# Absolute Total Care
# 2023 Virtual Provider Town Hall
# 3rd Quarter

11/8/2023

# 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 |
|---|---|
| **Jennifer Helms** | Vice President, Operations |
| **SaBrina Macon** | Director, Provider Relations |
| **Kristen Graham** | Manager, Provider Relations |
| **Janet Kimbrough** | Provider Engagement Administrator III |
| **Tonya Ruff** | Provider Engagement Administrator III |
| **Tracey Snowden** | Provider Engagement Administrator III |
| **LaToya Jones** | Provider Engagement Administrator II |
| **Porsha Lewis** | Provider Engagement Administrator II |

# Provider Engagement Team

| Name | Title |
|---|---|
| **S. Brandi Crosby** | Provider Engagement Administrator II |
| **Anna Truesdale** | Provider Engagement Administrator II |
| **Camille Gray** | Provider Engagement Administrator II |
| **Sarah Wilkinson** | Provider Engagement Administrator II |
| **Wendy McCrea** | Provider Engagement Administrator II |
| **Kisha Thomas** | Provider Engagement Administrator I |
| **Adria Felder** | Provider Engagement Administrator I |
| **Neshelle Miller** | Provider Engagement Administrator I |

# Quality Improvement and Case Management Team

| Name | Title |
|---|---|
| **Sharon Mancuso** | Vice President, Quality Improvement |
| **Janet Bergen** | Manager, Case Management |
| **Betty Smith** | Lead Program Coordinator |
| **Aimee Kincaid** | Senior Manager, Quality Improvement |
| **Jane Brown** | Quality Improvement, Project Manager |
| **Kellie Williamson** | 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

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Healthy Connections

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

# What Should Your Patients Do?

- Contact SCDHHS now to update their mailing address, contact information and other household details. This can be accomplished by:
  - Updating their information online at 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
  - Fax – (888) 820-1204
  - Email – 8888201204@fax.scdhhs.gov
  - Mail – SCDHHS, PO Box 100101, Columbia, SC 29202
  - In-person – Visit scdhhs.gov for a list of local eligibility offices
- Absolute Total Care members can call Absolute Total Care at (866) 433-6041 for questions and/or assistance with competing the annual review form.

# How Providers Can Help Patients


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

# Absolute Total Care is Here to Help

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

# Important Links and Contact Information

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

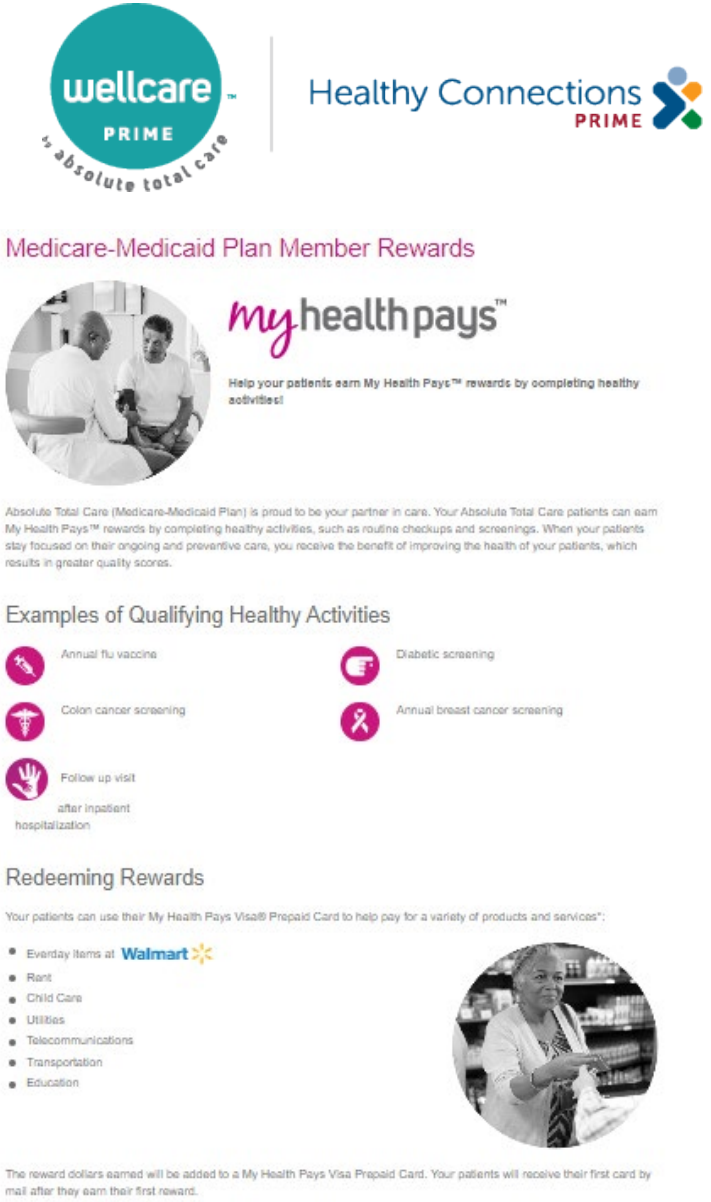
| Absolute Total Care | South Carolina Medicaid | Health Insurance Marketplace |
|---|---|---|
| 1-866-433-6041 | 1-888-549-0820 | 1-800-318-2596 |
| absolutetotalcare.com | apply.scdhhs.gov | healthcare.gov |

# Wellcare Prime by Absolute Total Care

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*

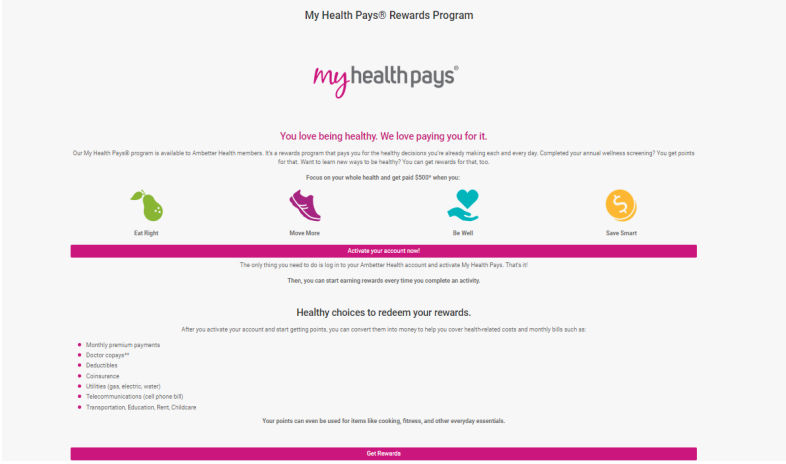


# Ambetter from Absolute Total Care

**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




*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

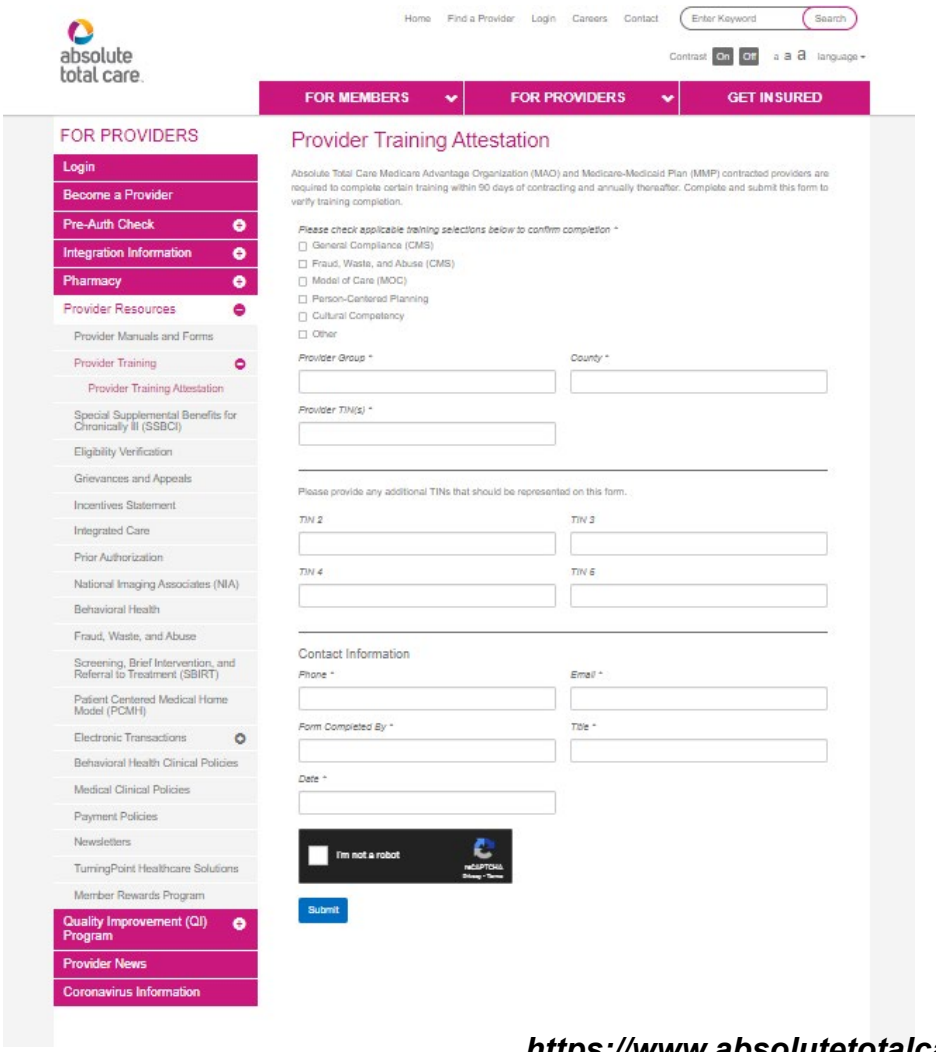
We partner with each of our contracted providers to ensure that you have received the necessary training to deliver quality care to our members and your patients and to be compliant with Centers for Medicare & Medicaid Services (CMS) and state requirements. All Medicare Advantage Organization (MAO) and 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 | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf |
| Fraud, Waste, and Abuse | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244-Print-Friendly.pdf |
| Model of Care (MOC)* | https://www.absolutetotalcare.com/providers/resources/provider-training.html |
| Person-Centered Planning** | https://www.absolutetotalcare.com/providers/resources/provider-training.html |

# Provider Training Attestation

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***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

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# 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, call the vendor directly at 1-866-827-7028 or email clientservices@lsaweb.com.*

