



Absolute Total Care  
2023 Virtual Provider Town Hall  
3rd Quarter

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11/8/2023

1-866-433-6041  
ATC-11082023-AP-1

[absolutetotalcare.com](https://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
- 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?
- PaySpan®
- Network Development and Participation
- Credentialing Rights
- Quality Improvement
- CAHPS® – Consumer Assessment of Healthcare Providers and Systems
- Start Smart for Your Baby Q&A
- Provider Satisfaction Survey



## Provider Engagement Team

Name	Title
<b>Jennifer Helms</b>	Vice President, Operations
<b>SaBrina Macon</b>	Director, Provider Relations
<b>Kristen Graham</b>	Manager, Provider Relations
<b>Janet Kimbrough</b>	Provider Engagement Administrator III
<b>Tonya Ruff</b>	Provider Engagement Administrator III
<b>Tracey Snowden</b>	Provider Engagement Administrator III
<b>LaToya Jones</b>	Provider Engagement Administrator II
<b>Porsha Lewis</b>	Provider Engagement Administrator II



## Provider Engagement Team

Name	Title
<b>S. Brandi Crosby</b>	Provider Engagement Administrator II
<b>Anna Truesdale</b>	Provider Engagement Administrator II
<b>Camille Gray</b>	Provider Engagement Administrator II
<b>Sarah Wilkinson</b>	Provider Engagement Administrator II
<b>Wendy McCrea</b>	Provider Engagement Administrator II
<b>Kisha Thomas</b>	Provider Engagement Administrator I
<b>Adria Felder</b>	Provider Engagement Administrator I
<b>Neshelle Miller</b>	Provider Engagement Administrator I



## Quality Improvement and Case Management Team

Name	Title
<b>Sharon Mancuso</b>	Vice President, Quality Improvement
<b>Janet Bergen</b>	Manager, Case Management
<b>Betty Smith</b>	Lead Program Coordinator
<b>Aimee Kincaid</b>	Senior Manager, Quality Improvement
<b>Jane Brown</b>	Quality Improvement, Project Manager
<b>Kellie Williamson</b>	Quality Improvement, Supervisor



## Poll Question #1

What area do you support in your organization/practice?

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



# Products and Services

# Absolute Total Care Healthy Connections Medicaid



Serving approximately 240,000 members statewide



## my health pays™

Help your patients earn My Health Pays™ rewards by completing healthy activities!

My Health Pays Rewards- Members can earn \$15 to \$50 per activity by completing healthy activities

- **Annual Flu Vaccination.**
- **Annual well-care visit with primary care provider.**
- **Infant and child well-care visits.**
- **Diabetes care includes HbA1c test and retinopathy screening (dilated eye exam).**
- **Annual cervical cancer screening.**
- **Annual breast cancer screening.**
- **Annual chlamydia screening.**
- **Adolescent immunizations.**
- **Prenatal doctor visit.**
- **Postpartum doctor visit.**

<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 <https://apply.scdhhs.gov/> and selecting the Check Status/Update Information; 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](https://apply.scdhhs.gov)
  - Fax – (888) 820-1204
  - Email – [8888201204@fax.scdhhs.gov](mailto:8888201204@fax.scdhhs.gov)
  - Mail – SCDHHS, PO Box 100101, Columbia, SC 29202
  - In-person – Visit [scdhhs.gov](https://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](http://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](https://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](https://absolutetotalcare.com)

South Carolina Medicaid  
1-888-549-0820  
[apply.scdhhs.gov](https://apply.scdhhs.gov)

Health Insurance Marketplace  
1-800-318-2596  
[healthcare.gov](https://healthcare.gov)

# Wellcare Prime by Absolute Total Care

Serving approximately 3,400 dual-eligible members (age 65+)

My Health Pays rewards-Members can earn \$20 per activity or up to \$120 per year by completing healthy activities

<https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards1.html>



## Medicare-Medicaid Plan Member Rewards



**myhealthpays™**

Help your patients earn My Health Pays™ rewards by completing healthy activities!

Absolute Total Care (Medicare-Medicaid Plan) is proud to be your partner in care. Your Absolute Total Care patients can earn My Health Pays™ rewards by completing healthy activities, such as routine checkups and screenings. When your patients stay focused on their ongoing and preventive care, you receive the benefit of improving the health of your patients, which results in greater quality scores.

