) Have up-to-date vaccinations
4) Complete a BMI measurement

Utilization Management

The YouthCare Utilization Management (UM) Program is designed to ensure members of YouthCare receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UM program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care, ancillary care, and behavioral health services.

YouthCare's UM program seeks to optimize a member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UM program aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and that meet professionally recognized standards of care.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under-utilization.
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.
- Identification and provision of care coordination and/or disease management for members at risk for significant health expenses or ongoing care.
- Development of an infrastructure to ensure that all YouthCare members establish relationships with their PCPs to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self management.
- Creation of partnerships with members/providers to enhance cooperation and support for UM program goals.

Utilization Management Contact Information

YouthCare Health*Choice* Illinois: **844-289-2264**

Prior Authorization

There are **3 ways** to submit for prior authorization:

1) **Electronic Submission (preferred):**
   Secure provider portal: Provider.ILYouthCare.com
2) **Fax:**
   Medical: **844-989-0154**
   Behavioral Health: **833-387-3173**
3) **Phone:**
   YouthCare Health*Choice* Illinois: **844-289-2264**

Please ensure that the TIN and NPI provided in prior authorization requests are accurate to avoid downstream claims payment issues.

Authorization must be obtained prior to the delivery of certain elective and scheduled services. Services that require authorization by YouthCare are listed on ILYouthCare.com. The PCP should contact the UM department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. **All out-of-network services require prior authorization.**

Emergency Room (ER) and urgent care services **never** require prior authorization. Providers should notify YouthCare of post-stabilization services such as, but not limited to, the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within two (2) business days of the service initiation. If notified after the 2 days, an administrative denial will take place.

Clinical information is required for ongoing care authorization of the service. Failure to obtain authorization may result in administrative claim denials. YouthCare providers are contractually prohibited from holding any YouthCare member financially liable for any service administratively denied by YouthCare for the failure of the provider to obtain timely authorization.

Authorization Timelines

Prior authorization should be requested at least 14 calendar days before the requested service delivery date. YouthCare decisions for requests for standard services will be made within 4 days. “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. The provider and member will be notified of the decision within one business day of the determination. Failure to submit necessary clinical information can result in an administrative denial of the requested service.

For urgent/expedited requests, a decision is made within 48 hours of receipt of all necessary information. Urgent criteria is defined as a medical/ behavioral health event that could seriously jeopardize the life, health or safety of the member or others, due to the member’s psychological

state. Or, in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. The provider and member will be notified of the decision within one business day of the determination.

Clinical Information

Authorization requests may be submitted by fax, phone, or secure provider portal. A referral specialist will enter the demographic information and transfer the information to a YouthCare nurse for the completion of medical necessity screening. For all services on the prior authorization list, documentation supporting medical necessity will be required.

YouthCare clinical staff will request clinical information that is minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), YouthCare is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations.

Information necessary for authorization of covered services may include but is not limited to:

- Member name and member ID number
- Provider name and telephone number
- Provider location, if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnoses, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/ proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Discharge plans

Notification of newborn deliveries should include the mother's name, date of delivery, method of delivery, and weight.

If additional clinical information is required, a YouthCare nurse or medical management representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

YouthCare affirms that utilization management decision making is based only on appropriateness of care and service and the existence of coverage.

YouthCare does not specifically reward practitioners or other individuals for issuing denials of service or care.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the YouthCare Medical Director and other clinical staff, is responsible for making utilization management decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Medical Necessity

Medical necessity is defined for YouthCare members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury.
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines.
- Not primarily for the personal comfort or convenience of the member, family, or provider.
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member.
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service.
- Not experimental or investigational or for research or education.

Review Criteria

YouthCare has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. Behavioral health UM uses InterQual in addition to American Society of Addiction Medicine (ASAM) criteria for all inpatient services; state service definitions are used for behavioral health community-based services.

InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services.

Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department. Practitioners also have the opportunity to discuss any medical

or pharmaceutical utilization management adverse determination with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination.

The Medical Director may be contacted by calling Provider Services and asking for the Medical Director. A medical management nurse may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals with the member's consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

YouthCare
Attn: Prior Auth Appeal
PO Box 733
Elk Grove Village, IL 60009-0733

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to YouthCare was not obtained due to extenuating circumstances related to the member. Requests for retrospective review, for services that require authorization by YouthCare, must be submitted promptly upon identification but no later than 90 days from the first date of service. A decision will be made within 30 calendar days following receipt of all necessary information for any qualifying service cases.

Referrals

As promoted by the Medical Home concept, PCPs should coordinate most of the healthcare services for YouthCare members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, paper referrals are not required. To better coordinate a member's healthcare, YouthCare encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the YouthCare network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network providers will require prior authorization by YouthCare.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the medical necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure. YouthCare follows the guidelines for assistant surgeons set forth in the State of Illinois Medicaid fee schedule.

Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

New Technology

YouthCare evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the YouthCare population.

Centene's Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department.

Notification of Pregnancy

YouthCare provides care coordination for pregnant members. It is critical to identify members as early in their pregnancy as possible. YouthCare asks that a managing physician notify the YouthCare prenatal team by completing the Notification of Pregnancy (NOP) within five days of the first prenatal visit. The NOP can be found under the Provider Resources/Forms page on ILYouthCare.com. Providers are expected to identify the estimated date of confinement and delivery facility. YouthCare will facilitate the physician's order of a 90-day supply of prenatal vitamins for the member to be delivered to the managing provider's office by the member's next prenatal visit. See the Care Coordination/Case Management section for information related to our Start Smart for Your Baby Program.

Discharge Planning

The YouthCare UM staff will coordinate the discharge planning efforts with the member/member's family or guardian, the hospital's UM and discharge planning departments and the member's attending physician/PCP in order to ensure that YouthCare members receive appropriate post-hospital discharge care.

Member Grievance

The YouthCare Grievance System includes an informal complaints process and a formally structured grievance and appeals (G&A) process. YouthCare's Grievance System is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR Section 438 Subpart F, including procedures to ensure expedited decision making when a member's health so necessitates.

Filing a Grievance

A member grievance is defined as any expression of dissatisfaction by a member about any matter other than an Action. The grievance process allows the member, or the member's authorized representative (guardian, caretaker, relative, PCP or other treating physician) acting on behalf of the member, to file a grievance either verbally or in writing, using any medium, at any time. If a member contacts YouthCare Member Services with a complaint, the Member Services staff member will attempt to resolve the issue immediately. If the issue is not resolved on the call to the satisfaction of the member, the Member Services representative will explain to the member their grievance rights.

If the member wants to file a grievance, the Member Services representative will route the grievance to the G&A department. YouthCare values its providers and will not retaliate in any way against providers who file a grievance on a member's behalf.

Acknowledgment

YouthCare shall acknowledge receipt of each grievance in writing within forty-eight (48)hours of receipt. The YouthCare Member Services representative will document the substance of an oral grievance, and attempt to resolve it immediately. For informal complaints, defined as those received verbally and resolved immediately to the satisfaction of the member or appointed representative, the Member Services representative will document the resolution details.

Timeframe & Notice of Grievance Resolution

Grievance investigation and resolution (for those grievances not resolved informally) will occur as soon as possible but not exceed ninety (90) calendar days from receipt of the grievance. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, YouthCare shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease [see 42 CFR § 438.406].

Written notification of the grievance resolution will include the results of resolution process and the date it was completed.

Medicaid Grievances may be submitted verbally or in writing to:

YouthCare
Attn: Grievance and Appeals
PO Box 733
Elk Grove Village, IL 60009-0733

or faxed to **833-920-1747**;
or emailed to gareferrals@centene.com

Member Appeals

YouthCare has a formally structured Appeals system that is compliant with the State of Illinois YouthCare contract, Section 45 of the Managed Care Reform and Patient Rights Act, the Health Carrier External Review Act and Subpart F of Section 438 of the Code of Federal Regulations. An appeal is the request for review of a decision made by the Contractor with respect to an Adverse Benefit Determination.

Filing an Appeal

The appeal may be requested orally or in writing within 60 days of YouthCare's Notice of Adverse Action to the member, oral requests for appeals must be followed by a written request. All appeals must be registered initially with YouthCare and if YouthCare's decision is adverse to the member, the member may file an appeal for a Fair Hearing with the state of Illinois.

Acknowledgement

YouthCare will notify the filing party, within two (2) days of receipt. Appeals will be fully investigated without deference to the denial decision.

Timeline and Notice of Appeal Resolution

The appeal will be reviewed by an appropriately licensed clinical peer who was not involved in any previous level of decision making regarding the request. YouthCare will render a decision and provide written notification within fifteen (15) business days after receipt of appeal. An extension of up to fourteen (14) calendar days may be requested by the member, or YouthCare as the plan can establish that the delay is in the interest of the member. For Medicaid only: A member or an authorized representative may request a standard or expedited External Independent Review (EIR) of an adverse determination. For MMAI Medicaid and Medicare/Medicaid service appeals: If the appeal decision is not fully in favor of the member, YouthCare must forward the appeal to the Independent Review Entity contracted by CMS (Maximus)

Expedited Appeals

Expedited appeals may be filed when either YouthCare or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a

provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

YouthCare will notify the filing party within 24 hours of receipt, of any additional information required to evaluate the appeal request. YouthCare will render a decision and provide notification within 24 hours after receipt of required information, not to exceed 72 hours of receipt of the initial request. YouthCare will make reasonable efforts to provide the member, PCP and any healthcare provider who recommended the service with prompt verbal notice of the decision followed by written notice within three (3) calendar days after the initial verbal notification.

