Absolute Total Care and Wellcare

Q2 2025 Virtual Provider Town Hall

absolute total care | Healthy Connections

ambetter. FROM absolute total care

wellcare PRIME by absolute total care | Healthy Connections PRIME

ATC-08252025-AP-1

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Question 1

What area do you support in your organization / practice?

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

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Health Plan Updates

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Case Management

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Case Management Services

Case Management is a FREE service provided by Absolute Total Care to help our members get the care and services they need. Our goal is to support our members in managing their health and improving their quality of life.

How do you use case management program services? Our Case Management services include:

- Referrals to specialists and other services
- Coordinating Care between doctors and other providers
- Developing Care Plans and setting health goals
- Learning About Other Services that can make our member's lives easier

How to become eligible for case management? Members may become eligible through:

- Referrals or medical claims
- A review of medical information by a Care Manager
- After being hospitalized
- A Care Manager may reach out to members to discuss your healthcare needs
- Provider referral

For more information or to request Case Management services, please contact Absolute Total Care at 1-866-433-6041 or visit Absolutetotalcare.com.

Case Management Referral Form

Updated Referral Form

A new Case Management Referral Form is now available to help streamline referrals and improve coordination of care.

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100 Center Point Circle, Suite 100
Columbia, SC 29210

Case Management Referral Form

Case Management at Absolute Total Care is a free service that helps members access necessary medical services and improve their health. The program offers referrals to specialists and services, coordinates communication between providers, sets personalized care plans and identifies additional helpful resources. Eligibility for Case Management can be determined through referrals or medical claims, medical reviews by a Case Manager, hospitalization or provider referrals. A Case Manager, who is typically a registered nurse or licensed social worker, assists with health-related questions, accessing care and teaching self-care strategies. For Case Management services, call 1-866-433-6041 or visit Absolutetotalcare.com.

Partner with us to empower your patients in taking control of their health and well-being. Use this form to refer an Absolute Total Care member to Case Management. Submit form to Case Management by mail or fax to 1-833-418-3676.

SECTION I: REFERRING PHYSICIAN OR PROVIDER INFORMATION	
Referral Date (mm/dd/yyyy) / /	Name of Person Submitting Referral
Organization (if applicable)	Phone Number (Referring Physician or Provider)
Fax Number (Referring Physician or Provider)	Email Address (Referring Physician or Provider)

SECTION II: MEMBER INFORMATION		
Member First and Last Name		Member ID Number
Member Address		
City	State	Zip Code
Member Phone Number	Member Email Address	

SECTION III: REASON FOR REFERRAL (Include primary diagnoses, conditions and admission history)

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

Simplified Medical Record Management

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Launch of Optum CPI's New Provider Portal

We're Enhancing the Provider Experience!

We are excited to announce the launch of Optum's new Provider Portal, designed to streamline payment integrity processes and improve provider interactions.

Key Benefits of the New Portal:

Simplified Medical Record Management
Providers can view and upload all medical record requests in one place.

Real-Time Status Updates
Track the status of medical record submissions with ease.

Enhanced Communication
Access Optum's review outcomes and rationale for better transparency.

Go Paperless!
Providers can opt for digital communications for greater efficiency.

What's Changing?

Providers will be directed to a new URL, found on Optum's medical record request letters, to upload their documentation. Providers can self-register to obtain full access for enhanced features or continue as non-registered users with the same current functionality.

The portal is now live and ready for providers to use! **paymentintegrityportal.optum.com/upload**

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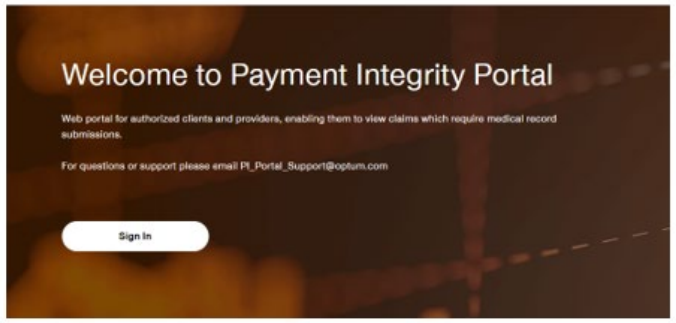
Optum CPI's New Provider Portal

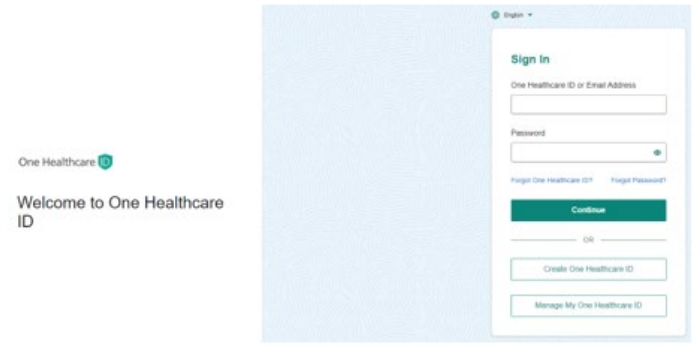
Creating a One Healthcare ID

Create a new One Healthcare ID

1. Navigate to paymentintegrityportal.optum.com/upload
2. Select "Sign In"

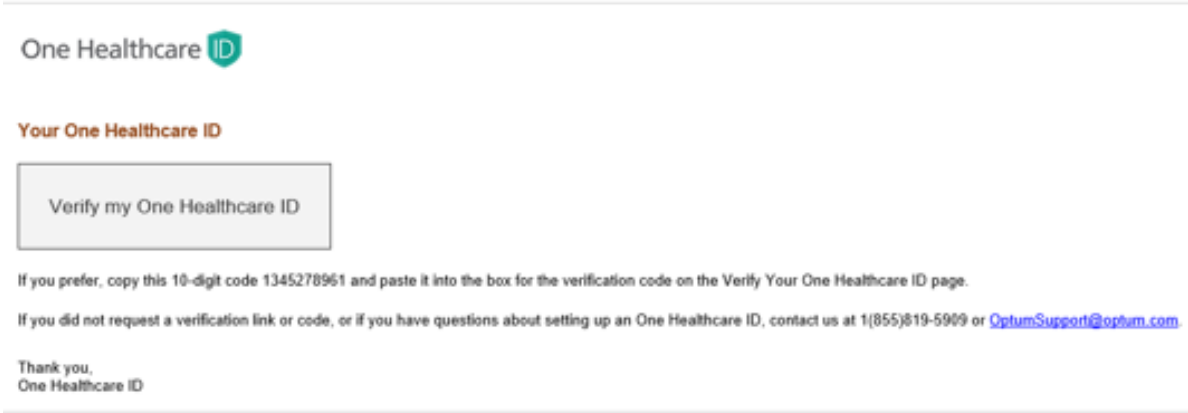


3. Select "Create One Healthcare ID"



4. Complete the form by entering the following:
   a. First name
   b. Last name
   c. Email address
   d. Create One Healthcare ID (create unique username)
   e. Password
   f. Confirm password
   g. Select and answer three security questions

5. Select "Continue"
6. A verification notification will be sent to your email. Copy the 10-digit code and paste it on the verification page or click the "Verify my One Healthcare ID" link.



7. Your OHID is now ready to use. Sign into the portal to submit medical records and manage claims.

paymentintegrityportal.optum.com/upload

Pharmacy

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Pharmacy

Use our Medicaid Comprehensive Drug Lists for more information on the drugs that are covered:

- Comprehensive Drug List June 2025 (PDF)
- CGM (Continuous Glucose Monitors)External Link

General Pharmacy Information:

- All opioids (excluding exemptions) will be limited to an initial seven (7) day supply.

2025 Comprehensive Drug List Updates:

- Drug List Updates - Effective January 1, 2025 (PDF)
- Drug List Updates - Effective July 1, 2025 (PDF)
- SCDHHS Preferred Drug List
- SCDHHS Preferred Drug List (PDL)External Link

Ambetter Pharmacy Requests https://www.absolutetotalcare.com/providers/pharmacy.html

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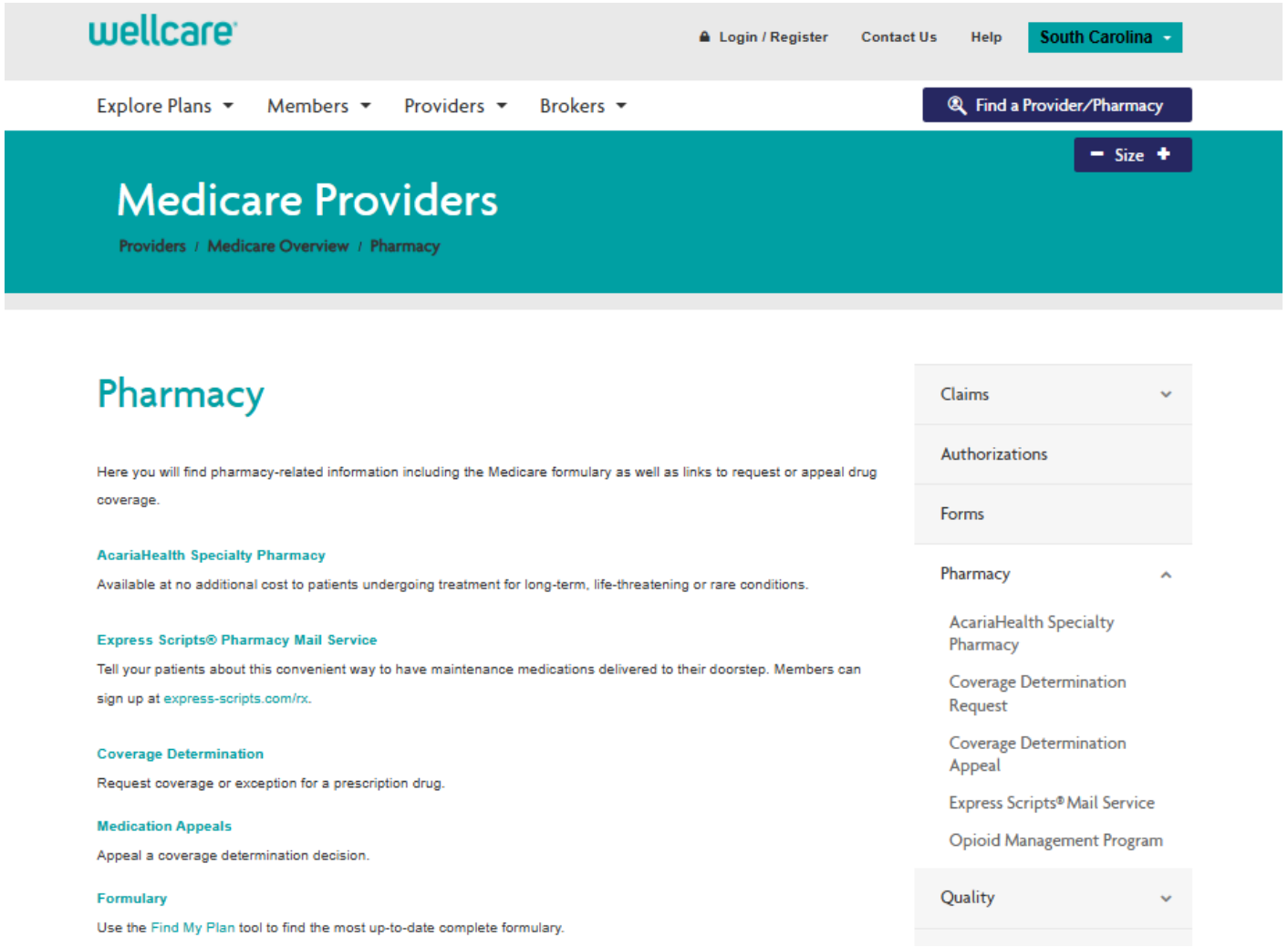
Pharmacy



https://www.wellcare.com/south-carolina/providers/medicare/pharmacy

Cover My Meds

ACCESSING COVER MY MEDS

Medicaid:

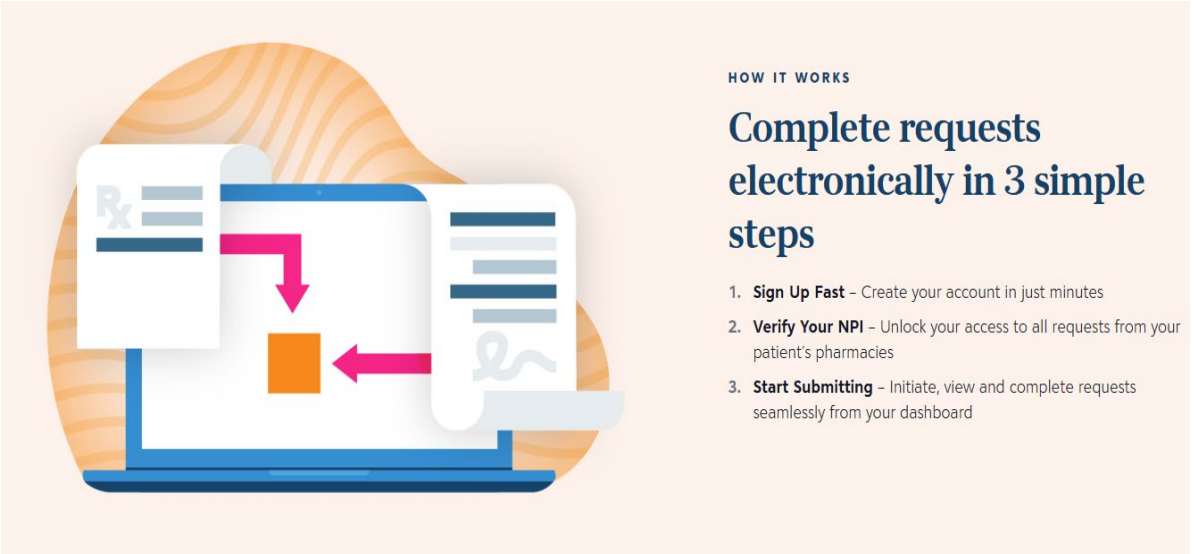
Cover My Meds Prior Auth Form

Wellcare:

Coverage Determination Request | Wellcare

Ambetter:

Cover My Meds Prior Auth



Provider Notification

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Healthy Connections

Provider Notification

April 29, 2025

Thank you for your continued partnership with Absolute Total Care.

Effective July 1, 2025, the following codes will no longer require prior authorization to be submitted to Absolute Total Care:

81257: **HBA1/HBA2** (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)

Please verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

If you have any questions, please contact your Provider Engagement Administrator or call Provider Services at 1-866-433-6041.

https://www.absolutetotalcare.com/providers/provider-news.html

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ambetter from Absolute Total Care

Provider Notification

ambetter FROM absolute total care

April 29, 2025

Thank you for your continued partnership with Ambetter from Absolute Total Care.

Effective July 1, 2025, the following code will require prior authorization to be submitted to Ambetter from Absolute Total Care:

- **J1439 Injection, ferric carboxymaltose, 1 mg**

The following code will no longer require prior authorization to be submitted:

- **81257 HBA1/HBA2** (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)

Please verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

If you have any questions, please contact your Provider Engagement Administrator or call Provider Services at 1-833-270-5443.

