MEDICAID PROVIDER MANUAL 2025

For more than 40 years, Centene Corporation® (Centene) has provided comprehensive managed care services to the Medicaid population across the United States. Centene provides Medicaid managed care services to members in South Carolina as Absolute Total Care. Centene and its wholly owned health plans have a long and successful track record offering Medicaid managed care services. Absolute Total Care will serve our South Carolina members consistent with our core philosophy that quality healthcare is best delivered locally.

Absolute Total Care is a South Carolina licensed Health Maintenance Organization Managed Care Organization (MCO) contracted with the South Carolina Department of Health and Human Services (SCDHHS) to serve Medicaid and other government services to program members. Absolute Total Care has developed the expertise to work with Medicaid members to improve their health status and quality of life. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Absolute Total Care will accomplish this goal by partnering with primary care providers (PCPs) who manage the healthcare of Absolute Total Care members.

Absolute Total Care's goals are as follows:

- Ensure access to primary and preventive care services.
- Ensure care is delivered in the best setting to achieve an optimal outcome.
- Improve access to all necessary healthcare services.
- Encourage quality, continuity and appropriateness of medical care.
- Provide medical coverage in a cost-effective manner.

All our programs, policies and procedures are designed with these goals in mind. Absolute Total Care provides all medically necessary care required by the SCDHHS MCO Policy and Procedure Guide. We hope that you will assist Absolute Total Care in reaching these goals, and we look forward to your active participation.

The purpose of this Provider Manual is to assist Absolute Total Care providers in delivering medical care to Absolute Total Care members. This manual serves as a guide pertaining to Absolute Total Care's policies and procedures when rendering medical services to our members. This is a supplement to your agreement with Absolute Total Care and includes information on billing, quality, credentialing and compliance requirements set forth by any statutory, regulatory, contractual and/or accreditation entities. Any revisions to this manual that result in a policy change will be implemented 30 days after notice is provided by mail, fax, electronic mail, or provider post bulletins. Up-to-date information may be found by visiting our website at absolutetotalcare.com.

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Contact Information

How to Reach Us

Absolute Total Care
100 Center Point Circle
Suite 100
Columbia, SC 29210
Provider and Member Services: 1-866-433-6041

Vendor Contacts

Vendor	Contact Number	Service
Behavioral Health	1-866-433-6041	Behavioral health services
Evolent (formerly (NIA) National Imaging Associates (NIA) (www.radMD.com)	1-866-312-9729	Authorizations for: • Musculoskeletal (MSK) and Interventional Pain Management (IPM) Procedures • Complex imaging, MRA, MRI, PET, CT scans • Outpatient physical and occupational therapy
Evolent (formerly New Century Health)	1-866-312-9279	Authorizations for oncology-related chemotherapeutic drugs and supportive agents
Nurse Advice Line	1-866-433-6041	24-hour nurse advice line and disease management
Envolve Vision	1-866-433-6041	Routine vision services
PaySpan	1-877-331-7154	835 vendor for EFT/ERA transactions
Centene Pharmacy Services	1-800-460-8988	Prior Authorization inquiries, coverage determinations, peer to peer reviews
Acaria Health Specialty Pharmacy	1-800-511-5144	Specialty pharmacy

Availability

Availability is defined as the extent to which Absolute Total Care contracts with the appropriate type and number of practitioners and providers necessary to meet the needs of its members within defined geographical areas. Absolute Total Care has implemented several processes to monitor its network for sufficient numbers and types of practitioners who provide primary care, behavioral healthcare and specialty care.

PCP availability is measured annually by Absolute Total Care. Member data regarding satisfaction with physician availability is collected annually by the Member Services Department. Results are reported and reviewed by the Quality Improvement Committee (QIC). The QIC, or designated subcommittee, will analyze the data and make recommendations to address deficiencies in the number, distribution, or type of practitioners available to the membership.

Accessibility

Accessibility is defined as the extent to which a member can obtain available services as needed. Such services refer to both telephone access and ease of scheduling an appointment, if applicable. Absolute Total Care monitors access to services by performing access audits, tracking applicable results of the Healthcare Effectiveness Data and Information Set (HEDIS)/Consumer Assessment of Health Plans Survey (CAHPS®), analyzing member complaints regarding access and reviewing telephone access.

24-Hour Access

You are responsible to maintain sufficient facilities and personnel to provide covered physician services and ensure services are available as needed 24 hours a day, 365 days a year. An after-hours telephone number must be provided to all members. The after-hours number must connect the member to an answering service, a call center system, a recording that directs the caller to another number to reach you or your authorized medical practitioner, or a system that automatically transfers the call to another telephone line that is answered by a person who will contact you.

A hospital may be used for the 24-hour telephone coverage requirement if the 24-hour access is **not** answered by the emergency room (ER) staff. You will establish a communication and reporting systemwith the hospital and the PCP must review the results of all hospital-authorized services.

Absolute Total Care will monitor physicians' offices through scheduled and unscheduled visitsand call coverage verification.

Appointment Access Standards

The following schedule should be followed regarding appointment availability for primary care and specialists:

Primary Care Provider Appointment Type	Access Standard
Routine visits	Within four to six weeks
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service deliverysite
24-hour coverage	24 hours a day, seven days a week, or triage system approved by Absolute Total

	Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment

Specialty Care Provider Appointment Type	Access Standard
Routine visits	Within four and a maximum of twelve weeks for unique specialists
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon referral

Behavioral Healthcare Specialist Appointment Type	Access Standard
Initial visit for routine care	Within 10 business days
Follow-up routine care	Within 30 calendar days of initial care
Care for a non-life-threatening emergency	Within 6 hours or referred to the emergency room or behavioral health crisis unit
Urgent or non-emergency visits	Within 48 hours

Absolute Total Care will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement (QI) Program.

Referrals

A PCP referral is not required for a member to see an Absolute Total Care network specialist. However, Absolute Total Care recommends that members always check with their PCP before going to a see a specialist. PCPs should refer members to the appropriate specialist for care.

Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Absolute Total Care **does not** guarantee that any provider will receive a set number of members. If a PCP wants to make a change to their panel capacity, the PCP must contact Provider Services at 1-866-433-6041. A PCP shall not refuse to treat members as long as the physician has an open panel status with Absolute Total Care.

PCPs must notify Absolute Total Care at least 45 days in advance of an inability to accept additional Medicaid-covered individuals under Absolute Total Care agreements. Absolute Total Care prohibits allproviders from intentionally segregating members from fair treatment and any covered services provided to other non-

Medicaid members.

If a PCP wishes to open or close a panel, the request must be in writing, signed on the provider's letterhead and mailed to:

Absolute Total Care
ATTN: Provider Data Management
100 Center Point Circle, Suite 100
Columbia, SC 29210

Changing Primary Care Providers (PCPs)

Primary Care Provider (PCP) Transfers

In order to maintain continuity of care, Absolute Total Care encourages members to build collaborative relationships with their PCP. Members may request to change their PCP at any time by calling Member Services at 1-866-433-6041, by completing the PCP Change Request Form on our website at absolutetotalcare.com or in the Secure Member Portal. PCP change requests will generally be processed on the same business day or by the next business day.

Members will receive an updated ID card within 14 days.

Contract Termination

Refer to your Absolute Total Care contract for specific information about terminating from Absolute Total Care's network of providers. The request will be reviewed based on the termination section in your contract agreement. All requests for termination must be in writing and signed on the provider's letterhead and addressed to:

Absolute Total Care
ATTN: VP, Network Development/Contracting
100 Center Point Circle, Suite 100
Columbia, SC 29210

Advance Directives

Absolute Total Care is committed to a member's awareness of advance directives and their rights to execute them. Absolute Total Care is equally committed to ensuring that its PCPs and staff understandand comply with their member responsibilities under federal and state law regarding advance directives.

PCPs delivering care to Absolute Total Care members must ensure **adult** members, who are 18 years of age and older, receive information on advance directives and are informed of their right to execute an advance directive. PCPs **must** document such information in the permanent medical record.

Absolute Total Care recommends to its PCPs that:

- At the first point of contact with the member, the PCP's office should ask if the member has executed an advance directive and the member's response should be documented inthe medical record.
- For those members with an executed advance directive during the first point of contact,the PCP's office should request a copy of the advance directive and document the request and delivery in the member's medical record.
- An advance directive should be included as a part of the member's medical record,including mental health directives.

- If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician (if applicable). Discussion should be documented in the medical record.
- If an advance directive has not been executed, the first point of contact within the office should ask the member if they desire more information about advance directives.
- If the member requests further information, member advance directive education and information should be provided.

Member Services assist members with questions regarding advance directives; **however, no employee of Absolute Total Care may serve as witness to an advance directive or as a member's designated agent or representative.**

You may obtain a copy of an advance directive online at Advance Directives (caringinfo.org).

Absolute Total Care's QI Department will monitor compliance with this provision during a medical record review. If you have any questions regarding advance directives, contact Provider Services at 1-866-433-6041 or visit our website at absolutetotalcare.com.

Provider Assistance with Public Health Services

Absolute Total Care is required to coordinate with public health entities regarding the provision of public health services. Providers must assist Absolute Total Care in these effortsby:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in the notification or referral of any communicable disease outbreaks involving members to the local public health entity, as defined by state law.
- Referring to the local public health entity for tuberculosis contact investigation, evaluation and the preventive treatment of persons with whom the member has come into contact.
- Referring members to the local public health entity for STD/HIV contact investigation, evaluation and preventive treatment of persons whom the member has come into contact.
- Referring members for Women, Infant and Children (WIC) services and information sharingas appropriate.
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhoodlead exposure.
- Assisting in the collection and verification of race/ethnicity and primary language data.

Additional Reporting Requirements

Absolute Total Care, in accordance with its contract with SCDHHS, must report the existence of certain information regarding its membership. For example, if a member is involved in an accident or becomes injured, this information should be shared with Absolute Total Care. This includes any incidents that occur prior to a member's coverage with Absolute Total Care. To report this type of information, please call Member Services at 1-866-433-6041. Please be prepared to supply as many details as possible including the date and cause of the accident, the injuries sustained by the member and whether or not any legal proceedings have been initiated. In addition, you must immediately report the death of an Absolute Total Care member.

Cultural Competency Overview

Absolute Total Care is a quality-driven organization that adopts continuous quality improvement that includes culturally and linguistically sensitive services as a core business strategy for the entire health plan. Guided by the concept of *cultural humility* that acknowledges the complexity of identities and the evolving and dynamic nature

of an individual's experience and needs (e.g., social, cultural, linguistic). Absolute Total Care employs a system perspective that values differences and is responsive to diversity at all levels. Cultural humility is community focused, and family oriented, valuing the differences and integration of cultural attitudes, beliefs and practices. These core components are integrated into diagnostic and treatment methods throughout the health care system to support the delivery of culturally relevant and competent care.

The health plan develops and implements a quality management strategy and a Culturally and Linguistically Appropriate Services (CLAS) Program that is embedded within every staff role and department function. Absolute Total Care approaches quality assurance, quality management, and quality improvement as a culture, integral to all day-to-day operations to provide services that are accessible and responsive to all members. This manner accounts for diverse cultural and ethnic backgrounds, varied health beliefs and practices, limited English proficiency (LEP), disabilities, and differential abilities, regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or degree of health literacy.

The purpose of the CLAS Program is to ensure the integration of the National CLAS Standards within the organization's operational framework to ensure equitable, culturally, and linguistically appropriate programs for our diverse population and to advance health equity. The health plan identifies goals and objectives that are integrated, ensuring services are provided in an accessible and responsive manner to all members.

Absolute Total Care implements processes that ensure the health care services provided have the flexibility to meet the unique needs of each member, accounting for the diverse cultural and ethnic backgrounds, varied health beliefs and practices, limited English proficiency, disabilities, and differential abilities, regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or degree of health literacy. Population health management initiatives adhere to the National CLAS Standards and achieve success within the following priority domains:

- Governance, Leadership, and Workforce
- Communication and Language Assistance
- Practitioner Network Cultural Responsiveness
- Data and Infrastructure

Absolute Total Care, as part of the credentialing process, will evaluate the cultural competency level ofits PCPs and provide access to training and toolkits to assist PCPs in developing culturally competent and culturally proficient practices.

Network providers must ensure that:

- Members understand that they have access to medical interpreters, signers and teletypewriter(TTY) services to facilitate communication without cost to the member.
- Care is provided with consideration of the members' race/ethnicity and language andits impact/influence on the members' health or illness.
- Office staff that routinely comes in contact with members have access to and participate in cultural competency training and development.
- Office staff responsible for data collection make reasonable attempts to collect race and language specific member information. Staff also must explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and/or their children.
- Treatment plans are developed, and clinical guidelines are followed with consideration of the members' race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender identity, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials in English, Spanish and all other prevalent non-English languages if required by SCDHHS.

Absolute Total Care is committed to helping providers develop a culturally competent and linguistically sensitive practice. For information on Absolute Total Care's Cultural Competency and Linguistically Appropriate Services (CCLAS) Program, please visit our website at absolutetotalcare.com. You can also request a hard copy by calling Provider Services at 1-866-433-6041.

Preparing Cultural Competency Development

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Absolute Total Care is committed to helping you reachthis goal. Take into consideration the following as you provide care to Absolute Total Care's membership:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patients' cultures and languages?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy and family definitions?
- Do you embrace differences as allies in your patients' healing process?

Medical Records

Absolute Total Care providers must keep accurate and complete medical records. Such records will enable you to render the highest quality healthcare service to members. They will also enable Absolute Total Care to review the quality and appropriateness of the services rendered. To ensure the member'sprivacy, medical records should be kept in a secure location. Absolute Total Care requires you to maintain all records for members for at least 10 years for adult patients and at least 13 years for minors. See the Member Rights section of this manual for policies on member access to medical records.

Required Information

Medical records mean the complete, comprehensive member records including, but not limited to X-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary and emergency care, prepared in accordance with all applicable SCDHHS rules and regulations and signed by the medical professional rendering the services.

All medical records, at a minimum, must contain the following items:

- Patient name, identification number, age, date of birth, sex, places of residence and employment and responsible party (member, parent, or guardian).
- Services provided through the MCO, date of service, service site and name of service provider.
- Medical history, diagnoses, prescribed treatment and/or therapy and drug(s) administered or dispensed.
- The medical record shall commence on the date of the first patient examination made through,or by the MCO.
- Referrals and results of specialist referrals.
- Documentation of emergency and/or after-hours encounters and follow up.
- Signed and dated consent forms.
- For pediatric records (under 19 years of age) record of immunization status.
- Documentation of advance directives (for pediatric records, if completed) and executed advance directive maintained in medical record.

Each visit must include the following items:

- Date
- Purpose of visit

- Diagnosis or medical impression
- Objective finding
- Assessment of patient's findings
- Plan of treatment, diagnostic tests, therapies and other prescribed regimens
- Medications prescribed
- Health education provided
- Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials
- Medication allergies
- Legible and organized documentation

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the member or member's legal guardian or representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

Written authorization is required for the transmission of the medical record information of a current or former Absolute Total Care member to any provider rendering services to an Absolute Total Care member.

Medical Records Transfer for New Members

You are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Absolute Total Care members. If the member or member's legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Medical Records Audits

Medical records may be audited at the request of Absolute Total Care to determine compliance with Absolute Total Care's standards for documentation. Medical records may also be audited to validate coordination of care and services provided to members, including over/under-utilization of specialists and to ensure providers are following National and State Coding Guidelines (i.e., National Correct Coding Initiatives [NCCI], Centers for Medicare & Medicaid Services [CMS], SCDHHS); as well as the outcome of such services may be assessed during a medical record audit.

Medical Necessity

Medically necessary services are those services utilized in the state Medicaid Program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations,the state plan and other state policy and procedures. These services are:

- Essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid Managed Care Member
- Are provided in the appropriate setting and at the appropriate level of care for the treatment of Member's medical condition
- Are provided in accordance with objective and evidence-based criteria and standards of medical practice

Services must be rendered in the most effective and conservative or substantially less costly setting available. Treatments and services rendered must also be clinically appropriate. Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage. In keeping with SCDHHS policies and procedures, Absolute Total Care shall not cover experimental, investigational, or cosmetic

procedures.

Absolute Total Care's Population Health and Clinical Operations/UM Department hours of operation are Monday through Friday (excluding holidays) from 8 a.m. to 6 p.m. For prior authorizations during business hours, the provider should contact:

Population Health and Clinical Operations/
UM Department
Telephone: 1- 866-433-6041
Fax: 1-866-912-3606

After hours and on holidays, please contact 1-866-433-6041 for urgent and emergent access to the UM Department for clinical determinations.

The Behavioral UM Department's hours of operation are Monday through Friday (excluding holidays) from 8 a.m. to 6 p.m. Behavioral UM staff can be reached by their toll-free number at 1-866-534-5976.

Behavioral Health Services
Telephone: 1-866-433-6041
Inpatient Fax: 1-866-535-6974
Outpatient Fax: 1-866-534-5976

Clinical Criteria Requirements

Information necessary for authorization may include but is not limited to:

- Member's name and ID number
- Physician's name and telephone number
- Facility name, if the request is for an inpatient, skilled nursing facility, long-term care facility admission, or outpatient services
- Reason for service, primary and secondary diagnoses, surgical procedures and surgery date
- Relevant clinical information, past/proposed treatment plan, surgical procedure and diagnostic procedures to support the appropriateness and level of service proposed
- Date of service, admission date, or proposed surgery date, if the request is for an inpatient admission
- Requested length of stay, if the request is for an inpatient admission
- Discharge plans, if the request is for an inpatient admission
- For obstetrical (OB) admissions, the date and method of delivery, estimated date of confinement and information related to the newborn or neonate
- Clinical reason for a delivery prior to 39 weeks gestation

If more information is required, the Population Health and Clinical Operations Team (medical director, registered nurse, or licensed practical nurse) will notify the requestor of the specific information needed to complete the authorization process.

Absolute Total Care affirms that UM decision-making is based only on appropriateness of care and service and the existence of coverage. Absolute Total Care does not specifically reward practitioners or other individuals for issuing denials of coverage or care.

Consistent with 3(i) and 422.208, delegated providers must ensure that compensation to individuals or entities

that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Failure to obtain a required prior authorization may result in payment denials.

Utilization Management (UM) Criteria

Absolute Total Care has adopted utilization review criteria developed by InterQual® Products.Specialists representing a national panel from community-based and academic practices develop InterQual® appropriateness criteria. InterQual criteria cover medical and surgical admissions, outpatient procedures and ancillary services. Additional criteria are established, periodically evaluated and updated with appropriate involvement from physician and other clinical members of the Clinical Policy Committee. InterQual® and other clinical criteria is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, considering special circumstances of each case that may require deviation from the norm stated in the screening criteria. **Criteria are used for the approval of medical necessity. When the requested service does not meet medical necessity benefit provisions, protocols or evidence-based medicine, the medical director will review and use this information in his or her determination and/or in the rendering of a denial decision. The member, member's representative, or provider may obtain a copy of the actual benefit provision, guideline, protocol, or other criterion on which the denial decision was based upon request to the UM Department at 1-866-433-6041.**

Practitioners also have the opportunity to discuss any medical UM denial decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. Absolute Total Care's Medical Director may be contacted by calling Absolute Total Care's main toll-free telephone number and asking for the medical director. Absolute Total Care delegates reviews to approved delegates, vendors, Medical Director Specialists, or other appropriate entity. Please refer to and pay careful attention to all communications and written correspondence such as RFI (requests for information) or denial notices for contact information and instructions to discuss the determination, schedule a peer-to-peer (P2P), submit requested or additional information. Failure to follow instructions may result in adverse actions such as delay, denial, misplaced, misrouted, or other similar effect. A Care Manager may also coordinate communication between the medical director and the requesting practitioner.

Members, a member's representative, or a healthcare professional with written member's consentmay request an appeal related to a medical necessity decision made during the authorization, pre- certification, or concurrent review process orally or in writing to:

Absolute Total Care
ATTN: Grievance and Appeals Department
100 Center Point Circle, Suite 100
Columbia, SC 29210
ATC-Appeals_Grievances@Centene.com
Telephone: 1-866-433-6041
Fax: 1-866-918-4457

Concurrent Review

Absolute Total Care's UM Department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning Departments and, when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's current status,

proposed care plan, discharge plans and any subsequent diagnostic testing or procedures. All requested clinical information (medical records) is required to be received by the date/time indicated from the concurrent review nurse. **Information not received will result in a denial due to Absolute Total Care's inability to determine medical necessity.**

Absolute Total Care's UM Department may contact the member's admitting physician's office or PCP's office prior to the discharge date established during the authorization process to check on the member's progress and to make certain the member receives medically necessary follow up services.

Observation Bed Guidelines

In the event that a member's clinical symptoms do not meet the criteria for an inpatient admission, but the treating physician believes that allowing the member to leave the hospital would likely put the member at serious risk, the member may be admitted to the facility for an observation period. Observation bed services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nurse or other staff. **Observation admissions do not require authorization unless the member stays beyond 48 hours.** These services are reasonable and necessary to:

- Evaluate an acutely ill member's condition.
- Determine the need for a possible inpatient hospital admission.
- Provide aggressive treatment for an acute condition.

An observation may last up to a maximum of 72 hours. In those instances that a member begins their hospitalization in an observation status and the member is changed to an inpatient admission, all incurred observation charges and services will be rolled into the acute reimbursement rate, or as designated by the contractual arrangement with Absolute Total Care and cannot be billed separately. It is the responsibility of the hospital to notify Absolute Total Care of the inpatient admission. Providers should not substitute outpatient observation servicesfor medically appropriate inpatient hospital admissions.

Discharge Planning

Discharge planning activities must be initiated upon admission. Absolute Total Care's Utilization Management and Population Health and Clinical Operations Department will coordinate the discharge planning efforts with the hospital's Utilization and Discharge Planning Departments and, when necessary, the member's attending physician/PCP to ensure that Absolute Total Care members receive appropriate post-hospital discharge care.

Prior Authorization

For the most up to date list of services that require authorization, visit our website at absolutetotalcare.com and use our online Pre-Auth Check Tool found at: https://www.absolutetotalcare.com/providers/preauth-check/medicaid-pre-auth.html. Criterion used in decision-making is available upon request to the provider, member, or member's authorized representative by contacting the UM Department.

The preferred and easiest method for submitting authorization requests is through the **Secure Web Portal** at www.absolutetotalcare.com. If a provider is already registered for the **Secure Web Portal** that registration will grant the provider access to submit request for Absolute Total Care, Wellcare Prime (Medicare-Medicaid Plan) and Ambetter from Absolute Total Care. If the provider is not already a registered user on the Secure Web Portal and needs assistance or training on submitting prior authorizations, the provider should contact Provider Relations.

Prior authorization is not a guarantee of payment. Payment of claims is subject to all of the terms and conditions of the member's benefit plan, including but not limited to, member eligibility, benefit coverage at

the time the services are provided and any pre-existing condition exclusions referenced in the member's benefit plan as well as provider contracts,correct coding and billing practices.

Inpatient Prior Authorization

- All pre-service, non-emergent, non-urgent elective, or scheduled inpatient admissions (except for normal newborn deliveries) require the physician's office to call within **10 calendar days** prior to the proposed admission date ***and the hospital to notify Absolute Total Care within one business day following the actual date of admission.***
  - Previously approved authorizations for scheduled procedures and services are separate and applicable only to the specific procedure(s) and service(s) indicated by the CPT or HCPCS code(s) authorized, and ***not*** for the actual inpatient hospital admission. Notification of inpatient admission (NOA) and authorization processes are still the responsibility of the provider/facility and submitted within 1 day after member is admitted. A separate authorization and determination for the admission will be communicated under a different authorization for the admission usually with an authorization number beginning with "IP". The provider and/or facility will receive written notification with the status and authorization per standard inpatient authorization protocols.
    **Note that inpatient authorization and notification still not required for PAR providers if member is admitted for observation level of care (LOC) of less than 48 hours.*
  - This requirement includes admission to any level of acute or sub-acute care, skilled nursing facilities, rehabilitation admissions, transplant services including pre- and post-transplant services and all other inpatient facility type admissions. This requirement also includes different levels of care within, in, or between facilities (i.e., transfer from acute to rehab or transfer to a different facility).
  - LTC facility at the skilled or intermediate levels of care (benefit restriction of first 90 days only).
- For all emergent or urgent inpatient admissions: the hospital must notify the UM Department within **one business day** following the date of admission. Clinical admission information must be provided.
- Newborn deliveries must be called in by the next business day after delivery.
- For observation stays that exceed **48 hours**, the hospital must notify the UM Department and clinical information must be provided.

