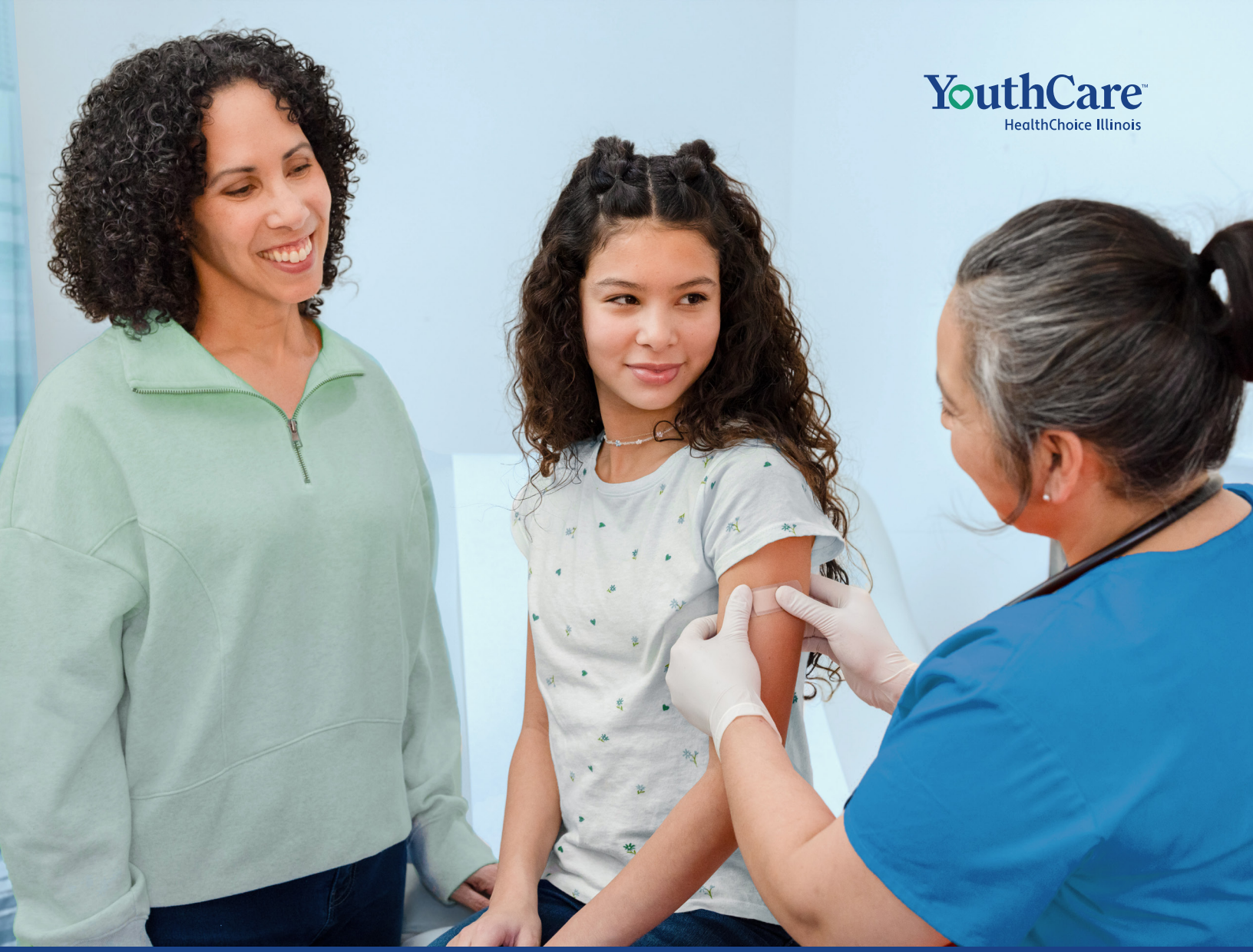
Provider Manual

February 2026

YouthCare™
HealthChoice Illinois



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.

February 2026 Manual Updates

YouthCare HealthChoice Illinois

This table highlights the most notable additions and updates. Not all changes are listed. Providers are encouraged to review the complete document and become familiar with its contents.

Section	Description	Page
Provider Resources – Provider Portal Resources	Updated functionality information	8
Pharmacy – Pharmacy Benefit Manager	Updated form for faxing medication prior authorization requests	23
Behavioral Health – Covered Services and Prior Authorization	Updated requirements for mental health and substance use disorder services to reflect Illinois legislation effective 1/1/26	29
Utilization Management – Service Authorization Program Overview	Updated to reflect all components of YouthCare's service authorization program	40
Utilization Management – Pre-Service Review (Prior Authorization)	Added information about services that require authorization from YouthCare vendor solutions Updated notification and authorization guidance for facility admissions and behavioral health services	41 42
Utilization Management – Peer-to-Peer Discussion	Added information about peer-to-peer discussion procedures and timeframes	45
Utilization Management – Concurrent Review and Discharge Planning	Added information about concurrent review and examples	45
Utilization Management – Administrative Days	Added information about Administrative Days and criteria for consideration	47
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YouthCare HealthChoice Illinois

About Us

YouthCare is a specialized healthcare program of the Illinois Department of Healthcare and Family Services (HFS) 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 plans. 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 healthcare services with the highest levels of member satisfaction. The provider manual contains a comprehensive overview of YouthCare operations, benefits, policies, and procedures.

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**, Monday – Friday, 8:30 a.m. – 5 p.m., 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 Hours of operation are Monday – Friday, 8:30 a.m. to 5 p.m.	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)

Provider Resources

YouthCare HealthChoice Illinois

YouthCare is dedicated to providing the tools and support providers need to deliver the best quality of care.

YouthCare Website

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

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

Provider Portal Resources

YouthCare offers time-saving tools through 24/7 access to our secure portals to manage administrative tasks. To make it easier to work with us, YouthCare has begun transitioning to Availity Essentials™ and expects the migration to be complete in 2027. Our current secure provider portal is still available during the transition.

Availity Essentials™

Utilize Availity Essentials for the following operational tasks:

- Validate eligibility and benefits
- Submit authorization requests and attachments
- Check authorization status
- Update and edit authorization requests
- Submit claims
- Check claim status (24 months from date of service)
- Correct and resubmit claims
- View payment history and Explanation of Payment
- View member gaps in care with the Risk Condition Validation (RCV) and Clinical Quality Validation (CQV) tools
- Receive PCP notifications

Providers working in Availity with other payers can use their existing credentials to access resources for YouthCare members. New users must register and create an account. Training resources are available. For assistance, contact Availity Client Services at **1-800-AVAILITY**.

Secure Provider Portal

Providers should utilize the YouthCare secure provider portal for the following administrative tasks:

- View and download a PCP panel (patient list)
- Check quality scorecards
- Submit administrative denial and provider claim disputes
- Access the Pay for Performance (P4P) program
- View fee schedule information
- Refer members to care management
- Complete patient assessments such as the Notification of Pregnancy
- Secure messaging with the health plan
- Submitting credentialing documentation and updating practice data
- Waiver provider billing

For additional questions about Availity or the YouthCare secure provider portal, contact your Provider Engagement representative.