Sincerely,

Ambetter from Absolute Total Care

https://www.absolutetotalcare.com/providers/provider-news.html

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Medicare Prior Authorization Change Summary

Effective 7/1/2025

Wellcare requires prior authorization (PA) as a condition of payment for many services. This Notice contains information regarding such prior authorization requirements and is applicable to all Medicare products offered by Wellcare.

Wellcare is committed to delivering cost effective quality care to our members. This effort requires us to ensure that our members receive only treatment that is medically necessary according to current standards of practice. Prior authorization is a process initiated by the physician in which we verify the medical necessity of a treatment in advance using independent objective medical criteria and/or in network utilization, where applicable.

It is the ordering/prescribing provider's responsibility to determine which specific codes require prior authorization.

Please verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered. NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED.

For complete CPT/HCPCS code listing, please visit the online **Prior Authorization Tool** webpage.

Effective July 1, 2025, the following are changes to prior authorization requirements:

Service Category	PA Rule	Services	Procedure Codes
Durable Medical Equipment	PA Required	Wheelchairs	E1012
		Mobility Devices	E0637
	No PA Required	Beds	E0184
		Neurostimulators	E0720, E0730
		Equipment & Accessories	E0953
		Wheelchairs	E0954, E0956, E0973, E0990, E1016, E1038, E2210, E2359, E2361, E2363, E2365, E2606, E2607, E2624, K0019, K0077, K0733
Other Medical Services	No PA Required	Wound Care	97605, 97606
Surgery Procedures	PA Required	Skin Grafts	Q4205

https://www.wellcare.com/en/south-carolina/providers/bulletins

Announcing Partnership with HealthMap Solutions

Effective 9/1/2025

https://www.wellcare.com/en/south-carolina/providers/bulletins/healthmap-solutions-announcement

Dear Provider,

Wellcare is partnering with Healthmap Solutions (Healthmap) to provide care coordination services within our kidney health management (KHM) program. As a leading national kidney health management company, the partnership with Healthmap will provide more comprehensive care for members with chronic kidney disease (CKD) stages 3, 4, 5, and end stage renal disease (ESRD).

If you have a patient with kidney disease, or chronic conditions that may lead to kidney disease, Healthmap may contact you to facilitate care. Healthmap provides collaborative recommendations through workflow-friendly clinical decision support.

Healthmap's KHM program integrates into your existing practice workflow to complement your patient's current plan of care. Healthmap can supply you with actionable information, based on industry proven best practices, and powered by data analytics, to more effectively anticipate and deliver the right clinical care.

We appreciate your ongoing care for our members. Be on the lookout for outreach from Wellcare and Healthmap for the introduction to our kidney health management (KHM) program. If you have any questions or concerns, please contact your Provider Services Representative.

Sincerely,
Wellcare

Payment Policies

Clinical Policies

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Medical Clinical Policies

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

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

Clinical policies help identify whether services are medically necessary based on information found in generally-accepted standards of medical practice, peer-reviewed medical literature, government agency/program approval status, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas affected by the policy, and other available clinical information.

- https://www.absolutetotalcare.com/providers/resources/behavioral-health-clinical-policies.html

Claims Payment Policies

- **Provide guidelines to administer payment rules based on correct coding principles**
- **Help determine if healthcare services are correctly coded for reimbursement**
- **Each rule is sourced from accepted coding standards, including:**
  - **CMS *Publication 100-04, Claims Processing Manual***
  - **CMS *National Correct Coding Initiative (NCCI) Policy Manual***
  - **AMA *Current Procedural Terminology (CPT) Guidance***
  - **Health plan clinical policies (medical necessity, appropriateness of care)**
  - **State-specific reimbursement guidance**

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

Balance Billing

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Balance Billing

WHAT IS BALANCE BILLING?

- Seeking payment from members for the difference between the billed charges and the contracted rate paid by the plan
  - Payments less any copays, coinsurance, or deductibles are considered payment in full

PROHIBITED BY FEDERAL LAW

- Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances
  - Original Medicare and Medicare Advantage providers and suppliers – not only those that accept Medicaid – must not charge individuals enrolled in the QMB program for Medicare cost-sharing

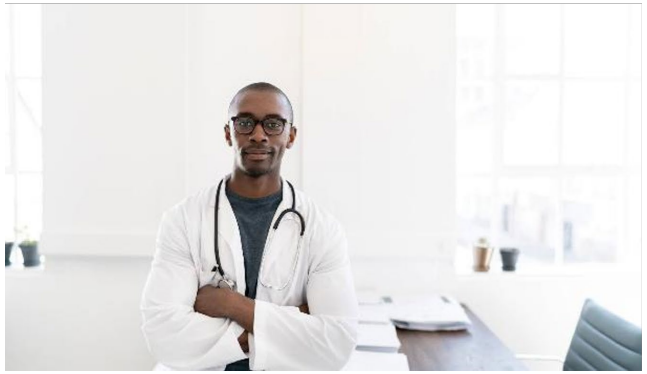
STEPS TO ENSURE COMPLIANCE WITH QMB BILLING PROHIBITIONS

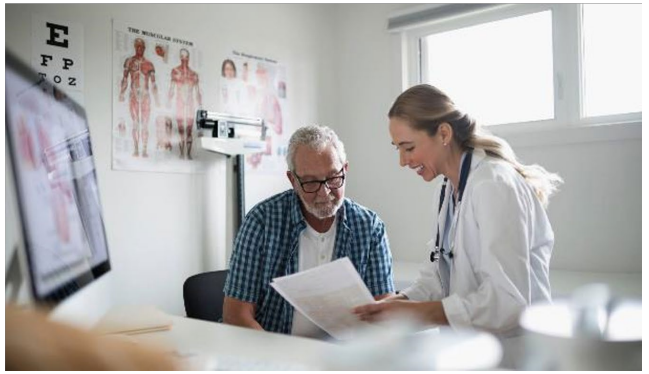
- Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services
- Ensure that a Member Acknowledgement Statement has been signed by both the provider and the Absolute Total Care member for non-covered services prior to rendering said service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

Member Overpayment Reimbursement Requirement

- Providers are required by 42 C.F.R. §422.270(b), to refund all amounts incorrectly collected from its Medicare patients. This includes reimbursements owed due to claims adjusted by the health plan when the member had previously paid the provider or provider office.

- Reimbursement is expected to be completed within a reasonable timeline and can be in the form of a check payment, member account credit, and/or other forms as deemed appropriate by the member/provider. Non-Compliance with timely reimbursement to make member whole can lead to Civil Monetary Penalties (CMP) imposed by CMS.





Eligibility

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Eligibility

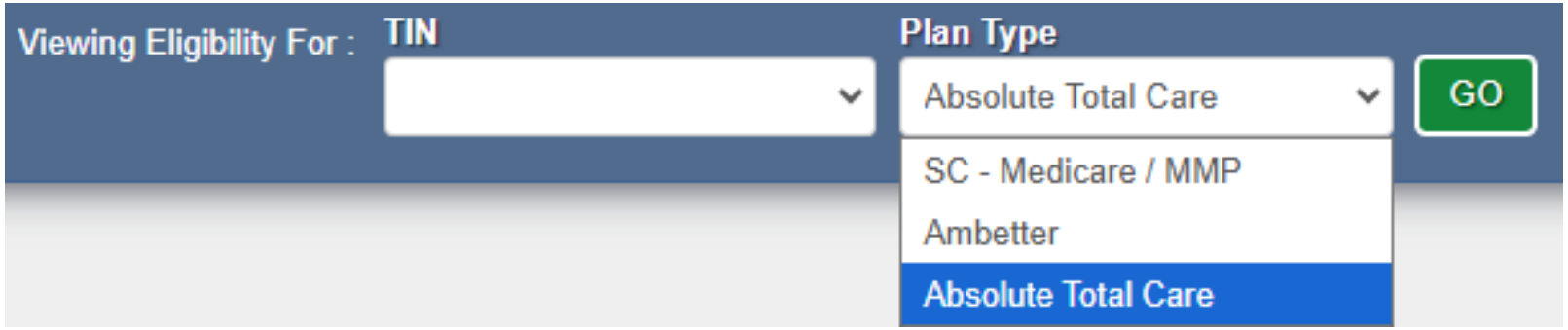
Member eligibility should be checked each month and each time prior to rendering services for all lines of business.

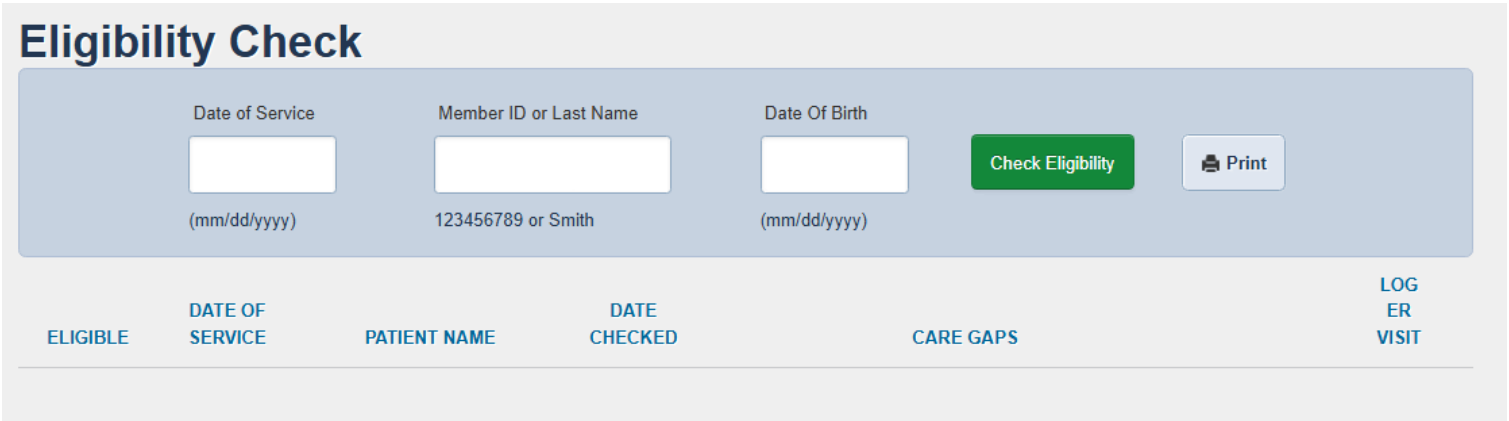
Eligibility can be verified through Absolute Total Care Provider Portal, Wellcare Provider Portal, Availity Essentials or the Interactive Voice Response (IVR)

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

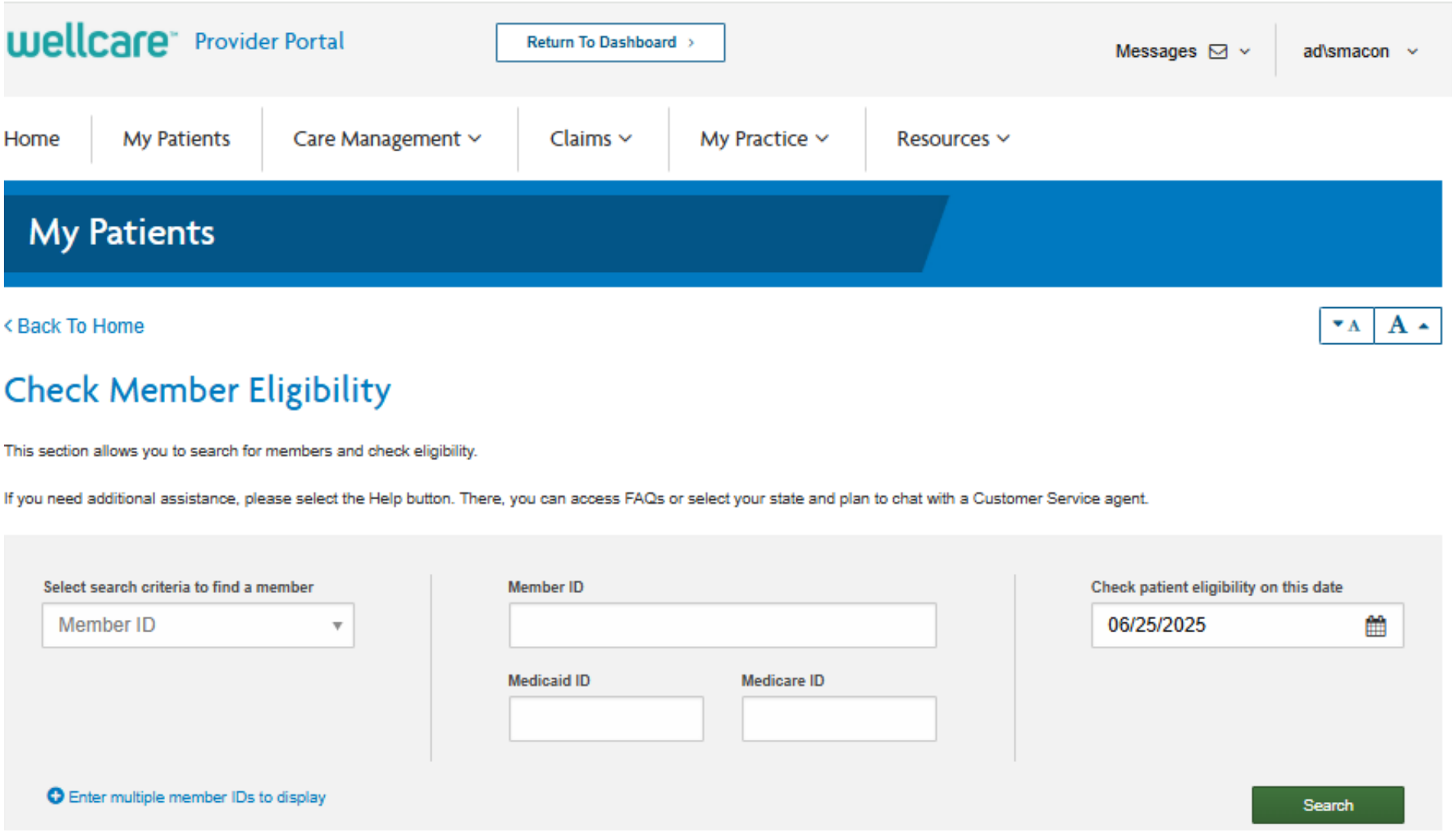
IVR is available 24 hours a day, seven days a week

Absolute Total Care Provider Portal





Wellcare Provider Portal



Availity Essentials: New Multi-Payer Portal

Centene Corporation has chosen Availity Essentials as its new, secure provider portal. Effective Sept. 24, 2024, providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources via Availity Essentials for Absolute Total Care Healthy Connections Medicaid, Ambetter from Absolute Total Care, Wellcare Prime by Absolute Total Care and Wellcare of South Carolina.

Here's how to get started:

If you are new to Availity Essentials, getting your Essentials account is the first step toward working with the Health Plan on Availity. Your provider organization's designated Availity administrator is the person responsible for registering your organization in Essentials and managing user accounts. This person should have legal authority to sign agreements for your organization. Visit Register and Get Started with Availity Essentials to enroll for training and access other helpful resources.

