Absolute Total Care

2023 Virtual Provider Town Hall

2nd Quarter

8/30/2023

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

Name	Title	Email
Jennifer Helms	Vice President, Operations	Jennifer.B.Helms@centene.com
SaBrina Macon	Director, Provider Relations	SaBrina.C.Macon@centene.com
Kristen Graham	Manager, Provider Relations	Kristen.Graham@centene.com
Janet Kimbrough	Provider Engagement Administrator III	Janet.H.Kimbrough@centene.com
Tonya Ruff	Provider Engagement Administrator III	Tonya.C.Ruff@centene.com
Tracey Snowden	Provider Engagement Administrator III	Tracey D.Snowden@centene.com
LaToya Jones	Provider Engagement Administrator II	LaToya.Jones3@centene.com
Porsha Lewis	Provider Engagement Administrator II	Porsha.Lewis@centene.com

Provider Engagement Team

Name	Title	Email
S. Brandi Crosby	Provider Engagement Administrator II	Shunta.Crosby@centene.com
Anna Truesdale	Provider Engagement Administrator II	Anna.Truesdale@centene.com
Camille Gray	Provider Engagement Administrator II	Camille.L.Gray@centene.com
Sarah Wilkinson	Provider Engagement Administrator II	Sarah.Wilkinson@centene.com
Wendy McCrea	Provider Engagement Administrator II	Wendy.McCrea@centene.com
Kisha Thomas	Provider Engagement Administrator I	Kisthomas@centene.com
Adria Felder	Provider Engagement Administrator I	Adria.Felder@centene.com
Neshelle Miller	Provider Engagement Administrator I	Neshelle.Miller@centene.com

Quality Improvement and Case Management Team

Name	Title	Email
Sharon Mancuso	Vice President, Quality Improvement	Sharon.Mancuso@centene.com
Janet Bergen	Manager, Case Management	JBergen@centene.com
Betty Smith	Lead Program Coordinator	BetSmith@centene.com
Aimee Kincaid	Senior Manager, Quality Improvement	Aimee.Kincaid@centene.com
Jane Brown	Quality Improvement, Project Manager	Jane.F.Brown@centene.com
Kellie Williamson	Quality Improvement, Supervisor	kellie.m.williamson@centene.com

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

absolute total care
Healthy Connections

- 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

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Healthy Connections

- 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 competing 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 from 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	South Carolina Medicaid	Health Insurance Marketplace
1-866-433-6041	1-888-549-0820	1-800-318-2596
absolutetotalcare.com	apply.scdhhs.gov	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

- 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

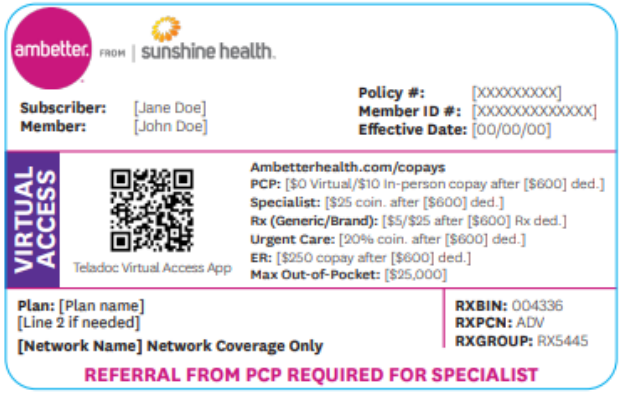
Ambetter Virtual Access was designed for members who desire a Virtual Primary Care experience.

- 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


ambetter. FROM | sunshine health.

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

Policy #: [XXXXXXXXX]
Member ID #: [XXXXXXXXXXXX]
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.

Ambetter from Sunshine Health is underwritten by Sunshine Health Plan, Inc.
AMB22-FL-C-00013

No Surprises Act

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

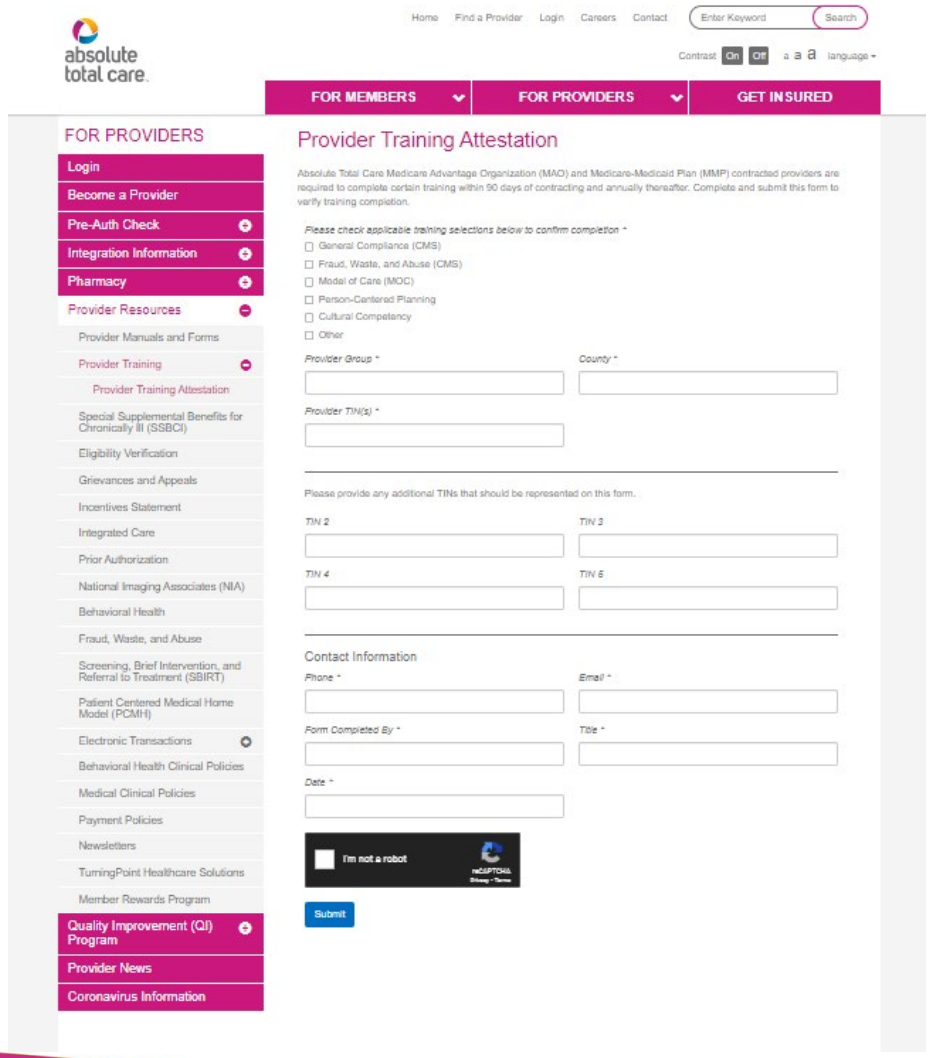
Annual Provider Training Requirements

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



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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.

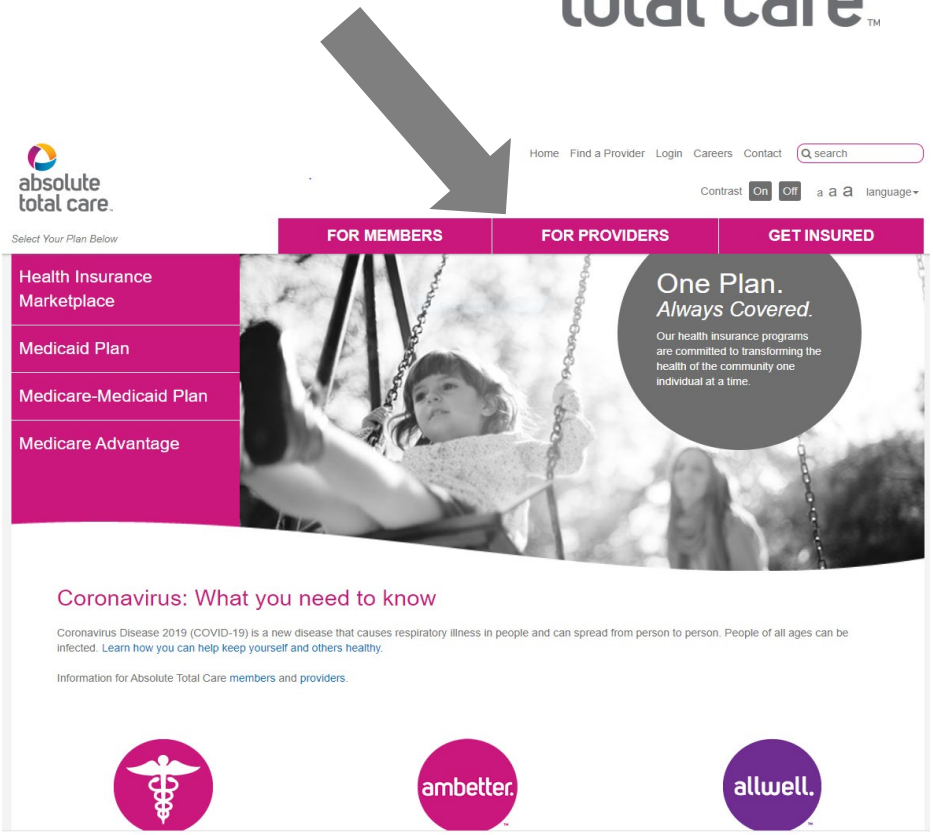
Websites and Secure Portals

Absolute Total Care Website

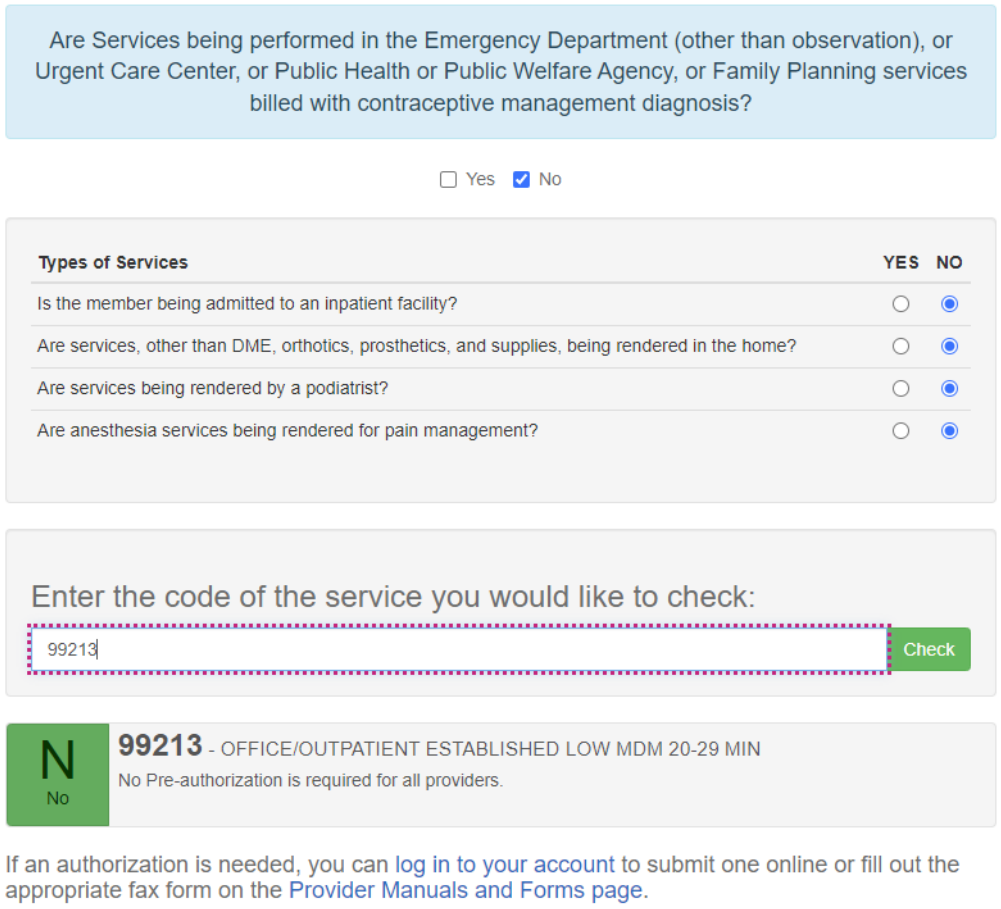
www.absolutetotalcare.com

For Providers section:

