



Absolute Total Care

2023 Virtual Provider Town Hall

2nd Quarter

8/30/2023

1-866-433-6041
ATC-08302023-AP-1

absolutetotalcare.com

Meeting Overview



- Absolute Total Care Healthy Connections Medicaid
 - Redetermination
- Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan)
- Ambetter from Absolute Total Care
 - Ambetter Virtual Access
 - No Surprises Act
- Wellcare Medicare Plans
- Annual Provider Training Requirements for Medicare
- Balance Billing
- No-cost interpreter services and oral translation services
- Website Features and Secure Provider Portal Features
- Claims 411 – Did You Know?
- Electronic Funds Transfer (EFT)
- Network Development and Participation
- Credentialing Rights
- Quality Improvement
- CAHPS® - Consumer Assessment of Healthcare Providers and Systems
- Start Smart for Your Baby Q&A

Provider Engagement Team



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Provider Engagement Team



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Poll Question #1



What area do you support in your organization/practice?

- Billing/Claims Payment/Revenue Cycle
- Community Relations
- Direct Patient Care
- Medical Management
- Network Development/Contracting
- Pharmacy
- Pre-cert/Authorizations
- Quality Improvement



Products and Services

Absolute Total Care Healthy Connections Medicaid



- Serving approximately 240,000 members statewide

- 2023 Benefit Highlights:
 - Telehealth services for medical and behavioral health
 - Copay waived for medically necessary COVID-19 testing
 - Sports physicals – one per calendar year

- My Health Pays Rewards- Members can earn \$5 to \$50 by completing healthy behaviors
 - <https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards.html>

Medicaid Annual Eligibility Review Process



- SCDHHS has reimplemented the standard annual review process effective April 1, 2023, and has begun reviewing groups of members each month over the next 12 months.
- SCDHHS will try to renew individuals' Medicaid eligibility with information readily available.
 - If the SCDHHS can verify continued eligibility, the member will receive a “continuation of benefits” notice and will not receive an annual review form.
- If continued eligibility cannot be confirmed, SCDHHS will mail an annual review form to the member to be completed and returned.
 - SCDHHS will notify the member via mail and text message (if email and cell phone number is on file).
- Members will have approximately 60 days to return the completed annual review form.
- Failure to return a completed annual review form may result in a member's loss of Medicaid benefits.
- Providers should know their patients' Medicaid coverage may be impacted when we restart of the standard annual review process.
- Providers should verify Medicaid eligibility, as members may no longer be eligible for Medicaid or may have changed managed care organizations (MCOs) during the review process.

How Does the Annual Review Process Affect Your Patients

- Some patients who complete an annual review form will no longer meet Medicaid eligibility requirements and their Medicaid coverage will end on the date specified in the notification from SCDHHS.
- Providers should verify Medicaid eligibility, as patients may no longer be eligible for Medicaid.
- These members will be forwarded to the Health Insurance Exchange where they may shop for and enroll in private medical insurance.
- These patients may also contact their current MCO for information on other coverage products they may qualify for on the Health Insurance Marketplace or check with their current employer to see if they offer health coverage.

How Does the Annual Review Process Affect Your Patients

- Some patients will submit an incomplete annual review form or may be required to submit additional information to verify eligibility.
- These patients will receive a follow-up letter from SCDHHS identifying the information needed to make an eligibility determination and the requirement to submit the information 15 days from the letter date.
- Patients whose Medicaid coverage ends due to the failure to submit an annual review form are encouraged to submit the completed form as soon as possible to allow SCDHHS to make an eligibility determination.
- If the annual review form is returned late and the patient is determined eligible, Medicaid coverage may be provided up to 90 days retroactively. Managed care enrollment is not retroactive. As a result, some patients will not be enrolled in an MCO for a period of time or may be enrolled in a different MCO.
- Providers should verify Medicaid eligibility starting April 1, 2023, as patients may no longer be eligible for Medicaid or may have changed managed care organizations (MCOs) during the review process.

What Should Your Patients Do?



- Contact SCDHHS now to update their mailing address, contact information and other household details. This can be accomplished by:
 - Updating their information online at apply.scdhhs.gov and selecting the “Update your address here” link in the center of the page; or
 - Calling Healthy Connections at (888) 549-0820 Monday through Friday from 8 a.m. to 6 p.m.; or
 - Visiting their local [Healthy Connections Local Eligibility Office](#) in person.
- Look for mail from Healthy Connections Medicaid starting April 1, 2023.
- Complete fully and clearly the annual review form and return all requested information by the date listed on the annual review form using one of the options below:
 - Online – Use our document upload tool at apply.scdhhs.gov
 - Fax – (888) 820-1204
 - Email – 8888201204@fax.scdhhs.gov
 - Mail – SCDHHS Central Mail, PO Box 100101, Columbia, SC 29202
 - In-person – Visit scdhhs.gov for a [list of local eligibility offices](#)
- Absolute Total Care members can call Absolute Total Care at (866) 433-6041 for questions and/or assistance with completing the annual review form.

How Providers Can Help Patients



- Encourage patients to update their mailing address and contact information with SCDHHS.
- Post the SCDHHS change of address flyer available on SCDHHS' website in a prominent place in the office. The flyer is available in [English](#) and [Spanish](#).
- Help patients understand that the standard annual reviews process went into effect April 1, 2023, and their Medicaid coverage may be impacted after this date.
- Remind patients that they may receive an annual review form or continuation of benefits notice in the mail from SCDHHS.
- Encourage patients to complete fully and clearly the annual review form and return all requested information by the date listed on the annual review form they receive.
- Visit, and encourage patients to, visit www.scdhhs.gov/annualreviews for the latest information and resources about Medicaid annual eligibility reviews.
- Encourage patients that have questions or need assistance completing the annual review form to contact their current MCO.
- Encourage patients that lose Medicaid coverage to contact their current MCO for information on other coverage products they may qualify for or check with their current employer to see if they offer health coverage.

Absolute Total Care is Here to Help



- Absolute Total Care will be conducting telephonic, email and text outreach to members to encourage members to complete fully and clearly the annual review form and return all requested information by the date listed on the annual review form they receive.
- Absolute Total Care will have information posted on our public website and secure member/provider portals on the annual review process.
- Absolute Total Care has Retention Specialists available to answer questions and assist members completing the annual review form.
- Absolute Total Care is available to partner on member events to assist with the annual review process.
- Absolute Total Care has in-office material available on the annual review process and other healthcare options we offer.

Important Links and Contact Information



- SCDHHS [Medicaid Annual Reviews](#) Resources
- apply.scdhhs.gov - contact information updates and document uploads
- SCDHHS [Provider Fact Sheet](#)
- SCDHHS [Member Fact Sheet - English](#)
- SCDHHS [Member Fact Sheet - Spanish](#)
- SCDHHS [Change of Address Flyer - English](#)
- SCDHHS [Change of Address Flyer - Spanish](#)
- [Healthy Connections Local Eligibility Offices](#)

Absolute Total Care
1-866-433-6041
absolutetotalcare.com

South Carolina Medicaid
1-888-549-0820
apply.scdhhs.gov

Health Insurance Marketplace
1-800-318-2596
healthcare.gov

Wellcare Prime by Absolute Total Care (Medicare- Medicaid Plan)



- Serving approximately 3,800 dual-eligible members (age 65+)

- 2023 Benefit Highlights:
 - State-wide service area
 - Telehealth services for medical and behavioral health
 - Transportation: Unlimited one-way rides to plan-approved locations
 - Over-the-counter: \$100 per calendar quarter
 - Hearing: One hearing aid per calendar year
 - Fitness: Up to \$250 toward gym membership

- My Health Pays rewards-Members can earn \$20 by completing healthy behaviors
 - <https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards1.html>

Ambetter from Absolute Total Care



FROM



- Health Insurance Marketplace
- Serving approximately 100,000 members statewide
- 2023 benefit highlights:
 - \$0 copay for telehealth services for medical care
 - Health Savings Accounts
 - Dental
 - Routine vision
 - Virtual plan option
 - Concierge services for disease management
- Balance billing protection via the “No Surprises Act”

Ambetter Virtual Access



FROM



Ambetter Virtual Access was designed for members who desire a Virtual Primary Care experience.

- Members enrolled in Ambetter Virtual Access-Teladoc require a referral from their PCP in order to see a specialist.
 - Members cannot self-direct care outside of PCP care
 - Non-emergent, non-authorized, out-of-network is not covered
 - Emergent & Authorized Services OON are covered

- Members 18 and above are assigned to a Teladoc PCP.
 - Minors are assigned to traditional brick and mortar PCPs.
 - Members can “opt-out” and choose an in-network brick and mortar PCP.
 - A member who opts out will lose the \$0 PCP copay benefit and a copay will apply.

- Members assigned to Teladoc can see any Teladoc provider within their group

Ambetter Virtual Access



Subscriber: [Jane Doe]
Member: [John Doe]

Policy #: [XXXXXXXXXX]
Member ID #: [XXXXXXXXXXXXXX]
Effective Date: [00/00/00]

VIRTUAL ACCESS

Teladoc Virtual Access App

Ambetterhealth.com/copays
PCP: [\$0 Virtual/\$10 In-person copay after [\$600] ded.]
Specialist: [\$25 coin. after [\$600] ded.]
Rx (Generic/Brand): [\$5/\$25 after [\$600] Rx ded.]
Urgent Care: [20% coin. after [\$600] ded.]
ER: [\$250 copay after [\$600] ded.]
Max Out-of-Pocket: [\$25,000]

Plan: [Plan name]
[Line 2 if needed]

[Network Name] Network Coverage Only

RXBIN: 004336
RXPCN: ADV
RXGROUP: RX5445

REFERRAL FROM PCP REQUIRED FOR SPECIALIST

Ambetter.SunshineHealth.com

Member/Provider Services: 1-877-687-1169
(Relay Florida 1-800-955-8770)
24/7 Nurse Line: 1-877-687-1169

Numbers below for providers:
Pharmacy Help Desk: 1-888-304-9081
EDI Payor ID: 68069

Medical Claims Address:
Sunshine Health
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

Scan to receive 20% off
Walgreens brand health and
wellness items*

* Exclusions and restrictions apply. See Walgreens.com/SmartSavings for details.

AMB23-FL-C-00013 Ambetter from Sunshine Health is underwritten by Sunshine Health Plan, Inc.
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No Surprises Act



FROM



The No Surprises Act is specific to the Ambetter (Marketplace) product.

Effective January 1, 2022 and applies to:

- Emergency care at out-of-network facilities
- Post stabilization care at out-of-network facilities
- Non-emergency services provided by out-of-network providers at in-network facilities, unless notice and consent is given
- Out-of-network air ambulance services
- No balance billing for out-of-network emergency services.
- No balance billing for non-emergency services rendered by nonparticipating providers at in-network hospitals and ambulatory surgical centers:
 - Emergency Medicine, Anesthesiology, Pathology, Radiology and Neonatology
 - Services provided by assistant surgeons, hospitalists, and intensivists
 - Items and services provided by a nonparticipating provider if there is no participating provider who can provide such item or service at the facility

Wellcare Medicare Advantage HMO



Health Maintenance Organization (HMO) – Traditional MA plan. All services must be provided within the Wellcare network unless an emergency or urgent need for care arises, or such service is not available in-network. Some services require prior authorization by Wellcare, or its designee.