Notice of Appeal Resolution

Written appeal resolution notice shall include the following information:

- The decision reached by YouthCare
- The date of decision
- For YouthCare Health*Choice* Illinois appeals not resolved wholly in favor of the member, the right to request a State fair hearing, and information as to how to do so
- For YouthCare Health*Choice* Illinois appeals not resolved wholly in favor of the member (except for denial of HCBS Waiver services), the right to request a review by an external independent entity within thirty (30) calendar days of the date of the appeal decision
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the YouthCare decision.

Appeals may be submitted verbally or in writing to:

YouthCare
Attn: Grievance and Appeals
PO Box 733
Elk Grove Village, IL 60009-0733

or faxed to **833-920-1747**;
or emailed to gareferrals@centene.com

State Fair Hearing Process

Any adverse action or appeal that is not resolved wholly in favor of the member by YouthCare may be appealed by the member or the member's authorized representative to HFS for a Fair Hearing conducted in accordance with 42 CFR § 431 Subpart.

Please contact:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington Street 4th Floor
Chicago, IL 60602

Toll-free: **855-418-4421**
TTY: **800-526-5812**
Fax: **312-793-2005**

YouthCare is responsible for providing to the HFS an appeal summary describing the basis for the denial. YouthCare will comply with HFS' fair hearing decision.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if YouthCare or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, YouthCare will authorize the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the state hearing decision. Additionally, in the event that services were continued while the appeal was pending, YouthCare will provide reimbursement for those services in accordance with the terms of the final decision rendered by HFS and applicable regulations.

Billing Requirements

Claims for services for YouthCare members are submitted to and processed by Meridian, our Medicaid plan, and follow standard Medicaid billing guidelines. When billing for services rendered to YouthCare members, providers must use the most current Medicaid-approved coding format (ICD-10, CPT, HCPCS, etc.) and/or state Medicaid guidelines for claims payment.

Following are the guidelines for claims submission to Meridian for YouthCare members:

- Providers must use a standard CMS 1500 Claim Form or UB-04 or the 837P or 837I formats if filing electronically.
- All paper claim submissions must be on an original "red" CMS-1500 claim form version 02/12.
- Providers must use industry standard procedure and diagnosis codes such as HCPCS, CPT, Revenue, or ICD-10, and Taxonomy codes billed in accordance with state Medicaid, as well as industry standard guidelines when submitting a claim
  - Providers should be familiar with and adhere to the billing guidelines as set forth in the Illinois Association of Medical Health Plans (IAMHP) Billing Guidelines which can be found online at IAMHP.net/providers under RESOURCE documents
- Prior authorization (PA), if required, must be obtained prior to submitting claims. PA requirements may be checked via the Prior Auth Check Tool on our website.
- Providers may submit and check the status of claims electronically via the secure provider portal.
- The standard submission of Medicaid claims must be within 180 days of the date of service.
- Adjudication of a claim is based on benefit coverage, meeting medical necessity criteria and the codes being submitted and considered for review, which can be found on the Illinois Medicaid Fee Schedule: https://hfs.illinois.gov/medicalproviders/medicaidreimbursement.html

To receive reimbursement in a timely manner, please ensure each claim:

- Is submitted according to the timely filing submissions outlined in the provider's Meridian Participating Provider Agreement
- Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service, as well as the corresponding NPI number
- Identifies the patient (member ID number assigned by Meridian, or recipient identification number, address, and date of birth)
- Identifies Meridian (plan name and/or ID number)
- Indicates the date (mm/dd/yyyy), place of service, and applicable modifiers
- Is for a covered service. (Services must be described using uniform billing codes and instructions (ANSI X12 837) and ICD 10-CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered clean claims)

- If necessary, substantiates the medical necessity and appropriateness of the care or services provided. This includes any applicable authorization number if prior authorization is required by Meridian
- Includes additional documentation based upon services rendered as reasonably required by Meridian Medical policies
- Is certified by the provider that the claim is true, accurate, prepared with the knowledge and consent of the provider, does not contain untrue, misleading, or deceptive information; is certified that the claim identifies each attending, referring, or prescribing physician, dentist, or other practitioner
- Is a claim for which the provider has verified the member's eligibility and enrollment in Meridian before the claim is submitted
- Is not a duplicate of a claim – providers must submit a corrected claim within 180 days of the DOS/discharge date, whichever is later
- Is submitted in compliance with all of Meridian's prior authorization and claims submission guidelines and procedures
- Is a claim for which provider has exhausted all known other insurance resources
- Is submitted electronically if the provider has the ability to submit claims electronically
- Uses the data elements of UB-04 or CMS 1500 as appropriate
- Is submitted with appropriate NPI, taxonomy, and provider TIN for services as registered in IMPACT and rendered on the submitted claim. Information on appropriate taxonomy and category of service can be found at the following link: https://hfs.illinois.gov/medicalproviders/handbooks/5010

Claims Submission

Clean Claim Definition

A clean claim means a claim received by Meridian for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Meridian.

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in a request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and also include claims not submitted within the filing deadlines.

Electronic Submission

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

Payor ID: 68069

Meridian Clearinghouse – Availity: **800-282-4548**

*Please note: Providers utilizing Change Healthcare as the clearinghouse must submit to Change Healthcare with Payor ID MCCIL. Please reach out to Change Healthcare with any questions.

Paper Claims

Mail paper claims to:

YouthCare
Attn: Claims Department
PO Box 4020
Farmington, MO 63640-4402

If you are re-submitting a claim form for a status or a correction, please indicate "Status" or "Claims Correction" on the claim.

Claim Rejection versus Claim Denial

All claims must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

- **REJECTION:** Rejections will not enter our claims adjudication system, so there will be no explanation or record of the claim in our system. A rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. The provider will receive a letter if the claim was submitted on paper or a rejection report if the claim was submitted electronically. In these instances, the claim will need to be corrected and re-submitted as a new claim.
- **DENIAL:** If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A denial is defined as a claim that has passed minimum edits and is entered into the system; however, it has been billed with invalid or inappropriate information causing the claim to deny. An explanation of payment (EOP) will be sent that includes the denial reason.

Claim Corrections and Resubmissions (Adjustments)

If a provider's claim has been denied or paid only in part due to an error on the original claim submission and the provider needs to make any corrections to a claim, the provider must correct that section of the claim and resubmit a corrected claim within 180 days from the last date of the correspondence/EOP, not to exceed one year from the DOS.

CMS-1500 claim forms should be submitted with the appropriate resubmission code (value of 7) in field 22 with the original claim number for the corrected claim. EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

UB-04s should be submitted with the appropriate resubmission code in the 3rd digit of the bill type (for corrected claim this will be 7) and the original claim number in field 64 of the paper claim. EDI 837I, data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

If a corrected claim is submitted without this information, the claim will be processed as a first-time claim and will deny as a duplicate. Additionally, this process is only the process for correcting denied claims or claims that were submitted with incorrect information, not correcting rejected claims.

Meridian encourages you to submit corrected claims via EDI with the information in the appropriate loop list above. However, you may choose to also utilize our secure provider portal. While it is not necessary to attach the original EOP or a claim adjustment request form when submitting through the web, you may attach if you choose.

Recoupments

In the event Meridian has overpaid a claim, the provider will receive notice and explanation of the overpayment, with the option to refund the overpayment. If no refund is received the provider will have overpayments recouped from future payments. To submit a refund check, please mail the check and supporting document to:

YouthCare – Meridian Health
Attn: Refunds
PO Box 856407
Minneapolis, MN 55585-6407

Refer to the IAMHP Comprehensive Billing Guide for more information.

Timely Filing:

The standard submission for professional and institutional Medicaid claims for both in-network and out-of-network providers is 180 days from the date of service to submit an initial claim. There are two exceptions to the timely filing guideline:

- Retroactive eligibility: These claims must be accompanied by documentation demonstrating proof of the eligibility change and must be received within 365 days of notification of the eligibility change
- Third party liability-related delays: These claims must be accompanied by a third-party liability (TPL) explanation of benefits and received within 90 days of the TPL processing date

Encounter Reporting Requirements

Providers in capitated or sub-capitated payment arrangements will be monitored for accurate and complete encounter reporting. The data that Meridian submits to the State of Illinois requires the provider's compliance with this requirement.

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

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

As part of Meridian's contract with providers, it is required that Provider Preventable Conditions (PPCs) associated with claims be reported to Meridian. PPCs address both hospital and non-hospital conditions identified by the state for non-payment. PPCs are broken into two distinct categories: Health Care-Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs).

HCACs are conditions/secondary diagnosis codes identified when not present on an inpatient admission. OPPCs are conditions occurring in any healthcare setting that could have reasonably been prevented through the application of evidence-based guidelines.

Claim Edits

Meridian uses claims editing software programs to assist in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and regulations. These software programs may result in claim edits for specific procedure code combinations.

Meridian utilizes code-auditing software for automated claims-coding verification and to ensure Meridian is processing claims in compliance with general industry standards. This auditing software applies to facility and professional claims. The code-auditing software takes into consideration the conventions set forth in the healthcare insurance industry, such as CMS policies, current health insurance and specialty society guidelines, and the American Medical Association's "CPT® Assistant Newsletter." Using a comprehensive set of rules, the code-auditing software provides consistent and objective claims review by:

- Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology as outlined by the association's CPT®-4 manual
- Evaluating the CPT®-4 and HCPCS codes submitted by detecting, correcting, and documenting coding inaccuracies including, but not limited to unbundling, up coding, fragmentation, duplicate coding, invalid codes, and mutually exclusive procedures
- Incorporating historical claims auditing functionality which links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service.

This software evaluates code combinations during auditing/processing of claims. Denial codes beginning with a lowercase x or y are generated by the code-auditing software or Meridian Payment Policies. The exact reason for denial will not show on the EOP (remittance). These denials cannot be reprocessed by Meridian Provider Services.
A claim dispute should be submitted via the secure provider portal with supporting documentation must be completed if the provider does not agree with the denial decision or adjustment request.