Interactive Voice Response (IVR) System

The IVR provides you with greater access to information. Contact Provider Services at **866-289-2264** to access the IVR 24 hours a day, seven days a week for functions such as:

- Checking member eligibility
- Checking claims status

Provider Services

The Provider Services 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 Provider Services at **866-289-2264**. Hours of operation are Monday – Friday, 8:30 a.m. to 5 p.m.

Provider Engagement

YouthCare is committed to delivering exceptional services that support your partnership with our plans. We strive to address operational concerns when they arise so that you can stay focused on patient care.

Our Provider Engagement department is experienced working with providers across the state and has access to tools and resources to support your practices.

Find contact information for your organization's representative by visiting the Provider Engagement web page. To help us deliver streamlined support and resolve issues faster, you may also complete the Provider Engagement Intake form. Inquiries are continuously monitored and assigned to a Provider Engagement team member best equipped to assist you. You may call Provider Services at **866-289-2264** to be connected with the appropriate personnel for your organization.

Top Reasons to Contact Your Provider Engagement Representative

1. To obtain assistance with Availity and other provider portal resources
2. To schedule in-service training for new staff
3. To conduct ongoing education for existing staff
4. To obtain clarification on policies and procedures
5. To obtain clarification on your provider contract
6. To request fee schedule information
7. To obtain responses to escalated claim questions
8. 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 Updates Tool or via the universal roster template

Member ID Card

All YouthCare members receive an ID card. 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. Providers must verify member 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 HealthChoice Illinois ID card:

Front

YouthCare HealthChoice Illinois

ILYouthCare.com

Regulatory Agency –
Healthcare and Family Services

Member Services:
844-289-2264 (TTY: 711)

Member Name: Jane Doe
Plan Name: YouthCare HealthChoice Illinois
Medicaid ID #: 123456789
Effective Date: 09/23/2023

PCP Name: Healthcare Center for Kids, Ltd.
PCP Number: 555-555-5555

RxBIN: 003858 **RxPCN:** MA **RxGROUP:** 2EJA

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MEMBERS
Behavioral Health, Vision, Dental, Transportation, 24/7 Nurse Advice Line: 844-289-2264 (TTY: 711)

PROVIDERS
24/7 Eligibility & Prior Auth Check: 844-289-2264
Pharmacists Only: 833-750-4409

PAPER CLAIMS
YouthCare HealthChoice IL
Attn: Claims
PO Box 4020
Farmington, MO 63640-4402

MAILING ADDRESS
YouthCare HealthChoice IL
PO Box 733
Elk Grove Village, IL
60009-0733

Verifying Eligibility

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

1 **Use Availity Essentials**	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 **Utilize the State of Illinois MEDI system**	The Medical Electronic Data Interchange (MEDI) system allows providers to verify Medicaid recipient eligibility.
3 **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.
4 **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 (PA). See the ***Prior Authorization section*** for information regarding the PA 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

Always check if PA is required before rendering services. See the ***Prior Authorization section*** for information regarding the prior authorization process. Covered services include:

- 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 a member's eyesight is changing). We cover refractions to determine a prescription for glasses.
- Health education programs, including diabetes education, heart health education, nutrition 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
- Cancer screening for cervical, breast, and skin cancers

Pregnancy and Maternity Services

- Outpatient services, including routine prenatal care and postpartum care 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 (after one month, the newborn should be enrolled separately)

Voluntary Contraception Services

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

Our members do not need a referral from a PCP and there is not a PA requirement to obtain these services.

Well-Child Care

The 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
90-day Prescriptions	Option for 90-day supply mailed to member's home
Dental Services	Services provided in school dental programs or dental offices
Dental 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 a PA
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 by leveraging our care coordination approach. This approach includes:

- Focus on early identification before conditions worsen
- Facilitate communication and coordination of services across medical and behavioral health specialties
- Identify and engage high-risk members
- Identify barriers to adherence with current treatment plans and goals
- Coordinate with member, their support system, and providers 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

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

Ensures YouthCare 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 (HRS)

The HRS is completed with all new members within 60 days of enrollment to identify those with unmet or ongoing needs, allowing 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
- 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

YouthCare care coordinators outreach to members through various activities to fulfill the following objectives:

- 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
- Build trust and influence members' behaviors because they are hired from within the community
- Identify and engage high-risk members
- 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)

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
- Appropriate children's immunizations
- Other necessary healthcare, diagnostic services, treatment, and other measures to ameliorate defects, physical, and mental illnesses and conditions identified

When Medically Necessary to determine the existence of suspected physical or mental illness, PCPs should provide inter-periodic screenings. While inter-periodic screenings may most commonly be performed for concerns about visual or dental health, PCPs should note that they may also be performed for any concern about mental or physical health.

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 initiatives to increase the percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. YouthCare will assist providers in identifying all members who are not up to date with immunizations.

Vaccines for Children (VFC) Program

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 Vaccines for Children (VFC) program. To enroll in the VFC program or receive more information, visit the Illinois Department of Public Health website.

YouthCare providers are expected to participate in the 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 guidelines below 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 Services

Service	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
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

Recommended Preventive Screenings (continued)

Service	Recommendation
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 (STI) counseling	Sexually active adolescents Youth with an increased risk for STI
Skin cancer counseling	Children, adolescents, and young adults ages 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 provider.

The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or maximum quantities. For more information, visit our pharmacy web page at ILYouthCare.com/providers/pharmacy.

Pharmacy Benefit Manager

YouthCare works with Express Scripts® to administer pharmacy benefits. Certain drugs require PA to be approved for payment by YouthCare. These include:

- All medications not listed on the YouthCare Preferred Drug List (PDL)
- Medications in the "Preferred with PA" and "Non-Preferred" tiers

Follow these steps for efficient processing of your PA requests:

1) Submit a formulary exception request online through CoverMyMeds

   OR

2) Complete the Medication Prior Authorization Request Form [PDF]
   - Fax completed form to Pharmacy Services at **844-205-3384**
   - Once approved, Pharmacy Services notifies the prescriber by fax and the member by mail

If the clinical information provided does not explain the reason for the requested medication requiring PA, 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**.

Pharmacy Services

PA Fax: **844-205-3384**

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

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 provider and member.
- If the request is denied, information about the denial and appeal rights will be provided to the provider and member.

Clinicians are requested to utilize the PDL when prescribing medication. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist will attempt to contact the provider to request a change to a product included in the YouthCare PDL.

Preferred Drug List (PDL)

The YouthCare PDL describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the program. The PDL is regulated by 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 Quality Improvement and Utilization Management Committee (QIUMC) has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring PA. If a patient requires medication that does not appear on the PDL, the clinician can submit a PA request for a non-preferred medication. The current PDL and a log of recent PDL updates 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 PDL. 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 PA is required.

Quantity Limitations

Quantity limitations have been implemented on certain medications to ensure 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 a generic substitution be made when a generic equivalent is available, except where branded products are preferred on the YouthCare 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.

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. Contact the YouthCare complaint and grievance coordinator (see ***Provider Complaints section***). A response will be rendered within 24 hours of receipt of complete information.

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 their office or to the member. For more information, call AcariaHealth at **855-535-1815**.

