meridian

Comprehensive Community Support Services

Frequently Asked Questions (FAQ)

Effective April 1, 2024, prior authorizations will be required for Comprehensive Community Support Services after the first 90 days of service for Meridian Medicaid Plan members.

FAQs:

- **What codes will be impacted?**
  - Codes H2015 and H2016 will require a prior authorization beginning April 1, 2024

- **When must prior authorization be submitted?**
  - A one-time waiver will be applied, and prior authorization will not be required for the first 90 days of service. For example, a member who starts services 7/1/24 would require a prior auth by 10/1/24 and forward. Anyone who is currently in care at start of the PA initiation of 4/1/24 will require an authorization on 7/1/24 and ongoing as care is requested and provided.

- **Will member utilization be tracked annually?**
  - Updated clinical information will be required at each concurrent review for ongoing utilization. Upon completion of a prior auth, provider will receive information regarding the approved timeframe for dates of service and the due date for the next concurrent review.

- **How will member utilization be tracked?**
  - Providers are responsible for tracking the initial 90 days of service for codes H2015 and H2016

- **How will prior authorization to be submitted?**
  - Providers are encouraged to submit clinical through the provider web portal: Log In Illinois Medicaid Plan (entrykeyid.com).
  - Providers with an existing Provider Portal account may enter their log-in credentials. New users can select 'Create New Account.'
  - Portal allows for direct uploads of clinical documentation. When uploading, the file name cannot contain any spaces.
  - Clinical records can also be sent to the outpatient fax number: **833-544-1828**

- **I am trying to submit a prior authorization via the portal and backdate my request but it's not allowing me to, what can I do?**
  - Meridian is aware and we are working to mitigate the issue. In the meantime, please utilize fax **833-544-1828** to submit your requests if you are experiencing challenges with backdating your request dates.
  - We continue to allow for backdating requests through August 31, 2024

- Can providers ask for any number of units within the prior auth form/portal? (Understanding how units, or timeframes, are requested and applied is still an open question for our providers.) Yes, providers should submit date ranges and units based on the needs of the member**.**

- For prior authorization forms submitted via fax, what NPI should providers include? Do providers need to include modifiers?
    - Billing NPI. Providers will not need to include modifiers as part of their request.

- **What will Turnaround Times (TAT) be for these requests?**
    - With a standard level of urgency, TAT will be four days from the date the request is received

- **Will change apply to YouthCare members?**
    - Prior authorizations for H2015 and H2016 will only apply for Medicaid and MMAI members, and not YouthCare or MLTSS.

- **How can providers access the prior authorization form?**
    - The prior auth form is available on the Meridian website:
    - ILmeridian.com/providers/preauth-check/medicaid-pre-auth.html
    - This form is only required for fax authorization requests, not web portal requests

- **How can providers verify which codes require prior authorization?**
    Through the Medicaid Pre-Auth page on the Meridian website:
    ILmeridian.com/providers/preauth-check/medicaid-pre-auth.html

- **Who can providers contact with questions?**
    - Providers may call Meridian Medicaid Provider Services at 866-606-3700, Monday through Friday, 8 a.m. to 5 p.m.

- **What clinical information should be submitted with a prior auth?**

The following should be used as a guide, and providers are to submit what they have available at time of review that substantiates the need for initial and ongoing care.

- Initial assessment
- Updated assessment and assessment tools such as IMCANS
- Evidence of member's participation and progress in program
- Up to date clinical notes showing evidence of required care
- The most up-to-date treatment plan including evidence of the member's participation and progress in the program, evidence that the treatment plan are being reviewed at least monthly by the community support team, and evidence that the member will benefit from continuation of services are needed.

For more information about the service and required clinical documentation, please reference the 89 Ill. Adm. Code 140.453