Services, excluding emergency and urgent care, always require prior authorization at any non-participating, out-of-network, or out-of-state facility, vendor, or provider.

Non-Inpatient Prior Authorizations

This is not an all-inclusive list. For a complete listing of non-inpatient services requiring prior authorization, please visit our website at absolutetotalcare.com.

Standard Service Authorization: Standard prior authorization requests should be submitted for medical necessity review at least **10 calendar days** before the scheduled service delivery date or as soon as the need for service is identified. Prior authorization decisions for non-urgent services shall be made within **14 calendar days** of receipt of the request for services. An extension may be granted for an additional **14 calendar days** if the member, the member's authorized representative, or the provider requests an extension or if Absolute Total Care can justify a need for additional information and the extension is in the member's best interest.

Expedited Service Authorization: In the event the provider indicates, or Absolute Total Care determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain,

maintain, or regain maximum function, Absolute Total Care will make an expedited authorization determination and provide notice within **72 hours** of receiving the request. Allsuch requests must be indicated as **urgent** when submitting to Absolute Total Care. An extension may be made up to **14 calendar days** if the member, the member's authorized representative, or the provider requests an extension or Absolute Total Care justifies a need for additional information and the extension is in the member's best interest.

Abortions: Abortions are covered according to applicable federal and state laws and regulations.

Therapeutic Abortions: Abortions and services associated with the abortion procedure shall be covered only when the physician has found, and certified in writing, that on the basis of his or her professional judgment, the pregnancy is a result of rape or incest or the member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the member in danger of death unless an abortion is performed and must be documented in the medical record by the attending physician stating why the abortion is necessary. Abortions must be documented with a completed Abortion Statement Form, which can be found on SCDHHS's website, to satisfy federal and state regulations.

Abortions which are reported with diagnosis and procedure codes for therapeutic abortions must be accompanied by complete medical records which substantiate life endangerment to the mother or that the pregnancy is the result of rape or incest **and** with the signed Abortion Statement Form. The patient's certification statement is only required in cases of rape or incest.

Required forms must be properly completed as described in the instructions and contain the name and address of the patient, the reason for the abortion and the physician's signature and date. The original forms must be maintained in the Medicaid MCO member's medical file and a copy must be submitted to Absolute Total Care for retention in the event of audit.

The following diagnosis codes are to be used in reporting therapeutic abortions:

- Diagnosis codes to be used only to report therapeutic abortions are O04.5; O04.6; O04.7; O04.80; O04.81; O04.82; O04.83; O04.84; O04.85; O04.86; O04.87; O04.88; O04.89; Z33.2.

Non-Elective Abortions: All non-elective abortions, including spontaneous, missed, incomplete, septic and hydatidiform mole abortions, require only that the medical record verify such a diagnosis. Legible medical records should be included with all non-elective abortion claims and should include admission history and physical, discharge summary, pathology report, operative report and physician progress notes unless otherwise noted below.

The following diagnosis codes are to be used in reporting non-elective abortions:

- The appropriate other diagnosis codes (e.g., O01.0; O01.1; O01.9 O02.0; O02.1; O02.81; O02.89;O02.9; O03.0; O03.1; O03.2; O03.30; O03.31; O03.32; O03.33; O03.34; O03.35; O03.36; O03.37;O03.38; O03.39; O03.4; O03.5; O03.6; O03.7; O03.80; O03.81; O03.82; O03.83; O03.84; O03.85;O03.86; O03.87; O03.88; O03.89; O03.9) should be reported for non-elective abortions. The following diagnosis codes do not require documentation: O01.0; O01.1; O01.9 O02.0; O02.1; O02.81; O02.89; O02.9; O36.4XX0, O36.4XX1, O36.4XX2, O36.4XX3, O36.4XX4, O36.4XX5, O36.4XX9, O42.00, O42.019, O42.90, O42.919, O42.011, O42.012, O42.013, O42.02, O42.911, O42.912, O42.913, O42.92, O42.10, O42.111, O42.112, O42.113, O42.119, O42.12.

Hysterectomies: Medically necessary hysterectomies must meet the following requirements:

- The member or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.

- The member or her representative, if any, must sign and date an acknowledgment of receipt of Consent for Sterilization Form (Form HHS-687) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.
- The Consent for Sterilization Form (Form HHS-687) is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.
- The acknowledgment form is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required.
- The hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.
- The hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.
- All prior approval requests for hysterectomies must be submitted with the Consent for Sterilization Form (Form HHS-687) for review. There is a 30-day wait period from the date the Consent for Sterilization Form (Form HHS-687) is signed before the surgery is performed. For urgent and emergent hysterectomy cases the 30-day wait is not required, however the reasonfor the emergency must be provided by the provider.

Sterilizations: Non-therapeutic sterilization must be documented with a completed Consent for Sterilization Form (Form HHS-687), which will satisfy federal and state regulations. Sterilization requirements include the following:

- Sterilization shall mean any medical procedure, treatment, or operation done for the purpose of rendering an individual permanently incapable of reproducing.
- The individual to be sterilized shall give informed consent not less than 30 calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. A new Consent for Sterilization Form (Form HHS-687) is required if 180 calendar days have passed before the surgery is provided.
- The completed Consent for Sterilization Form (Form HHS-687) cannot be obtained while the patient is in the hospital for labor, childbirth, abortion, or under the influence of alcohol or other substances that affects the patient's state of awareness.
- The individual to be sterilized is at least 21 years old at the time consent is obtained.
- The individual to be sterilized is mentally competent.
- The individual to be sterilized is not institutionalized (i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined ina mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed).
- The individual has voluntarily given informed consent on the approved Consent for Sterilization Form (Form HHS-687).

Transplant-Related Services: Providers should contact Absolute Total Care Central Transplant Unit (CTU) at 1-866-753-5659 for assistance with all transplant cases. All other prior authorization, pharmacy, and inpatient admission notification and authorization guidelines remain. Absolute Total Care is responsible for reimbursement of all approved and medically necessary transplant services, including the transplant event, for dates of service on and after February 1, 2024. For service dates prior to this date, all transplant services except for corneal transplants and post-transplant services are reimbursed through South Carolina Medicaid fee-for-service (FFS).

- Transplant services will not be reimbursed unless coordinated by an Absolute Total Care's Care Manager;
- Transplant care coordination ensures members receive all medically necessary services before and after the transplant, including necessary pharmacy services; and

- Coordinated Care Managers also help to address potential barriers and to ensure that all state guidelines and protocols, including in-state and out-of-state evaluations, transportation, and other services are followed to prevent disruptions in needed care and services for these vulnerable and high-risk members.

Developmental Evaluation Services: Developmental Evaluation Services are defined as medically necessary comprehensive neuro-developmental and psychological developmental, evaluation and treatment services for members between the ages of 0 through the month of their 21st birthday. These members have or are suspected of having a developmental delay, behavioral or learning disability, or other disabling condition. These services are for facilitating correction or amelioration of physical, emotional and/or mental illnesses and other conditions, which if left untreated, would negatively impact the health and quality of life of the member. No referral is necessary.

Utilization Management
Telephone: 1-866-433-6041
Fax: 1-866-918-4451

Notification of Pregnancy

Submit a completed Notification of Pregnancy Form for expectant mothers after their first prenatal visit to notify Absolute Total Care of the pregnancy, the estimated date of confinement and delivery facility. The form will enroll members into our Start Smart for Your Baby® Program (StartSmart). The earliest possible completion of the Notification of Pregnancy Form allows Absolute Total Care to best use our services to keep expectant mothers engaged with their pregnancy, as well as to achieve a healthy pregnancy outcome. The Notification of Pregnancy Form can be found at absolutetotalcare.com under Provider Resources. **Fax the completed Notification of Pregnancy Formto 1-866-653-6961**.

Second Opinion

Members, a member's representative, or a healthcare professional with member's consent may request and receive a second opinion from a qualified professional within Absolute Total Care's network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Services rendered by out-of-network providers may require a prior authorization. For an updated list ofthose services, visit our website at absolutetotalcare.com and review the online Pre-Auth Check Tool.

Assistant Surgeon

Reimbursement is provided to assistant surgeons when medically necessary. Absolute Total Care utilizes guidelines for assistant surgeons as set forth by the American College of Surgeons.

Hospital medical staff by-laws that require an assistant surgeon to be present for a designated procedure is not grounds for reimbursement. Medical staff by-laws alone do not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests an assistant surgeonbe present for the surgery. Coverage and subsequent reimbursement for an assistant surgeon's service is based on the medical necessity of the procedure itself and the assistant surgeon's presenceat the time of the procedure.

Continuity of Care

In some instances, Absolute Total Care will authorize payment for a provider other than Absolute Total Care's PCP to coordinate the member's care. The services initiated prior to the member's enrollment with Absolute Total Care must have been covered under Fee-For-Service or approved by the prior MCO. These services shall be continued until the PCP evaluates the member and a new plan of care is established. Authorization is typically for a period of no longer than 90 days or until a participating provider with equivalent expertise can be

identified.

If a network provider cannot provide the same or clinically equivalent services without disrupting care to the member, Absolute Total Care will approve the services without regard of network status until one or more of the following occurs:

- the service(s) are no longer medically necessary, or;
- service(s) can be initiated and continued by a network provider without disrupting care to the member, or;
- clinically equivalent service(s) can be provided and obtained by a network provider without disrupting care to the member.

Absolute Total Care may request evidence of previously approved and covered services such as paid claims history, authorization approval notices, and/or documented administration record in the member's clinical file. Requests for services of new members should indicate continuity of care guidelines in the request and include notification letter from Medicaid FFS or other MCO showing approval.

Care Management Services

Medical and behavioral care management is a collaborative process which assesses, plans, implements, coordinates,monitors and evaluates the options and services to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes. Care coordination/management is a member-centered, goal-oriented, culturally relevant and logically managed process to help ensure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Absolute Total Care's Care Managers support the physician by tracking adherence with the care management plan, and facilitating communication between the member, the member's managing physician the Care Manager. The Care Manager also facilitates referrals and linkages to community-based organizations (CBO), such as food banks, local health departments and school-based clinics. The managing physician maintains responsibility for the patient's ongoing care needs. The Care Manager contacts the managing physician to assist with coordination of care and to ensure adherence to the person-centered plan of care.

Absolute Total Care provides individual care management services for members who have high-risk, high-cost, complex, or catastrophic conditions. The Care Manager collaborates with all providers involved to coordinate care and provide referral assistance and other care coordination as required. The Care Manager may also assist with a member's transition to other care, as indicated, when Absolute Total Care benefits end and/or provider ends contract.

Care Management Process

Absolute Total Care's care management for high-risk, complex, or catastrophic conditions contains the following key elements:

- Screen and identify members who potentially meet the criteria for high-risk care management
- Assess the member's risk factors to determine the need for care management
- Obtain acceptance from the member to participate in care management
- Notify the member's PCP of the member's enrollment in Absolute Total Care's Care Management Program
- Develop and implement a person-centered individualized care plan that accommodates the specific cultural and linguistic needs of the member
- Establishment of treatment objectives and monitoring of outcomes
- Refer and assist the member in ensuring timely access to providers

- Coordinate medical, residential, social and other support services
- Monitor care/services
- Close gaps in care
- Revise the Individual plan of care as necessary
- Track plan outcomes
- Follow-up post discharge from care management

Lead Case Management

Absolute Total Care will review eligible children with blood lead levels (BLL) $\geq$ 5 ug/dL for care management eligibility. Services may include family education about lead poisoning, referral in obtaining lead abatement, coordination of testing of siblings of those children identified with high blood lead levels, scheduling of appointments and transportation when needed.

Chronic and Complex Conditions

Absolute Total Care provides individual care management services for members who have chronic, complex, high-risk, high-cost, or other catastrophic conditions. Members with special healthcare needs are included in the Chronic and Complex Care Management Care Coordination Program. A Care Manager will work with all providers involved to coordinate care and provide referral assistance and other support as required. Absolute Total Care also uses disease management programs and associated practice guidelines and protocols for members with chronic conditions, including conditions such as asthma and diabetes.

Members who qualify for chronic or complex care management services have an ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. These limitations are expected to last at least 12 months with a resulting functional limitation, reliance on compensatory mechanisms, such as medication, special diet, or assistive device and require service use or need beyond that which is normally considered routine.

The Care Manager coordinates care needs, assists in identifying and obtaining supportive community resources and arranges for long-term referral services as needed. The Care Manager may identify (and a member may request) a specialist with whom a member with a chronic condition has an ongoing relationship, who may serve as the PCP and coordinate services on the member's behalf.

Members determined to need a course of treatment or regular care monitoring may have direct access to a specialist as appropriate for the member's condition and identified needs, such as througha standing referral or an approved number of visits. A member's PCP will develop a treatment plan with the member's participation and in consultation with any specialists caring for the member.
Absolute Total Care's Medical Director oversees these processes in accordance with state standards.

Absolute Total Care encourages all PCPs and physicians to call Member Services to refer a member to care management when a member is identified that meets the criteria for a chronic or complex condition.

Foster Care

We have programs in place if you are caring for a child in foster care. Our program aims to identify health conditions that require prompt medical attention, assist with care coordination, including: acute illness, chronic conditions, therapy, nutritional and dental programs, and identifying signs of abuse or neglect. We communicate with foster parents and case workers to ensure children and their caregivers have access to the best in network providers for care. We assign a care manager/care coordinator to assist foster parents navigate care.

Absolute Total Care encourages all PCPs and physicians to call Member Services to refer a member to care management when a member is identified that meets the criteria for a chronic or complex condition.

Member Services Department
Telephone: 1-866-433-6041
Fax: 1-866-912-3610

Chronic Condition/Lifestyle Health Coaching Programs

As a part of Absolute Total Care's population health quality improvement efforts, health coaching programs are offered to members. Components of the programs available include, but are not limited to:

- Increasing coordination between the medical, social and educational communities
- Assuring that referrals are made to proper providers, including dental providers
- Improving levels of screening at birth and more consistent referrals to and from Early Intervention Programs
- Ensuring active and coordinated physician/specialist participation
- Identifying modes of delivery for coordinated care services, such as home visits, clinic visits and telephone contacts depending on the circumstances and needs of the memberand his or her family
- Increasing the ability of the member and member's caregiver to self-manage chronic conditions

Asthma Program

The Asthma Disease Management Program targets Absolute Total Care members with asthma who are over-using rescue medications, having repeated visits to the ER, or being admitted to the hospital with a primary diagnosis of asthma. A Care Manager will contact members/caregivers and provide additional education. The Care Manager coordinates care with the member's PCP. The goals of this program include increasing positive clinical outcomes for the member and controlling the asthma in order to improve the quality of life for the member.

Absolute Total Care's Asthma Disease Management Program utilizes evidence-based guidelines sponsored by the National Asthma Education and Prevention Program, education, care assessment, in-home visits for high-risk members unable to be reached by telephone, initial telephone visits, physician communication and follow-up visits as indicated by the member's ability to self-manage and remain compliant with the plan of care.

Diabetes Program

Absolute Total Care's Diabetes Program targets members who have been diagnosed and treated for diabetes mellitus. Members are stratified based on the severity of their illness so that interventions can be targeted to the appropriate population. Through this program, Absolute Total Care members can receive additional education, care management and support from the Population Health and Clinical Operations Department to enhance positive clinical outcomes.

Emergency Room (ER) Diversion Program

The Population Health and Clinical Operations Department identifies members who misuse or utilize ER services inappropriately. The target population for this program is those individuals who use the ER for treatment of non-emergent medical conditions rather than their PCP or urgent care. The goals and objectives of the ER Diversion Program are to:

- Empower members towards achievement of optimum health, functional capability and quality of life through improved management and understanding of their disease or condition
- Assist members in accessing available and appropriate benefits and resources

- Work collaboratively with members, family, significant others, providers and community organizations to develop goals and assist/empower members in achievingthose goals
- Assist members by facilitating timely coordination of appropriate services in the most appropriate settings
- Maximize benefits and resources through oversight and cost-effective UM
- Decrease medically unnecessary admissions and/or readmissions for the same or similar diagnosis
- Decrease non-emergent ER usage
- Increase PCP usage

Perinatal/High-Risk Obstetrical

Pregnancy, labor and delivery account for a large portion of care provided to Absolute Total Care members. Those at high-risk for complications of pregnancy and poor neonatal outcomes are provided care coordination services through our Start Smart for Baby Program. The goals of the program are to screen all pregnant members, identify and coordinate care for pregnant members (who are at high-risk for complications of pregnancy) and assure that all members have access to appropriate care for diagnosis, monitoring and treatment of pregnancy. For any high-risk ancillary service. Ancillary services include, but are not limited to, home pregnancy monitoring, home infusion therapy, education or testing and the provision of durable medical equipment (DME). For service authorization call 1-866-433-6041 or fax 1-866-912-3606.

Absolute Total Care will provide educational opportunities to inform our members about the benefits and risks associated with behaviors that may affect the outcome of their pregnancy and facilitate transitions to home when outcomes are less than ideal. We will provide educational opportunity andsupport for pregnant women and their partners about appropriate care of newborns as well as identifying pediatric providers and access to care for their newborn.

When an event occurs resulting in an early delivery and resultant admission to a Neonatal Intensive Care Unit, our Care Managers will work with the hospital neonatal providers, discharge planners and managing pediatric provider to ensure a smooth transition to home and coordination of ongoing follow- up care as needed.

Other chronic condition and care management programs are developed based on SCDHHS contract or as determined through Absolute Total Care's analysis of the membership in conjunction with the Quality Management Committee.

Providers are asked to contact Member Services to refer a member identified in need of care coordination or case management intervention:

Member Services Department
Telephone: 1-866-433-6041
Fax: 1-866-918-4451

Preventive and Clinical Practice Guidelines and Protocols Including Chronic Care

Absolute Total Care Preventive and Clinical Practice Guidelines are based on the health needs and opportunities for improvement identified as part of the Quality Program. Whenever possible, Absolute Total Care adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions. These guidelines have been reviewed by our QIC, which includes representation from Absolute Total Care network physicians. We encourage providers to use these guidelines as a basis for

developing a personalized treatment plan for our members and to aid members in making decisions about their healthcare. Absolute Total Care may measure compliance with these guidelines through monitoring of related HEDIS measures and/or through random ambulatory medical record audits.

Absolute Total Care UM, member education, coverage of services and other areas in which the guidelines apply are consistent with these guidelines. These guidelines are used for both preventive services as well as for the management of chronic diseases.

Preventive and Chronic Disease Guidelines include, but are not limited to:

Preventive Guidelines

- Adult Immunization Schedule by Age: Recommendations for Adults 19 Years or Older
- Adult Preventive Health Guidelines:
    - The Adult Well-Male Examination
    - Well-Woman Preventive Visits
- Childhood Lead Poisoning Prevention: Guidelines and Recommendations
- Recommendations for Preventive Pediatric Health Care: Lead
- Children and Adolescent Immunization Schedule by Age: Recommendations for Ages 18 years or Younger
- Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who are More Than 1 Month Behind
- Prevention and Control of Seasonal Influenza with Vaccines
- Recommendations for Preventive Pediatric Health Care
- Early and Periodic Screening, Diagnostic and Treatment (Medicaid)

Quick Reference Guidelines Summaries

- Standards of Medical Care in Diabetes
- Guidelines for Perinatal Care
- Optimizing Postpartum Care
- Sickle Cell Disease
- Guidance on Blood Pressure Management in Low-Risk Adults with State 1 Hypertension

Full Clinical Practice Guidelines

- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Practice Guideline for the Treatment of Patients with Bipolar Disorder
- Standards of Medical Care in Diabetes: Summary of Revisions
- APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts
- Evidence-Based Management of Sickle Cell Disease
- 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Bipolar Disorder
- Practice Guideline for the Treatment of Patients with Substance Use Disorders
- 2020 Focused Updates to the Asthma Management Guidelines
- 2020 Focused Updates to the Asthma Management Guidelines At-A-Glance
- Hypertension: Clinical Guidance and Practice

Guidelines are reviewed and updated annually or upon significant change. Current preventive and clinical practice guidelines are available on our provider website and may be mailed to practitioners as part of disease management or other QI Program initiatives. The guidelines can be found at absolutetatelcare.com under the

Quality Improvement Program section, or you may request a hard copy by calling Provider Services at 1-866-433-6041.

New Technology

Absolute Total Care evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical and behavioral healthcare procedures, drugs and/or devices. The medical director and/or Population Health and Clinical Operations Department may identify relevant topics for review pertinent to Absolute Total Care's population. The Clinical Policy Committee reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

When a request is made for coverage with a new technology, which has not been reviewed by the Clinical Policy Committee, Absolute Total Care's Medical Director will review all information and make aone-time determination within two business days of receipt of all information. This new technology request will then be reviewed at the next regular meeting of the Clinical Policy Committee. If you need a new technology benefit determination or have an individual case review for new technology, please contact the Provider Services at 1-866-433-6041. SCDHHS will be notified in writing **30 days** following any material change to the Population Health and Clinical Operations Program.

Screening Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is an evidenced based, integrated and comprehensive approach to the identification, intervention and treatment of substance (drug and alcohol) usage, domestic violence, depression andtobacco use in pregnant women to include 12 months postpartum. This initiative is a collaboration between SCDHHS, Absolute Total Care (and all South Carolina Medicaid managed care plans) and stateagencies to include the South Carolina Department of Health and Environmental Control (SCDHEC) andthe Department of Alcohol and Other Drug Abuse Substances (DAODAS).

Screening

Screening is the process of identifying substance use, behavioral health issues and domestic violence in the members using the Universal Screening Tool. The Healthcare Common Procedure Coding System (HCPCS) code for the screening is H0002 and may be billed once during a fiscal year (July 1st toJune 30th). All positive screening should be billed using H0002 with an HD modifier. Physicians and their clinical/social work staff are allowed to perform the Screening but may only be billed under the physician. **Non-clinical staff** are not permitted to perform the screening.

Brief Intervention

Brief intervention is a five-to-10-minute session to raise awareness with the member of the risksassociated with behaviors. The brief intervention should motivate the member to engage in choices that support a healthy pregnancy. The HCPCS code for Brief Intervention is H0004 and may be billed twice per year (July 1st through June 30th). All brief interventions that result in referral to treatment should be billed using H0004 with an HD modifier. Physicians and their clinical/social work staff are allowed to perform the brief intervention but may only be billed under the physician.

Referral to Treatment
Referral to treatment identifies the risk and the member accepts a referral to an outside agency for assistance to change their behavior.

Procedure	Code
Screening	H0002
Positive Screen	H0002 HD modifier
Brief Intervention	H0004
Brief Intervention Resulting in a Referral	H0004 HD modifier

For more information and details on SBIRT, visit absolutetotalcare.com.

Routine, Urgent and Emergency Care Services Defined

Members are encouraged to contact their PCP prior to seeking care, although it is not required in an emergency.

The following are definitions for **routine**, **urgent** and **emergency services**.

Routine Services
Services to treat a condition that would have no adverse effects if not treated within four to six weeks or could be treated in a less acute setting (e.g., physician's office) or by the patient. Examples include treatment of a cold, flu, or mild sprain.

Urgent* Services
Services furnished to treat a medical condition that requires attention within 48 hours. If the condition is left untreated for 48 hours or more, it could develop into an emergency condition.

Emergency* Medical Condition
An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess and average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, impairment to bodily functions or dysfunction of any bodily organ or part.

An emergency service area covers inpatient and outpatient services that are as follows:

- Furnished by a qualified individual provider or entity that is engaged in the delivery of services,or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services; and
- Needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

*Emergency care is not subject to prior authorization or pre-certification. Urgent care provided in an urgent care facility **does not** require prior authorization. A qualified provider, regardless of network participation, must provide emergency services. The PCP plays a major role in educating Absolute TotalCare members about appropriate and inappropriate use of hospital emergency rooms. The PCP is responsible to follow up on members who receive emergency care from other providers.