## Examples of Qualifying Healthy Activities



Annual flu vaccine



Diabetic screening



Colon cancer screening



Annual breast cancer screening



Follow up visit  
after inpatient  
hospitalization

## Redeeming Rewards

Your patients can use their My Health Pays Visa® Prepaid Card to help pay for a variety of products and services\*:

- Everyday items at **Walmart** 
- Rent
- Child Care
- Utilities
- Telecommunications
- Transportation
- Education



The reward dollars earned will be added to a My Health Pays Visa Prepaid Card. Your patients will receive their first card by mail after they earn their first reward.



# Ambetter from Absolute Total Care



FROM



## Members can earn \$500 or more by completing health activities

- Health Insurance Marketplace
- Serving approximately 160,000 members statewide
- 2023 benefit highlights:
  - \$0 copay for telehealth services for medical care
  - Health Savings Accounts
  - Dental buy-up options
  - Routine vision buy-up options
  - Virtual plan option
  - Concierge services for disease management
- Balance billing protection via the “No Surprises Act”

## My Health Pays Rewards Program

My Health Pays® Rewards Program

**myhealthpays**

You love being healthy. We love paying you for it.

Our My Health Pays® program is available to Ambetter Health members. It's a rewards program that pays you for the healthy decisions you're already making each and every day. Completed your annual wellness screening? You get points for that. Want to learn new ways to be healthy? You can get rewards for that, too.

Focus on your whole health and get paid \$500\* when you:

- Eat Right
- Move More
- Be Well
- Save Smart

**Activate your account now!**

The only thing you need to do is log in to your Ambetter Health account and activate My Health Pays. That's it! Then, you can start earning rewards every time you complete an activity.

**Healthy choices to redeem your rewards.**

After you activate your account and start getting points, you can convert them into money to help you cover health-related costs and monthly bills such as:

- Monthly premium payments
- Doctor copays\*\*
- Deductibles
- Coinsurance
- Utilities (gas, electric, water)
- Telecommunications (cell phone bill)
- Transportation, Education, Rent, Childcare

Your points can even be used for items like cooking, fitness, and other everyday essentials.

**Get Rewards**

<https://ambetter.absolutetotalcare.com/health-plans/my-health-pays.html>



# 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.

Additional benefits may include:

- No or low monthly health plan premiums with predictable copays for in-network services
- Outpatient prescription drug coverage
- Routine dental, vision and hearing benefits
- Preventive care from participating Providers with no copayment



# Wellcare Medicare Advantage PPO

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

- Referrals not required from 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

We partner 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



# Annual Provider Training Requirements

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

# Provider Training Attestation



The screenshot shows the 'Provider Training Attestation' page. At the top, there is a navigation bar with 'Home', 'Find a Provider', 'Login', 'Careers', and 'Contact'. A search bar is on the right. Below the navigation bar are three tabs: 'FOR MEMBERS', 'FOR PROVIDERS', and 'GET INSURED'. The 'FOR PROVIDERS' tab is active. On the left is a sidebar menu with various options, including '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', and 'Coronavirus Information'. The main content area is titled 'Provider Training Attestation'. It contains a paragraph explaining that providers are required to complete certain training within 90 days of contracting. Below this is a section for training selections with checkboxes for 'General Compliance (CMS)', 'Fraud, Waste, and Abuse (CMS)', 'Model of Care (MOC)', 'Person-Centered Planning', 'Cultural Competency', and 'Other'. There are also dropdown menus for 'Provider Group' and 'County', and a text field for 'Provider TIN(s)'. A section for 'Additional TINs' has four text fields labeled 'TIN 2', 'TIN 3', 'TIN 4', and 'TIN 5'. The 'Contact Information' section includes fields for 'Phone', 'Email', 'Form Completed By', 'Title', and 'Date'. At the bottom, there is a reCAPTCHA widget and a 'Submit' button.

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



# 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://www.scdhhs.gov/sites/default/files/SCDue2/Improper%20Billing%20Guidance%20for%20Providers%20%28Sep%2025%202017%29.pdf>



## No Cost Interpreter Services and Oral Translation Service



# 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. Commitment includes:

- 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.
- 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.
- 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.
- 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 ASL interpreter requested please use the vendor portal: [www.lsaweb.com](http://www.lsaweb.com), call the vendor directly at 1-866-827-7028 or email [clientservices@lsaweb.com](mailto:clientservices@lsaweb.com).*

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



# Websites and Secure Portals

# Absolute Total Care Website



www.absolutetotalcare.com

A screenshot of the Absolute Total Care website. At the top right is the company logo. Below it is a navigation bar with links for Home, Login, Careers, and Contact, along with a search bar and utility links for Contrast, On, Off, a, and language. A large grey arrow points from the top of the page down to the 'FOR PROVIDERS' dropdown menu. The main content area has a purple sidebar with links for 'Ambetter Health Insurance Marketplace', 'Healthy Connections Medicaid', 'Wellcare Prime Medicare-Medicaid Plan', and 'Wellcare Medicare'. The main content area features a banner with a child on a swing and the text 'One Plan. Always Covered.' Below this is a section for 'Coronavirus: What You Need to Know' with a link to learn more. A blue box highlights 'The Interoperability and Patient Access Rule'. At the bottom, three icons represent 'Find A Provider', 'Health Insurance Marketplace', and 'All Together Now'.