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



Pre-Auth Lookup Tool

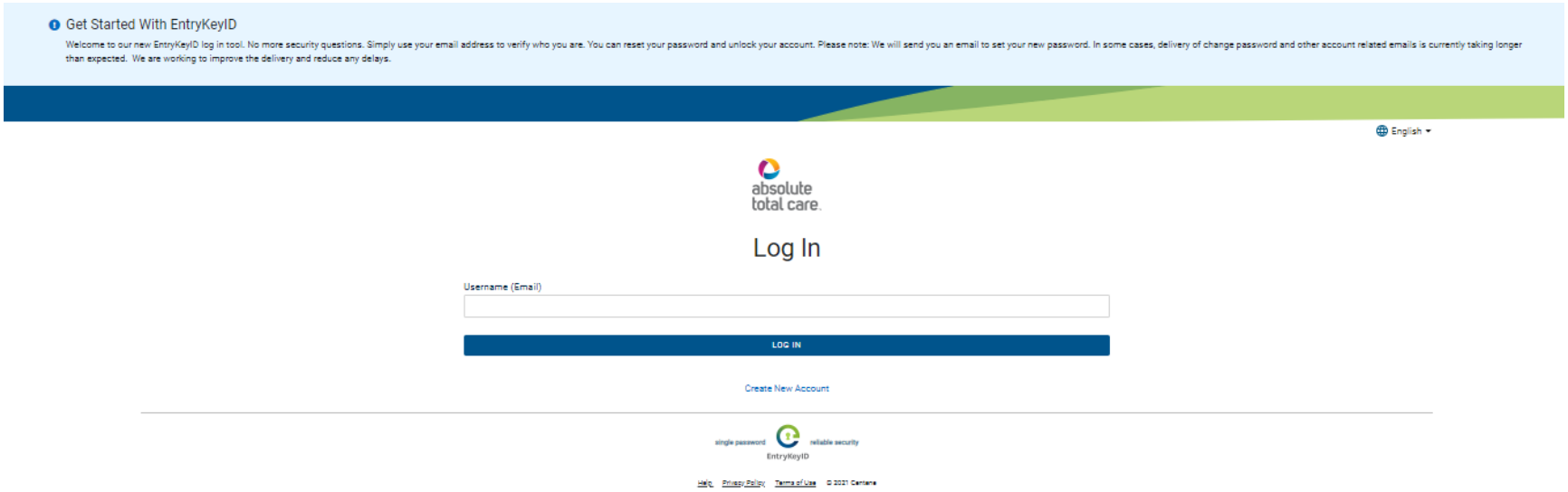


Authorization Vendors

- 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

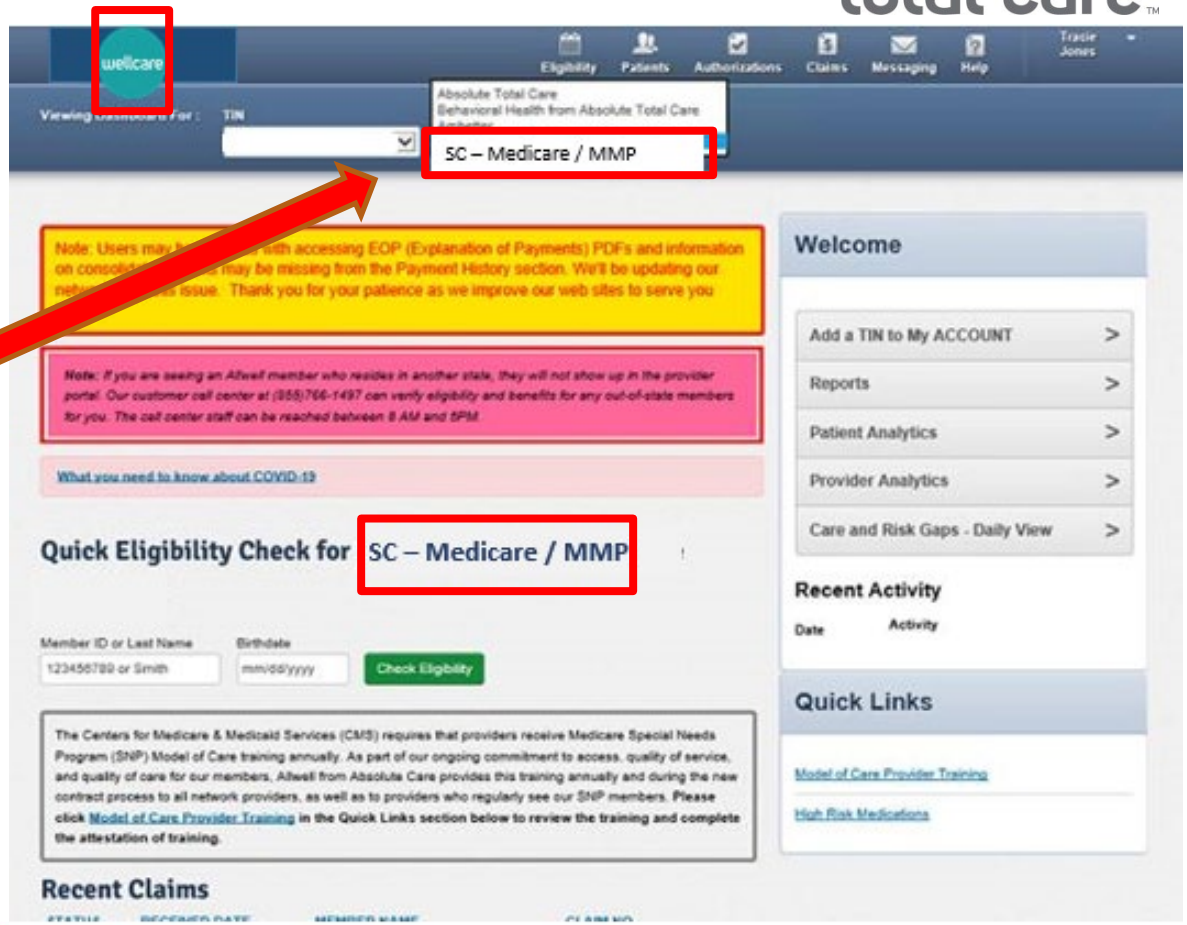
- Log in: https://www.absolutetotalcare.com/login.html



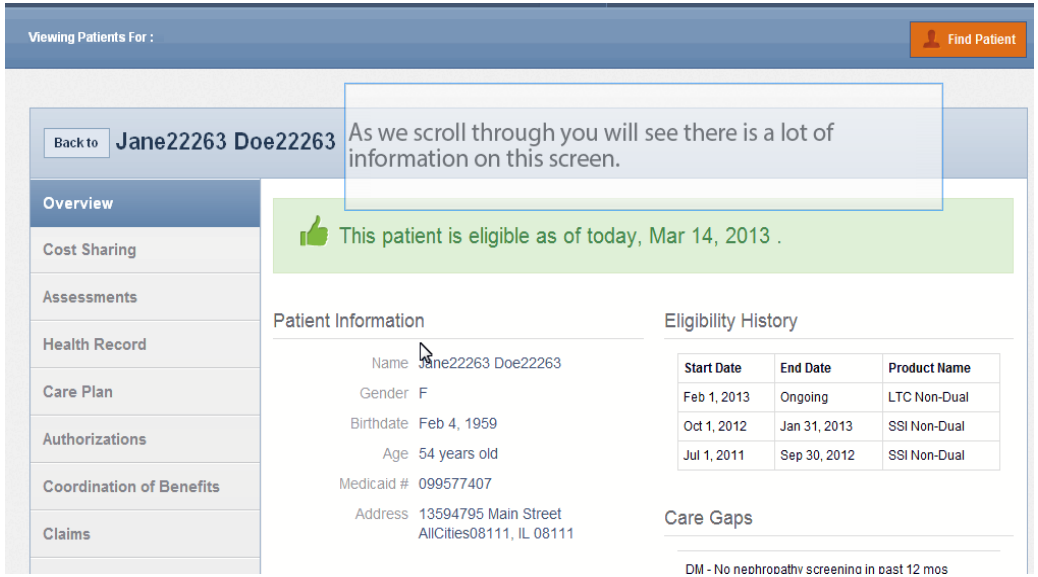
Absolute Total Care Secure Provider Portal

Updated logo and plan name in drop down

Medicare Advantage and MMP Members



Absolute Total Care Secure Provider Portal



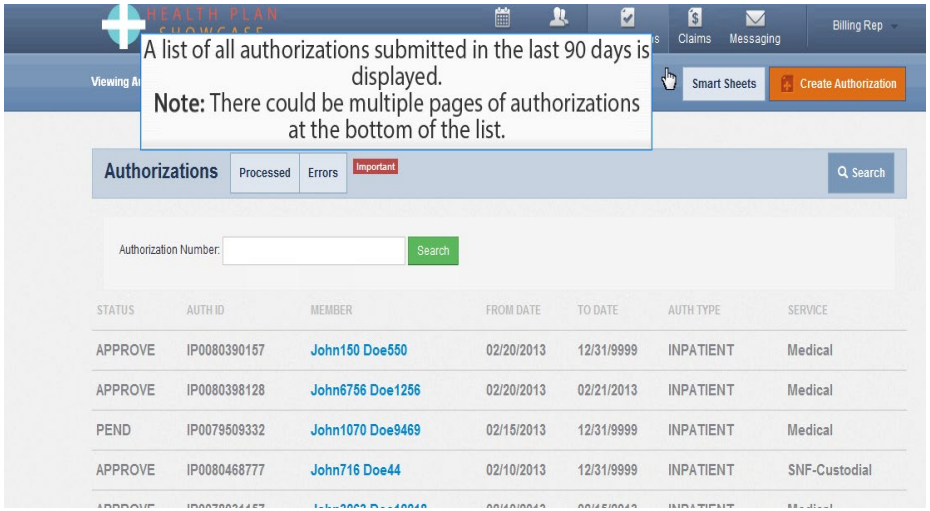
Member eligibility should be checked each month and each time prior to rendering services