For detailed information on specific code-edit criteria, please access our secure provider portal. Code edits can be reviewed in the "Clear Claim Connection" link.

Coordination of Benefits (COB)

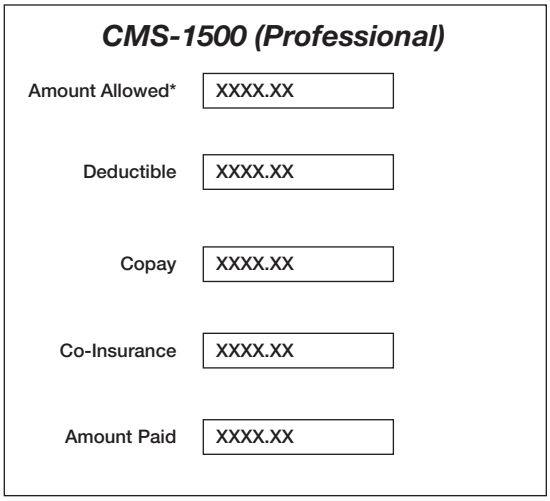
Meridian appreciates your assistance and cooperation in notifying us when any other coverage exists, such as, but not limited to, other healthcare plans and worker's compensation benefits. In the event that Meridian is not the only insurance coverage for the member, Meridian should be billed as the secondary payer for all services rendered and is responsible only for the difference between what the primary insurance pays and the allowable Medicaid fee schedule. You can submit your COB claims electronically.

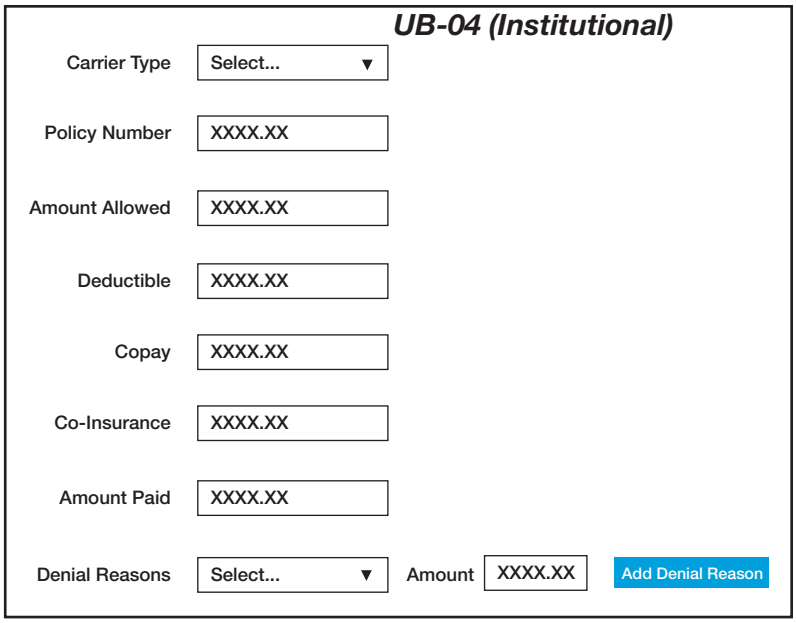
Third Party Coverage

Topic	Description
Identification of Third Party Resources	Providers must always identify third party resources and report third party payments in the appropriate item(s) on the claim. Third party resources must be identified even when the payer does not cover the services.
Commercial Insurance Payments	If payments are made by a commercial insurance, the EOB must be submitted with the claim.
Medicaid Deductible	If the beneficiary's Medicaid deductible amount is met in the middle of a service so that part of the charge is the beneficiary's responsibility and part is Medicaid's responsibility, enter the remaining Medicaid liability for the service in item 24F of the service line.
Evidence of Other Insurance Response	When billing on the CMS 1500 paper claim form, providers must submit evidence of other insurance responses (EOBs, denials, etc.) when billing for covered services. If billing electronically, no EOB is necessary, as all required data are part of the electronic format. However, in all cases where a provider is billing on the CMS 1500 claim form, a copy of the Medicare EOB must be submitted with the claim.
Injectable Drugs Covered as a Pharmacy Benefit by Third Party Payers	When billing for injectable drugs that are not covered as a pharmacy benefit by a third party payer but covered as a physician service by Medicaid, the provider must reflect the payment from the carrier on the claim. The fixed copay/coinsurance/deductible must be reported in the appropriate field on the electronic claim form and in Item 24F on the CMS 1500 paper form.

Provider Portal COB Submission

Meridian does not require a copy of the Explanation of Payment (EOP) when COB claims are submitted electronically through your clearinghouse or via the secure provider portal. When using the secure provider portal, input your COB information directly in the data fields or attach the EOP to the claim. The data fields used to populate COB information are outlined on the next page:





Electronic Data Interchange (EDI) – Clearinghouse Submission

For clearinghouse 837 transactions, simply code the transaction to include the loop for COB as outlined below. For questions on setting up your 837, please contact your clearinghouse.

COB Field Name The below should come from the primary payer's Explanation of Payment	**8371 – Institutional EDI Segment and Loop**	**837P – Professional EDI Segment and Loop**
COB Paid Amount	If 2320/AMT01=D, map AMT02 or 2430/SVD02	If 2320/AMT01=D, map AMT02 or 2430/SVD02
COB Total Non-Covered Amount	If 2320/AMT01=A8, map AMT02	If 2320/AMT01=A8, map AMT02
COB Remaining Patient Liability	If 2300/CAS01=PR, map CAS03 Note: Segment can have six occurrences. Loop2320/AMT01=EAF, map AMT02, whcih is the sum of all of CAS03 with segments presented with a PR.	If 2320/AMT01=EAF, map AMT02
COB Patient Paid Amount		If 2320/AMT01=F5, map AMT02
COB Patient Paid Amount Estimated	If 2300/AMT01=F3, map AMT02	

COB Field Name The below should come from the primary payer's Explanation of Payment	8371 – Institutional EDI Segment and Loop	837P – Professional EDI Segment and Loop
Total Claim Before Taxes Amount	If 2400/AMT01=N8, map AMT02	If 2320/AMT01=T, map AMT02
COB Claim Adjudication Date	If 2330B/DTP01=573, map DTP03	If 2330B/DTP01=573, map DTP03
COB Claim Adjustment Indicator	If 2330B/REF01=T4, map REF02	If 2330B/REF01=T4, map REF02 with a Y

Notes:

- Calculations can be required depending on how the Primary Payer paid the services, i.e., either individual service lines or rolled up to a claim level. Example: The sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (LOOP ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02). Expressed as a calculation for given payer: {Loop ID-2320 AMT02 payer payment} = {sum of Loop ID-2430 SVD02 payment amounts} minus {sum of Loop ID-2320 CAS adjustment amounts}.
- SBR01+S, then Loop 2320 is used to generate COB

Electronic Remittance Advice and Electronic Funds Transfer

Meridian partners with PaySpan Health to offer a solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Using this free service, providers can take advantage of EFTs and ERAs to settle claims electronically without making an investment in expensive EDI software. Following a fast online enrollment, you will be able to receive ERAs and import the information directly into your Practice Management or Patient Accounting System, eliminating the need to key remittance data off paper remittances.

PaySpan Health Benefits to Providers

- **Free service** – Providers are not charged any fees to use the service.
- **Eliminate re-keying of remittance data** – Electronic remittance advices can be imported directly into Practice Management or Patient Accounting Systems, eliminating the need for manual keying off of paper advices.
- **Maintain control over bank accounts** – Providers keep control over the destination of claim payment funds. Multiple practices and accounts are supported.
- **Match payments to advices quickly** – Providers can associate electronic payments with electronic remittance advices quickly and easily.
- **Pursue secondary billings faster** – Accelerates the revenue life cycle.
- **Improve cash flow** – Electronic payments can mean faster payments, leading to improvements in cash flow.

- **Connect with multiple payers** – Providers can quickly connect with any payers using PaySpan Health to settle claims.

With PaySpan Health, you have several options for viewing and receiving remittance details. PaySpan Health will match your preference for remittance information with the following options (potentially constrained by payers):

- EDI 835 ERA data file that can be downloaded directly to your Practice Management or Patient Accounting System
- Electronic remittance advice presented online and printed in your location

You can enroll online at payspanhealth.com or by contacting Payformance Corporation at **877-331-7154**.

Provider Appeals and Claim Dispute Process

- **Provider Appeals (Post-Service Medical Necessity Appeals)** – provider appeals are related to authorizations that were denied in whole or in part for medical necessity. Provider appeals are submitted post-service. An authorization denial will result in a denied claim.
- **Provider Claim Disputes** – provider claim disputes are related to claim payment denials, including claims denied for authorization when the provider failed to obtain a required authorization, and claim processing and/or payment discrepancies.

Meridian's provider appeal and claim dispute process is available to all providers, regardless of whether they are in- or out-of-network.

Medical Necessity Appeals

A medical necessity appeal is the first and only level of plan appeal for the member and provider relating to medical necessity determinations. Medical necessity appeals must be filed by one of the following: the member, the member's authorized representative, the member's provider of record, or a healthcare practitioner with knowledge of the member's medical condition acting on the member's behalf. They may be filed pre-service on the member's behalf with permission, or post-service on the provider's behalf.

Medical Necessity appeals may be for the following:

- Denied Days for an Inpatient Stay or Denied Level of Care for an Inpatient Stay
- Denied Air Ambulance Transport
- Denied Hospice Stay
- Readmissions

Pre-service medical necessity appeals must be filed as outlined in the Billing & Claims Section of this manual. See Standard & Expedited Member Appeals.

Providers are reminded that they should not perform services that are not authorized without exhausting all available steps of the appeal process including the State Fair Hearing with HFS as outlined in the Grievance and Appeals section of this manual.