For Providers section:

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

# Pre-Auth Lookup Tool



**DISCLAIMER:** All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the [Medicaid Provider Manual](#). If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

## Prior authorization for medications will **NOT** be accepted through the web portal.

For Pharmacy prior authorization requests, please visit our [pharmacy page](#).

- 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](#).
- Dental services for members under 21 need to be verified by [SCDHHS](#) through the EPSDT program.
- Complex imaging, MRA, MRI, PET, CT scans need to be verified by [N/A](#).
- Outpatient rehabilitative and habilitative physical medicine services PT, OT, and Speech need to be verified by [N/A](#).  
\*Note - excludes services in the home setting.

For non-participating providers, [Join Our Network](#).

Prior authorization is required for all non-emergent services provided by non-contracted, out-of-state providers.

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"/>

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](#).

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

Check

**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 **Engolve 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 aged 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

# Secure Provider Portal



Use dropdown menu to select line of business



# 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

**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 nephroathy screening in cast 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]

Back to Claims Claim Details

Claim # [redacted] Denied

+Copy Claim / Correct Claim / Reconsider Claim

Claim Accepted → In Process → Denied

**Member**  
Member Name: [redacted]  
Member ID: [redacted]  
Member DOB: [redacted]

**Provider**  
Ref/Act No.: [redacted]  
Servicing Provider: [redacted]  
Services NPI: [redacted]

**Claim**  
DOS Range: 01/22/2019 - 01/22/2019  
Received Date: 01/25/2019  
Blind Amount: \$160.00

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Payment Amount	Payment Date	Check No.	Status	Payment Codes
1	01/22/2019	99213	S82132 D, S82112 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]

Cancel [Submit]

**Reconsider Claim**

Claim No: S025NEED7212

Reconsideration type  
Select Reconsideration Type... [dropdown]

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

Claim Details

Claim # [redacted]

**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

Cancel [Submit]

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



The screenshot displays the Wellcare website interface. At the top right is the Wellcare logo. The navigation bar includes links for 'Explore Plans', 'Members', 'Providers', and 'Brokers'. A search bar and utility links like 'Login / Register', 'Contact Us', and 'Help' are also present. The 'Providers' section is highlighted, featuring a teal header with the text 'Providers' and a sub-header 'We partner with providers to develop and deliver high-quality, cost-effective health care solutions.' Below this are buttons for 'Getting Started' and 'Non-Wellcare Providers'. Three main content areas are visible: 'NEWS' (with sub-links for ICD-10 Compliance, Bulletins, and Newsletters), 'MEDICARE' (with sub-links for Resources, Claims, and Secure Login), and 'TOOLS' (with sub-links for Authorization Lookup and Clinical Guidelines). A 'Provider Bulletins' section includes a photo of a doctor with a child and a 'Read Bulletins' button. At the bottom, a 'Need help? We're here for you.' banner features a 'Contact Us' button.

# Pre-Auth Lookup Tool



wellcare™  [Login / Register](#) [Contact Us](#) [Help](#) [South Carolina](#)

[Explore Plans](#) [Members](#) [Providers](#) [Brokers](#) [Find a Provider/Pharmacy](#) [Size](#) [Print](#)

## Providers

[Providers](#) / [Authorization Lookup](#)

## 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 : 10/2/2023 14:50:16 PM

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

## Related Information

[CareCore National](#)



# 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.



# \*\*Vendor Update\*\*



## **NCH Oncology Pathway Solutions / Cardiology Management Program**

Wellcare has partnered with New Century Health (NCH) to implement a new oncology prior authorization program, Oncology Pathway Solutions. Effective **October 1, 2023**, NCH will manage prior authorization requests for Medical Oncology and Radiation Oncology treatments provided in an outpatient setting. This includes all oncology-related chemotherapeutic drugs and supportive agents and radiation oncology treatments.

Wellcare has also partnered with New Century Health (NCH) to implement a new cardiology prior authorization program, the Cardiology Management Program. This program is intended to help providers easily and effectively deliver quality patient care. Effective **October 1, 2023**, cardiology services rendered in a physician's office, in an outpatient hospital ambulatory setting, or in an inpatient setting (planned professional services only) must be submitted to NCH for prior authorization. Approvals issued by Wellcare before October 1, 2023, are effective until the authorization end date, but all prior authorization requests needed after October 1, 2023, must be submitted to NCH.