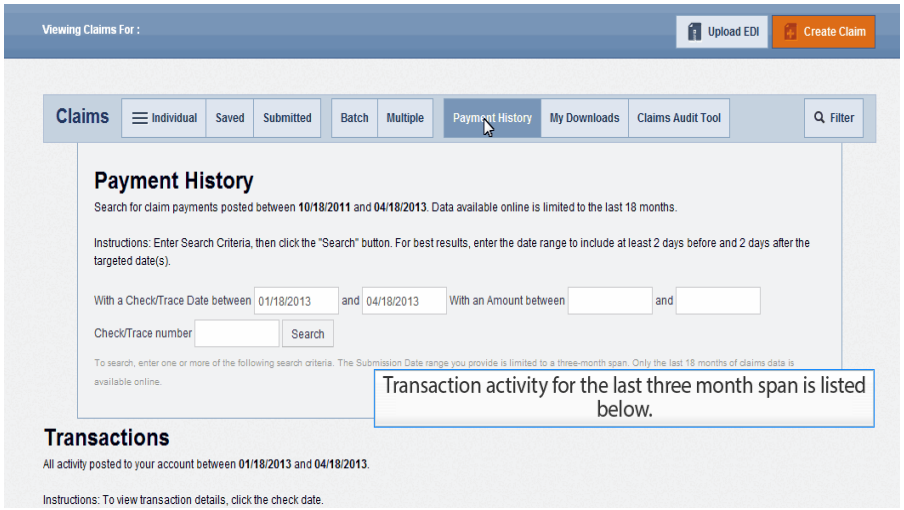
The Absolute Total Care Secure Provider Portal or the Interactive Voice Response (IVR) system are available 24 hours a day, seven days a week

- 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)

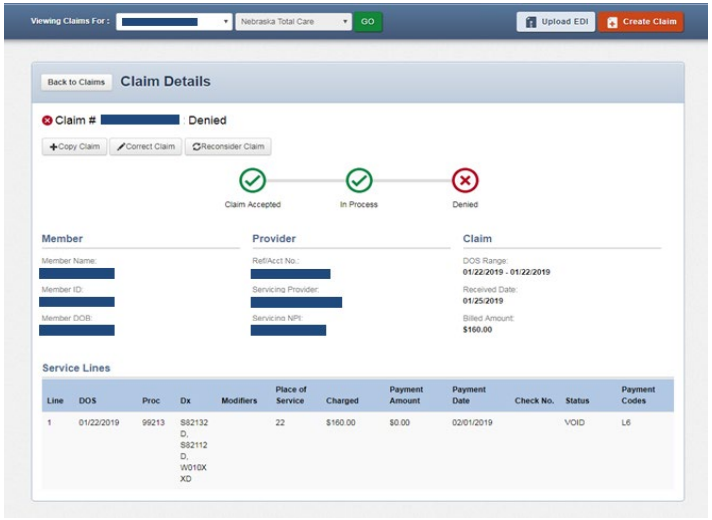
Absolute Total Care Secure Provider Portal