HMO with Point-of-Service Option (HMO-POS) – The point-of-service (POS) benefit allows Members to access most Medicare-covered, Medically Necessary services from non-network providers, and they are entitled to use their POS option anywhere in the United States.

State	Services NOT covered by POS benefit
Arkansas, , Florida, Georgia, Illinois, Kentucky, Michigan, Mississippi, New Jersey, Ohio, South Carolina, Tennessee, and Texas	Services not covered by Medicare

Wellcare Medicare Advantage PPO



With the Wellcare Medicare Advantage PPO plan, members enjoy the freedom to receive healthcare services from Medicare providers of their choice. As an eligible Medicare provider, Wellcare reimburses you at 100% of the Medicare allowable rate for all plan-covered, medically necessary services for our PPO members – whether you are contracted with us or not.

INCREASED FLEXIBILITY

- The Wellcare Medicare Advantage PPO plan offers members flexibility as they navigate their care journeys. PPO members don't need a referral from a primary care physician for specialist or hospital visits. However, using providers in Wellcare's network may cost less than choosing one that is out-of-network. Medicare providers who do not contract with Wellcare are under no obligation to treat our members, except in emergency situations.

In addition, the Wellcare Medicare Advantage PPO plan:

- Offers a simple copayment for doctor visits, hospital stays and many other healthcare services, making healthcare costs more predictable
- Gives members Medicare Parts A, B, and D coverage as well as vision, dental, and hearing benefits not covered by original Medicare
- Covers all original Medicare services and follows original Medicare's coverage rules
- Only covers medically necessary services rendered by providers who are eligible to participate in Medicare

Annual Provider Training Requirements



Absolute Total Care partners with each of our contracted providers to ensure that you have received the necessary training to deliver quality care to our members and your patients and to be compliant with Centers for Medicare & Medicaid Services (CMS) and state requirements. All Medicare Advantage Organization (MAO) and Medicare-Medicaid Plan (MMP) contracted providers are required to complete the following trainings within 90 days of contracting and annually thereafter:

- General Compliance
- Fraud, Waste, and Abuse
- Model of Care (MOC)*
- Person-Centered Planning**
- Cultural Competency

<https://www.absolutetotalcare.com/providers/resources/provider-training/model-of-care-provider-training.html>

Provider Training Attestation



Home Find a Provider Login Careers Contact

Enter Keyword Search

Contrast On Off a a a language

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

- Login
- Become a Provider
- Pre-Auth Check
- Integration Information
- Pharmacy
- Provider Resources
 - Provider Manuals and Forms
 - Provider Training
 - Provider Training Attestation
 - Special Supplemental Benefits for Chronically Ill (SSBCI)
 - Eligibility Verification
 - Grievances and Appeals
 - Incentives Statement
 - Integrated Care
 - Prior Authorization
 - National Imaging Associates (NIA)
 - Behavioral Health
 - Fraud, Waste, and Abuse
 - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
 - Patient-Centered Medical Home Model (PCMH)
 - Electronic Transactions
 - Behavioral Health Clinical Policies
 - Medical Clinical Policies
 - Payment Policies
 - Newsletters
 - TurningPoint Healthcare Solutions
 - Member Rewards Program
- Quality Improvement (QI) Program
- Provider News
- Coronavirus Information

Provider Training Attestation

Absolute Total Care Medicare Advantage Organization (MAO) and Medicare-Medical Plan (MMP) contracted providers are required to complete certain training within 90 days of contracting and annually thereafter. Complete and submit this form to verify training completion.

Please check applicable training selections below to confirm completion *

- General Compliance (CMS)
- Fraud, Waste, and Abuse (CMS)
- Model of Care (MOC)
- Person-Centered Planning
- Cultural Competency
- Other

Provider Group * County *

Provider TIN(s) *

Please provide any additional TINs that should be represented on this form.

TIN 2 TIN 3

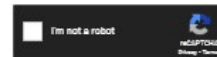
TIN 4 TIN 5

Contact Information

Phone * Email *

Form Completed By * Title *

Date *



Submit

Balance Billing



- What is balance billing?
 - Seeking payment from members for the difference between the billed charges and the contracted rate paid by the plan
 - Payments less any copays, coinsurance, or deductibles are considered payment in full
- Prohibited by federal law
 - Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances
 - Original Medicare and Medicare Advantage providers and suppliers – not only those that accept Medicaid – must not charge individuals enrolled in the QMB program for Medicare cost-sharing

Balance Billing



- Steps to ensure compliance with QMB billing prohibitions:
 - Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services
 - Ensure that a Member Acknowledgement Statement has been signed by both the provider and the Absolute Total Care member for non-covered services prior to rendering said service
 - If you have erroneously billed these members, recall the charges (including referrals to collection agencies) and refund the invalid payments
 - Healthy Connections prime link <https://msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing-healthy-connections-prime-members-0>

No Cost Interpreter Services and Oral Translation Service



Absolute Total Care is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. In order to meet this need, Absolute Total Care is committed to the following:

- Having trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with members as needed.
- Providing Language Line services that will be available 24/7 in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.
- In-person interpreter services are made available when Absolute Total Care is notified two business days in advance of the member's scheduled appointment.
- Providing TTY access for members who are hearing impaired through 711.
- Absolute Total Care medical/nurse advice line is available 24/7 for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line.
- Providing or making available Member Services and health education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee.

For an interpreter for a medical visit, contact Member Services at 1-866-433-6041 (TTY: 711).

For ASL interpreter requested please use the vendor portal: www.lsaweb.com, call the vendor directly at 1-866-827-7028 or email clientservices@lsaweb.com.



Websites and Secure Portals

Absolute Total Care Website



www.absolutetotalcare.com

For Providers section:

- Pre-Auth Check Tool
- Clinical and Payment Policies
- Forms- Medical and Pharmacy Auths

A screenshot of the Absolute Total Care website. A large grey arrow points from the top logo area to the 'FOR PROVIDERS' navigation tab. The website header includes the Absolute Total Care logo, navigation links (Home, Find a Provider, Login, Careers, Contact), a search bar, and accessibility options (Contrast, On, Off, a, a, language). The main navigation bar has three tabs: 'FOR MEMBERS', 'FOR PROVIDERS', and 'GET INSURED'. The 'FOR PROVIDERS' tab is active, showing a sidebar with menu items: 'Health Insurance Marketplace', 'Medicaid Plan', 'Medicare-Medicaid Plan', and 'Medicare Advantage'. The main content area features a banner with a child on a swing and the text 'One Plan. Always Covered.' Below the banner is a section titled 'Coronavirus: What you need to know' with a brief description and a link to learn more. At the bottom, there are three circular icons: a caduceus, 'ambetter.', and 'allwell.'

Pre-Auth Lookup Tool



Are Services being performed in the Emergency Department (other than observation), or Urgent Care Center, or Public Health or Public Welfare Agency, or Family Planning services billed with contraceptive management diagnosis?

Yes No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Are services being rendered by a podiatrist?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

99213

N
No

99213 - OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20-29 MIN
No Pre-authorization is required for all providers.

If an authorization is needed, you can [log in to your account](#) to submit one online or fill out the appropriate fax form on the [Provider Manuals and Forms](#) page.

Authorization Vendors



- Vision Services need to be verified by Envolve Vision.
- Musculoskeletal Services need to be verified by Turning Point
- Hospice requests should be submitted to SC DHHS Medicaid Fee for Service program.
- Oncology/supportive drugs for members age 18 and older need to be verified by New Century Health.
- Complex imaging, MRA, MRI, PET, CT scans need to be verified by National Imaging Associates (NIA).
- Outpatient rehabilitative and habilitative physical medicine services PT, OT, and Speech need to be verified by NIA.

Absolute Total Care Secure Provider Portal



- Log in: <https://www.absolutetotalcare.com/login.html>

Get Started With EntryKeyID

Welcome to our new EntryKeyID log in tool. No more security questions. Simply use your email address to verify who you are. You can reset your password and unlock your account. Please note: We will send you an email to set your new password. In some cases, delivery of change password and other account related emails is currently taking longer than expected. We are working to improve the delivery and reduce any delays.

English



Log In

Username (Email)

LOG IN

[Create New Account](#)



[Home](#) [Privacy Policy](#) [Terms of Use](#) © 2021 Centene

Absolute Total Care Secure Provider Portal



A screenshot of the Absolute Total Care Secure Provider Portal. The top navigation bar includes a "medicare" logo (highlighted with a red box), and menu items for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, a dropdown menu is open, showing "Absolute Total Care Behavioral Health from Absolute Total Care" and "SC - Medicare / MMP" (highlighted with a red box). A red arrow points from the text "Updated logo and plan name in drop down" to the "medicare" logo and the dropdown menu. The main content area features a yellow note about EOP PDFs, a pink note about Allwell members in other states, and a "Quick Eligibility Check for SC - Medicare / MMP" section (highlighted with a red box). This section includes input fields for "Member ID or Last Name" (123456789 or Smith) and "Birthdate" (mm/dd/yyyy), and a "Check Eligibility" button. Below this is a text box about CMS requirements for Medicare Special Needs Program training. The right sidebar contains a "Welcome" section with links for "Add a TIN to My ACCOUNT", "Reports", "Patient Analytics", "Provider Analytics", and "Care and Risk Gaps - Daily View". It also has a "Recent Activity" table and a "Quick Links" section with links for "Model of Care Provider Training" and "High Risk Medications".

Updated logo and plan name in drop down

Medicare Advantage and MMP Members

Absolute Total Care Secure Provider Portal



Viewing Patients For : Find Patient

[Back to Jane22263 Doe22263](#) As we scroll through you will see there is a lot of information on this screen.

Overview

- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Coordination of Benefits
- Claims

Eligibility

This patient is eligible as of today, Mar 14, 2013 .

Patient Information

Name: Jane22263 Doe22263
Gender: F
Birthdate: Feb 4, 1959
Age: 54 years old
Medicaid #: 099577407
Address: 13594795 Main Street
AllCities08111, IL 08111

Eligibility History

Start Date	End Date	Product Name
Feb 1, 2013	Ongoing	LTC Non-Dual
Oct 1, 2012	Jan 31, 2013	SSI Non-Dual
Jul 1, 2011	Sep 30, 2012	SSI Non-Dual

Care Gaps

DM - No nephropathy screening in past 12 mos

Member eligibility should be checked each month and each time prior to rendering services

The Absolute Total Care Secure Provider Portal or the Interactive Voice Response (IVR) system are available 24 hours a day, seven days a week

- Absolute Total Care 1-866-433-6041 (Medicaid)
- Wellcare by Allwell 1-855-766-1497 (Medicare)
- Ambetter by Absolute Total Care 1-833-270-5443 (Marketplace)
- Wellcare Prime by Absolute Total Care 1-855-735-4398 (Medicare-Medicaid Plan)
- Wellcare Medicare 1-866-270-5223 (Medicare)

Absolute Total Care Secure Provider Portal

Authorizations and Claims



HEALTH PLAN
 Viewing Authorizations

A list of all authorizations submitted in the last 90 days is displayed.
Note: There could be multiple pages of authorizations at the bottom of the list.