Prior authorization can be requested by:

Visiting NCH's Web portal at [my.newcenturyhealth.com](http://my.newcenturyhealth.com), or

Calling 1-888-999-7713, Option 1 (Monday–Friday, 8 a.m.–8 p.m. EST)



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

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
<b>No drafted claims found</b>		
◀ ◀ 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

# Wellcare Secure Portal



## Self-Service Secure Web Portal Offering and Benefit

Service	Web Portal
Appeal Requests/Status (Rx)	☑ Fastest Results
Appeals & Disputes	☑ Fastest Results
Authorization Requests	☑ Fastest Results
Authorization Requirements	☑ Fastest Results
Authorization Status	☑ Fastest Results
Benefits & Eligibility	☑ Fastest Results
Claim Status	☑ Fastest Results
Claim Submission (and Corrections)	☑ Fastest Results
Co-payment Information	☑ Fastest Results
Coverage Determination Requests/Status (Rx)	☑ Fastest Results
Form Requests	☑ Fastest Results
Provider Resources	☑ Fastest Results

**Note:** For contract-related questions and/or web portal training, providers should continue to contact their Provider Relations representative.

# Wellcare Secure Portal



## Chat

Faster than email and easier than phone calls, Chat is a convenient way to ask simple questions and receive real-time support. Providers now have the ability to use our Chat application instead of calling and speaking with agents. Here are some ways our Chat support can help you and your staff:

- Web support assistance
- Real-time claim adjustments

### Explore the benefits you will experience by using live Chat!

**Convenience** - Live Chat offers the convenience of getting help and answers without needing to have a phone call.

**Increase Efficiency** - If you ever have to wait for a Chat agent to respond, it's easy to carry on with your other tasks and responsibilities.

**Documentation of Interaction** - Chat logs provide transparency and proof of contact. When customers engage with customer support via phone, they don't typically receive a recording of the verbal conversation. Live Chat software gives you the option of printing a transcription of the conversation afterward.





## Poll Question #2

Is your practice using Absolute Total Care and/or Wellcare provider portal?





## Poll Question #3

How are you utilizing the provider portal?

- Benefits/Eligibility
- Prior Authorization
- Claim submission/status
- Appeals/Reconsideration



## Poll Question #4

What other sources do you use instead of Absolute Total Care/Wellcare provider portal to obtain information?



# 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 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	<b>Secure Provider Portal:</b> <a href="http://www.AbsoluteTotalCare.com/Login">www.AbsoluteTotalCare.com/Login</a> or <b>EDI Payer Numbers:</b> 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	<b>Secure Provider Portal:</b> <a href="http://www.AbsoluteTotalCare.com/Login">www.AbsoluteTotalCare.com/Login</a> or <b>EDI Payer Numbers:</b> 68069 - Emdeon/WebMD/Envoy/PayerPath	<u>Ambetter from Absolute Total Care</u> P.O. Box 5010 Farmington, MO 63640-5010
MMP		<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															
<b>Medicare Advantage</b>	<p>Register online using the simplified, enhanced provider registration process at <a href="http://PaySpan.com">PaySpan.com</a> or call 1-877-331-7154</p> <p>Or</p> <p>Change Healthcare EDI Clearinghouse 1-877-411-7271.</p> <p><b>CHANGE HEALTHCARE CLEARINGHOUSE PAYER IDS (CPIDS)</b></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"> <li>Fee-for-Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication.</li> <li>Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication.</li> </ul> <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><b>Wellcare</b> <b>Attn: Claims Department</b> <b>P.O. Box 31372</b> <b>Tampa, FL 33631-3372</b></p>
Claim Type	Fee-for-Service (CH - Chargeable) Submissions	Encounter (RF - Reporting only) Submissions															
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Claim Type	FFS (CH - Chargeable) Submissions	Encounter (RF - Reporting only) Submissions															
Professional or Institutional	14163	59354															





## CLAIMS SUBMISSIONS DATE OF SERVICE GUIDANCE

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

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

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



# Provider Timeframes

## Claim Adjustments, Reconsiderations, and Disputes

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

**Mailing Address**  
 P.O. Box 3060  
 Farmington, MO 63640-3822

	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



# Wellcare Provider Timeframes, Claim Adjustments, and 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



# PaySpan®

PaySpan provides 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

# PaySpan®



## 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.



## PaySpan®

- 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](mailto:providersupport@payspanhealth.com), by phone at 1-877-331-7154 or on the web at [payspanhealth.com](http://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](mailto: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](mailto: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](mailto: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](mailto: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](mailto:SouthCarolinaPDM@centene.com)