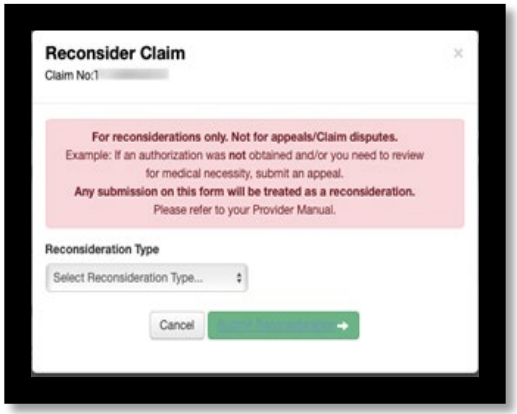
Authorizations and Claims

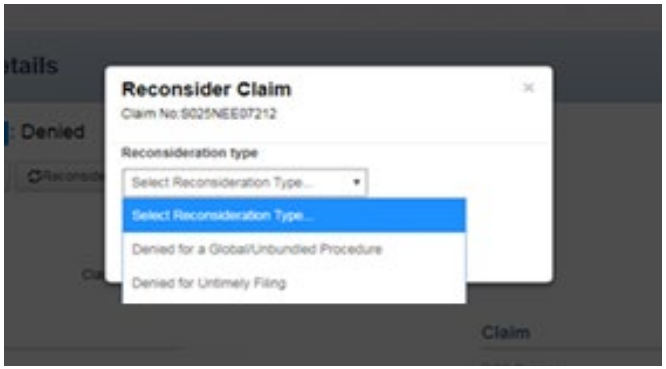


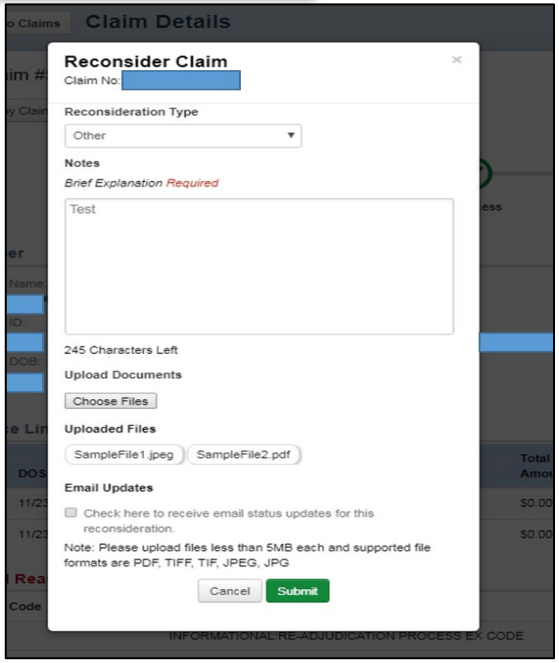


Absolute Total Care Secure Provider Portal
Provider Reconsideration

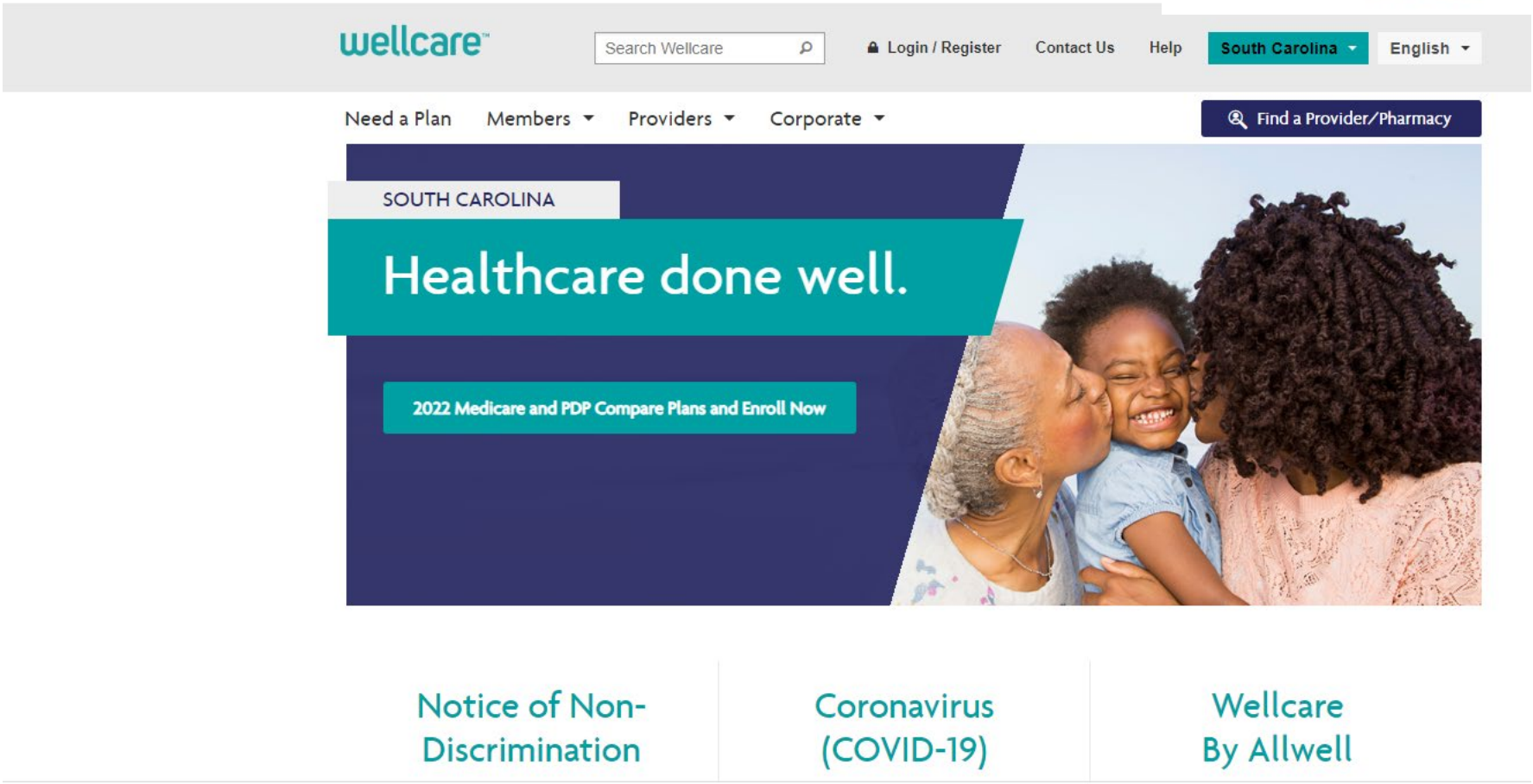






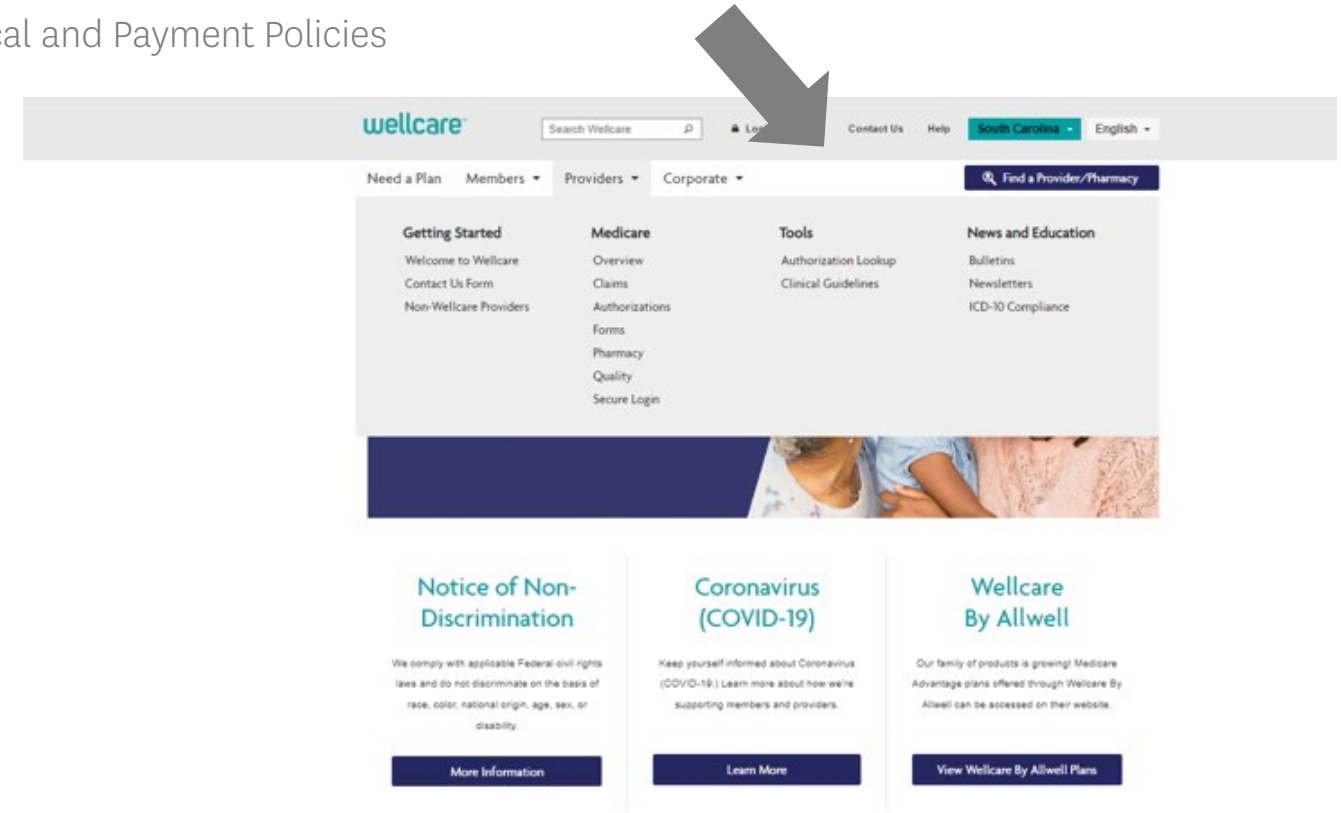


Wellcare Website

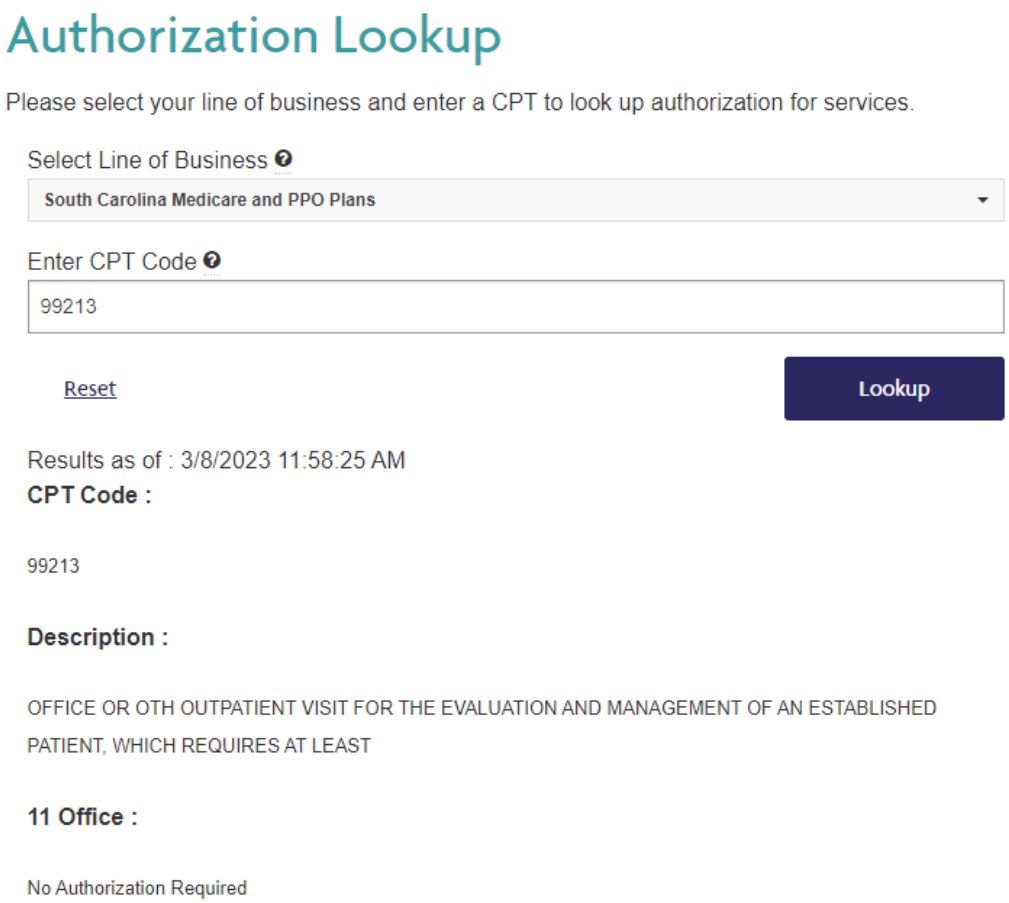


Wellcare Website

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



Pre-Auth Lookup Tool

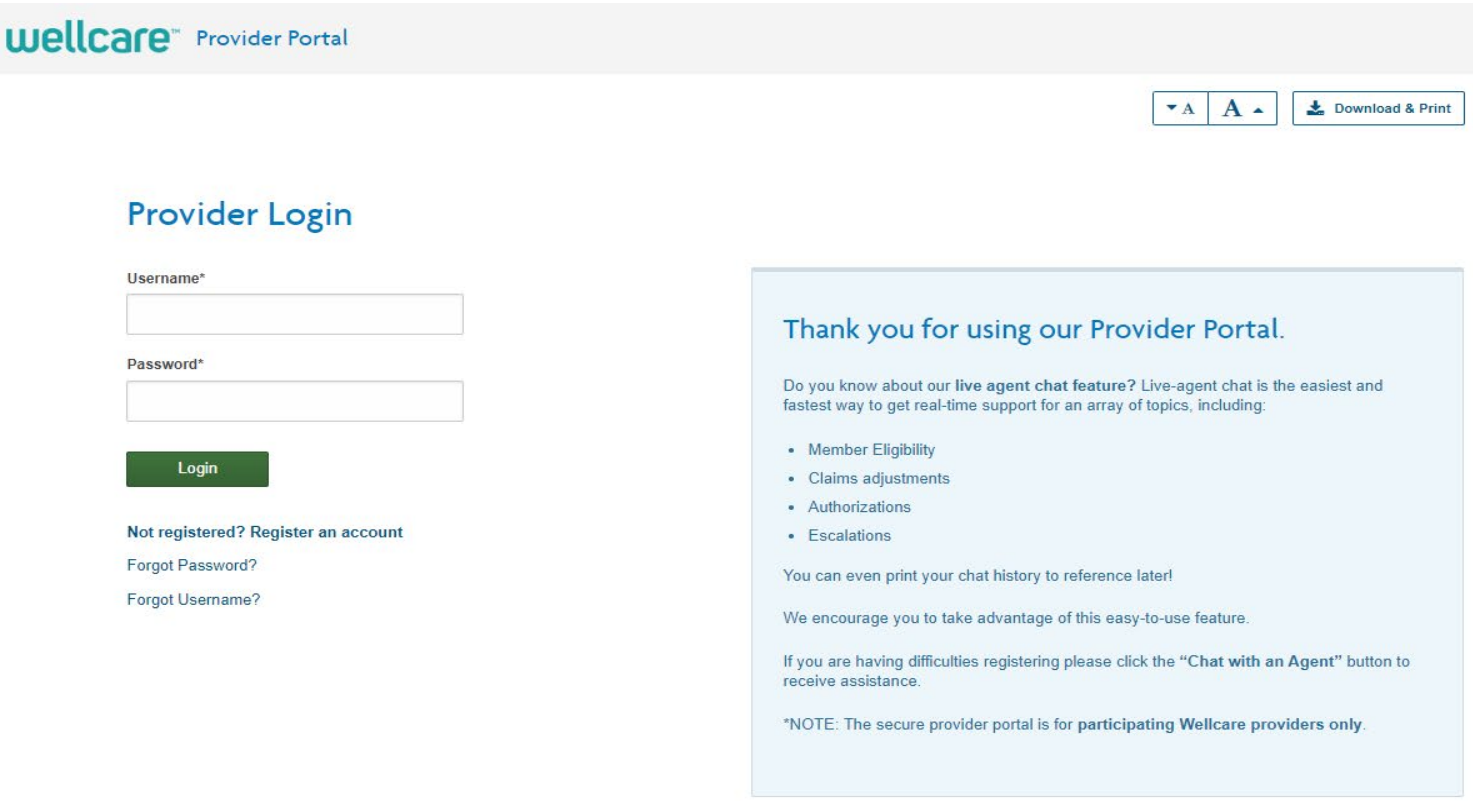


Authorization Vendors

- 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.