In emergency medical conditions the facility should use its best efforts to contact the PCP, or in the case of a pregnant woman, the member's OB. The facility should document all attempts to contact the PCP or the obstetrician and determinations made on appropriate care. At no time should emergency services be withheld or delayed.

For billing information please refer to the General Billing Guidelines section of this Provider Manual.

The attending ER physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

Absolute Total Care will not retroactively deny a physician claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature; however, the prudent layperson test will be applied to the payment to the facility for charges. If a member is referred to the ER by an authorized representative acting on behalf of Absolute Total Care, such as the PCP, specialist,or nurse advice line, the emergency services will be covered.

The facility should verify member eligibility as soon as possible after the member presents to the ER.

Post-stabilization Care Services
Absolute Total Care covers and pays for post-stabilization care and services in accordance with the provisions of 42 CFR § 422.113(c), state and federal guidelines. Post-stabilization care and services are covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition or to improve or resolve the member's condition.

Absolute Total Care covers:

- Post-stabilization care services obtained within or outside the Plan that are pre-approved by a Plan provider or other Plan representative.
- Post-stabilization care services obtained within or outside the Plan that are not pre-approved by a Plan provider or other Plan representative, but administered to maintain, improve, or resolve the member's stabilized condition within one hour of a request to Absolute Total Care for pre-approval of further post-stabilization care services.
- Post-stabilization care services obtained within or outside the Plan that are not pre-approved by a Plan provider or other Plan representative, but administered to maintain, improve, or resolve the member's stabilized condition if Absolute Total Care:
    - Receives a valid request and/or notification of the need to authorize potentially urgent services but does not respond to a request for pre-approval within one (1) hour.
    - Cannot be contacted, and the treating provider can provide evidence of the failed attempts corroborating the narrative that reasonable effort was made, but unsuccessful, to contact the plan; or
    - Representative and the treating physician cannot reach an agreement concerning the member's care and a Plan physician is not available for consultation. The Plan must give the treating physician the opportunity to consult with a Plan physician and the treating physician may continue with care of the patient until a Plan physician is reached.
- Transfer of a member presenting for emergency care to another medical facility.

Absolute Total Care's coverage for post-stabilization care services that are not pre-approved ends when:

- A Plan physician with privileges at the treating hospital assumes responsibility of the member's care;
- A Plan physician assumes responsibility of the member's care through transfer;

- A Plan representative and the treating physician reach agreement concerning the member's care; or
- The member is discharged.

Absolute Total Care limits member cost sharing for post-stabilization out of network (OON) services to no more than cost sharing from a network provider. Once the member's emergency medical condition is stabilized, Absolute Total Care requires authorization for hospital admission or prior authorization for follow-up care.

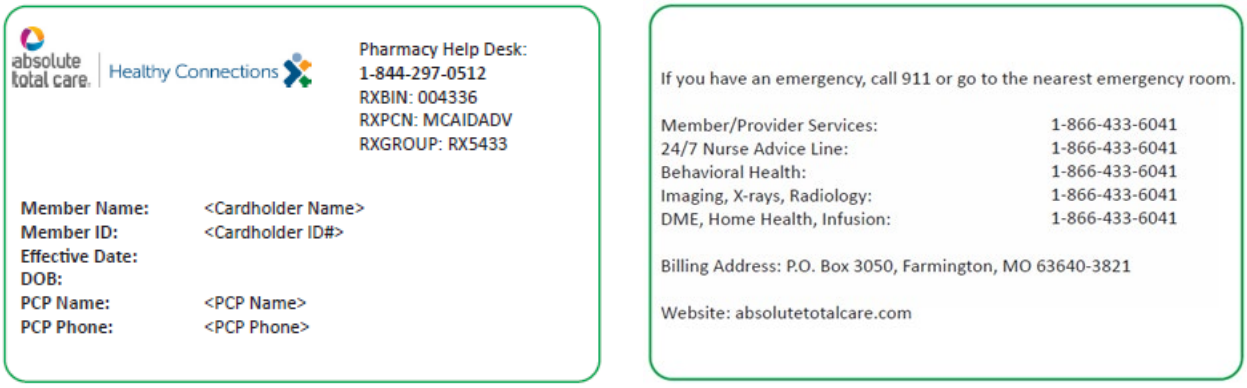
Eligibility

The state of South Carolina has the sole responsibility for determining eligibility for Medicaid for all coverage groups except for Supplemental Security Income (SSI). The Social Security Administration (SSA) determines eligibility for SSI.

Those eligible persons who are assigned to Absolute Total Care currently include individualsin the following categories:

- Temporary Assistance for Needy Families (TANF);
- Sixth Omnibus Budget Reconciliation Act (SOBRA) – Pregnant women and children,including presumptive eligibility; and
- Social Security Income (SSI) without Medicare.

Sample member ID card:



Verifying Eligibility

Providers are responsible for verifying eligibility every time a member schedules an appointment and when they arrive for services. PCPs should also verify that a member is their assigned member.

Eligibility can be verified through:

- Our **Secure Provider Portal**, where you can obtain member eligibility information.
- Our Interactive Voice Response (IVR) system at 1-866-433-6041.

The preferred and easiest method to verify eligibility and benefits is through the **Secure Web Portal** at www.absolutetotalcare.com. Using the **Secure Web Portal**, any registered provider can quickly check member eligibility, benefits, and much more. If the provider is not already a registered user on the Secure Web Portal and needs assistance or training on submitting prior authorizations, the provider should contact Provider Relations.

Providers may also call the SCDHHS IVR System at 1-866-912-3604 for quick eligibility verification or check online at www.scdhhs.gov (must have a provider login).

NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

Until the actual date of enrollment with Absolute Total Care, Absolute Total Care is not financially responsible for services the prospective member receives. In addition, Absolute Total Care is not financially responsible for services members receive after their coverage has been terminated. Absolute Total Care is responsible for those individuals who are Absolute Total Care members at the time of a hospital inpatient admission and change health plans during that confinement.

Newborn Enrollment

Newborns of Absolute Total Care members will be enrolled in Absolute Total Care for the first 90 calendar days from birth, unless otherwise specified by the mother prior to delivery. The newborn shall continue to be enrolled in Absolute Total Care unless the mother changes to another health planduring the second or third month of the newborn's life. If the mother changes to a new health plan, the newborn will be moved to the new plan with the mother unless the mother requests that the newborn stay on Absolute Total Care's plan.

Providers are encouraged to refer the mother to Absolute Total Care to select a PCP for their newborn.A newborn enrollment packet will be mailed to all Absolute Total Care expectant mothers. This packet includes information that the newborn will be auto assigned to Absolute Total Care and that the mother may select a PCP for her newborn prior to the birth by contacting Member Services. If the mother does not select a PCP after delivery, a PCP will automatically be assigned to the newborn.

To make a PCP selection for the newborn, members should be referred to:

Member Services Department
Telephone: 1-866-433-6041

All providers are also encouraged to direct the mother to her county caseworker to ensure the newborn is officially deemed eligible for the Medicaid Program.

Eligibility for newborns whose mothers are Absolute Total Care members on the date of delivery is effective on the date of birth.

Frequently, Absolute Total Care receives a claim(s) for a newborn prior to the state sending the member's eligibility information. It is imperative for providers to obtain a newborn's Medicaid ID number prior to billing for services. Without a member Medicaid ID number on the claim, the claim will be denied.

The above describes Absolute Total Care's general approach and is subject to modification inaccordance with SCDHHS policies.

End Stage Renal Disease (ESRD)

Absolute Total Care follows the policies and procedures for ESRD as outlined in the SCDHHS Physicians Services Provider Manual. Absolute Total Care will reimburse as the primary sponsor of ESRD services, during the initial 90-day waiting period required by Medicare for eligibility determination. When it has been determined that the member is ineligible for Medicare coverage, Absolute Total Care will continue to reimburse ESRD services as the primary sponsor.

Absolute Total Care will not reimburse as primary sponsor for any Medicare-covered services once a determination of Medicare eligibility is received from the Social Security Administration. This would include any services provided after the 90-day waiting period, even if the Medicare determination is pending.

The ESRD facility, as the primary provider, is responsible for ensuring a Medicare application is made on behalf of the beneficiary.

We encourage you to complete and submit the CMS Form 2728 within the first 30 days of the member's receipt of dialysis treatments. If a member is denied Medicare coverage, a copy of the Medicare denial letter must be faxed immediately to Absolute Total Care's ESRD Program Coordinator at 1-866-912-3606.

Enrollment/Marketing Guidelines

Absolute Total Care's contract with SCDHHS defines how Absolute Total Care and its providers market and advertise the program. Accordingly, providers may not include any reference to their affiliation with SCDHHS or Absolute Total Care in their marketing or advertising without prior approval from Absolute Total Care and SCDHHS. SCDHHS requires providers to submit to Absolute Total Care samples of any marketing materials containing the Absolute Total Care or Healthy Connections logos they intend to distribute and to obtain state approval prior to distribution or display. Absolute Total Care's Marketing and Communications Department and Compliance Department submit these materials to SCDHHS.

Please contact Absolute Total Care prior to beginning any communications or marketing initiatives.

Non-Adherent Members

Absolute Total Care does recognize that there may be instances when a PCP may need help in managing non-adherent members. If you should have an issue with a member regarding a member's behavior (member being disruptive, unruly, threatening, or uncooperative to the extent that the member seriously impairs the provider's ability to provide services to the member or to other members) and the member's behavior is not caused by a physical or behavioral condition, cooperation with treatment and/or completion of treatment, or making or presenting for appointments, please contact Provider Services at 1-866-433-6041.

A PCP may request a member be transferred to another practice for any of the following reasons:

- Repeated disregard of medical advice
- Repeated disregard of member responsibilities
- Personality conflicts between physician and/or staff with member

All requests to remove a member from a panel must be made in writing and contain detailed documentation. The request must be directed to:

Absolute Total Care
Operations Department
ATTN: Enrollment and Eligibility
100 Center Point Circle, Suite 100
Columbia, SC 29210

Upon receipt of such request, the Absolute Total Care may:

- Interview the provider or their staff who is requesting the disenrollment, as well as any additional relevant providers
- Interview the member
- Review any relevant medical records
- Involve other Absolute Total Care departments as appropriate to resolve the issue

A PCP should **never** request a member to be disenrolled for any of the following reasons:

- Adverse change in the member's health status or utilization of services which are medically necessary for the treatment of a member's condition
- On the basis of the member's handicap, race, color, national origin, sex, age, disability, political beliefs or religion
- Previous inability to pay medical bills or previous outstanding account balances prior tothe member's enrollment with Absolute Total Care

Covered Services

Ambulance Transportation (Emergency and Non-Emergency)

Absolute Total Care will pay for all transportation services provided via ambulance (provider code 82) for **all** member ambulance transports for Advanced Life Support (ALS) or Basic Life Support (BLS) – either emergency or non-emergency transports billable by an ambulance provider as medically necessary. These trips may be routine or non-routine transports to a Medicaid-covered service. Absolute Total Care will provide stretcher trips, as well as air ambulance or medivac transportation.

After-Hours Services (CPT 99050 and 99051)

99050: Services provided in the office at times other than regularly scheduled office hours or days when the office is normally closed (i.e., Sundays and holidays) and may be billed in addition to other services.

99051: Services provided in the office during regularly scheduled evening, weekend, or holiday office hours and may be billed in addition to other services.

The above codes may only be billed by PCPs (defined as pediatricians or family practice, general practice, internal medicine, or OB/GYN specialists).

Audiological Services

Absolute Total Care will pay for audiological services including diagnostic, screening, preventive and/or corrective services provided to individuals with hearing disorders or for the purpose of determining the existence of a hearing disorder by or under the direction of an audiologist. A physician or other Licensed Practitioner of the Healing Arts (LPHA), within the scope of his or her practice under state law, must refer individuals to receive these services. Audiological services involve testing and evaluation of hearing-impaired children ages 20 years and younger who may or may not be improved with medication or surgical treatment. This includes services related to hearing aid use. Limits: covered for ages 20 years and younger.

Targeted Case Management

This service is available to non-institutionalized individuals with Intellectual and Developmental Disability, emotionally disturbed children, certain pregnant women and other targeted groups with complex medical conditions. Members with medical conditions, such as ESRD, HIV/AIDS, metastaticcancers, progressive degenerative disorders, other catastrophic illness and injuries and transplant recipients that require pre- and post-transplant care coordination are evaluated for care management. Care management services are defined as those services necessary to coordinate an optimum lifestyle for the targeted population. The services include:

- Monitoring the patient's needs
- Working collaboratively with the affected member's PCP or other healthcare providersto coordinate medical needs
- Referring to providers for medical, educational, legal and rehabilitative services, with documented follow up
- Assessing for Social Determinants of Health and making referrals to CBOs

The Care Management Department will assist in self-sufficiency of the member and act as a deterrent to institutional care by facilitating service delivery. The Care Manager does not provide counseling services.

BabyNet Services

BabyNet services are for children from birth to age three (3) with developmental delays, or conditions associated with developmental delays, meeting SCDHHS BabyNet eligibility criteria. Contact Provider Services for more information, including eligibility requirements.

Chiropractic Services

Chiropractic services are available to all recipients. Chiropractic services are limited to manual manipulation of the spine to correct a subluxation. Chiropractic visits are counted separately from the ambulatory visit limit. Absolute Total Care's Chiropractic Network is Health Network Solutions (HNS). An HNS provider must render all chiropractic services. This service has a limit of six visits peryear (July 1 through June 30).

Circumcisions

A circumcision is covered during the initial newborn stay and up to 180 days after delivery in the office setting (Place of Service 11) without a prior authorization. Prior authorizations are required forall other locations and after 180 days of birth.

Communicable Disease Services

Absolute Total Care covers services to help control and prevent diseases including Tuberculosis (TB), Syphilis, Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) and other sexually transmitted diseases (STDs). Covered services include examinations, assessments, diagnostic procedures, health education and counseling, treatment, and contact tracing, provided according to the Centers for Disease Control and Prevention (CDC) standards. In addition, specialized outreach services such as Directly Observed Therapy (DOT) are covered for TB cases. Members have the freedom to receive testing and counseling services from any approved Medicaid enrolled provider or any public health agency without any restrictions.

Durable Medical Equipment (DME) and Orthotics and Prosthetics

DME provides therapeutic benefits or enables a recipient to perform certain tasks that the member would be unable to undertake otherwise due to certain medical conditions and/or illnesses. DME canwithstand repeated use and is primarily and customarily used for medical reasons and is appropriate and suitable for use in the home. **Included are medical supply products, surgical supplies, traction equipment, walkers, canes, crutches, kidney machines, ventilators, oxygen and other items when ordered by a physician as medically necessary in the treatment of a specific medical condition. The attending physician has the responsibility of determining the type or model of equipment and length of time the equipment is needed through a written necessity statement. Approval for Absolute Total Care coverage of products requiring prior authorization is patient-specific and is determined according to certain established criteria.** Luxury and deluxe models are restricted if standard models would be appropriate. Repairs to medical equipment are covered if reasonable.

Absolute Total Care follows SCDHHS DME rental guidelines. Prior authorization may be required forsome DME.

- Capped rental equipment cannot initially be purchased. A capped rental item is only considered

purchased when it has been rented for a maximum of 10 months. Some examplesof capped rental equipment include manual hospital beds with mattress side rails, respiratory assist devices, insulin pumps and standard manual wheelchairs.

- Most parenteral infusion pumps are capped rental items except nutrition infusion pumps with or without an alarm, stationary and portable parenteral nutrition infusion pumps, ambulatory infusion pumps and stationary parenteral infusion pumps. These items are not considered purchased after the tenth month of rental and can continue to be rented.
- Limited rental equipment has a limited rental period and cannot be rented over 10 months. Some examples of limited rental equipment include powered air overlay mattresses, powerpressure-reducing air mattresses and negative pressure wound therapy electrical pumps.
- Maintenance of rented equipment is not covered by Absolute Total Care. Parts and supplies
- used in the maintenance of rented equipment are included in the rental payment of the equipment.

Absolute Total Care also covers certain prosthetic and orthotic devices when ordered by a physician and determined to be medically necessary. Absolute Total Care only covers hearing aids and hearing aid accessories for members aged 20 years and younger with a prior authorization. For a complete listof covered codes that may be rendered by physician offices, visit absolutetotalcare.com and use the online Pre-Auth Check Tool.

Provider Type by Taxonomy	Service
DME, O&P, Home Health, Home Infusion	DME, O&P, Home Health, Home Infusion
Physician Office	DME and O&P

Covered services by provider type are determined by SCDHHS fee schedules. You will receive a notification of non-benefit if the Current Procedural Terminology (CPT) or HCPCS code you are billing is not listed on the fee schedule for your provider type. Please contact Absolute Total Care at1-866-433-6041 if you have any questions.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

This program provides free medical check-ups for all Medicaid-eligible members through the month oftheir 21st birthday and treatment for medical problems. It is designed to be a preventive program.

Family Planning Services

This program provides counseling, diagnosis, treatment and birth control drugs and supplies to help prevent unplanned and unintended pregnancy.

All family planning services should be provided on a voluntary and confidential basis to all members, including those that are less than 18 years of age.

Covered services prescribed and furnished by physicians, hospitals, clinics and pharmacies include:

- Examinations
- Assessments
- Diagnostic procedures
- Health education and counseling services related to alternative birth control and prevention;
- Traditional contraceptive drugs and supplies
- Preventive contraceptive methods

Members should be encouraged to receive family planning services through their PCP or by appropriate referral

to promote the integration of these services with their total plan of care. Members have the freedom to receive family planning services from any appropriate Medicaid provider without any restrictions.

Federally Qualified Health Center (FQHC)
Healthcare services furnished by FQHCs are cost-based reimbursed through encounter codes at an all-inclusive rate that reflects the cost of services.

Home Health Services
These services cannot be restricted to a requirement that the individual be homebound. The use of a homebound requirement under the Medicaid home health benefit violates federal regulatory requirements at 42 CFR Section 440.230(c) and Section 440.240(b). Home health services cannot otherwise be restricted to services furnished in the home itself. A Medicaid Home Health beneficiarycan receive home health services in the beneficiary's place of residence, a doctor's office, outpatient clinic, an adult day center, or in another type of outpatient facility, not including a hospital or skilled nursing facility. These services include skilled nursing; home health aide; physical, occupational and speech therapy services; and physician ordered supplies. These services have a limitation of 50 visits per member per year (July 1 through June 30). Prior authorization is required.

Inpatient Hospital Services
Absolute Total Care will pay for medically necessary inpatient hospital care. Medicaid will pay for a semi-private room only unless it is medically necessary to have a private room. The need for this caremust be medically necessary and is reviewed by the UM Department throughout the admission for appropriate level of care. Prior authorization is required.

Inpatient Physician Visits
Absolute Total Care will pay for a physician to visit patients in the hospital. If the patient must be seen by more than one physician while in the hospital, Absolute Total Care will pay for those visits.

Institutional Long-Term Care Facilities
Institutional long-term care services include nursing facility and rehabilitative services at the skilled or intermediary level of care. Absolute Total Care covers first 90 days of continuous confinement in a long-term care facility only when the CLTC Certification (Form 181) has been completed by SCDHHS prior to admission, a level of care determination is indicated on the form and the completed form is provided to Absolute Total Care. This responsibility can be up to 120 continuous days of confinement or until the member can be disenrolled at the earliest effective date allowed by system edits, at which time payment for institutional long-term care services will be reimbursed by Medicaid Fee-For Service. Prior authorization is required.

Laboratory and X-ray
Quest Laboratory, Laboratory Corporation of America (LabCorp) and in-network local and regional laboratories are our preferred clinical laboratories. For a list of in-office laboratory testing covered by Absolute Total Care, please refer to the Physician's Office Lab Testing Payment Policy found on our website absolutetotalcare.com on the Provider Resources page at. Absolute Total Care will also pay for X-ray services ordered by a physician that are medically necessary. CT, PET and MRI scans require prior authorization through Evolent, whether the service is rendered in a provider's office or in an Evolent- contracted, free-standing facility. Evolent can be reached by calling 1-866-312-9729.

Oncology Services
Absolute Total Care will pay for medically necessary oncology and hematology services. Oncology-related chemotherapeutic drugs and support services require prior authorization through Evolent. Evolent services are for in-network oncology/hematology providers submitting requests for members who are not pregnant and are 19 years of age and older. All chemotherapy treatment plan requests (with Cancer Diagnosis) must be

prescreened by Evolent at https://my.newcenturyhealth.com. Evolent can also be reached by calling 1-866-312-9729.

Orthopedic, Musculoskeletal, Interventional Pain Management and Spinal Surgery Services
Absolute Total Care will pay for medically necessary orthopedic and spinal surgery services. Orthopedic and spinal surgery services require prior authorization through Evolent (formerly NIA) by phone (1-866-312-9729), fax (800-784-6864) or secure portal (www.radMD.com). Note that the radMD portal is the preferred and fastest method.

Outpatient Hospital Services
Absolute Total Care will pay for medically necessary outpatient hospital visits.

Physician Services
Absolute Total Care will pay for medically necessary physician services. All symptomatic visits to physicians or physician extenders within the scope of their licenses are covered benefits. Physician services, including services while admitted in the hospital, outpatient hospital department, in a clinic setting, or in a physician's office, are covered benefits. Physician services are unlimited.

Podiatry Services
Members may receive medically necessary podiatry care from an in-network PCP or a podiatrist, Prior authorization is required.

Rehabilitative Therapy Services for Members with Special Needs (Non-Hospital Based)
These services are available to members aged 20 years and younger with special needs (e.g., sensory impairments, Intellectual Disability/Related Disabilities (ID/RD), physical disabilities, developmental disabilities and delays) and to members of any age who are enrolled in the Intellectual Disability/Related Disabilities (ID/RD) waiver and the Head and Spinal Cord Injury Waiver. For services to be covered, the member must have an Individualized Family Service Plan (IFSP), an Individualized Education Plan (IEP), or a valid treatment plan and be referred by either the South Carolina Department of Disabilities and Special Needs, SCDHEC, the South Carolina School for the Deaf and the Blind, or a local Education Agency (School District).

Frequency limits: Combined total of 105 hours (420 units) per year (July 1 through June 30). Prior authorization is required through Evolent when services are rendered in an outpatient setting. Initial evaluations do not require an authorization.

Rural Health Clinic Services (RHCs)
Healthcare services furnished by RHCs are cost-based reimbursed through encounter codes at an all-inclusive rate that reflects the cost of the services (up to the current year's Medicaid CAP).

School-Based Mental Health Services
Absolute Total Care, in partnership with SCDHHS, helps increase access to mental health assessment, intervention and treatment services by empowering health clinicians to render treatment onsite in South Carolina's public schools. Absolute Total Care's notification and prior authorization requirements may be required prior to rendering services. Services that are covered include:

- Diagnostic Assessment – initial and follow up (90791/H0031)
- Service Plan Development (H0032)
- Crisis Management (H2011)
- Individual Psychotherapy (90832/90834/90837)
- Family Psychotherapy (90846/90847)
- Group Psychotherapy (90853)

The following professionals may be reimbursed for providing RBHS described in this bulletin in the school setting:

- Licensed Independent Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor
- Licensed Psycho-Educational Specialist
- Licensed Master Social Worker (Supervision Required)
- Mental Health Professional (Supervision Required)
- Qualified Clinical Professional (DMH only)

Therapy

Therapy can be provided in the following situations as ordered by a physician:

- In a long-term care facility (payment is included in the Medicaid payment to the long-term care facility, inpatient only);
- As a home health service;
- As an inpatient in a hospital, which has a certified therapy department, and therapy may be continued at the hospital as an outpatient if ordered by the doctor;
- Therapy may be continued at the hospital as an outpatient if ordered by a doctor **and** the member is age 20 years and younger;
- By an independent therapist for members aged 20 years and younger; and
- When prior approved by a sponsoring agency, such as the Department of Education orSCDHEC.

Therapy provided in an Inpatient and observation status, acute rehab hospital inpatient, home health, assisted living and inpatient and outpatient skilled nursing facility settings require prior authorization from Absolute Total Care. Prior authorization is required through Evolent when services are rendered in anoutpatient setting.