If you already work in Essentials, you can log in to your existing Essentials account to enjoy these benefits:

- Verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and more.
- Look for additional functionality in the Health Plan's payer space on Essentials and use the heart icon to add apps to My Favorites in the top navigation bar.
- Save provider information in Essentials and auto-populate it to save time and prevent errors.

We encourage you to use Availity Essentials for transactions. With an active Availity Essentials account, providers will have immediate access to new health plans and features as soon as they become available. Our current secure portal will still be available for other functions you may use today, and we will notify you when our current secure portal will be retired.

We're excited to welcome you to Availity Essentials, helping you transform the way you impact patient care. If you need additional assistance with your registration, please call Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Mon. through Fri., 8 am – 8 pm. EST. For general questions, please contact Provider Services or reach out to your Provider Engagement Administrator.

Question 2

Are you currently using Availity?

- ☐ YES
- ☐ NO

Annual Provider Training Requirements

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Annual Provider Training Requirements

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

Cultural Competency

The ability of healthcare providers and organizations to understand, respect, and effectively respond to the cultural and linguistic needs of diverse patient populations.

Person-Centered Planning

A collaborative approach to care that focuses on an individual's unique goals, preferences, and strengths to guide decision-making and support.

General Compliance

Ensures compliance with industry regulations. This reduces the risk of violations that could lead to legal consequences.

Model of Care (MOC)

A structured approach to delivering healthcare services that outlines how, when, and by whom care is provided to meet patients' needs effectively and efficiently.

Fraud, Waste & Abuse

Intentional deception or misrepresentation (fraud), careless or inefficient use of resources (waste), and practices that are inconsistent with sound fiscal or medical practices (abuse), all of which lead to unnecessary costs to the healthcare system.

Annual Provider Training Requirements

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

Behavior Health Provider Training Opportunities

- **Absolute Total Care offers additional trainings for medical and behavioral health providers to recognize the intent of the Behavioral Health HEDIS measures and share strategies to impact quality care and outcomes for our members.**

Initiation and Engagement, Follow-Up After Emergency Department or High Intensity Care for Substance Use Disorders: Optimizing the IET, FUA, and FUI HEDIS® Measures (Absolute Total Care)

Follow-Up Care After a Hospital or Emergency Department Visit for Mental Illness: Optimizing the FUH and FUM HEDIS® Measures (Absolute Total Care)

Strategies to Improve Cardiovascular, Diabetes, and Metabolic Monitoring: APM, SSD, SMC, and SMD HEDIS® Measures (Absolute Total Care)

Antidepressant Medication Management and Antipsychotic Medication Adherence: Optimizing the AMM and SAA HEDIS® Measures (Absolute Total Care)

Additional Provider Training Opportunities

Behavioral Health

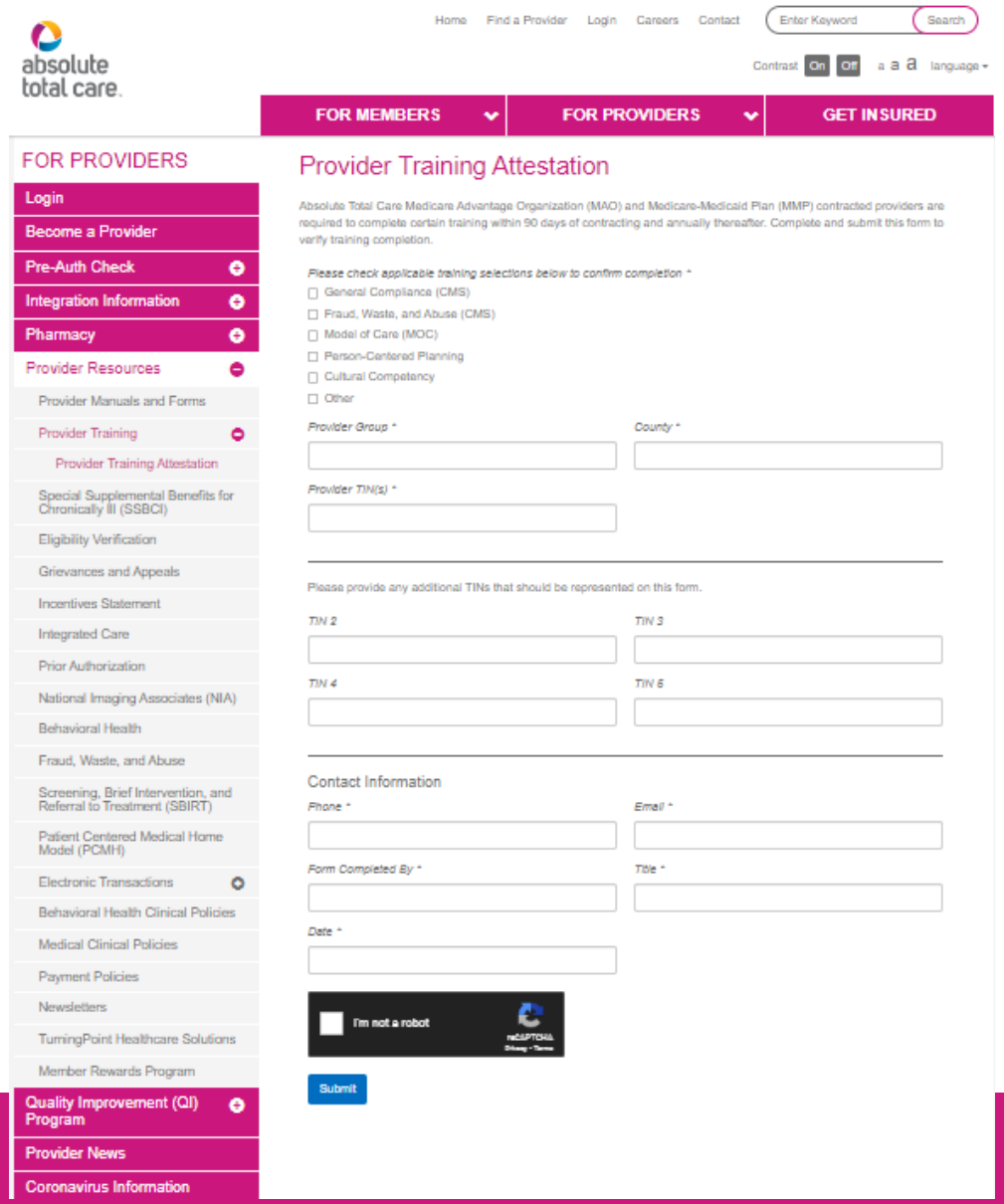
(Ambetter) Antidepressant Medication Management, Follow-Up After Hospitalization for Mental Illness, and Initiation and Engagement of Substance Use Disorder Treatment: Optimizing the AMM, FUH, and IET HEDIS® Measures (Absolute Total Care)

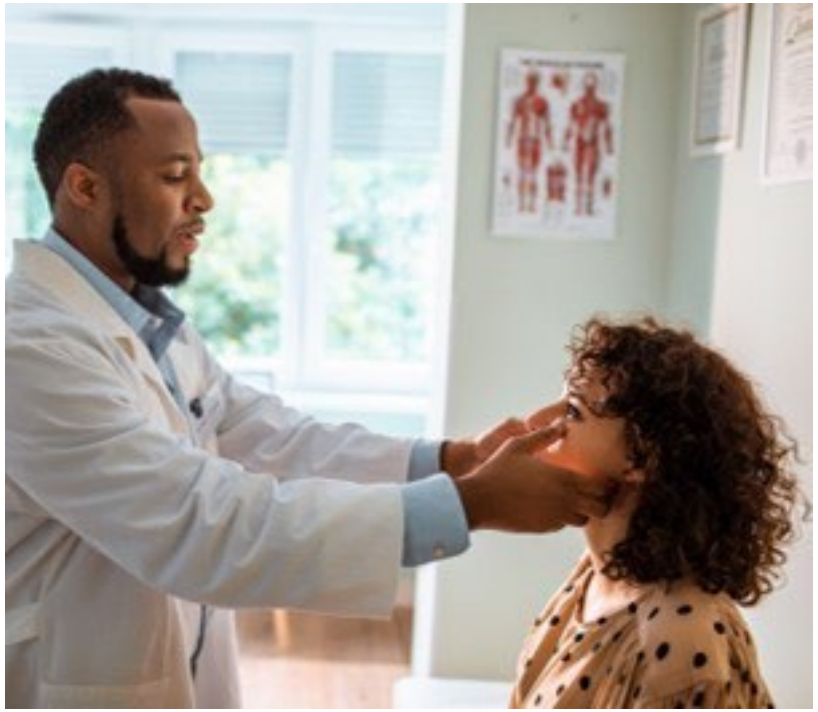
Enhancing Member Experience with Behavioral Health Care Services: Experience of Care and Health Outcomes (ECHO) Survey (Absolute Total Care)

Strategies to Minimize the Risk of Opioid Overuse and Misuse: Optimizing the Impact of the POD, COU, UOP, and HDO HEDIS® Measures (Absolute Total Care)

Optimizing the Impact of the ADD and APP HEDIS® Measures: Follow-Up Care for Children Prescribed Medication for ADHD and the Use of Psychosocial Care for Children and Adolescents Prescribed Antipsychotics (Absolute Total Care)

Provider Training Attestation





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

Accessibility and Availability Standards

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Accessibility and Availability

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.

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

- All Providers must adhere to standards of timeliness for appointments and in-office waiting times.
- These standards take into consideration the immediacy of the Member's needs.
- Absolute Total Care and Wellcare will monitor Providers against the standards for each line of business to help Members obtain needed health services within acceptable appointment times, in-office waiting times, and after-hours standards.
- Providers not in compliance with these standards will be required to implement corrective actions.

Access Standards - Medicaid

Primary Care Provider Appointment Type	Access Standard
Routine Visits	Within 4-6 weeks
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24-hour coverage	24 hours a day, 7 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 4-6 weeks
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
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 non-life-threatening emergency visits	Within 6 hours or referred to the emergency room or behavioral health crisis unit
Urgent or non-emergency visits	Within 48 hours

Access Standards – Medicare-Medicaid Plan

Primary Care and Specialist Appointment Type	Access Standard
Routine appointment and physicals	Within 4 weeks
Primary care urgent (non-life-threatening emergency) visits	Within 1 week of the request
Urgent specialty care	Should be available within 24 hours of referral
Referrals to specialist	Should be available within 4 weeks of the request
Emergency care	Should be received immediately and be available 24 hours a day
Persistent symptoms	Must be treated no later than the end of the following working day after initial contact with the PCP
Behavioral health urgent care	48 hours
Non-urgent appointment for sick visit	Should be available within 72 hours of the request
Behavioral Healthcare Specialist Appointment Type	**Access Standard**
Initial visit for routine care	Within 10 days
Urgent or non-emergency visits	Within 24 hours
Emergency	Immediately

Access Standards - Medicare

Primary Care and Specialist Appointment Type	Access Standard
PCP-Urgent	Within 24 hours
PCP-Non-urgent	Within 1 week of the request
PCP-Regular and routine	Within 30 calendar days
All specialists (including high volume and high impact) - Urgent	Within 24 hours
All specialists (including high volume and high impact) - Urgent	Within 30 calendar days
Behavioral health provider - Urgent care	48 hours
Behavioral health provider – Initial routine care	Within 10 business days
Behavioral health provider – Non-life-threatening emergency	6 hours
Behavioral health provider – Initial routine care follow-up	Within 10 business days

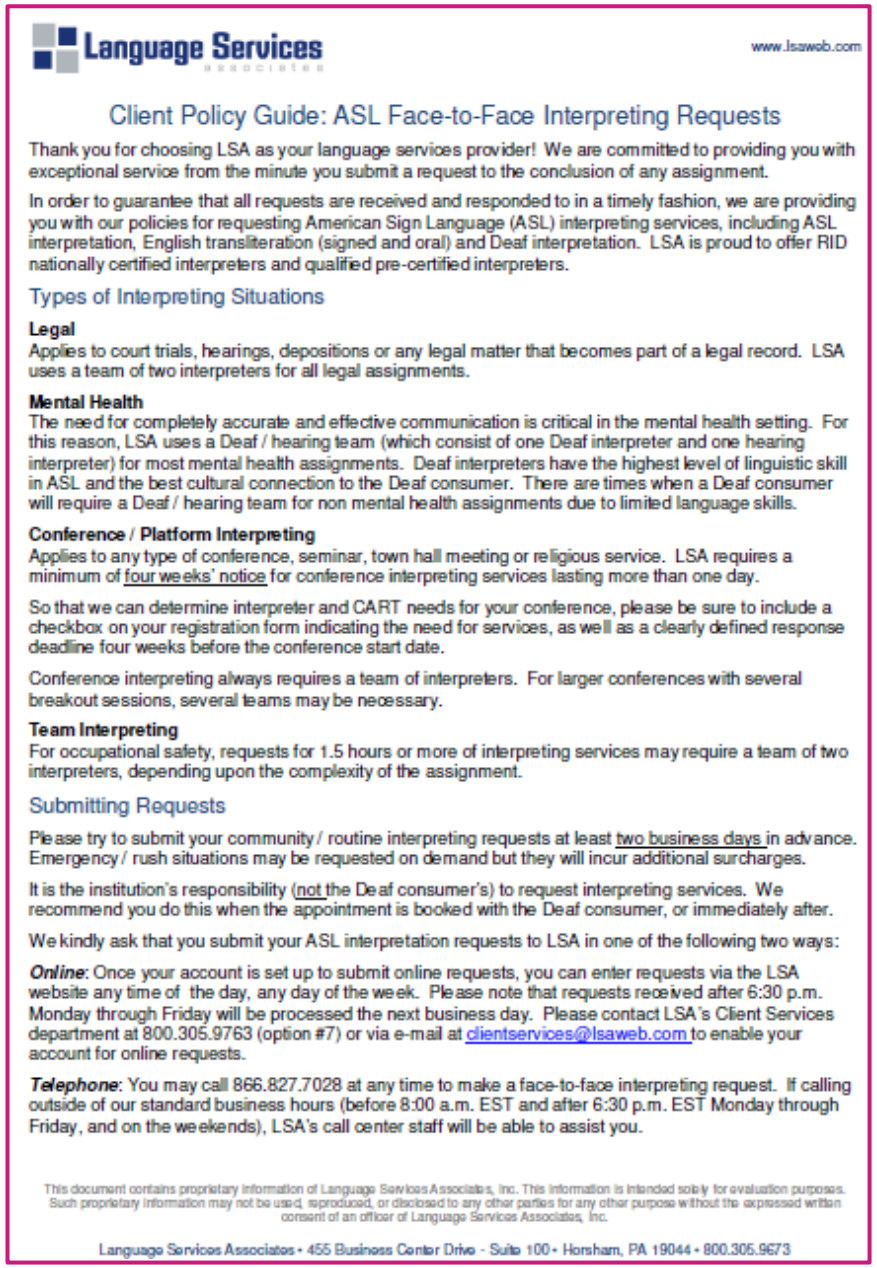
Access Standards - Ambetter

Appointment Type	Access Standard
PCP's - Routine visit	30 calendar days
PCP's – Adult sick visit	48 hours
PCP's – Pediatric sick visit	24 hours
Behavioral health non-life-threatening emergency	6 hours or direct member to crisis center or emergency room (ER)
Specialist	Within 30 calendar days
Urgent care providers	24 hours
Behavioral health urgent care	48 hours
After hours care	Answering service 24 hours a day, 7 days a week instructions on how to reach a physician
Emergency	24 hours a day, 7 days a week