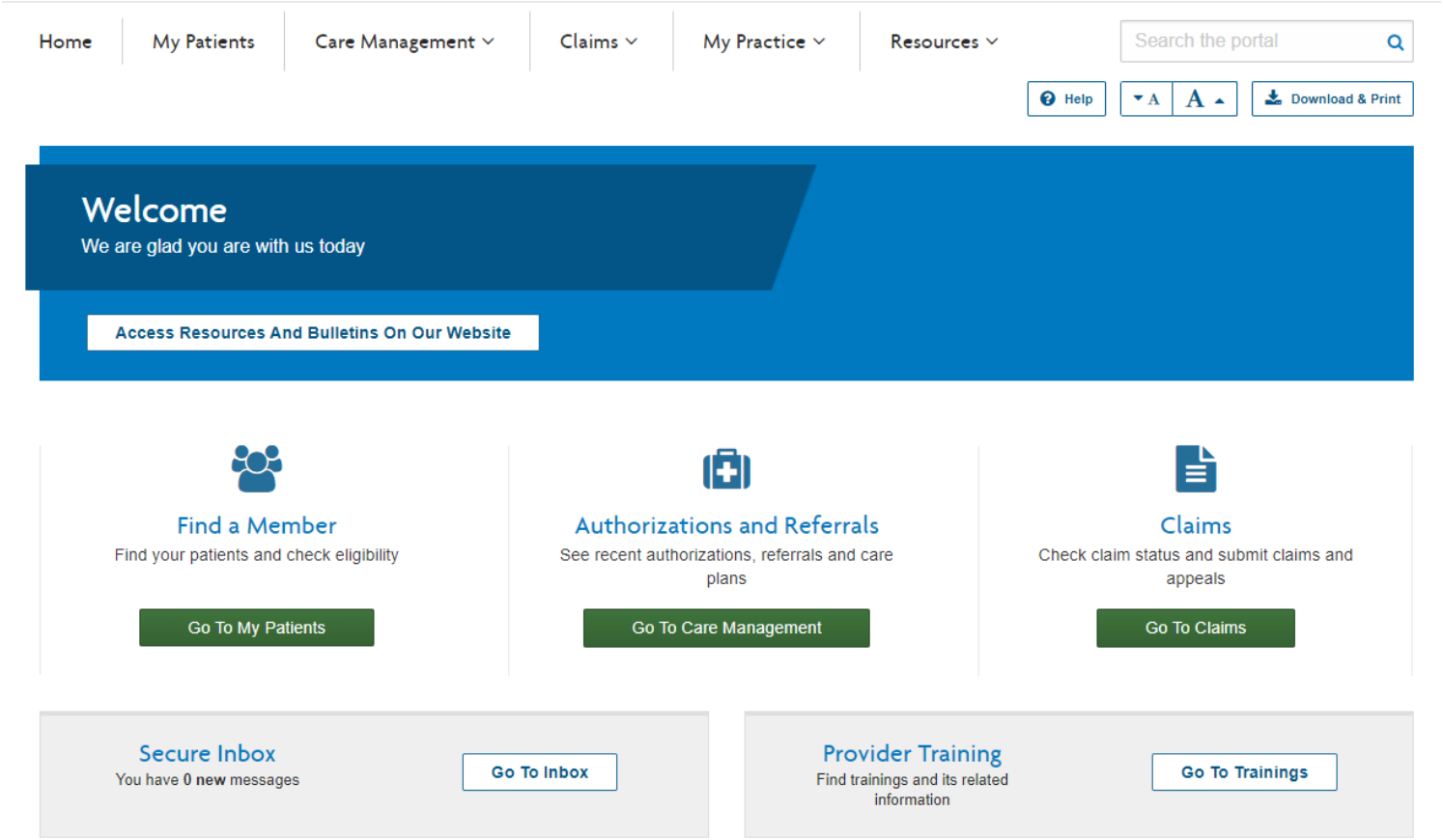
Wellcare Secure Portal

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



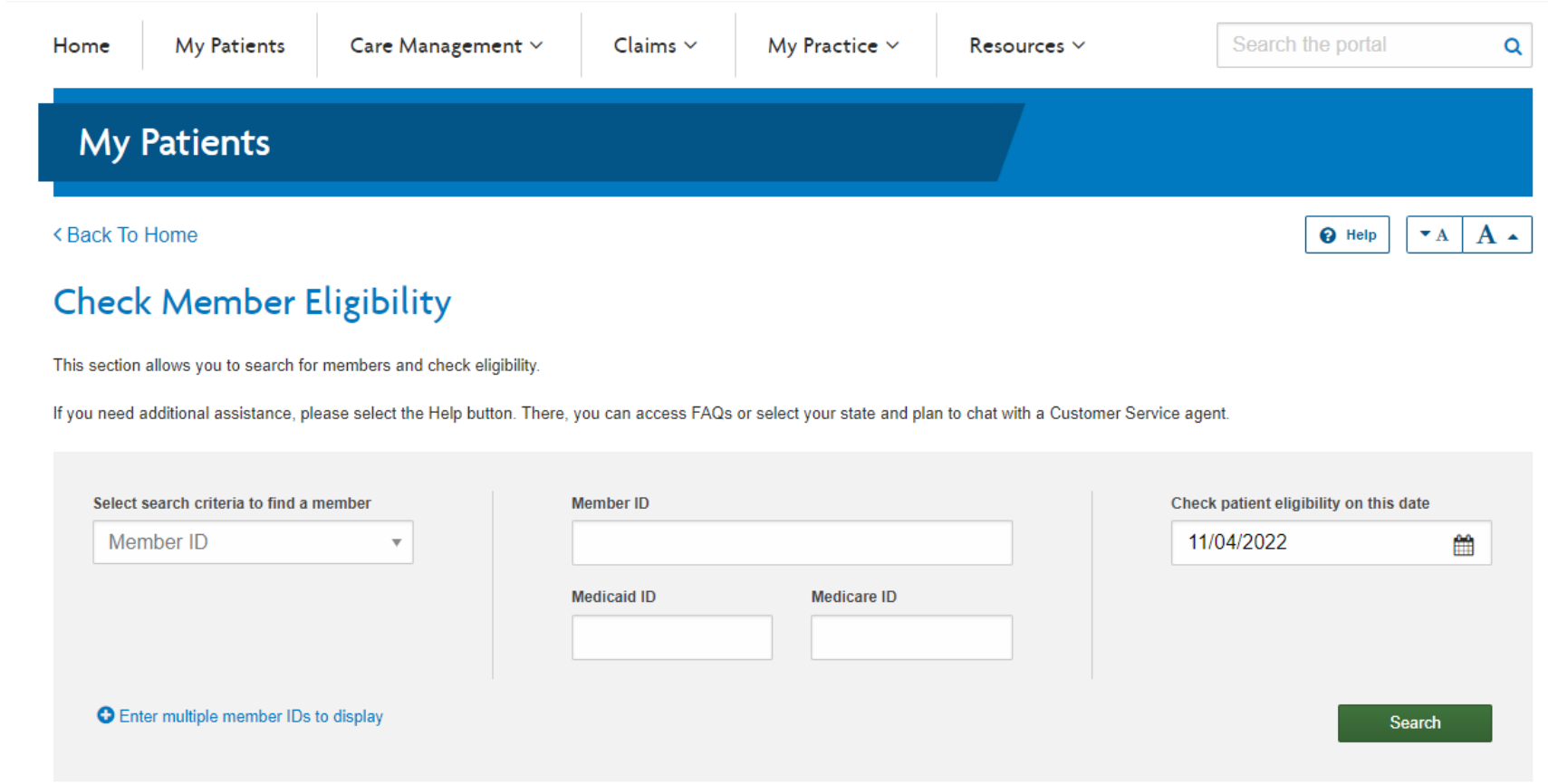
Wellcare Secure Portal

Home Screen



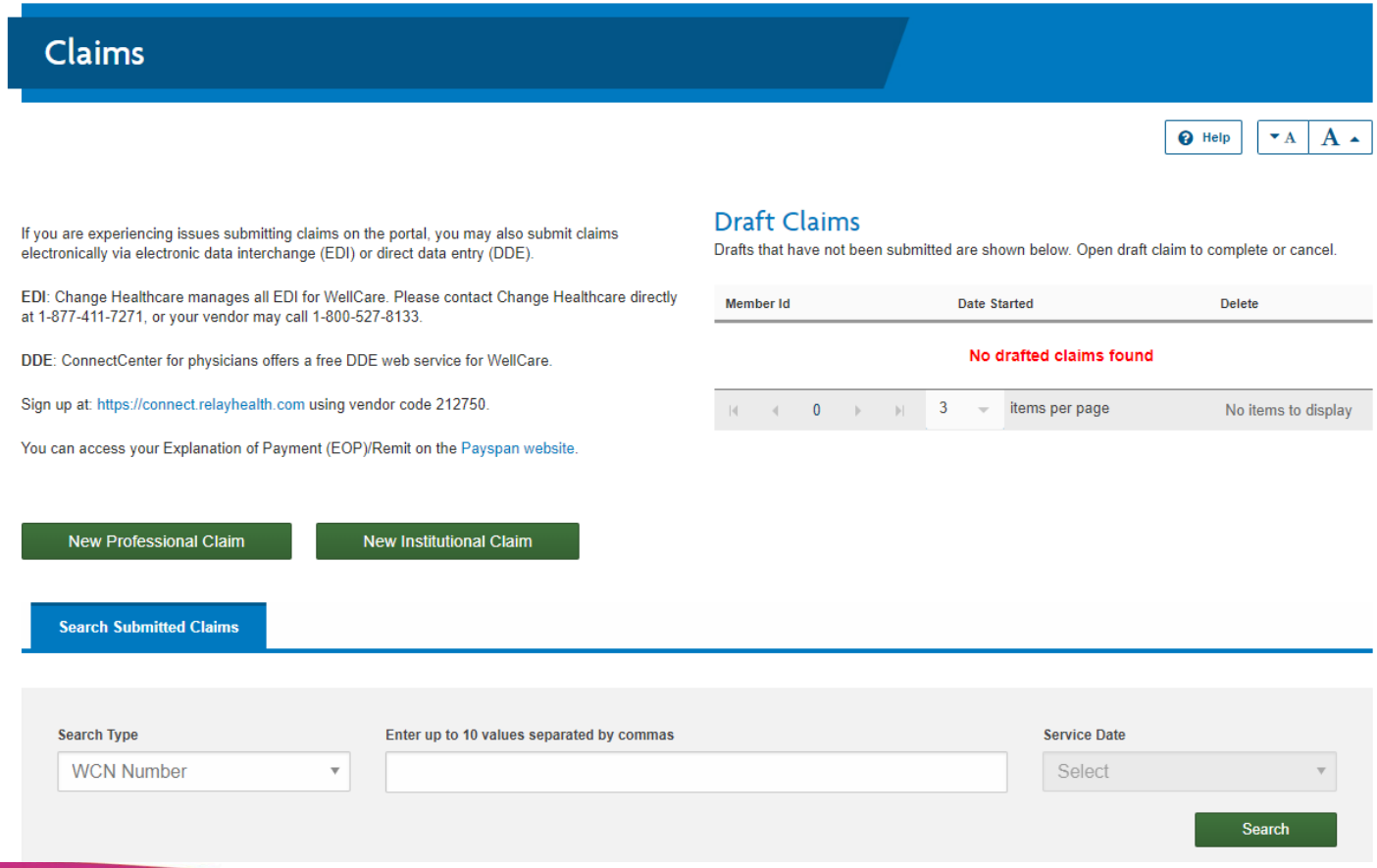
Wellcare Secure Portal

Eligibility and Member Information



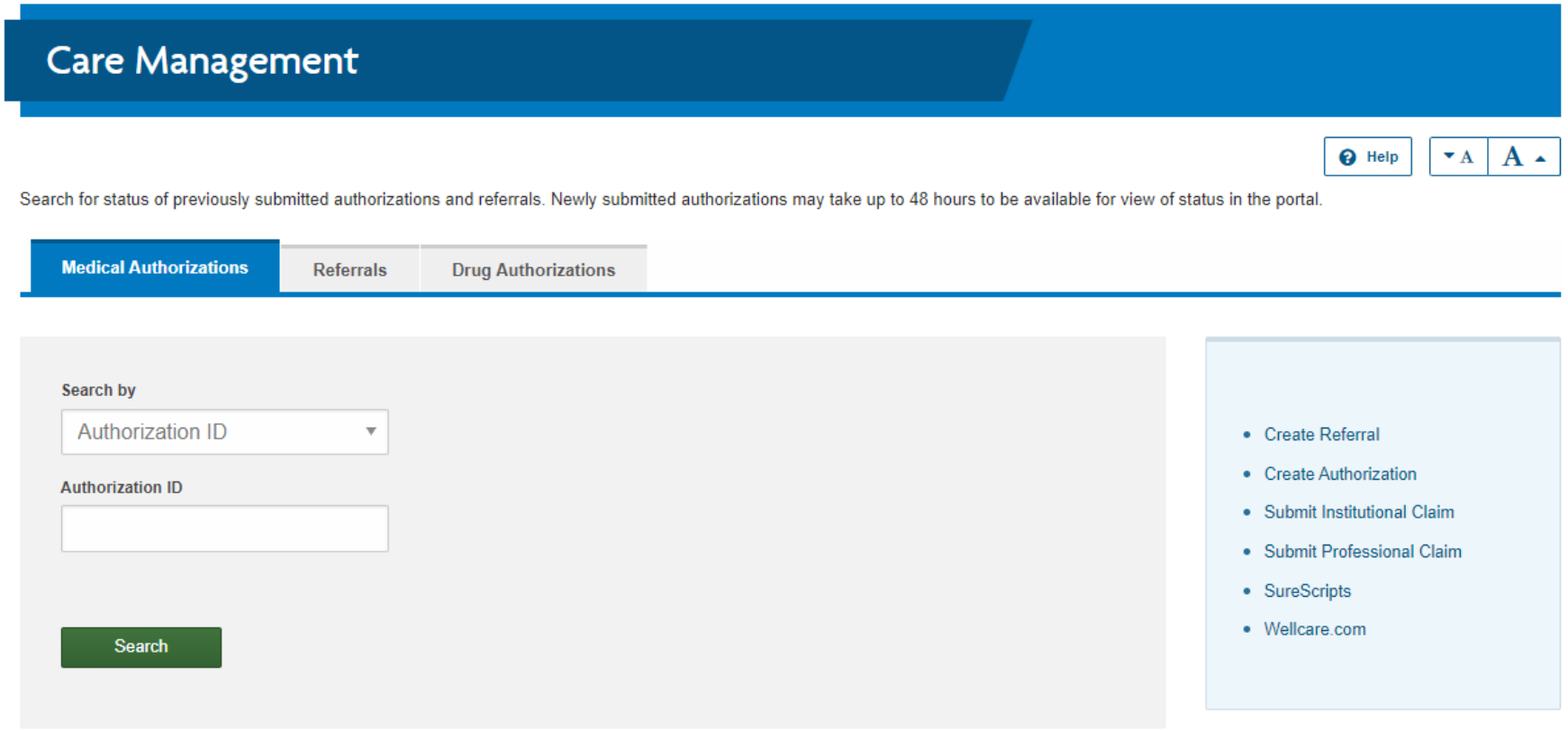
Wellcare Secure Portal

Claims



Wellcare Secure Portal

Authorizations



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	Absolute Total Care P.O. Box 3050 Farmington, MO 63640-3821 Behavioral Health: P.O. Box 7001 Farmington, MO 63640-3811
Marketplace	**Secure Provider Portal:** www.AbsoluteTotalCare.com/Login or **EDI Payer Numbers:** 68069 - Emdeon/WebMD/Envoy/PayerPath	Ambetter from Absolute Total Care P.O. Box 5010 Farmington, MO 63640-5010
MMP		Wellcare Prime by Absolute Total Care 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:

<table>
<tr><th>Line of Business</th><th>Electronic Claim Submission</th><th>Paper Claim Submission</th></tr>
<tr><td>Medicare Advantage</td><td>Register online using the simplified, enhanced provider registration process at PaySpan.com or call 1-877-331-7154
Or
Change Healthcare EDI Clearinghouse
1-877-411-7271.

CHANGE HEALTHCARE CLEARINGHOUSE PAYER IDS (CPIDS)
<table><tr><th>Claim Type</th><th>Fee-for-Service (CH - Chargeable) Submissions</th><th>Encounter (RF - Reporting only) Submissions</th></tr><tr><td>Professional</td><td>1844</td><td>3211</td></tr><tr><td>Institutional</td><td>8551</td><td>4949</td></tr></table>
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:
• 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><tr><th>Claim Type</th><th>FFS (CH - Chargeable) Submissions</th><th>Encounter (RF - Reporting only) Submissions</th></tr><tr><td>Professional or Institutional</td><td>14163</td><td>59354</td></tr></table></td><td>Wellcare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372</td></tr>
</table>

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

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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

*from date of service
**Waiver of Liability required
***from date of last processed claim

Mailing Address

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

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

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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

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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

8/30/2023

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

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

Provider Focus Quick Tips