# Network Development and Participation

- ✓ Network Development
  - To request a new Medicare agreement, send an email to [ATC\\_Contracting@centene.com](mailto: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](mailto:ATC_Contracting@centene.com)
  
- ✓ To add a new practitioner, providers must contact their Provider Engagement Administrator
  - 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](mailto:SouthCarolinaPDM@centene.com))
  - Recredentialing is performed at least every 36 months
  - Provider updating existing participating providers and locations may do so by contacting your Provider Engagement Administrator



# 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](mailto: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](mailto:jane.f.brown@centene.com)





# CAHPS<sup>®</sup>

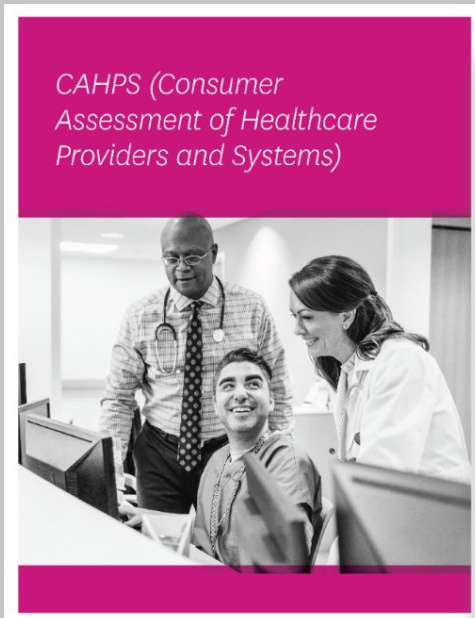
## Consumer Assessment of Healthcare Providers and Systems



# 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**  
[Getting Care Quickly](#)  
[Getting Needed Care](#)  
[Getting Care Quickly](#)

## CAHPS (Consumer Assessment of Healthcare Providers and Systems)

Every year, a random sample of about 100,000 patients is surveyed about their experience with their doctors, services, and health care. It is a good idea for you as a provider of knowing that your patients are satisfied, not only **with the health care services but also with their health care experience.**

CAHPS surveys allow patients to tell you the aspects of care delivery that matter the most to them. As a HEALTH PLAN, we are committed to working with our providers to deliver an outstanding patient experience.

As a provider, you are the most critical component of that experience, so we want to ensure that you know exactly how your patients are feeling, so you can make a moment to review a 10 to 15 minute survey with some of the key topics included in the survey.

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**CAHPS MEASURE: GETTING NEEDED CARE**

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

**Incorporate the following into your daily practice:**

- **Specialists should help coordinate specialty appointments** for urgent cases
- Encourage patients to complete necessary orders in the **patient portal** whenever able
- Inform patients of when and if care is needed **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 get the care they need for an acute symptom or condition as soon as they want the care, within 15 minutes.

**Incorporate the following into your daily practice:**

- Require **few appointments each day** as you seek to increase the support staff
- Offer appointments with a **nurse practitioner or physician assistant** for short notice appointments
- Maintain an **effective triage system** to ensure that all under-visit patients are seen right away or provided alternate care via phone and urgent care
- Exp. patients like need if there is a longer wait time. Have options to give them the **option to reschedule**

CAHPS/HOS Provider Resource Guide

CAHPS/HOS Provider Resource Guide

**PROVIDER ENGAGEMENT COLLATERAL**  
[How Well Doctors Communicate](#)  
[Care Coordination](#)  
[Rating of Health Care Quality](#)

## CAHPS (Consumer Assessment of Healthcare Providers and Systems)

**CAHPS MEASURE: CARE COORDINATION**

The Care Coordination measure assesses providers' assistance with managing the dispersed and conflicting health care systems, including access to medical records, timely follow-up on test results, and education on prescription medications.

**Incorporate the following into your daily practice:**

- Ensure there is regular communication with **patients recently discharged** from a facility
- Integrate full 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** to each visit

**CAHPS MEASURE: HOW WELL DOCTORS COMMUNICATE**

The How Well Doctors Communicate measure assesses patients' perception of the quality of communication with their doctor. Consider asking the teach-back method to a sample patient to understand their health information.

**What to Teach-Back?**

- A way to ensure you (the healthcare provider) have explained information clearly, it is not a lost or confused patient
- Asking patients (or family members) to explain in their own words what they need to know or do, and getting it wrong
- A way to check for understanding and, if needed, to explain and clarify again
- A **never-skipped health care intervention** that improves not only provider communication and patient health outcomes

**CAHPS MEASURE: RATING OF HEALTH CARE QUALITY**

The Rating of Health Care Quality measure assesses patients' overall quality of their health care on a 10-point scale.