Claims Messaging Billing Rep
 Smart Sheets Create Authorization

Authorizations Processed Errors Important Search

Authorization Number: Search

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	AUTH TYPE	SERVICE
APPROVE	IP0080390157	John150 Doe550	02/20/2013	12/31/9999	INPATIENT	Medical
APPROVE	IP0080398128	John6756 Doe1256	02/20/2013	02/21/2013	INPATIENT	Medical
PEND	IP0079509332	John1070 Doe9469	02/15/2013	12/31/9999	INPATIENT	Medical
APPROVE	IP0080468777	John716 Doe44	02/10/2013	12/31/9999	INPATIENT	SNF-Custodial

Viewing Claims For: Upload EDI Create Claim

Claims Individual Saved Submitted Batch Multiple Payment History My Downloads Claims Audit Tool Filter

Payment History
 Search for claim payments posted between 10/18/2011 and 04/18/2013. Data available online is limited to the last 18 months.
 Instructions: Enter Search Criteria, then click the "Search" button. For best results, enter the date range to include at least 2 days before and 2 days after the targeted date(s).
 With a Check/Trace Date between 01/18/2013 and 04/18/2013 With an Amount between and
 Check/Trace number Search
 To search, enter one or more of the following search criteria. The Submission Date range you provide is limited to a three-month span. Only the last 18 months of claims data is available online.

Transaction activity for the last three month span is listed below.

Transactions
 All activity posted to your account between 01/18/2013 and 04/18/2013.
 Instructions: To view transaction details, click the check date.

Absolute Total Care Secure Provider Portal Provider Reconsideration



Viewing Claims For: [Dropdown] Nebraska Total Care [GO] [Upload EDI] [Create Claim]

Claim Details

Claim # [Redacted] Denied

Claim Accepted
 In Process
 Denied

Member		Provider		Claim	
Member Name:	[Redacted]	Ref/Act No.:	[Redacted]	DOS Range:	01/22/2019 - 01/22/2019
Member ID:	[Redacted]	Servicing Provider:	[Redacted]	Received Date:	01/25/2019
Member DOB:	[Redacted]	Servicing NPI:	[Redacted]	Billed Amount:	\$160.00

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Payment Amount	Payment Date	Check No.	Status	Payment Codes
1	01/22/2019	99213	B8213Z D, B82112 D, W010X XD		22	\$160.00	\$0.00	02/01/2019		VOID	L6

Reconsider Claim

Claim No: [Redacted]

For reconsiderations only. Not for appeals/Claim disputes.
Example: If an authorization was not obtained and/or you need to review for medical necessity, submit an appeal.
Any submission on this form will be treated as a reconsideration.
Please refer to your Provider Manual.

Reconsideration Type

Select Reconsideration Type... [Dropdown]

Reconsider Claim

Claim No: S025NEE07212

Reconsideration type

Select Reconsideration Type... [Dropdown]

- Select Reconsideration Type...
- Denied for a Global/Unbundled Procedure
- Denied for Untimely Filing

Claim Details

Reconsider Claim

Claim No: [Redacted]

Reconsideration Type

Other [Dropdown]

Notes

Brief Explanation Required

Test

245 Characters Left

Upload Documents

Choose Files

Uploaded Files

SampleFile1.jpeg SampleFile2.pdf

Email Updates

Check here to receive email status updates for this reconsideration.

Note: Please upload files less than 5MB each and supported file formats are PDF, TIFF, TIF, JPEG, JPG

INFORMATIONAL RE-ADJUDICATION PROCESS EX CODE

Wellcare Website



wellcare™

Search Wellcare

Login / Register

Contact Us

Help

South Carolina

English

Need a Plan

Members

Providers

Corporate

Find a Provider/Pharmacy

SOUTH CAROLINA

Healthcare done well.

2022 Medicare and PDP Compare Plans and Enroll Now



Notice of Non-Discrimination

Coronavirus (COVID-19)

Wellcare By Allwell

Wellcare Website



- For Providers section
- Pre-Auth Check Tool
- Forms
- Clinical and Payment Policies

A screenshot of the Wellcare website. At the top, there is a grey navigation bar with the Wellcare logo on the left, a search bar in the center, and links for "Contact Us" and "Help" on the right. Below the search bar, there are dropdown menus for "South Carolina" and "English". A grey arrow points to the "Providers" dropdown menu. Below the navigation bar, there is a main menu with four columns: "Getting Started", "Medicare", "Tools", and "News and Education". Each column contains several links. Below the main menu, there is a banner image showing a person's hands. At the bottom, there are three white boxes with teal text and dark blue buttons. The first box is titled "Notice of Non-Discrimination" and contains text about federal civil rights laws. The second box is titled "Coronavirus (COVID-19)" and contains text about staying informed. The third box is titled "Wellcare By Allwell" and contains text about Medicare Advantage plans.

wellcare™

Search Wellcare

Contact Us Help South Carolina English

Need a Plan Members Providers Corporate Find a Provider/Pharmacy

Getting Started
Welcome to Wellcare
Contact Us Form
Non-Wellcare Providers

Medicare
Overview
Claims
Authorizations
Forms
Pharmacy
Quality
Secure Login

Tools
Authorization Lookup
Clinical Guidelines

News and Education
Bulletins
Newsletters
ICD-10 Compliance

Notice of Non-Discrimination
We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, sex, or disability.
[More Information](#)

Coronavirus (COVID-19)
Keep yourself informed about Coronavirus (COVID-19.) Learn more about how we're supporting members and providers.
[Learn More](#)


Wellcare By Allwell
Our family of products is growing! Medicare Advantage plans offered through Wellcare By Allwell can be accessed on their website.
[View Wellcare By Allwell Plans](#)


Pre-Auth Lookup Tool



Authorization Lookup

Please select your line of business and enter a CPT to look up authorization for services.

Select Line of Business 

South Carolina Medicare and PPO Plans 

Enter CPT Code 

99213

[Reset](#)

[Lookup](#)

Results as of : 3/8/2023 11:58:25 AM

CPT Code :

99213

Description :

OFFICE OR OTH OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST

11 Office :

No Authorization Required

Authorization Vendors



- eviCore is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: Lab Management and Sleep Diagnostics.
- NIA (National Imaging Associates) is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: Advanced Radiology, Advanced Cardiology, Pain Management, Physical, Occupational and Speech Therapy.
- HealthHelp is our in-network vendor for the following programs, and provider resources can be accessed through the corresponding program links: Radiation Therapy and Medical Oncology.
- CareCentrix is our in-network vendor for the following programs and provider resources can be accessed through the corresponding program links: Skilled Nursing Facility, Long Term Acute Care and Inpatient Rehab.
- TurningPoint is our in-network Surgical Quality & Safety Management Program vendor for the following programs Orthopedic Surgery and Spinal Surgery.

Wellcare Secure Portal



Log in: <https://provider.wellcare.com/>

wellcare™ Provider Portal

▼ A A ▴ Download & Print

Provider Login

Username*

Password*

Login

Not registered? Register an account

Forgot Password?

Forgot Username?

Thank you for using our Provider Portal.

Do you know about our **live agent chat feature**? Live-agent chat is the easiest and fastest way to get real-time support for an array of topics, including:

- Member Eligibility
- Claims adjustments
- Authorizations
- Escalations

You can even print your chat history to reference later!

We encourage you to take advantage of this easy-to-use feature.

If you are having difficulties registering please click the "Chat with an Agent" button to receive assistance.

*NOTE: The secure provider portal is for participating Wellcare providers only.

Wellcare Secure Portal

Home Screen



[Home](#)

[My Patients](#)

[Care Management](#) ▾

[Claims](#) ▾

[My Practice](#) ▾

[Resources](#) ▾

Search the portal



Help

▾ A A ▴

Download & Print

Welcome

We are glad you are with us today

[Access Resources And Bulletins On Our Website](#)



Find a Member

Find your patients and check eligibility

[Go To My Patients](#)



Authorizations and Referrals

See recent authorizations, referrals and care plans

[Go To Care Management](#)



Claims

Check claim status and submit claims and appeals

[Go To Claims](#)

Secure Inbox

You have 0 new messages

[Go To Inbox](#)

Provider Training

Find trainings and its related information

[Go To Trainings](#)

Wellcare Secure Portal

Eligibility and Member Information



Home

My Patients

Care Management ▾

Claims ▾

My Practice ▾

Resources ▾

Search the portal



My Patients

[← Back To Home](#)

Help

A

Check Member Eligibility

This section allows you to search for members and check eligibility.

If you need additional assistance, please select the Help button. There, you can access FAQs or select your state and plan to chat with a Customer Service agent.

Select search criteria to find a member

Member ID ▾

Member ID

Medicaid ID

Medicare ID

Check patient eligibility on this date

11/04/2022



Enter multiple member IDs to display

Search

Wellcare Secure Portal

Claims



Claims

Help [font size controls]

If you are experiencing issues submitting claims on the portal, you may also submit claims electronically via electronic data interchange (EDI) or direct data entry (DDE).

EDI: Change Healthcare manages all EDI for WellCare. Please contact Change Healthcare directly at 1-877-411-7271, or your vendor may call 1-800-527-8133.

DDE: ConnectCenter for physicians offers a free DDE web service for WellCare.

Sign up at: <https://connect.relayhealth.com> using vendor code 212750.

You can access your Explanation of Payment (EOP)/Remit on the [Payspan website](#).

Draft Claims

Drafts that have not been submitted are shown below. Open draft claim to complete or cancel.

Member Id	Date Started	Delete
No drafted claims found		
◀ ◀ 0 ▶ ▶ 3 items per page No items to display		

New Professional Claim

New Institutional Claim

Search Submitted Claims

Search Type

WCN Number

Enter up to 10 values separated by commas

Service Date

Select

Search

Wellcare Secure Portal

Authorizations



Care Management

[Help](#) [A](#) [A](#)

Search for status of previously submitted authorizations and referrals. Newly submitted authorizations may take up to 48 hours to be available for view of status in the portal.

Medical Authorizations

Referrals

Drug Authorizations

Search by

Authorization ID ▼

Authorization ID

Search

- [Create Referral](#)
- [Create Authorization](#)
- [Submit Institutional Claim](#)
- [Submit Professional Claim](#)
- [SureScripts](#)
- [Wellcare.com](#)



Claims 411 – Did You Know?

Claims 411 – Did You Know?