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

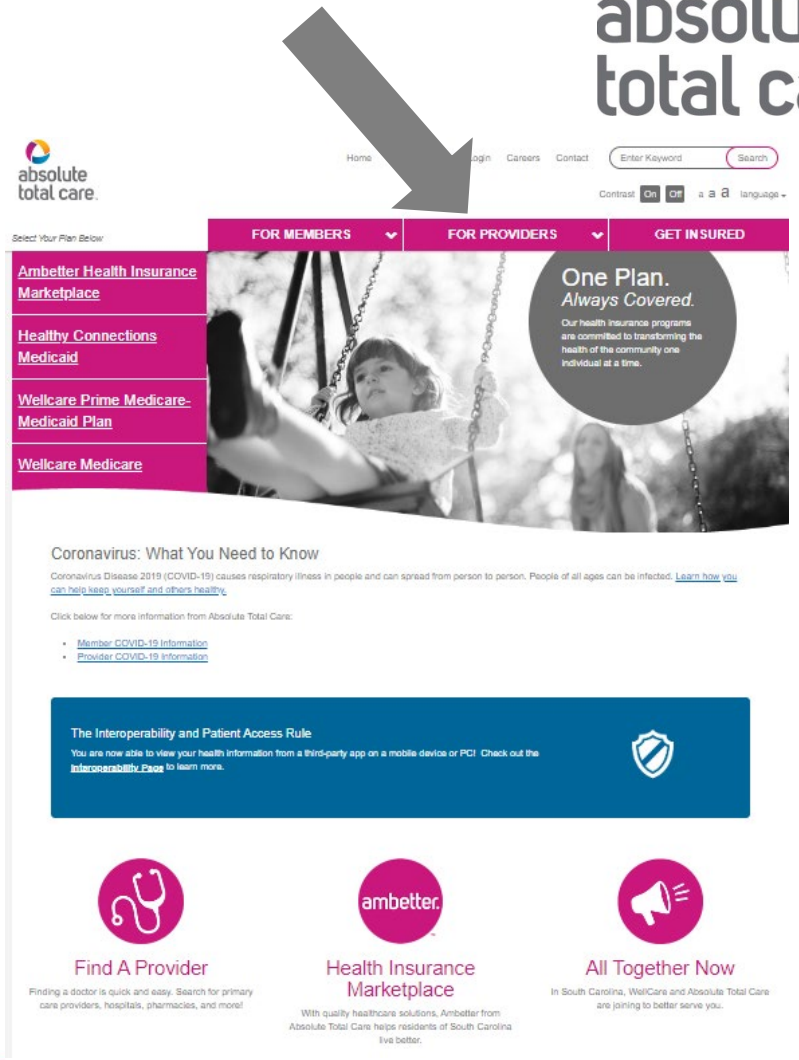
# Websites and Secure Portals

# Absolute Total Care Website

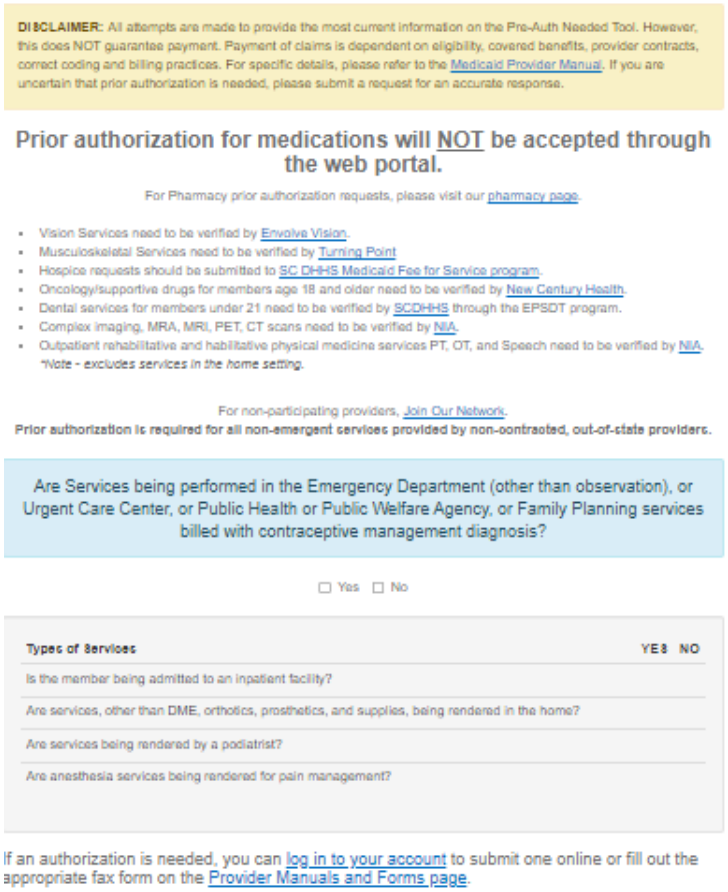
www.absolutetotalcare.com

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 NIA.
- Outpatient rehabilitative and habilitative physical medicine services PT, OT, and Speech need to be verified by NIA.

**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? | | |
| Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home? | | |
| Are services being rendered by a podiatrist? | | |
| Are anesthesia services being rendered for pain management? | | |

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.

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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? | ○ | ◉ |
| Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home? | ○ | ◉ |
| Are services being rendered by a podiatrist? | ○ | ◉ |
| Are anesthesia services being rendered for pain management? | ○ | ◉ |

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.

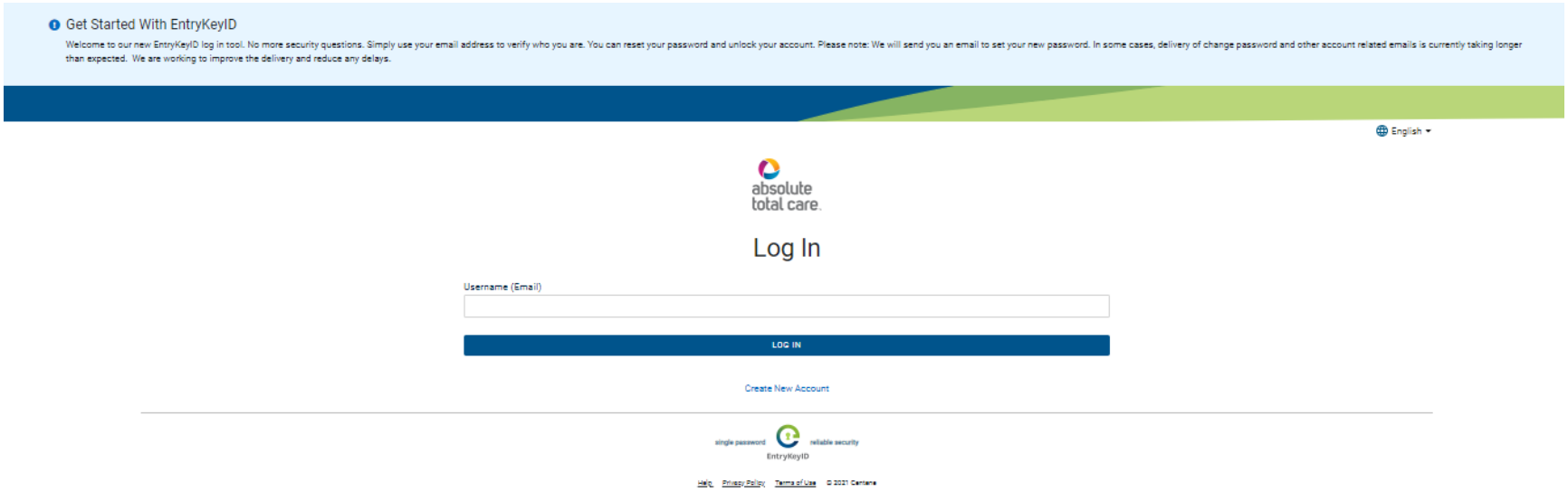
If an authorization is needed, you can log in to your account to submit one online or fill out the appropriate fax form on the Provider Manuals and Forms page.

# Authorization Vendors

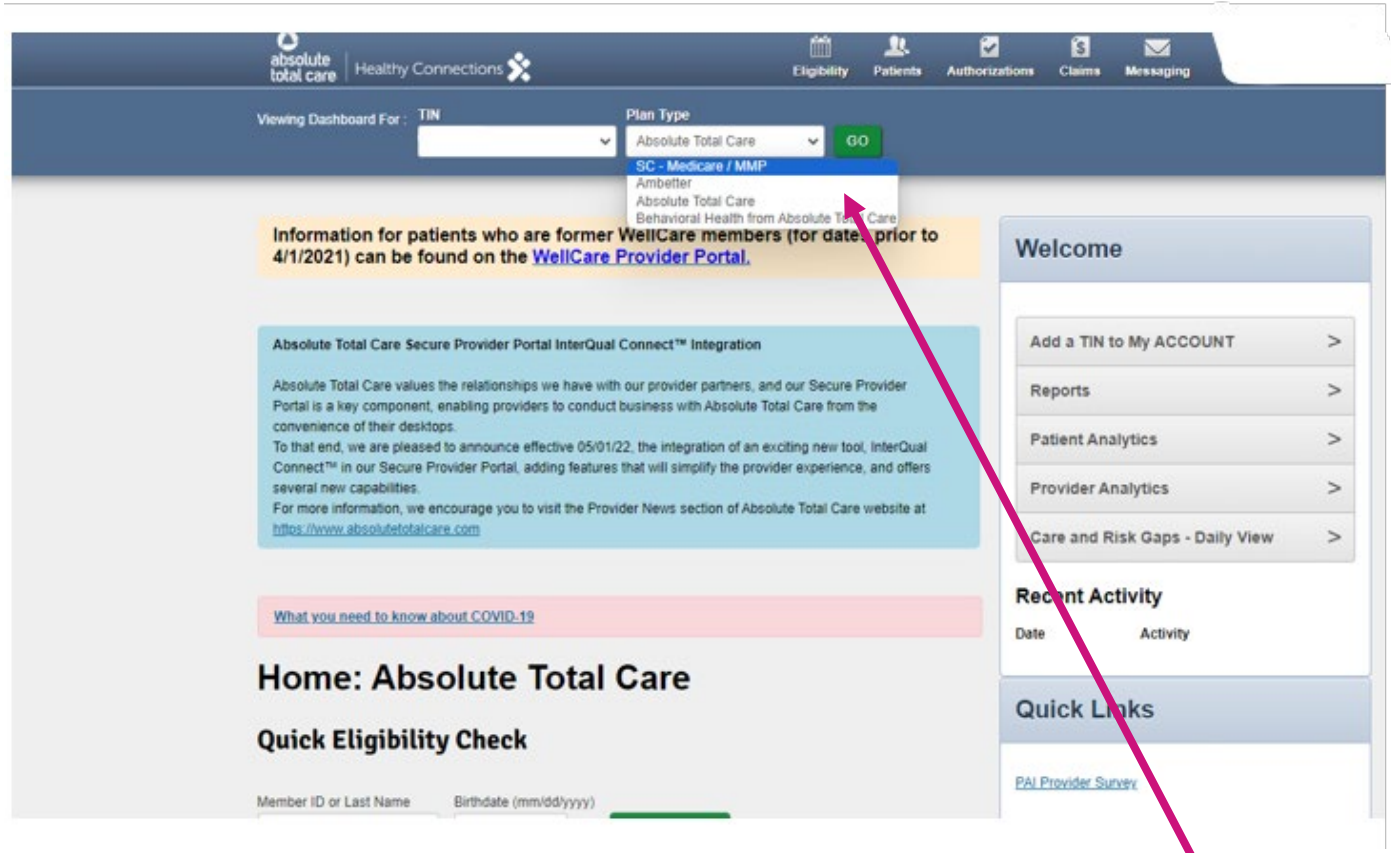
- Vision Services need to be verified by Envolve Vision.
- Musculoskeletal Services need to be verified by Turning Point
- Hospice requests should be submitted to SC DHHS Medicaid Fee for Service program.
- Oncology/supportive drugs for members aged 18 and older need to be verified by New Century Health.
- 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

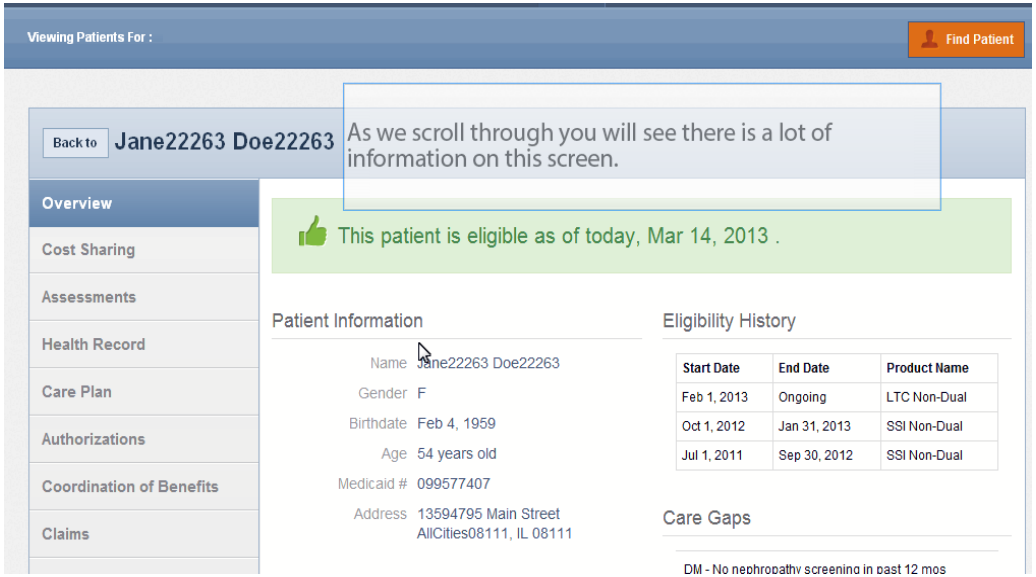


# Secure Provider Portal




Use dropdown menu to select line of business

# Secure Provider Portal



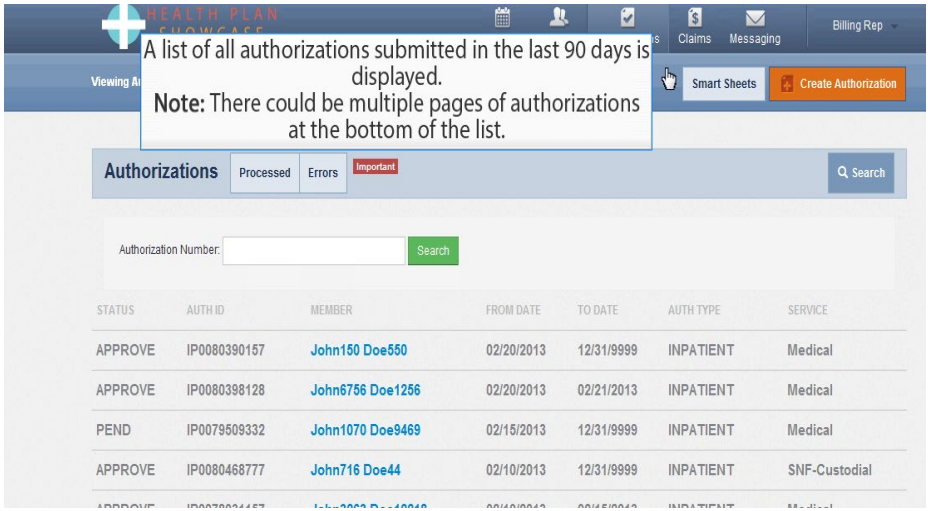

Member eligibility should be checked each month and each time prior to rendering services

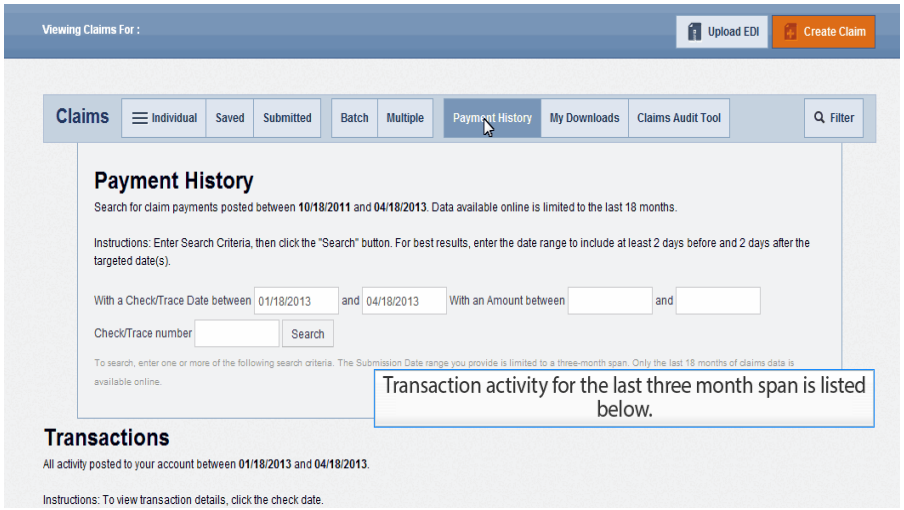
The Absolute Total Care Secure Provider Portal or the Interactive Voice Response (IVR) system are available 24 hours a day, seven days a week.