**Incorporate the following into your daily practice:**

- Encourage patients to make **short routine appointments** for checkups or follow-up visits as soon as they can - need or convenience assessment
- Focus on **open care gaps** when scheduled follow-up visits are not met
- Make use of the **post-visit call** when requesting patient satisfaction

CAHPS/HOS Provider Resource Guide

## 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 # 5

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



## Poll Question #6

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 (mm/dd/yyyy):** [blue box]

Last Name: [blue box] First Name: [blue box]

Mailing Address: [blue box]

City: [blue box] State: [blue box] Zip Code: [blue box]

Home Number: [blue box] Cell Number: [blue box]

Email Address: [blue box]

**OB Provider Information**

**\*OB Provider Name:** [red box]

**\*OB Provider TIN# ID #:** [red box]

OB Provider Mailing Address: [blue box]

OB Provider City: [blue box] OB Provider State: [blue box] OB Provider Zip Code: [blue box]

OB Provider Phone Number: [blue box] Today's Date (mm/dd/yyyy): [blue box]

**General Information**

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

**\*Due Date (mm/dd/yyyy):** [red box] Date of first prenatal visit (mm/dd/yyyy): [blue box]

Date of last Pap Smear (mm/dd/yyyy): [blue box] Date of last Chlamydia Screening (mm/dd/yyyy): [blue 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): [blue box]  
If other ethnicity, please specify: [blue box]

Preferred Language (if other than English): [blue box]

Number of Full Term Deliveries: [blue box] Number of Preterm Deliveries: [blue box]

Number of Miscarriages/Abortions: [blue box] Number of Stillbirths: [blue box]

Any social needs? Yes  No   
If yes, please specify social needs: [blue box]

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

Pri-Pregnancy Weight: [blue box] Pri-Pregnancy BMI: [blue box]

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

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

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**\*Member ID:** [red box] **DOB (mm/dd/yyyy):** [blue box]

Last Name: [blue box] First Name: [blue 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  Stillborn? 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 <0.3 weeks this pregnancy? Yes  No  If yes, Length: [blue box] cm.

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

Current Twins? Yes  No  Current Triplets? Yes  No  Discomfort 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 hypertension? Yes  No

Current mental health concerns? Yes  No

If yes, please specify mental health concerns: [blue box]

Current STD? Yes  No  If yes, please list STD's: [blue box]

Current tobacco use? Yes  No  If yes, please specify amount used: [blue box]

Current alcohol use? Yes  No  If yes, please specify amount used: [blue box]

Current street drug use? Yes  No  If yes, please specify amount used: [blue box]

Are there any other significant risk factors? Yes  No

If yes, please list other risk factors: [blue box]

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## 2023 Provider Satisfaction Survey





Questions?





# APPENDIX



# 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 Engagement Territory Assignment

NAME	TITLE	PHONE #	EMAIL	TERRITORY (COUNTY)
Adria Felder	Provider Engagement Administrator I	(803) 315-8405	<a href="mailto:Adria.Felder@CENTENE.COM">Adria.Felder@CENTENE.COM</a>	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	<a href="mailto:Kisthomas@centene.com">Kisthomas@centene.com</a>	Dialysis Centers and Ambulatory Surgery Centers
Neshelle Miller	Provider Engagement Administrator I	(803) 972-1460	<a href="mailto:Neshelle.Miller@centene.com">Neshelle.Miller@centene.com</a>	Durable Medical Equipment and Home Health (statewide)
Anna Truesdale	Provider Engagement Administrator II	(803) 427-3260	<a href="mailto:Anna.Truesdale@CENTENE.COM">Anna.Truesdale@CENTENE.COM</a>	Federally Qualified Health Center (Statewide)
Camille Gray	Provider Engagement Administrator II	(803) 213-1661	<a href="mailto:Camille.L.Gray@centene.com">Camille.L.Gray@centene.com</a>	Aiken, Allendale, Bamberg, Barnwell, Calhoun, Edgefield and Orangeburg