Interpreter / Translation Services

absolute total care

ASL Interpretation Services



Language Services associates

www.lsawob.com

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

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

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

Types of Interpreting Situations

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

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

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

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

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

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

Submitting Requests

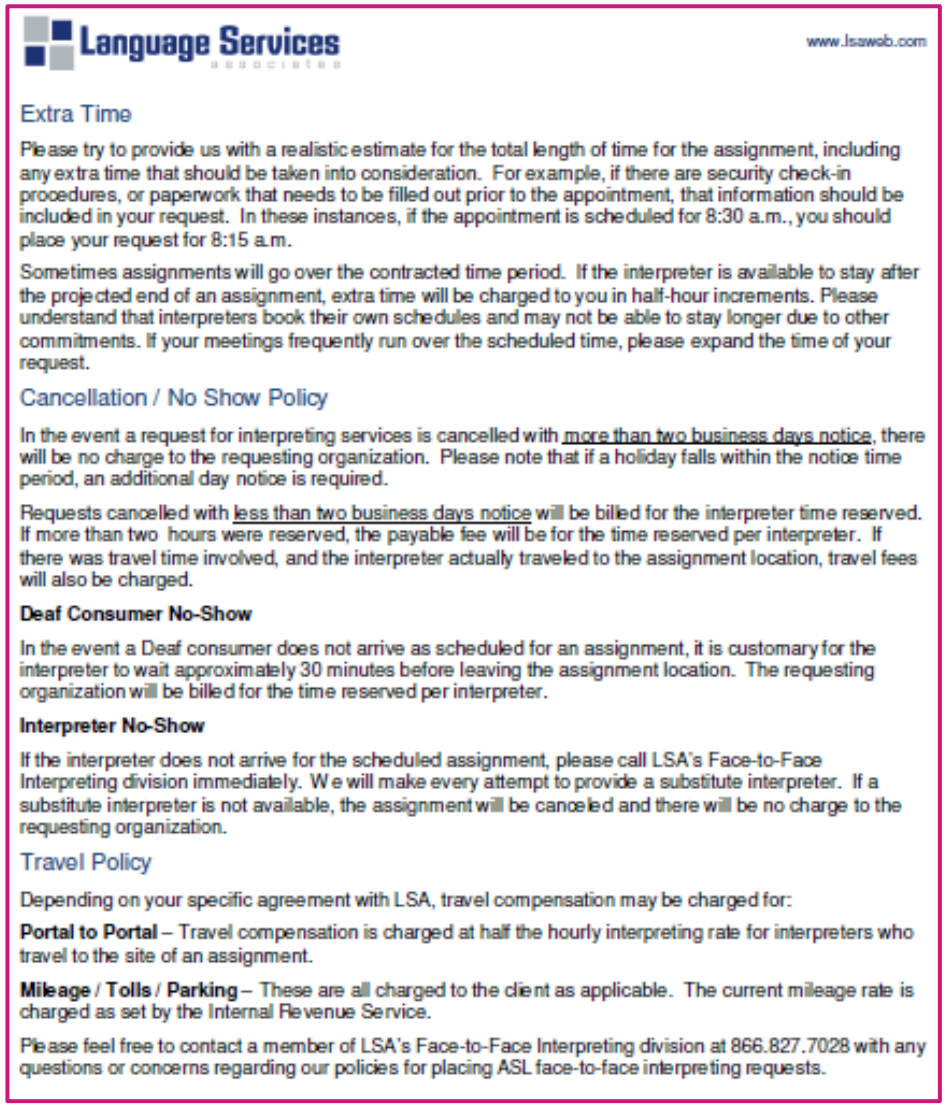
Please try to submit your community / routine interpreting requests at least two business days in advance. Emergency / rush situations may be requested on demand but they will incur additional surcharges.

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

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

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

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



Language Services associates

www.lsawob.com

Extra Time

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

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

Cancellation / No Show Policy

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

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

Deaf Consumer No-Show

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

Interpreter No-Show

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

Travel Policy

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

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

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

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

Please request a copy of this policy from your Provider Engagement Administrator if needed

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Requesting Interpreter Services

At Wellcare Health Plans, Inc., we value everything you do to deliver quality care to our members – your patients – and to ensure they have a positive health care experience. That's why we strive to see that members who need language services have adequate communication support. We have resources available to provide assistance when you identify members who have potential cultural or language barriers. These include:

- Interpreter services for languages other than English or members who have limited English proficiency
- Sign language interpreter services for the hearing impaired
- Telephone system technology (TTY line) for the hearing impaired

Providers can access communication support for medical encounters as follows:

- Non-urgent – If a member needs a sign language or foreign language interpreter for a medical appointment, the Customer Service Department arranges for this service through a locally contracted vendor. **Live, in-person translation is preferred to telephonic translation in non-urgent cases; the telephonic service will only be used when an interpreter for the required language cannot be found in or near the particular area.** Please request interpreter services at least 5 business days in advance by completing the Interpreter Request Form and emailing it to **InterpreterRequests@wellcare.com**.
- Urgent/Emergent – If a member needs language translation at the time of an urgent or emergent encounter and the provider does not have bilingual staff, the provider should call Customer Service. The Customer Service agent will work to patch in a translator for telephonic translation.

As a general rule, Wellcare discourages the use of patients' family members, particularly minor children, as translators. Family members may not be capable of translating medical terminology. In addition, patients may hesitate to speak candidly about their health problems in the presence of young family members.

Wellcare pays all costs of commercial language services required by its members, including services rendered in a provider's office or facility, as long as the translator is not on the staff of the facility.

Electronic Media for the Hearing Impaired

Members have access to the TTY line for hearing impaired services. Wellcare's Customer Service Department is responsible for any necessary follow-up calls to the member. The toll-free TTY number can be found on the member's identification card.

https://www.wellcare.com/south-carolina/providers/medicare

wellcare

Cost Center:
(Internal Use Only)

Interpreter Request Form

* Indicates required field. Please complete all required fields or the request will not be fulfilled.

* Please check type of Interpreter:

ASL (American Sign Language) * If Trilingual, specify what third language is required: _____

☐ Tactile ☐ Spanish ☐ Other Language: _____

* Person Needing Interpreter: _____ Wellcare Member ID: _____

* Member/Prospective Member's Phone Number: _____

* Appointment Date: _____ * Appointment Time and Duration: _____

* Appointment Address: _____

Member's Interpreter Preference (Female/Male): _____

* Event Description/Appointment Type: _____

* Primary Contact Name: _____ * Contact's Phone Number: _____

* Provider Name: _____ Provider's Wellcare ID: _____

Additional Important Information: _____

Please email the completed form to **InterpreterRequests@wellcare.com**.

Requests cannot be made more than 30 days in advance of the scheduled appointment date.

We cannot guarantee an interpreter if the request is received less than 5 business days before the appointment.

Quality care is a team effort. Thank you for playing a starring role!

Electronic Funds Transfer

absolute total care

PaySpan® Benefits

PaySpan® provides an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment.

PAYSPAN®

- Elimination of paper checks/virtual credit card payment.
- Convenient payments and retrieval of remittance information.
- Electronic Remittance Advice (ERAs) presented online.
- HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System.
- Reduce accounting expenses: Electronic remittance advices can be imported directly into practice management or patient accounting systems.
- Improve cash flow: Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts: You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advices quickly: You can associate electronic payments with ERAs quickly and easily.
- Manage multiple payers: Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts, as desired.

PaySpan®

- Providers can register using PaySpan's enhanced provider registration process at http://www.payspanhealth.com/.

- Providers can access additional resources by clicking Need More Help on the PaySpan® homepage or link directly to https://www.payspanhealth.com/nps/Support/Index.

- PaySpan® Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 1-877-331-7154 or on the web at https://www.payspanhealth.com/.

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Risk Adjustment

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Risk Adjustment

CONTINUITY OF CARE (COC) INCENTIVE PROGRAM

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

CLINICAL DOCUMENTATION IMPROVEMENT PROGRAM

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

Please reach out to your Provider Engagement Account Manager for more information regarding these programs.

Risk Adjustment Training for Providers (Medicare)

The Clinical Documentation Improvement (CDI) TEAM invites you to attend a pre-recorded webinar that will cover risk adjustment, coding, documentation and best practices to promote quality documentation, accurate coding and regulatory compliance.

Registration Link: https://centene.az1.qualtrics.com/jfe/form/SV_eu66FH2kJ6hUeOO

Link to Prerecorded Webinar: https://centene.qumucloud.com/view/fYzA4SnMBWU60OpfrBXHvd

Clinical Documentation Improvement (CDI) 2025 Webinar Series

Risk Adjustment, Coding and Documentation Education

Join us for discussions to help you optimize documentation and risk adjustment coding.

- Learn how to stay compliant with regulatory requirements.
- Learn compliant coding practices and accurately capture a patient's complexity.
- Learn to identify elements to support code assignment
- ……And more!

Live risk adjustment education* tailored for healthcare providers, non-physician providers, coders billers, administrative and support staff.

Register here!

Advance registration is required. Utilize the corresponding registration link provided for each topic to register (links are unique to each webinar). If you have questions or need assistance with registration, email us at: CDIWebinars@centene.com

Some sessions may qualify for approved CEU credits.* ***https://www.absolutetotalcare.com/providers/resources/provider-training.html*

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Quality Improvement

absolute total care

Partnership for Quality (P4Q) Bonus Program

The 2025 Partnership for Quality Program has been extended to all South Carolina Product lines: Absolute Total Care, Ambetter and Wellcare.

Absolute Total Care understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because Absolute Total Care recognizes these important partnerships, we are pleased to offer the 2025 Partnership for Quality (P4Q) Bonus Program, which rewards PCPs for improving quality and closing gaps in care.

The measurement period is Jan. 1 to Dec. 31, 2025. Absolute Total Care must receive all claims/encounters by January 31, 2026.

2025 Partnership For Quality (P4Q)

ABSOLUTE TOTAL CARE

Program Measures	Amount Per
ADD - ADHD Maintenance Phase Visit	$50
AMR - Asthma Medication Ratio 5 - 64 yrs	$50
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$50
EED - Diabetes – Dilated Eye Exam	$50
GSD - Diabetes HbA1c < 8	$50
BPD - Diabetes BP < 140/90	$50
CHL - Chlamydia Screening in Women	$50
CIS - Childhood Immunization Status Combo 10	$50
COL - Colorectal Cancer Screening	$50
IMA - Immunizations for Adolescents Combo 2	$50
KED - Kidney Health for Patients With Diabetes	$50
PPC - Postpartum Visit	$50
PPC - Prenatal Visit (Timeliness)	$50
PRS-E - Prenatal Immunizations	$50
SPC - Statin Therapy for Patients with CVD	$50
SPC - Statin Adherence for Patients with CVD	$50
SPD - Statin Therapy for Patients With Diabetes	$50
SPD - Statin Adherence for Patients with Diabetes	$50

WELLCARE

Program Measures	Amount Per
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$75
COA – Care for Older Adults – Functional Status*	$25
COL – Colorectal Cancer Screen	$50
EED – Diabetes – Dilated Eye Exam	$25
FMC – F/U ED Multiple High Risk Chronic Conditions	$50
GSD – Diabetes HbA1c <= 9	$75
KED – Kidney Health Evaluation for Patients with Diabetes	$50
Medication Adherence – Blood Pressure Medications	$50
Medication Adherence – Diabetes Medications	$50
Medication Adherence – Statins	$50
OMW – Osteoporosis Management in Women Who Had Fracture	$50
SPC – Statin Therapy for Patients with CVD	$25
SUPD – Statin Use in Persons With Diabetes	$25
TRC – Medication Reconciliation Post Discharge	$25

**Special Needs Plan (SNP) members only.*

AMBETTER

Program Measures	Amount Per
AMR - Asthma Medication Ratio 5 - 64 yrs	$50
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$50
EED - Diabetes – Dilated Eye Exam	$50
GSD - Diabetes HbA1c < 9	$50
CHL - Chlamydia Screening in Women	$50
CIS - Childhood Immunization Status Combo 10	$50
COL – Colorectal Cancer Screening	$50
IMA - Immunizations for Adolescents Combo 2	$50
KED - Kidney Health for Patients With Diabetes	$50
PDC - Proportion of Days Covered - Diabetes	$50
PDC - Proportion of Days Covered - Statins	$50
PPC - Postpartum Visit	$50
PPC - Prenatal Visit (Timeliness)	$50

CPT II and HCPCS Billing

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

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

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

How does this help you, our Providers?

- ✓ Fewer dropped codes by Billing Companies due to non-payable codes
- ✓ Better reporting of open and closed care needs for your assigned members
- ✓ Increase in Payment for Quality (P4Q) due to submission of additional codes
- ✓ Collection of HEDIS® measure data year round, resulting in fewer chart requests during chart collection season

What measures do these codes apply to?

- ✓ Controlling Blood Pressure
  - Blood pressure results
- ✓ Comprehensive Diabetes Care
  - Hba1c levels
  - Nephropathy – urine protein tests or treatment
  - Diabetic Retinal Eye Exams, DRE
- ✓ Care of Older Adults
  - Pain Assessment
  - Medication List and Review
  - Functional Status Assessment
- ✓ Medication Reconciliation Post Discharge
  - Medication List and Review after hospital discharge

CPTII Codes and HCPCS Billing PRO_91371E_Approved_01112022.pdf

What measures do these codes apply to?

Controlling Blood Pressure

- Blood pressure results

A1C levels

Diabetic Retinal Eye Exams

Care of Older Adults

- Pain Assessment
- Medication List and Review
- Functional Status Assessment

Medication Reconciliation Post Discharge

- Medication List and Review after hospital discharge

Electronic Medical Record (EMR) System

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

Reduce provider office staff activities regarding HEDIS Hybrid chart chase requests

Decrease and avoid duplication of over utilization or retrieval efforts

Lead to improved HEDIS performance reporting

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

Supplemental Data Feed

Monthly Supplemental Data Feed

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

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

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

CAHPS®

Consumer Assessment of Healthcare Providers and Systems

absolute total care™

Quality Rating Systems and CAHPS

MEDICAID

Rating System: HPR (Health Plan Rating System)

What role does CAHPS play?

HPR is based on the performance of dozens of measures of care. There are 3 subcategories: Patient Experience, Rates for Clinical Measures, and NCQA Health Plan Accreditation. CAHPS contributes to the Customer Satisfaction subcategory under Patient Experience.

MEDICARE AND MMP

Rating System: Star Ratings

What role does CAHPS play?

Star Rating is annually calculated using measures from multiple data sources. Data sources include: HEDIS, Pharmacy data, Member Surveys, and Plan Administrations. CAHPS contributes to the Member Surveys subcategory.

MARKETPLACE

Rating System: QRS (Quality Rating System)

What role does CAHPS play?