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

# Absolute Total Care Secure Provider Portal

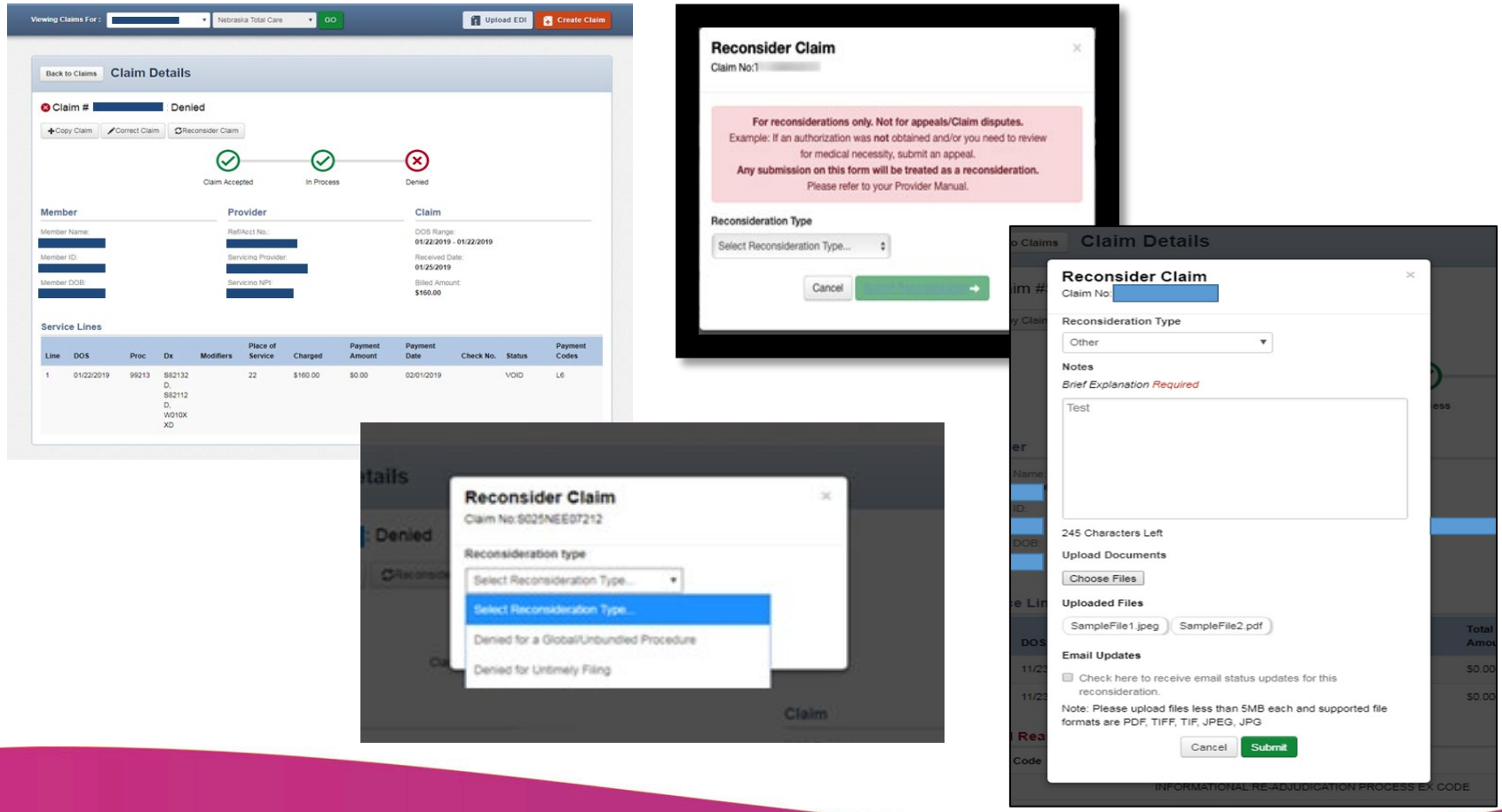
## Authorizations and Claims



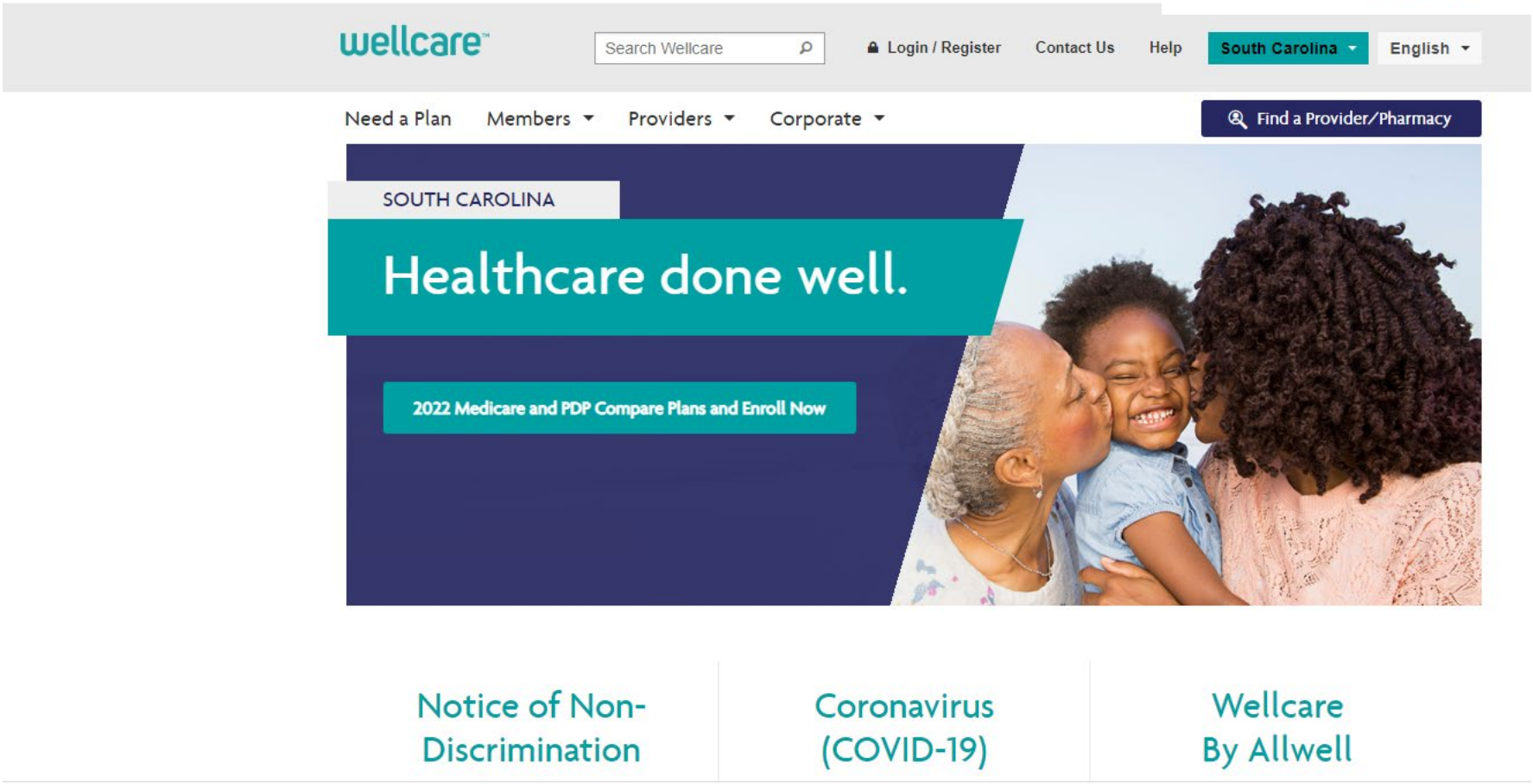



# Absolute Total Care Secure Provider

## Portal Provider Reconsideration

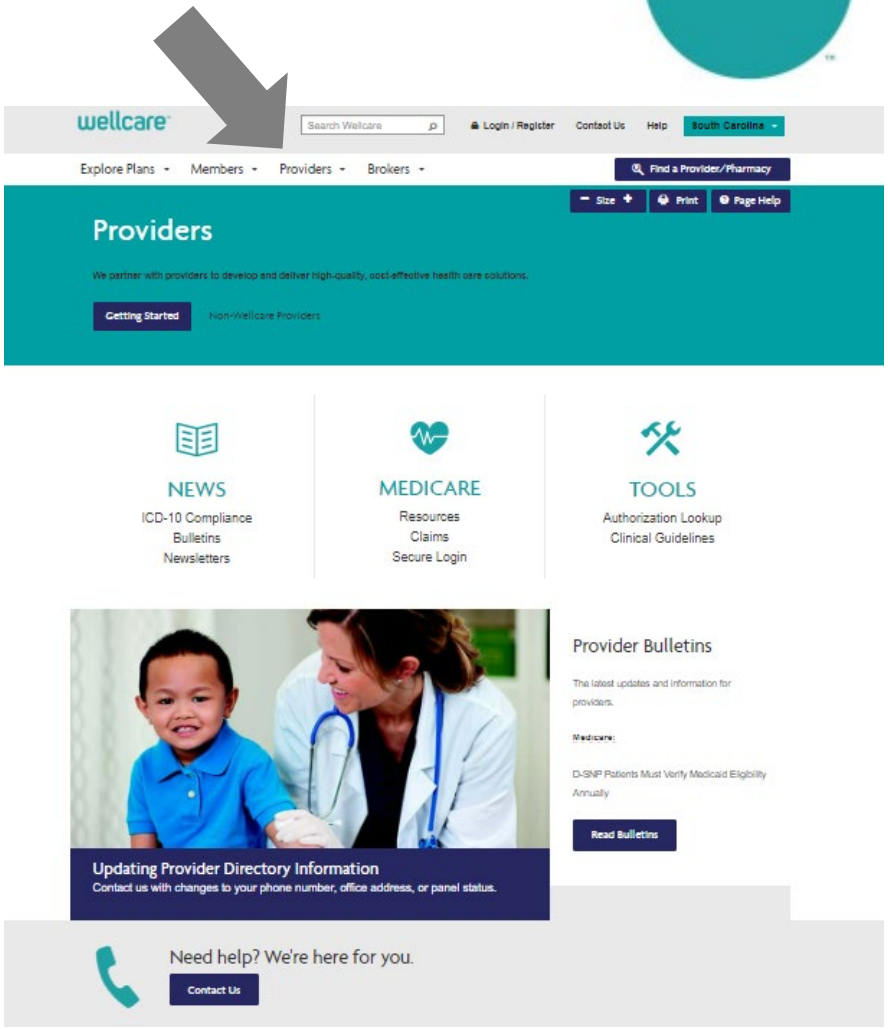


# Wellcare Website

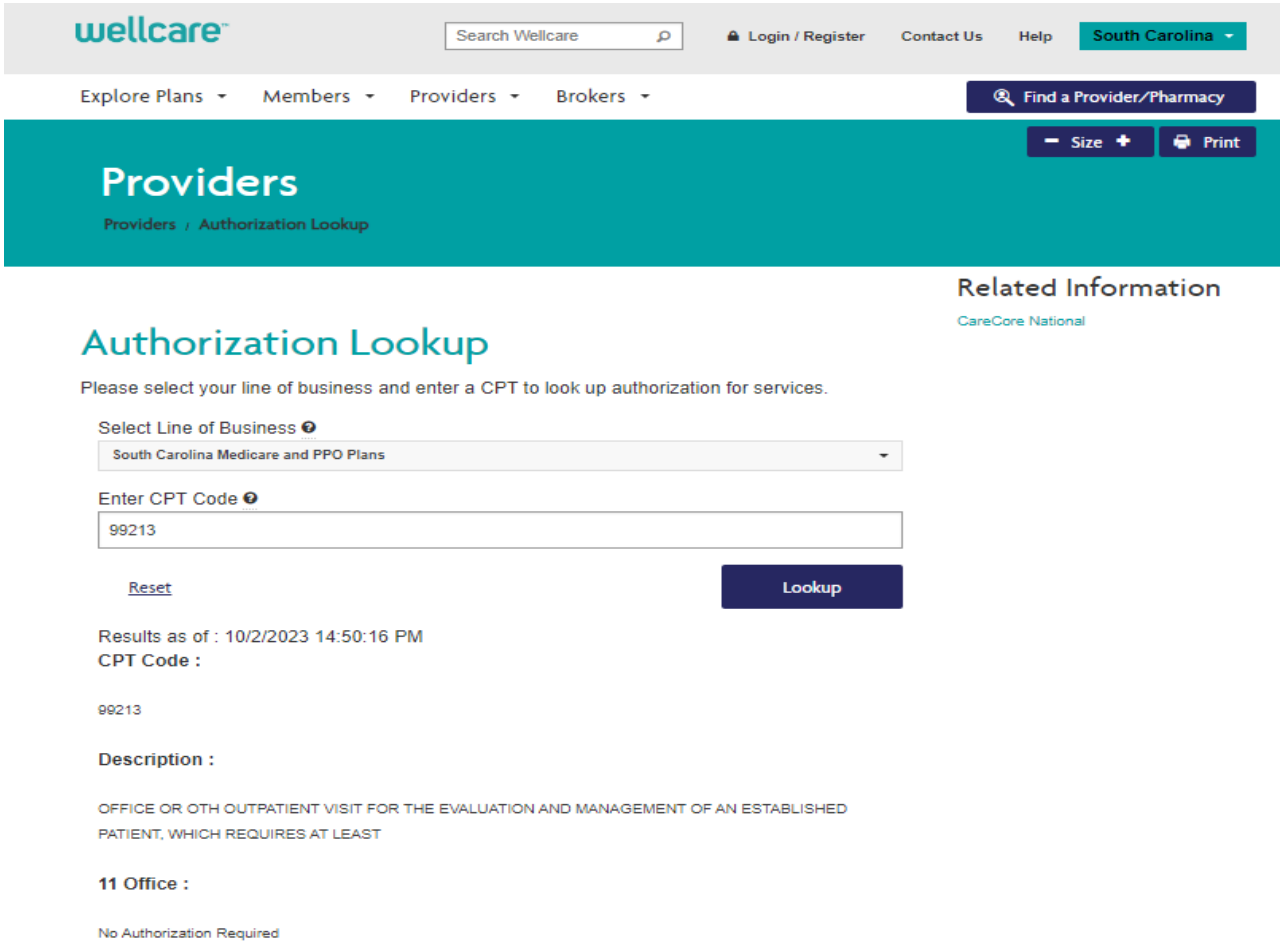


# Wellcare Website

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



# Pre-Auth Lookup Tool



# Authorization Vendors

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