Psychotropic Medications

YouthCare works with the DCFS Office of the Guardian to review all psychotropic medication requests that require consent, pursuant to DCFS Rule 325.

- To request consent, prescribers should submit an electronic Psychotropic Medication Request Form (CFS 431-A) through the DCFS Guardian Consent Portal
- Alternatively, a completed Psychotropic Medication Request Form (CFS 431-A) [PDF] may be faxed to **312-814-7015**

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

Medications may have separate age limits, quantity limits, and/or PA requirements established in partnership with the Illinois Department of Healthcare and Family Services (HFS).

For additional information about the psychotropic medication consent process, visit our Pharmacy page at ILYouthCare.com/providers/pharmacy.

Maintenance Medications

YouthCare offers a 90-day (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. Call Express Scripts at **833-750-4409** to initiate a new 90-day supply prescription.

Pharmacy & Therapeutics Review

The YouthCare 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.

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

YouthCare members seeking BH, mental health, or substance use disorder services may self-refer to a network provider. Contact Provider Services at **844-289-2264** for assistance with identifying a BH provider, coordinating services for a member, and/or fulfilling notification or authorization requirements for BH services.

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

Continuity of Care

When a member is newly enrolled and has been previously receiving BH services, YouthCare will make its best efforts to maximize the transition of the member's care by providing for the transfer of pending authorizations and coordinating with providers.

BH Providers and PCP Coordination

YouthCare encourages PCPs to consult with their members' BH, 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 training to PCPs and BH providers 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 BH service providers whenever there is a BH 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 BH treatment
- If the member is receiving treatment for a BH 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 in Availity or by contacting Provider Services. Practitioners should screen for the existence of co-occurring BH, mental health, and substance use conditions and make appropriate referrals. BH practitioners should refer members with known or suspected untreated physical health problems or disorders to their PCP for examination and treatment.

We offer provider training on screening tools that can be used to identify possible BH and substance use disorders.

YouthCare requires practitioners to 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 any major changes in psychotropic medication(s) within 14 days of the visit or medication order; and
- The results of functional assessments.

Covered Services and Prior Authorization

Reference the online Prior Auth Check Tool 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 (CMHC) services, including crisis services

See the IAMHP Comprehensive Billing Manual at IAMHP.org/providers for information about billing YouthCare for BH services.

Behavioral Health Prior Authorization and Notification Requirements

Utilize these notification and authorization requirements for behavioral health services.

Mental Health Services	
Notification required within 48 hours (Effective 1/1/26, notification is required within 48 hours of admission. If notification requirements are met, concurrent review will not be initiated for the first 72 hours of admission.)	• Inpatient hospitalization
Notification required within 24 hours (Effective 1/1/26, notification is required within 24 hours of initiation of services. Concurrent review may begin after the 24-hour notification period.)	• Partial hospitalization • Intensive outpatient program • Adaptive Behavior Treatment – initial assessment
Prior authorization required	• Adaptive Behavior Treatment (initial assessment requires notification within 24 hours)
No prior authorization required	• Community Support Team • Electroconvulsive therapy • Psychiatric evaluation • Psychological evaluation • Psychological and neuropsychological testing • Medication management • Crisis intervention • Treatment planning development/review/modification • Community Support Services, individual and group • Outpatient therapy
Substance Use Disorder Services	
Notification required within 24 hours (Effective 1/1/26, notification is required within 24 hours of initiation of services. Concurrent review may begin after the 24-hour notification period.)	• Inpatient hospitalization • Detoxification • Substance use – Residential
No prior authorization required	• Medication administration

Children's Mental Health and Mobile Crisis Response Services

YouthCare works with Mobile Crisis Response Program providers to administer crisis intervention services for members who require BH 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 90 minutes of notification that a member is experiencing a behavioral health crisis, which will include, at a minimum, the completion of the Illinois Medicaid Crisis Assessment Tool (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, 24 hours a day, to contact the Mobile Crisis Response system in moments of crisis
- Establishing a Crisis Safety Plan unique for members who present in BH crisis and providing families of members with physical copies of the Crisis Safety Plan consistent with the following timelines:
  - Prior to completion of the crisis screening event for any member stabilized in the community; and
  - Prior to the member's discharge 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
  - Providers must 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 coordination staff as consistent with the authorizations established by consent or release
- Must be available 365 days a year, 24 hours a day
- For members who experience a crisis event, YouthCare will convene an Interdisciplinary Care Team (ICT) meeting for the member:
  - Within 14 days after the event if the member is stabilized within the community
  - Within 14 days post-discharge if the member is hospitalized
- YouthCare will ensure that the member has a scheduled appointment with a BH provider and the member's primary care provider (PCP) or psychiatric resource within 30 days after the member discharges from hospitalization
- YouthCare includes DCFS in the member's ICT for all youth in care
- 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 follows the process and procedures of the Illinois Crisis and Referral Entry Services (CARES) program. YouthCare partners with CARES to authorize and dispatch Mobile Crisis Services. YouthCare and CARES monitor contracted Mobile Crisis Response providers to ensure timely face-to-face screening occurs for members experiencing behavioral health crises and that they receive clinically appropriate follow up.

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 coordinating 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 providers working in individual practices, large multi-specialty group settings, or home and community-based service settings.

The program is based upon a coordinated care model that uses a multi-disciplinary Care Coordination team, with a recognition that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with members and their PCPs to achieve the highest possible levels of wellness, functioning, and quality of life.

YouthCare utilizes 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. We actively link 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 the plan reflects 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.

Our Care Coordination team is available to help all providers improve the health of YouthCare members. Contact us to speak with a member's care coordination team.

YouthCare HealthChoice Illinois:
Care Coordination Department
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 experienced working with people with physical and/or mental health conditions. In addition, there is a team dedicated to assisting members with intellectual/developmental disabilities. The teams have experience with the YouthCare member population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services.

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

Care Coordinator Responsibilities

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:

- Helping members obtain services
- Visiting members in their residence, as clinically appropriate, to assess health status, evaluate needs, and develop a care plan
- Communicating with providers on services that are authorized according to the care plan
- Discharge planning
- Supporting improved quality of life for members

Contact the Care Coordination department for changes in a member's status, questions regarding services, or other member issues at **844-289-2264**.

Care Plans

YouthCare members with moderate, high, or complex acuities have an identified Interdisciplinary Care Team (ICT) 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 ICT.

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 care plan, YouthCare care coordinators will work directly with home and community-based services providers to fulfill 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.

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 program to other plans/agencies such as another managed care organization, the Department of Rehabilitative Services and HFS.

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

Notification of Pregnancy

It is critical to identify members as early in their pregnancy as possible. A completed Notification of Pregnancy (NOP) directs members to individualized resources, including our Start Smart for Your Baby® program. The NOP alerts and engages the plan about a member's pregnancy and is preferred over claims-based awareness.

YouthCare asks that a managing physician notify the YouthCare prenatal team by completing the Notification of Pregnancy (NOP) within five (5) days of the first prenatal visit. Providers are expected to identify the estimated date of delivery and the 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.