- Most common claim rejections:
 - Member Not Valid at Date of Service (DOS)
 - Invalid Member
 - Invalid Member DOB
- Most common claim denials:
 - Services Not on the Fee Schedule are Not Separately Reimbursable
 - This Service is Not Covered
 - Duplicate Claim Service
 - CMS Medicaid NCCI Unbundling
 - No Authorization on File that Matches Service(s) Billed
- Pre-authorization
 - All inpatient services require an authorization
 - Professional services being performed per inpatient stay require a separate authorization and must be obtained to avoid claims denying for no authorization on file

Claims 411 – Did You Know?



Clinical Policies

Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include, but are not limited to, policies relating to evolving medical technologies and procedures, as well as pharmacy policies.

Payment Policies

Healthcare claims payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding. They are used to help identify whether healthcare services are correctly coded for reimbursement. Each payment rule is sourced by a generally accepted coding principle.

All policies found in the Absolute Total Care Payment/Clinical Policy Manual apply with respect to Absolute Total Care members. Policies in the Absolute Total Care Payment/Clinical Policy Manual may have either an Absolute Total Care or a “Centene” heading.

<https://www.absolutetotalcare.com/providers/resources/clinical-payment-policies.html>

Claims Submission



Claims must be filed electronically or sent directly to our claims processing center. Claims mailed to the physical office address will be returned and will not be able to be processed.

For claims processing efficiency, Absolute Total Care encourages providers to submit claims electronically.

Claims Submission



Submit following one of the procedures below,
according to line of business:

Line of Business	Electronic Claim Submission	Paper Claim Submission
Medicaid	Secure Provider Portal: www.AbsoluteTotalCare.com/Login or EDI Payer Numbers: 68069 - Emdeon/WebMD/Envoy/PayerPath 42772 - Relay Health/McKesson 68068 - Behavioral Health	<u>Absolute Total Care</u> P.O. Box 3050 Farmington, MO 63640-3821 <u>Behavioral Health:</u> P.O. Box 7001 Farmington, MO 63640-3811
Marketplace	Secure Provider Portal: www.AbsoluteTotalCare.com/Login or	<u>Ambetter from Absolute Total Care</u> P.O. Box 5010 Farmington, MO 63640-5010
MMP	EDI Payer Numbers: 68069 - Emdeon/WebMD/Envoy/PayerPath	<u>Wellcare Prime by Absolute Total Care</u> P.O. Box 3060 Farmington, MO 63640-3822

Claims Submission - Wellcare



- Claims are not accepted at local office
- Submit following one of the procedures below, according to line of business:

Line of Business	Electronic Claim Submission	Paper Claim Submission															
Medicare Advantage	<p>Register online using the simplified, enhanced provider registration process at PaySpan.com or call 1-877-331-7154</p> <p>Or</p> <p>Change Healthcare EDI Clearinghouse 1-877-411-7271.</p> <p>CHANGE HEALTHCARE CLEARINGHOUSE PAYER IDS (CPIDS)</p> <table border="1"> <thead> <tr> <th>Claim Type</th> <th>Fee-for-Service (CH - Chargeable) Submissions</th> <th>Encounter (RF - Reporting only) Submissions</th> </tr> </thead> <tbody> <tr> <td>Professional</td> <td>1844</td> <td>3211</td> </tr> <tr> <td>Institutional</td> <td>8551</td> <td>4949</td> </tr> </tbody> </table> <p>If your clearinghouse or billing system is not connected to Change Healthcare and requires a 5-digit Payer ID, please use the following according to Fee-for-Service or Encounters file type:</p> <ul style="list-style-type: none"> Fee-for-Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication. Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication. <table border="1"> <thead> <tr> <th>Claim Type</th> <th>FFS (CH - Chargeable) Submissions</th> <th>Encounter (RF - Reporting only) Submissions</th> </tr> </thead> <tbody> <tr> <td>Professional or Institutional</td> <td>14163</td> <td>59354</td> </tr> </tbody> </table>	Claim Type	Fee-for-Service (CH - Chargeable) Submissions	Encounter (RF - Reporting only) Submissions	Professional	1844	3211	Institutional	8551	4949	Claim Type	FFS (CH - Chargeable) Submissions	Encounter (RF - Reporting only) Submissions	Professional or Institutional	14163	59354	<p>Wellcare Attn: Claims Department P.O. Box 31372 Tampa, FL 33631-3372</p>
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Claim Type	FFS (CH - Chargeable) Submissions	Encounter (RF - Reporting only) Submissions															
Professional or Institutional	14163	59354															

Transition to Wellcare



CLAIMS SUBMISSIONS DATE OF SERVICE GUIDANCE

Date of Service	Health Plan	Health Plan Name	Transaction Type	Paper Claim Submissions	
Before 01/01/2023	Wellcare by Allwell Medicare	Wellcare No Premium (HMO) Wellcare Dual Liberty (HMO D-SNP) Wellcare Dual Access (HMO D-SNP)	Fee-For-Service & Encounter	EDI	Payer ID 68069
				Portal	https://www.absolutetotalcare.com/login.html
				Paper	Absolute Total Care P.O. Box 3060 Farmington, MO 63640
After 01/01/2023	Wellcare	Wellcare No Premium (HMO) Wellcare Assist (HMO) Wellcare Dual Liberty (HMO D-SNP)	Fee-For-Service	EDI	Payer ID 14163
				Portal	https://provider.wellcare.com/Provider/Login
				Paper	Wellcare Attn: Claims Department P.O. Box 31372 Tampa, FL 33631-3372
After 01/01/2023	Wellcare	Wellcare No Premium (HMO) Wellcare Assist (HMO) Wellcare Dual Liberty (HMO D-SNP)	Encounter	EDI	Payer ID 59354
				Portal	https://provider.wellcare.com/Provider/Login
				Paper	Wellcare Attn: Claims Department P.O. Box 31372 Tampa, FL 33631-3372

Claim Adjustments, Reconsiderations, and Disputes



Claim Adjustments: Requests to change the initial claim

Reconsiderations: Submitted when a provider disagrees with how a clean or adjusted claim was processed

Disputes: Submitted when a provider has received an unsatisfactory response to a previous reconsideration request

Provider Timeframes Claim Adjustments, Reconsiderations, and Disputes



MEDICAID		
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	365	365
Claim Adjustment	365	365
Claim Dispute	60	60
Decision Timeframes	Par	Non-Par
Dispute Decision	30	30
Mailing Address		
P.O. Box 3050 Farmington, MO 63640-3821		

MARKETPLACE		
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	120	120
Claim Adjustment	60	60
Claim Reconsideration	60	60
Claim Dispute	60	60
Decision Timeframes	Par	Non-Par
Appeal Decision	30	30
Dispute Decision	30	30
Mailing Address		
P.O. Box 5010 Farmington, MO 63640-5010		

Provider Timeframes Claim Adjustments, Reconsiderations, and Disputes



	MMP	
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	365	365
Claim Adjustment	365*	365*
Claim Reconsideration	365*	365*
Claim Appeal	60	60**
Claim Dispute	60	60
Decision Timeframes	Par	Non-Par
Appeal Decision	30	60
Dispute Decision	30	30

Mailing Address

P.O. Box 3060
Farmington, MO 63640-3822

*from date of service

**Waiver of Liability required

***from date of last processed claim

Wellcare Provider Timeframes Claim Adjustments & Disputes



	PAR	NON-PAR
Claim initial/resubmission	180*	180*
Claim Payment Dispute	90*	90*
Claim Payment Policy Dispute	30***	30***
Appeal (Medical)	90	60**

*from date of service

**Waiver of Liability required

***from date of last processed claim

Electronic Funds Transfer



Absolute Total Care and PaySpan are in partnership to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment.

PaySpan Benefits:

- Elimination of paper checks
- Convenient payments and retrieval of remittance information.
- Electronic Remittance Advice (ERAs) presented online.
- HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System.
- Reduce accounting expenses: Electronic remittance advices can be imported directly into practice management or patient accounting systems

Electronic Funds Transfer



PaySpan Benefits [CON'T]

- Improve cash flow: Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts: You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advices quickly: You can associate electronic payments with ERAs quickly and easily.
- Manage multiple payers: Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts, as desired.

Electronic Funds Transfer



- Providers can register using PaySpan's enhanced provider registration process at <http://www.payspanhealth.com/>
- Providers can access additional resources by clicking Need More Help on the PaySpan homepage or link directly to <https://www.payspanhealth.com/nps/Support/Index>.
- PaySpan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 1-877-331-7154 or on the web at payspanhealth.com.



NETWORK DEVELOPMENT AND PARTICIPATION

Network Development and Participation



- Network Participation
 - The enrollment, credentialing and recredentialing processes exist to ensure that participating providers meet and remain compliant to the criteria established by Absolute Total Care, as well as government regulations and standards of accrediting bodies
- Network Development
 - To request a new agreement, send an email to ATC_Contracting@centene.com
 - For contract updates and questions (i.e., change of ownership, TIN changes, amendments, etc.), send an email to ATC_Contracting@centene.com
- To add a new practitioner, providers must submit a Provider Data (Add) Form and Current W-9 to SouthCarolinaPDM@centene.com to begin the credentialing process
 - This process takes approximately 60 days to complete (follow ups prior to receiving the Welcome Letter can be done so by emailing SouthCarolinaPDM@centene.com)
 - Recredentialing is performed at least every 36 months
 - Provider updating existing participating providers and locations may do so by emailing the Provider Data Form (Update) to SouthCarolinaPDM@centene.com

Credentialing Rights



All practitioners requesting participation with ATC have the right to review information obtained by ATC to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source. This does not allow a practitioner to review references, personal recommendations or other information that is peer review protected.

Should a practitioner believe any of the information used in the credentialing/recredentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party.

To request release of such information, a written request must be submitted to the ATC Credentialing Department. Upon receipt of this information, the practitioner will have 14 days to provide a written explanation detailing the error or the difference in information to ATC. ATC's Credentialing Committee will then include this information as part of the credentialing/recredentialing process.



Quality Improvement

Key Quality Improvement Activities



Path to Successful Member Care

- Member Visits
- Flu Vaccinations

Path to Successful Provider Satisfaction

- HEDIS Hybrid
- Data Requests
- Claims Coding for Gap Closure

Path to Successful Annual Surveys

- CAHPS



CPT II and HCPCS Billing

Important Information on CPT II and HCPCS Codes

We're asking our providers to make sure to use accurate CPT Category II codes and HCPCS codes to improve efficiencies in closing patient care gaps and in data collection for performance measurement. When you verify that you performed quality procedures and closed care gaps, you're confirming that you're giving the best of quality care to our members.

Absolute Total Care allows the billing of these important codes without a denial of "non-payable code" to assist in the pursuit of quality.

The fee schedule includes CPTII and HCPCS codes at a price of \$0.01.



CPTII Codes and HCPCS Billing PRO_91371E_Approved_01112022.pdf

What measures do these codes apply to?