# **Vendor Update**

## NCH Oncology Pathway Solutions / Cardiology Management Program

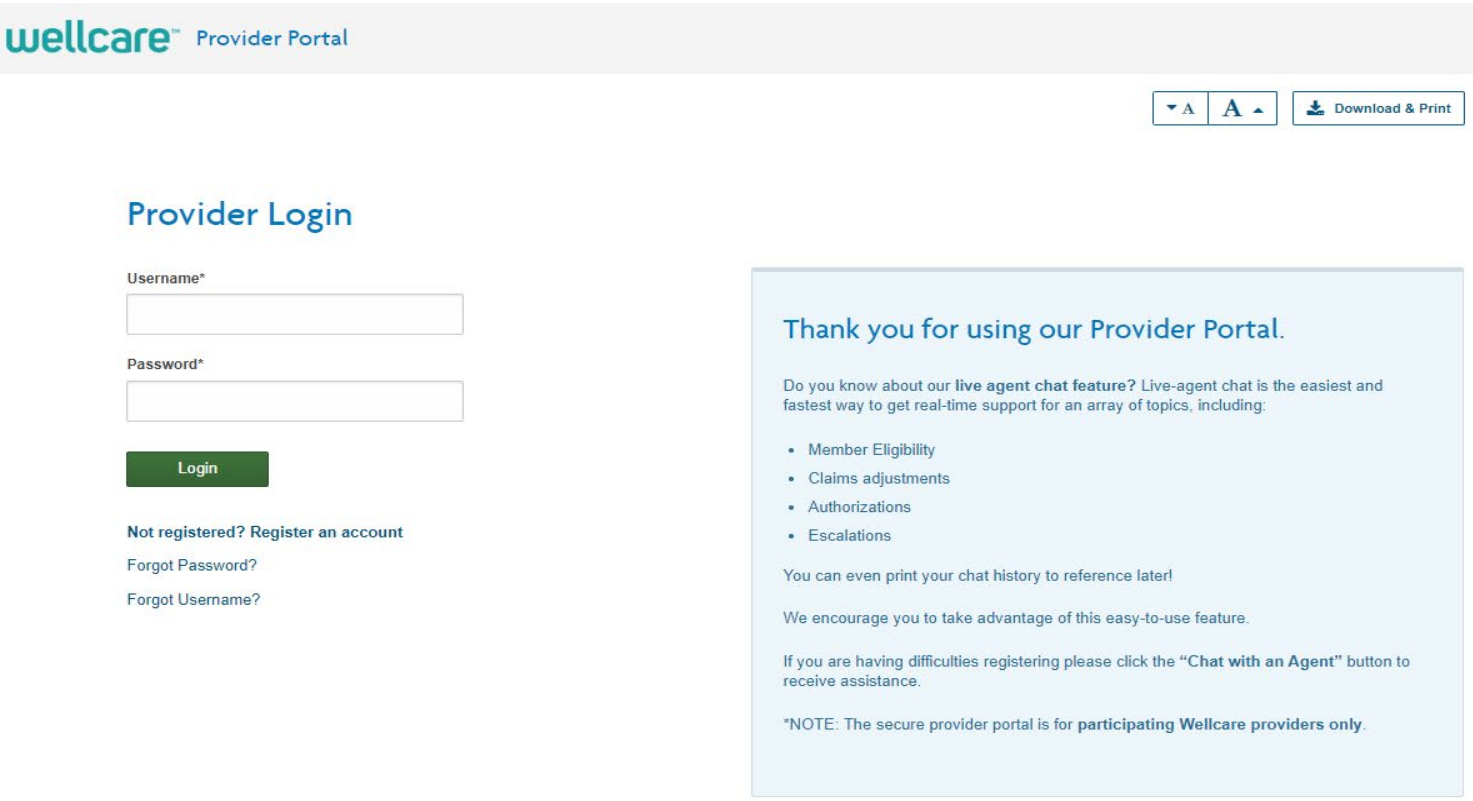
Wellcare has partnered with New Century Health (NCH) to implement a new oncology prior authorization program, Oncology Pathway Solutions. Effective **October 1, 2023**, NCH will manage prior authorization requests for Medical Oncology and Radiation Oncology treatments provided in an outpatient setting. 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, or
Calling 1-888-999-7713, Option 1 (Monday–Friday, 8 a.m.–8 p.m. EST)