Providers have 90 days to file an appeal from the date of the Adverse Benefit Determination letter. All post-service medical necessity appeals must be filed in writing and sent to:

Mail:
YouthCare
ATTN: Prior Auth Appeal
PO Box 733
Elk Grove Village, IL 60009-0773

Fax: **833-383-1503**

Claim Reconsiderations and Disputes

If a provider is not satisfied with the claims disposition, a Request for Reconsideration can be submitted via the secure provider portal. Please attach needed documents and explanation of what should be reconsidered.

Disputes must be filed within 90 days from the remittance date. Disputes submitted after the timeframe has expired may not be reviewed. All disputes must be received within 365 days of the DOS to be considered for review, unless otherwise specified within the provider contract.

If the original determination is upheld, the provider will be notified within 30 days of receipt of the dispute. If additional information is needed, such as medical records, then Meridian will respond within 30 days of receiving the necessary information. The written determination will include a detailed explanation of the determination. If the original determination is overturned, the provider will see payment details on the EOP.

There is only one level of dispute available within Meridian. All dispute determinations are final. If a provider disagrees with Meridian's determination regarding a dispute, the in- or out-of-network provider may pursue other options as outlined on the following page.

Claim Dispute Types

Type	Where to Submit
Administrative Denial Claim Disputes Appeal of a claim denied for failure to obtain authorization according to timeframe and prior authorization requirements. If your claim is denied due to a denial or partial denial of the prior authorization request, you must follow the member appeal process. Meridian's claim dispute policy does not routinely allow retroactive authorization reviews and the overturning of claim denials when a required prior authorization has not been obtained. IMPORTANT: If you have an authorization number for a denied or partially denied auth and are appealing the authorization denial please follow the post service medical necessity denial process	Two ways to submit: 1. Secure provider portal (preferred) 2. Via mail: **Meridian** ATTN: Provider PO Box 4020 Farmington, MO 63640-4402
Provider Claim Dispute Disputes related to claims processing are handled separately from Administrative Denial Disputes. Claim disputes are disputes regarding the following: • Inaccurate Payment or Denial • Coding Edits (Correct Coding Initiative (CCI) edits) • Claims Denied as a Duplicate • Untimely Filing Providers electing to dispute the disposition or reimbursement level of a claim may do so via the secure provider portal (preferred): • Select the claim and provide appropriate reason for the dispute. • Supporting documents can be attached, i.e., medical records, etc. • The dispute will be reviewed by a dispute analyst. • If your original claim reimbursement is updated, you will receive new reimbursement • If your original claim reimbursement is upheld, a letter will be sent acknowledging the reason for dispute being upheld.	Two ways to submit: 1. Secure provider portal (preferred) 2. Via mail: **Meridian** ATTN: Provider Claim Disputes PO Box 4020 Farmington, MO 63640-4402

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 Meridian Medicaid post-service claim appeal process, please call **866-606-3700** (**TTY: 711**) for more information.

Member Rights & Responsibilities

YouthCare HealthChoice Illinois

YouthCare members have the following rights and responsibilities.

General Member Rights and Responsibilities:

Member Rights:

- Be treated with respect and dignity at all times
- Have your personal health information and medical records kept private except where allowed by law
- Be protected from discrimination
- Receive information from YouthCare in other languages or formats such as with an interpreter or Braille
- Receive information on available treatment options and alternatives
- Receive information necessary to be involved in making decisions about your healthcare treatment and choices
- Refuse treatment and be told what may happen to your health if you do
- Receive a copy of your medical records and in some cases request that they be amended or corrected
- Choose your own primary care provider (PCP) from YouthCare. You can change your PCP at any time
- File a complaint (sometimes called a grievance), or appeal without fear of mistreatment or backlash of any kind
- Request and receive in a reasonable amount of time, information about YouthCare, its providers, and policies

Member Responsibilities:

- Treat your doctor and the office staff with courtesy and respect
- Carry your YouthCare ID card with you when you go to your doctor appointments and to the pharmacy to pick up your prescriptions
- Keep your appointments and be on time for them
- If you cannot keep your appointments cancel them in advance
- Follow the instructions and treatment plan you get from your doctor
- Tell YouthCare and your caseworker if your address or phone number changes
- Read your member handbook so you know what services are covered and if there are any special rules

Specific Member Rights and Responsibilities:

Members receiving the Persons with Disabilities, Persons with HIV or AIDS, and Persons with Brain Injury HCBS Waivers have specific rights and responsibilities, which include:

- Apply or reapply for waiver services.
- Receive a timely decision on eligibility for waiver services based on a complete assessment of member's disability.
- Receive an explanation in writing, should they be determined ineligible for waiver services, telling the member why services were denied.
- Receive an explanation about waiver services that the member may receive.
- Partner with care coordinator in making informed choices for waiver services care plan.
- Appeal any decision with which the member does not agree.
- Be informed of the Client Assistance Program (CAP).
- Be provided with a form of communication appropriate to accommodate the member's disability.
- Fully participate in the waiver services care plan.
- Set realistic goals and participate in writing waiver services care plan with care coordinator.
- Follow through with member's plan for rehabilitation.
- Review rehabilitation case record with a staff member present.
- Communicate with care coordinator and ask questions when member does not understand services.
- Keep a copy of waiver services plan and any amendments related to the plan.
- Keep original documents and send only copies to care coordinator's office.
- Notify care coordinator of any change in personal condition or work status.
- Be aware of financial eligibility requirements for some services.
- Participate with care coordinator in any decision to close member's case.

Member Freedom of Choice

YouthCare ensures that members have freedom of choice of the providers they utilize for waiver services. YouthCare members have the option to choose their providers, which includes all willing and qualified providers.

Subject to the member's care plan, member access to in-network non-medical providers offering waivered services will not be limited or denied except when quality, reliability or similar threats pose potential hazards to the well-being of our members. Freedom of choice with network providers will not be limited for plan participants, nor will providers of qualified services be stopped from providing such service as long as the goal of high quality, cost efficient care is met or exceeded and providers adhere to the contractual standards outlined in the YouthCare contract with the state of Illinois. We encourage our providers to share this information with members as well.

Provider Rights & Responsibilities

YouthCare
HealthChoice Illinois

All YouthCare providers have the following rights and responsibilities.

General Provider Rights and Responsibilities:

Safety and Respect

- Be treated by their patients and other healthcare workers with dignity and respect.
- Treat members with fairness, dignity, and respect.
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
- Follow all state and federal laws and regulations related to patient care and patient rights.

Full Benefits and Plan Information

- Contact YouthCare's Provider Services with any questions, comments, or problems, including suggestions for changes in the QIP's goals, processes, and outcomes related to member care and services.
- Obtain and report to YouthCare information regarding other insurance coverage.
- Participate in YouthCare data collection initiatives, such as HEDIS and other contractual or regulatory programs.

Quality Improvement and Utilization Management

- Cooperate with Quality activities and allow use of performance data.
- Receive accurate and complete information and medical histories for members' care.
- Collaborate with other healthcare professionals who are involved in the care of members.
- Expect other network providers to act as partners in members' treatment plans.
- Expect members to follow their directions, such as taking the right amount of medication at the right times.
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments;
  - Provide information regarding the nature of treatment options;
  - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered; and
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment.

- Have access to information about YouthCare's quality improvement programs, including program goals, processes, and outcomes that relate to member care and services, and information on safety issues.
- Review and adhere to evidence-based clinical practice guidelines adopted by YouthCare. A list of practice guidelines is available on our website.
- Comply with YouthCare's Medical Management program as outlined in this manual.
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
- Contact YouthCare to verify member eligibility or coverage for services, if appropriate.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.

Medical Autonomy

- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Respect members' advance directives and include these documents in the members' medical records.
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.

Timely Access to Care

- Provide members, upon request, with information regarding office location and hours of operation.

Cultural, Linguistic, and Disability Competency

- To follow YouthCare's policies and procedures on providing accessible, culturally and linguistically competent care.
- Provide full and equal access to healthcare services and facilities, make reasonable modifications necessary to make services accessible, and provide effective communication methods to meet the needs of all members, including those with disabilities.

- Provide flexible scheduling to meet the needs of their members.
- Provide members, upon request, with information regarding accessibility, and languages, including the ability to communicate with sign language.
- Provide accessible, culturally and linguistically competent care.
- To communicate with members in a manner that accommodates their individual needs and work with YouthCare to coordinate specialized services (e.g., including medical interpreters for all members, hearing impaired services for those who are deaf or hard of hearing, and accommodations for enrollees with cognitive limitations).
- To provide oral interpretation services free of charge for all non-English languages.
- To notify members that oral interpretation is available and how to access those services.

Critical Incident Prevention and Reporting

- To follow YouthCare's policies and procedures related to reporting Critical Incidents such as Abuse, Neglect, and Exploitation.

Significant Event Reporting

- To follow State mandates and YouthCare's policies and procedures related to reporting Significant Events such as Abuse and Neglect.

Patient Privacy and Security

- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- To follow YouthCare's policies and procedures on Patient Privacy, Confidentiality, and Security.
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allow members to request restriction on the use and disclosure of their personal health information.
- All health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

Medical Records

- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.

Billing, Claims, and Preventing Fraud, Waste, and Abuse

- To follow YouthCare's policies and procedures on preventing Fraud, Waste, and Abuse, and billing and claims.
- Disclose overpayments or improper payments to YouthCare.

- Not be excluded, penalized, or terminated from participating with YouthCare for having developed or accumulated a substantial number of patients in the YouthCare network with high-cost medical conditions.
- Disclose to YouthCare, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between YouthCare and the physician or physician group.

Member Suspension

- Make a complaint or file an appeal against YouthCare and/or a member.