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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

8/30/2023

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: DOB (mmddyyyy):

Last Name: First Name:

Mailing Address:

City: State: Zip Code:

Home Number: Cell Number:

Email Address:

OB Provider Information

*OB Provider Name:

*OB Provider TIN/ID #:

OB Provider Mailing Address:

OB Provider City: OB Provider State: OB Provider Zip Code:

OB Provider Phone Number: Today's Date (mmddyyyy):

General Information

Primary Insurance (for mom or baby) other than Medicaid? Yes No

*Due Date (mmddyyyy): Date of first prenatal visit (mmddyyyy):

Date of last Pap Smear (mmddyyyy): Date of last Chlamydia Screening (mmddyyyy):

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):

If other ethnicity, please specify.

Preferred Language (if other than English):

Number of Full Term Deliveries: Number of Preterm Deliveries:

Number of Miscarriages/Abortions: Number of Stillbirths:

Any social needs? Yes No

If yes, please specify social needs:

Enrolled in WIC? Yes No Planning to Breastfeed? Yes No Height: (Feet, Inches)

Pre-Pregnancy Weight: Pre-Pregnancy BMI:

Age less than 16? Yes No Age greater than 40? Yes No

***Are there any known pregnancy risk factors?** Yes No

Rev. 04 01 2011
SC-PNOP-5033

*Member ID: DOB (mmddyyyy):

Last Name: First Name:

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 Sickle 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 <03 weeks this pregnancy? Yes No If yes, Length ___cm.

Current gestational diabetes? Yes No Current preeclampsia? Yes No Current oligohydramnios? Yes No

Current Twins? Yes No Current Triplets? Yes No Discordant 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 Bacteriuria this pregnancy? Yes No

Current severe hyperemesis? Yes No

Current mental health concerns? Yes No

If yes, please specify mental health concerns.

Current STD? Yes No If yes, please list STD's.

Current tobacco use? Yes No If yes, please specify amount used.

Current alcohol use? Yes No If yes, please specify amount used.

Current street drug use? Yes No If yes, please specify amount used.

Are there any other significant risk factors? Yes No

If yes, Please list other risk factors:

Rev. 04 01 2011
SC-PNOP-5033-S

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

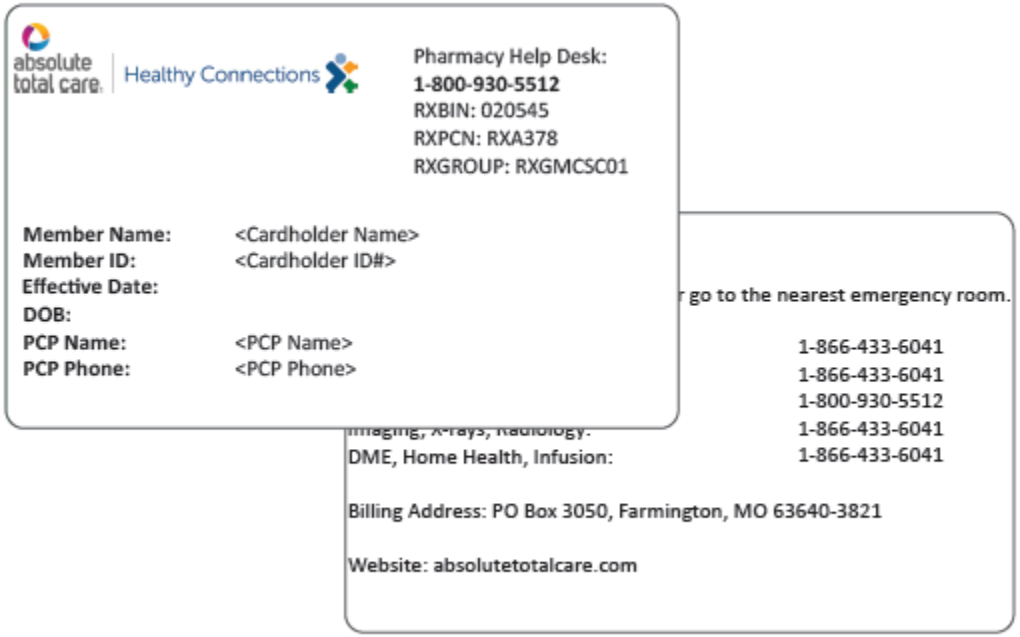
- *Provider Groups: AnMed Health, Atrium Health, Newberry Hospital, Self Regional, SC Oncology Associates*

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*

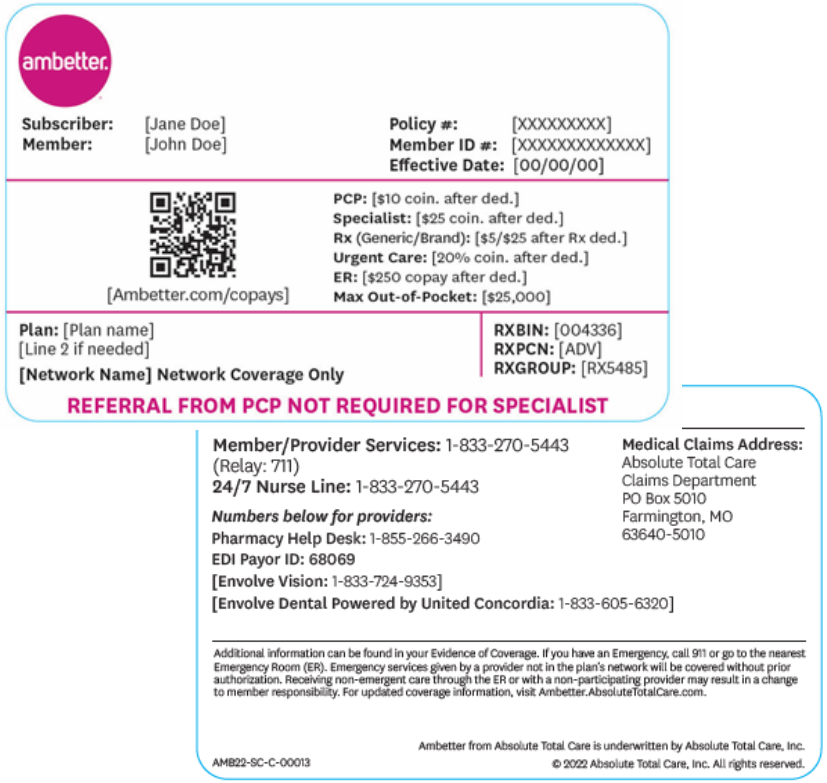
Medicaid Member ID Card

absolute total care™
Healthy Connections



Ambetter from Absolute Total Care Member ID Card (2023)