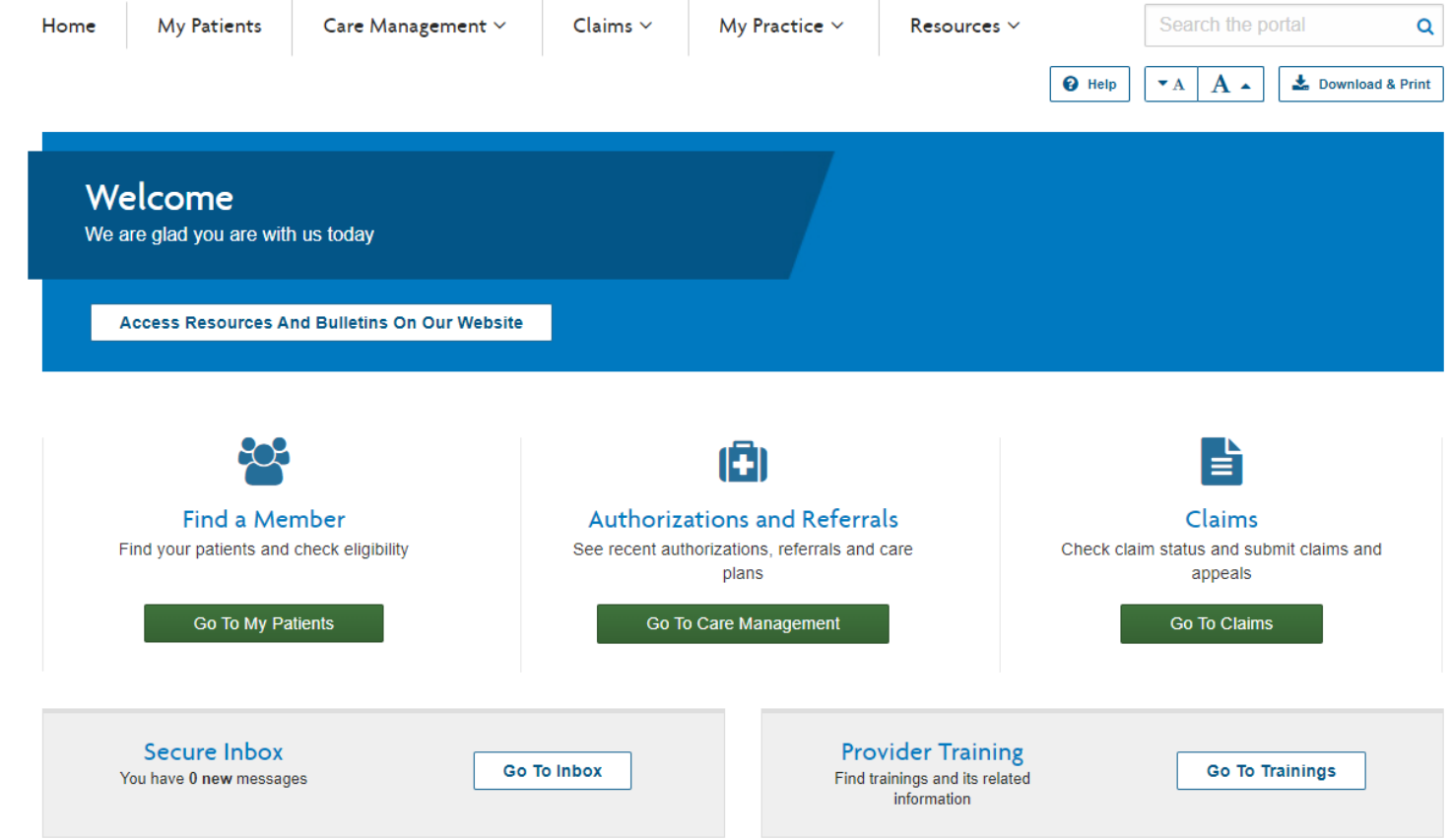
# Wellcare Secure Portal

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



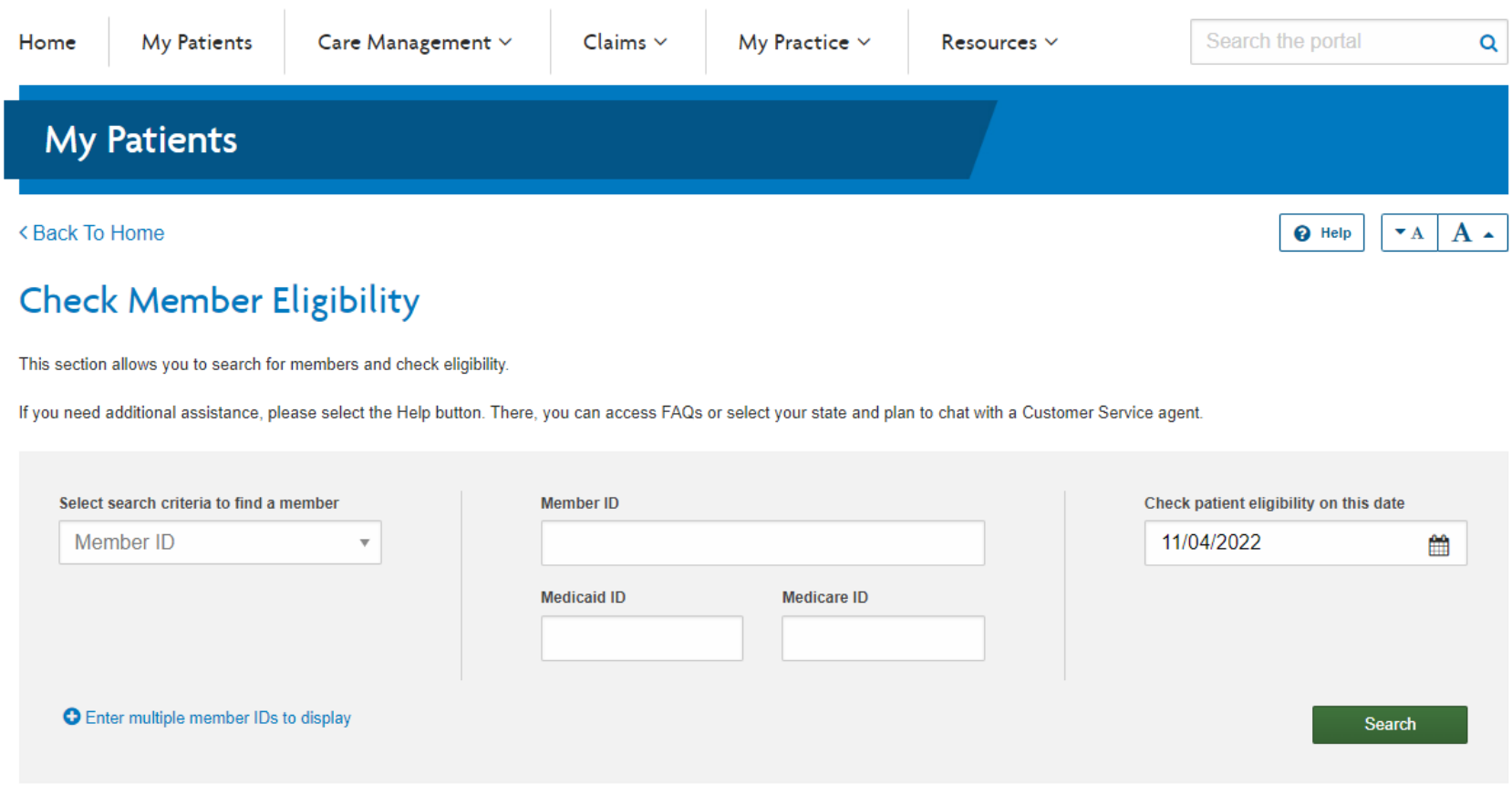
# Wellcare Secure Portal

## Home Screen



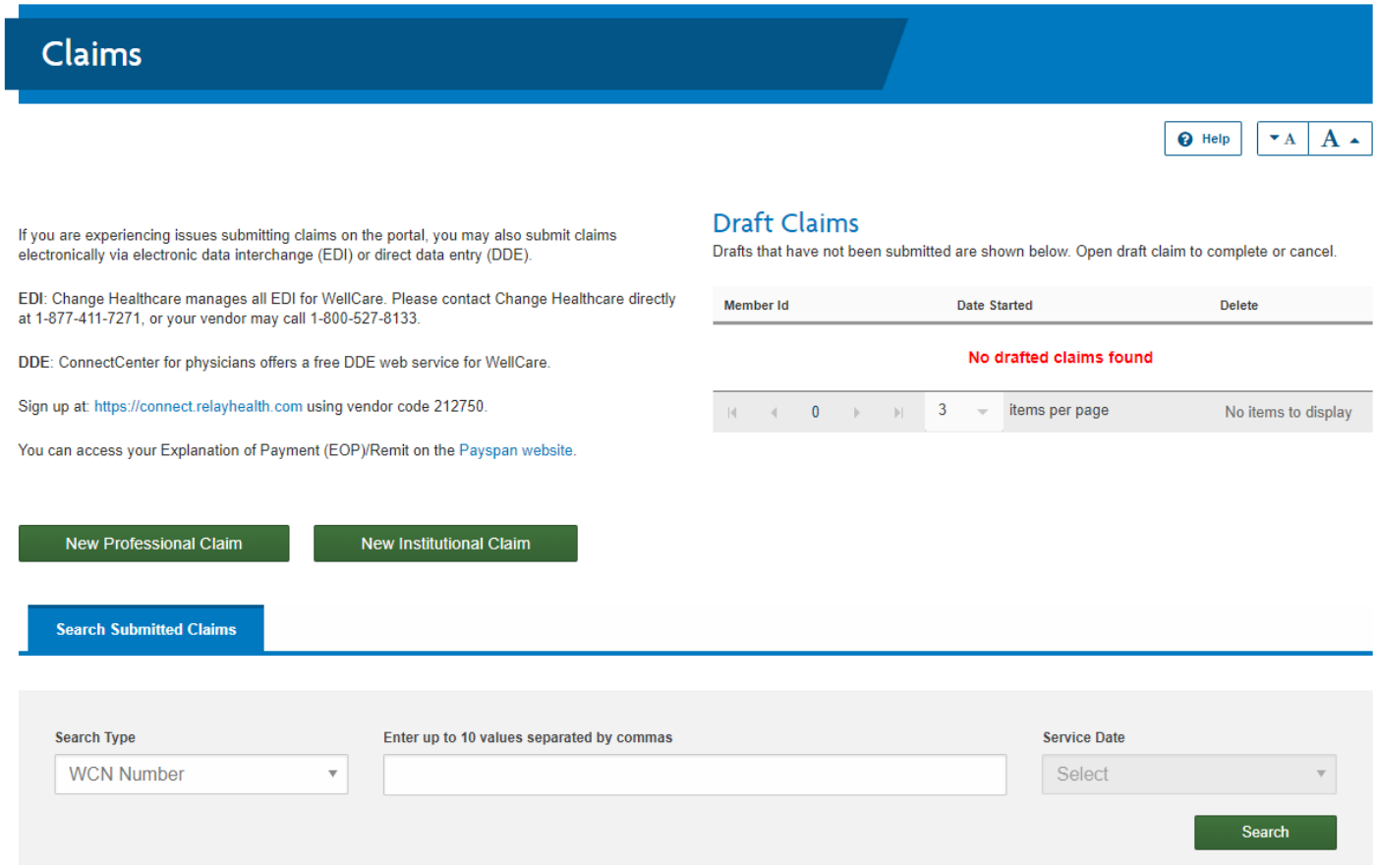
# Wellcare Secure Portal

## Eligibility and Member Information



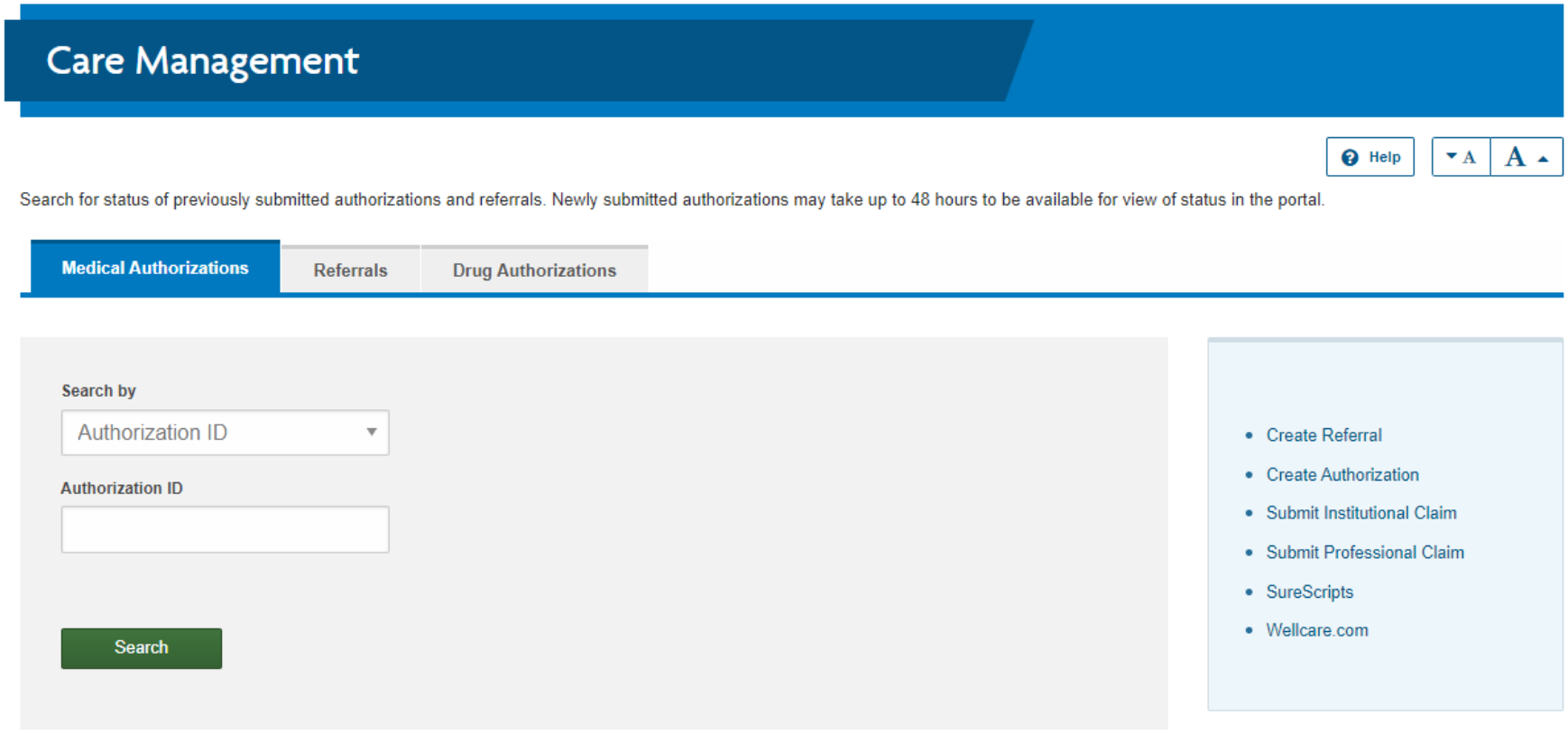
# Wellcare Secure Portal

## Claims



# Wellcare Secure Portal

## Authorizations



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

# Claims Submission - Wellcare

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

<table>
<tr><th>Line of Business</th><th>Electronic Claim Submission</th><th>Paper Claim Submission</th></tr>
<tr><td>Medicare Advantage</td><td>Register online using the simplified, enhanced provider registration process at PaySpan.com or call 1-877-331-7154<br>Or<br>Change Healthcare EDI Clearinghouse<br>1-877-411-7271.<br><br>CHANGE HEALTHCARE CLEARINGHOUSE PAYER IDS (CPIDS)<br><table><tr><th>Claim Type</th><th>Fee-for-Service (CH - Chargeable) Submissions</th><th>Encounter (RF - Reporting only) Submissions</th></tr><tr><td>Professional</td><td>1844</td><td>3211</td></tr><tr><td>Institutional</td><td>8551</td><td>4949</td></tr></table><br>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:<br>• Fee-for-Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication.<br>• Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication.<br><table><tr><th>Claim Type</th><th>FFS (CH - Chargeable) Submissions</th><th>Encounter (RF - Reporting only) Submissions</th></tr><tr><td>Professional or Institutional</td><td>14163</td><td>59354</td></tr></table></td><td>Wellcare<br>Attn: Claims Department<br>P.O. Box 31372<br>Tampa, FL 33631-3372</td></tr>
</table>

# Wellcare

**CLAIMS SUBMISSIONS DATE OF SERVICE GUIDANCE**

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

# Claim Adjustments, Reconsiderations, and Disputes

Claim Adjustments: *Requests to change the initial claim*

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

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

# Provider Timeframes

## Claim Adjustments, Reconsiderations, and Disputes

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

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

# Provider Timeframes

## Claim Adjustments, Reconsiderations, and Disputes

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

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

| Mailing Address |
|---|
| P.O. Box 3060<br>Farmington, MO 63640-3822 |

# 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, by phone at 1-877-331-7154 or on the web at payspanhealth.com.

# NETWORK DEVELOPMENT AND PARTICIPATION

11/8/2023

# Network Development and Participation

- ✓ Network Participation
  - The enrollment, credentialing and recredentialing processes exist to ensure that participating providers meet and remain compliant to the criteria established by Absolute Total Care, as well as government regulations and standards of accrediting bodies

- ✓ Network Development
  - To request a new agreement, send an email to ATC_Contracting@centene.com
  - For contract updates and questions (i.e., change of ownership, TIN changes, amendments, etc.), send an email to ATC_Contracting@centene.com