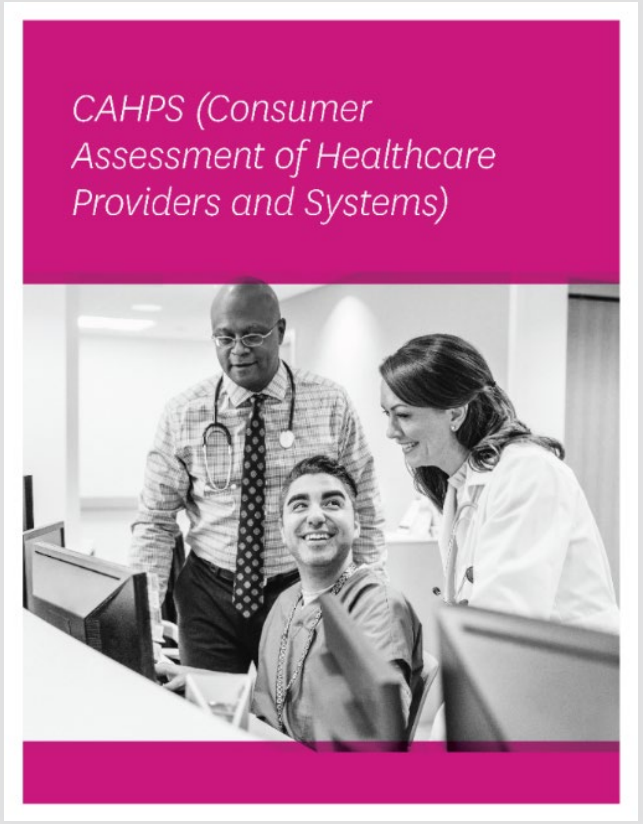
ARS is made up of 3 summary categories: Clinical Quality Management, Enrollee Experience and Plan Efficiency, Affordability and Management. The QHP Enrollee Experience Survey draws heavily form the CAHPS survey. Most survey questions fall under the Enrollee Experience summary indicator, but several questions are included in the Clinical Quality Management and Plan Efficiency, Affordability and Management summary indicators.

Survey Detail by Product

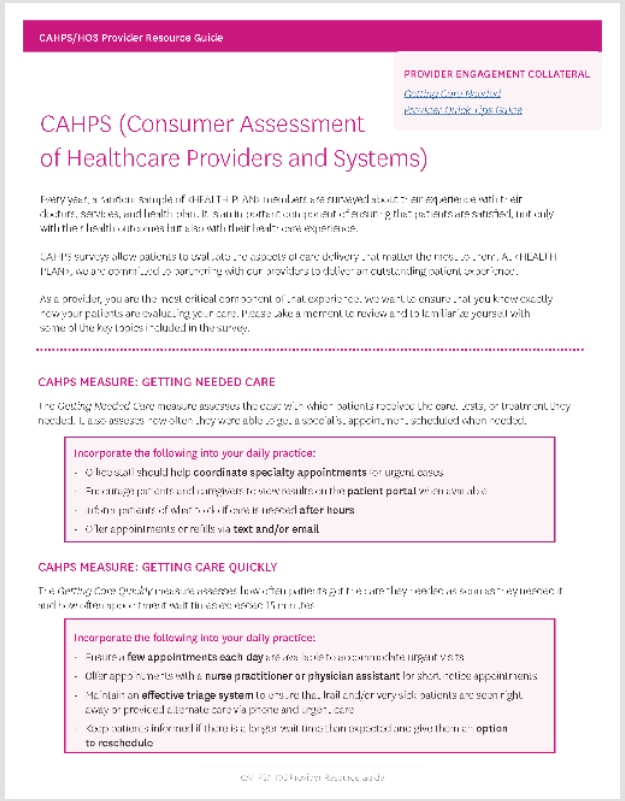
- The CAHPS survey is conducted annually however, the timeline varies slightly by product.
- The image provided reflects a breakdown of each product, important timeframes/deadlines, survey type, survey length, and sample size.

	MEDICAID	MEDICARE	MARKETPLACE
SURVEY TIME PERIOD*	January - May	March - May	February - May
SUBMISSION DEADLINE*	End of May	Mid-June	End of May
SURVEY TYPE/ REQUIREMENT	Adult Child Child CCC	Min. of 600 continuously enrolled members for 6 months required	Min. of 500 continuously enrolled members for 6 months required
SURVEY LENGTH	Adult- 40 questions Child- 41 questions Child CCC- 76 questions	MAPD- 68 questions PDP- 26 questions	68 questions
SAMPLE SIZE	Adult- 1,350 Child- 1,650 Child CCC- 3,490	MAPD- 800 PDP- 1500	1300
SUPPLEMENTAL QUESTIONS	Max of 12	Max of 12	Not Permitted
LANGUAGE	English and Spanish	English, Spanish, Chinese, Vietnamese, and Korean	English, Spanish, and Chinese
BLACK OUT PERIOD	No Blackout Period	February - June	January - May

CAHPS® Provider Resource Guide



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

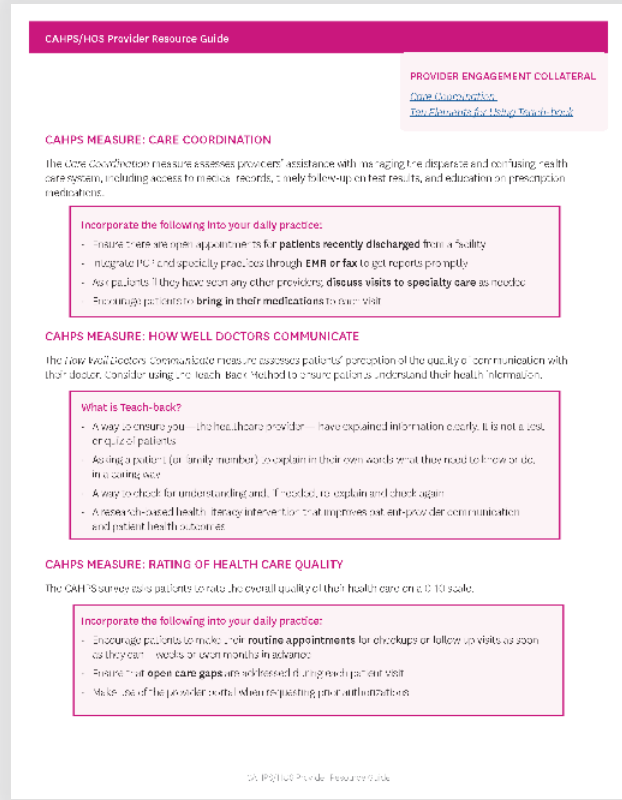

CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL

CAHPS (Consumer Assessment of Healthcare Providers and Systems)

CAHPS MEASURE: GETTING NEEDED CARE

CAHPS MEASURE: GETTING CARE QUICKLY


CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL

CAHPS MEASURE: CARE COORDINATION

CAHPS MEASURE: HOW WELL DOCTORS COMMUNICATE

CAHPS MEASURE: RATING OF HEALTH CARE QUALITY

Provider Focus Quick Tips

Getting Needed Care

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

Care Coordination

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

Getting Care Quickly

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

Rating of Health Care

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

Provider Satisfaction Survey

IN PROGRESS

PROVIDER SATISFACTION SURVEY

2025 ANNUAL PROVIDER SATISFACTION

- Our annual provider satisfaction survey has launched, and we hope providers will take a moment to share feedback.
- This survey serves as the foundation for key improvement initiatives that we undertake each year, and provider feedback is critical to making sure we address the issues that are important to our network providers.
- Please share feedback so we can continue to improve your experience in doing business with us.

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Scan the QR Code to learn more about our Provider Resources, such as manuals, forms and quick reference guides

Absolute Total Care is committed to giving our providers the tools & support you need.

absolutetotalcare.com

wellcare™

Scan the QR Code to learn more about our Provider Resources, such as manuals, forms and quick reference guides

Absolute Total Care is committed to giving our providers the tools & support you need.

wellcare.com/medicare

Open for Q&A

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Appendix

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Wellcare Medical Clinical Policy Updates

The following Medicare Clinical Policies contain changes to their previous versions, have been approved for use by Medicare QIC and will be effective on the date listed below:

April 20, 2025

- MC.CP.MP.182 Short Inpatient Hospital Stay
- MC.CP.MP.190 Outpatient Oxygen Use
- MC.CP.MP.22 Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)
- MC.CP.MP.247 Transplant Service Documentation Requirements
- MC.CP.MP.248 Facility-based Sleep Studies for Obstructive Sleep Apnea
- V1.2025 Concert Genetic Testing: Aortopathies and Connective Tissue Disorders
- V1.2025 Concert Genetic Testing: Cardiac Disorders
- V1.2025 Concert Genetic Testing: Dermatologic Conditions
- V1.2025 Concert Genetic Testing: Epilepsy, Neurodegenerative, and Neuromuscular Conditions
- V1.2025 Concert Genetic Testing: Exome and Genome Sequencing for the Diagnosis of Genetic Disorders
- V1.2025 Concert Genetic Testing: Eye Disorders
- V1.2025 Concert Genetic Testing: Gastroenterologic Disorders (non-cancerous)
- V1.2025 Concert Genetic Testing: General Approach to Genetic and Molecular Testing
- V1.2025 Concert Genetic Testing: Hearing Loss
- V1.2025 Concert Genetic Testing: Hematologic Conditions (non-cancerous)
- V1.2025 Concert Genetic Testing: Hereditary Cancer Susceptibility
- V1.2025 Concert Genetic Testing: Immune, Autoimmune, and Rheumatoid Disorders
- V1.2025 Concert Genetic Testing: Kidney Disorders
- V1.2025 Concert Genetic Testing: Lung Disorders
- V1.2025 Concert Genetic Testing: Metabolic, Endocrine, and Mitochondrial Disorders
- V1.2025 Concert Genetic Testing: Multisystem Inherited Disorders, Intellectual Disability, and Developmental Delay
- V1.2025 Concert Genetic Testing: Prenatal Cell-Free DNA Testing
- V1.2025 Concert Genetic Testing: Pharmacogenetics (Version A)
- V1.2025 Concert Genetic Testing: Preimplantation Genetic Testing
- V1.2025 Concert Genetic Testing: Prenatal and Preconception Carrier Screening
- V1.2025 Concert Genetic Testing: Prenatal Diagnosis (via Amniocentesis, CVS, or PUBS) and Pregnancy Loss
- V1.2025 Concert Genetic Testing: Skeletal Dysplasia and Rare Bone Disorders
- V1.2025 Concert Genetics Oncology: Algorithmic Testing
- V1.2025 Concert Genetics Oncology: Cancer Screening
- V1.2025 Concert Genetics Oncology: Circulating Tumor DNA and Circulating Tumor Cells (Liquid Biopsy)
- V1.2025 Concert Genetics Oncology: Cytogenetic Testing
- V1.2025 Concert Genetics Oncology: Molecular Analysis of Solid Tumors and Hematologic Malignancies

https://www.wellcare.com/providers/medicare-bulletins/medical-clinical-policy-updates

Wellcare Medical Clinical Policy Updates

The following Medicare Clinical Policies contain changes to their previous versions, have been approved for use by Medicare QIC and will be effective on the date listed below:

August 1, 2025:

- CPG Grid: Adopted Clinical Practice and Preventive Health Guidelines
- V1.2025 Concert Genetic Testing: Pharmacogenetics (Version B)
- MC.CP.MP.57 Lung Transplantation
- MC.CP.MP.69 Modulated Radiation Therapy (IMRT)
- MC.CP.MP.101 Donor Lymphocyte Infusion
- MC.CP.MP.160 Implantable Wireless Pulmonary Artery Pressure Monitoring
- MC.CP.MP.170 Peripheral Nerve Blocks and Ablation of Peripheral Nerves for Pain Management
- MC.CP.MP.246 Pediatric Kidney Transplant

https://www.wellcare.com/providers/medicare-bulletins/medical-clinical-policy-updates

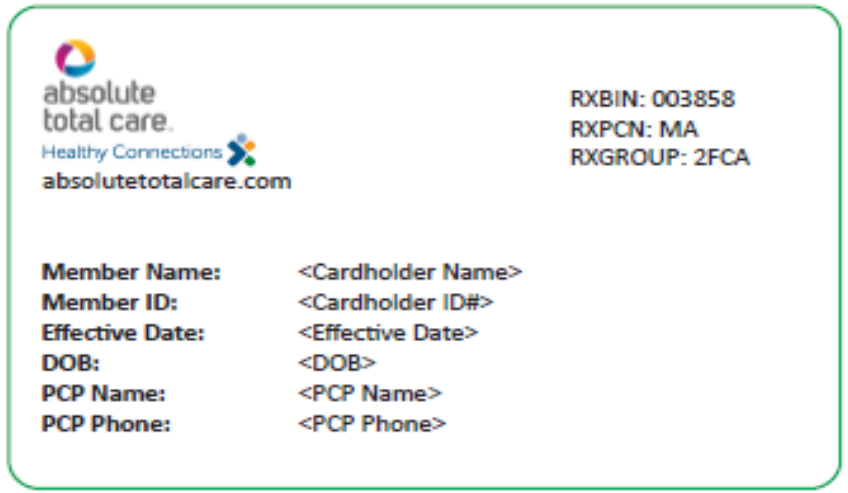
absolute total care™
Healthy Connections

Absolute Total Care
Healthy Connections Medicaid

Transforming the health of the communities we serve, one person at a time.

Absolute Total Care
Healthy Connections Medicaid

Front 2025-Member ID Card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Healthy Connections
absolutetotalcare.com

RXBIN: 003858
RXPCN: MA
RXGROUP: 2FCA

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

- ATC and Healthy Connections Logo
- Member Name
- Member ID: ATC unique member Medicaid ID number, required for all members & used when filing claims
- Effective Date: Indicates when the member becomes eligible for benefits and services
- PCP Name
- PCP Phone Number
- RxBIN/RxPCN: Required for pharmacy benefits processing

Back 2025-Member ID Card


If you have an emergency, call 911 or go to the nearest emergency room.