Providers have two options for submitting an NOP on a member's behalf:

1. YouthCare secure provider portal — Preferred and quickest method
   - When logged into the portal, access the "Member Overview" page and navigate to the "Assessments" tab
   - Find the "SSFB Provider Notification of Pregnancy" and select "Fill Out Now"
   - Complete and submit the NOP
2. Provider fax
   - Complete the fillable NOP form [PDF], accessible from the Manuals, Forms and Resources page for providers
   - Fax it to **833-898-8954**

High-Risk Pregnancy Program

YouthCare will place high-risk pregnant members in our Start Smart for Your Baby (SSFB) program which incorporates case management, care coordination, and disease management. SSFB's goal is to enhance obstetrical and pediatric care services while reducing pregnancy-related complications such as premature deliveries, low birth weight deliveries, and NICU admissions.

SSFB is a unique prenatal program that provides pregnancy and parenting education to all pregnant members, while providing case management to high- and moderate-risk members through the postpartum period. A care coordinator will work with members at high risk of premature delivery or who experience complications from pregnancy. 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. YouthCare's Utilization Management department should be immediately notified of all members considered as potential transplant candidates. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

Value-Added Services

YouthCare HealthChoice Illinois

24/7 Nurse Advice Line

When members have questions about their health, their PCP, and/or need access to care, we are here for them. YouthCare offers a 24/7 Nurse Advice Line service at **844-289-2264** to promote health education and preventive care.

Registered nurses are available 24/7 to provide basic health education, offer nurse triage services, and answer questions about urgent or emergency access. The staff often answers routine health questions but are also available to triage more complex health issues using nationally recognized protocols. Members with chronic conditions, 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 regular business hours when the Member Services department is closed. English-and Spanish-speaking staff are available and can provide additional interpreter services if necessary.

Virtual Care

All members have 24/7 access to telehealth services for non-emergency health issues. YouthCare also partners with specialty virtual providers to offer members additional support in areas such as eating disorders, social skills, substance use, and more.

Find additional information about telehealth services for members at ILyouthcare.com/members/youthcare/benefits-services/telehealth.html.

Member Rewards Program

The goal of YouthCare's member 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.

YouthCare HealthChoice Illinois Rewards Program – My Health Pays™ Rewards

The My Health Pays™ rewards program is offered to YouthCare members. My Health Pays rewards members with a pre-paid debit card to purchase health and wellness items or even necessities like utilities, transportation, childcare, and more. Preventive services that may qualify for rewards through the program include completion of an initial HRS, 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 staffed with a team from the local communities served and is 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. Community Health Services are an integrated component of our case management program to link YouthCare members with the community served.

YouthCare Community Health Services outreach teams are hired from within the community to ensure culturally competent outreach is conducted with the unique characteristics and needs of the local area at the forefront. Community Health Services staff are members of our Integrated Care Team that assist with member outreach, conduct member home visits, coordinate with social services, and attend community functions to provide health education and outreach. The team will make home visits to members if we cannot reach them by phone or who require a face-to-face approach.

To refer a member, contact Provider Services at **844-289-2264**.

YouthCare Community Health Services also works with providers and other local organizations to organize healthy lifestyle events.

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 functionality. Members may use this cell phone to call their care coordinator, PCP, specialty physician, the 24/7 Nurse Advice Line, 911, or other members of their healthcare team. In some cases, YouthCare may provide MP3 players with preprogrammed educational programs for those with literacy issues or in need of additional education.

Disease Management and 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
- Certain behavioral health conditions

Members are linked to the Health Coaching team, which includes registered nurses, registered dietitians, 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 (see *Specialty Pharmacy Provider section*).

To refer a member for disease management call Provider Services at **844-289-2264**.

Transportation Benefits

YouthCare covers services to help transport members to their appointments. These include:

- Healthcare appointments
- Court-ordered activities
- Visits to siblings and birth family
- Activities to address social drivers of health needs, like going to food pantries, applying for WIC benefits, and obtaining housing assistance resources
- Activities to support cultural/ethnic identity

Transportation services must be arranged by calling **844-289-2264 at least three (3) calendar days in advance**.

Other Value-Added Benefits

Free Gym Memberships

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

To qualify for free gym memberships, members must:

1) Complete a Health Risk Screening (HRS)
2) Go to the gym at least four (4) times a month to maintain eligibility for the program

Free YMCA Memberships

All members between the ages of 6 and 18 are eligible to receive a free YMCA membership. In order to qualify, youth must complete a HRS and annual well-child visit. Foster families may be able to obtain free after-school care through the YMCA for members who qualify.

Free After-School Care

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

To qualify for free after-school care, members must:

1) Complete a HRS
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 HRS
2) Complete an annual well-child visit
3) Have up-to-date vaccinations
4) Complete a BMI measurement

Service Authorization Program Overview

The YouthCare service authorization program is designed to ensure members receive access to the right care, at the right place, and at the right time. The program assures members receive safe, high-quality, and equitable care through **pre-service**, **concurrent**, **retrospective**, and **peer-to-peer reviews**. For program definitions, refer to the service authorization program glossary on our website.

Our comprehensive program applies to all eligible members across all product types, age categories, and diagnoses. The 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 utilization management (UM) team seeks to optimize each member's health status, sense of well-being, productivity, and access to quality healthcare while 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
- Developing and distributing clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identifying and providing care coordination and/or disease management to members at risk for significant health expenses or ongoing care
- Developing an infrastructure to ensure that all YouthCare members establish relationships with their PCPs to obtain preventive care
- Implementing programs that encourage preventive services and chronic condition self-management
- Creating partnerships with members and providers to enhance cooperation and support for UM program goals

Utilization Management Contact Information

YouthCare HealthChoice Illinois: **844-289-2264**

Pre-Service Review (Prior Authorization)

Prior authorization (PA) or precertification is a **pre-service review** of medical information before the delivery of healthcare services. The purpose is to determine if the care and setting are medically appropriate according to established guidelines, and to engage YouthCare's Care Coordination team. Additional information about clinical guidelines can be found on our Service Authorization Program web page.

Determining Services That Require Prior Authorization

Providers can search code-specific criteria using the YouthCare Prior Auth Check Tool. Failure to obtain prior authorization may result in denial of the claim. All services (except emergency services) for out-of-network providers require prior authorization.

How to Request Prior Authorization

There are three ways to submit PA requests:

1) **Electronic Submission (preferred):**
   Availity Essentials
2) **Fax:**
   - Complete the YouthCare Inpatient PA Form [PDF] or YouthCare Outpatient PA Form [PDF]
   - Fax the completed form to the appropriate number below:
     - Medical requests: **844-989-0154**
     - Behavioral health requests: **833-387-3173**
3) **Phone:**
   Call Provider Services at **844-289-2264**, Monday – Friday, 8:30 a.m. to 5 p.m.

Please ensure the TIN and NPI provided in PA requests are accurate to avoid claims payment issues.

Submit PAs for certain services through vendor solutions for review as noted below:

Service Type	Vendor Links
Dental	Centene Dental Services
MRA, MRI, PET, CT Scans, and Cardiac Imaging	Evolent
Speech, Occupational and Physical Therapy	Evolent
Pharmacy	covermymeds
Non-Emergent Non-Ambulance Transportation	MTM

Emergency and urgent care services never require PA. 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 two 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

PA should be requested at least 14 calendar days before the requested service delivery date. YouthCare decisions for standard service requests will be made within five (5) 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 (1) business day of the determination. Failure to submit necessary clinical information can result in an administrative denial of the requested service.