- ✓ To add a new practitioner, providers must submit a Provider Data (Add) Form and Current W-9 to SouthCarolinaPDM@centene.com to begin the credentialing process
  - This process takes approximately 60 days to complete (follow ups prior to receiving the Welcome Letter can be done so by emailing SouthCarolinaPDM@centene.com)
  - Recredentialing is performed at least every 36 months
  - Provider updating existing participating providers and locations may do so by emailing the Provider Data Form (Update) to SouthCarolinaPDM@centene.com

# Network Development and Participation

- ✓ Network Development
  - To request a new Medicare agreement, send an email to ATC_Contracting@centene.com
  - For contract updates and questions (i.e., change of ownership, TIN changes, amendments, etc.), send an email to ATC_Contracting@centene.com

- ✓ To add a new practitioner, providers must 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)
  - 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

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## Path to Successful Member Care

- Member Visits
- Flu Vaccinations

## Path to Successful Provider Satisfaction

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

## Path to Successful Annual Surveys

- CAHPS

# CPT II and HCPCS Billing

## Important Information on CPT II and HCPCS Codes

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

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

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


CPTII Codes and HCPCS Billing PRO_91371E_Approved_01112022.pdf

# What measures do these codes apply to?

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

# Electronic Medical Record (EMR) System

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## Remote Access to EMR

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

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

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

# Supplemental Data Feeds

## Monthly Supplemental Data Feed

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

- Close care gaps
- Improve our HEDIS scores
- Potential incentives
- Reduces request for medical records

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

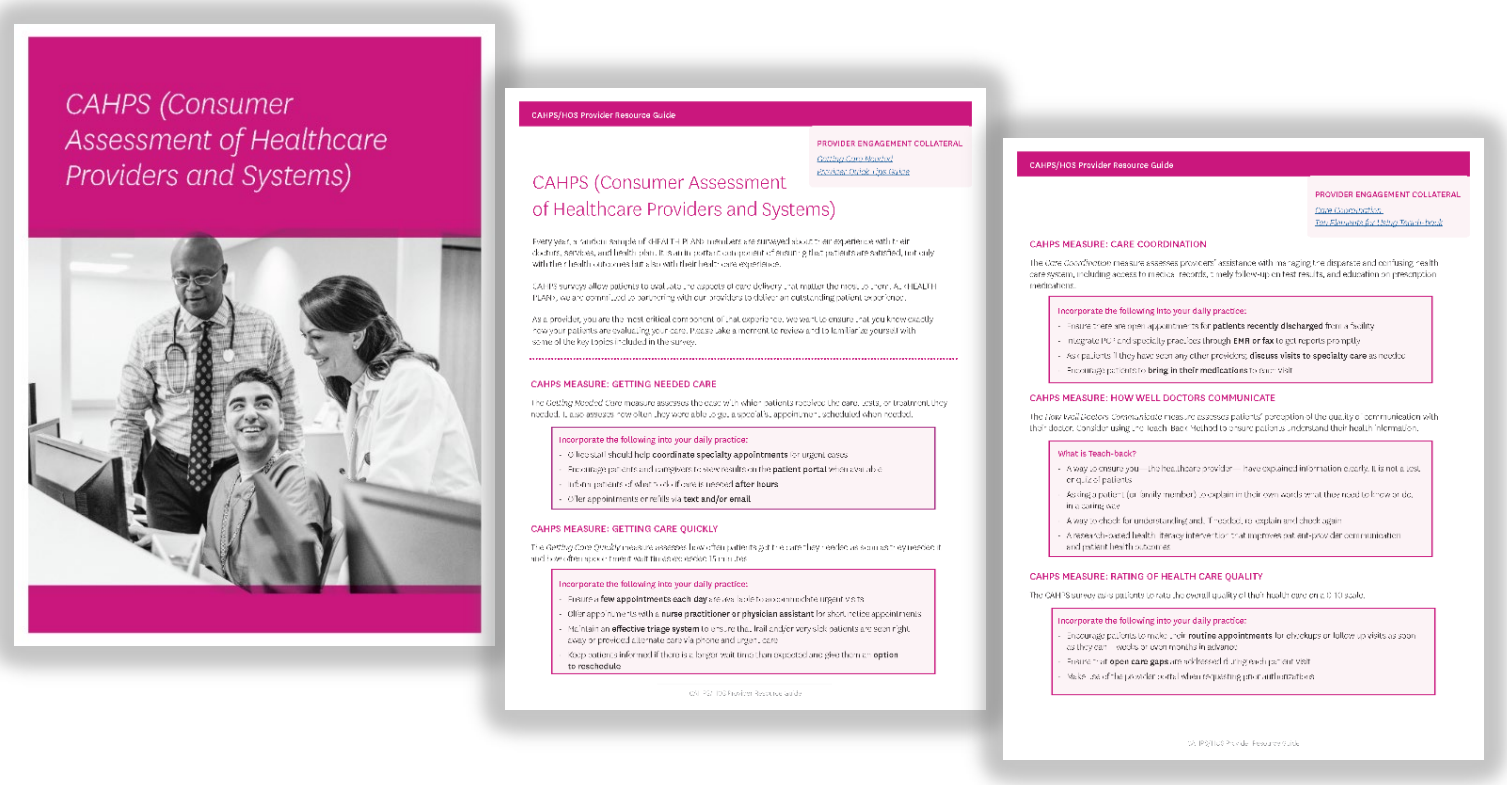
# CAHPS®
# Consumer Assessment of Healthcare Providers and Systems

11/8/2023

# Importance of CAHPS®

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

# CAHPS® Provider Resource Guide




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

# Provider Focus Quick Tips

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## Getting Needed Care

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

## Getting Care Quickly

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

## Care Coordination

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

## Rating of Health Care

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

# Poll Question # 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

11/8/2023

# Risk Adjustment

## Continuity of Care Incentive Program

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

## Clinical Documentation Improvement Program

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

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

# START SMART FOR YOUR BABY

11/8/2023

# 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

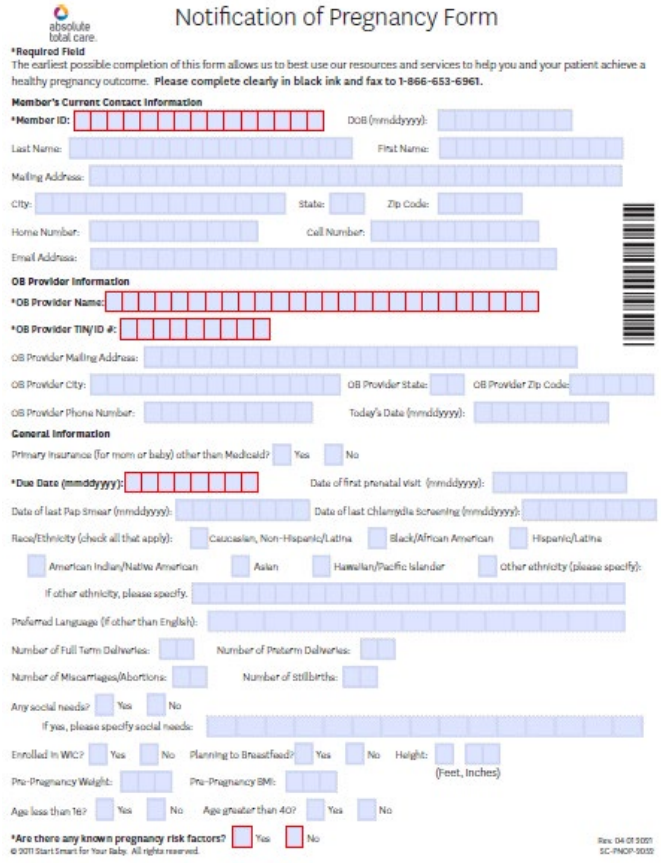
# Start Smart for Your Baby

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



Notification of Pregnancy Form

absolute total care.

***Required Field**

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

**Member's Current Contact Information**

*Member ID: DOB (mmddyyyy):

Last Name: First Name:

Mailing Address:

City: State: Zip Code:

Home Number: Cell Number:

Email Address:

**OB Provider Information**

*OB Provider Name:

*OB Provider TIN/ID #:

OB Provider Mailing Address:

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

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

**General Information**

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

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

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

Race/Ethnicity (check all that apply): Caucasian, Non-Hispanic/Latina Black/African American Hispanic/Latina

American Indian/Native American Asian Hawaiian/Pacific Islander Other ethnicity (please specify):

If other ethnicity, please specify.

Preferred Language (if other than English):

Number of Full Term Deliveries: Number of Preterm Deliveries:

Number of Miscarriages/Abortions: Number of Stillbirths:

Any social needs? Yes No

If yes, please specify social needs:

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

Pre-Pregnancy Weight: Pre-Pregnancy BMI:

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

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



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SC-PNOP-5033

*Member ID: DOB (mmddyyyy):

Last Name: First Name:

**History**

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

Currently on 17P? Yes No

Recent delivery (within past 12 months)? Yes No Recent delivery (within past 6 months)? Yes No

Previous C-Section? Yes No Previous severe preeclampsia? Yes No

Diabetes (prior to pregnancy)? Yes No Sickle Cell? Yes No

Asthma? Yes No If yes, are asthma symptoms worse during pregnancy? Yes No

High Blood Pressure (prior to pregnancy)? Yes No If yes, is high blood pressure well controlled? Yes No

Previous neonatal death or stillborn? Yes No

If yes, was neonatal death associated with an underlying maternal health condition? Yes No

HIV Positive? Yes No HIV Negative? Yes No HIV Test Refused? Yes No AIDS? Yes No

Seizure disorder? Yes No If yes, has there been a seizure within the last 6 months? Yes No

**Current Pregnancy**

Preterm labor this pregnancy? Yes No Current placenta previa? Yes No

Vaginal bleeding after 14 weeks? Yes No

Shortened Cervix <23 weeks this pregnancy? Yes No If yes, Length: ___cm.

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

Current Twins? Yes No Current Triplets? Yes No Discordant growth? Yes No

Current fetal growth restriction? Yes No Current congenital anomalies? Yes No

BMI < 20 or poor weight gain during this pregnancy? Yes No UTI/Pyelo Bacteriuria this pregnancy? Yes No

Current severe hyperemesis? Yes No

Current mental health concerns? Yes No

If yes, please specify mental health concerns.

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

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

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

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

Are there any other significant risk factors? Yes No

If yes, Please list other risk factors:



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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 | Adria.Felder@CENTENE.COM | Ambulatory/EMS, Health Network Solutions, Chiropractors, Long Term Acute Care, Rehabilitation Facility and Skilled Nursing Facilities |
| Kisha Thomas | Provider Engagement Administrator I | (803) 904-6430 | Kisthomas@centene.com | Dialysis Centers and Ambulatory Surgery Centers |
| Neshelle Miller | Provider Engagement Administrator I | (803) 972-1460 | Neshelle.Miller@centene.com | Durable Medical Equipment and Home Health (statewide) |
| Anna Truesdale | Provider Engagement Administrator II | (803) 427-3260 | Anna.Truesdale@CENTENE.COM | Federally Qualified Health Center (Statewide) |
| Camille Gray | Provider Engagement Administrator II | (803) 213-1661 | Camille.L.Gray@centene.com | Aiken, Allendale, Bamberg, Barnwell, Calhoun, Edgefield and Orangeburg |

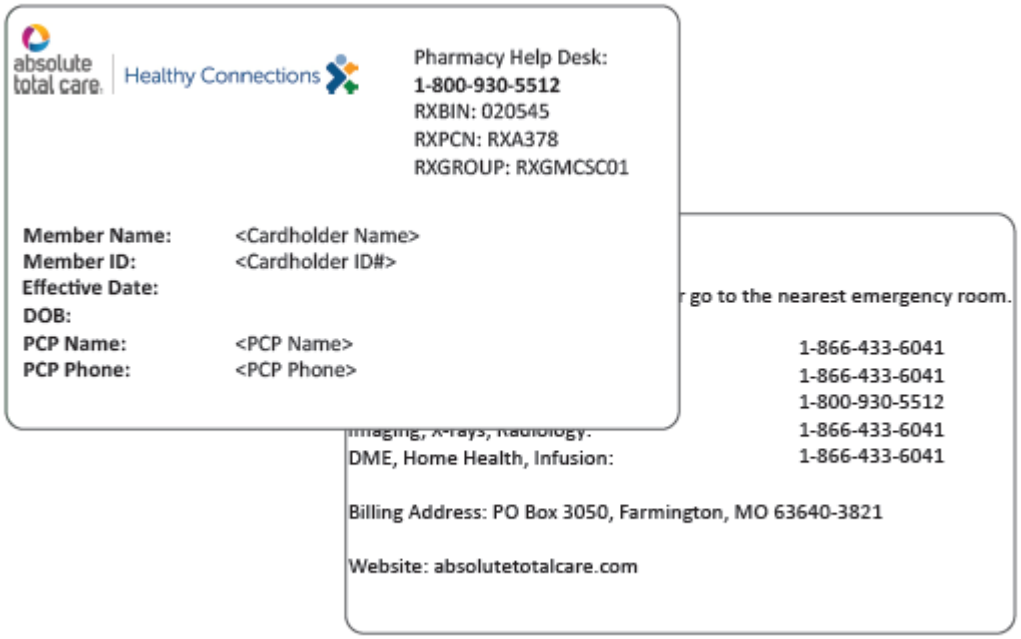
# ATC Provider Engagement Territory Assignment

| NAME | TITLE | PHONE # | EMAIL | TERRITORY (COUNTY) |
|---|---|---|---|---|
| Wendy McCrea | BH Provider Engagement Administrator II | (803) 260-7093 | Wendy.McCrea@CENTENE.COM | 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 | Sarah.Wilkinson@centene.com | Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Marion, Marlboro and Williamsburg |
| Porsha Lewis | Provider Engagement Administrator II | (803) 873-8691 | Porsha.Lewis@centene.com | Chester, Fairfield, Kershaw, Lee, Lexington, Richland, Saluda, Sumter, Border GA counties and Tenet Health |
| LaToya Jones | Provider Engagement Administrator II | (803) 553-7324 | Latoya.Jones3@Centene.com | Abbeville, Anderson, Cherokee, Greenville, Greenwood, Lancaster, Laurens, McCormick, Newberry, Oconee, Pickens, Spartanburg, Union, York and Border-NC |
| S. Brandi Crosby | Provider Engagement Administrator II | (843) 518-3918 | shunta.crosby@centene.com | 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 | Janet.H.Kimbrough@centene.com | 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 | Tracey.D.Snowden@centene.com | AnMed Health, Atrium Health, Newberry Hospital, Self Regional, SC Oncology Associates |
| Tonya Ruff | Provider Engagement Administrator III | (864) 492-5669 | Tonya.C.Ruff@centene.com | 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



# Ambetter Virtual Access

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

- Members enrolled in Ambetter Virtual Access-Teladoc require a referral from their PCP 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.