Provider Termination

- Notify YouthCare in writing if the provider is leaving or closing a practice.
- Providers must give YouthCare notice, in writing, if they wish to initiate voluntary termination procedures following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send written notice of the termination following the advance notice requirements in their agreement. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to YouthCare or the member.
- YouthCare will notify affected members in writing of a provider's termination. If the terminating provider is a PCP, YouthCare will request that the member select a new PCP. If a member does not select a PCP prior to the provider's termination date, YouthCare will automatically assign one to the member.
- Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days or until YouthCare can arrange for appropriate healthcare for the member with a participating provider.
- Upon request from a member undergoing active treatment related to a chronic or acute medical condition, YouthCare will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, YouthCare will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

PCP Responsibilities

The Primary Care Provider (PCP) is the cornerstone of YouthCare's service delivery model. The PCP serves as the "medical home" for the member.

The "medical home" concept assists in establishing a member-provider relationship, supports continuity of care, eliminates redundant services, and ultimately improves outcomes in a more cost effective way.

YouthCare offers a robust network of PCPs to ensure every member has access to a PCP within reasonable travel distance standards. Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, and Family and General Practitioners. Non-physicians who may serve as PCPs include physician assistants and nurse practitioners. Physicians, physician assistants, and nurse practitioners in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Health Department setting may also serve as PCPs.

YouthCare offers pregnant members, or members with chronic illnesses, disabilities, or special healthcare needs the option of selecting a specialist as their PCP. A member, family member, caregiver or medical consenter may request a specialist as a PCP at any time. A member of our Integrated Care Team (ICT) will contact the member, caretaker or medical consenter, as applicable, within three (3) business days of the request to schedule an assessment. Our Chief Medical Officer will review assessment results and approve requests after determining that the member meets criteria and that the specialist is willing to fulfill the PCP role. The ICT member will work with the member and previous PCP if necessary, to safely transfer care to the specialist.

PCP Rights and Responsibilities include:

- Educating members on how to maintain healthy lifestyles and prevent serious illness.
- Providing screening, well care, and referrals to community health departments and other agencies in accordance with HFS provider requirements and public health initiatives.
- Obtaining authorizations for selected inpatient and outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization.
- Being available for, or provide on-call coverage through another source, 24-hours a day for management of member care. After-hour access to the Health Home or covering YouthCare provider can be via answering service, pager, or phone transfer to another location; recorded message instructing the member to call another number; or nurse helpline. In each case, all calls must be returned within 30 minutes.
- Agreeing to all of YouthCare's provider compliance policies and procedures, including those related to patient privacy, confidentiality, and security; preventing fraud, waste, and abuse; and reporting critical incidents such as abuse, neglect, and exploitation.
- YouthCare PCPs should refer to their contract for complete information regarding providers' obligations and mode of reimbursement.

Primary Care Case Management (PCCM) Program

To promote the "medical home" concept, YouthCare allows PCPs to participate in our "Primary Care Case Management" (PCCM) Program. Providers who participate in this program are eligible to receive a monthly capitation amount for each member who either selects the provider as his/her PCP, or who has been assigned to him/her as a PCP. A provider must be willing to meet the criteria described below in order to qualify for the PCCM program reimbursement:

1) Participate in or coordinate the member's care during and after an inpatient admission;
2) Provide members with comprehensive primary care services and covered preventive services in accordance with the recommendation of the U.S. Preventive Health Services Task Force: medically indicated physical examinations, health education, laboratory services referrals for necessary prescriptions and other services such as mammograms and pap smears;
3) Provide or arrange for all appropriate immunizations for members;
4) Maintain office hours of no less than thirty (30) hours per week for PCP's in an individual (solo) practice. PCP's in a group practice may have office hours less than twenty four (24) hours per week as long as their group practice hours equal or exceed forty (40) hours per week;
5) Maintain the appointment accessibility standards defined on page 71 and, upon notification of a member's hospitalization or emergency room visit, a follow up appointment available within seven days of discharge;
6) Coordinate with YouthCare's Disease Management program including collaborating with case managers as requested;
7) Set up a recall system to outreach to members who miss an appointment to reschedule the appointment as needed;
8) Educate members and remind them of preventive and immunization services, or preventive services missed or due based on the periodicity schedule;
9) Use electronic claim submission for claim transactions YouthCare is able to accept, within six months of the execution of the provider's agreement; and
10) Register with YouthCare Electronic Funds Transfer (EFT) vendor to receive electronic claim payments and remittance advices, upon execution of the Provider Agreement.

Assignment To PCP

For members who have not selected a PCP prior to their enrollment date, YouthCare will use an auto-assignment algorithm to assign an initial PCP 30 days after enrollment.. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1) Member history with a PCP. The algorithm will first look for a previous relationship with a provider.
2) Family history with a PCP. If the member has no previous relationship with a PCP, the algorithm will look for a PCP to which someone in the member's family, such as a sibling, is or has been assigned.
3) Appropriate PCP type. The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.
4) Geographic proximity of PCP to member residence.

Terminating Care of a Member

A PCP may terminate the care of a member in his/her panel if the member:

- Repeatedly breaks appointments
- Repeatedly fails to keep scheduled appointments
- Is abusive to the provider or the office staff (physically or verbally)
- Fails to comply with the treatment plan

The provider may discontinue seeing the member after the following steps have been taken:

1) The incidents have been properly documented in the member's chart
2) A certified letter has been sent to the member documenting the reason for the termination, indicating the date for the termination, informing the member that the provider will be available for emergency care for the next 30 days from the date of the letter, and instructing the member to call YouthCare's member services department for assistance in selecting a new primary care provider
3) A copy of the letter is sent to YouthCare and a copy is kept in the member's chart

Specialist Responsibilities

The PCP is responsible for coordinating the members' healthcare services and making referrals to specialty providers when care is needed that is beyond the scope of the PCP. The specialty physician may order diagnostic tests without PCP involvement by following YouthCare referral guidelines. The specialty physician must abide by the prior authorization requirements when ordering diagnostic tests; however, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency situation.

Specialist Rights and Responsibilities include:

- Maintaining contact with the PCP and coordinate the member's care.
- Obtaining referral or authorization from the member's PCP and/or YouthCare Medical Management department (Medical Management) as needed before providing services.
- Providing the PCP with consult reports and other appropriate records within five business days.
- Being available for or providing on-call coverage through another source 24-hours a day for management of member care. After-hours access can be via answering service, pager, or phone transfer to another location; recorded message instructing the member to call another number; or nurse helpline. In each case, all calls must be returned within 30 minutes.
- Agreeing to communicate with enrollees in a manner that accommodates the enrollee's individual needs and work with YouthCare to coordinate specialized services (e.g., interpreters, hearing impaired services for those who aredeaf or hard of hearing and accommodations for enrollees with cognitive limitations).

HCBS Waiver Provider Responsibilities

HCBS Waiver Service Provider Rights and Responsibilities include:

- Working collaboratively with YouthCare's care coordination team to provide services according to the care plan.
- Providing only the services as outlined in the care plan. If you believe a change is necessary for the member's well-being, contact YouthCare's Integrated Care Team to discuss the change.
- Maintaining contact with the PCP.
- Obtaining authorization from a YouthCare Care Coordinator as needed before providing services.
- Obtaining authorizations for selected inpatient and outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization.

Suspending Waiver Services

A home and community-based services provider may suspend the services of a member if the member or authorized representative causes a barrier to care or unsafe conditions. Any incidents of barriers to care and/or unsafe conditions should be reported to the YouthCare Care Coordinator by calling Member Services. The Care Coordinator will work directly with the provider to resolve any potential issues, and if necessary, temporarily suspend services.

Hospital Responsibilities

YouthCare utilizes a network of hospitals to provide services to YouthCare members. Hospital Rights and Responsibilities include:

- Obtaining authorizations for selected outpatient and ALL inpatient services as listed on the current prior authorization list. Emergency Room care does not require prior authorization.
- Notifying YouthCare's Medical Management department of emergency hospital admissions, elective hospital admissions and newborn deliveries within 24-48 hours of the admission.
- Notifying the PCP, when possible, within 24-48 hours after the member's visit to the emergency department.
- Notifying YouthCare's Medical Management department of members who may benefit from care coordination services – such as members who may have frequent visits to the emergency room.
- Notifying YouthCare's Medical Management department of YouthCare member emergency room visits for the previous business day. This can be done via fax or electronic file. The notification should include member's name, Medicaid ID, presenting symptoms, diagnosis, date of service, and member phone number, if available.

YouthCare hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

Voluntarily Leaving the Network

Providers must give YouthCare notice, in writing, if they wish to initiate voluntary termination procedures following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send written termination notices. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to YouthCare or the member.

YouthCare will notify affected members in writing of a provider's termination. If the terminating provider is a PCP, YouthCare will request that the member select a new PCP. If a member does not select a PCP prior to the provider's termination date, YouthCare will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days or until YouthCare can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, YouthCare will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, YouthCare will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Provider Accessibility Standards & Procedures

YouthCare
HealthChoice Illinois

Appointment Accessibility Standards

YouthCare follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. YouthCare monitors compliance with these standards on an annual basis. Providers must offer hours of operation to YouthCare members no less than those hours offered to commercial enrollees or Medicaid fee-for-service enrollees.

The following table outlines the scheduling timeframe for each type of service that must be followed by all providers:

Type Of Service	Scheduling Timeframe
Emergency Care	Immediate
Urgent Care	One (1) business day
Non-Urgent Symptomatic	Within three (3) weeks
Routine Preventative Care	Within five (5) weeks For infants under the age of six (6) months: Within two (2) weeks
Pregnant Youth Visits	1st Trimester: 2 weeks 2nd Trimester: 1 week 3rd Trimester: 3 days
Average Offce Wait Time	Equal to or less than one (1) hour
Provider Appointment	No more than six (6) scheduled per hour
After Hours	24/7 coverage (voicemail only not acceptable)

In addition to the above accessibility standards and in accordance to the requirements set forth by the Illinois Department of Healthcare and Family Services, a PCPs panel size may not exceed 600 YouthCare members.