- Controlling Blood Pressure
 - Blood pressure results
- Hba1c levels
- Diabetic Retinal Eye Exams
- Care of Older Adults
 - Pain Assessment
 - Medication List and Review
 - Functional Status Assessment
- Medication Reconciliation Post Discharge
 - Medication List and Review after hospital discharge

Electronic Medical Record (EMR) System



Remote Access to EMR:

Allows designated health plan representatives access to your medical records directly through remote access.

- Reduce provider office staff activities regarding HEDIS Hybrid chart chase requests
- Decrease and avoid duplication of over utilization or retrieval efforts
- Lead to improved HEDIS performance reporting

- Contact Jane Brown via email at jane.f.brown@centene.com



Supplemental Data Feeds



Monthly Supplemental Data Feed

This type of file transfer utilizes specific data extracts from the Electronic Medical Record (EMR). Data is transmitted securely via SFTP.

- Close care gaps
 - Improve our HEDIS scores
 - Potential incentives
 - Reduces request for medical records
- Contact Jane Brown via email at jane.f.brown@centene.com





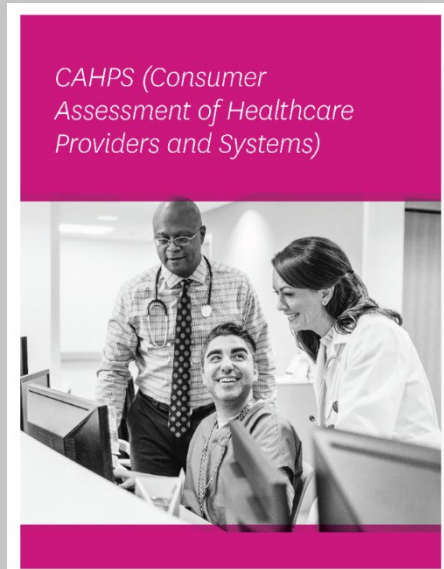
CAHPS®
Consumer Assessment of Healthcare Providers
and Systems



Importance of CAHPS®

- CAHPS is a program of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.
- CAHPS is a tool used to evaluate *member perception and overall satisfaction* in order to improve *the member experience*. CAHPS allows health plans to receive anonymous feedback from its members.
- CAHPS is the interaction and conversations with the front desk, any staff, and especially their providers.
- CAHPS survey aims to capture accurate and complete information regarding real experiences with individuals' healthcare.
- CAHPS scores account for CMS Medicare STAR Ratings, NCQA Health Insurance Plan Ratings, CMS Marketplace Quality Rating System (QRS) and SCDHHS Medicaid Quality Withhold Program.

CAHPS® Provider Resource Guide



CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL
[Change Care Model](#)
[Provider Check-Up Guide](#)

CAHPS (Consumer Assessment of Healthcare Providers and Systems)

Every year, a national sample of about 1.5 million patients are surveyed to learn their experiences with their doctors, services, and health care. It's one of the ways we determine if our patients are satisfied, and only with the Health Care Satisfaction Survey (HOS) can we learn about their care experience.

CAHPS surveys often ask you to call into the context of care delivery, so make the most of it. At HEALTH PLAN, we've gotten used to working with our providers to deliver an outstanding patient experience.

As a provider, you are the most critical care provider that experience, so we're ensuring that you're directly reviewing your patients are evaluating your care. Please take a moment to review and to familiarize yourself with some of the key points included in the survey.

CAHPS MEASURE: GETTING NEEDED CARE

The Getting Needed Care measure assesses the extent to which patients receive the care, tests, or treatment they needed. It also assesses how often they were able to go to a specialist, appointment, scheduled when needed.

Incorporate the following into your daily practice:

- **Use social media to help coordinate specialty appointments or urgent care**
- **Reassign patients and complete to see a specialist on the patient portal on one call**
- **Refer patients of other providers received after hours**
- **Offer appointments or referrals via text and/or email**

CAHPS MEASURE: GETTING CARE QUICKLY

The Getting Care Quickly measure assesses how often patients wait to see a doctor, nurse, or other healthcare professional and how long it takes to get the care they need.

Incorporate the following into your daily practice:

- **Offering few appointments each day or one with an advanced care appointment**
- **Offer appointments with a nurse practitioner or physician assistant for short routine appointments**
- **Hold an on-site triage system at the front desk, triage center, or other staffed location to see patients on-site right away or provide immediate care via phone and urgent care**
- **Display a list of available services and offer patients the option to reschedule**

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CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL
[Change Care Model](#)
[Provider Check-Up Guide](#)

CAHPS MEASURE: CARE COORDINATION

The Care Coordination measure assesses providers' adherence with managing referrals and receiving health care reports, including seeing the care, records, timely follow-up on test results, and medication or prescription refills.

Incorporate the following into your daily practice:

- **Ensure there are open gaps with **6** patients recently discharged from a facility**
- **Integrate the test and specialty practices through EMR or fax to get reports promptly**
- **Ask patients if they have seen any other providers, discuss visits to specialty care as needed**

Encourage patients to bring in their medications on their visit

CAHPS MEASURE: HOW WELL DOCTORS COMMUNICATE

The How Well Doctors Communicate measure assesses patients' perception of the quality of communication with their doctor, considering using the health care methods to ensure patients understand their health information.

What is Teach-back?

- **Always encourage your healthcare provider to have explained information clearly. If it is not clear, or if it is not clear to you, ask for clarification.**

Asking a patient (or family member) to explain in their own words or at their next visit or call. This is called teach-back.

Always confirm for understanding. If needed, re-explain and check again.

A **teach-back** is a health care strategy to ensure that patients understand their health information and that they can act on it.

CAHPS MEASURE: RATING OF HEALTH CARE QUALITY

The Rating of Health Care Quality measure assesses patients' overall quality of their health care experience.

Incorporate the following into your daily practice:

- **Encourage patients to make **non-routine** appointments for check-ups or follow-up visits or zoom visits when needed or appropriate in advance**
- **Provide **15** of open care gaps when needed during medical visit**
- **Make use of the provider portal when requesting patient information**

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Consumer Assessment of Healthcare Providers and Systems (CAHPS) | Absolute Total Care

Provider Focus Quick Tips



Getting Needed Care

- For urgent specialty appointments, office staff should help coordinate with the appropriate specialty office.
- If a patient portal is available, encourage patients and caregivers to view results there.



Getting Care Quickly

- Maintain an effective triage system to ensure that frail and/or very sick patients are seen right away or provided alternate care via phone and urgent care.
- For patients who want to be seen on short notice but cannot access their doctor, offer appointments with a nurse practitioner or physician assistant.
- Ensure a few appointments each day are available to accommodate urgent visits.
- Address the 15-minute wait time frame by ensuring patients are receiving staff attention.
- Keep patients informed if there is a wait and give them the opportunity to reschedule.



Care Coordination

- Ensure there are open appointments for patients recently discharged from a facility.
- Integrate PCP and specialty practices through EMR or fax to get reports on time.
 - Ask patients if they've seen any other providers. If you are aware specialty care has occurred, please mention it and discuss as needed.
 - Encourage patients to bring in their medications to each visit.



Rating of Health Care

- Encourage patients to make their routine appointments for checkups or follow up visits as soon as they can – weeks or even months in advance.

Poll Question #2



- Does your organization/practice offer patient portal access to schedule appointments?

Poll Question #3



- Does your organization/practice encourage patients to schedule routine checkups/follow ups at check-out?



RISK ADJUSTMENT

Risk Adjustment



Continuity of Care Incentive Program

Designed to support your outreach to members for annual visits and condition management, which will help us better identify members who are eligible for case management. The program achieves this goal by increasing visibility into members' existing medical conditions for better quality of care for chronic condition management and prevention. Providers earn bonus payments for proactively coordinating preventive medicine and for thoroughly addressing patients' current conditions to improve health and clinical quality of care.

Clinical Documentation Improvement Program

- Help providers understand and apply risk adjustment concepts
- Assist in the application of documentation and coding best practices to workflows
- Trainings are scheduled throughout the year and are available to providers

Please reach out to your Provider Representative for more information regarding these programs.



START SMART FOR YOUR BABY

Start Smart for Your Baby



- Program goals
 - Early identification of pregnant members and their risk factors
 - Reducing the risk of pregnancy complications
 - Better birth outcomes
- Strategy
 - Submission of Notification of Pregnancy (NOP) Form
 - High-risk members are prioritized for Care Management Program
 - OB Nurse Care Managers collaborate with members and providers to improve maternal and infant health

Start Smart for Your Baby



- OB incentive reimbursements:
 - Office staff NOP incentive:
 - Provider office staff can be reimbursed up to \$25 for each NOP Form, up to a total of \$500 for the year
 - \$25 check per form submitted during first and second month
 - \$20 check per form submitted during third and fourth month
 - \$15 check per form submitted during fifth and sixth month
 - If an NOP Form has already been received from another source, subsequent NOP Forms would not be eligible for incentive reimbursement
 - Provider office staff must submit a copy of the NOP Form along with the Pregnancy Incentive Reimbursement Form to receive the incentive

Start Smart for Your Baby



- Notification of Pregnancy (NOP) Form sample

absolute total care

Notification of Pregnancy Form

***Required Field**
The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 1-866-653-6961.**

Member's Current Contact Information

*Member ID: [red box] DOB (mmddyyyy): [red box]
 Last Name: [red box] First Name: [red box]
 Mailing Address: [red box]
 City: [red box] State: [red box] Zip Code: [red box]
 Home Number: [red box] Cell Number: [red box]
 Email Address: [red box]

OB Provider Information

*OB Provider Name: [red box]
 *OB Provider TINID #: [red box]
 OB Provider Mailing Address: [red box]
 OB Provider City: [red box] OB Provider State: [red box] OB Provider Zip Code: [red box]
 OB Provider Phone Number: [red box] Today's Date (mmddyyyy): [red box]

General Information

Primary insurance (for mom or baby) other than Medicaid? Yes No
 *Due Date (mmddyyyy): [red box] Date of first prenatal visit (mmddyyyy): [red box]
 Date of last Pap smear (mmddyyyy): [red box] Date of last chlamydia screening (mmddyyyy): [red box]
 Race/Ethnicity (check all that apply): Caucasian, Non-Hispanic/Latina Black/African American Hispanic/Latina
 American Indian/Native American Asian Hawaiian/Pacific Islander Other ethnicity (please specify): [red box]
 If other ethnicity, please specify: [red box]
 Preferred Language (if other than English): [red box]
 Number of Full Term Deliveries: [red box] Number of Preterm Deliveries: [red box]
 Number of Miscarriages/Abortions: [red box] Number of Stillbirths: [red box]
 Any social needs? Yes No
 If yes, please specify social needs: [red box]
 Enrolled in WIC? Yes No Planning to Breastfeed? Yes No Height: [red box] (feet, inches)
 Pre-Pregnancy Weight: [red box] Pre-Pregnancy BMI: [red box]
 Age less than 18? Yes No Age greater than 40? Yes No

*Are there any known pregnancy risk factors? Yes No

Rev. 04 01 2021
SC-PNCP-3022

*Member ID: [red box] DOB (mmddyyyy): [red box]
 Last Name: [red box] First Name: [red box]