Member/Provider Services:	1-866-433-6041
24/7 Nurse Advice Line:	1-866-433-6041
Behavioral Health:	1-866-433-6041
Imaging, X-rays, Radiology:	1-866-433-6041
DME, Home Health, Infusion:	1-866-433-6041
Pharmacy Help Desk (Pharmacists Only):	1-833-750-4506

Billing Address: P.O. Box 3050, Farmington, MO 63640-3821

absolutetotalcare.com

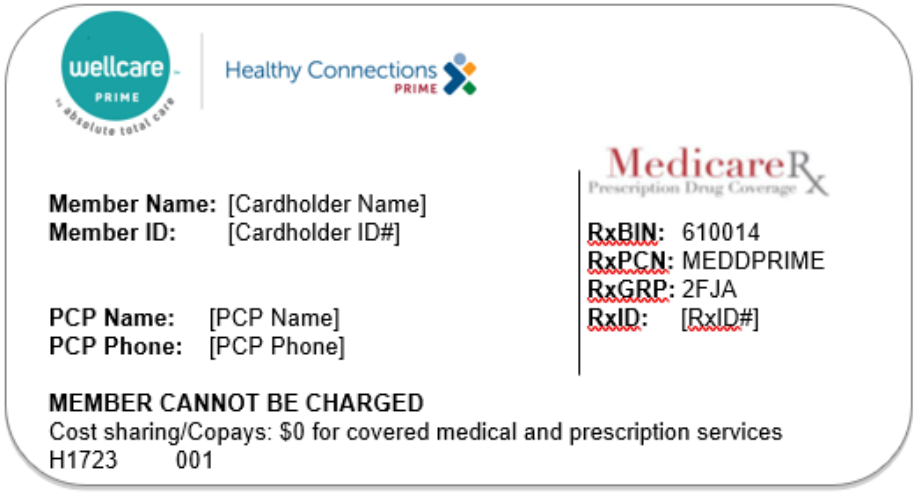
- Member/Provider Services Number: A toll-free number for questions and information, including the Nurse Advice Line, behavioral health, imaging, X-rays, durable medical equipment (DME), home health services and more
- Pharmacy Help Desk: Pharmacist only
- ATC Billing Address
- ATC Website

Wellcare Prime by Absolute Total Care

https://mmp.absolutetotalcare.com

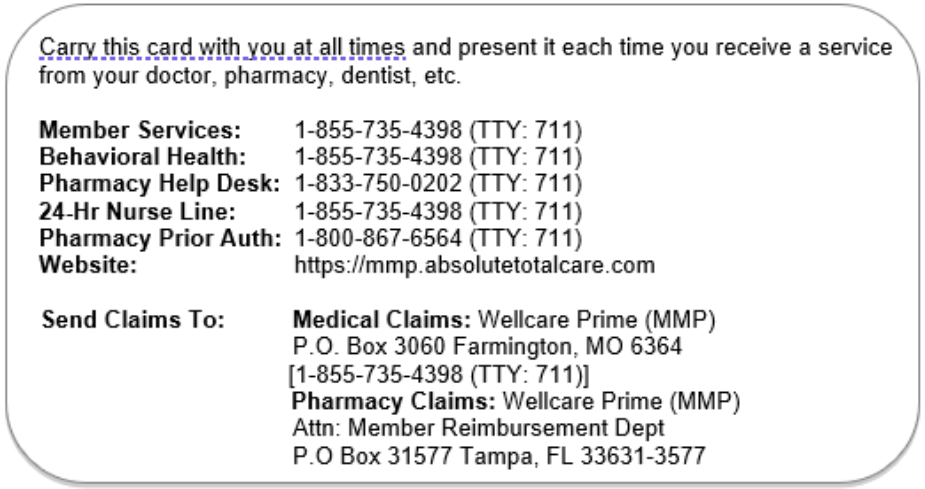
Wellcare Prime by Absolute Total Care

FRONT 2025-MEMBER ID CARD



- Wellcare Prime Healthy Connections Prime Logo
- Member Name
- Member ID: Wellcare Prime unique member ID
- PCP Name
- PCP Phone Number
- RxBIN/RxPCN: Required for pharmacy benefits processing
- Disclaimer: Member cannot be charged

BACK 2025-MEMBER ID CARD



- Member/Provider Services Number: A toll-free number for questions and information, including the Nurse Advice Line, behavioral health, imaging, X-rays, durable medical equipment (DME), home health services and more
- Pharmacy Help Desk: Pharmacist only
- Pharmacy Prior Authorization
- Wellcare Prime Website
- Wellcare Prime Billing Address: Medical and pharmacy

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

Medicare Prescription Payment Plan (M3P)

Available January 1, 2025, the Medicare Prescription Payment Plan (M3P) will help eligible members afford their medications by spreading costs over time.

2025 Medicare Financial Updates

Medicare members will benefit from the elimination of the prescription drug coverage gap. Additionally, annual out-of-pocket (OOP) costs for prescription medications will be capped at $2,000, with the option for beneficiaries to spread these costs evenly throughout the plan year.

Part D Cost-Sharing Update

Participants will pay $0 at the pharmacy for covered Part D medications. Any applicable cost-sharing will be billed monthly, allowing members to manage expenses more predictably throughout the year.

Voluntary Program Enrollment

The program is voluntary, and eligible members may choose to opt in during the annual enrollment period or at any time throughout the plan year. Members can conveniently enroll online, by phone, or by mail.

Phone: 1-833-750-9969
Online:
expressscripts.com/mppp
Mail: Express Scripts Medicare
Prescription Payment Plan
P.O. Box 2
St. Louis, MO 63166

- **Excludes plans that solely charge $0 cost sharing for Part D covered drugs.**
- **See your plan's Evidence of Coverage for more details.**

Ambetter from Absolute Total Care

My Health Pays Rewards Program

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

Ambetter Health Premier

Effective January 1, 2025
Bronze, Silver, Gold (core) network will be renamed PREMIER

FRONT 2025-MEMBER ID CARD

ambetter. FROM | absolute total care

REFERRAL NOT REQUIRED

PREMIER

MEMBER: [Jane Doe]
Subscriber: [John Doe]
Policy: [XXXXXXXXX] **Member ID:** [XXXXXXXXXXXX]
Plan: [Plan name]
[Network Name] Network Coverage Only
RXBIN: 003858 **RXPCN:** A4 **RXGROUP:** 2DQA
Effective Date: [00/00/00]

COPAYS
PCP: [$10 copay after ded.]
Specialist: [$25 coin. after ded.]
Urgent Care: [20% coin. after ded.]
ER: [$250 copay after ded.]

COST SHARES
INN DED Ind/Fam: [$7,965/$18,000]
OON DED Ind/Fam: [$22,500/$45,000]
INN MOOP Ind/Fam: [$9,200/$25,000]
OON MOOP Ind/Fam: [$25,000/$45,000]

For detailed benefit information, please visit AmbetterHealth.com/copays

BACK 2025-MEMBER ID CARD

Ambetter.AbsoluteTotalCare.com

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

Numbers below for providers:
Pharmacist Only: 1-833-750-4237
EDI Payor ID: 68069
[Centene Vision Services: 1-833-724-9353]
[Centene Dental Services supported by United Concordia: 1-833-605-6320]

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

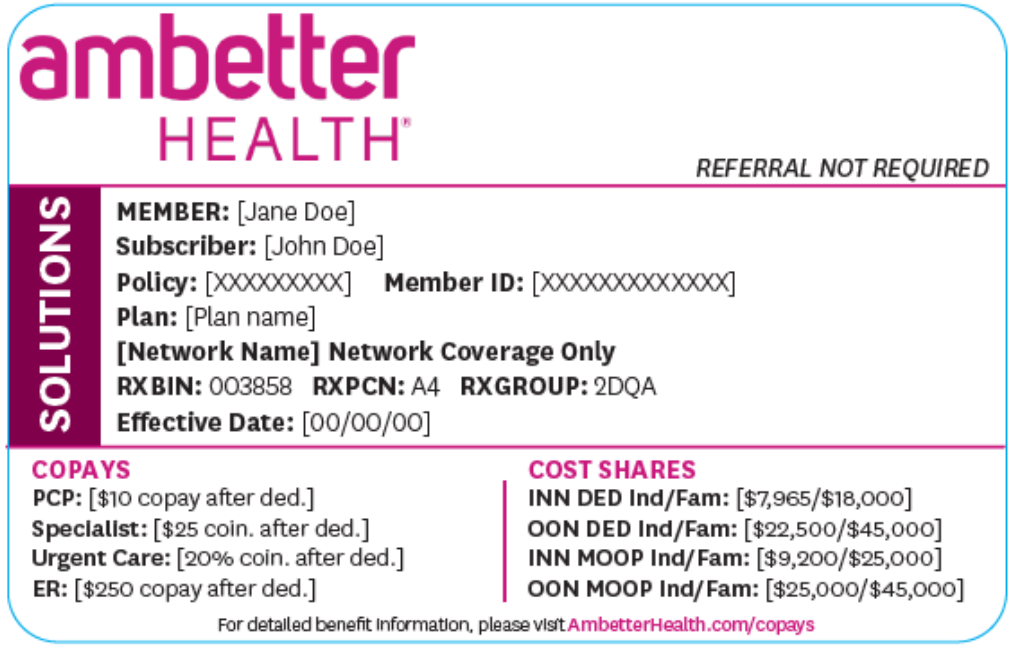
AMB24-SC-C-00040

Ambetter from Absolute Total Care is underwritten by Absolute Total Care, Inc., which is a Qualified Health Plan issuer in the South Carolina Health Insurance Marketplace.

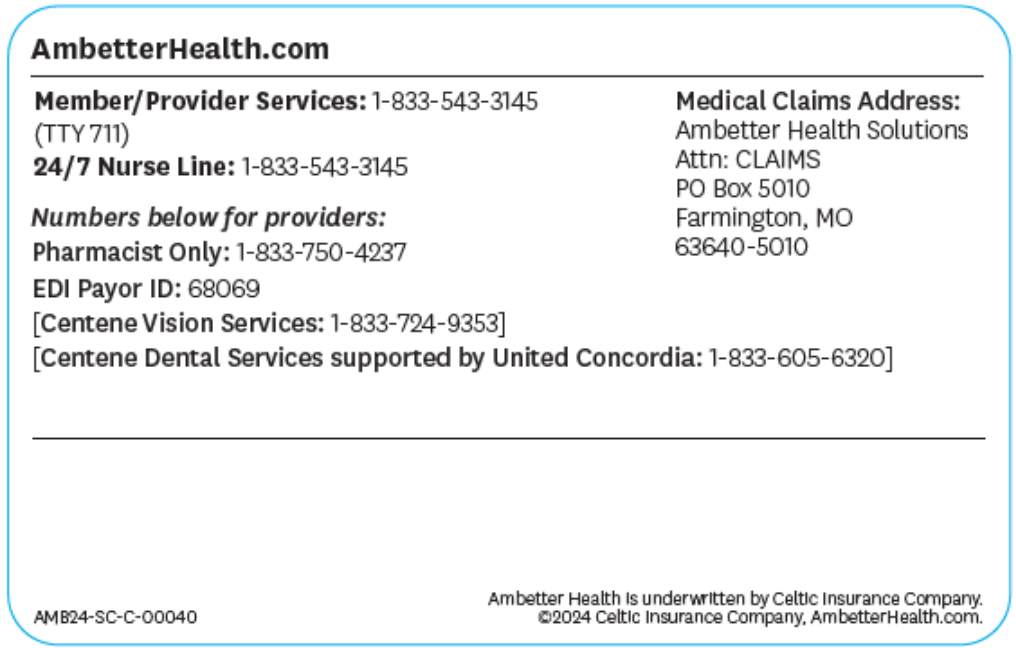
Ambetter Health Solutions

Ambetter Health (ICHRA)
Network name: SOLUTIONS

FRONT 2025-MEMBER ID CARD



BACK 2025-MEMBER ID CARD



Ambetter Health Solutions plans are “off-exchange” options for individuals purchasing health insurance through defined contributions or health reimbursement arrangements, such as an individual coverage health reimbursement arrangement (ICHRA) or qualified small employer health reimbursement arrangement (QSHERA). Plans are available in the bronze, silver and gold levels.

Ambetter Health Solutions plans are available for 2025 coverage in Georgia, Indiana, Mississippi, Missouri, Ohio and South Carolina.

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Start Smart for Your Baby

absolute total care™

PROGRAM GOALS

- Early identification of pregnant members and their risk factors
- Reducing the risk of pregnancy complications
- Better birth outcomes

STRATEGY

- Submission of Notification of Pregnancy (NOP) Form
- High-risk members are prioritized for Care Management Program
- OB Nurse Care Managers collaborate with members and providers to improve maternal and infant health

Start Smart for Your Baby

absolute total care™

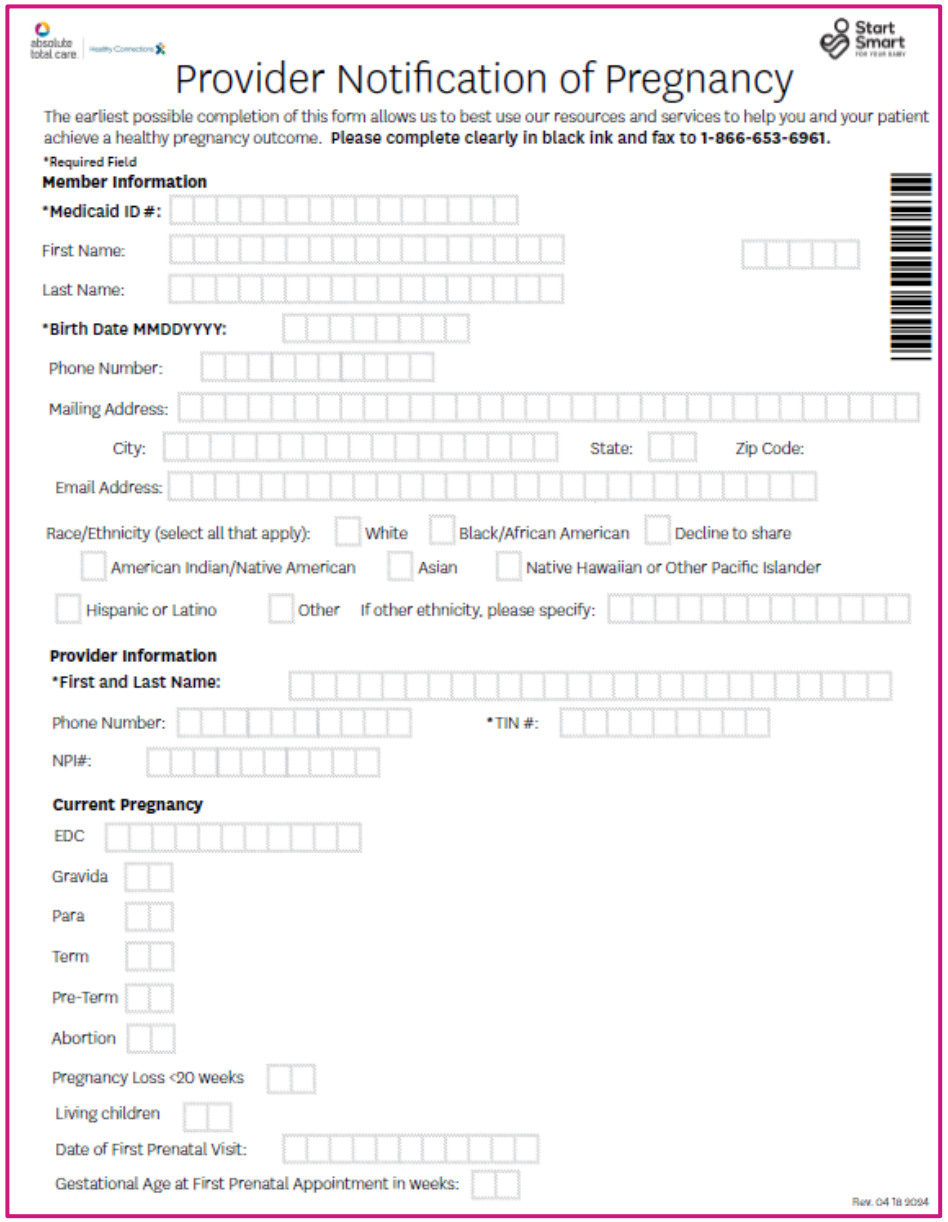
OB Incentive Reimbursements

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

Start Smart for Your Baby®

Start Smart for Your Baby

Notification of Pregnancy (NOP) Form Sample



absolute total care | Healthy Connections

Start Smart

Provider Notification of Pregnancy

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

*Required Field

Member Information

*Medicaid ID #:

First Name:

Last Name:

*Birth Date MMDDYYYY:

Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share

American Indian/Native American Asian Native Hawaiian or Other Pacific Islander

Hispanic or Latino Other If other ethnicity, please specify:

Provider Information

*First and Last Name:

Phone Number: *TIN #:

NPI#:

Current Pregnancy

EDC

Gravida

Para

Term

Pre-Term

Abortion

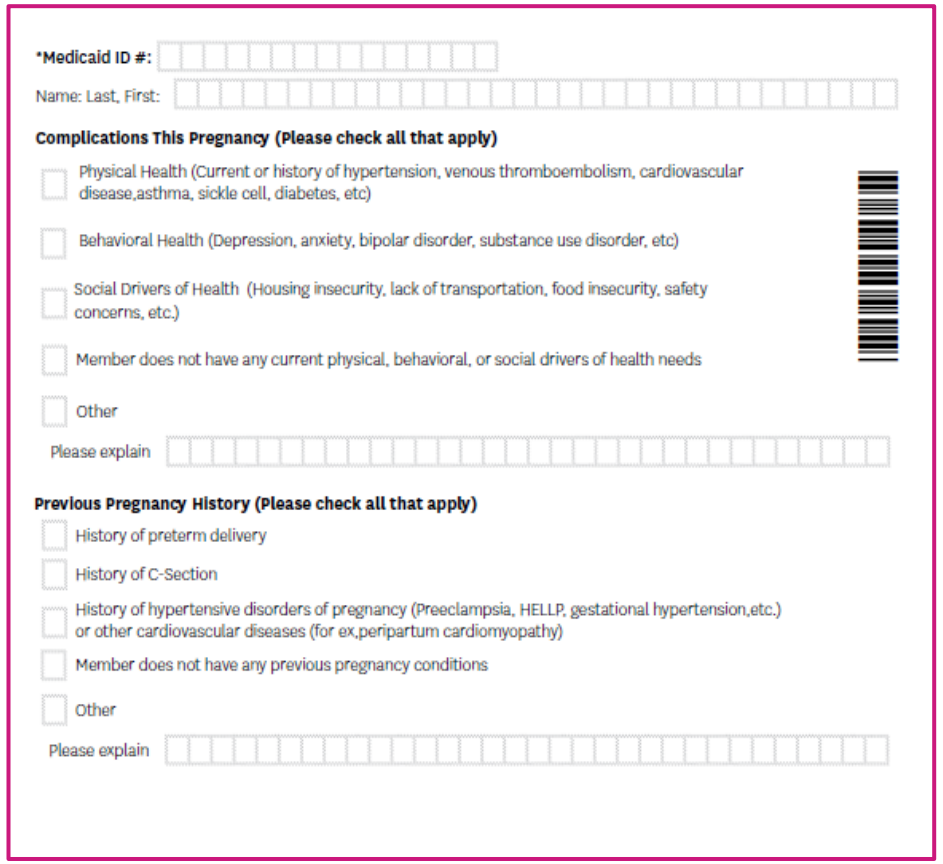
Pregnancy Loss <20 weeks

Living children

Date of First Prenatal Visit:

Gestational Age at First Prenatal Appointment in weeks:

Rev. 04 18 2094



*Medicaid ID #:

Name: Last, First:

Complications This Pregnancy (Please check all that apply)

Physical Health (Current or history of hypertension, venous thromboembolism, cardiovascular disease,asthma, sickle cell, diabetes, etc)

Behavioral Health (Depression, anxiety, bipolar disorder, substance use disorder, etc)

Social Drivers of Health (Housing insecurity, lack of transportation, food insecurity, safety concerns, etc.)

Member does not have any current physical, behavioral, or social drivers of health needs

Other

Please explain

Previous Pregnancy History (Please check all that apply)

History of preterm delivery

History of C-Section

History of hypertensive disorders of pregnancy (Preeclampsia, HELLP, gestational hypertension,etc.) or other cardiovascular diseases (for ex,peripartum cardiomyopathy)

Member does not have any previous pregnancy conditions

Other

Please explain

Start Smart FOR YOUR BABY®

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Wellcare Medicare Advantage

Wellcare Medicare Advantage HMO

Health Maintenance Organization (HMO)

- This is a traditional Medicare Advantage (MA) plan.
- All services must be delivered by providers within the Wellcare network, except in cases of emergency, urgent care, or when a medically necessary service is unavailable in-network.
- Certain services require prior authorization from Wellcare or its designated entity.

No or low monthly health plan premiums with predictable copays for in-network services

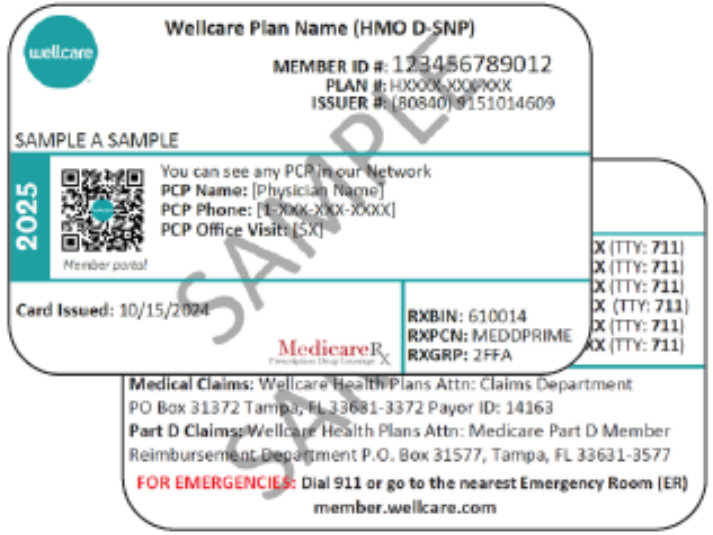
Outpatient prescription drug coverage

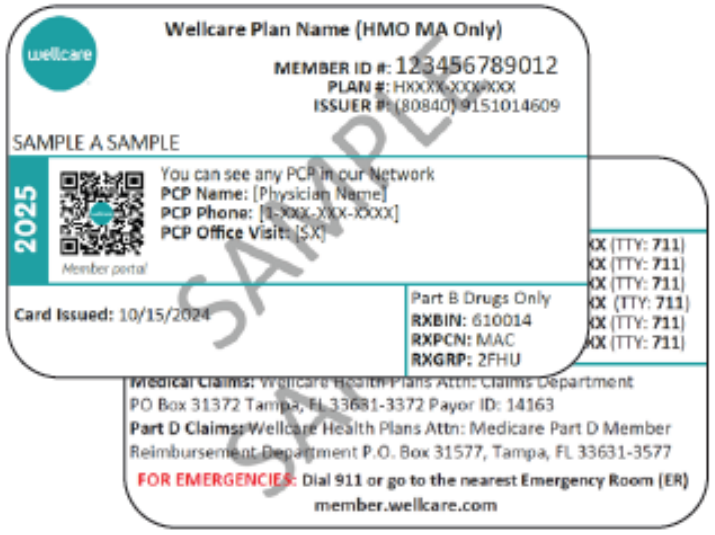
Routine dental, vision and hearing benefits

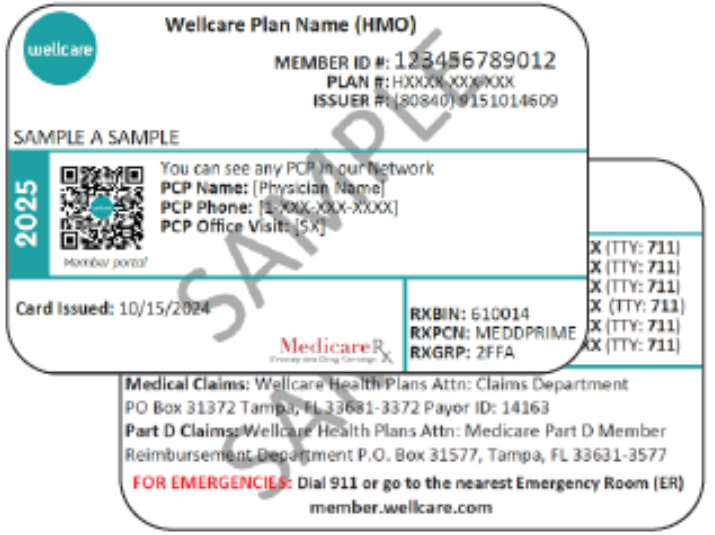
Preventive care services by participating providers are covered with no member copayment

Medicare – HMO / HMO D-SNP

2025-MEMBER ID CARD







Wellcare Medicare Advantage PPO

As an eligible Medicare provider, Wellcare reimburses you at 100% of the Medicare allowable rate for all plan-covered, medically necessary services for our PPO members – whether you are contracted with us or not.

The Wellcare Medicare Advantage PPO plan:

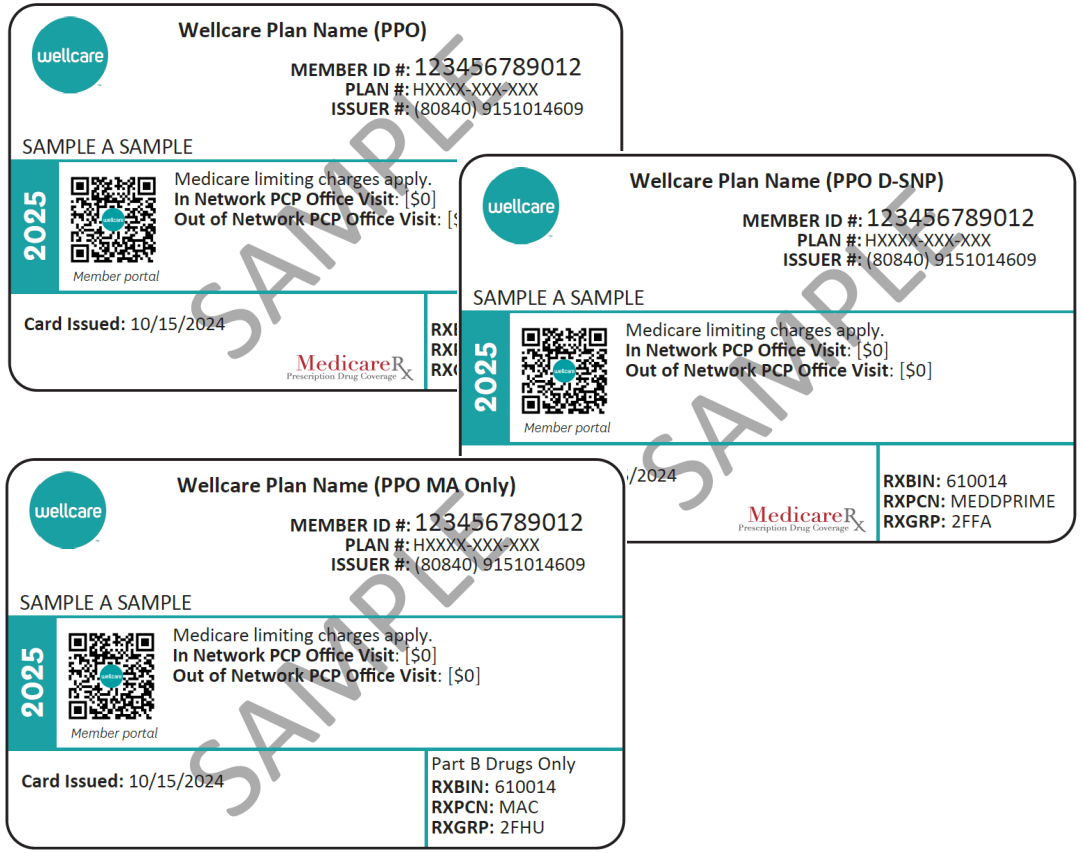
- Offers predictable costs through simple copayments for doctor visits, hospital stays, and many other healthcare services.
- Provides comprehensive coverage, including Medicare Parts A, B, and D, along with additional benefits such as vision, dental, and hearing—services not covered by Original Medicare.
- Covers all services included under Original Medicare and adheres to Original Medicare's coverage rules.
- Limits coverage to medically necessary services provided by healthcare professionals who are eligible to participate in Medicare.

INCREASED FLEXIBILITY

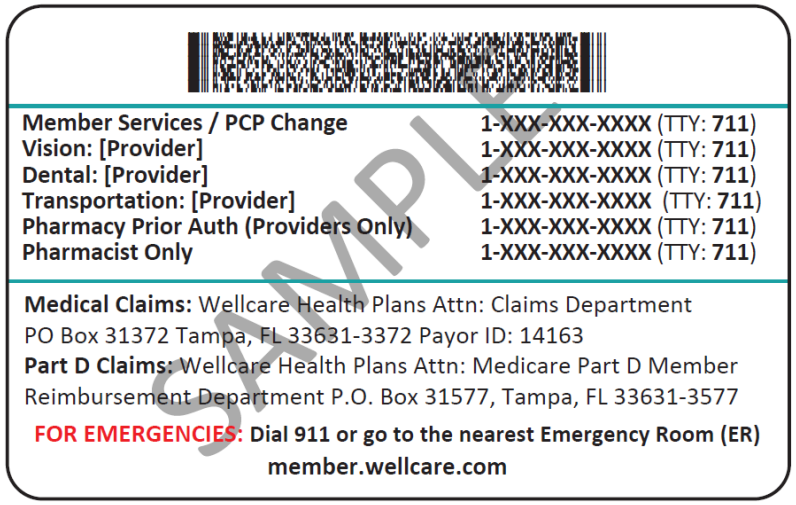
Referrals from a primary care physician are not required for specialist or hospital visits. However, members may pay lower costs when they use providers within the Wellcare network. Please note: Medicare providers not contracted with Wellcare are not required to treat members, except in emergencies.