Covered Therapy Services for Members Over Age 20

If members are over 20 years old and **not** on a Fee-For-Service waiver, reimbursement is allowed for physical, occupational, and speech therapies performed under the following guidelines. The member'srecord must substantiate at least **one** of the following requirements for therapy:

- The attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay and therapy continues on an outpatient basis until that plan of treatment is concluded.
- The attending physician prescribes therapy as a direct result of outpatient surgery.
- The attending physician prescribes therapy to avoid an inpatient hospital admission.

Therapy provided in an Inpatient and observation status, acute rehab hospital inpatient, home health, assisted living, and inpatient and outpatient skilled nursing facility settings require prior authorization from Absolute Total Care. Prior authorization is required through Evolent when services are rendered in an outpatient setting.

Vision Care

Members under 21 get an eye exam and one complete pair of glasses (frame and lenses) once every 12 months. Members 21 and older can get medically necessary eye exams.

If you have any questions about these services or additional benefits, please contact Provider Servicesat 1-866-433-6041.

Mental Health, Alcohol and Other Drug Abuse

Assertive Community Treatment (ACT) Services

Absolute Total Care covers ACT services for adult members in accordance with SCDHHS policies and procedures, contract, and other applicable guidelines. ACT is a best practice community-based treatment for members with severe mental illness and designed to treat members without restrictions to location or hours. Providers should be properly credentialed and authorized to render these services and are required to meet all SCDHHS and Absolute Total Care criteria and billing guidelines. Reimbursement and billing is per diem, requires prior authorization from Absolute Total Care, and limited to 15 units per month (in accordance with SCDHHS guidelines, ACT providers are required to continue to provide services to these members if needed and necessary even if the monthly limit has been reached and excess services not eligible for reimbursement).

Developmental Evaluation and Testing Services

Absolute Total Care is responsible for reviewing, authorizing and reimbursing for certain Developmental Evaluation Services (DES). These are medically necessary, comprehensive, neurodevelopmental and psychological developmental, evaluation and treatment services for members between the ages of 0 through the month of their 21st birthday. These members have or are suspected of having a developmental delay, behavioral or learning disability, or other disabling condition. DES are provided only at the Developmental Evaluation Centers located:

1. Department of Pediatrics at the Greenville Hospital in Greenville;
2. University School of Medicine, University of South Carolina in Columbia; or
3. Medical University of South Carolina in Charleston.

Mental/Behavioral Health Initial Evaluation and Management

Medical doctors and private psychiatrists may bill 90801 and 90802 in office services to Absolute Total Care. A maximum of one psychiatric assessment every six months is allowed for adult and child members.

Mental/Behavioral Health Services

All inpatient and outpatient behavioral health services including South Carolina DAODAS, Psychiatric Residential Treatment Services (PRTF), autism spectrum disorder (ASD) and Rehabilitative Behavioral Health Services (RBHS) are authorized and provided by behavioral health clinicians. Call 1-866-433-6041 or visit the Provider Resources link online at absolutetotalcare.com for information on how to obtain prior authorization for these services.

Psychiatric Services

Psychiatric services to include assessment, treatment plan development and modification and therapy services are covered services for all members.

Services Not Covered by Absolute Total Care

Some services are not covered by Absolute Total Care. These services include:

- Abortions (elective) except in the case of rape, incest, or when medically necessary to save the mother's life (must have supporting SCDHHS Abortion Statement Form signed by physician and medical documentation)
- Acne treatment for members who are 19 years of age and older
- Acupuncture and biofeedback services
- Care for the treatment of obesity unless medically necessary
- Care provided by any provider, when the insured has other primary coverage at the time of the episode of care
- Care or supplies that are not medically necessary
- Comfort items in the hospital (e.g., TV or telephone)

- CLTC Waiver Home and Community Based Services (covered by Medicaid Fee-for-Service)
- Cosmetic surgery/procedures
- Court-ordered testing
- Dental services (covered by Medicaid Fee-for-Service/DentaQuest)
- Experimental care, such as drugs and supplies, not covered by Medicaid
- Experimental or investigational procedures, technologies, or supplies
- Hospice care covered by Medicaid Fee-for-Service
- Infertility services
- Transplants, except corneal, covered by Medicaid Fee-for-Service
- Paternity testing
- Reversal of sterilization services
- Routine adult vision services and hardware
- Services to find cause of death
- Sex therapy or marriage therapy
- Shots to travel outside of the country
- Sterilization of a person who is age 21 years or younger, mentally incompetent, or
- Institutionalized

Note that neither lists of covered and non-covered benefits and services are all-inclusive. Medicaid benefits and services are continuously reviewed, amended and updated by SCDHHS and Absolute Total Care.

Out-of-Network Services and Providers

Absolute Total Care realizes that there may be times when a member needs care from a provider who is not in Absolute Total Care's network. Absolute Total Care will approve medical services to an out-of-network provider if these services:

- Are not available by an in-network provider
- Can't be provided in-network in a timely manner
- Are medically necessary, as determined by the member's physician and Absolute Total Care

Prior authorization may be required based on service. Based on Absolute Total Care's contract with SCDHHS, services provided by an out-of-network provider for which Absolute Total Care has adequate network coverage may be reimbursed at a rate below the Medicaid fee schedule.

Enhanced Benefits for Absolute Total Care Members

Absolute Total Care has developed a package of enhanced services for its members that includes benefits in addition to the SCDHHS covered services. The enhanced services were designed to improve members' well-being, encourage responsible and prudent use of healthcare benefits, and enhance the cost effectiveness of the South Carolina Medicaid Program.

Nurse Advice Line

Our members have many questions about their health, PCPs and access to emergency care. Absolute Total Care offers a nurse advice line service to encourage members to talk with their PCP and to promote education and preventive care.

Our nurse advice line is a 24-hour nurse line for members. Our registered nurses provide basic health education and nurse triage, as well as answer questions about urgent or emergency access. The nurses often answer questions about pregnancy and newborn care. In addition, members with chronic problems like asthma or diabetes are referred to Care Management for education and encouragement to improve their health.

Members may use our nurse advice line to request information about providers and services available in their community after Absolute Total Care's hours and on holidays. PCPs can utilize our nurse advice line to verify eligibility any time of the day. The nurse advice line staff is conversant in both English and Spanish, and they can offer the Language Line for additional translation services. Each nurse documents their calls in a web-based data system using Barton Schmitt, M.D. triage protocols for pediatrics and McKesson proprietary products to perform triage services for adults. These protocols are widely used in nurse call centers and have been reviewed and approved by physicians from around the country.

We provide this service to support your practice and offer access to a registered nurse for our members every day. If you have any additional questions, please call Provider Services or the nurseadvice line at 1-866-433-6041.

Start Smart for Your Baby® (Start Smart)

Start Smart is Absolute Total Care's special program for women who are pregnant. This program provides educational materials that tackle the most critical issues affecting the child's development during pregnancy. Start Smart offers a preventive approach that encourages prenatal education forthe expectant mother in an effort to achieve the best possible outcome. Start Smart encourages pregnant women to keep their prenatal care appointments, educates members and their families about pregnancy, identifies members who may be at high risk for developing complications, and provides support in dealing with medical, socioeconomic and environmental issues that may contribute to complications or inhibit a member's ability to receive optimal healthcare.

Identifying pregnant members as early as possible, providing them with adequate prenatal care and guidance, as well as addressing complications as effectively as possible should result in improved outcomes for both the mother and the newborn baby.

My Health Pays™ Member Rewards

Earning My Health Pays™ Reward Dollars

After a member completes a healthy activity, Absolute Total Care will add the reward dollars they have earned directly to their My Health Pays™ Visa® Prepaid Card.

We will mail their My Health Pays™ Visa Prepaid Card to them after they complete their first healthy activity. They can keep earning My Health Pays™ rewards by completing more healthy activities. Their rewards will be added to their card once we are notified.

How to Earn

Members can earn My Health Pays™ rewards for things like screenings, preventive care and more. Please visit absolutetotalcare.com for more details.

My Health Pays™ rewards can help members pay for:

- Everyday items at Walmart*
- Utilities
- Transportation
- Telecommunications
- Childcare services
- Education

- Rent
- Cable

Members can log in to their secure member account to see their My Health Pays™ rewards balance.

**This card may not be used to buy alcohol, tobacco, or firearms products.*

This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.

Non-Emergency Transportation Services

Absolute Total Care members may need transportation to or from a Medicaid-covered service to receive medically necessary care. Non-emergency transportation is only available to eligible recipients who cannot obtain transportation on their own through other available means, such as by family, friends, or community resources.

The South Carolina Medicaid transportation program provides non-emergency transportation for members through ModivCare. If a member needs to schedule a ride for non-emergency reasons, the member should call the call the ModivCare reservation line for the region that the member's county islocated in. Regions and telephone numbers can be found by visiting the following website: https://memberinfo.logisticare.com/scmember and Absolute Total Care's Member Handbook. They will schedule the ride for the member. The member may also call Member Services at 1-866-433-6041if they are having difficulty scheduling a ride for a medical appointment. Member Services will assist the member in contacting the transportation broker to arrange transportation.

Member Benefit Grid and Copays

NOTE: Effective July 1, 2024, South Carolina Health Connections (Medicaid) and Absolute Total Care no longer require a copay for any service. Some services below have a copay and the copays listed apply only to services received before July 1, 2024.

Benefits	Coverage	Limits	Authorization Requirements	Copay Before July 1, 2024	Copay After July 1, 2024
Abortion Procedure	Covered	Covered according to applicable federal and state laws and regulations. Written physician certification of the need for the abortion required.	Prior approval required.	$0	$0
Acne	Covered	Ages 18 and younger. Limits apply.		$0	$0

Acupuncture and Biofeedback Service	Not Covered			N/A	N/A
Ambulance Services– Emergency and Non-Emergency	Covered			$0	$0
Ambulatory Surgical Center	Covered	Copay is applied per day.	Prior approval may be required for some services.	$3.30	$0
Autism Spectrum Disorder (ASD) Treatment Services	Covered			$0	$0
Audiology Services	Covered	Ages 20 and younger.		$0	$0
BabyNet	Covered	Ages 3 and younger.		$0	$0
Bariatric Surgery – Surgery for Morbid Obesity	Covered		Prior approval required.	$0	$0
Behavioral Health - Evaluation (Outpatient)	Covered	One evaluation every six months.		$0	$0
Behavioral Health – Medical Office Visit (Psychiatrist or Nurse Practitioner Only)	Covered	Psychiatrist or nurse practitioner only.		$0	$0
Birthing Centers	Covered		Prior approval required.	$0	$0
Biopharmaceuticals (Specialty Injectables)	Covered		Prior approval required.	$3.40	$0
Cardiac Rehabilitation Services	Covered		Prior approval may be required for some services.	$0	$0
Chemotherapy Services	Covered		Prior approval may be required for some services.	$0	$0
Chiropractic Services	Covered	One per day/six per year		$0	$0
Circumcision	Covered	Covered during the initial newborn stay and up to 180 days after delivery in the office setting. Otherwise, prior approval required.	Prior approval may be required.	$0	$0
Clinic Visits	Covered			$0	$0
Cosmetic Surgery	Not Covered			N/A	N/A
Dermatology Services	Covered	Cosmetic is not covered.	Prior approval may be required for some services.	$0	$0
Dental Services	Covered by SCDHHS	Covered by SCDHHS/DentaQuest.		N/A	N/A
Developmental Evaluation Services	Covered	Covered for members between the ages of 0 and 21.		$0	$0

Diabetic Shoes	Covered	One pair per year (three inserts per year).		$0	$0
Diabetic Supplies (Test Strips, Lancets, Pen Needles)	Covered	Quantity limits may apply.	Prior approval may be required.	$3.40	$0
Diabetic Education	Covered			$0	$0
Dialysis	Covered		Prior approval required.	$0	$0
Durable Medical Equipment (DME) – Including, but not limited to, Rental Equipment, Supplies, Wheelchairs, Ventilators, Oxygen, Monitors, Lifts, Nebulizers, and Bili-Blankets.	Covered		Prior approval may be required for some equipment.	$0	$0
Emergency Care (In-Network and Out-of-Network)	Covered			$0	$0
Emergency Transportation	Covered			$0	$0
Enteral/Parenteral Nutrition Therapy	Covered	If provided via tube and sole source of nutrition.		$0	$0
Family Planning Services	Covered	Self-referrals: in- and out-of-network providers covered.		$0	$0
Fluoride Rinse/Varnish	Covered	As a part of EPSDT only.		$0	$0
Genetic Testing	Covered		Prior approval required.	$0	$0
Hearing Tests, Aids, and Devices	Covered	Ages 20 and younger.	Prior approval required.	$0	$0
Home Health Care	Covered	50 visits per year (July 1 through June 30).	Prior approval required.	$0	$0
Home Infusion Therapy	Covered		Prior approval may be required for some medications.	$0	$0
Hospice Care	Covered by SCDHHS			$0	$0
Hysterectomy	Covered	Completed Consent for Sterilization Form (Form HHS-687) required.	Prior approval required.	$0	$0
Infertility Services	Not Covered	N/A		N/A	N/A
Infusion Centers	Covered			$0	$0
Inpatient Behavioral Health Services	Covered		Prior approval required.	$25.00	$0
Inpatient Medical/Surgical Services	Covered		Prior approval required.	$25.00	$0
Inpatient Pediatric	Covered		Prior approval	$0	$0

Rehabilitation Services			required.		
Insulin Pumps	Covered		Prior approval required.	$0	$0
Laboratory Services	Covered		Prior approval required for some services.	$0	$0
Long-Term Care Facility	Covered	SCDHHS CLTC Certification (Form 181) must be completed prior to admission.	Prior approval required.	$0	$0
Maternity Services	Covered		Prior approval required for some services.	$0	$0
Newborn Hearing Screening	Covered	Included in the Core Benefits when provided to newborns in an inpatient hospital.		$0	$0
Non-Emergency Medical Transportation	Covered by SCDHHS			N/A	N/A
Non-Participating Providers	Covered	Must be medically necessary and service not available in network.	Prior approval required.	Varies	$0
OB Ultrasounds	Covered	Maternal-fetal medicine provider: no limitation. All other providers: three ultrasounds per pregnancy.		$0	$0
Office Visits (PCP/Specialists) (Well and Sick Visits)	Covered			$0	$0
Oncology-Related Chemotherapeutic Drugs and Support Services	Covered		Prior approval required.	$3.40 for self-administered drugs only.	$0
Orthopedic and Spinal Surgery	Covered		Prior approval required.	$0	$0
Orthotics and Prosthetics	Covered	Braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body.	Prior approval required for some services.	$0	$0
Outpatient Hospital Services (Non-Emergency)	Covered		Prior approval required for some services.	$3.40	$0
Outpatient Surgery and Procedures	Covered		Prior approval required for some services.	$3.40	$0
Pain Management Services	Covered		Prior approval required for some	$0	$0

			services.		
Podiatry Services	Covered		Prior approval required for some services.	$0	$0
Power Wheelchairs	Covered	Every seven years, limited accessories covered.	Prior approval required.	$0	$0
Prescriptions and Medications	Covered	Subject to age and quantity limits per Comprehensive Drug List (CDL).	Prior approval may be required for some medications.	$3.40 $0 copay for select medications on the CDL for asthma, COPD, smoking cessation, and diabetes.	$0
Pulmonary Rehabilitation Services	Covered			$0	$0
Rehabilitative Therapies for Children, Non-Hospital Based	Covered	Ages 20 and younger, combined total of 105 hours (420 units) per year (July 1 through June 30).	Prior approval required.	$0	$0
Reversal of Sterilization	Not Covered			N/A	N/A
Smoking Cessation Products	Covered	Subject to quantity limits per Comprehensive Drug List (CDL).		$0 copay for smoking cessation medications on CDL.	$0
Sterilization	Covered	Completed Consent for Sterilization Form (Form HHS-687) required.		$0	$0
Substance Use Disorder Services	Covered		Prior approval required for some services.	$0	$0
Transplants	Covered		Prior approval required.	$0	$0
Vaccines/Immunizations (Adult)	Covered	Covered in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) vaccine recommendations guidelines for adult		$0	$0

		beneficiaries 19 years of age and older.			
Vaccines/Immunizations (Children)	Covered	Ages 18 and younger.		$0	$0
Vision – Routine Screening (Children)	Covered	Ages 20 and younger. One pair of glasses every 12 months. One replacement set every 12 months.		$0	$0
X-Ray/Radiology and Imaging Services	Covered		Prior approval required for some services.	$0	$0

Absolute Total Care Members Exempt from Copayments:
From birth to the date of their 19th birthday
Living in long-term care facilities
During pregnancy
Members of a federally recognized tribe when services are rendered by the Catawba Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawba Service Unit.

South Carolina Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services and Standards

EPSDT is a program of comprehensive preventive health services available to Absolute Total Care recipients through the month of their 21st birthday. The program is designed to maintain health by providing early intervention to discover and treat health problems. EPSDT is a preventive program that combines diagnostic screening and medically necessary follow-up care for dental, vision and hearing examinations for eligible members.

EPSDT services include:

- Outreach and informing
- Screening in accordance with the SCDHHS and the American Academy of Pediatrics periodicity schedule
- Tracking compliance with EPSDT requirements
- Diagnostic and treatment services

Standards for proving EPSDT services are described and are included in the SCDHHS MCO Policies and Procedures Manual.

PCPs are required to perform EPSDT medical check-ups in their entirety and at the required intervals. All components of exams must be documented and included in the medical record of each EPSDT-eligible member. Initial well-child exams are to be completed within 90 days of the initial

effective date of membership and within 24 hours of birth for all newborns.

The components of these visits are as follows:

- **Comprehensive Health and Developmental History:** Including assessment of both physical and mental health development.
- **Comprehensive Unclothed Physical Exam.**
- **Appropriate Immunizations:** According to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.
- **Blood Lead Screening:** For children from the ages of six months through 72 months. A Lead Screening Questionnaire should be completed at the time of each routine office visit for children in this age group. All children are considered at-risk and must be screened for lead poisoning. CMS requires that all children receive a screening blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 5ug/dl obtained by capillary specimen must be confirmed using a venous blood sample**.**
- **Anemia Screening and Laboratory Tests:** as indicated, as well as is appropriate for age and risk factors (including a hematocrit or hemoglobin test performed between six and nine months of age and at least once during adolescence for menstruating females).
- **Blood Pressure**: Blood pressure should be measured on children ages three and over at each screening.
- **Anticipatory Guidance/Health Education:** Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms for the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- **Vision Screening:** Vision should be assessed at each screening. In infants, the history and subjective findings of the ability to regard and reach for objects, the ability to demonstrate an appropriate social smile and to have age-appropriate interaction with the examiner is sufficient. At ages four and older, objective measurement using the age-appropriate Snellen Chart, Goodlite Test, or Titmus Test should be done and recorded. If needed, a referral should be made to an ophthalmologist or optometrist.
- **Dental Screening:** A general assessment of the dental condition (teeth and/or gums) is obtained on all children, including fluoride treatments. Children with their first tooth eruption and age two and older should be referred to a dentist.
- **Topical Fluoride Varnish:** The best practices of the American Academy of Pediatrics recommend that children up to three years old who are at high risk for dental caries should receive fluoride varnish application in their PCPs office during their EPSDT visit two times per year (once every six months) and in their dental home two times per year (once every six months). The American Dental Association has established a new Current Dental Terminology (CDT) procedure code, D1206, for the application of topical fluoride varnish. The PCP will bill this procedure to Absolute Total Care on the CMS 1500 Claim Form.
- **Hearing Screening:** A hearing test is required appropriate to the child's age and educational level. For the child under age four, hearing is determined by whatever method is normally used by a provider, including, but not limited to, a hearing kit. For the child over age four, an audiometer, if available, is recommended. If needed, an appropriate referral should be made to a specialist. It is recommended that high-risk neonates be evaluated with objective

measures, such as brain stem evoked response testing, prior to discharge from the hospital nursery.

- **Other Necessary Healthcare:** States must provide other necessary healthcare, diagnosis services, treatment and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.
- **Periodic Screening:** EPSDT beneficiaries are eligible to receive 20 screenings in 21 years of life. Screening ranges are determined according to age of the child and, in some circumstances, when last screened. EPSDT visits are recommended at the ages listed below.

Infancy	Early Childhood	Late Childhood and Adolescence
Birth 3-5 days One month Two months Four months Six months Nine months	12 months 15 months 18 months 24 months 30 months 3 years 4 years	Ages 5 years and up through the month of the child's 21st birthday – every year

Neonatal exams are identified from hospital claim and not billable as an EPSDT screening.

Preventive health is a major principal on which MCOs are based, measured and held accountable. Absolute Total Care supports its contracted PCPs to encourage their Absolute Total Care members to participate in the state of South Carolina preventive care program, EPSDT. Absolute Total Care will send reminders of the need for a well-child examination to all EPSDT-eligible members. A copy of Absolute Total Care's EPSDT Program description can be found at absolutetotalcare.com in the Provider Manuals and Forms section.

Vaccines and Immunizations

Children must be immunized during medical check-ups according to the current ACIP Schedule.

Absolute Total Care encourages all members who are age 18 years or younger to be immunized by their PCP unless medically contraindicated or against parental religious beliefs. Providers shall report all immunizations to the State Immunization Information System (SIIS) administered by SCDHEC.

Since immunizations are a required component of EPSDT screening services, an assessment of the child's immunization status should be made at each screening and immunizations administered as appropriate. If the child is due for an immunization, it must be administered at the time of the screening. However, if illness precludes immunization, the reason for delay should be documented in the child's record. An appointment should be given to return for administration of immunization at a later date.

PCPs should participate with the Vaccines for Children (VFC) Program. If a provider does not routinely administer immunizations as part of their practice, they should refer the child to the county health department but must maintain a current record of the child's immunization status.

For PCPs, providing immunizations to our members is one of the most important services rendered. The VFC Program provides PCP practices with the pediatric vaccines needed to administer this

service.

Providers will be required to include CPT coding on all administered VFC supplied vaccine products. The appropriate vaccine CPT code must be included on the CMS 1500 Claim Form when filing for reimbursement for the administration of these vaccines. **Submitted claims are denied when the appropriate CPT code is not billed.**

Immunizations are covered under the medical benefit for adult members ages 19 and older in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) vaccine recommendations guidelines. Covered services include the vaccine and administration of the vaccine. Adult vaccinations and immunizations include pneumococcal, influenza, Hepatitis A and B, Human Papillomaviris (HPV), measles, mumps, rubella and varicella (MMRV), rabies, serogroup B meningococcal (MenB); measles, mumps, and rubella (MMR); varicella (VAR); Tetanus and diphtheria toxoids (Td); Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) and varicella (MMRV).

Immunizations are covered under the pharmacy benefit for adult members ages 19 and older as indicated on the prescription drug list (PDL).

Blood Lead Screening

Absolute Total Care EPSDT Guidelines include Lead Screening/Assessment for children from the ages of six months through 72 months. A Lead Screening Questionnaire should be completed at the time of each routine office visit for children in this age group.

All Medicaid children are considered at increased risk for having elevated blood lead levels. A blood lead test must be used when screening Medicaid-eligible children. An elevated BLL is considered anything $\geq$5 ug/dL. A blood lead test result equal to or greater than 5 ug/dL obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample. According to CMS policy, all Medicaid children require a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning.

Domestic Violence

Absolute Total Care's membership may include individuals at risk for becoming victims of domestic violence. Thus, it is especially important that providers are vigilant in identifying these members. Member Services can help members identify resources to protect them from further domestic violence.

South Carolina residents who are victims of domestic violence may be referred to the National Domestic Violence Hotline, at 1-800-799-SAFE (7233) for information about local domestic violence programs and shelters within the state of South Carolina.

Additionally, providers are mandated to report all suspected child abuse or neglect as described. **State law requires reporting by any person if he or she has "reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse." Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Providers should report any suspected child abuse or neglect immediately to South Carolina Department of Social Services Child Protective Services in the appropriate county.**

General Billing Guidelines

Physicians, other licensed health professionals, facilities and ancillary providers contract directly with Absolute Total Care for payment of covered services.