History

Previous Preterm delivery (<37 weeks)? Yes No If yes, was the delivery spontaneous? Yes No
 Currently on TTP? Yes No
 Recent delivery (within past 12 months)? Yes No Recent delivery (within past 6 months)? Yes No
 Previous C-section? Yes No Previous severe preeclampsia? Yes No
 Diabetes (prior to pregnancy)? Yes No Stickle Cell? Yes No
 Asthma? Yes No If yes, are asthma symptoms worse during pregnancy? Yes No
 High Blood Pressure (prior to pregnancy)? Yes No If yes, is high blood pressure well controlled? Yes No
 Previous neonatal death or stillborn? Yes No
 If yes, was neonatal death associated with an underlying maternal health condition? Yes No
 HIV Positive? Yes No HIV Negative? Yes No HIV Test Refused? Yes No AIDS? Yes No
 Seizure disorder? Yes No If yes, has there been a seizure within the last 6 months? Yes No

Current Pregnancy

Preterm labor this pregnancy? Yes No Current placenta previa? Yes No
 Vaginal bleeding after 14 weeks? Yes No
 Shortened Cervix <33 weeks this pregnancy? Yes No If yes, Length: [red box] cm.
 Current gestational diabetes? Yes No Current preeclampsia? Yes No Current oligohydramnios? Yes No
 Current Twins? Yes No Current Triplets? Yes No Discrepant growth? Yes No
 Current fetal growth restriction? Yes No Current congenital anomalies? Yes No
 BMI < 20 or poor weight gain during this pregnancy? Yes No UTI/Pyelo Bacteruria this pregnancy? Yes No
 Current severe hypotension? Yes No
 Current mental health concerns? Yes No
 If yes, please specify mental health concerns: [red box]
 Current STD? Yes No If yes, please list STD's: [red box]
 Current tobacco use? Yes No If yes, please specify amount used: [red box]
 Current alcohol use? Yes No If yes, please specify amount used: [red box]
 Current street drug use? Yes No If yes, please specify amount used: [red box]
 Are there any other significant risk factors? Yes No
 If yes, please list other risk factors: [red box]

Rev. 04 01 2021
SC-PNCP-3022-3



Questions

APPENDIX



- ATC/Wellcare Resources
- Member ID Cards Images
- CMS Notification of Balance Billing Regulations
- ATC Provider Annual Training Requirements
- Cultural Competence and Linguistics Mandatory Training Guidelines



ATC Provider Resources

<https://www.absolutetotalcare.com/providers/resources/forms-resources.html>

<https://ambetter.absolutetotalcare.com/provider-resources/manuals-and-forms.html>



Wellcare Provider Resources

<https://www.wellcare.com/South-Carolina/Providers/Medicare/Training/New-Provider-Portal-Overview-Training>

<https://www.wellcare.com/Global-Content/Trainings/AcctRegandAffil>

ATC Provider Network Territory Assignment



Adria Felder, Provider Engagement Administrator I

(803)315-8405, Adria.Felder@CENTENE.COM

Ambulatory/EMS, Health Network Solutions, Chiropractors, Long Term Acute Care, Rehabilitation Facility and Skilled Nursing Facilities

Kisha Thomas, Provider Engagement Administrator I

(803) 904-6430, Kisthomas@centene.com

Dialysis Centers and Ambulatory Surgery Centers

Neshelle Miller, Provider Engagement Administrator I

(803) 972-1460, Neshelle.Miller@centene.com

Durable Medical Equipment and Home Health (statewide)

ATC Provider Network Territory Assignment



Anna Truesdale, Provider Engagement Administrator II

Cell: (803) 427-3260, Anna.Truesdale@CENTENE.COM

Federally Qualified Health Center (Statewide)

Camille Gray, Provider Engagement Administrator II

(803) 213-1661, Camille.L.Gray@centene.com

- *Counties: Aiken, Allendale, Bamberg, Barnwell, Calhoun, Edgefield and Orangeburg*

Wendy McCrea, BH Provider Engagement Administrator II

803-260-7093, Wendy.McCrea@CENTENE.COM

Behavioral Health to include school districts, Department of Alcohol and Other Drug Abuse Services, SC Department of Mental Health

ATC Provider Network Territory Assignment



Sarah Wilkinson, Provider Engagement Administrator II

(843) 344-0009, Sarah.Wilkinson@centene.com

- *Counties: Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Marion, Marlboro and Williamsburg*

Porsha Lewis, Provider Engagement Administrator II

(803) 873-8691, Porsha.Lewis@centene.com

- *Counties: Chester, Fairfield, Kershaw, Lee, Lexington, Richland, Saluda, Sumter, Border GA counties and Tenet Health*

LaToya Jones, Provider Engagement Administrator II

(803) 553-7324, Latoya.Jones3@Centene.com

- *Counties: Abbeville, Anderson, Cherokee, Greenville, Greenwood, Lancaster, Laurens, McCormick, Newberry, Oconee, Pickens, Spartanburg, Union, York and Border-NC*

S. Brandi Crosby, Provider Engagement Administrator II

(843) 518-3918, shunta.crosby@centene.com

- *Counties: Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Border GA-Savannah and MUSC*

ATC Provider Network Territory Assignment



Janet Kimbrough, Provider Engagement Administrator III
803-873-4454, Janet.H.Kimbrough@centene.com

- *Provider Groups: Abbeville Medical Center, Bon Secours St Francis, CenterWell Senior Primary Care, Preferred Care of Aiken, Prisma Health- Upstate, Spartanburg Regional Health/Regional HealthPlus*

Tracey Snowden, Provider Engagement Administrator III
(803)606-5328, Tracey.D.Snowden@centene.com



- *Provider Groups: AnMed Health, Atrium Health, Newberry Hospital, Self Regional, SC Oncology Associates*

Tonya Ruff, Provider Engagement Administrator III
(864) 492-5669, Tonya.C.Ruff@centene.com

- *Provider Groups: HCA Healthcare, Lexington Medical Center, McLeod Health, Palmetto Primary Care Physician, Prisma Health Midlands, Roper St. Francis Healthcare, SC Pediatric Alliance*

Medicaid Member ID Card



  Pharmacy Help Desk:
1-800-930-5512
RXBIN: 020545
RXPCN: RXA378
RXGROUP: RXGMCSC01

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>
Effective Date:
DOB:
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

go to the nearest emergency room.

1-866-433-6041
1-866-433-6041
1-800-930-5512
1-866-433-6041
1-866-433-6041

imaging, x-rays, radiology.
DME, Home Health, Infusion:

Billing Address: PO Box 3050, Farmington, MO 63640-3821

Website: absolutetotalcare.com

Ambetter from Absolute Total Care Member ID Card (2023)



FROM



Core ID Cards

Subscriber: [Jane Doe]
Member: [John Doe]

Policy #: [XXXXXXXXXX]
Member ID #: [XXXXXXXXXXXXXXXXXX]
Effective Date: [00/00/00]

[Ambetter.com/copays]

PCP: [\$10 coin. after ded.]
Specialist: [\$25 coin. after ded.]
Rx (Generic/Brand): [\$5/\$25 after Rx ded.]
Urgent Care: [20% coin. after ded.]
ER: [\$250 copay after ded.]
Max Out-of-Pocket: [\$25,000]

Plan: [Plan name]
[Line 2 if needed]
[Network Name] Network Coverage Only

RXBIN: [004336]
RXPCN: [ADV]
RXGROUP: [RX5485]

REFERRAL FROM PCP NOT REQUIRED FOR SPECIALIST

Member/Provider Services: 1-833-270-5443
(Relay: 711)
24/7 Nurse Line: 1-833-270-5443

Numbers below for providers:
Pharmacy Help Desk: 1-855-266-3490
EDI Payor ID: 68069
[Involve Vision: 1-833-724-9353]
[Involve Dental Powered by United Concordia: 1-833-605-6320]

Medical Claims Address:
Absolute Total Care
Claims Department
PO Box 5010
Farmington, MO
63640-5010

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.AbsoluteTotalCare.com.

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AMB22-SC-C-00013

Virtual ID Cards

Subscriber: [Jane Doe]
Member: [John Doe]

Policy #: [XXXXXXXXXX]
Member ID #: [XXXXXXXXXXXXXXXXXX]
Effective Date: [00/00/00]

[Ambetter.com/copays]

PCP: [\$10 coin. after ded.]
Specialist: [\$25 coin. after ded.]
Rx (Generic/Brand): [\$5/\$25 after Rx ded.]
Urgent Care: [20% coin. after ded.]
ER: [\$250 copay after ded.]
Max Out-of-Pocket: [\$25,000]

Plan: [Plan name]
[Line 2 if needed]
[Network Name] Network Coverage Only

RXBIN: [004336]
RXPCN: [ADV]
RXGROUP: [RX5485]

REFERRAL FROM PCP REQUIRED FOR SPECIALIST

Member/Provider Services: 1-833-270-5443
(Relay: 711)
24/7 Nurse Line: 1-833-270-5443

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EDI Payor ID: 68069

Medical Claims Address:
Absolute Total Care
Claims Department
PO Box 5010
Farmington, MO
63640-5010

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AMB22-SC-C-00013

Medicare-Wellcare Member ID Card (2023)



HMO and HMO DSNP

PPO



[Wellcare Plan Name]
[Plan Contract PBP]
Card Effective Date: 01/01/2023

Member: **SAMPLE A SAMPLE**
Member ID: **23456789** Issuer: **80840** Policy #: [xx123]
You can see any PCP on our Network
PCP Name: ALLISON SMITH
PCP Phone: [x-xxx-xxx-xxxx]
[IPA:]
[IPA NAME] [IPA123]

PCP Office Visit: [\$x]

Medicare^R
Prescription Drug Coverage X


RXBIN: [xxxxx]
RXPCN: MEDDADV
RXGRP: [xxxxx]
Card Issued: 10/15/2022

FOR MEMBERS
For questions or to change your PCP: [x-xxx-xxx-xxxx]
Member Services: [x-xxx-xxx-xxxx] TTY: 711
Nurse Advice Line: [x-xxx-xxx-xxxx]

FOR PROVIDERS
Provider Service: [x-xxx-xxx-xxxx]
Vision (For Providers and Members): [x-xxx-xxx-xxxx]
Dental (For Providers and Members): [x-xxx-xxx-xxxx]

SUBMIT MEDICAL CLAIMS TO
Wellcare Health Plans Attn: Claims Department PO Box 31372
Tampa, FL 33631-3372
Payor ID: 14163

Your current co-pay, PCP and benefit details can be found online/mobile app:
www.wellcare.com/medicare



[Wellcare Plan Name]
[Plan Contract PBP]
Card Effective Date: 01/01/2023

Member: **SAMPLE A SAMPLE**
Member ID: **23456789** Issuer: **80840** Policy #: [xx123]

[IPA:]
[IPA NAME] [IPA123]

In Network PCP Office Visit: [\$x]
Out Of Network PCP Office Visit: [\$x]

Medicare^R
Prescription Drug Coverage X

RXBIN: [xxxxx]
RXPCN: MEDDADV
RXGRP: [xxxxx]
Card Issued: 10/15/2022

FOR MEMBERS
For questions or to change your PCP: [x-xxx-xxx-xxxx]
Member Services: [x-xxx-xxx-xxxx] TTY: 711
Nurse Advice Line: [x-xxx-xxx-xxxx]



FOR PROVIDERS
Provider Service: [x-xxx-xxx-xxxx]
Vision (For Providers and Members): [x-xxx-xxx-xxxx]
Dental (For Providers and Members): [x-xxx-xxx-xxxx]

SUBMIT MEDICAL CLAIMS TO
Wellcare Health Plans Attn: Claims Department PO Box 31372
Tampa, FL 33631-3372
Payor ID: 14163

Your current co-pay, PCP and benefit details can be found online/mobile app:
www.wellcare.com/medicare

Wellcare Prime by Absolute Total Care (MMP) Member ID Card (2023)



Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

MEMBER CANNOT BE CHARGED
Cost sharing/Copays: \$0 for covered medical and prescription services
H1723 001

MedicareRx Prescription Drug Coverage

RxBIN: 004336
RxPCN: MEDDADV
RxGRP: RX8143
RxID: <RxID#2>

at all times and present it each time you receive a service acy, dentist, etc.