# ATC Provider Engagement Territory Assignment



NAME	TITLE	PHONE #	EMAIL	TERRITORY (COUNTY)
Wendy McCrea	BH Provider Engagement Administrator II	(803) 260-7093	<a href="mailto:Wendy.McCrea@CENTENE.COM">Wendy.McCrea@CENTENE.COM</a>	Behavioral Health to include school districts, Department of Alcohol and Other Drug Abuse Services, SC Department of Mental Health
Sarah Wilkinson	Provider Engagement Administrator II	(843) 344-0009	<a href="mailto:Sarah.Wilkinson@centene.com">Sarah.Wilkinson@centene.com</a>	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Marion, Marlboro and Williamsburg
Porsha Lewis	Provider Engagement Administrator II	(803) 873-8691	<a href="mailto:Porsha.Lewis@centene.com">Porsha.Lewis@centene.com</a>	Chester, Fairfield, Kershaw, Lee, Lexington, Richland, Saluda, Sumter, Border GA counties and Tenet Health
LaToya Jones	Provider Engagement Administrator II	(803) 553-7324	<a href="mailto:Latoya.Jones3@Centene.com">Latoya.Jones3@Centene.com</a>	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	<a href="mailto:shunta.crosby@centene.com">shunta.crosby@centene.com</a>	Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Border GA-Savannah and MUSC



# ATC Provider Engagement Territory Assignment

NAME	TITLE	PHONE #	EMAIL	TERRITORY (COUNTY)
Janet Kimbrough	Provider Engagement Administrator III	(803) 873-4454	<a href="mailto:Janet.H.Kimbrough@centene.com">Janet.H.Kimbrough@centene.com</a>	Abbeville Medical Center, Bon Secours St Francis, CenterWell Senior Primary Care, Preferred Care of Aiken, Spartanburg Regional Health/Regional HealthPlus
Tracey Snowden	Provider Engagement Administrator III	(803) 606-5328	<a href="mailto:Tracey.D.Snowden@centene.com">Tracey.D.Snowden@centene.com</a>	AnMed Health, Atrium Health, Newberry Hospital, Self Regional, SC Oncology Associates
Tonya Ruff	Provider Engagement Administrator III	(864) 492-5669	<a href="mailto:Tonya.C.Ruff@centene.com">Tonya.C.Ruff@centene.com</a>	HCA Healthcare, Lexington Medical Center, McLeod Health, Palmetto Primary Care Physician, Prisma Health Midlands, Prisma Health- Upstate, Roper St. Francis Healthcare, SC Pediatric Alliance

# Medicaid Member ID Card

   	<b>Pharmacy Help Desk:</b> <b>1-800-930-5512</b> RXBIN: 020545 RXPCN: RXA378 RXGROUP: RXGMCSC01
<b>Member Name:</b> <Cardholder Name> <b>Member ID:</b> <Cardholder ID#> <b>Effective Date:</b> <b>DOB:</b> <b>PCP Name:</b> <PCP Name> <b>PCP Phone:</b> <PCP Phone>	<b>Emergency:</b> 1-866-433-6041 <b>Imaging, X-rays, Radiology:</b> 1-866-433-6041 <b>DME, Home Health, Infusion:</b> 1-866-433-6041 <b>1-800-930-5512</b> <b>1-866-433-6041</b> <b>1-866-433-6041</b> <b>Billing Address:</b> PO Box 3050, Farmington, MO 63640-3821 <b>Website:</b> absolutetotalcare.com

go to the nearest emergency room.

# 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 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 from Absolute Total Care Member ID Card (2023)



FROM



## Core ID Cards

**Subscriber:** [Jane Doe]

**Member:** [John Doe]

**Policy #:** [XXXXXXXX]

**Member ID #:** [XXXXXXXXXXXXXX]

**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

[Envolv Vision: 1-833-724-9353]

[Envolv 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](http://Ambetter.AbsoluteTotalCare.com).

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## Virtual ID Cards

**Subscriber:** [Jane Doe]

**Member:** [John Doe]

**Policy #:** [XXXXXXXX]

**Member ID #:** [XXXXXXXXXXXXXX]

**Effective Date:** [00/00/00]

VIRTUAL ACCESS

[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

**Numbers below for providers:**

**Pharmacy Help Desk:** 1-855-266-3490

**EDI Payor ID:** 68069

**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](http://Ambetter.AbsoluteTotalCare.com).

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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

# Medicare-Wellcare Member ID Card (2023)



## HMO and HMO DSNP



**[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<sup>R</sup>**  
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](http://www.wellcare.com/medicare)

**FOR EMERGENCIES**  
Dial 911 or go to the nearest Emergency Room.

## PPO



**[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<sup>R</sup>**  
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](http://www.wellcare.com/medicare)

**FOR EMERGENCIES**  
Dial 911 or go to the nearest Emergency Room.

# 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>

Carry this card with you at all times and present it each time you receive a service from your doctor, pharmacy, 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](http://mmp.absolutetotalcare.com)