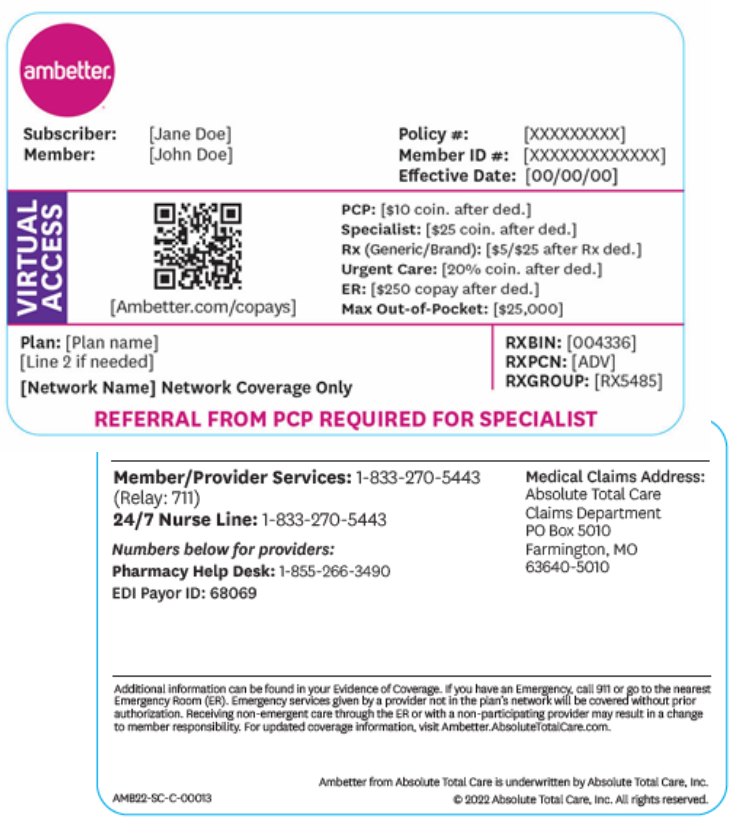
- Members 18 and above are assigned to a Teladoc PCP.
  - Minors are assigned to traditional brick and mortar PCPs.
  - Members can “opt-out” and choose an in-network brick and mortar PCP.
  - A member who opts out will lose the $0 PCP copay benefit and a copay will apply.

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

# Ambetter from Absolute Total Care Member ID Card (2023)

## Core ID Cards


## Virtual ID Cards



# No Surprises Act

- The No Surprises Act is specific to the Ambetter (Marketplace) product.
- Effective January 1, 2022 and applies to:
  - Emergency care at out-of-network facilities
  - Post stabilization care at out-of-network facilities
  - Non-emergency services provided by out-of-network providers at in-network facilities, unless notice and consent is given
  - Out-of-network air ambulance services
- No balance billing for out-of-network emergency services.
- No balance billing for non-emergency services rendered by nonparticipating providers at in-network hospitals and ambulatory surgical centers:
  - Emergency Medicine, Anesthesiology, Pathology, Radiology and Neonatology
  - Services provided by assistant surgeons, hospitalists, and intensivists
  - Items and services provided by a nonparticipating provider if there is no participating provider who can provide such item or service at the facility

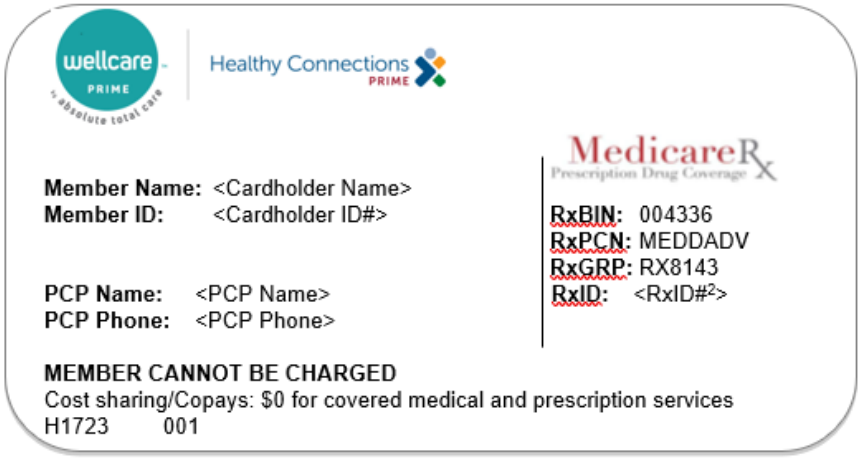
# Medicare-Wellcare Member ID Card (2023)

## HMO and HMO DSNP


## PPO

# 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>

MedicareRx Prescription Drug Coverage

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

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

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 |

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

**Claim Inquiry:** Attn: Member Reimbursement Dept.
P.O Box 31577 Tampa, FL 33631-3577
<1-855-735-4398 (TTY: 711)>

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

absolute total care™

May 19, 2016

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

**BALANCE BILLING IS PROHIBITED**

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

**WHAT CAN BE BILLED TO MEMBERS?**

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

**ABOUT HEALTHY CONNECTIONS PRIME**

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

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

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

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

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

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


**Wellcare Prime members can be billed for:**

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

**How Wellcare Prime resolves balance billing issues with the provider:**

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

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

# MMP Example EOP- Medicaid

## BALANCE BILLING

PAY TO: [redacted]

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

| | |
|---|---|
| Payment Date: | 8/17/2022 |
| 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: 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<br>$66.87 | $0.00 | $0.00 | $0.00<br>$0.00 | $0.00<br>$0.00 | $145.00<br>$116.00 | $0.00 | $0.00 | MX PM Aa | $0.00<br>$0.00 |
| | | | Sub-total | | $310.00<br>$66.87 | $0.00 | $0.00 | $0.00<br>$0.00 | $0.00<br>$0.00 | $145.00<br>$116.00 | $0.00 | $0.00 | | $0.00<br>$0.00 |
| | | | Total | | $310.00<br>$66.87 | $0.00 | $0.00 | $0.00<br>$0.00 | $0.00<br>$0.00 | $145.00<br>$116.00 | $0.00 | $0.00 | | $0.00<br>$0.00 |

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

# Annual Provider Training Requirements

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

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

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

**Required Training Resources**

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

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

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

ATC-06072021-AP-2 Approved 06072021
SC1PROLTR75289E_0000

# Culturally and Linguistically Appropriate Services (CLAS) Program

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

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

# Cultural Competency Quick Reference Guide

**What is cultural competency?**

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

**Purpose of cultural competency**

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

**You will learn:**

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

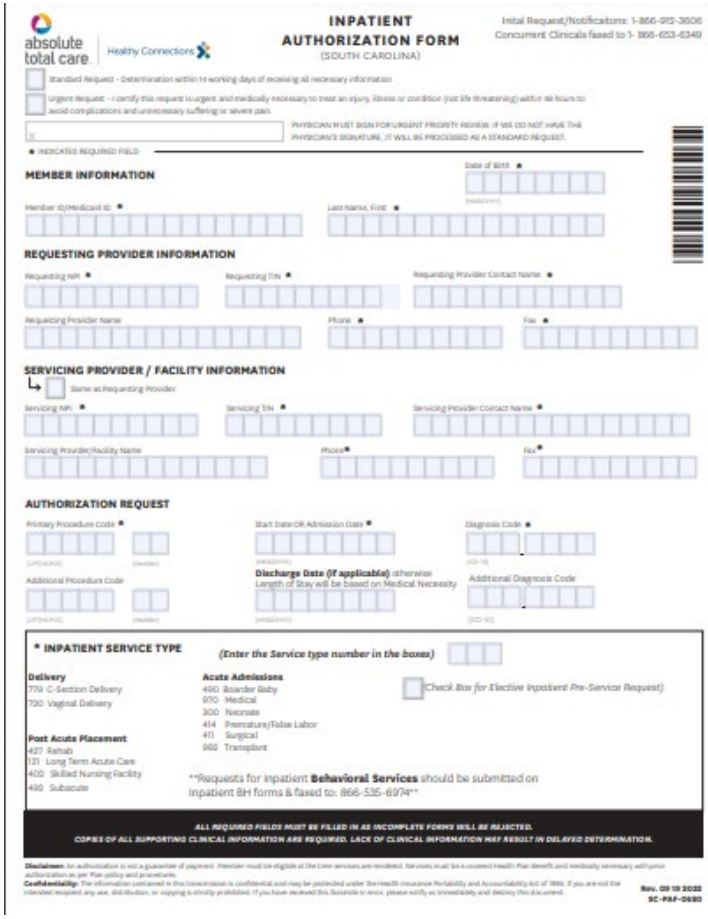
**Resources**

Resources for Cultural Competency training can be found on Wellcare Prime by Absolute Total Care's website on the Provider Manuals and Forms page (https://www.absolutetotalcare.com/providers/resources/forms-resources.html).

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

# Authorization Forms

absolute total care
Healthy Connections



absolute total care | Healthy Connections

**INPATIENT AUTHORIZATION FORM**
(SOUTH CAROLINA)

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

Standard Request - Determination within 14 working days of receiving all necessary information

Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

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

* INDICATES REQUIRED FIELD

**MEMBER INFORMATION**

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

**REQUESTING PROVIDER INFORMATION**

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

**SERVICING PROVIDER / FACILITY INFORMATION**

Same as Requesting Provider
Servicing NPI * | Servicing TIN * | Servicing Provider Contact Name *
Servicing Provider/Facility Name | Phone* | Fax*

**AUTHORIZATION REQUEST**

Primary Procedure Code * | Start Date OR Admission Date * | Diagnosis Code *
Additional Procedure Code | **Discharge Date (if applicable)** otherwise Length of Stay will be based on Medical Necessity | Additional Diagnosis Code

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

**Delivery**
779 C-Section Delivery
780 Vaginal Delivery

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

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

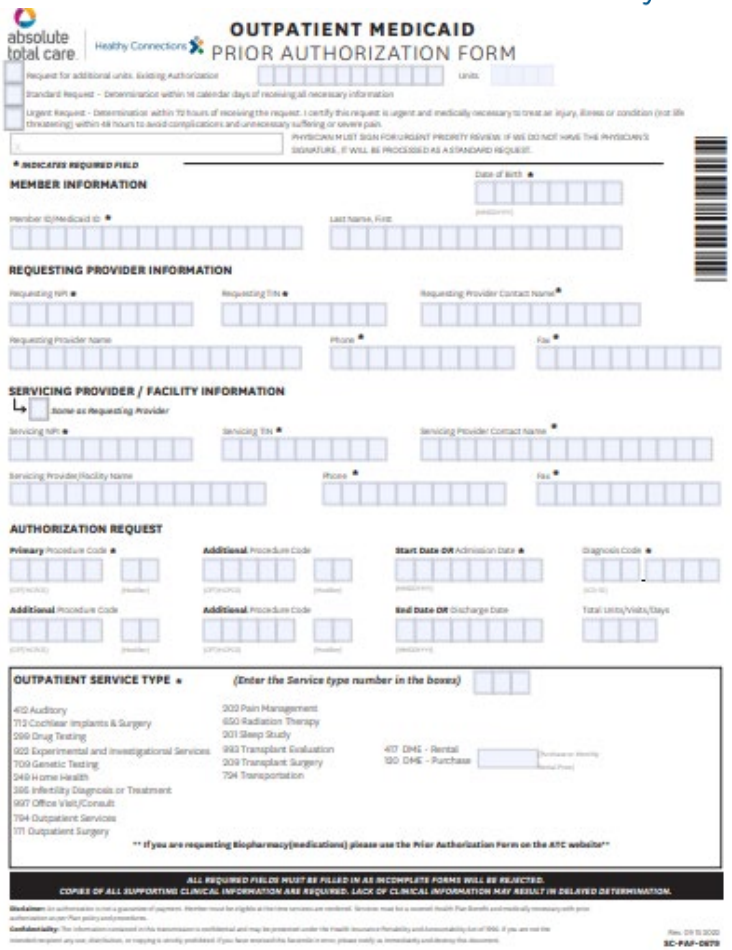
*Check Box for Elective Inpatient Pre-Service Request)*