Core ID Cards



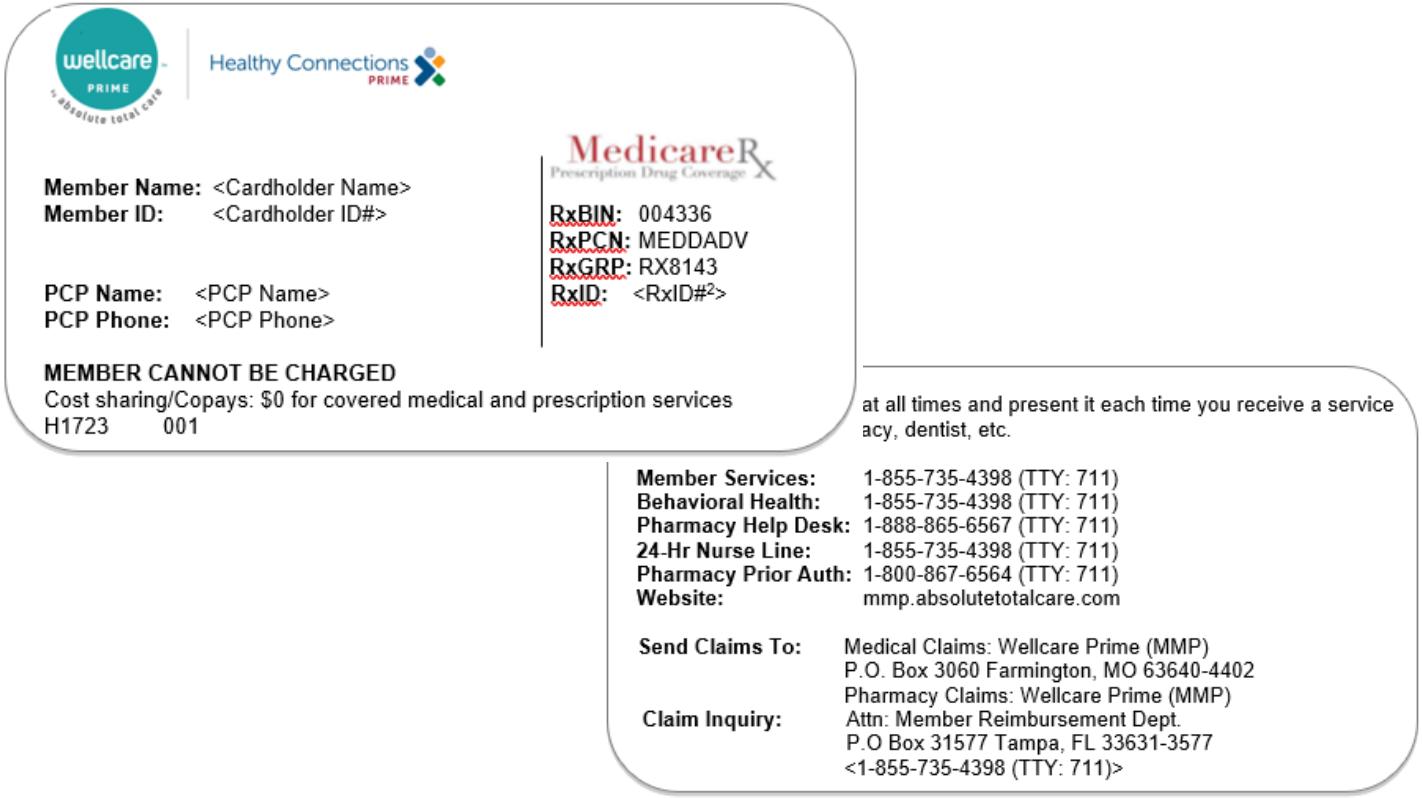
Virtual ID Cards

Medicare-Wellcare Member ID Card (2023)

HMO and HMO DSNP

PPO

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



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.

1-855-735-4398
mmp.absolutetotalcare.com

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

wellcare PRIME by Absolute Total Care | Healthy Connections PRIME

PAY TO: [redacted]

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

Payee ID: UDEF
IRS#: [redacted]

Insured Name: [redacted] **Mbr No:** [redacted] **MRN:** [redacted] **Claim/Ctrl No:** [redacted]
Patient Name: [redacted] **SvcProv No:** **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: [redacted]

Payee ID: [redacted]
IRS#: [redacted]

Insured Name: [redacted] **Mbr No:** [redacted] **MRN:** [redacted] **Claim/Ctrl No:** [redacted]
Patient Name: [redacted] **SvcProv No:** **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.

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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

1-855-735-4398
mmp.absolutetotalcare.com

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:

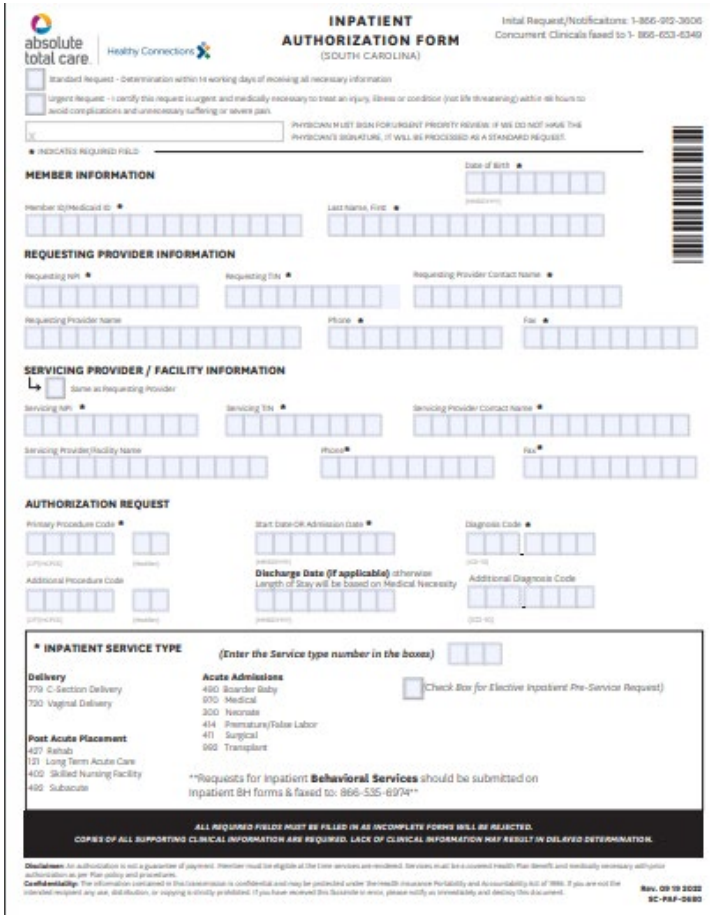
- What is cultural competency
- Sources of diversity
- Steps for becoming culturally competent
- Communicating across cultures
- Tips for successful cross-cultural communications

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)

Inital Request/Notifications: 1-866-912-3606
Concurrent Clinicals faxed to 1- 866-653-6349

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.

X _____ 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

Member ID/Medicaid ID ★ | Last Name, First ★ | Date of Birth ★

REQUESTING PROVIDER INFORMATION

Requesting NPI ★ | Requesting TIN ★ | Requesting Provider Contact Name ★
Requesting Provider Name | Phone ★ | Fax ★

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider
Servicing NPI ★ | Servicing TIN ★ | 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
779 C-Section Delivery
780 Vaginal Delivery

Post Acute Placement
401 Rehab
101 Long Term Acute Care
402 Skilled Nursing Facility
466 Subacute

Acute Admissions
480 Boarder Baby
970 Medical
300 Neonate
414 Premature/False Labor
411 Surgical
992 Transplant

☐ *Check Box for Elective Inpatient Pre-Service Request)*

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 a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.
Confidentiality: The information contained in this transmission 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 facsimile in error, please notify us immediately and destroy this document.

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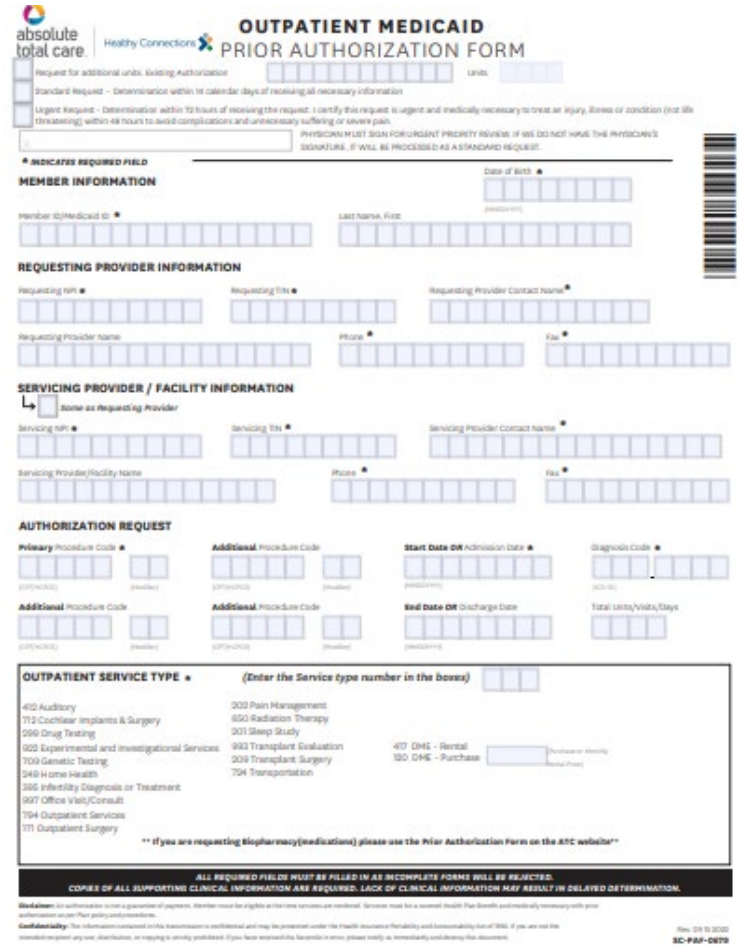
SC-PAF-0680



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.

X _____ 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

Member ID/Medicaid ID ★ | Last Name, First | Date of Birth ★

REQUESTING PROVIDER INFORMATION

Requesting NPI ★ | Requesting TIN ★ | Requesting Provider Contact Name ★
Requesting Provider Name | Phone ★ | Fax ★

SERVICING PROVIDER / FACILITY INFORMATION

☐ *Same as Requesting Provider*
Servicing NPI ★ | Servicing TIN ★ | 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)*

412 Auditory
713 Cochlear Implants & Surgery
099 Drug Testing
923 Experimental and Investigational Services
709 Genetic Testing
949 Home Health
395 Infertility Diagnosis or Treatment
997 Office Visit/Consult
704 Outpatient Services
171 Outpatient Surgery
909 Pain Management
650 Radiation Therapy
901 Sleep Study
993 Transplant Evaluation
909 Transplant Surgery
794 Transportation
417 DME - Rental
190 DME - Purchase

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

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 a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.
Confidentiality: The information contained in this transmission 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 facsimile in error, please notify us immediately and destroy this document.