For urgent/expedited PA requests, a decision is made within 48 hours of receipt of all necessary information. Urgent criteria are 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, the member would be subject to adverse health consequences without the care or treatment that is being requested. The provider and member will be notified of the decision within one (1) business day of the determination.

Behavioral Health Notification Requirements

- **Inpatient behavioral healthcare:** Providers should notify YouthCare within 48 hours of admission. If notification requirements are met, utilization review will not be initiated for the first 72 hours of admission.
- **Substance use residential treatment:** Providers should notify YouthCare within 24 hours of initiation of services. Utilization review may begin after the 24-hour notification period.
- **Outpatient behavioral healthcare (including partial hospitalization and intensive outpatient treatment):** Providers should notify YouthCare within 24 hours of initiation of services. Utilization review may begin after the 24-hour notification period.

Facility Admission Guidance

- **Planned (elective) inpatient hospital admissions** must have PA before the admission occurs.
- **Unplanned inpatient hospital admissions** require notification to YouthCare within 48 hours of admission to the facility. If notification requirements are met, utilization review will not be initiated for the first 72 hours of admission.
- **Skilled nursing, long-term acute care, and rehabilitation facility admissions** require PA before the admission occurs.

Clinical Information

Authorization requests may be submitted through Availity, by fax, or phone. An authorization specialist will enter the requested information and transfer the authorization request to a YouthCare nurse for the completion of medical necessity screening. For all services requiring PA, 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 provider of the specific information needed to complete the authorization process.

Clinical Decisions

YouthCare affirms that UM decision-making is based only on appropriateness of care and service and the existence of coverage. All adverse determinations are made by a medical director and are not based solely on guidelines. YouthCare does not reward our providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

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 UM 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 determined that the member's medical symptoms or conditions require the services that cannot be safely provided as an outpatient service
- Not experimental, investigational, or for research or education purposes

Review Guidelines

YouthCare has adopted utilization review guidelines developed by McKesson InterQual® products to determine medical necessity for healthcare services. The behavioral health utilization management team uses InterQual in addition to American Society of Addiction Medicine (ASAM) guidelines for all inpatient services; state service definitions are used for behavioral health community-based services. Find additional details about evidence-based clinical guidelines on our Service Authorization Program web page.

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

Guidelines 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 guidelines used to make a specific adverse determination by contacting the Utilization 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.

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.

Peer-to-Peer Discussion

A peer-to-peer discussion is an opportunity for a treating physician to discuss medical criteria and guidelines with the health plan medical director. Medical directors review cases based on medical information submitted to the health plan.

Treating physicians who would like to discuss a utilization review determination or a request for further documentation with the decision-making medical director may do so at any time during the review process by contacting Provider Services at **844-289-2264**. A peer-to-peer discussion performed after an adverse benefit determination may result in an overturn. The request must be submitted **within ten (10) calendar days** of the initial denial notification. YouthCare will work with the treating physician to schedule the peer-to-peer review **within three (3) business days** of receipt of the request.

Medical directors may verbally notify the provider of their decision during or after the peer-to-peer discussion. All providers will be notified of YouthCare's decision in writing **within 24 hours** of the peer-to-peer review.

Pre-Service Medical Necessity Appeals

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:

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

Fax: **833-383-1503**

For information on appealing an adverse determination for services that have already been rendered, see the ***Post-Service Medical Necessity Appeals section*** within the ***Billing & Claims chapter***.

Concurrent Review and Discharge Planning

Concurrent review is an assessment of ongoing clinical care to determine if services being provided meet clinical guidelines for the appropriate level of care and setting. Licensed clinical reviewers assess the care and services provided, and the member's response to the care, by applying clinical guidelines.

Inpatient concurrent review supports the coordination of the member's discharge plan. Meridian's reviewers work with the facility discharge planners to:

- Identify the member's discharge planning needs
- Facilitate the transition of the member from one level of care to another
- Obtain clinical information and facilitate the authorization of post-discharge services

Meridian's nurse reviewers are assigned to members at specific acute care facilities to promote collaboration with the facility's review staff and management of the member across the continuum of care.

Nurse reviewers assess the care and services provided in an inpatient setting and the member's response to the care by applying InterQual® guidelines. Together with the facility's staff, Meridian's UM clinical staff coordinates the member's discharge needs.

Meridian's nurse reviewers work with the hospital/facility discharge planners to:

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

Examples of Services Eligible for Concurrent Review

Concurrent review may apply to care or services delivered in inpatient or outpatient settings. For inpatient concurrent review requests, if the discharge is confirmed at the time of the initial request/notification of the admission, retrospective review may be applied.

Examples of concurrent reviews:

- A continued stay review for an inpatient facility stay
- A new admission to a facility when the plan is notified after the admission has occurred, but before the member has been discharged
- An extension to a specified course of allergy injections
- An extension to a series of physical or occupational therapy treatments
- A specified plan of continuation of home health services
- Continued rental or purchase of oxygen and its related durable medical equipment (DME)

Discharge Planning

YouthCare UM staff will coordinate 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 to ensure that YouthCare members receive appropriate post-hospital discharge care.

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 case.

Examples of Services Eligible for Retrospective Review

YouthCare may make retrospective medical necessity review decisions when:

- A member was discharged from an inpatient admission prior to timely notification to the health plan
- Non-routine obstetrical admissions require additional days of service
- Authorization or timely notification was not obtained due to extenuating circumstances
  - Services received prior to the date of notification may be retrospectively reviewed for up to five (5) calendar days if there are extenuating circumstances; dates prior to five (5) calendar days are administratively denied

Meridian does not retroactively authorize services rendered. Follow pre-service review procedures for services that require authorization.

Administrative Days

Administrative Days may be requested once the facility receives notification that medical necessity criteria are no longer met and a denial has been issued. Administrative Days provide reimbursement, at a reduced rate, when a member no longer meets medical necessity criteria for the current level of care and there are barriers to discharge. Please note, if Administrative Days are approved, providers waive their appeal rights and may not appeal the medical necessity denial.

Administrative Days Request Procedure and Criteria

Request Administrative Days by faxing supporting documentation to the appropriate number listed below. Label your submission "Administrative Days Request."

- Physical Health Fax: **844-989-0154**
- Behavioral Health Fax: **833-387-3173**

Criteria for Administrative Days consideration include:

- Member is covered by Medicaid.
- Initial admission diagnosis required an acute inpatient level of care.
  - Initial admission was authorized by YouthCare.
  - Notification requirements were met, and the date and time of the admission and notification should be included with the request.

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 care, YouthCare encourages specialists to communicate with and route referrals through the PCP, rather than making specialist referrals 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 PA from 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 bylaws that require an assistant surgeon to be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity. Reimbursement is not 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 team 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, contact the Medical Management department at **844-289-2264**.

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 necessary for a member's health.

Filing a Grievance

A member grievance is defined as any expression of dissatisfaction by a member about any matter other than an administrative action that can be appealed. 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. 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 will acknowledge receipt of each member grievance. 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 grievances not resolved informally) will occur as soon as possible but not exceed 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 will 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 the resolution process and the date it was completed.