**Send Claims To:** Medical Claims: Wellcare Prime (MMP)  
P.O. Box 3060 Farmington, MO 63640-4402

**Claim Inquiry:** Pharmacy Claims: Wellcare Prime (MMP)  
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](mailto: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](http://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- Medicaid BALANCE BILLING



PAY TO:



### 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

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 \$68.87	\$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
<b>Sub-total</b>					\$310.00 \$68.87	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$145.00 \$116.00	\$0.00	\$0.00		\$0.00 \$0.00
<b>Total</b>					\$310.00 \$68.87	\$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	<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf</a>
Fraud, Waste, and Abuse	<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244-Print-Friendly.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244-Print-Friendly.pdf</a>
Model of Care (MOC)*	<a href="https://www.absolutetotalcare.com/providers/resources/provider-training/model-of-care-provider-training.html">https://www.absolutetotalcare.com/providers/resources/provider-training/model-of-care-provider-training.html</a>
Person-Centered Planning**	<a href="https://www.absolutetotalcare.com/providers/resources/provider-training.html">https://www.absolutetotalcare.com/providers/resources/provider-training.html</a>

\*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)



Healthy Connections  
PRIME

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



Healthy Connections  
PRIME

## 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



# Pregnancy Notification Form



## 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: [ ] (Foot, inches)  
 Pre-Pregnancy Weight: [ ] Pre-Pregnancy BMI: [ ]  
 Age less than 18? Yes [ ] No [ ] Age greater than 40? Yes [ ] No [ ]

\*Are there any known pregnancy risk factors? Yes [ ] No [ ]

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Rev. 08 18 2018  
 SC-PNCP-0032

\*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 TZP? 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 [ ] AIG? 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 Bacteria this pregnancy? Yes [ ] No [ ]  
 Current severe hypotension? 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: [ ]

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**ATC-062320-0-P-1**

Rev. 08 18 2018  
 SC-PNCP-0032-0

# SC DHHS 1716 Form for Newborns



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES Healthy Connections MEDICAID		Request for Medicaid ID Number - Infant						
<b>I. Provider Information</b>								
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)								
<b>II. Mother's Information</b>								
First Name, Middle Name, Last Name				Date of Birth (mm/dd/yyyy)				
Street Address	City	County	State	ZIP code				
Social Security Number		Medicaid ID#						
<b>III. Child's Information</b>								
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								
<table border="1"> <tr> <td style="writing-mode: vertical-rl; transform: rotate(180deg);">PROVIDER ONLY</td> <td>Child's Medicaid ID Number: _____</td> <td>Effective date of eligibility: _____</td> <td style="writing-mode: vertical-rl; transform: rotate(180deg);">FACILITY ONLY</td> </tr> </table>					PROVIDER ONLY	Child's Medicaid ID Number: _____	Effective date of eligibility: _____	FACILITY ONLY
PROVIDER ONLY	Child's Medicaid ID Number: _____	Effective date of eligibility: _____	FACILITY ONLY					
<b>IV. Mail the Completed Form</b>								
Mail the completed form to:		Fax:						
SCDHHS - Central Mail PO Box 100101 Columbia, SC 29202-3101		(888) 820-1204						

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

[https://www.scdhhs.gov/sites/default/files/documents/FM%201716%20ME\\_1.pdf](https://www.scdhhs.gov/sites/default/files/documents/FM%201716%20ME_1.pdf)



# 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](mailto: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.

# Change of Address Flyer



English

Are you a Healthy Connections Medicaid member?

Have you moved?



➤ **Let us know!**

Make sure your mailing and home **address**, **contact information** and other **household details** are up to date so we can reach you about any changes in your Medicaid.

Change your address, email or phone number online at [apply.scdhhs.gov](https://apply.scdhhs.gov).



SCAN ME



**Call (888) 549-0820**  
Monday through Friday from 8 a.m. to 6 p.m.

Visit your local eligibility office.



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Healthy Connections  
MEDICAID

Revised January 2023

Spanish

¿Es usted miembro de Healthy Connections Medicaid?

¿Te has mudado?



➤ **¡Háganoslo saber!**

Asegúrese de que su **dirección** postal y la de su domicilio, la **información de contacto** y otros **datos del hogar** están actualizados para que podamos ponernos en contacto con usted sobre cualquier cambio en su Medicaid.

Haga cambios de su dirección, correo electrónico email o número de telefono por internet en [apply.scdhhs.gov](https://apply.scdhhs.gov).



SCAN ME



**Llame al (888) 549-0820**  
De lunes a viernes, de 8 a.m. a 6 p.m.

Visite su oficina local de elegibilidad.



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Healthy Connections  
MEDICAID

Revised January 2023



# Adjournment