Telephone Arrangement Standards

PCPs and Specialists must:

- Answer member telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and reschedule no-show appointments.

- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
  - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes.
  - Same day for non-symptomatic concerns.
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record.

YouthCare will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

Provider Coverage

PCPs and specialty physicians must arrange for coverage with another YouthCare network provider during scheduled or unscheduled time off. The covering provider must have an active Illinois Medicaid ID number and an active NPI number in order to receive payment. The covering physician is compensated in accordance with the terms of his/ her contractual agreement.

24-Hour Access

YouthCare's PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed 24-hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- After-hours, a provider must have arrangements for:
  - Access to a covering physician,
  - An answering service,
  - Triage service, or
  - A voice message that provides a second phone number that is answered.
- Any recorded message must be provided in English and Spanish.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision.

The PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

YouthCare will monitor providers' offices through scheduled and unscheduled visits conducted by our Provider Relations staff.

Member Panel Capacity

All PCPs reserve the right to limit the number of members they are willing to accept into their panel. YouthCare DOES NOT guarantee that any provider will receive a certain number of members.

If a PCP declares a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact YouthCare Provider Services. A PCP shall not refuse to treat members as long as the provider has not reached their requested panel size.

Providers shall notify YouthCare in writing at least 45 calendar days in advance of their inability to accept additional Medicaid covered persons under YouthCare agreements. In no event shall any established patient who becomes a covered person be considered a new patient. YouthCare prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

Cultural, Linguistic, & Disability Access Requirements & Services

YouthCare
HealthChoice Illinois

Cultural Competency

Cultural Competency requires the tailoring of services and supports to meet the unique social, cultural, and linguistic needs of your patient.

CMS requires providers to provide care to members in a culturally competent manner, being sensitive to language, culture, and reading comprehension capabilities. YouthCare offers interpreter services to any non-English speaking member. There is no charge to access this service. To take advantage of free interpretation services, call Member and Provider Services at 844-289-2264 and ask for an interpreter.

YouthCare promotes shared decision making by encouraging providers to freely communicate with patients regarding treatment regimen, including medication treatment options, regardless of benefit coverage limitations.

YouthCare maintains a Cultural Competency Plan that monitors the availability of the following services at the health plan and provider level:

- Language Services;
- Transportation services; and
- Reasonable accommodations for members with disabilities to access services and/or facilities.

In addition, YouthCare and participating Providers share responsibility for:

- Informing patients of the availability of cultural, linguistic and disability access services, at no cost to Medicaid patients;
- Providing diversity and cultural competency training to all staff; and
- Promoting a culturally, linguistically and disability diverse workforce that reflects the diversity of its patients.

Legal & Regulatory Framework

Health plans and Providers must adhere to federal and state laws and regulations that prohibit discrimination on the basis of race, color, national origin, sex, age, or disability.
The National Culturally and Linguistically Appropriate Services (CLAS) Standards consist of 15 operating principles that assist health care organizations in this effort. Specifically, the CLAS Standards are a set of recommended action steps intended to help organizations implement and maintain culturally and linguistically appropriate services.

For a copy of the National CLAS Standards, please visit https://allianceforclas.org//wp-content/uploads/2011/05/EnhancedNationalCLASStandards.pdf.

Language Services

Effective communication with patients who have limited English proficiency or who are deaf, hard of hearing, or speech disabled is crucial to ensuring better health outcomes.

YouthCare offers the following language services at no cost to you:

- Language Line (200+ languages available 24 hours a day, 7 days a week)
- Interpreters in your office or hospital (5-7 business days advance notice preferred)
- Materials in other languages and formats.

When working with an interpreter, the American Academy of Family Physicians recommends that practitioners:

- Use professional interpreters rather than family and friends
- Speak directly to the patient rather than the interpreter
- Keep sentences short and pause to allow time for interpretation

Accommodating People with Disabilities

The Americans with Disabilities Act (ADA) defines a person with a disability as:

A person who has a physical or mental impairment that substantially limits one or more major life activity, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability.

People with disabilities are entitled, by law, to fair and equal access to healthcare services and facilities. YouthCare ensures equal access in partnership with participating providers by maintaining an ADA Plan. The ADA Plan monitors the following:

- Physical accessibility of Provider offices
- Quality of the Health Plan's free transportation services
- Complaints related to the Health Plan and/or Provider's failure to offer reasonable accommodations to patients with a disability

Accommodations for people with disabilities include, but are not limited to:

- Physical accessibility
- Accessible medical equipment (e.g., examination tables and scales)
- Policy modification (e.g., to permit use of service animals)
- Effective communication (e.g., minimize distractions and stimuli for members with intellectual and developmental disabilities).

Resources

Contact Provider Services for language or transportation services assistance.

Visit ILYouthCare.com for:

- YouthCare's Cultural Competency Plan
- Provider-specific Cultural Competency educational materials. Providers interested in additional education and training can contact Provider Services.

Provider/Staff Education and Training

To accommodate the needs of diverse populations, it is important for providers and their staff to annually participate in ongoing training and education efforts that encompass a range of activities from self-study education materials to interactive group learning sessions. The Meridian Provider Relations department supports these efforts by collaborating with providers and their staff to offer up-to-date training resources and programs. Training topics available include, but are not limited to:

- Provider Orientation
- HIPAA Privacy and Security
- Fraud, Waste, and Abuse
- Recipient Rights and Reporting Abuse and Neglect and Critical Incidents
- Person-centered Planning
- Cultural Competency
- Americans with Disabilities Act (ADA)
- Independent living and recovery
- Wellness principles
- Delivering services to LTSS and HCBS populations
- Self-determination
- Disability literacy training
- Care Coordination
- Quality Improvement
- Interdisciplinary care team (ICT) training, including:
  - Roles and responsibilities of the ICT
  - Communication between providers and the ICT
  - Care plan development
  - Consumer direction
  - Any Health Information Technology necessary to support care coordination

Annual mandatory training modules are available online by visiting Meridian's website at ILmeridian.com. If you complete mandatory training with another health plan, please fill out the Attestation Form and return to Meridian via one of the following methods:

Fax: **833-560-2915**
Email: ilproviderrelations@mhplan.com

Mail:
Meridian
Network Development – Attestation
1333 Burr Ridge Parkway, Suite 100
Burr Ridge, IL 60527

In addition, the Provider Relations department holds monthly provider and staff training webinars.

If you would like to request a training session or participate in one of Meridian's scheduled sessions, please call your Provider Relations Representative or the Member and Provider Services department at **866-606-3700** (**TTY: 711**), Monday through Friday, 8 a.m. to 5 p.m. or via email to ProviderHelp.IL@mhplan.com.

Quality Program

YouthCare
HealthChoice Illinois

The Quality Program utilizes a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring to improve the quality of clinical care and non-clinical services our members receive. Areas subject to quality oversight include:

- Health plan programs and services.
- Appropriate utilization of healthcare resources.
- Continuity and coordination of care (including Behavioral Health).
- Patient Safety and Peer Review.
- Practitioner adherence to clinical practice guidelines. A list of evidence-based practice guidelines adopted by the health plan are available at ILYouthCare.com/providers/quality-improvement/practice-guidelines.html.
- Member Satisfaction with the health plan and providers.
- Provider Satisfaction with the health plan.
- Health plan and Provider compliance with federal and state cultural, linguistic, and disability laws and regulations.

Quality Program Activities and Performance

YouthCare communicates activities and outcomes of its quality improvement program to both members and providers through avenues including, but not limited to:

- Member newsletter
- Provider newsletter
- Web portal

To request additional information on the Quality program and/or the program's progress in meeting performance goals, please contact Provider Services.

Practitioner Involvement

YouthCare recognizes the integral role practitioner involvement plays in the success of our programs and services. YouthCare encourages practitioner representation on key quality committees including, but not limited to:

- Quality Improvement Committee
- Quality Improvement Utilization Management Committee
- Credentialing Committee
- Peer Review Committee

If you are interested in joining a Committee, please contact Provider Services.

Provider Performance & Financial Incentives

Provider evaluation in key performance areas is a required part of YouthCare's contract with the Department of Healthcare and Family Services (HFS) and NCQA Health Plan Accreditation.

YouthCare reviews provider specific performance data including, but not limited to:

- HEDIS measurement data (see below)
- Complaint and appeal data
- Sentinel events and/or adverse outcomes
- Adoption of clinical practice guidelines
- Medical record keeping practices

Provider Financial Incentives Program (P4P Program)

YouthCare maintains a PCP-driven pay-for performance (P4P) program with a focus on preventive and screening services. Performance is evaluated using administrative HEDIS measurement data. Each measure included in the P4P program is assigned its own incentive dollar amount.

Providers who meet or exceed established HEDIS performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by YouthCare in publications such as newsletters, bulletins, press releases, and recognized in our provider directories.

Provider-specific HEDIS scorecards are available on the secure provider portal.

Healthcare Effectiveness Data & Information Set (HEDIS)

HEDIS reporting is a required part of NCQA Health Plan Accreditation and YouthCare's contract with the Department of Healthcare and Family Services to measure performance on important dimensions of care and service. HEDIS is used to:

- Compare the performance of health plans
- Make improvements to quality of care and services
- Award accreditation status to health plans
- Assist consumers in selecting health plans and providers

What can be done to improve HEDIS scores?

- Understand HEDIS measure requirements and timelines for completion
- Review gaps-in-care reports
- Engage your patients early each year to promote preventive care and schedule visits for needed services
- Submit claim/encounter data for each and every service rendered
- Accurate and timely submission of claim/ encounter data will reduce the number of medical record reviews required for HEDIS rate calculation

- Bill CPT II codes for HEDIS measure results such as diabetes labs, eye exam, and blood pressure
- Establish a supplemental data feed with YouthCare to combat claims lag and receive credit for services not easily captured via claims submission
- Ensure chart documentation accurately reflects all services provided
- Notify Provider Relations immediately with any updates to your provider roster.
- Encourage your patients who are not listed as part of your panel to update their assigned PCP with the health plan

For more information, please contact Provider Relations. We offer on-site education and assistance to help you improve overall HEDIS performance.