Medicaid grievances may be submitted in writing to:

Fax: **833-920-1747**

Email: gareferrals@centene.com

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

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 YouthCare 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. 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 15 business days from receipt of the appeal. An extension of up to 14 calendar days may be requested by the member or YouthCare if the plan can establish that the delay is in the interest of the member. A member or an authorized representative may request a standard or expedited External Independent Review (EIR) of an adverse determination.

Expedited Appeals

Expedited appeals may be filed when either YouthCare or the member's provider determines that the time allotted for a standard resolution could seriously jeopardize the member's life, 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.

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

Notice of Appeal Resolution

Written appeal resolution notice will include the following information:

- The decision reached by YouthCare
- The date of the decision
- For YouthCare HealthChoice 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 HealthChoice 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 30 calendar days of the date of the appeal decision

Appeals may be submitted verbally or in writing to:

Fax: **833-920-1747**

Email: ILYouthCareG&A@centene.com

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

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.

Contact:

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

Fax: **312-793-2005**

Email: HFS.FairHearings@illinois.gov

Phone: **855-418-4421**, **TTY: 800-526-5812**

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 72 hours after receipt of the State Fair 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.

The following are guidelines for claims submission to Meridian for YouthCare members:

- Providers must use a standard CMS 1500 Claim Form or UB-04 Claim Form, 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 Medicaid Health Plans (IAMHP) Billing Manual which can be found online at IAMHP.org/providers
- 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 through Availity Essentials
- The standard timely filing submission of Medicaid claims must be within 180 days from 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: hfs.illinois.gov/medicalproviders/medicaidreimbursement

To receive reimbursement in a timely manner, 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 (TIN) 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 Medicaid 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 — See ***Member Benefits and Limitations section***. (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 PA 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 – Corrected claims must be submitted per the guidelines that follow in the provider manual
- Is submitted in compliance with all of Meridian's PA and claims submission guidelines and procedures
- Is a claim for which the 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: 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 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 should 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 must 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**

*__Note:__ Providers utilizing Change Healthcare as the clearinghouse must submit to Change Healthcare with Payor ID MCCIL. Contact Change Healthcare with any questions.

Paper Claims Submission

Mail 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, 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; 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 a paper claim was submitted or a rejection report if the claim was submitted electronically. In these instances, the claim will need to be corrected and resubmitted 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 be denied. An explanation of payment (EOP) will be sent that includes the denial reason.

Claim Corrections and Resubmissions

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 EOP/correspondence, not to exceed one year from the date of service.

- 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. This process is only 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 also utilize Availity Essentials to submit corrected claims.

Medical Claim Refunds/Recoupments

In the event Meridian has overpaid a claim, the provider will receive a 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 send a refund for a claim overpayment, mail a check and requested documentation to:

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

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 (TPL)-related delays:** These claims must be accompanied by a 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 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.

To assess the quality of care, determine utilization patterns, and evaluate 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, which must then submit it to HFS. Both Meridian and the 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 AMA'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 that links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service

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

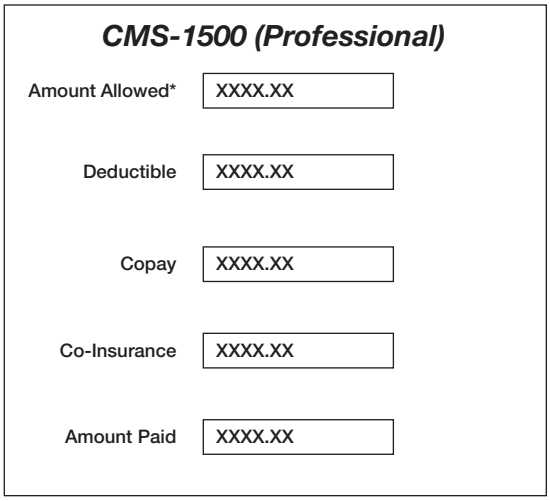
Meridian's software evaluates code combinations during auditing/processing of claims. Denial codes beginning with a lowercase x or y are generated by the code-auditing software or Meridian Payment Policies. The exact reason for denial will not show on the EOP (remittance). These denials cannot be reprocessed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

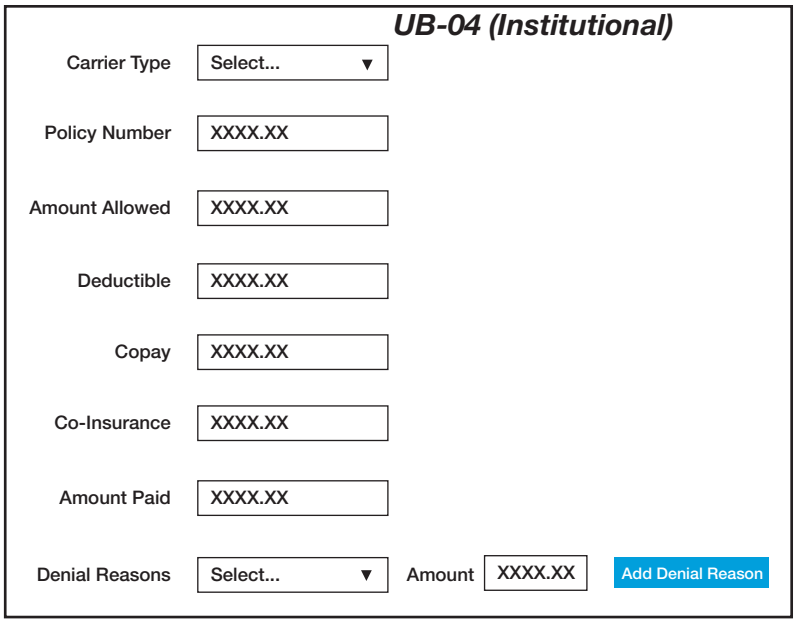
Coordination of Benefits (COB)

Meridian appreciates your assistance and cooperation in notifying us when any other coverage exists, such as, but not limited to, other healthcare plans and workers' compensation benefits. If 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 through the secure provider portal.

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 portal, input your COB information directly in the data fields. The data fields used to populate COB information are outlined on the following page:





Third Party Coverage

Topic	Description
Identification of Third-Party Resources	Providers must always identify third-party resources and report third-party payments 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 commercial insurance, the Explanation of Benefits (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 claim form.

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, contact your clearinghouse.

COB Field Name (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, which 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	
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 – ERAs can be imported directly into practice management or patient accounting systems, eliminating the need for manual keying of paper remittance 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 ERAs 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 to settle claims

With PaySpan, you have several options for viewing and receiving remittance details. PaySpan will match your preference for remittance information with the following options:

- 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 PaySpan Inc. 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.

Post-Service 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 (authorization denial). 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 (see ***Pre-Service Medical Necessity Appeals section***) 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

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 ***Grievances and Appeals section*** of this manual.

Providers have 90 days to file a post-service appeal from the date of the Adverse Benefit Determination letter. (Do not use this option if you fail to get an authorization. See the ***Claim Disputes section*** that follows.) 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 Disputes

If a provider is not satisfied with the claims disposition, a claim dispute can be submitted via the secure provider portal (preferred). A completed Provider Claim Dispute form [PDF] can also be mailed to the address listed on the form. Attach or enclose the necessary documents and an explanation of what should be reconsidered.