It is important that providers ensure Absolute Total Care has accurate billing information on file. Please confirm with Provider Services that the following information is current in our files:

- **Provider name** (as noted on his/her current W-9 Form);
- **Provider National Provider Identifier (NPI)**;
- **Physical location address** (as noted on current W-9 Form);
- **Billing name and address** (if different); and
- **Tax Identification Number (TIN).**

Providers must bill with their NPI number in box 24J. Absolute Total Care will return or reject claims, when billing information does not match the information that is currently in our files. **Claims missing the requirements in bold will be returned** and a notice will be sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be entered into the system.

We recommend that providers notify Absolute Total Care in advance of changes pertaining to billing information. Please submit this information on a W-9 Form. Changes to a provider's TIN and/or address are **not** acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service;
- The service(s) provided is a state-sanctioned and approved covered Medicaid benefit and eligible for reimbursement on the date of service;
- Compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual

Providers must submit all claims and encounters within 365 days from the date of service, unless Absolute Total Care or its vendors created the error. The filing limit may be extended for newborn claims. Claims where Absolute Total Care is the secondary payer and where the eligibility has been retroactively received by Absolute Total Care have up to a maximum of 365 days.

Absolute Total Care must comply with state and federal requirements mandating provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR 434.6(a)12 (2016, as amended) 42 CFR 438.3(g) (2016, as amended) and 42 CFR 447.26 (2016, as amended).

All adjustments and corrections must be received and resolved within 365 days from the date of service to be considered for payment.

Electronic Claims Submission

Network providers are encouraged to participate in Absolute Total Care's Electronic Claims/Encounter Filing Program. The plan has the capability to receive electronic professional, institution, or encounter transaction. In addition, it has the ability to generate an electronic remittance advice known as an Explanation of Payment (EOP). Providers can submit electronically using a clearinghouse or Absolute Total Care's Secure Provider Portal. For more information on electronic filing, contact:

Absolute Total Care
C/o Centene EDI Department
Telephone: 1-800-225-2573, ext. 25525
Email: EDIBA@centene.com

EDI Payer Numbers:
68069 - Emdeon/WebMD/Envoy/Payerpath
42772 - Relay Health/McKesson

Visit our website at absolutetotalcare.com for a complete list of payer ID numbers.

All providers are required to follow Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 format for claim submissions and all CPT and National Correct Coding Initiative (NCCI) guidelines. **Absolute Total Care timely filing is within 365 days from the date of service.**

Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

National Provider Identifier (NPI)

Absolute Total Care requires all claims to be submitted with a provider's NPI. Absolute Total Care will require this on all electronic and paper claim submissions. Providers must send a copy of the confirmation letter from the enumerator to Absolute Total Care to ensure that the NPI is loaded correctly into our claims payment database. Providers may register for an NPI and download forms at https://nppes.cms.hhs.gov/NPPES/.

Claims Submission

Absolute Total Care's preferred method of claim submission is electronic claim submission through the free and secure provider portal or Electronic Data Interchange(EDI). If you must submit a paper claim, please send to the address below and follow the imaging requirements listed below.
All claims sent to the wrong address will cause a delay in processing. Please ensure your claims are sent to the below addresses for proper and timely processing.

Online Claim Submission

For providers who have internet access and choose not to submit claims via EDI or paper, Absolute Total Care has made it easy and convenient to submit claims directly using **Secure Web Portal** at www.absolutetotalcare.com. Providers may file first time claims individually or submit first time batch claims using the **Secure Web Portal**. You will also have the capability to find, view, and correct and previously processed claims. Detailed instructions for submitting via the secure provider portal are also found on our website; you must login to the secure site to access this manual.

Claims Submission Options

<table>
<tr>
<td>Electronic Claims (Medical):

Absolute Total Care EDI Payer Numbers: 68069 – Emdeon/WebMD/Envoy/Payerpath4272 – Relay Health/McKesson</td>
<td rowspan="2">Medical Appeals:
Absolute Total Care
ATTN: Grievance and Appeals
100 Center Point Circle, Suite 100
Columbia, SC 29210

(Must have denial letter from medical director and member completed Appointment of Authorized Representative Form before an appeal may be submitted.)

Appeals must be submitted within 60 days from the date on the Adverse Benefit Determination Notice.</td>
</tr>
<tr>
<td>Paper Claims (Medical):
Absolute Total Care
P.O. Box 3050
Farmington, MO 63640-3821

Secure Provider Portal (Medical):
www.absolutetotalcare.com/login</td>
</tr>
</table>

Claim Adjustments (Corrections/Resubmissions) and Reconsiderations:

Absolute Total Care
P.O. Box 3050
Farmington, MO 63640-3821

Absolute Total Care (Medical)
ATTN: Refunds
P.O. Box 602939
Charlotte, NC 28260-2939

Behavioral Health Services (Refunds)
Absolute Total Care
P.O. Box 3656
Carol Stream, IL 60132-3656

Adjustment and reconsideration filing limit: 365 days from date of service.

Behavioral Health Claims:
Absolute Total Care
P.O. Box 7001
Farmington, MO 63640-3811
EDI Payer ID: 68068

Envolve Vision Electronic Claims:
EDI Payer ID: 56190

Paper Claims:
Envolve Vision
P.O. Box 7548
Rocky Mountain, NC 27804

Filing limits: Please refer to your agreement with Envolve Vision.

Evolent authorized services will be submitted to Absolute Total Care's claim address:

EDI Payer Numbers:
68069 - Emdeon/WebMD/Envoy/Payerpath
4272 - Relay Health/McKesson

Filing limit: 365 days from date of service.

Paper Claims authorized by Evolent:
Absolute Total Care
P.O. Box 3050
Farmington, MO 63640-3821

Filing limit: 365 days from date of service.

If you are experiencing problems with electronic claims submission, please email our EDI Team for assistance at ediba@centene.com. Absolute Total Care partners with Payformance to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). To learn more and register, please call 1-877-331-7154 and press #1, or email providersupport@payspanhealth.com.

Imaging Requirements

Absolute Total Care uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Dos

- **Do** use the correct P.O. Box number.
- **Do** submit all claims in a 9" x 12" or larger envelope.
- **Do** type all fields completely and correctly.
- **Do** use black or blue ink only.
- **Do** submit on a proper and current form (CMS 1500 or UB-04 Claim Form).

Don'ts

- **Don't** submit handwritten claim forms.
- **Don't** use red ink on claim forms.
- **Don't** circle any data on claim forms.
- **Don't** add extraneous information to any claim form field.
- **Don't** use highlighter on any claim form field.
- **Don't** submit photocopied claim forms (black and white).
- **Don't** submit carbon copied claim forms.
- **Don't** submit claim forms via fax.

Clean Claim Definition

Absolute Total Care uses SCDHHS's definition of a clean claim. A clean claim means a claim received by Absolute Total Care for adjudication in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Absolute Total Care.

What Is an Encounter Versus a Claim?

You are required to submit an encounter or claim for each service that you render to an Absolute Total Care member.

- If you are the PCP for an Absolute Total Care member and receive a monthly capitation amount for services, you must file a "proxy claim" (also referred to as an "**encounter**") on a CMS 1500 Claim Form for each service provided. Since you will have received a pre-payment in the form of capitation, the "proxy claim" or "**encounter**" is paid at zero-dollar amounts. **It is mandatory that your office submit encounter data**. Absolute Total Care utilizes the encounter reporting to evaluate all aspects of quality and UM, and it is required by the state of South Carolina and CMS.
- A **claim** is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as a CMS 1500 or UB-04 Claim Form. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim.

Procedures for Filing a Claim/Encounter Data

Absolute Total Care encourages all providers to file claims/encounters electronically. See the Claim Submission Options section of this Provider Manual for more information on how to initiate electronic claims/encounters. Please remember the following when filing your claim/encounter:

- All documentation **must** be legible.
- PCPs and all participating providers must submit claims or encounter data for every member visit, even though they may receive a monthly capitation payment.

- Providers must ensure that all data and documents submitted to Absolute Total Care are accurate, complete and truthful to their best knowledge, information and belief.
- All claims and encounter data must be submitted on either Claim Form CMS 1500, UB-04, or by electronic media in an approved format.
- Review and retain a copy of the error report that is received for claims that have been submitted electronically, then correct any errors and resubmit with your next batch of claims.
- Providers must submit all claims and encounters within 365 days of the date of service.
- Coordination of Benefits claim must be submitted with the appropriate primary payer's EOP information. Contact your clearinghouse or our EDI Department at ediba@centene.com or by calling 1-800-225-2573, ext. 25525.
- Any provider for covered services must never bill Absolute Total Care members unless the criterion listed under the Billing the Member section of this Provider Manual is met.
- In a workers' compensation case for which Absolute Total Care is not financially responsible, the provider should directly bill the employer's workers' compensation carrier for payment.

Claim Payment

Absolute Total Care will pay 90% of clean claims within 30 days of receipt and 99% of clean claims within 90 days of receipt. It is the provider's responsibility to cross check their submitted claims audit report to processed claims EOPs from Absolute Total Care. Also, this is available at absolutetotalcare.com, but requires registration to access the Secure Provider Portal.

Claim Adjustments (Corrections/Resubmissions) and Reconsiderations

A **claim adjustment (correction/resubmission)** is a request to change the initial claim:

- To correct a billing error (invalid or incorrect information) in the initial claim submission.
    - To reprocess a previous partially denied claim. Adjustment requests related to partially denied claims should be submitted in their entirety as originally filed.

A **claim reconsideration** is submitted when a provider disagrees with how a clean or adjusted claim was processed. Examples include but are not limited to:

- Denials related to code edit or authorization (including lack of authorization). Requests related to code edit or authorizationdenial require medical records and must accompany the request for reconsideration.
- Payment amount which does not align with expected payment.

Submitters have **365 calendar days** from the date of service (as confirmed on the EOP) to file a timely adjustment or reconsideration request via EDI, on the Secure Provider Portal at absolutetotalcare.com (the preferred and fastest method) or by mail to the address below. Requests submitted via mail must include a completed Provider ClaimAdjustment/Reconsideration Form, which can be found on our website at absolutetotalcare.com and supporting documentation.

Submit claim adjustments and reconsiderations to the following address:

Absolute Total Care
P.O. Box 3050
Farmington, MO 63640-3821

Absolute Total Care shall process and finalize all claim adjustment and reconsideration requests to a paid or denied status normally within **30 business days** of receipt of the adjustment or reconsideration request. Any response to approved adjustments will be provided by way of check with accompanying explanation of payment.

If a provider has a question or is not satisfied with the information they have received related to a claim, they can contact Provider Services at 1-866-433-6041.

Provider Dispute System

If a contracted or non-contracted provider is not satisfied with the outcome of a previous adjustment request or request for reconsideration, the provider may submit a formal dispute to Absolute Total Care. Providers may contact Absolute Total Care with concerns in-person or by telephone, email, or writing and will receive instruction on how to file a formal provider dispute. However, to be classified a providerdispute these concerns must be submitted in writing and include the Provider Dispute Form and supporting documentation.

To submit a provider dispute please download and complete the Provider Dispute Form from the Provider Resources section on our website at absolutetotalcare.com. The provider can consolidate disputes of multiple claims that involve the same or similar payment, regardless of the number of individual patients or payment claims.

The completed Provider Dispute Form must be submitted to Absolute Total Care within **60 calendar days** from the receipt of notice of an adverse action. Any disputes received outside of this time framewill not be reviewed. In addition to claim disputes, contracted providers may also dispute Absolute Total Care's policies and procedures, administrative functions, contract provision, or other action, function, or process specified by state Medicaid guidelines, SCDHHS, and Absolute Total Care's policies and procedures. Pursuant to our current policies, and state Medicaid guidelines, providers are not permitted to appeal and dispute any of the following:

- Adverse benefit determinations and actions related to pre-service and/or concurrent authorization determinations for which the provider is not acting as an authorized representative of the member as defined by SCDHHS.
  **Note: Appeals related to a provider acting as an authorized representative of the Medicaid member are processed as a member grievance or appeal in accordance with SCDHHS regulations and Absolute Total Care's policies and procedures.*
- Denials, rejections, or nonpayment of rendered services not covered or approved for reimbursement by SCDHHS and Absolute Total Care
- Denials and payment adjustments for National Correct Coding Initiative (NCCI)
- Rejection, denial, or nonpayment of services not billed on a "clean claim" as defined by this manual.

Absolute Total Care will fully investigate the provider dispute and render a decision within 30 calendar days of the receipt of the provider dispute. If additional information is required to render a decision on the dispute, Absolute Total Care may extend the time frame by 15 calendar days based on mutual agreement of the provider with Absolute Total Care.

Disputes received that are related to claims and claim payments for covered services for which there is no previous request on file, may, at the discretion of Absolute Total Care, be processed instead as a request for reconsideration or adjustment. Providers whose disputes are reclassified as a first level appeal (reconsideration/adjustment) in these cases will still maintain and not lose their right to dispute provided that all other dispute guidelines and requirements, including timely filing, submission

method, required form(s) and information, and all other policies and procedures are followed.

If you wish to file a dispute, please send the Provider Dispute Form and supporting documentation to:

Absolute Total Care
Provider Disputes
P.O. Box 3050
Farmington, MO 63640-3821

Fee Schedule and Code Updates

Updates to billing-related codes or fee schedules (e.g., CPT, HCPCS, ICD, DRG and revenue codes) shall become effective on the date ("Code Change Effective Date" or "Fee Change Effective Date") that is the latter of:

- The first day of the month following 30 days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code/fee updates; or
- The effective date of such code/fee updates, as determined by such governmental agency.

Claims processed prior to the Code/Fee Change Effective Date will not be reprocessed to reflect any code updates.

Common Billing Errors

In order to avoid rejected claims or encounters always remember to:

- Submit all J-codes with the appropriate National Drug Control (NDC) number and format.
- Bill the primary diagnosis in the first field following NCCI guidelines.
- Use **specific** and **current** ICD, CPT or HCPCS codes. Avoid the use of non-specific or "catch- all" codes (i.e., 99070). Out-of-date codes will be denied.
- Submit all claims/encounters with the proper provider number.
- Submit all claims/encounters with the member's complete Medicaid ID number.
- Verify other insurance information entered on claim.

Code Auditing and Editing

Absolute Total Care uses HIPAA-compliant code auditing software to improve accuracy and efficiency in claims processing, payment and reporting. The software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier and place of service codes against correct coding guidelines. While code auditing software is a useful tool to ensure provider compliance with correct coding, it will not wholly evaluate all clinical patient scenarios. Consequently, Absolute Total Care uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. Absolute Total Care may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with correct coding guidelines.

Absolute Total Care may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement. Other policies (e.g., clinical policies) or contract terms may further determine whether a technology, procedure or treatment that is not addressed in a Payment Policy is payable by Absolute Total Care. When state Medicaid coverage provisions conflict with Payment Policy coverage provisions, state Medicaid coverage provisions take

precedence. Absolute Total Care Payment Policies can be found at absolutetotalcare.com under Provider Resources.

Code-Editing Assistant

A web-based code auditing reference tool designed to "mirror" how Absolute Total Care's code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers. This allows Absolute Total Care to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services **before** claims are submitted.
- *Proactively* determine the appropriate code/code combination representing the service for accurate billing purposes.
- *Retrospectively* access the clinical edit clarifications on a denied claim for billed services after an EOP has been received.

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered. However, this is not a guarantee of payment for the claim combination submitted.

Billing Codes

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT, HCPCS or ASA and ICD codes. Submit institutional claims with valid revenue codes **and** CPT or HCPCS (when applicable), ICD codes and DRG codes (when applicable).

Absolute Total Care recognizes the medical terminology as defined in the CPT, Fourth Edition, published by the American Medical Association; and the diagnosis codes as defined in the International Classification of Diseases, Tenth Edition (ICD-10) and provided by the U.S. National Center for Health Statistics.

Absolute Total Care recognizes the medical terminology as defined in the following:

- Current Procedural Terminology (CPT®), Fourth Edition, published by the American Medical Association (AMA)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases, Tenth Revision (ICD- 10) and provided by the U.S. National Center for Health Statistics

Billing Forms

Providers submit claims using standardized claim forms whether filing on paper or electronically.

Submit claims for professional services and DME on a CMS 1500 Claim Form. The following areas of information on CMS 1500 Claim Forms are common submission requirements of a clean claim accepted for processing:

- Full member name;
- Member's date of birth;
- Valid member ID number;

- Appropriate NDC number for all J-codes;
- Appropriate Clinical Laboratory Improvement Amendments (CLIA) number for all laboratory services;
- Complete service level information:
    - Date of service;
    - Diagnosis;
    - Place of service;
    - Authorization number when appropriate;
    - Procedural coding (appropriate and current CPT and ICD codes); and
    - Charge information and units.
- Servicing provider's name, address and Medicaid ID number;
- Provider's NPI;
- Provider's federal TIN; and
- All mandatory fields must be complete and accurate.

Submit claims for hospital-based inpatient and outpatient services as well as swing bed services on a UB-04 Claim Form.

Third-Party Liability

Third-party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer- related, self-insured, self-funded, or commercial carrier, automobile insurance and workers' compensation) or program that is, or may be, liable to pay all or part of the healthcare expenses of the member.

Except for BabyNet and Children's Rehabilitative Services, Medicaid is always the payer of last resort. Absolute Total Care providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Absolute Total Care members. **The provider has 365 days from the date of service to submit first time claims. Denied claims for additional information may be submitted with the additional information needed within 365 days from the date of service for reimbursement consideration**.

If third-party liability coverage is determined after services are rendered, Absolute Total Care will coordinate with the provider to pay any claims that may have been denied for payment due to third-party liability.

Billing the Member

Absolute Total Care reimburses only services that are covered, medically necessary services through Medicaid. Carved out services outlined earlier in this manual should be billed to the state Medicaid Fee-For-Service Program. **Providers may not bill Absolute Total Care members for covered services.** A provider may only bill an Absolute Total Care member if the provider obtains written consent from the member as outlined in the Member Acknowledgment Statement section of this Provider Manual.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if the provider has counseled the member of their out-of-pocket responsibilities and obtained a signed member acknowledgement statement to bill for non-covered or non-medically necessary services **prior** to the service(s) being rendered.

A member acknowledgement statement must include all of the following:

- The cost of each service.
- The member's acknowledgement of responsibility for payment statement:

  *"I understand that, in the opinion of [**provider's name**], the services or items that I have requested to be provided to me on [**dates of service**] may not be covered by my Medicaid plan, Absolute Total Care, as being reasonable and medically necessary for my care. I understand that Absolute Total Care through its contract with the SCDHHS determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive, if these services or items are determined not to be reasonable and medically necessary for my care."*
- The member's signature.

Providers must keep signed member acknowledgement statements**.**

Balance Billing Prohibition

Members cannot be balance billed by any provider for authorized services, including in-network services and authorized out-of-network services. This includes services that are covered, and services not covered unless a Member Acknowledgement Statement has been signed by both the provider and Absolute Total Care's member for non-covered services prior to rendering said services. Please reference the Member Acknowledgement Statement section of this Provider Manual for requirements. Providers may not bill members for such services if the Member Acknowledgement Statement is not obtained prior to rendering said services.

Balance billing is prohibited under the terms of your provider agreement with Absolute Total Care, Absolute Total Care's Provider Manual and South Carolina State Medicaid rules and regulations:

- Members cannot be billed for the difference between the provider's usual and customary charge and the provider's contracted rate.
- Members cannot be billed for the difference between the amount billed by the provider and the amount paid by Absolute Total Care.
- Absolute Total Care members cannot be billed, nor can any deposits be collected from Absolute Total Care members, for any amounts other than allowable copayment, which cannot exceed the copayment amount allowed by SCDHHS.
- If a member does not keep a scheduled appointment, you are not permitted to bill the member or Absolute Total Care for the missed appointment.

Hospital Claims

Absolute Total Care will process and reimburse for inpatient hospital claims that qualify for additional outlier reimbursement under SCDHHS guidelines as follows. This policy only affects inpatient hospitals claims that meet the following two criteria:

1. Claims that qualify for outlier reimbursement based on the billed amount; and
2. Claims with billed charges in excess of $200,000.

It is Absolute Total Care's policy to request both an itemized bill and the patient's medical records for any inpatient claim that meets both criteria as detailed above. Upon receipt, these requested records will be reviewed for the appropriateness of all charges in accordance with the generally accepted charging practices and NCCI Guidelines.

Eligible outlier claims will have their total claim reimbursement divided into two parts – the applicable DRG case rate and the potential calculated outlier portion. The DRG case rate will be calculated and released for payment immediately to the provider, but the outlier portion of the total reimbursement will be held until the requested documentation is received and reviewed in accordance with this policy. Once charges are reviewed and validated, the outlier portion of the reimbursement will be released, and the total claims payment will have been adjudicated.

Forensic Review Process

- DRG+Outlier are paid and one line which doesn't impact payment is denied.
- A letter will be sent to you requesting both an itemized bill and the patient's medical records.
- The records are sent to the Claims Department, who will forward the claim and medical records to forensic review vendor, The Assist Group.
- The Assist Group reviews the claim and records and informs the Claims Department of the results of the review highlighting exceptions.
- The claim is adjusted based on the exceptions. You will be sent a second letter informing you of the status of the exceptions.

Emergency Room (ER) Claims

Absolute Total Care global period for ER claims is 24 hours. Authorization is not required for ER services.

Requirements for 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. **Failure of an applicant to provide adequate information to meet all criteria may result in termination of the application process.**

Note: In order to maintain a current provider profile, providers are required to notify Absolute Total Care of any relevant changes to their credentialing information in a timely manner.

Practitioners must submit at a minimum the following information when applying for participation with Absolute Total Care:

- Complete signed and dated Absolute Total Care Standardized Credentialing Form of Council for Affordable Quality Health Care (CAQH) Provider Data Form, the application must include the following:
    - Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions and/or felony convictions; lack of current illegal substance and/or alcohol abuse; mental and physical competence and ability to perform the essential functions of the position, with or without accommodation.
- Copy of current malpractice insurance policy fact sheet that includes expiration dates, amounts of coverage and provider's name;
- Copy of current Federal Drug Enforcement Administration (DEA) Certificate;
- Copy of current State Controlled Substance Certificate for South Carolina;
- W-9 Form;

- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable);
- Copy of current unrestricted state license to practice in South Carolina;
- Evidence of Specialty/Board Certification (if applicable);
- Proof of highest level of education (certificate or letter certifying formal post-graduate training) if practitioner is not board certified;
- Copy of CLIA Certificate (if applicable);
- Ability to demonstrate enumeration by National Plan and Provider Enumeration System (NPPES), depicting the provider's unique NPI; and
- Nurse practitioners: current written protocol and name of preceptor (supervising) physician.

Organizational providers must submit at a minimum the following information when applying for participation with Absolute Total Care:

- Complete Credentialing Application;
- Copy of Current General Liability Insurance Policy Fact Sheet that includes expiration dates and amounts of coverage;
- Other applicable current state/federal/licensures (i.e., CLIA, DEA, South Carolina Controlled Substance Certificate, Pharmacy, or Department of Health);
- Copy of current accreditation/certification by a nationally recognized accrediting body or site evaluation results by a government agency if not accredited;
- Attestation of current professional liability coverage in the minimum amounts of $1,000,000 per occurrence and $3,000,000 aggregate;
- Copy of current CMS Certification, if applicable;
- W-9 Form; and
- Ability to demonstrate enumeration by NPPES, depicting the provider's unique NPI.

Absolute Total Care will review for the following information:

- Current, unrestricted state license to practice, if license is required to practice
- Education and training and/or board certification
- Reports of malpractice settlements via the National Practitioner Data Bank (NPDB)
- Current DEA Registration
- Hospital privileges in good standing at a participating Absolute Total Care hospital
- Justification of gaps of six months or greater within the past five years of work history
- Medicare/Medicaid-specific exclusions and/or determination if disbarment, suspension, or other exclusion from participation in federal procurement activities via Office of Inspector General (OIG), System of Award Management (SAM), South Carolina Excluded Providers List (SC EPLS) and South Carolina Termination for Cause List
- Potential fraudulent activity by ensuring provider is not listed on the Social Security Administration's Death Master File
- Proof of professional and/or general liability coverage in an amount accepted by Absolute Total Care
- Proof of collaborative agreement, protocols, or other written authorization with a licensed physician (if applicable)

Note: All providers must be enrolled in the South Carolina Healthy Connections Medicaid Program. Providers must be credentialed and contracted prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed and have an executed contract.