Provider Satisfaction Survey

YouthCare conducts an annual provider satisfaction survey. Participants are randomly selected to participate in the survey which is anonymous. The survey measures provider satisfaction with YouthCare and includes questions related to key health plan functions:

- Billing/Claims
- Utilization Management
- Quality Management
- Network/Coordination of Care
- Pharmacy
- Health Plan Call Center Services Staff
- Provider Relations

Survey results are used to develop quality initiatives to improve provider satisfaction with the health plan.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The CAHPS survey is an annual survey that measures patient satisfaction with health plan and practitioner services. The survey includes questions that evaluate satisfaction with the following:

- Overall Satisfaction with Personal Doctor
- Overall Satisfaction with Specialist
- How Well Doctors Communicate
- Care Coordination
- Getting Care Quickly
- Getting Needed Care
- Health Plan Customer Service
- Overall Satisfaction with Health Plan

Patient responses to the CAHPS survey are used to improve the quality of our programs and services, and to monitor our member's satisfaction with our provider network. Member feedback is shared with providers as part of our improvement efforts.

Medical Records Standards

YouthCare
HealthChoice Illinois

YouthCare Providers must keep complete and accurate medical records in accordance with state and federal regulatory and contractual requirements. Regulatory standards for practitioner documentation and maintenance of medical records address:

- Medical record content and organization
- Ease of medical record retrieval
- Maintaining confidentiality for all protected health information (PHI)

At a minimum, the Illinois Department of Healthcare and Family Services (HFS) requires that entries in the medical record are dated and signed by the rendering practitioner, and include the following information, where applicable:

- Past medical/surgical history, social history and family history, with updates as needed
- Preferred language and interpretation/ translation needs
- Disability access needs
- Obstetrical history and profile
- Immunization record
- Risk assessment
- History of present illness and physical findings
- Weight and height information and, as appropriate, growth charts
- Diagnostic assessments
- Diagnostic and therapeutic orders
- Instruction for follow-up care
- Referral information
- Reports of procedures, tests and results
- Practitioner review of consult/referral reports, and diagnostic test results
- Unresolved and/or continuing problems are addressed in subsequent visit(s)
- Health education and anticipatory guidance provided
- Family planning and counseling
- Hospital admissions and discharges

Medical Records Release

Medical records should be kept in a secure location and only accessed by authorized personnel.

Copies of medical records may only be released to authorized persons upon request, and the information contained therein must be limited to the "minimum necessary". Members have the right to request a copy of their medical records, and to request that the records be amended or corrected, as specified in 45 C.F.R. part 164.

Medical Records Transfer for New Members

Medical records must be provided to any new PCP to whom a patient transfers. For newly assigned YouthCare patients, PCP's must document in the medical record any attempts to obtain the patient's historical medical records.

Medical Records Audits

YouthCare is required by CMS and HFS to conduct randomized medical record audits to ensure maintenance of the medical record keeping standards outlined above. YouthCare will provide official verbal and/or written notice prior to conducting a medical record audit and inform you of the outcome of the audit.

Provider Credentialing

Providers applying for participation with YouthCare must be credentialed with Illinois Medicaid through the IMPACT system as directed by HFS.

Providers will also be required to be re-credentialed with Illinois Medicaid through and in accordance with the IMPACT system every three years. In addition to providers being credentialed through the IMPACT system, Meridian shall require other enrollment information in order to enroll providers into YouthCare. Enrollment data shall be submitted to Meridian by the provider via the Illinois Association of Medicaid Health Plans (IAMHP) Universal Roster that can be found on their website.

IMPACT Enrollment

Providers wishing to participate with YouthCare or non-contracted providers seeking reimbursement must be enrolled with HFS' IMPACT system to provide services to members. If you are already enrolled with IMPACT, simply complete an online application to join the network at our company website. You may also send an email to ILjoinOurNetwork@centene.com to obtain a contract for participation and enrollment criteria.

Providers who have not submitted a claim to the State for reimbursement within 18 months may be at risk for inactivation of the Medicaid ID number. The provider must then call the Provider Participation Unit (PPU) at **217-782-0538** or write to the following location to verify their address:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
PO Box 19114
Springfield, IL 62794-9114

Should too much time elapse before contacting the PPU, the provider could become inactive with Medicaid Assistance Program (MAP). If this happens, the provider will have to re-enroll with MAP prior to seeing a YouthCare member. For additional information or questions regarding MAP participation, providers may visit hfs.illnois.gov.

All providers meeting the above affiliation requirements may submit for participation into the YouthCare provider network. YouthCare will not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment; nor will Meridian discriminate against any provider acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

Re-credentialing

To comply with accreditation standards, YouthCare conducts the re-credentialing process for providers at least every three years, in compliance with the Illinois Register Department of Public Health, Section 965.300 Single Credentialing Cycle. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the YouthCare network.

In between credentialing cycles, YouthCare conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate Illinois state licensing agency, board, or commission for a review of newly-disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, YouthCare reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare and/or Medicaid programs.

Additionally, between credentialing cycles, a provider may be requested to supply current proof of any credentials such as Illinois licensure, malpractice insurance, DEA registration, a copy of certificate of cultural competency training, etc. that have expiration dates prior to the next review process.

A provider's agreement may be terminated if at any time it is determined by the YouthCare's Board of Directors or the Credentialing Committee that credentialing requirements are no longer being met.

Credentialing Committee

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination. Committee meetings are held at least quarterly and more often as deemed necessary.

NOTE: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Right to Review & Correct Information

All providers participating within the YouthCare network have the right to review information obtained by YouthCare to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the State Licensing Agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the YouthCare credentialing department. Upon receipt of this information, the provider will have 14 calendar days to provide a written explanation detailing the error or the difference in information to the YouthCare credentialing department. The YouthCare Credentialing Committee will then include this information as part of the credentialing/re credentialing process.

Right to Be Informed of Application Status

All providers who have submitted an application to join YouthCare have the right to be informed of the status of their application upon request. To obtain status, contact the YouthCare Provider Relations department.

Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to appeal the decision in writing within 14 calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the YouthCare network.

Appeals will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 calendar days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.

Disclosure of Ownership & Control Interest Statement

YouthCare
HealthChoice Illinois

The Enrollment Disclosure Statement Form (HFS form 1513 – http://www2.illinois.gov/hfs/SiteCollectionDocuments/hfs1513.pdf) is required documentation and verification of your eligibility to provide services. In addition, the federal regulations set forth in 42 CFR 455.105 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency certain business transactions. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

42 CFR 455.105 states in relevant part:

"(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about —

1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) Denial of federal financial participation (FFP).

1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).

2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied."

Provider Complaints

YouthCare HealthChoice Illinois

YouthCare has established a provider complaint system that allows a provider to dispute the policies, procedures, or any aspect of the administrative function, including the proposed action.

NOTE: The process for appeals of medical necessity decisions (actions) is outlined above in the Member Appeals Section of this Manual.

Providers may submit a complaint via telephone, written mail, electronic mail or in person. YouthCare has designated a Provider Complaints Coordinator (PCC) to process provider complaints. Provider complaints will be thoroughly investigated using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying YouthCare's written policies and procedures.

After the complete review of the provider complaint, the PCC will provide a written notice of resolution to the Provider within thirty (30) days from the date of the decision.

Provider Complaints may be submitted verbally or in writing to:

YouthCare
Attn: Provider Complaints
PO Box 733
Elk Grove Village, IL 60009-0733

YouthCare Health*Choice* Illinois: **844-289-2264**

In addition to communicating the provider complaint process through this Manual, YouthCare communicates the provider complaint process during provider orientation and on its website.

What is Fraud, Waste and Abuse?

Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347)

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Abuse includes any action(s) that may, directly or indirectly, result in one or more of the following: Unnecessary costs to the health care system, including the Medicare and Medicaid programs; Improper payment for services; and Payment for services that fail to meet professionally recognized standards of care Services that are medically unnecessary.

Examples of Fraud, Waste and Abuse

- Upcoding
- Unbundling
- Billing incorrect CPT code to identify a service.
- Incorrect use of modifiers
- Billing for services outside of the provider's scope of practice
  - Billing and performing services that are not medically appropriate.
  - Excessive units of service or excessive services per day
  - Billing for services not rendered.
  - Member identity theft

YouthCare, through Meridian, takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a Fraud, Waste, Abuse (FWA) program that complies with both state and federal regulations. Meridian, in conjunction with Centene, successfully operates a FWA unit. Meridian performs front-and back-end audits to ensure compliance with billing regulations. Our sophisticated code-editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this Provider Manual.

Centene's Special Investigations Unit (SIU) performs audits, which may result in actions against those who, individually or as a practice, commit fraud, waste and abuse including, but not limited to:

- Conducting remedial education and/or training intended to eliminate the inappropriate or egregious action(s)
- Implementation of more stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Referral to appropriate agencies for Civil and/or Criminal Prosecution
- Implementation of any other remedies available to rectify the FWA.

The SIU uses a variety of mechanisms to detect potential FWA. All key functions, including Claims, Provider Services, Member Services, Medical Management, as well as providers and members share the responsibility to detect and report fraud. Review mechanisms include audit, review of provider billing patterns, hotline reporting, claim review, data validation, and data analysis.

The SIU conducts two types of reviews: **Prepay** – submitted claims are pended for further review and medical records must be submitted in order for the claims to be considered for payment. Pended claims will be documented on the Explanation of Payment (EOP).