Member Services: 1-855-735-4398 (TTY: 711)
Behavioral Health: 1-855-735-4398 (TTY: 711)
Pharmacy Help Desk: 1-888-865-6567 (TTY: 711)
24-Hr Nurse Line: 1-855-735-4398 (TTY: 711)
Pharmacy Prior Auth: 1-800-867-6564 (TTY: 711)
Website: mmp.absolutetotalcare.com

Send Claims To: Medical Claims: Wellcare Prime (MMP)
P.O. Box 3060 Farmington, MO 63640-4402
Pharmacy Claims: Wellcare Prime (MMP)
Claim Inquiry: Attn: Member Reimbursement Dept.
P.O Box 31577 Tampa, FL 33631-3577
<1-855-735-4398 (TTY: 711)>



Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth St., SW; Suite 4T20
Atlanta, GA 30303



May 19, 2016

TO: Providers
SUBJECT: Prohibition on Balance Billing of Healthy Connections Prime Members

BALANCE BILLING IS PROHIBITED

Balance billing is the practice in which providers bill dually eligible beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare cost-sharing. This population is exempt from paying any cost-sharing for deductibles, coinsurance and co-payments related to Medicare services and prescription drugs. Healthy Connections Prime Members are considered QMBs. Please be advised that it is **unlawful for providers to "balance bill" any patient who is a member of Healthy Connections Prime** for any covered services. Balance billing for Healthy Connections Prime members is billing the patients for the difference between what the Medicare-Medicaid plan (MMP) pays and the retail price you charge for your services. The provider must accept payment in full from the Medicare-Medicaid plan (MMP) and should not deny any services to members for non-payment. Providers who inappropriately balance bill Healthy Connections Prime members are subject to sanctions and/or termination of their MMP provider agreement.

WHAT CAN BE BILLED TO MEMBERS?

1. For non-covered items and services, providers must give members advance notice that such items or services will be non-covered and have a written agreement with the members for these non-covered items or services. If such notice is not given and the agreement is not in place, providers may not bill members for such items or services.
2. For certain Medicaid-only items and services (such as durable medical equipment and home health agency care), members can be billed the allowable Medicaid co-pays.

ABOUT HEALTHY CONNECTIONS PRIME

Healthy Connections Prime is a new option for South Carolina seniors 65 and older with Medicare and Healthy Connections Medicaid. It is part of a national initiative designed to integrate all the services of Medicare, Medicare Part D and Medicaid into a single set of benefits fully managed by an MMP. Visit the Provider page on the Healthy Connections Prime website (<http://www.scdhhs.gov/prime>) to learn more details about the program or email PrimeProviders@scdhhs.gov with any questions.



Prohibition on Billing Medicare-Medicaid Plan (MMP) Enrollees for Medicare Cost-Sharing

This communication serves as a reminder that for Wellcare Prime by Absolute Total Care Healthy Connections Prime members, providers **may not bill and/or collect** any Medicare cost-sharing amounts, including deductibles, coinsurance, and copayments that may be represented on the Explanation of Payment (EOP), as they are not the member's responsibility.

This practice, known as "balance billing", is prohibited by Federal Law and as stipulated under your Wellcare Prime/Healthy Connections Prime Provider Services Agreement. **Please be advised that it is unlawful for providers to "balance bill" any patient who is a member of Healthy Connections Prime for any covered services.**

If your patient presented the following Member ID Card, you provided services to Wellcare Prime (Healthy Connections Prime) MMP member:



Wellcare Prime members can be billed for:

- Medicaid participation in cost of care amounts for long-term services and supports as determined by SCDHHS.
- Medicaid copay for Medicaid only covered Durable Medical Equipment (DME) items.

How Wellcare Prime resolves balance billing issues with the provider:

- Wellcare Prime informs the provider that the member has been inappropriately balance billed and educates the provider on balance billing.
- If Wellcare Prime reimbursed the member for an inappropriately balance billed amount, the plan will notify the provider and request reimbursement be made to the plan.
- If after outreach and education efforts to the provider, Wellcare Prime identifies ongoing inappropriate balance billing activities, Wellcare Prime may take disciplinary action up to and including termination of the Provider Agreement.

For more information regarding balance billing please refer to the Wellcare Prime Provider Manual at absolutetotalcare.com. You can also refer to CMS' Balance Billing Prohibition Notice at this link (<https://msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing-healthy-connections-prime-members-0>) on the Healthy Connections Prime website. If you have any questions, please contact Member Services at 1-855-735-4398.

MMP Example EOP- Medicare Balance Billing



Run Date: 8/9/2022

Page 1 of 4



EXPLANATION OF PAYMENT
Wellcare Prime by Absolute Total Care
Medicare-Medicaid Plan
100 Center Point Circle, Suite 100
Columbia, SC 29210
1-855-735-4398

Payment Date:	8/9/2022
Payment #:	0900158619
Payment Amt:	\$116.00

PAY TO:
[REDACTED]

Payee ID: UDEF
IRS#: [REDACTED]

Insured Name:	[REDACTED]	Mbr No:	[REDACTED]	MRN:	[REDACTED]	Claim/Ctrl No:	[REDACTED]
Patient Name:	[REDACTED]	SvcProv No:	[REDACTED]			PatCtrl No:	[REDACTED]
Servicing Provider:	[REDACTED]	NPI:	[REDACTED]			Group:	MMP SC ATC

Please note: Medicare crossover claim forwarded to Medicaid for secondary payment. Please do not bill the patient.

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	WrapPaymt	Deduct/ CoPay	Coinsur/ Penalty	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
0100	7/20/2022	99214		1.00	\$310.00 \$145.00	0.00	\$0.00 \$0.00	\$29.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00	\$0.00	10 21	\$116.00 \$0.00
			Sub-total		\$310.00 \$145.00	\$0.00	\$0.00 \$0.00	\$29.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00	\$0.00		\$116.00 \$0.00
			Total		\$310.00 \$145.00	\$0.00	\$0.00 \$0.00	\$29.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00	\$0.00		\$116.00 \$0.00

Explanation Code	Description
10	PAY - PAID PER CONTRACTUAL AGREEMENT
21	PAID-COINSURANCE APPLIED

MMP Example EOP- Medicaid

Balance Billing



Run Date: 8/17/2022



EXPLANATION OF PAYMENT
 Wellcare Prime by Absolute Total Care
 Medicare-Medicaid Plan
 100 Center Point Circle, Suite 100
 Columbia, SC 29210
 1-855-735-4398

Payment Date:	8/17/2022
Payment #:	
Payment Amt:	\$0.00

PAY TO:



Payee ID: [REDACTED]
 IRS#: [REDACTED]

Insured Name:	[REDACTED]	Mbr No:	[REDACTED]	MRN:	[REDACTED]	Claim/Ctrl No:	[REDACTED]
Patient Name:	[REDACTED]	SvcProv No:	[REDACTED]	Carrier:	MM	PatCtrl No:	[REDACTED]
Servicing Provider:	[REDACTED]	NPI:	[REDACTED]			Group:	SCTCC - BERKELEY

Please note: This bill has crossed over from Medicare to Medicaid. Payment is now complete.

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur/ Penalty	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
0100	7/20/2022	99214		1.00	\$310.00 \$66.87	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$145.00 \$116.00	\$0.00	\$0.00	MX PM Aa	\$0.00 \$0.00
			Sub-total		\$310.00 \$66.87	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$145.00 \$116.00	\$0.00	\$0.00		\$0.00 \$0.00
			Total		\$310.00 \$66.87	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$145.00 \$116.00	\$0.00	\$0.00		\$0.00 \$0.00

Explanation Code	Description
Aa	INFORMATIONAL: CLAIM PROCESSED THROUGH COORDINATION OF BENEFITS
MX	PAY: MAXIMUM ALLOWABLE HAS BEEN PAID BY PRIME INS
PM	PAY: PCP IS NOT EFFECTIVE AT THE TIME OF SERVICE

Annual Provider Training Requirements

Absolute Total Care partners with all of our contracted providers to ensure that you have received the necessary training to deliver quality care to our members and your patients and to be compliant with Centers for Medicare & Medicaid Services (CMS) and state requirements. All Medicare Advantage Organization (MAO) and Medicare-Medicaid Plan (MMP) contracted providers are required to complete the following trainings within 90 days of contracting and **annually** thereafter:

- General Compliance (Compliance)
- Fraud, Waste, and Abuse
- Model of Care (MOC)*
- Person-Centered Planning**

General Compliance and Fraud, Waste, and Abuse trainings are posted on the CMS Medicare Learning Network (MLN) website at <http://go.cms.gov/mln>, and links to the specific trainings can be found in the table below. The MOC training* and Person-Centered Planning training** can be found on the Absolute Total Care website as indicated in the table below. Once practitioners have taken the required trainings, we ask that you attest to their completion by filling out an Attestation Form or submitting CMS certificates of completion. While the training itself must be completed by every participating practitioner, attestation can be completed one time for all practitioners within a given provider group.

Required Training Resources

Required Training	Training Location
General Compliance	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf
Fraud, Waste, and Abuse	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244-Print-Friendly.pdf
Model of Care (MOC)*	https://www.absolutetotalcare.com/providers/resources/provider-training/model-of-care-provider-training.html
Person-Centered Planning**	https://www.absolutetotalcare.com/providers/resources/provider-training.html

*MOC training is required for providers who directly or indirectly facilitate and/or provide Medicare Part C or D benefits for any Allwell from Absolute Total Care HMO SNP Member. Please refer to the Quick Reference Guide for additional information on MOC training.

**Person-Centered Planning training is required for providers who directly or indirectly provide services for our Absolute Total Care MMP members.