Once the application is completed, Absolute Total Care's Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting. Recredentialing is performed at

least every 36 months.

Nurse Practitioners as a Primary Care Provider (PCP)

Medicaid MCOs may utilize nurse practitioners to provide healthcare services under the following conditions:

- To ensure nurse practitioners are able to perform the healthcare services allowed within the parameters of the South Carolina Nurse Practice Act (State Statute Section 40-33), Absolute Total Care must:
    - Validate nurse practitioner status;
    - Confirm the nurse practitioner's ability to provide the allowed services as evidenced by written protocols; and
    - Verify there is a process in place to accommodate medically necessary hospital admissions.
- Supervising physicians (preceptors) for practices staffed only by nurse practitioners must also be enrolled in the MCO's network and must have an active license. MCOs must:
    - Authenticate the formal relationship between the nurse practitioner and supervising physician (i.e., preceptor); and
    - Contract with any off-site supervising physician who is not already enrolled in the plan's network.

  Note: If the supervising physician will not enroll, the nurse practitioner-only practice cannot be enrolled into or, if already enrolled, cannot remain in the MCO's network.
- Members shall not be automatically assigned to a nurse practitioner; however, members may choose a nurse practitioner to provide the healthcare services allowed with their scope of services. Nurse practitioners submitted on provider files to the enrollment broker must be coded to allow member choice only.

Credentialing Committee

The Credentialing Committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination and direction of the credentialing procedures, including provider participation, denial and termination.

Committee meetings are held monthly and more often as deemed necessary.

Certification and Licensing Requirements

A set of minimum level criteria established by Absolute Total Care will be used to determine physicians', other professional providers' and organizational providers' participation. The minimum criteria include:

- **Ambulance Transportation**
    - Must be licensed by SCDHEC.
- **Ambulatory Surgical Centers**
    - Must be surveyed and licensed by SCDHEC and certified by CMS.
- **Certified Nurse Midwife/Licensed Midwife**
    - A certified nurse midwife must be licensed to practice as a registered nurse by the Board of Nursing under the South Carolina Department of Labor, Licensing and Regulations and certified as a nurse midwife by the Division of Competency Assessment.
    - A certified nurse midwife must be licensed by SCDHEC.
    - A certified nurse midwife's services are limited by practice protocol.

- **Certified Registered Nurse Anesthetist (CRNA)/Anesthesiologist Assistant (AA)**
    - The Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse
    - Anesthetists must license a CRNA to practice as a registered nurse in South Carolina in which he or she is rendering services and currently certified.
    - A CRNA is authorized to perform anesthesia services only and may work independently or under the supervision of an anesthesiologist.
    - An AA must be licensed to practice as an AA in South Carolina.
- **Dispensing Physician**
    - Must be licensed by the Board of Medical Examiners, under the South Carolina Department of Labor, Licensing and Regulations.
- **ESRD Clinics**
    - Must be surveyed and licensed by SCDHEC and certified by CMS.
- **FQHCs**
    - Must have a Notice of Grant Award under 319, 330, or 340 of the Public Health Services Act and be certified by CMS.
    - Provider's billing laboratory procedures must have a CLIA Certificate.
- **Home Health**
    - Must be surveyed and licensed by SCDHEC and certified by CMS.
- **Inpatient/Outpatient Hospitals**
    - Must be surveyed and licensed by SCDHEC and certified by CMS
- **Infusion Centers**
    - There are no licensing requirements or certification for infusion centers.

- **Laboratory Certification**
    - In accordance with federal regulations, all laboratory-testing facilities providing services must have a CLIA Certificate of Waiver or a Certificate of Registration with CLIA identification number.
    - Laboratories can only provide services that are consistent with their type of CLIA certification.
- **Long-Term Care Facilities/Nursing Homes**
    - Must be surveyed and licensed under state law and certified as meeting the Medicaid and Medicare requirements of participation by SCDHEC.
- **Mail-Order Pharmacy**
    - Must be licensed by the appropriate state board.
    - A special non-resident South Carolina permit number is required of all out-of-state providers. The Board of Pharmacy, under the South Carolina Department of Labor, Licensing and Regulations, issues such permits.
    - Be enrolled in the South Carolina Medicaid program and receive official notification of enrollment.
- **Mammography Services**
    - The United States Department of Health and Human Services, Public Health Services and Food and Drug Administration must certify facilities providing screening and diagnostic mammography services.
- **Medical Professionals**
    - Individual medical professionals must all have a current unrestricted license and be certified to practice by the appropriate board/licensing body. Medical professionals include, but are not limited to physicians, physician assistants, podiatrists, chiropractors, private therapists and audiologists.
- **Mobile Ultrasound**
    - No license or certification required.
- **Nurse Practitioner and Clinical Nurse Specialist**
    - A registered nurse must complete an advanced formal education program and be licensed and certified by the South Carolina Board of Nursing under the South Carolina Department of Labor, Licensing and Regulations, or the appropriate medical board in South Carolina.
    - Services are limited by practice protocol.
- **Pharmacy**
    - Permit must be issued by the Board of Pharmacy under the South Carolina Department of Labor, Licensing and Regulations.
- **Physician's Assistants**
    - A health professional that performs such tasks as approved by the State Board of Medical Examiners in a dependent relationship with a supervising physician or under direct personal supervision of the attending physician.
- **Physiology Labs**
    - Providers must be enrolled with Medicare.
- **Podiatrists**
    - Must be licensed by the Board of Podiatry Examiners, under the South Carolina Department of Labor, Licensing and Regulations.
    - Provider's billing laboratory procedures must have a CLIA Certificate.
    - Laboratories can only provide services that are consistent with their type of CLIA certification.
- **Portable X-ray**
    - Must be surveyed by SCDHEC and certified by CMS.

- **RHCs**
    - Must be surveyed and licensed by SCDHEC and certified by CMS.
    - Providers billing laboratory procedures must have a CLIA Certificate.
    - Laboratories can only provide services that are consistent with their type of CLIA certificate.
- **Stationary X-ray**
    - SCDHEC registration.

Recredentialing

Absolute Total Care conducts the recredentialing process for providers at least every three years from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status, which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners (including PCPs and specialists), ancillary providers and/or facilities previously credentialed to practice within Absolute Total Care's network.

Additionally, between credentialing cycles, a provider may be requested to supply current proof of any credentials (e.g., state licensure, malpractice insurance, DEA registration, or a copy of a Certificate of Cultural Competency Training) that have expiration dates prior to the next review process.

A provider's agreement may be terminated if at any time it is determined by Absolute Total Care's Board of Directors or the Credentialing Committee that credentialing requirements are no longer being met.

Practitioner Credentialing Rights

All practitioners requesting participation with Absolute Total Care have the right to review information obtained by Absolute Total Care to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank and malpractice insurance carriers, as well as the South Carolina State Board of Medical Examiners and South Carolina State Board of Nursing for nurse practitioners. 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 Absolute Total Care's 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 Absolute Total Care. Absolute Total Care's Credentialing Committee will then include this information as part of the credentialing/recredentialing process.

Practitioners also have the right to request status of their credentialing/recredentialing application by contacting Provider Services at 1-866-433-6041.

Practitioner Appeal Rights

If your network participation is restricted, suspended, or terminated based on quality of care or service, you have the right to appeal the disciplinary action. You may request an appeal by submitting a written request within 30 days from receipt of notification.

Quality Improvement (QI) Program

Absolute Total Care's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, over/under utilization, continuity and coordination of care, patient safety and administrative and network services.

Absolute Total Care recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Absolute Total Care will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, Absolute Total Care will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and the designation of adequate resources to support the interventions. Whenever possible, Absolute Total Care's Quality Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

Program Structure

Absolute Total Care's Board of Directors oversees development, implementation and evaluation of the Quality Program and has the ultimate authority and accountability for oversight of the quality of care and services provided to members.

The QIC is Absolute Total Care's senior level and network physicians committee accountable directly to the Board of Directors. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivery and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective and systematic monitoring; identification, evaluation and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers and staff regarding the QI, UM and Credentialing programs both at aggregate and by line of business. The QIC is supported by the Member Advisory Committee, Credentialing Committee, Peer Review Committees, HEDIS Steering Committee and the Member and Provider Satisfaction Work Groups.

Absolute Total Care recognizes the integral role of practitioner involvement in the success of its Quality Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Absolute Total Care encourages PCP, behavioral health, pediatrics, OB/GYN, specialist and allied health practitioner representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, Peer Review Committee and select ad-hoc committees.

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in Absolute Total Care QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow Absolute Total Care the use of their performance data for quality improvement activities.

Quality Improvement (QI) Program Goals

ATC's primary goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered. The Quality Program focuses on the health priorities defined by a combination of the CDC 6|18 Initiative, Healthy People 2020 and 2030, the National Institutes of Health and other evidence-based sources. Performance measures are aligned to specific priorities and goals used to drive quality improvement and operational excellence.

ATC's Quality Program priorities and goals support the Centene Corporation purpose of Transforming the Health of the Community, One Person at a Time and the mission of Better Health Outcomes at Lower Costs employing the three core brand pillars: a focus on the individual; an innovative, whole-health, well-coordinated system of care; and active local and community involvement.

Quality Improvement (QI) Program Scope

The scope of the Quality Program is comprehensive and addresses both the quality and safety of clinical care and the quality of service provided to Absolute Total Care's members as defined by the South Carolina Medicaid Program. Absolute Total Care incorporates all demographic groups, lines of business, benefit packages, care settings and services in its QI activities including preventive care, emergency care, primary care, specialty care, acute care, short-term care and ancillary services. Absolute Total Care's Quality Program monitors the following:

- Acute and chronic care management;
- Behavioral healthcare services;
- Clinical quality initiatives;
- Compliance with member confidentiality laws and regulation;
- Compliance with preventive health and clinical practice guidelines;
- Continuity and coordination of care;
- Delegated entity oversight;
- Department performance and service;
- Member and provider cultural competency;
- Member enrollment and disenrollment;
- Member grievance and appeal system;
- Member satisfaction;
- Patient safety;
- Pharmacy services;
- Provider and Absolute Total Care's after-hours telephone accessibility;
- Provider appointment availability and accessibility;
- Provider network adequacy and capacity;
- Provider satisfaction;
- Quality of care review;
- Selection and retention of providers (credentialing and recredentialing); and

- Utilization management, including under-and over-utilization.

Additional information on the QI Program is available online at absolutetotalcare.com. Providers may also call Provider Services at 1-866-433-6041 to request a hard copy of QI Program documents.

Interaction with Functional Areas

The QI Department maintains strong working relationships with key functional areas within the health plan such as Provider Network Services, Member Services and Connections, UM, Regulatory Compliance and the Grievance and Appeals Coordinator(s). QI is integrated throughout Absolute Total Care and represents the strong commitment to quality of care and services for members.

- **Provider Network Services**, such as Provider Services and Contracting and the QI Department work together to verify that clinical materials distributed to providers are understandable and useful and that providers understand the members' rights and responsibilities and treat enrolled members accordingly. These departments also coordinate efforts for appropriate access and availability through ongoing monitoring.
- **Members Services, Care Management and the QI staff** collaborate in relation to Member Satisfaction Survey activities, to include performance improvement projects. The QI, Member Services and Care Management departments work collaboratively to maintain performance data related to EPSDT outreach activities and any other QI activities related to member services functions, including call center functions, are tracked, trended and used as a tool to identify opportunities for performance improvement, as appropriate.
- **UM Department** provides UM, care management and disease- focused services to enrolled members. UM staff identifies and refers quality concerns to the QI Department for investigation and recommends benefit enhancements and participates in QI activities and projects.
- **Regulatory Compliance and the QI Department** work together to ensure that Absolute Total Care's initiatives comply with state contract and accreditation requirements for National Committee for Quality Assurance (NCQA).
- **Grievance and Appeals coordinator(s) and Provider Services** work closely with the QI Department to ensure that:
    - Any grievance related to a quality-of-care issue is promptly investigated;
    - Grievances and second-level reviews of grievances and administrative reviews are handled timely;
    - Data collection and reporting is in compliance with relevant contractual and regulatory requirements; and
    - Reporting to appropriate QI committees occurs.

Performance Improvement Process

Absolute Total Care's QIC reviews and adopts an annual Quality Program Description and QI Work Plan based on managed care Medicaid appropriate industry standards. The QIC adopts traditional quality, risk, UM approaches to problem identification with the objective of identifying improvement opportunities. As part of this approach, the plan president or designee and the medical director, in conjunction with the QI Department, determine the scope and frequency of QI initiatives (e.g., clinical and non-clinical performance improvement projects and focus studies). Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or the service. Other initiatives will be selected to test an innovative strategy. Each initiative topic will reflect distinctive regional emphasis on populations and cultures. Once a QI topic is selected, the QI Department, in conjunction with specific functional areas as appropriate, will present the

proposed QI initiative to the QIC for approval. The QIC will select those initiatives that have the greatest potential for improving health outcomes or the quality of service delivered to the plan's members and network providers.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow the plan to monitor improvement over time.

The development and selection of clinical performance improvement projects are the responsibility of the QIC due to its clinical representation. The QIC continues to monitor progress of clinical performance improvement projects. Absolute Total Care's Quality Program allows for continuous performance of QI activities through analysis, evaluation and improvement in the delivery of healthcare provided to all members and has established mechanisms to track issues over time.

Annually, Absolute Total Care develops a QI Work Plan for the upcoming year. The QI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The QI Work Plan integrates QI activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QI Work Plan.

The QI Work Plan is used by the QI Department to manage projects. Also, it is used by the QICs, QI sub-committees and Absolute Total Care Board of Directors to monitor progress. The QI Work Plan is modified and enhanced throughout the year.

At any time, Absolute Total Care providers may request information on Absolute Total Care's QI Program, including a description of the Quality Program and a report on the plan's progress in meeting the Quality Program goals, by contacting Absolute Total Care's QI Department.

Feedback on Physician Specific Performance

As part of the QI process, performance data on each provider is reviewed and evaluated and may be used for QI activities. The Credentialing Committee and/or other committees involved in the QI may do this. This review of provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency and in-office waiting time;
- Preventive care, including well-child exams, immunizations, lead screening, cervical cancer screening, breast cancer screening and screening for detection of chronic diseases, such as diabetes and kidney disease;
- Prenatal care;
- Member complaint and grievance data;
- UMN data including referrals/1000 and bed days/1000 reports;
- Sentinel events and/or adverse outcomes; and
- Compliance with clinical practice guidelines.

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a set of standardized performance measures developed by The National Committee for Quality Assurance (NCQA) to allow comparison across health plans. Purchasers and consumers use

HEDIS® scores to distinguish between health plans based on comparative quality instead of cost differences. HEDIS® reporting is a required part of the SCDHHS contract. Through HEDIS®, Absolute Total Care is accountable for the timeliness and quality of healthcare services (e.g., acute, preventive and mental health) delivered to its diverse membership.

HEDIS® consists of multiple measures across six domains of care, for which Absolute Total Care contractually reports rates to the state based on claims and medical record review data.

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems

As the state and federal governments move toward a quality-driven healthcare industry, HEDIS® rates are essential for health plans and individual providers. State purchasers of healthcare use the aggregated HEDIS® rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Physician-specific scores indicate evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs, such as 'pay for performance' and 'quality bonus funds. These programs incentivize providers with an increased premium based on the scoring of such quality indicators used in HEDIS®.

How are Healthcare Effectiveness Data and Information Set (HEDIS®) rates calculated?
HEDIS® scores are calculated using two data sets: administrative and hybrid. Administrative data is a claim or encounter data submitted to the health plan. The Hybrid data is administrative data and a sample of medical records data. The Hybrid data requires the review of a random sample of member medical records to abstract data for services rendered and not reported to the health plan through claims/encounter data. Accurate and timely claim/ encounter data reduces the need for medical record review. Services not billed or not billed accurately are not in the calculation.

Who conducts the Medical Record Reviews for Healthcare Effectiveness Data and Information Set (HEDIS®)?
Absolute Total Care will contract with a national medical record review vendor to conduct the HEDIS® medical record reviews on its behalf. Medical record review audits for HEDIS® occur annually in quarters one and two. You may receive a call from a medical record review representative if your patients fall into the HEDIS® samples for Absolute Total Care. Your prompt cooperation with the medical record review representative is greatly needed and appreciated.

Absolute Total Care contracts with medical records review vendors to offer the provider community medical record correspondence options. These options include confidential fax, traditional mail, or onsite retrieval by a qualified staff. These various options allow you, as the provider, to choose the most convenient method for your practice.

As a reminder, HIPAA Privacy Rules (45 CFR 164.506) permits protected health information for use or disclosure for the purpose of treatment, payment, or healthcare operations. Request do not require consent or authorization from the member/patient. The medical record review vendor will sign a HIPAA-compliant Business Associate Agreement with Absolute Total Care, which allows them to collect protected health information on our behalf.

How can I improve my Healthcare Effectiveness Data and Information Set (HEDIS®) score?

- Understand the technical specifications established for each HEDIS® measure.
- Use care gap information to manage the assigned population
- Submit claim/encounter data for every service rendered
- Make sure that chart Documentation: reflects all services billed
- Bill (or report by encounter submission) for all delivered services, regardless of contract status
- Submit all claim/encounter data in an accurate and timely manner
- Consider including CPT II codes to provide additional details and reduce medical record requests

Contact the Quality Improvement department at Absolute Total Care if you have any questions, comments, or concerns regarding the annual HEDIS® project or the medical record reviews.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

CAHPS® is a member satisfaction survey included as a part of HEDIS® and NCQA accreditation. This standardized survey is administered annually to members by an NCQA-certified survey vendor. The survey provides information on members' experiences with the Managed Care Organization (MCO) services. This data gives Absolute Total Care a general indication of how well Absolute Total Care meets members' expectations.

The CAHPS® survey focuses on three population cohorts:

- Adult
- Child
- Child with Chronic Conditions

Composite scores summarize member responses in the following key areas:

- Getting Needed Care
- Getting Care Quickly
- Care Coordination
- How Well Doctors Communicate
- Rating of Health Care Quality

Provider Satisfaction Survey

Absolute Total Care conducts an annual provider satisfaction survey, which includes questions to evaluate provider satisfaction with our services, such as claims, communications, UM and provider services. An external vendor conducts the survey. The vendor randomly selects participants, meeting specific requirements outlined by Absolute Total Care, and the participants are kept anonymous. We encourage you to respond in a timely matter to the survey as the results of the survey are analyzed and used as a basis for forming provider-related QI initiatives. Other surveys may be used for provider feedback as well.

Feedback of Aggregate Results

Aggregate results of studies and guideline compliance audits are presented to the QIC. Participating physician members of the QIC provide input into action plans and serve as a liaison with physicians in the community. Aggregate results are also published in public communications.

At least quarterly, a provider relations specialist meets with PCPs and bi-annually with high volume specialists to review policies, guidelines, indicators, medical record standards and provide feedback of

audit/study results. These sessions are also an opportunity for providers to suggest revisions to existing materials and recommend priorities for further initiatives. When a guideline, indicator, or standard is developed in response to a documented quality of care deficiency, Absolute Total Care disseminates the materials through an in-service training program to upgrade providers' knowledge and skills. Absolute Total Care's Medical Director and Pharmacist conduct special training and meetings to assist physicians and other providers with QI and service improvement efforts.

Fraud, Waste and Abuse

Absolute Total Care is committed to preventing, detecting, identifying and reporting suspected cases of fraud, waste, and abuse and has a Fraud, Waste and Abuse Program that complies with all state and federal laws. Absolute Total Care, in conjunction with its management company, Centene, successfully operates a Payment Integrity Department and a Special Investigations Unit. Absolute Total Care routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claim's payment process. To better understand this system, please review the Billing and Claims section of this manual. The Special Investigations Unit performs retrospective audits, which in some cases result in taking actions against providers who commit fraud, waste and/or abuse. These actions include, but are not limited to:

- Remedial education and training to prevent the billing irregularity;
- More stringent utilization review;
- Recoupment of previously paid monies;
- Termination of provider agreement or other contractual arrangement;
- Civil and/or criminal prosecution; and
- Any other remedies available to rectify.

Some of the most common errors seen are:

- Unbundling of codes;
- Up-coding services;
- Add-on codes without primary CPT;
- Diagnosis and/or procedure code not consistent with the patient's age/gender;
- Use of exclusion codes;
- Excessive use of units;
- Misuse of benefits; and
  Claims for services not rendered.

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664. Absolute Total Care takes all reports of potential fraud, waste and abuse very seriously and will investigate all reported issues.

Compliance Authority and Responsibility

Absolute Total Care's Vice President of Compliance has overall responsibilityand authority for carrying out the provisions of the Compliance Program.

Absolute Total Care is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

Absolute Total Care's provider network must cooperate fully in making personnel and/or

subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations, at the provider's own expense.

These are the primary agencies to which incidents or practices of abuse and/or fraud are to be reported:

Absolute Total Care Fraud, Waste and Abuse Reporting Contact Information

Mail: Absolute Total Care
Compliance Department
100 Center Point Circle, Suite 100
Columbia, SC 29210

Absolute Total Care Fraud and Abuse Hotline: 1-866-685-8664 (All calls are confidential.)

Email: atc.compliance@centene.com

South Carolina Department of Health and Human Services (SCDHHS) Fraud, Waste and Abuse Reporting Contact Information

Mail: SCDHHS Division of Program Integrity
P.O. Box 8206
Columbia, SC 29202
Telephone: 1-888-364-3224
Email: fraudres@scdhhs.gov

Absolute Total Care's staff is available to answer any questions or concerns you have regarding fraud, waste and abuse. Please contact Provider Services at 1-866-433-6041 with any questions.

Member Services

Absolute Total Care is committed to providing its members with information about the health benefits that are available to them through Absolute Total Care. Absolute Total Care encourages members to take responsibility for their healthcare by providing basic information to assist with making decisions about their healthcare choices.

Absolute Total Care has developed targeted programs to address the needs of its members. Members may attend classes and receive specific disease management bulletins and treatment updates, appointment reminder cards and informational mailings.

As a provider for Absolute Total Care, please remember that it is your obligation to identify any member who requires translation, interpretation, or sign language services. Absolute Total Care will pay for these services whenever you need them to effectively communicate with an Absolute Total Care member. Absolute Total Care members are not to be held liable for these services. To arrange for any of the above services, please call Provider Services at 1-866-433-6041.

Member Materials

Members will receive various pieces of information from Absolute Total Care through mailings, on our website and through face-to-face contact. These materials include:

- Quarterly newsletters
- Targeted disease management brochures
- Provider directory
- Nurse advice line information
- ER information
- Member Handbook, which includes:
    - Benefit information
    - Member rights and responsibilities

Providers interested in receiving any of these materials may visit absolutetotalcare.com or contact:

Member Services Department
Telephone: 1-866-433-6041 (TTY: 711)
Fax: 1-866-912-3610

Provider Bill of Rights

Absolute Total Care providers shall be assured of the following rights:

- A healthcare professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his or her patient for the following:
    - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
    - Any information the member needs in order to decide among all relevant treatment options;
    - The risks, benefits and consequences of treatment or non-treatment;
    - The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions;
    - To receive information on the grievance, appeal and State Fair Hearing procedures
    - To have access to Absolute Total Care's policies and procedures covering the authorization of services;
    - To be notified of any decision by Absolute Total Care to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested;
    - To challenge on behalf of Absolute Total Care members the denial of coverage of, or payment for, medical assistance;
    - Absolute Total Care provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; and
    - To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

Member Rights

Members are informed of their rights and responsibilities through the Member Handbook. Absolute Total Care providers are also expected to respect and honor members' rights and to post the Member Rights and Responsibilities in their offices.