The code EXye will be attached to all pended claims and a letter will be sent providing additional details If you receive a prepay notification letter advising that claim services have been pended EXye, please follow the instructions in the letter.

Do NOT submit the requested records to Meridian; instead please submit hard copies of all documentation, including a copy of the relevant EOP(s) to the following address:

Meridian
Attention Claim Department
PO Box 7300
Farmington, MO 63640

Or you may submit via the secure provider portal: Requested prepayment review documentation may be submitted via the secure provider portal under the "Reconsider Claim" Section. Select "Audit-Medical Records requested." from the drop-down menu to ensure the records are correctly routed for review.

Retrospective review – comprehensive review of member medical records for claims previously paid.

A retrospective review may consist of a request for medical records. If required, a letter will be sent outlining the documents necessary to conduct the review. Please follow the instructions in the letter explaining how to submit documentation. Do NOT send requested documents directly to Meridian; instead, please follow the instructions in the letter for obtaining access to Centene's secure portal, or mail copies of the records to the following address:

St. Louis Address:
Centene Special Investigations
Unit ATTN: Project Coordinator
7700 Forsyth Blvd 5th Floor, Room 519
Clayton, MO 63105

Once a retrospective review has been completed, notification of the results will be provided. The notification will include instructions on how to remedy any identified overpayment or alternatively guidance on submitting an appeal.

A request to appeal must be submitted within sixty (60) calendar days. To submit an appeal to Meridian, please follow instructions in the letter to obtain access to our secure portal to upload records or you may submit the appeal request, including all supporting documentation to the following address:

St. Louis Address:
Centene Special Investigations
Unit ATTN: Project Coordinator
7700 Forsyth Blvd 5th Floor, Room 519
Clayton, MO 63105

Please note that the Illinois Department of Healthcare and Family Services, State Illinois Handbook for Practitioners Rendering Medical Services, DEFINITIONS (illinois.gov) outlines that in the absence of proper and complete medical records, claim payments will be made, and payments previously made will be recouped. Additionally, lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

Sampling and Extrapolation

The Illinois Department of Healthcare and Family Services and Meridian audits may involve the use of sampling and extrapolation. Audit sampling is the application of an audit procedure to less than 100 percent of the claims in an audit universe. Under this procedure, Meridian selects a statistically valid random sample of the claims during the audit period in question and audits the provider's records for those claims. Meridian uses random sampling to estimate the parameters of a population, in order to measure and control sampling risk. Through the use of random sampling, every sample unit of the population is equally likely to be in the sample. Random sampling allows Meridian to achieve statistical validity and ensures that the sample represents the entire population of claims.

All overpayments determined by an audit of the claims in the sample are totaled and extrapolated to the entire universe of claims during the audit/review period. Following final determinations, the provider must pay Meridian the entire extrapolated amount of any overpayments calculated using this process.

Reporting Suspected Fraud, Waste and Abuse

Participating providers are required to report to Meridian any cases of suspected fraud, waste and abuse, inappropriate practices, or other inconsistencies of which they have knowledge or suspicion.

Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone 24/7 to the confidential FWA Hotline at **1-866-685-8664**
- By email: special_investigations_unit@centene.com

Note: We keep your identity confidential.

Relevant FWA Laws

There are several relevant laws that apply to Fraud, Waste and Abuse:

The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when health care providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

- Knowingly presenting a false or fraudulent claim for payment or approval
- Knowingly making or using, or causing to be made or used, a false record or statement to have a false or fraudulent claim paid or approved by the government
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or decrease an obligation to pay or transmit property to the government

Anti-Kickback Statute

- The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a federal health care program. Remuneration includes anything of value, directly or indirectly, overtly, or covertly, in cash or in kind.

Self-Referral Prohibition Statute (Stark Law)

- Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship unless an exception applies.

Health Insurance Portability and Accountability Act (HIPAA) requires in part:

- Transaction standards
- Minimum security requirements
- Minimum privacy protections for protected health information
- National Provider Identification (NPI) numbers

Critical Incidents and Significant Events

YouthCare
HealthChoice Illinois

Critical Incidents

Providers and YouthCare are mandated by the Centers for Medicare and Medicaid Services and the Illinois Department of Healthcare and Family Services to report critical incidents. A **critical incident** is any actual or alleged incident or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of an individual.

Examples of critical incidents include, but are not limited to:

- Abuse (i.e., physical, verbal/emotional and sexual).
- Neglect (i.e., passive neglect, willful deprivation, isolation and self-neglect).
- Exploitation (i.e., illegal use of assets or resources of a member with disabilities).
- Suicide attempts.
- Unauthorized use of restraints and restrictive interventions on patient.

All critical incidents involving YouthCare members must be reported to:

A Critical Incident Report must be submitted to Meridian by email to criticalincidents@mhplan.com no later than 48 hours following the discovery of the incident.

- For youth ages 18 years and over, contact **Adult Protective Services Hotline** (**1-866-800-1409**).
- For children under the age of 18, contact **Child Abuse Hotline** (**1-800-252-2873**).
- For members who have disabilities and who reside in or receive services from DHS-operated or DHS-funded agencies, contact **DHS/Office of the Inspector General** (**1-800-368-1463**).

Significant Events

Providers and YouthCare are mandated by the Illinois Department of Healthcare and Family Services and the Illinois Department of Children & Family Services (DCFS) to report significant events. A **significant event** is a significant, sometimes traumatic occurrence that impacts children and youth served by DCFS.

Examples of significant events include, but are not limited to:

- Death Reports Involving Children and Youth;
- Reports of Missing or Abducted Children and Youth in Care;
- Alleged Child Abuse/Neglect and Human Trafficking Involving Children and Youth in Care;
- Encounters with Law Enforcement Involving Children and Youth in Care;
- Behavior Related Incidents Involving Children and Youth in Care;
- Sexualized Behavior Incidents Involving Children and Youth in Care;

- Medical/Psychiatric Incidents Involving Children and Youth in Care; and
- Identification of a Pregnant and Parenting Child or Youth in Care.

A Significant Event Report must be submitted to Meridian by email to criticalincidents@mhplan.com no later than 48 hours following the discovery of the incident.

State reporting requirements include but are not limited to:

- Child's DCFS/POS Worker
- State Central Register Hotline **800-252-2873** for incidents of child or youth deaths, suspected child abuse or neglect and human trafficking.
- Child Intake and Recovery Unit **800-503-0184** for incidents involving children or youth missing or abducted from their placement. Incidents must be reported within 1 hour.

Please contact Provider Services or refer to DCFS Procedures 331 for further details on Significant Event Reporting.

Provider Resources

YouthCare HealthChoice Illinois

YouthCare is dedicated to providing the tools and support providers need to deliver the best quality of care to our members. Below are a few resources providers can utilize.

YouthCare Website

Providers should use ILYouthCare.com as their main source of information related to our plan and products. Providers can access the following information at ILYouthCare.com:

- IAMHP Comprehensive Billing Manual
- Member Handbook and benefit information
- Prior Authorization Check Tool
- Clinical Guidelines
- Provider Forms
- Policies and Procedures
- Provider Newsroom

We are continually updating our website with the latest news and information, so save ILYouthCare.com to your Internet "Favorites" list and check our site often!

Secure Provider Portal

The YouthCare secure provider portal allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations, and send/receive messages to communicate with YouthCare staff. YouthCare's contracted providers and their office staff have the opportunity to register for our secure provider portal in just four easy steps.

The secure provider portal offers tools which make obtaining and sharing information easy! It's simple and secure! Go to Provider.ILYouthCare.com to get started.

Through the secure provider portal, you can:

- View the PCP panel (patient list)
- View and submit claims and adjustments
- View and submit authorizations
- View payment history
- View member gaps in care
- View quality scorecard
- Check member eligibility, and
- Contact us securely and confidentially

For further information regarding billing and claims submission, please refer to IAMHP.org/providers.

Please contact your Provider Relations representative for a tutorial on the secure provider portal.

Interactive Voice Response (IVR) System

The IVR provides you with greater access to information. Through the IVR you can:

- Check member eligibility
- Check claims status
- Access YouthCare information 24 hours a day, seven days a week, 365 days a year

Provider Services

Provider Services is a provider's first point of contact at YouthCare. This department works with all other departments to ensure that providers and their support staff receive the necessary assistance and information.

If you have questions about YouthCare's operations, benefits, policies, and/or procedures; contact the Provider Services department.

Provider Relations

YouthCare's Provider Relations department is designed around the concept of making your experience a positive one by being your advocate within YouthCare. The Provider Relations department is responsible for providing the services listed below which include but are not limited to:

- Initial Point of Contact regarding Provider Data Management.
- Maintenance of existing YouthCare Provider Manual.
- Development of alternative reimbursement strategies.
- Researching of trends in claims inquiries to YouthCare.
- Pool settlement updates/status.
- Network performance profiling.
- Individual physician performance profiling.
- Physician and office staff orientation.
- Hospital and ancillary staff orientation.
- Ongoing provider education, updates, and training.

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to YouthCare enrolled membership.

To contact the Provider Relations representative for your area by phone, please call the Provider Services toll free help line. If you prefer to send an email, please include your name, call-back phone number, and provider Tax ID with your inquiry to ILYouthCare@centene.com.

Top 10 Reasons to Contact Your PR Representative

1. To obtain assistance with the secure provider portal
2. To schedule an in-service training for new staff
3. To conduct ongoing education for existing staff
4. To obtain clarification of policies and procedures
5. To obtain clarification of a provider contract
6. To request fee schedule information
7. To obtain responses to membership list questions
8. To obtain responses to escalated claim questions
9. To learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility
10. To ask questions about updating your information (i.e., practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance) using the Provider Update Tool or via the universal roster template

YouthCare

HealthChoice Illinois

ILYouthCare.com