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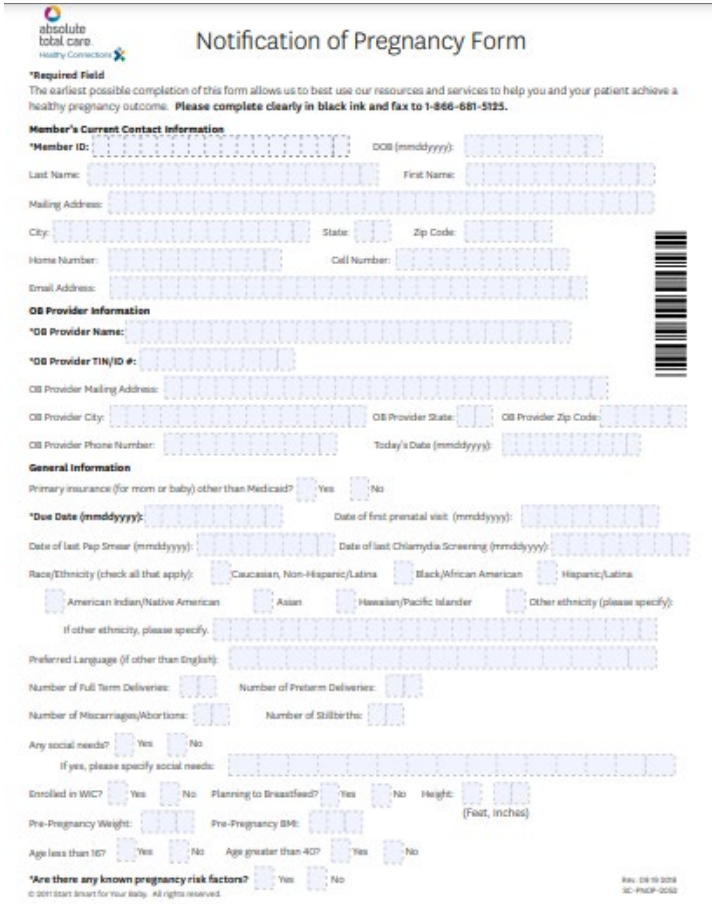
SC-PAF-0679

Pregnancy Notification Form



absolute total care Healthy Connections

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 1-866-681-5125.**

Member's Current Contact Information

*Member ID: DOB (mmddyyyy):

Last Name: First Name:

Mailing Address:

City: State: Zip Code:

Home Number: Cell Number:

Email Address:

OB Provider Information

*OB Provider Name:

*OB Provider TIN/ID #:

OB Provider Mailing Address:

OB Provider City: OB Provider State: OB Provider Zip Code:

OB Provider Phone Number: Today's Date (mmddyyyy):

General Information

Primary insurance (for mom or baby) other than Medicaid? Yes No

*Due Date (mmddyyyy): Date of first prenatal visit (mmddyyyy):

Date of last Pap Smear (mmddyyyy): Date of last Chlamydia Screening (mmddyyyy):

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):

If other ethnicity, please specify.

Preferred Language (if other than English):

Number of Full Term Deliveries: Number of Preterm Deliveries:

Number of Miscarriages/Abortions: Number of Stillbirths:

Any social needs? Yes No

If yes, please specify social needs:

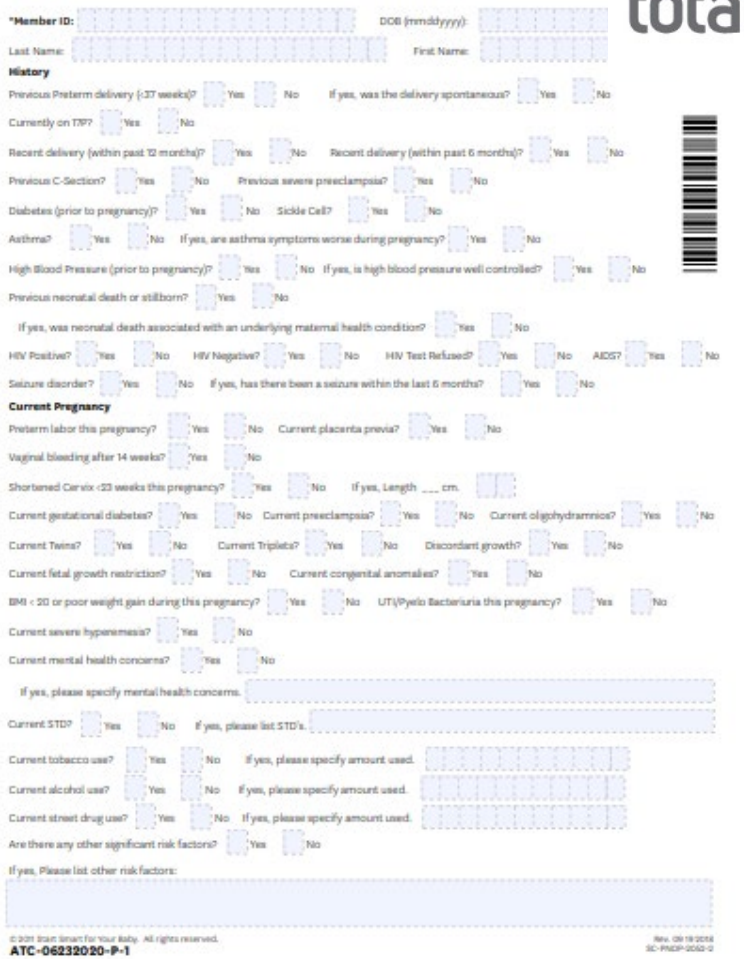
Enrolled in WIC? Yes No Planning to Breastfeed? Yes No Height: (Feet, Inches)

Pre-Pregnancy Weight: Pre-Pregnancy BMI:

Age less than 16? Yes No Age greater than 40? Yes No

***Are there any known pregnancy risk factors?** Yes No

Rev. 09 19 2018
SC-PNOP-2052



*Member ID: DOB (mmddyyyy):

Last Name: First Name:

History

Previous Preterm delivery (<37 weeks)? Yes No If yes, was the delivery spontaneous? Yes No

Currently on TIP? 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 Sickle 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 <23 weeks this pregnancy? Yes No If yes, Length ___ cm.

Current gestational diabetes? Yes No Current preeclampsia? Yes No Current oligohydramnios? Yes No

Current Twins? Yes No Current Triplets? Yes No Discordant 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 Bacteriuria this pregnancy? Yes No

Current severe hyperemesis? Yes No

Current mental health concerns? Yes No

If yes, please specify mental health concerns.

Current STD? Yes No If yes, please list STD's.

Current tobacco use? Yes No If yes, please specify amount used.

Current alcohol use? Yes No If yes, please specify amount used.

Current street drug use? Yes No If yes, please specify amount used.

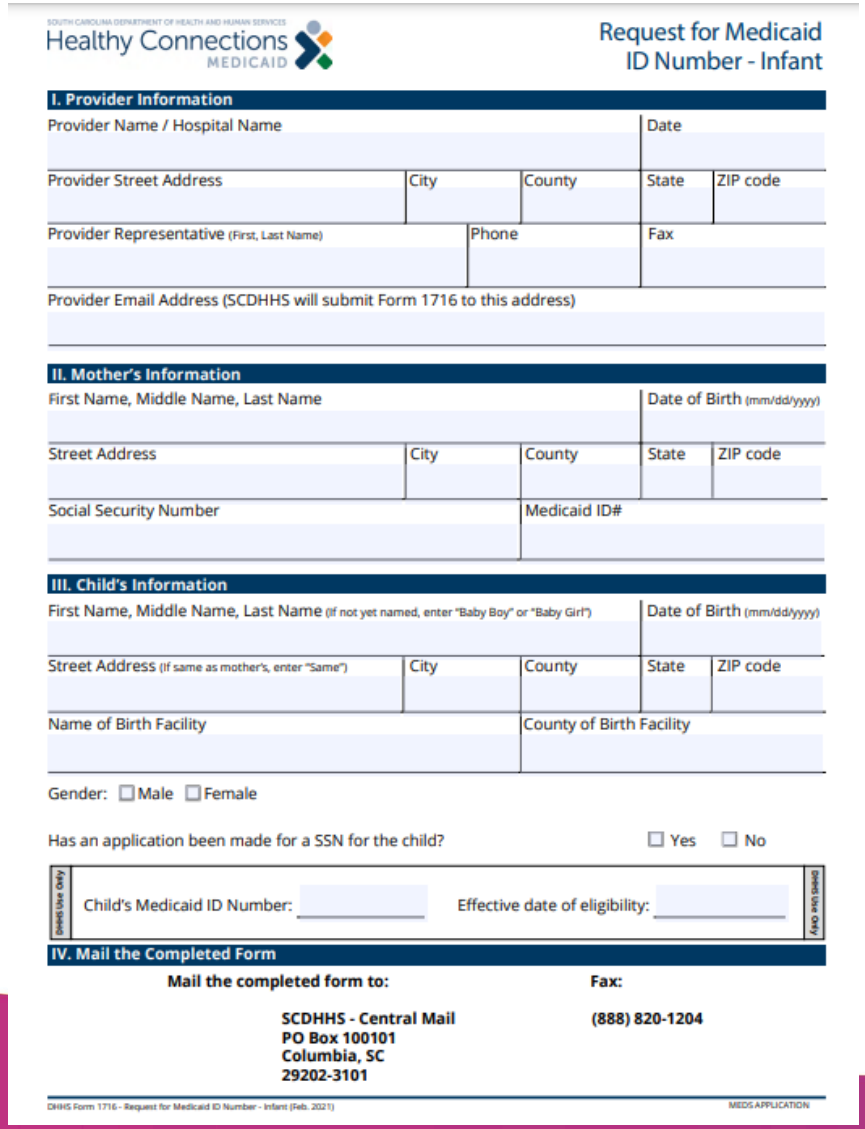
Are there any other significant risk factors? Yes No

If yes, Please list other risk factors:

ATC-06232020-P-1

Rev. 09 19 2018
SC-PNOP-2052-2

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: ☐ Male ☐ Female

Has an application been made for a SSN for the child? ☐ Yes ☐ No

DHHS Use Only — Child's Medicaid ID Number: _____ Effective date of eligibility: _____ — DHHS Use Only

IV. Mail the Completed Form

Mail the completed form to:

SCDHHS - Central Mail
PO Box 100101
Columbia, SC
29202-3101

Fax:

(888) 820-1204

DHHS Form 1716 - Request for Medicaid ID Number - Infant (Feb. 2021) MEDS APPLICATION

absolute total care™

ASL Interpretation Services

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

absolute total care™

Language Services Associates www.lsawob.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.

Language Services Associates www.lsawob.com

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