Culturally and Linguistically Appropriate Services (CLAS) Program

[https://www.absolutetotalcare.com/content/dam/centene/absolute-total-care/test/2023%20CLAS%20Program%20Description%20\(1\).pdf](https://www.absolutetotalcare.com/content/dam/centene/absolute-total-care/test/2023%20CLAS%20Program%20Description%20(1).pdf)



Cultural Competency Quick Reference Guide

What is cultural competency?

- A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups, and the sensitivity to know how these differences influence relationships with members
- It is a set of complimentary behaviors, attitudes, and policies that help professionals work effectively with people of different cultures

Purpose of cultural competency

- Learn about, understand and provide excellent customer service to all members across all segments of the population
- Promote sensitivity to the needs of patients who are members of various racial, religious, age, gender, or ethnic groups
- Accommodate the patient's culturally-based attitudes, beliefs, and needs

You will learn:

- What is cultural competency
- Sources of diversity
- Steps for becoming culturally competent
- Communicating across cultures
- Tips for successful cross-cultural communications

Resources

Resources for Cultural Competency training can be found on Wellcare Prime by Absolute Total Care's website on the Provider Manuals and Forms page

(<https://www.absolutetotalcare.com/providers/resources/forms-resources.html>).

- Medicare-Medicaid Plan (MMP) Provider Manual
- Cultural Competency PDF

Authorization Forms



absolute total care | Healthy Connections **INPATIENT AUTHORIZATION FORM (SOUTH CAROLINA)** Initial Request/Notifications: 1-866-912-3626 Concurrent: Clinics faxed to 1- 866-633-6349

Standard Request - Determination within 14 working days of receiving all necessary information
 Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

PHYSICIAN MUST SIGN FOR URGENT PRIORITY REVIEW. IF WE DO NOT HAVE THE PHYSICIAN'S SIGNATURE, IT WILL BE PROCESSED AS A STANDARD REQUEST.

INDICATES REQUIRED FIELD

MEMBER INFORMATION Date of Birth

Member ID/Medicaid ID Last Name, First

REQUESTING PROVIDER INFORMATION

Requesting NPI Requesting Title Requesting Provider Contact Name

Requesting Provider Name Phone Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI Servicing Title Servicing Provider Contact Name

Servicing Provider/Facility Name Phone Fax

AUTHORIZATION REQUEST

Primary Procedure Code Start Date OR Admission Date Diagnosis Code

Additional Procedure Code Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity Additional Diagnosis Code

INPATIENT SERVICE TYPE (Enter the Service type number in the boxes)

Delivery	Acute Admissions
770 C-Section Delivery	690 Standalone Baby
790 Vaginal Delivery	900 Medical
	200 Neonates
	414 Prematurity/Pain Labor
	411 Surgical
	990 Transplant
Post Acute Placement	
457 Rehab	
121 Long Term Acute Care	
400 Skilled Nursing Facility	
490 Subacute	

Requests for inpatient Behavioral Services should be submitted on inpatient BH forms & faxed to: 866-535-6974

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
 COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be covered under their benefit and medically necessary under their authorization as per Plan policy and provisions.
Confidentiality: The information contained in this document is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient, any use, distribution, or copying is strictly prohibited. If you have received this document in error, please notify us immediately and destroy this document.

Rev. 09/19/2022 SC-PAP-0620

absolute total care | Healthy Connections **OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM**

Request for additional units. Existing Authorization units

Standard Request - Determination within 14 calendar days of receiving all necessary information
 Urgent Request - Determination within 72 hours of receiving the request. I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

PHYSICIAN MUST SIGN FOR URGENT PRIORITY REVIEW. IF WE DO NOT HAVE THE PHYSICIAN'S SIGNATURE, IT WILL BE PROCESSED AS A STANDARD REQUEST.

INDICATES REQUIRED FIELD

MEMBER INFORMATION Date of Birth

Member ID/Medicaid ID Last Name, First

REQUESTING PROVIDER INFORMATION

Requesting NPI Requesting Title Requesting Provider Contact Name

Requesting Provider Name Phone Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI Servicing Title Servicing Provider Contact Name

Servicing Provider/Facility Name Phone Fax

AUTHORIZATION REQUEST

Primary Procedure Code Additional Procedure Code Start Date OR Admission Date Diagnosis Code

Additional Procedure Code Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days

OUTPATIENT SERVICE TYPE (Enter the Service type number in the boxes)

402 Auditory	303 Pain Management
712 Cochlear Implants & Surgery	650 Radiation Therapy
299 Drug Testing	301 Sleep Study
623 Experimental and Investigational Services	993 Transplant Evaluation
700 Genetic Testing	309 Transplant Surgery
346 Home Health	794 Transportation
366 Infectious Diagnosis or Treatment	
697 Office Visit/Consult	
794 Outpatient Services	
171 Outpatient Surgery	

407 DME - Rental Purchase (Purchase only)
 100 DME - Purchase (Purchase only)

** If you are requesting Biopharmacy (medications) please use the Prior Authorization Form on the ATC website**

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SC DHHS 1716 Form for Newborns



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES Healthy Connections MEDICAID		Request for Medicaid ID Number - Infant			
I. Provider Information					
Provider Name / Hospital Name				Date	
Provider Street Address		City	County	State ZIP code	
Provider Representative (First, Last Name)		Phone	Fax		
Provider Email Address (SCDHHS will submit Form 1716 to this address)					
II. Mother's Information					
First Name, Middle Name, Last Name				Date of Birth (mm/dd/yyyy)	
Street Address		City	County	State ZIP code	
Social Security Number			Medicaid ID#		
III. Child's Information					
First Name, Middle Name, Last Name (if not yet named, enter "Baby Boy" or "Baby Girl")				Date of Birth (mm/dd/yyyy)	
Street Address (if same as mother's, enter "Same")		City	County	State ZIP code	
Name of Birth Facility			County of Birth Facility		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female					
Has an application been made for a SSN for the child? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Distinctive Only	Child's Medicaid ID Number: _____			Effective date of eligibility: _____	Distinctive Only
IV. Mail the Completed Form					
Mail the completed form to:			Fax:		
SCDHHS - Central Mail PO Box 100101 Columbia, SC 29202-3101			(888) 820-1204		

ASL Interpretation Services

Please request a copy of this policy from your PR Rep if needed



www.lsaweb.com

Client Policy Guide: ASL Face-to-Face Interpreting Requests

Thank you for choosing LSA as your language services provider! We are committed to providing you with exceptional service from the minute you submit a request to the conclusion of any assignment.

In order to guarantee that all requests are received and responded to in a timely fashion, we are providing you with our policies for requesting American Sign Language (ASL) interpreting services, including ASL interpretation, English transliteration (signed and oral) and Deaf interpretation. LSA is proud to offer RID nationally certified interpreters and qualified pre-certified interpreters.

Types of Interpreting Situations

Legal

Applies to court trials, hearings, depositions or any legal matter that becomes part of a legal record. LSA uses a team of two interpreters for all legal assignments.

Mental Health

The need for completely accurate and effective communication is critical in the mental health setting. For this reason, LSA uses a Deaf / hearing team (which consist of one Deaf interpreter and one hearing interpreter) for most mental health assignments. Deaf interpreters have the highest level of linguistic skill in ASL and the best cultural connection to the Deaf consumer. There are times when a Deaf consumer will require a Deaf / hearing team for non mental health assignments due to limited language skills.

Conference / Platform Interpreting

Applies to any type of conference, seminar, town hall meeting or religious service. LSA requires a minimum of four weeks' notice for conference interpreting services lasting more than one day.

So that we can determine interpreter and CART needs for your conference, please be sure to include a checkbox on your registration form indicating the need for services, as well as a clearly defined response deadline four weeks before the conference start date.

Conference interpreting always requires a team of interpreters. For larger conferences with several breakout sessions, several teams may be necessary.

Team Interpreting

For occupational safety, requests for 1.5 hours or more of interpreting services may require a team of two interpreters, depending upon the complexity of the assignment.

Submitting Requests

Please try to submit your community / routine interpreting requests at least two business days in advance. Emergency / rush situations may be requested on demand but they will incur additional surcharges.

It is the institution's responsibility (not the Deaf consumer's) to request interpreting services. We recommend you do this when the appointment is booked with the Deaf consumer, or immediately after.

We kindly ask that you submit your ASL interpretation requests to LSA in one of the following two ways:

Online: Once your account is set up to submit online requests, you can enter requests via the LSA website any time of the day, any day of the week. Please note that requests received after 6:30 p.m. Monday through Friday will be processed the next business day. Please contact LSA's Client Services department at 800.305.9763 (option #7) or via e-mail at clientservices@lsaweb.com to enable your account for online requests.

Telephone: You may call 866.827.7028 at any time to make a face-to-face interpreting request. If calling outside of our standard business hours (before 8:00 a.m. EST and after 6:30 p.m. EST Monday through Friday, and on the weekends), LSA's call center staff will be able to assist you.

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Page 1 of 2



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Extra Time

Please try to provide us with a realistic estimate for the total length of time for the assignment, including any extra time that should be taken into consideration. For example, if there are security check-in procedures, or paperwork that needs to be filled out prior to the appointment, that information should be included in your request. In these instances, if the appointment is scheduled for 8:30 a.m., you should place your request for 8:15 a.m.

Sometimes assignments will go over the contracted time period. If the interpreter is available to stay after the projected end of an assignment, extra time will be charged to you in half-hour increments. Please understand that interpreters book their own schedules and may not be able to stay longer due to other commitments. If your meetings frequently run over the scheduled time, please expand the time of your request.

Cancellation / No Show Policy

In the event a request for interpreting services is cancelled with more than two business days notice, there will be no charge to the requesting organization. Please note that if a holiday falls within the notice time period, an additional day notice is required.

Requests cancelled with less than two business days notice will be billed for the interpreter time reserved. If more than two hours were reserved, the payable fee will be for the time reserved per interpreter. If there was travel time involved, and the interpreter actually traveled to the assignment location, travel fees will also be charged.

Deaf Consumer No-Show

In the event a Deaf consumer does not arrive as scheduled for an assignment, it is customary for the interpreter to wait approximately 30 minutes before leaving the assignment location. The requesting organization will be billed for the time reserved per interpreter.

Interpreter No-Show

If the interpreter does not arrive for the scheduled assignment, please call LSA's Face-to-Face Interpreting division immediately. We will make every attempt to provide a substitute interpreter. If a substitute interpreter is not available, the assignment will be canceled and there will be no charge to the requesting organization.

Travel Policy

Depending on your specific agreement with LSA, travel compensation may be charged for:

Portal to Portal – Travel compensation is charged at half the hourly interpreting rate for interpreters who travel to the site of an assignment.

Mileage / Tolls / Parking – These are all charged to the client as applicable. The current mileage rate is charged as set by the Internal Revenue Service.

Please feel free to contact a member of LSA's Face-to-Face Interpreting division at 866.827.7028 with any questions or concerns regarding our policies for placing ASL face-to-face interpreting requests.



Adjournment