Absolute Total Care members have the following rights:

- To be treated with respect and with due consideration for his or her dignity and the right to privacy and non-discrimination as required by law.
- To participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
- To request and receive a copy of their medical records and request that their medical record be amended or corrected.
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information including enrollment notices, information materials, instructional materials, available treatment options and alternatives in a manner and format that may be easily understood.
- To receive assistance from both SCDHHS and Absolute Total Care in understanding the requirements and benefits of the health plan.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- To receive information about the basic features of managed care, which populations may or may not enroll in the program, and Absolute Total Care's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information on the following:
    - *Benefits covered.*
    - *Procedures for obtaining benefits, including any authorization requirements*
    - *Cost-sharing requirements.*
    - *Service area.*
    - *Names, locations, telephone numbers of non-English language speaking Absolute Total Care providers, including at a minimum, PCPs, specialists and hospitals.*
    - *Any restrictions on member's freedom of choice among network providers.*
    - *Providers not accepting new patients.*
    - *Benefits not offered by Absolute Total Care but available to members and how to obtain those benefits, including how transportation is provided.*
- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
- To receive information on the grievance, appeal and State Fair Hearing procedures.
- To receive detailed information on emergency and after-hours coverage, including, but not limited to:
    - *What constitutes an emergency medical condition, emergency services and post-stabilization services.*
    - *That emergency services do not require prior authorization.*
    - *The process and procedures for obtaining emergency services.*
    - *The locations of any emergency settings and other locations at which providers and*

hospitals furnish emergency services and post-stabilization services covered under the contract.
    - *The right to use any hospital or other setting for emergency care.*
    - *Post-stabilization care services rules in accordance with federal guidelines.*
- To expect their medical records and care be kept confidential as required by law.
- To receive Absolute Total Care's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
- To exercise these rights without adversely affecting the way Absolute Total Care, its providers, or SCDHHS treat the member.
- To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law.
- To receive timely access to care, including referrals to specialists when medically necessary without barriers.
- To choose a PCP and to change to another PCP.
- To choose a person to act on their behalf.
- To voice grievances or file appeals about Absolute Total Care decisions that affect their privacy, benefits, or the care provided.
- To make recommendations regarding Absolute Total Care's member rights and responsibilities policy.
- To file for a State Fair Hearing with SCDHHS.
- To make an advance directive, such as a living will.
- To receive information about Absolute Total Care, its benefits, its services, its practitioners, providers, member rights and responsibilities.
- To have a candid discussion about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To get a second opinion from a qualified healthcare professional.
    - *You have the right to a second opinion about your care.*
    - *This means talking to a different provider about an issue to see what they have to say. The second provider is able to give you their point of view. This may help you decide if certain services or methods are best for you. If you want to hear another point of view, tell your PCP.*
    - *Choose an Absolute Total Care contracted provider to give you a second opinion. There is no charge to you. Your PCP or Member Services can help you find a provider. If you are unable to find a provider in Absolute Total Care's network, we will help you find a provider outside the network. There is no charge to you if you need a second opinion from a provider outside the network.*
    - *Any tests that are ordered for a second opinion must be given by a provider in Absolute Total Care's network. Your PCP will look at the second opinion and help you decide on a treatment plan that will work best for you.*

Member Responsibilities

Absolute Total Care members have the following responsibilities*:*

- To inform Absolute Total Care of the loss or theft of their ID card.
- To present their ID card when using healthcare services.
- To be familiar with Absolute Total Care procedures to the best of their ability.
- To call or contact Absolute Total Care to obtain information and have questions clarified.
- To provide information (to the extent possible) that Absolute Total Care and its practitioners

and providers need in order to provide care.

- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with their practitioners/providers.
- Make every effort to keep a scheduled appointment or cancel an appointment in advance of when it is scheduled.
- To inform their provider on reasons they cannot follow the prescribed treatment of care recommended.
- To understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To access preventive care services.
- To follow the policies and procedures of the SCDHHS Medicaid Plan.
- To be honest with providers and treat them with respect and kindness.
- To get regular medical care from their PCP before seeing a specialist.
- To follow the steps of the appeal process.
- To notify SCDHHS, Absolute Total Care and your providers of any changes that may affect their membership, healthcare needs or access to benefits. Some examples may include:
    - *If they have a baby.*
    - *If their address changes.*
    - *If their telephone number changes.*
    - *If they or one of their children are covered by another health plan.*
    - *If they have a special medical concern.*
    - *If their family size changes.*
- To keep all their scheduled appointments, be on time for those appointments and cancel 24 hours in advance if they cannot keep an appointment.

Member Grievances

A **grievance** is an expression of dissatisfaction about any matter other than an "adverse benefit determination" such as:

- Wait time to see a doctor;
- Rudeness of a provider or office staff; or
- Unclean facilities.

Grievances may be filed either orally or in writing with Absolute Total Care at any time. A member or a member's authorized representative can file a grievance with Absolute Total Care. An authorized representative is a person or provider a member gives the right to act on their behalf.

A member can give permission for a person or a provider to act on their behalf in writing by completing and submitting the Appointment of Authorized Representative Form found on our website at absolutetotalcare.com.

If needed, Absolute Total Care will assist members in filing a grievance. This includes providing assistance with accessing auxiliary aids and services upon request, such as providing interpreter services and hearing-impaired services, if needed, at no cost to the member. Absolute Total Care does not treat members differently because they have filed a grievance and their benefits will not be affected.

To file a grievance, members can do one of the following:

- Call Member Services at 1-866-433-6041.
- Mail, email, or fax a completed Grievance Form or written letter telling us why they are not satisfied. Obtain a Grievance Form from our website at absolutetotalcare.com or by calling

Member Services. Information should include:

- Member's first and last name;
- Member's Absolute Total Care member ID number;
- Member's address and telephone number; and
- The reason for the grievance.

Mail: Absolute Total Care
Grievance and Appeals Coordinator
100 Center Point Circle, Suite 100
Columbia, SC 29210

Fax: 1-866-918-4457

Email: atc-appeals_grievances@centene.com

- Members can present their evidence in person at the address above

Absolute Total Care will send a letter to the member confirming the receipt of the grievance within **five calendar days.** We will try to reach a resolution right away. If not, we will send a written decision within **90 calendar days** from receipt of the grievance. Absolute Total Care may extend the time frame to resolve the grievance up to **14 calendar days** if the member or the member's authorized representative requests additional time or Absolute Total Care can demonstrate that there is a need for additional information that is in the member's best interest. If the time frame is extended, Absolute Total Care will make a reasonable effort to give the member prompt oral notice of the delay. Absolute Total Care will give the member written notification within **two calendar days**, including the reason for the additional time to resolve the issue as well as information on their right to file a grievance if they disagree with the decision.

If a member is not satisfied with the first decision of a grievance, the member can request a second review of the grievance within **30 calendar days** from the receipt of the notice of the original decision. Absolute Total Care will review the grievance again. The second grievance review will be completed by someone who did not make the decision on the first grievance review. After the first and second review of the grievance have been completed, the member does not have the right to file a State Fair Hearing.

Medical Appeals

An appeal is the request for review of an "action," as adverse benefit determination is defined in 42.CFR § 438.400, or a request to change a previous decision made by Absolute Total Care. NCQA refers to all requests to reverse a decision as appeals.

An adverse benefit determination is defined as:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the state.
- The failure of an MCO, PIHP, or PAHP to act within the time frames provided in 42 CFR § 438.408(b)(1)and (2) regarding the standard resolution of grievances and appeals.

- For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.
- The denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities.

An appeal may be filed within **60 calendar days** from the date on the Adverse Benefit Determination Notice. The Adverse Benefit Determination Notice will explain the action Absolute Total Care has taken, explain the appeals process, and include a copy of the **Appeal Form**. Information on the appeals process and a copy of the Appeal Form can also be found on our website at absolutetotalcare.com.

Who can file an appeal?

- A member ora member's authorized representative can file an appeal with Absolute Total Care.
- An authorized representative is a person or provider a member gives the right to act on their behalf in writing or is already legally authorized to act on behalf of the member such as a parent or legal guardian
- A member can give permission for a person or a provider to act on their behalf in writing or by completing the **Appointment of Authorized Representative Form** found on our website at absolutetotalcare.com.

An appeal may be requested in writing or orally. Requests for an appeal that are received without the member's written consent cannot be processed. General consents signed by the member such as consent of financial liability, consent for treatment, or consent to disclose PHI do not meet compliance standards for appeals. It is recommended the Appointment of Authorized Representative form be used. However, in cases that form is not used, or the provider utilizes their own form, the written consent must specifically authorize a person or facility to act as an authorized representative for the member and include, at a minimum, the member's name, DOB, date and signature. Software that allows electronic or remote signing of documents, such as DocuSign, are acceptable only when they can be authenticated by including a unique signature ID (usually below or beside the name).

If needed, Absolute Total Care will assist members in filing an appeal. This includes providing assistance with accessing auxiliary aids and services upon request, including interpreter services and hearing-impaired services, if needed, at no cost to the member. Absolute Total Care cannot and will not treat members differently because they have filed an appeal and their benefits will not be affected.

To file an appeal, do one of the following:

- Call Member Services at 1-866-433-6041.
- Mail, email or fax a completed Appeal Form or written letter about the appeal. Obtain an Appeal Form from our website at absolutetotalcare.com or by calling Member Services. A copy of the Appeal Form is also included with the Adverse Benefit Determination Notice. Information should include:
    - Member's first and last name;
    - Member's Absolute Total Care member ID number;
    - Member's address and telephone number; and
    - The reason for the appeal.

Mail: Absolute Total Care
Attn: Grievance and Appeals Coordinator
100 Center Point Circle, Suite 100
Columbia, SC 29210

Fax: 1-866-918-4457

Email: atc-appeals_grievances@centene.com

- Members can present their evidence in person at the address above, in writing, or by telephone.

Absolute Total Care will send a letter letting the member know that we received the appeal. Members also have the right to present evidence and testimony and make legal and factual arguments regarding their appeal in person, in writing, or by telephone. Members also have the right to receive, at no charge and upon oral or written request, any evidence and documents regarding their appeal or review inperson at Absolute Total Care's office address listed above.

There are two kinds of member appeals.

Standard Appeal

Absolute Total Care will provide a written decision within **30 calendar days** from the date the request was received.

Expedited Appeal

If a decision on an appeal is required immediately due to the member's physical or mental health needs, or that could seriously jeopardize the member's life or ability to attain, maintain, or regain maximum function, and which cannot wait with the standard resolution time, an expedited appeal may be requested. Absolute Total Care's decision on the expedited resolution will be provided within **72 hours** of the receipt of the request.

If the request for an expedited appeal is denied, Absolute Total Care will make efforts to contact the member and provider promptly by telephone. In addition, the member and provider will be sent a written notice within **two calendar days**. Absolute Total Care will follow the standard appeal timeframe and provide a written decision within **30 calendar days** from the original appeal request.

Extension of an Appeal

Absolute Total Care may extend the time frame to resolve a standard or an expedited appeal up to **14 calendar days** if the member or the member's authorized representative request an extension, or Absolute Total Care can demonstrate that there is a need for additional information that is in the member's best interest. If the timeframe is extended, Absolute Total Care will make a reasonable effort to give the member prompt oral notice of the delay. Absolute Total Care will give the member written notification within **two calendar days**, including the reason for the additional time to resolve the issue as well as information on their right to file a grievance if they disagree with the decision.

The appeal is reviewed, and a final decision will be made by a medical director or appropriately licensed clinical peer who has the appropriate clinical expertise as determined by the state in treating the member's condition, who was not involved in the prior decision and did not report to the original decision-maker.

Absolute Total Care will not take punitive action against a provider who requests an expedited resolution or supports a member's appeal request.

Absolute Total Care shall retain grievance and appeal records and reports for a period of at least 10 years from the date the appeal or grievance has been resolved. If any litigation, claim negotiation, audit or other action involving the documents or records has been started before the expiration of the 10-year

period, the records shall be retained until the completion of the action and resolution of issues which arise from it or until the end of the regular 10-year period, whichever is later.

Member Rights to a State Fair Hearing

If the member is not satisfied with the final appeal decision, the member or the member's authorized representative may file an appeal directly to SCDHHS Division of Appeals and Hearings. The request for a State Fair Hearing must be made within **120 calendar days** from the date on the Adverse Benefit Determination Notice.

Request for a State Fair Hearing must be in writing and sent to:

South Carolina Department of Health and Human Services
Division of Appeals and Hearings (Suite 901)
P.O. Box 8206
Columbia, SC 29202-8206

Telephone: 1-803-898-2600

Continuation of Benefits

Absolute Total Care members may continue receiving services or items until a decision is made about his or her appeal or State Fair Hearing process if the member was receiving ongoing services that were suspended, reduced, or terminated. To ensure continuation of currently authorized services the member or the member's authorized representative must file an appeal and request for services within **10 calendar days** from the date on the Adverse Benefit Determination Notice, with the exception that a provider cannot request continuation of services for the member.

Members may be required to pay the costs of the services if the final appeal or State Fair Hearing decision is averse to the member.

Absolute Total Care will continue the member's benefits if the following conditions are met:

- The member or the member's authorized representative files the appeal timely;
- The action involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The member requested extension of benefits timely.

If Absolute Total Care continues or reinstates the care at the member request while the appeal is pending, the care must be continued until one of the following occurs:

- The member or the member's authorized representative withdraws the appeal request;
- Ten calendar days pass after the date on Absolute Total Care's Adverse Benefit Determination Notice providing the resolution of the appeal, unless the member, within the 10-day time frame, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;
- A State Fair Hearing officer issues a decision adverse to the member; or
- The time period or service limits of a previously authorized service has been met.

Assistance and Contacting Absolute Total Care

Absolute Total Care's Grievance and Appeals Coordinator is available to assist members who need help in filing a grievance or request for appeal or in completing any element in the grievance or appeal process. Members may seek assistance or initiate a grievance or request for appeal by calling 1-866-433-6041 (TTY: 711).

Appointment of Authorized Representative

The MCO contract allows for a provider or another person to act on behalf of the member with the **member's written consent**. The authorized representative can file a grievance or an appeal or request a State Fair Hearing, with the exception that a provider cannot request continuation of benefits. A member can give written consent for a provider, another person, or an attorney to act on their behalf by completing and submitting the Appointment of Authorized Representative Form found on our website at absolutetotalcare.com. A copy of the completed Authorized Representative Form will need to be attached when an authorized provider or person files a grievance, an appeal, or requests a State Fair Hearing on behalf of a member. Requests that are received without the member's consent cannot be processed.

Ombudsman

The member has the right to be represented in the appeal process by anyone they choose, including an attorney, but representation is not required. The state of South Carolina can provide representation through its health insurance ombudsman office. To contact the service, call 803-734-5049, or mail the South Carolina Office of Ombudsman, Wade Hampton Building, 1205 Pendleton Street, Columbia, SC 29201.

Special Services to Assist with Members

Absolute Total Care has designed its programs and trained its staff to ensure that each member's cultural needs are considered in carrying out Absolute Total Care operations. Providers should remain cognizant of the diverse Absolute Total Care population. Members' needs may vary depending on their gender, ethnicity, age and beliefs. We ask that you recognize these needs in serving your patients. Absolute Total Care is always available to assist your office in providing the best care possible to the members.

Interpreter/Translation Services

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

- Having individuals available who are trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with members as needed.
- Providing Language Line services that will be available 24 hours a day, seven days a week 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 in advance of the member's scheduled appointment in order to allow for a more positive encounter between the member and provider; telephonic services are available for those encounters involving urgent/emergent situations, as well as non-urgent/emergent appointments as requested.
- Providing TTY access for members who are hearing impaired through 711.
- Absolute Total Care medical advice line, nurse advice line, provider 24-hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line.
- Providing or making available Member Services and health education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee.

Providers must call Member Services at 1-866-433-6041 if interpreter services are needed. Please have the member's ID number, date/time service is requested and any other documentation that would assist in scheduling interpreter services.

Covered Pharmacy Services

Prescription drug benefits are managed though Absolute Total Care and are administered by Absolute Total Care's pharmacy benefit manager. Absolute Total Care uses a Comprehensive Drug List (CDL) which includes all drugs on the SCDHHS Single Drug List, effective July 1, 2024, as well as additional drugs. This is a list of prescription drugs approved by Absolute Total Care for use by our members. All generic drugs and certain brand-name drugs listed in the CDL are covered. Some drugs, even though

they are listed on the CDL, may have special limitations, such as quantity limits and age restrictions. Others may require the member to try and fail other preferred medications first. Non-CDL drugs may be requested through the prior authorization process. Some drugs are excluded from the pharmacy benefits, such as those for infertility and cosmetic purposes. The CDL is available to providers on our website at absolutetotalcare.com. Most drugs are allowed up to a 31-day supply.

Pharmacy Policy

Absolute Total Care's pharmacy benefit provides access to a broad range of approved medications using a CDL. The CDL does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the independent professional judgment of the physician or pharmacist; or
- Relieve the physician or pharmacist of any obligation to the patient or others.

The CDL is administered by the P&T Committee, composed of the medical director, pharmacy director and community-based PCP and specialists. The primary function of the committee is to assist with the maintenance of Absolute Total Care's CDL and to establish programs and procedures for promoting positive patient outcomes in the Medicaid population. All CDL changes are reported to SCDHHS for review and approval.

Generic substitution is mandatory when a generic equivalent is available. All branded products that have three or more A-rated generic equivalents will be reimbursed at the maximum allowable cost. The mandatory generic substitution provision is waived for drugs that have a narrow therapeutic index.

Pharmacy Prior Authorization

The CDL attempts to provide appropriate and cost-effective drug therapy to all participants covered by Absolute Total Care's pharmacy program. If a patient requires medication that does not appear on the CDL, the physician can make a request for a non-preferred medication. It is anticipated that such exceptions will be rare and that CDL medications will be appropriate to treat the vast majority of medical conditions. The P&T Committee or the Clinical Practitioners Advisory Committee established the prior authorization criteria. In order for a member to receive coverage for a medication requiring prior authorization, the physician or pharmacist must submit a Prior Authorization Request Form. **To ensure timely processing of requests, all relevant clinical information and previous drug history must be included, and the form faxed or telephoned to:**

Prior Authorization Telephone: 1-866-399-0928
Prior Authorization Fax: 1-833-982-4001

Prior authorization requests will be reviewed, and notification of a decision will be made within **24 hours** from the time a complete request was received in accordance with all requirements set forth in 42 CFR 438.210(d)(3), as prescribed by Section 1927(d)(5)(A) of the Act.

Over-the-Counter (OTC) Medications

Many OTC medications are available to our members on the CDL. OTC medications must be written on a valid prescription, by a licensed prescriber, in order to be filled by the pharmacy.

Injectables and Oral Anti-Cancer Drugs

Some injectable drugs and oral cancer drugs that can be self-administered by the patient or family member are listed in the CDL and are covered under the pharmacy benefit. The majority of self-administered injectable drugs, and several oral anti-cancer drugs, will require prior authorization from Absolute Total Care prior to dispensing.

72- Hour Emergency Supply Policy

State and federal law require that a pharmacy dispense a 72-hour emergency supply of medicine to any member awaiting prior authorization determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour emergency supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour emergency supply of medication, whether or not the prior authorization request is ultimately approved or denied. If the pharmacy requires further assistance for any reason, they may call Pharmacy Services at 1-866-399-0928.

Continuity of Care/Transition of Care

The continuity of care process promotes the appropriate, safe and effective transition of medications for new members on a prescription drug not on Absolute Total Care's CDL to a prescription drug on the PDL. The member will be allowed to fill the prescription for an additional 30 calendar days, up to 90 days, without requiring a prior authorization or disruption.

Transition of Health Records
Providers furnishing services to Members must maintain and share a Member health record in accordance with professional standards (42 CFR 438.208(b)(5).

Exclusions

Most prescriptions are limited to a 31-day supply per fill. The following drug categories are not part of Absolute Total Care's PDL and are not covered regardless of circumstance:

- Weight control products (except lipase inhibitors);
- Investigational pharmaceuticals or products;
- Pharmaceuticals identified by CMS as less than effective and identical, related, or similar drugs (DESI drugs);
- Injectable pharmaceuticals (except those listed in the PDL);
- Fertility products;
- Infusion supplies;
- Nutritional supplements;
- Pharmaceuticals used for cosmetic purposes or hair growth;
- Gender reassignment products; and
- Erectile dysfunction products prescribed to treat impotencies.

Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes Beneficiary practices that result in unnecessary cost to the Medicaid Program.

ACIP: Centers for Disease Control Advisory Committee on Immunization Practices.

Action: The denial or limited authorization of a requested service, including the type or level of Service:

- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the State;
- The failure of Absolute Total Care to process Grievances, Appeals or expedited Appeals within the timeframes required; or
- For a resident of a rural area with only one Medicaid Managed Care Organization (MCO), the denial of a Medicaid member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside Absolute Total Care's network.

Additional Services: A Covered Service provided by Absolute Total Care which is currently a Non-Covered Service(s) by the SC State Plan for Medical Assistance or is an additional Medicaid Covered Service furnished by Absolute Total Care to Medicaid Managed Care Program members for which Absolute Total Care receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in this contract.

Administrative Days: Inpatient hospital days associated with nursing home level patients who no longer require acute care and are waiting for nursing home placement. Administrative Days must follow an acute inpatient stay.

Adverse Benefit Determination: An Adverse Benefit Determination is:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered Benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the Claim does not meet the definition of a "Clean Claim" at 42 CFR §447.45(b) of this chapter is not an Adverse Benefit Determination.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of Absolute Total Care to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.
- For a resident of a rural area with only one MCO, the denial of a Member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.
- The denial of a Member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Alternative Payment Model (APM): A form of payment reform that incorporates quality and total cost of care into the reimbursement for medical services, as opposed to paying Claims with a traditional Medicaid Fee for Service Rate.

Ambulance Services: Ambulance Services, including Ambulance Services dispatched through 911 or its local equivalent, where other means of transportation would endanger the Beneficiary's health (42 CFR §422.113(a)).

American Health Information Management Association (AHIMA): A professional organization for the

field of effective management of health data and Health Record needed to deliver quality healthcare to the public management.

American National Standards Institute (ANSI): The American National Standards Institute is a private non-profit organization that oversees the development of voluntary consensus standards for products, services, processes, systems, and personnel in the United States.

ANSI ASC X12N 837P: The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P (Professional) Version 5010A1 is the current electronic Claim version.

Appeal: A request for review of an Adverse Benefit Determination, as defined in 42 CFR § 438.400.

Applicant: An individual: seeking Medicaid eligibility through written application and whose signed application for Medicaid has been received by the South Carolina Department of Health and Human Services (SC DHHS).

Authorized Representative: An individual granted authority to act on a member's behalf through a written document signed by the Applicant or member, or through another legally binding format subject to applicable authentication and data security standards. Legal documentation of authority to act on behalf of an Applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of the Applicant's or member's signature.

Baby Net: The Early Intervention System under Part C of the Individuals with Disabilities Education Act (IDEA Part C). For children from birth to age three (3) meeting BabyNet eligibility criteria, the early intervention services offered in the program build upon and provide support and resources to assist and enhance the learning and development of infants and toddlers with disabilities and special needs.

Behavioral Health: A state of health that encompasses mental, emotional, cognitive, social, behavioral stability including freedom from substance use disorders.

Behavioral Health Provider: Individuals and/or entities that provide Behavioral Health Services.

Behavioral Health Services: The blending of mental health disorders and/or substance use disorders prevention in treatment for the purpose of providing comprehensive services.

Beneficiary: An Applicant approved for and receiving Medicaid Benefits.

Benefit or Benefits: The health care services set forth by SCDHHS, for which Absolute Total Care has agreed to provide, arrange, and be held fiscally responsible. Also referenced as Core Benefits or Covered Services.

CAHPS: The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of patients' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality.

Care Coordination: The manner or practice of planning, directing and coordinating health care needs and services of Medicaid Managed Care Program Members.

Care Coordinator: The individual responsible for planning, directing and coordinating services to meet identified health care needs of Medicaid Managed Care Program members.

Care Management: Care Management is a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aim of improving patients' functional health status, enhancing coordination of care, eliminating duplication of services and reducing the need for expensive medical services (NCQA).

Case: An event or situation.

Case Management: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes (CMSA, n.d.)

Case Management Society of America (CMSA): A non-profit association dedicated to the support and development of the profession of Case Management (www.cmsa.org).

Centers for Medicare and Medicaid Services (CMS): The federal Agency within the U.S. Department of Health and Human Services with responsibility for the Medicare, Medicaid, and the state Children's Health Insurance Program.