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

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

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

Rev. 09 19 2022
SC-PAF-0680



absolute total care | Healthy Connections

**OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM**

Request for additional units: Existing Authorization | Units:

Standard Request - Determination within 14 calendar days of receiving all necessary information

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

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

* INDICATES REQUIRED FIELD

**MEMBER INFORMATION**

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

**REQUESTING PROVIDER INFORMATION**

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

**SERVICING PROVIDER / FACILITY INFORMATION**

Same as Requesting Provider
Servicing NPI * | Servicing TIN * | Servicing Provider Contact Name *
Servicing Provider/Facility Name | Phone * | Fax *

**AUTHORIZATION REQUEST**

Primary Procedure Code * | Additional Procedure Code | Start Date OR Admission Date * | Diagnosis Code *
Additional Procedure Code | Additional Procedure Code | End Date OR Discharge Date | Total Units/Visits/Days

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

412 Auditory
713 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
709 Genetic Testing
249 Home Health
266 Infertility Diagnosis or Treatment
997 Office Visit/Consult
794 Outpatient Services
771 Outpatient Surgery
302 Pain Management
650 Radiation Therapy
301 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
794 Transportation
417 DME - Rental
120 DME - Purchase

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

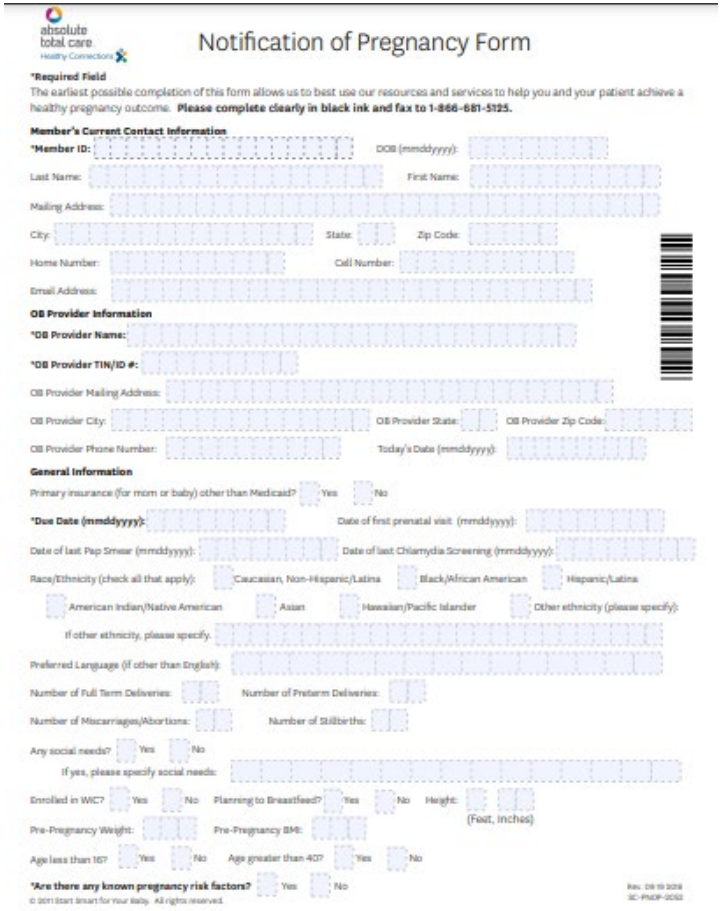
**ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.**
**COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.**

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

Rev. 09 19 2022
SC-PAF-0679

# Pregnancy Notification Form

absolute total care
Healthy Connections



absolute total care Healthy Connections

## Notification of Pregnancy Form

***Required Field**

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 1-866-681-5125.**

**Member's Current Contact Information**

*Member ID: DOB (mmddyyyy):

Last Name: First Name:

Mailing Address:

City: State: Zip Code:

Home Number: Cell Number:

Email Address:

**OB Provider Information**

*OB Provider Name:

*OB Provider TIN/ID #:

OB Provider Mailing Address:

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

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

**General Information**

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

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

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

Race/Ethnicity (check all that apply): Caucasian, Non-Hispanic/Latina Black/African American Hispanic/Latina

American Indian/Native American Asian Hawaiian/Pacific Islander Other ethnicity (please specify):

If other ethnicity, please specify.

Preferred Language (if other than English):

Number of Full Term Deliveries: Number of Preterm Deliveries:

Number of Miscarriages/Abortions: Number of Stillbirths:

Any social needs? Yes No

If yes, please specify social needs:

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

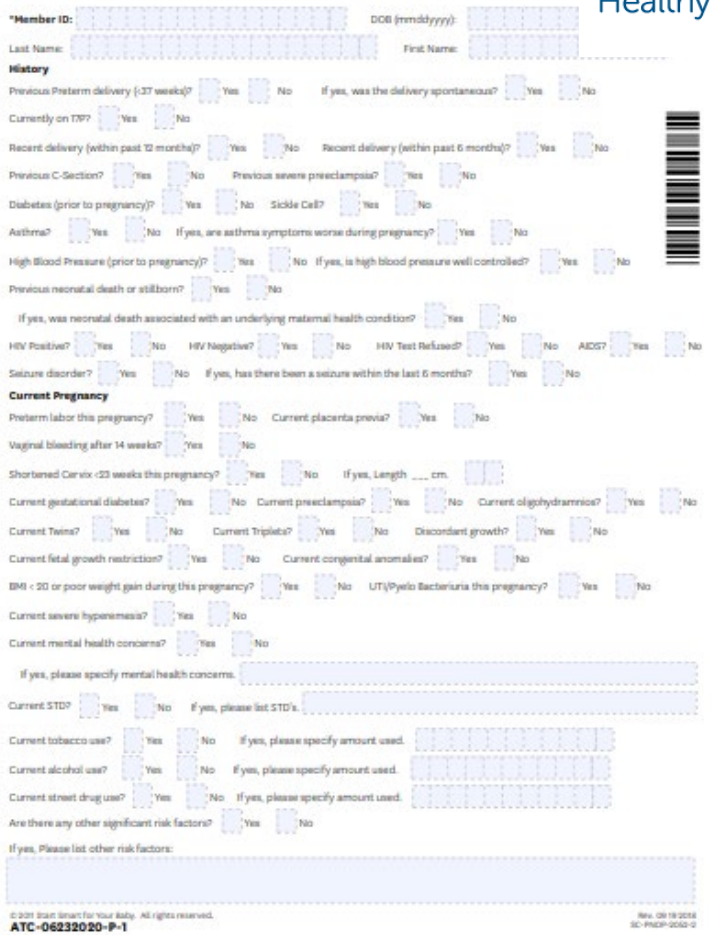
Pre-Pregnancy Weight: Pre-Pregnancy BMI:

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

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



Rev. 09 19 2018
SC-PNOP-0053



*Member ID: DOB (mmddyyyy):

Last Name: First Name:

**History**

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

Currently on TIP? Yes No

Recent delivery (within past 12 months)? Yes No Recent delivery (within past 6 months)? Yes No

Previous C-Section? Yes No Previous severe preeclampsia? Yes No

Diabetes (prior to pregnancy)? Yes No Sickle Cell? Yes No

Asthma? Yes No If yes, are asthma symptoms worse during pregnancy? Yes No

High Blood Pressure (prior to pregnancy)? Yes No If yes, is high blood pressure well controlled? Yes No

Previous neonatal death or stillborn? Yes No

If yes, was neonatal death associated with an underlying maternal health condition? Yes No

HIV Positive? Yes No HIV Negative? Yes No HIV Test Refused? Yes No AIDS? Yes No

Seizure disorder? Yes No If yes, has there been a seizure within the last 6 months? Yes No

**Current Pregnancy**

Preterm labor this pregnancy? Yes No Current placenta previa? Yes No

Vaginal bleeding after 14 weeks? Yes No

Shortened Cervix <23 weeks this pregnancy? Yes No If yes, Length ___ cm.

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

Current Twins? Yes No Current Triplets? Yes No Discordant growth? Yes No

Current fetal growth restriction? Yes No Current congenital anomalies? Yes No

BMI < 20 or poor weight gain during this pregnancy? Yes No UTI/Pyelo Bacteriuria this pregnancy? Yes No

Current severe hyperemesis? Yes No

Current mental health concerns? Yes No

If yes, please specify mental health concerns.

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

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

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

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

Are there any other significant risk factors? Yes No

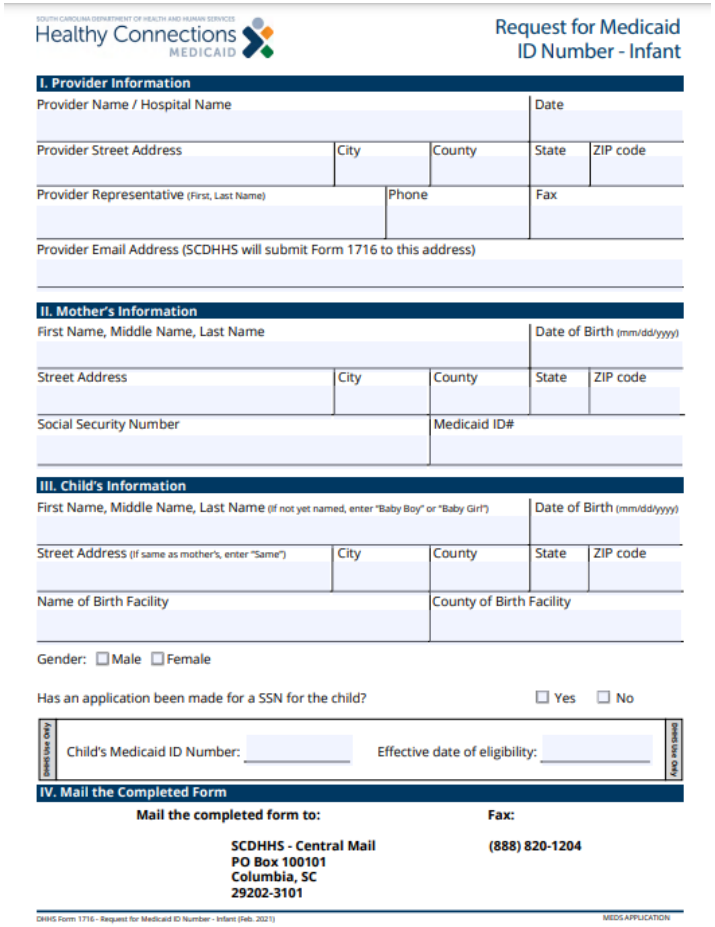
If yes, Please list other risk factors:



**ATC-06232020-P-1**

Rev. 09 19 2018
SC-PNOP-0053-0

# SC DHHS 1716 Form for Newborns



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

**Request for Medicaid ID Number - Infant**

**I. Provider Information**

Provider Name / Hospital Name | Date

Provider Street Address | City | County | State | ZIP code

Provider Representative (First, Last Name) | Phone | Fax

Provider Email Address (SCDHHS will submit Form 1716 to this address)

**II. Mother's Information**

First Name, Middle Name, Last Name | Date of Birth (mm/dd/yyyy)

Street Address | City | County | State | ZIP code

Social Security Number | Medicaid ID#

**III. Child's Information**

First Name, Middle Name, Last Name (If not yet named, enter "Baby Boy" or "Baby Girl") | Date of Birth (mm/dd/yyyy)

Street Address (If same as mother's, enter "Same") | City | County | State | ZIP code

Name of Birth Facility | County of Birth Facility

Gender: ☐ Male ☐ Female

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

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

**IV. Mail the Completed Form**

**Mail the completed form to:**

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

**Fax:**

**(888) 820-1204**

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

*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

absolute total care™

Language Services Associates www.lsawob.com

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

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

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

### Types of Interpreting Situations

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

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

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

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

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

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

### Submitting Requests

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

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

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

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

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





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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

absolute total care™

## 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.**

SCAN ME

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

**Visit your local eligibility office.**

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 direccion, correo electrónico email o número de telefono por internet en 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.**

Healthy Connections MEDICAID

Revised January 2023

# Adjournment