Disputes must be filed within 90 days of the remittance date. Disputes submitted after the timeframe has expired may not be reviewed. All disputes must be received within 365 days of the date of service 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 binding arbitration 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. **IMPORTANT:** If you have an authorization number for a denied or partially denied authorization request and are appealing the authorization denial follow the Post-Service Medical Necessity Appeals process	Two ways to submit: 1. Secure provider portal (preferred) 2. Via mail: **Meridian** ATTN: Provider Appeals 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	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, call Meridian Provider Services at **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 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 their healthcare treatment and choices
- Refuse treatment and be told what may happen to their health if they do
- Receive a copy of medical records and, in some cases, request that they be amended or corrected
- Choose their own PCP from the YouthCare network; members can change their 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 doctors and office staff with courtesy and respect
- Carry their YouthCare ID card with them when going to appointments and to the pharmacy to pick up prescriptions
- Keep appointments and be on time for them
- Cancel appointments in advance if and when conflicts arise
- Follow the instructions and treatment plan from their doctor
- Tell YouthCare and caseworkers if their address or phone number changes
- Read their member handbook to understand 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 the 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 a YouthCare care coordinator to make informed choices for a 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 developing waiver services care plan with the care coordinator
- Follow through with the member's plan for rehabilitation
- Review rehabilitation case record with a staff member present
- Communicate with the care coordinator and ask questions when the member does not understand services
- Keep a copy of the waiver services plan and any amendments related to the plan
- Keep original documents and send only copies to the care coordinator's office
- Notify the care coordinator of any change in personal condition or work status
- Be aware of financial eligibility requirements for some services
- Participate with the care coordinator in any decision to close the 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 Provider Services with any questions, comments, or problems, including suggestions for changes in the Quality Improvement Program's (QIP) 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 QIP 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
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment

- Have access to information about YouthCare's QIP, including program goals, processes, and outcomes that relate to member care and services, as well as 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 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

- 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 language services, including the ability to communicate with sign language
- Provide accessible, culturally and linguistically competent care
- 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)
- Provide oral interpretation services free of charge for all non-English languages
- Notify members that oral interpretation is available and how to access those services

Critical Incident Prevention and Reporting

- Follow YouthCare's policies and procedures related to reporting critical incidents such as abuse, neglect, and exploitation

Significant Event Reporting

- 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
- 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 they relate 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 restrictions on the use and disclosure of their personal health information
- Use all health information, including information related to patient conditions, medical utilization, and pharmacy utilization, available through provider portals or any other means, 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

- 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 and Voluntarily Leaving the Network

- 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 Provider 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
  - 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
- 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

PCP Responsibilities

The 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 and 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, caregiver, 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 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 PA list, except for emergency services up to the point of stabilization
- Being available for, or providing on-call coverage through another source, 24-hours a day for management of member care
  - After-hour access to the Medical 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
  - 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, such as: 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 30 hours per week for PCPs in an individual (solo) practice (PCPs in a group practice may have office hours less than 24 hours per week as long as their group practice hours equal or exceed 40 hours per week)
5) Maintain the appointment accessibility standards defined in the ***Provider Accessibility Standards & Procedures section*** and, upon notification of a member's hospitalization or emergency room visit, ensure a follow-up appointment is available within seven (7) 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 (6) months of the execution of the provider's agreement
10) Register with YouthCare's Electronic Funds Transfer (EFT) vendor to receive electronic claim payments and remittance advices upon execution of the Provider Agreement

Assignment to a 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 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 PCP
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 PA 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 to coordinate the member's care
- Obtaining referral or authorization from the member's PCP and/or YouthCare Medical Management department as needed before providing services
- Providing the PCP with consult reports and other appropriate records within five (5) 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
  - All calls must be returned within 30 minutes
- Agreeing to communicate with enrollees in a manner that accommodates each enrollee's individual needs and work with YouthCare to coordinate specialized services (e.g., interpreters, hearing impaired services for those who are deaf or hard of hearing, and accommodations for enrollees with cognitive limitations)

HCBS Waiver Provider Responsibilities

Home and Community-Based Services (HCBS) Waiver 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 PA list, except for emergency services up to the point of stabilization

Suspending Waiver Services

An HCBS 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 Provider 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 PA list (emergency care does not require PA)
- 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
- Appropriate hospital personnel will engage YouthCare's Care Coordination team, as needed, to support members with post-acute healthcare needs, 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
  - Notification can be done via fax or electronically
  - The notification should include member's name, Medicaid ID number, presenting symptoms, diagnosis, date of service, and member phone number, if available

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

Appointment Accessibility Standards

YouthCare follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. We monitor 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.

YouthCare recognizes that providing medical care is not always a predictable experience. Emergencies and episodic increases in the demand for services will challenge the ability of an office to meet the expectations for medical care access. However, in the normal course of providing medical care, provider offices should regularly meet these expectations.

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

YouthCare Appointment and Timely Access to Care Standards *Medical coverage 24 hours a day, 7 days a week*	
Primary Care Appointments	
Type of Care/Appointment	**Length of Wait Time**
Preventative/Routine Care (Child < 6 months)	Within two (2) weeks of request
Preventative/Routine Care (Child ≥ 6 months)	Within five (5) weeks of request
Urgent/Non-Emergent (Medically Necessary) Care	Within one (1) business day of request
Non-Urgent/Non-Emergent Conditions	Within three (3) weeks of request
Initial Prenatal w/o Problems (First Trimester)	Within two (2) weeks of request
Prenatal (Second Trimester)	Within one (1) week of request
Prenatal (Third Trimester)	Within three (3) calendar days of request
Office Wait Time	Within thirty (30) minutes
Different Hours for Member Plans	No, hours must be the same for all members and patients

YouthCare Appointment and Timely Access to Care Standards *Medical coverage 24 hours a day, 7 days a week*	
Behavioral Health Appointments	
Type of Care/Appointment	**Length of Wait Time**
Life-Threatening Emergency	Immediate admittance or referred to the emergency room
Non-Life-Threatening Emergency	Within six (6) hours of request
Urgent Care Visit	Within forty-eight (48) hours of request
Initial Visit for Routine Care	Within ten (10) business days of request
Follow-Up Visit for Routine Care	Within twenty (20) business days of request
Office Wait Time	Within thirty (30) minutes

Specialty Care Appointments	
Type of Care/Appointment	**Length of Wait Time**
Preventative/Routine Care (Child < 6 months)	Within two (2) weeks of request
Preventative/Routine Care (Child ≥ 6 months)	Within five (5) weeks of request
Urgent/Non-Emergent (Medically Necessary) Care	Within one (1) business day of request
Non-Urgent/Non-Emergent Conditions	Within three (3) weeks of request
Office Wait Time	Within thirty (30) minutes
Different Hours for Member Plans	No, hours must be the same for all members and patients

Primary Care After-Hours Requirements – Acceptable after-hours access mechanisms include:
Answering service
On-call pager/cellular connection
Call Forwarding to Practitioner's Home/Other Location
Published after-hours telephone number and recorded voice message directing patients to a practitioner for Urgent and Non-Life-Threatening conditions.
The message **should not instruct patients to obtain treatment at the emergency room for non-life-threatening emergencies** but MUST direct patients in a medical emergency to call 911 or go to the nearest emergency room/urgent care

YouthCare Appointment and Timely Access to Care Standards *Medical coverage 24 hours a day, 7 days a week*
Voice message MUST contain ONE of the following
Message forwards to on-call practitioner
Message forwards to an answering service
Message gives the on-call practitioner's number
Message gives the on-call practitioner's pager number
Message refers patient to another office, practitioner, or on-call service
Message may not only direct patients to the emergency room. The patient must be able to leave a message for an on-call doctor, speak with an on-call doctor, or be forwarded to an on-call doctor.