Certificate of Coverage: The term describing services and supplies provided to Medicaid Managed Care Program Members, which includes specific information on Benefits, coverage limitations and services not covered. The term "Certificate of Coverage" is interchangeable with the term "Evidence of Coverage".

Cesarean Section: A surgical procedure used to deliver a baby through incisions in the mother's abdomen and uterus.

Claim: A bill for services, a line item of services, or all services for one Recipient within a bill.

Clean Claim: Claims that can be processed without obtaining additional information from the Provider of the service or from a Third Party.

CMS 1500: Universal Claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.

Code of Federal Regulation (CFR): The Code of Federal Regulations (CFR) is an annual codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

- The CFR is divided into fifty (50) titles representing broad areas subject to Federal regulation.
- Each Title is divided into chapters that are assigned to agencies issuing regulations pertaining to that broad subject area. Each chapter is divided into parts and each part is then divided into sections -- the basic unit of the CFR.
- The purpose of the CFR is to present the official and complete text of agency regulations in one organized publication and to provide a comprehensive and convenient reference for all those who may need to know the text of general and permanent federal regulations.
- The CFR is keyed to and kept up to date by the daily Federal Register. These two publications must be used together to determine the latest version of any given rule. When a federal agency publishes a regulation in the Federal Register, that regulation usually is an amendment to the

existing CFR in the form of a change, an addition, or a removal.

Compliance Plan: A collection of written policies, procedures, and standards of conduct that articulate Absolute Total Care's commitment to comply with all applicable requirements and standards under the contract, and all federal and State requirements.

Continuity of Care: Activities that ensure a continuum approach to treating and providing health care services to Medicaid Managed Care Members consistent with 42 CFR § 438.208, the provisions outlined in this contract and the Managed Care Process and Procedure Manual. This includes, but is not limited to, ensuring appropriate referrals, monitoring, and follow-up to Providers within the network; ensuring appropriate linkage and interaction with Providers outside the network; processes for effective interactions between Medicaid Managed Care Members, in network and out-of-network Providers; and identification and resolution of problems if those interactions are not effective or do not occur.

Copayment: Any cost-sharing payment for which the Medicaid Managed Care Program member is responsible.

Core Benefits: A schedule of health care Benefits provided to Medicaid Managed Care Program members enrolled in the Absolute Total Care Plan as specified under the terms of the contract with SCDHHS.

Covered Services: Services included in the South Carolina State Plan for Medical Assistance and covered under Absolute Total Care. Also referred to as Benefits or Covered Benefits.

Credentialing: Absolute Total Care's determination as to the qualifications and ascribed privileges of a specific Provider to render specific health care services.

Credible Allegation of Fraud: A credible allegation of fraud may be an allegation, which has been verified by the State. Allegations are considered to be credible when they have indications of reliability, and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. Sources include but are not limited to the following: fraud hotline complaints; claims data mining; and patterns identified through Provider audits, civil false Claims Cases, and law enforcement investigations.

Cultural Competency: A set of interpersonal skills that promote the delivery of services in a culturally competent manner to all Medicaid Managed Care Members—including those with limited English proficiency and diverse cultural and ethnic backgrounds—allowing for 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 Medicaid Managed Care Members (as required by 42 CFR § 438.206).

Current Procedural Terminology (CPT): Medical nomenclature used to report medical procedures and services under public and private health insurance programs (American Medical Association).

Days: Calendar Days unless otherwise specified.

Drug Utilization Review (DUR): A structured program that monitors and evaluates the use of outpatient prescriptions drugs. The program aims to ensure appropriate, medically necessary, and safe drug therapy and prevents fraud, misuse, and abuse.

Dual Diagnosis or Dual Disorders: An individual who has both a diagnosed mental health problem and a problem with alcohol and/or drug use.

Dual Eligible (a.k.a. Dual Eligibles): Individuals that are enrolled in both Medicaid and Medicare Programs and receive Benefits from both Programs.

Durable Medical Equipment: Equipment that provides therapeutic benefits or enables beneficiaries to perform certain tasks that they are unable to undertake otherwise due to certain medical conditions and/or illness.

Early and Periodic Screening Diagnosis and Treatment (EPSDT): The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

- Early: Assessing and identifying problems early
- Periodic: Checking children's health at periodic, age-appropriate intervals
- Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- Diagnostic: Performing diagnostic tests to follow up when a risk is identified, and
- Treatment: Control, correct or reduce health problems found.

States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on federal guidelines.

Eligible or Eligibles: A person who has been determined eligible to receive services as provided for in the SC State Plan for Medical Assistance under Title XIX.

Emergency Medical Condition: Medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and Outpatient Services that are as follows: furnished by a Provider that is qualified to furnish these services and needed to evaluate or stabilize an Emergency Medical Condition.

Encounter: Any service provided to a Medicaid Managed Care Program member regardless of how the service was reimbursed and regardless of Provider type, practice specialty, or place of services. This would include expanded services/Benefits as defined in this contract.

Enrollee: A Medicaid Beneficiary who is currently enrolled in the State's Medicaid Managed Care Program, specifically a Managed Care Organization (MCO). Other Managed Care Programs may include, but are not limited to: PIHP, PAHP, or PCCM (42 CFR § 438.10 (a)).

Enrollment: The process in which a Medicaid Eligible selects or is assigned to an "MCO" and goes through a managed care educational process as provided by SCDHHS or its agent.

Enrollment (Voluntary): The process in which an Applicant/Recipient selects an "MCO" and goes

through an educational process to become a Medicaid Managed Care Program member of the “MCO”.

Evidence of Coverage: The term which describes services and supplies provided to Medicaid Managed Care Program members, which includes specific information on Benefits, coverage limitations and services not covered. The term "Evidence of Coverage" is interchangeable with the term "Certificate of Coverage."

Excluded Services: Services that are covered by Medicaid but is reimbursed by the state through fee-for-service and not Absolute Total Care.

Exclusion: Items or services furnished by a specific Provider who has defrauded or abused the Medicaid Program will not be reimbursed under Medicaid.

Family Planning Services: Preconception services that prevent or delay pregnancies and do not include abortion or abortion related services. The services that include examinations and assessments, diagnostic Procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics, and pharmacies.

Federally Qualified Health Center (FQHC): A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants. A FQHC is eligible for state-defined cost-based reimbursement from the Medicaid fee-for-service Program. A FQHC provides a wide range of primary care and enhanced services in a medically underserved Area.

Fee-for-Service (FFS) Medicaid Rate: A method of making payment for health care services based on the current Medicaid fee schedule.

Fraud: In accordance with 42 § CFR 455.2 Definitions, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes under applicable federal or State law.

Fraud Waste Abuse (FWA): FWA is the collective acronym for the terms Fraud, Waste and Abuse.

Grievance: Means an expression of dissatisfaction about any matter other than an Action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the member's rights.

Grievance System: Refers to the overall system that includes Grievance process, Appeals process, and Medicaid Managed Care Member access to state fair hearing.

Health Care Professional – A Physician or any of the following: a podiatrist, pharmacist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health Maintenance Organization (HMO): A domestic licensed organization that provides or arranges for the provision of basic and supplemental health care services for members in the manner prescribed by the South Carolina State Department of Insurance and qualified by CMS.

Health Record: A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical health care services whether provided by Absolute Total Care, it's In Network Provider, or any out of Plan Providers. At a minimum, for hospitals and mental health hospitals, the Health Record must include:

- Identification of the Beneficiary.
- Physician name.
- Date of admission and dates of application for and authorization of Medicaid Benefits if application is made after admission; the plan of care (as required under 456.170 (mental hospitals) or 456.80 (hospitals).
- Initial and subsequent continued stay review dates (described under 456.233 and 465.234 (for mental hospitals) and 456.128 and 456.133 (for hospitals).
- Reasons and plan for continued stay if applicable.
- Other supporting material the committee believes appropriate to include.
- For non-mental hospitals only: date of operating room reservation and justification of emergency admission if applicable.

Healthcare Effectiveness Data and Information Set (HEDIS): Standards for the measures are set by the NCQA.

High-Risk Member: The High-Risk Members do not meet Low- or Moderate-Risk criteria.

Home and Community Based Services (HCBS): In-home or community-based support services that assist persons with long term care needs to remain at home as authorized in an approved 1915(c) Waiver or 1915(i) State Plan.

Home Health Services: Healthcare services delivered in a person's place of residence, excluding nursing homes and institutions, and include intermittent skilled nursing, home health aide, physical, occupational and speech therapy services and physician-ordered supplies.

Hospice Services: A service in which the Member is provided palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals.

Hospital Swing Beds: Hospitals participating in both the Medicaid and Medicare Programs, in addition to providing an inpatient hospital level of care, may also provide nursing facility levels of care and be reimbursed as "swing bed" hospitals. A swing bed hospital must be located in a rural area, have fewer than one hundred (100) inpatient beds exclusive of Newborn and intensive care type beds, and be surveyed for compliance by DHEC and certified as meeting federal and State requirements of participation for swing bed hospitals.

Improper Payment: Any payment that is made in error or in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements: to an ineligible Recipient; for ineligible goods or services; for goods or services not received (except for such payments where authorized by law); that duplicates a payment; or that does not account for credit for applicable discounts.

In Lieu of Service (ILOS): Those services as defined in 42 CFR § 438.3(e)(2).

In Network Provider: – A provider that is under contract with Absolute Total Care to render services to

the Absolute Total Care's covered membership.

Independent Community Pharmacy: A pharmacy provider that is defined as such through the licensing by the South Carolina Board of Pharmacy.

Indian Health Care Provider (IHCP): A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Indian Managed Care Entity (IMCE): - A MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

Inmate: One who is housed or confined to a correctional facility (e.g. prison, prison facility, jail etc.) for one or more consecutive calendar months. This does not include individuals on Probation or Parole or who are participating in a community program. Pursuant to 42 CFR § 435.1010, an Inmate of a public institution is defined as "a person living in a public institution", and a public institution is defined as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control."

Inquiry: A routine question about a Benefit. An inquiry does not automatically invoke a Plan sponsor's Grievance or coverage determination process.

Institutional Long-Term Care: A system of health and social services designed to serve individuals who have functional limitations that impair their ability to perform activities of daily living (ADL's). It is care or services provided in a facility that is licensed as a nursing facility, or a hospital that provides swing bed or Administrative Days.

Intensive Case Management (ICM): ICM refers to: a more intensive type of intervention in comparison to a standard or traditional Case Management / disease management program where the activities used help ensure the patient can reach his/her care goals and a more frequent level of interaction– direct and indirect contact, more time spent–with the Medicaid Managed Care Member. This may include the use of special technology and/or devices, such as telemonitoring devices.

Legal Representative: A person who has been granted legal authority to look after another's affairs, such as an attorney, executor, administrator, holder of power of attorney, etc.

Limited English Proficiency: Potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient and may be eligible to receive language assistance for a particular type of service, Benefit, or encounter.

Long-term Services and Supports (LTSS): Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider- owned or controlled residential setting, a nursing facility, or other institutional setting.

Low-Risk Member: The Low-Risk Members do not meet Moderate or High-Risk criteria.

Managed Care Organization (MCO): An entity that has, or is seeking to qualify for, a Comprehensive Risk Contract that is: a federally qualified HMO that meets the advance directive requirements of subpart I of 42 CFR Part 489; or any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Recipients within the area serviced by the entity; and meets the solvency standards of 42 CFR §438.116. This includes any of the entity's employees, affiliated Providers, agents, or contractors.

Managed Care Plan/Health Plan: The term "plan" means the same as "Absolute Total Care," "Managed Care Plan," or"HMO/MCO."

Management Service Agreements: A type of Subcontract with an entity in which Absolute Total Care delegates some or all of the comprehensive management and administrative services necessary to fulfill Absolute Total Care's obligations to the Department under the terms of this contract.

Medicaid: The medical assistance Program authorized by Title XIX of the Social Security Act.

Medical Benefit: Benefit that is covered under a beneficiary's medical insurance plan and billed through a CMS 1500 form.

Medical Management: Medical Case Management is a collaborative process that facilitates recommended treatment plans to ensure the appropriate medical care is provided to Medicaid members. It refers to the planning and coordination of health care services appropriate to achieve the goal of medical rehabilitation.

Medical Necessity: Services utilized in the State Medicaid Program, including quantitative and non-quantitative treatment limits, to determine the level of need for medical services rendered, as indicated in State statutes and regulations, the State Plan, and other State policy and Procedures.

Medicare: A federal health insurance program for people 65 or older and certain individuals with disabilities.

Member Incentive: Incentives to encourage a Medicaid Managed Care Member to change or modify behaviors or meet certain goals.

Member or Medicaid Managed Care Member: An eligible person who is currently enrolled with SCDHHS approved Medicaid Managed Care CONTRACTOR. This term is used interchangeably with "Enrollee" and "Beneficiary".

Moderate-Risk Member: The Moderate-Risk Members do not meet Low- or High-Risk criteria.

National Committee for Quality Assurance (NCQA): A private, 501(c)(3) non-for-profit organization founded in 1990 and dedicated to improving health care quality.

National Drug Code (NDC): A unique 10-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The segments identify the labeler or vendor, product (within the scope of the labeler), and trade package (of this product).

National Practitioner Data Bank: A central repository for adverse action and medical malpractice payments.

National Practitioner Database (NPDB): The federal information repository dedicated to improving health care quality, promoting patient safety, and preventing fraud and abuse.

Negative PDL Change: Defined as any of the following changes: removal of a drug or therapeutic drug class from a single preferred drug list (formulary); increasing the cost-sharing/co-pay status of a drug on the single preferred drug list(formulary) subsequent to a change in step therapy; adding or making more restrictive utilization management requirements on a drug or therapeutic drug class, including: prior authorization requirements, quantity limits, and step therapy requirements.

Newborn: A live child born to a member during her membership or otherwise eligible for Voluntary Enrollment.

Non-Contract Provider: Providers that are licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency that have not contracted with or are not employed by Absolute Total Care to provide health care services.

Non-Covered Services: Services not covered under the SC State Plan for Medical Assistance.

Non-Emergency: An encounter with a health care Provider by a Medicaid Managed Care Program member who has presentation of medical signs and symptoms that do not require immediate medical attention.

Non-Participating Provider/Physician: A Provider/Physician licensed to practice who has not contracted with or is not employed by Absolute Total Care to provide health care services.

Outpatient Services: Preventive, diagnostic, therapeutic, rehabilitative, surgical, mental health, facility services for dental, and Emergency Services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally, not exceeding twenty-four (24) hours.

Overpayment: The amount paid by Absolute Total Care to a Provider, which is in excess of the amount that is allowable for services furnished under Section 1902 of the Act, or to which the Provider is not entitled, and which is required to be refunded under Section 1903 of the Act.

Pharmacy Benefit: Outpatient prescriptions that are billed through a pharmacy point of sale system and dispensed by a pharmacist.

Physician: Any of the following types of professionals that are legally authorized by the state to practice, regardless of whether they are Medicare, Medicaid, or Children's Health Insurance Program (CHIP) Providers: Doctors of medicine or osteopathy; Doctors of dental medicine or dental surgery; Doctors of podiatric medicine; Doctor of optometry; Chiropractors.

Post Stabilization Services: Covered Services, related to an emergency medical condition that are provided after an Enrollee is stabilized to maintain the stabilized condition or are provided to improve or resolve the Enrollee's condition when Absolute Total Care does not respond to a request for pre-approval within one (1) hour, Absolute Total Care cannot be contacted, or Absolute Total Care's Representative and the treating Physician cannot reach an agreement concerning the Member's care

and an Absolute Total Care's Provider is not available for consultation.

Premium: A monthly fee that may be paid to Medicare or Medicaid.

Prevalent Non-English Language: A non-English language determined to be spoken by a significant number or percentage of potential Enrollees and Enrollees that are limited English proficient.

Primary Care Provider (PCP): A general practitioner, family Physician, internal medicine Physician, obstetrician/gynecologist, or pediatrician who serves as the entry point into the health care system for the member. The PCP is responsible for providing primary care, coordinating, and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.

Primary Care Services: All health care services, and laboratory services customarily furnished by or through a general practitioner, family Physician, internal medicine Physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

Prior Authorization: The act of authorizing specific approved services by Absolute Total Care before rendered.

Protected Health Information (PHI): PHI protected health information as defined in 45 CFR §160.103.

Provider: In accordance with 42 CFR § 400.203 Definitions specific to Medicaid, any individual or entity furnishing Medicaid services under a Provider agreement with Absolute Total Care or the Medicaid agency. These may include the following: Any individual, group, Physicians (such as but not limited includes Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Outpatient Center (free standing or owned) Clinics and Laboratories) furnishing Medicaid services under an agreement with the Medicaid agency; or For the Medicaid Managed Care Program, any individual, group, Physicians (including but not limited to Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Clinics, Outpatient Centers (free standing or owned) and Laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.

Provider Dispute: A dispute between a Provider and Absolute Total Care. Disputes may include, but will not be limited to: Lost or incomplete Claim(s); Request(s) for additional explanation from Absolute Total Care for service(s) or treatment(s) rendered by a Provider; Inappropriate or unapproved referral(s) initiated by Provider(s); or any other reason for billing or non-billing related Disputes.

Provider Dispute System: Formal internal system for Providers to dispute the Absolute Total Care's Policies, Procedures, or any aspect of the Absolute Total Care's administrative functions.

Provider Incentives or Provider-Designated Incentives: Provider-Designated Incentives are those incentives paid by Absolute Total Care to qualified Providers for achieving designated goals. Provider-Designated Incentives are paid for the Programs listed in the SCDHHS Managed Care Process and Procedure Manual.

Provider Network: The providers with which a Managed Care Organization (MCO) contracts or makes arrangements to furnish covered health care services to Medicaid Members under an MCO coordinated care or network plan.

Quality: The degree to which Absolute Total Care increases the likelihood of desired health outcomes

of its Enrollees through structural and operational characteristics and the provision of health services consistent with current professional knowledge.

Quality Assessment: Measurement and evaluation of success of care and services offered to individuals, groups or populations.

Quality Assessment and Performance Improvement (QAPI): Activities aimed at improving the quality of care provided to enrolled members through established quality management and performance improvement processes.

Quality Assurance: The process of assuring that the delivery of health care services provided to members are appropriate, timely, accessible, available, and medically necessary.

Quality Assurance Committee: A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.) that represent Absolute Total Care's participating network of Providers, including representation from Absolute Total Care's management or Board of Directors, from a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.) with an emphasis on primary care, such as obstetrics and pediatrics.

Recipient: A person who is determined eligible to receive services as provided for in the SC State Plan for Medical Assistance.

Recoupment: The recovery by, or on behalf of, either the State Agency or Absolute Total Care of any outstanding Medicaid debt.

Redetermination: A person who has been determined eligible to receive services as provided for in the SC State Plan for Medical Assistance under Title XIX after formerly not being eligible under the SC State Plan for Medical Assistance under Title XIX.

Referral Services: Health care services provided to Medicaid Managed Care Program members outside Absolute Total Care's designated facilities or its Providers when ordered and approved by the Absolute Total Care, including, but not limited to, out-of-Plan services which are covered under the Medicaid Program and reimbursed at the Fee-For-Service Medicaid Rate.

Representative: Any person who has been delegated the authority to obligate or act on behalf of another.

Request for Reconsideration: An informal provider claim appeal when the provider disagrees with the processing and/or payment (or non-payment) of a clean claim. Sometimes called a "1st-level" claim appeal and usually submitted prior to submitting a formal dispute in most cases.

Rural Health Clinic (RHC): A South Carolina licensed Rural Health Clinic is certified by the CMS and receiving Public Health Services grants. A RHC eligible for state defined cost-based reimbursement from the Medicaid fee-for-service Program. A RHC provides a wide range of primary care and enhanced services in a medically underserved area.

Screen or Screening: Assessment of a member's physical or mental condition to determine evidence or indications of problems and the need for further evaluation or services.

Serious Mental Illness (SMI): Individuals who have a serious mental illness as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) under the following categories: schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, major depressive disorders, or a diagnosis of obsessive-compulsive disorder. OR Children and adolescents ages 7-18 with any of the above diagnoses or who are considered seriously emotionally disturbed, regardless of current diagnosis. Along with the above listed criteria, the individual must also experience both of the following: At least one acute admission to a psychiatric hospital or two or more emergency department visits within the past 12 months for crisis intervention and treatment of a mental disorder AND Specific symptoms or disturbances cause the member difficulty in accessing appropriate behavioral health, medical, educational, social, developmental, or other supportive services required for optimal functioning.

Service Area: The geographic area in which Absolute Total Care is authorized to accept enrollment of eligible Medicaid Managed Care Members into Absolute Total Care's Health Plan. The Service Area must be approved by SCDOI.

Significant Change: - A major decline or improvement in a Member's status that meets all the following requirements: The change would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, and the decline is not considered "self-limiting"; The change impacts more than one area of the resident's health status; and The change requires interdisciplinary review and/or revision of the care plan.

South Carolina Department of Health and Human Services (SCDHHS): SCDHHS and Department are interchangeable terms and definitions they are one in the same and one maybe be used to define the other in this document. as well as in the MCO Contract.

Social Security Administration (SSA): An independent agency of the United States federal government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' Benefits.

South Carolina Healthy Connections Choices: South Carolina Medicaid's contracted Enrollment broker for Managed Care Members.

South Carolina Healthy Connections Medicaid: The Title XIX program administered by the Department, also known as South Carolina Medicaid.

South Carolina Medicaid Network Provider: A Provider of healthcare services or products which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved and enrolled by the Department, licensed and/or credentialed which accepts as payment in full for providing benefits to Medicaid Managed Care Members amounts pursuant to Absolute Total Care's reimbursement provisions, business requirements and schedules.

South Carolina State Plan for Medical Assistance (State Plan): A plan, approved by the Secretary of HHS, which complies with 42 U.S.C.A. § 1396a, and provides for the methodology of furnishing services to Recipients pursuant to Title XIX.

Specialist: A healthcare professional who treats only certain parts of the body, certain health conditions, or certain age groups.

Special Populations: Individuals that may require unique considerations and/or tailored health care services that should be incorporated into a Care Management Plan that guarantees that the most appropriate level of care is provided for these individuals.

Subcontract: A written agreement between Absolute Total Care and a Third Party to perform a part of Absolute Total Care's obligations as specified under the terms of the MCO Contract.

Subcontractor: Any organization or person who provides any business functions or service for Absolute Total Care specifically related to securing or fulfilling Absolute Total Care's obligations to the Department under the MCO Contract.

Subrogation: The right of the Department to stand in the place of Absolute Total Care or client in the collection of Third-Party Resources.

Supplemental Security Income (SSI): Benefits paid to disabled adults and children who have limited income and resources.

Suspension of Payment for Credible Allegation: In accordance with 42 CFR § 455.23 Suspension of payment in cases of fraud, means that all Medicaid payments to a Provider are suspended after the agency determines there is a Credible Allegation of Fraud for which an investigation is pending under the Medicaid Program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

Targeted Case Management (TCM): Services that assist individuals in gaining access to needed medical, social, educational, and other services as authorized under the State Plan. Services include a systematic referral process to Providers.

Third Parties: Third Parties are other individuals or entities, whether or not they operate in the United States.

Third Party Liability (TPL): Collection from other parties who may be liable for all or part of the cost of items or health care services provided to a Medicaid Managed Care Program member.

Third Party Resources: Any entity or funding source other than the Medicaid Managed Care Program member or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care provided to a Medicaid Managed Care Program member.

Transition Plan: A formal document that provides a detailed description of the process for transitioning Medicaid Managed Care Members between various healthcare settings or from out-of-network Providers to Absolute Total Care's Provider network to ensure optimal Continuity of Care. Functions include coordination of hospital/institutional discharge planning and post discharge care, assisting to schedule any follow-up appointments, collaborating with the hospital/institution discharge planner/coordinator to implement the discharge plan in the enrollee's home, facilitating communication with community service providers and coordination of care after emergency department visits.

UB-04: A uniform bill for inpatient and outpatient hospital billing. The required form is the UB04 CMS 1500.

Urgent Care: Medical conditions that require attention within forty-eight (48) hours. If the condition is

left untreated for forty-eight (48) hours or more, it could develop into an emergency condition.

Waste: The unintentional misuse of Medicaid funds through inadvertent error that most frequently occurs as incorrect coding and billing.