Telephone Scheduling 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 must 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 ongoing 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 must 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
  - 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.

Member Panel Capacity

In addition to YouthCare's accessibility standards and in accordance to with the requirements set forth by HFS, a PCP's panel size may not exceed 600 YouthCare members.

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 cannot refuse to treat members as long as the provider has not reached their requested panel size.

Providers must 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 can 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 support to meet the unique social, cultural, and linguistic needs of members.

The Centers for Medicare & Medicaid Services (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
- Reasonable accommodations for members with disabilities to access services and/or facilities

YouthCare and participating providers share responsibility for:

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

YouthCare's cultural competency training resources can be accessed on the Meridian website for providers under Annual Training.

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 healthcare 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, visit allianceforclas.org.

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

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 providers' 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)

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 Engagement department supports these efforts by collaborating with providers and their staff to offer up-to-date training resources and programs available on the Meridian provider website. Training topics available include, but are not limited to:

- New 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, fill out the Attestation Form [PDF] and return it to Meridian via one of the following methods:

Fax: **312-980-0418**
Email: ILproviderrelations@mhplan.com

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

You can also register for monthly provider and staff training webinars. If you would like to request a training session, call your Provider Engagement representative or email ILproviderrelations@mhplan.com.

Quality Program

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 is available at ILyouthcare.com/providers/quality-improvement/practice-guidelines
- 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 Communications

YouthCare communicates activities and outcomes of its Quality Improvement Program to both members and providers through avenues including, but not limited to:

- Member monthly newsletter
- Provider monthly newsletter
- Monthly Quality education webinars hosted for providers
- Secure provider portals
- YouthCare and Meridian social media platforms

Practitioner Involvement

YouthCare recognizes the integral role practitioner involvement plays in the success of our programs and services. We encourage 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, 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 HFS 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 Engagement 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, contact Provider Engagement. 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
- Provider Engagement

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 members' satisfaction with our provider network. Member feedback is shared with providers as part of our improvement efforts.

Medical Records Standards

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, HFS requires that entries in the medical record are dated and signed by the rendering practitioner, and include the following information, where applicable:

- Enrollee identification information
- 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
- Allergy history
- Periodic exam record
- Risk assessment
- History of present illness and physical findings
- Weight and height information and, as appropriate, growth charts
- Diagnostic assessments
- Clinical observations, including results of 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 the new PCP to whom a member transfers. For newly assigned YouthCare members, PCPs must document in the medical record any attempts to obtain the member'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 IMPACT Enrollment, Credentialing, and Re-Credentialing

Providers applying for participation with YouthCare must be credentialed with Illinois Medicaid through the Illinois Medicaid Program Advanced Technology (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 five years. Additionally, YouthCare requires enrollment information to load and enroll providers accurately. Submission of the Illinois Association of Medicaid Health Plans (IAMHP) Universal Roster, found on their website, is also required.

Providers with general questions about IMPACT or provider enrollment should contact:

Email: IMPACT.Help@illinois.gov

Phone: **877-782-5565** (select option #1)

Joining the Network

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, complete a Network Intake Form on our website to request to join our provider network. You may also email to ILJoinOurNetwork@centene.com to obtain a contract for participation and enrollment criteria.

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 YouthCare 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 registered in IMPACT prior to accepting or treating members. PCPs cannot accept member assignments until they are fully registered in IMPACT.

Provider Complaints

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

NOTE: The processes for post-service appeals of medical necessity decisions (actions) and claim disputes are outlined in the ***Billing & Claims section*** of this manual.

Providers may submit a complaint via telephone, written mail, e-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 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 Provider Services: **844-289-2264**

Fraud, Waste, & Abuse

YouthCare takes the detection, investigation, and prosecution of fraud and abuse very seriously and has a Fraud, Waste, and Abuse (FWA) program that complies with both state and federal regulations.

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 healthcare 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 healthcare 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; and services that are medically unnecessary.

Examples of FWA

- 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, with its parent company Centene, successfully operates a Special Investigations Unit (SIU) to detect, investigate, and prosecute FWA. YouthCare 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, review the ***Billing & Claims section*** of the manual.

Centene's SIU performs prepayment and retrospective audits, which may result in actions against those who, individually or as a practice, commit FWA, 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 the 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 health plan functions, including Claims, Provider Services, Member Services, Medical Management, as well as providers and members, share responsibility for detecting and reporting fraud. Review mechanisms include auditing, 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 with details. If you receive a prepay notification letter advising that claim services have been pended EXye, follow the instructions in the letter.

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

Meridian
Attn: Claim Department
PO Box 4020
Farmington, MO 63640

You may submit requested prepayment review documentation 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. Follow the instructions in the letter explaining how to submit documentation. Do NOT send requested documents directly to Meridian;

instead, follow the instructions in the letter for submitting documentation through the secure provider portal, or mail copies of the records to the following address:

Centene Special Investigations
7700 Forsyth Blvd, Suite 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 request.

A request to appeal must be submitted within 60 calendar days from receipt of the Proposed Action-Findings letter. Follow instructions in the letter to obtain access to our secure provider portal to upload records, or you may submit the appeal request, including all supporting documentation to the following address:

Centene Special Investigations
7700 Forsyth Blvd, Suite 519
Clayton, MO 63105

Note that the HFS "Handbook for Practitioners Rendering Medical Services" outlines that in the absence of proper and complete medical records, claim payments will not 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

HFS 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 to measure and control sampling risk. Using 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 FWA

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

Providers can confidentially report suspected FWA in the following ways:

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

Relevant FWA Laws

There are several relevant laws that apply to FWA:

- The **Federal False Claims Act (FCA)** (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government healthcare 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 FCA 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 to decrease an obligation to pay or transmit property to the government
- 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 or 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
- The **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 CMS and HFS 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 a patient

All critical incidents involving YouthCare members must be reported to:

A completed Critical Incident Report [PDF] 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 the Adult Protective Services Hotline (**866-800-1409**).
- For children under the age of 18, contact Child Abuse Hotline (**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 (**800-368-1463**).

Significant Events

Providers and YouthCare are mandated by HFS 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
- Identification of a pregnant and parenting child or youth in care

A Significant Event Report [PDF] 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 at **800-252-2873** for incidents of child or youth deaths and suspected incidents of child abuse, neglect, and/or human trafficking
- Child Intake and Recovery Unit at **800-503-0184** for incidents involving children or youth missing or abducted from their placement. Incidents must be reported within one (1) hour.

Contact Provider Services or refer to DCFS Procedures 331 for further details.

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