Medicare – PPO / PPO D-SNP / PPO HMO MA Only

FRONT 2025-MEMBER ID CARD



BACK 2025-MEMBER ID CARD



Medicare – PPO (HMO) and PPO HMO D-SNP

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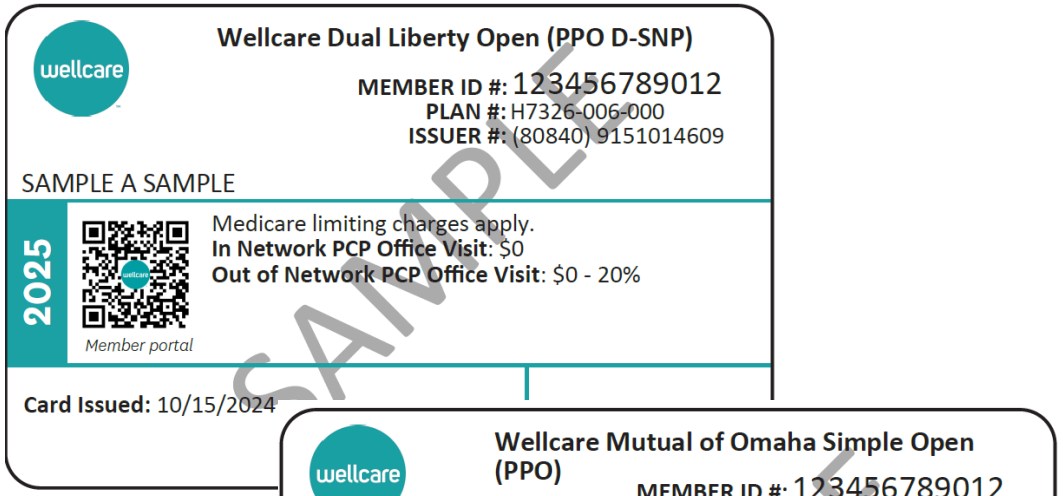

BACK 2025-MEMBER ID CARD

Medicare – Prescription Drug Plan (PDP)

FRONT 2025-MEMBER ID CARD

BACK 2025-MEMBER ID CARD

Authorization Vendors

Vision Services need to be verified by Envolve Vision.
Musculoskeletal Services need to be verified by Evolent.
Hospice requests should be submitted to SC DHHS Medicaid Fee for Service program.
Oncology/supportive drugs for members aged 18 and older need to be verified by New Century Health.
Dental Services for members under 21 need to be verified by SCDHHS through the EPSDT program.
Complex imaging, MRA, MRI, PET, CT scans need to be verified by National Imaging Associates (NIA).
Outpatient rehabilitative and habilitative physical medicine services PT, OT, and Speech need to be verified by Evolent

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Healthy Connections

Absolute Total Care 2025 Enhanced Benefits

Absolute Total Care members get added benefits along with medical coverage. These extra benefits, tools and services are at no cost to you. Call Member Services at **1-866-433-6041 (TTY: 711)** or visit **absolutetotalcare.com** for more information.

Benefit	Description
24-Hour Nurse Advice Line	Connect with a registered nurse, 24 hours a day, 7 days a week, 365 days a year. Call 1-866-433-6041 (TTY: 711) and select "Member Services" then "Nurse Advice Line" at the prompt to reach a nurse.
Car Seat, Stroller or Playpen	Complete six prenatal visits to qualify. Limit one per pregnancy.
Diaper Rewards Program	Receive one package of diapers and wipes after completing each of these visits: 6-week postpartum visit; 1, 2, 4, 6, 9 and 12-month infant well visits.
Electric Breast Pump	Receive an electric breast pump when you are due to deliver within 12 weeks or have delivered within the past 30 days or had a NICU baby in the last 90 days.
General Education Development (GED) Testing	Offered at no-cost to our members aged 16 over who are not enrolled in high school or did not graduate from high school.
MyHealthPays® Rewards Program	Earn reward dollars for completing healthy behaviors. Use reward dollars for everyday items at Walmart or to help pay for utilities, transportation, telecommunications, childcare services, education or rent.
Over the Counter (OTC) Benefit	Receive up to $60 of eligible OTC items annually per household. $15 quarterly allowance per household. Unused funds at the end of each quarter do not carry over.
Postpartum Meals	Receive 14 free, home-delivered meals for qualifying birth parents who have a delivery on record.
*Reading Skills Development Program	Improve reading skills with a membership in our reading skill enhancement program for eligible members in pre-kindergarten to fifth grade. Program provides books and tutoring sessions.
*Sports Activity Fee	Members aged 5-18 can receive up to $50 annually per member through the My Health Pays program to cover the program activity/registration fee.
Sports Physical	Receive one sports physical per year for members 5-18 years old.
Start Smart for Your Baby Program	Receive tips and resources to help you, your new baby, and your family get off to a great start.

Effective 1/1/2025

The member handbook is available at **absolutetotalcare.com**. For a printed copy of the member handbook or any other materials on our website, we will send it to you free of charge. Call Member Services: 1-866-433-6041 (TTY: 711).

100 Center Point Circle, Suite 100, Columbia, SC 29210 | 1-866-433-6041 (TTY: 711)

absolutetotalcare.com

ATC-11202024-M-3-WM-N

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Authorization Vendors and Partners

- eviCore **is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: Lab Management and Sleep Diagnostics.**
- Evolent **is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: Advanced Radiology, Advanced Cardiology, Pain Management, Physical, Occupational and Speech Therapy and Musculoskeletal (MSK) Management program.**
- CareCentrix **is our in-network vendor for the following programs and provider resources can be accessed through the corresponding program links: Skilled Nursing Facility, Long Term Acute Care and Inpatient Rehab.**
- New Century Health **is our in-network vendor for Oncology Pathways Solutions: Medical and Radiation Oncology, as well as Cardiology Management Program as of October 1, 2023.**

HEALTH PLAN PARTNERS

Contracted Networks

HEARING

HCS

Phone: **1-866-344-7756**

VISION

Premier

Phone: **1-866-419-1009**

DENTAL

Liberty

Phone: **1-866-544-4362**

TRANSPORTATION

ModivCare aka LogistiCare

Phone: **1-877-718-4201**

wellcare PRIME — absolute total care

Healthy Connections PRIME

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

May 19, 2016

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

BALANCE BILLING IS PROHIBITED

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

WHAT CAN BE BILLED TO MEMBERS?

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

ABOUT HEALTHY CONNECTIONS PRIME

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

Credentialing Rights

absolute total care

Credentialing Rights

Practitioners seeking participation with ATC are entitled to review the information ATC collects to assess their credentialing and recredentialing applications, including details from external primary sources. However, they cannot access references, personal recommendations, or peer-review protected information.

If a practitioner believes any information used in the credentialing or recredentialing process to be incorrect, or if any information gathered during the primary source verification process differs from what the practitioner submitted, they have the right to correct any erroneous information provided by another party.

To obtain such information, you must send a written request to the ATC Credentialing Department. Once the information is received, the practitioner has 14 days to submit a written explanation highlighting any errors or discrepancies to ATC. Subsequently, ATC's Credentialing Committee will incorporate this information into the credentialing or recredentialing process.

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Annual Provider Training Requirements

Annual Provider Training Requirements

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

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

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

Required Training Resources

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

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

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

ATC-06072021-AP-2 Approved 06072021
SC1PROLTR75289E_0000

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

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

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

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

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

Wellcare Prime members can be billed for:

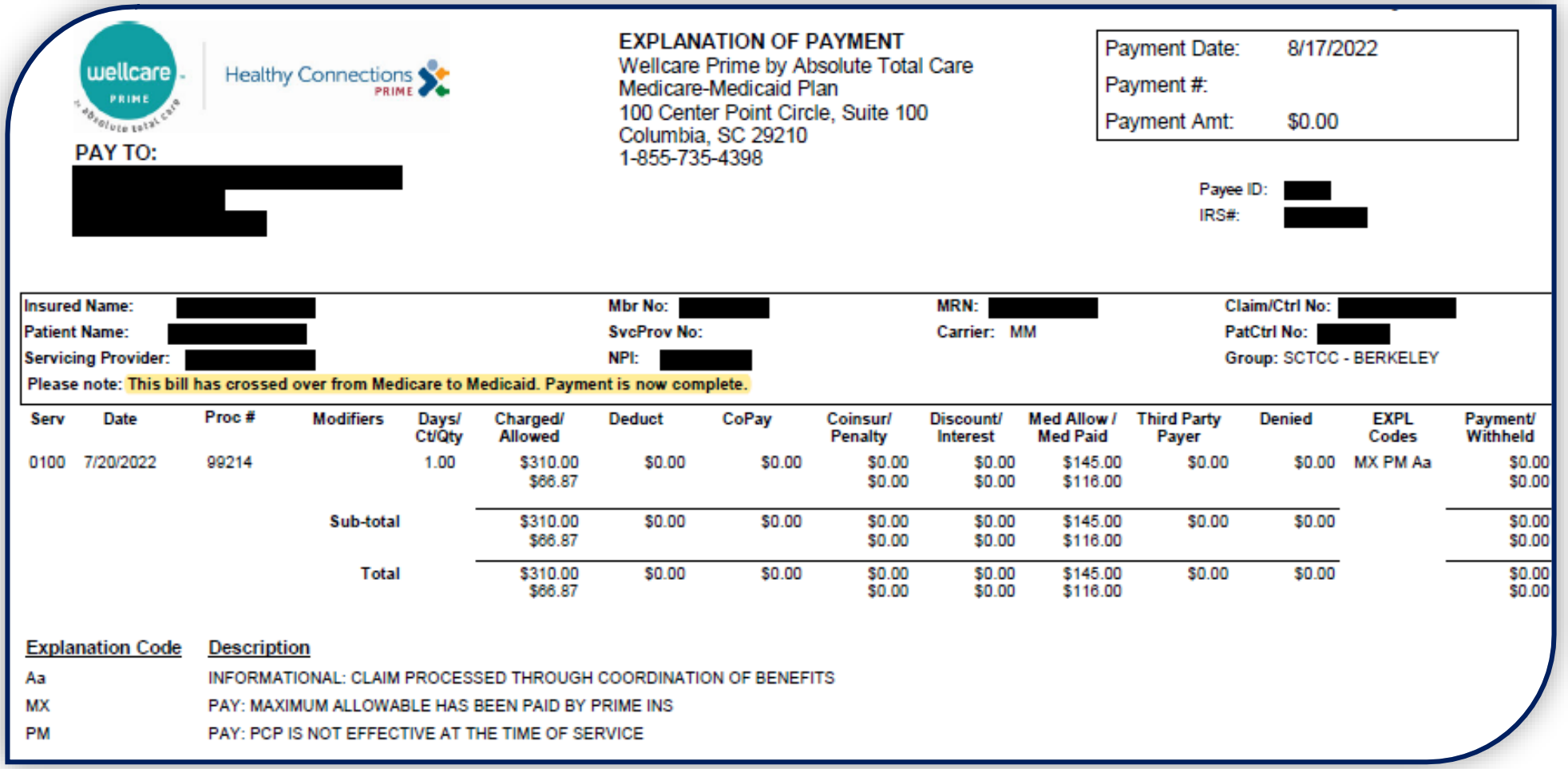
- Medicaid participation in cost of care amounts for long-term services and supports as determined by SCDHHS.
- Medicaid copay for Medicaid only covered Durable Medical Equipment (DME) items.

How Wellcare Prime resolves balance billing issues with the provider:

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

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

MMP Example EOP – Medicaid Balance Billing



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

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

PAY TO: [redacted]

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

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

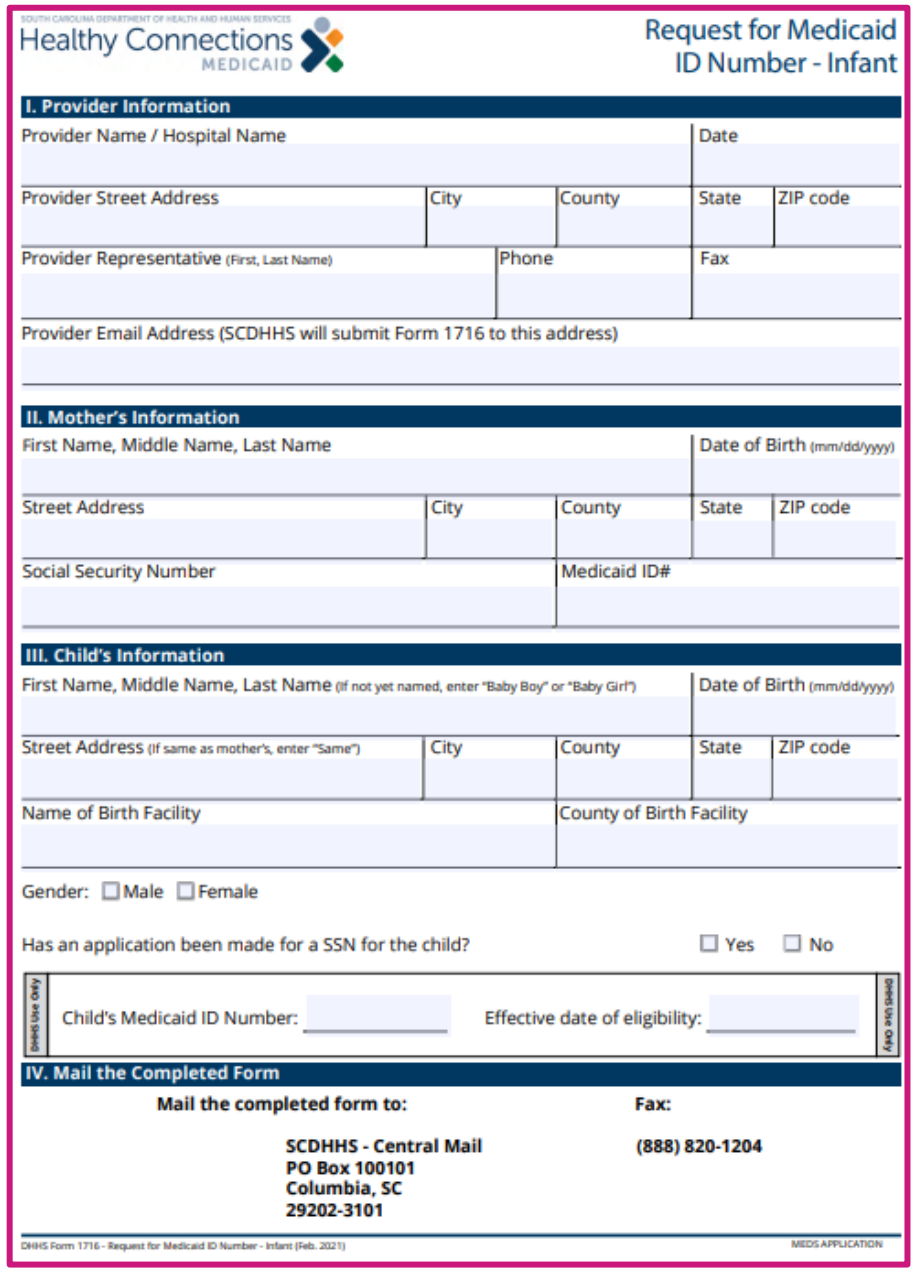
Please note: This bill has crossed over from Medicare to Medicaid. Payment is now complete.

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

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

SC DHHS 1716 Form for Newborns

https://www.scdhhs.gov/sites/default/files/documents/FM%201716%20ME_1.pdf



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Request for Medicaid ID Number - Infant

I. Provider Information

Provider Name / Hospital Name | Date

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

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

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

II. Mother's Information

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

Street Address | City | County | State | ZIP code

Social Security Number | Medicaid ID#

III. Child's Information

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

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

Name of Birth Facility | County of Birth Facility

Gender: ☐ Male ☐ Female

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

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

IV. Mail the Completed Form

Mail the completed form to:

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

Fax:

(888) 820-1204

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

Medicare Prescription Payment Program (M3P)

Effective January 1, 2025

Medicare Prescription Payment Program

A New Program That Makes Rx Drugs More Affordable by Allowing Medicare Members to Spread Their Prescription Costs Over Time

Passed into law August 2022 by President Biden, H.R. 5376 — Inflation Reduction Act (IRA) includes policies on Medicare drug pricing. The IRA significantly reforms the Medicare Part D benefit design, including a new program, Medicare Prescription Payment Plan (M3P), which will be available to all eligible Medicare members[1], beginning **Jan. 1, 2025**.

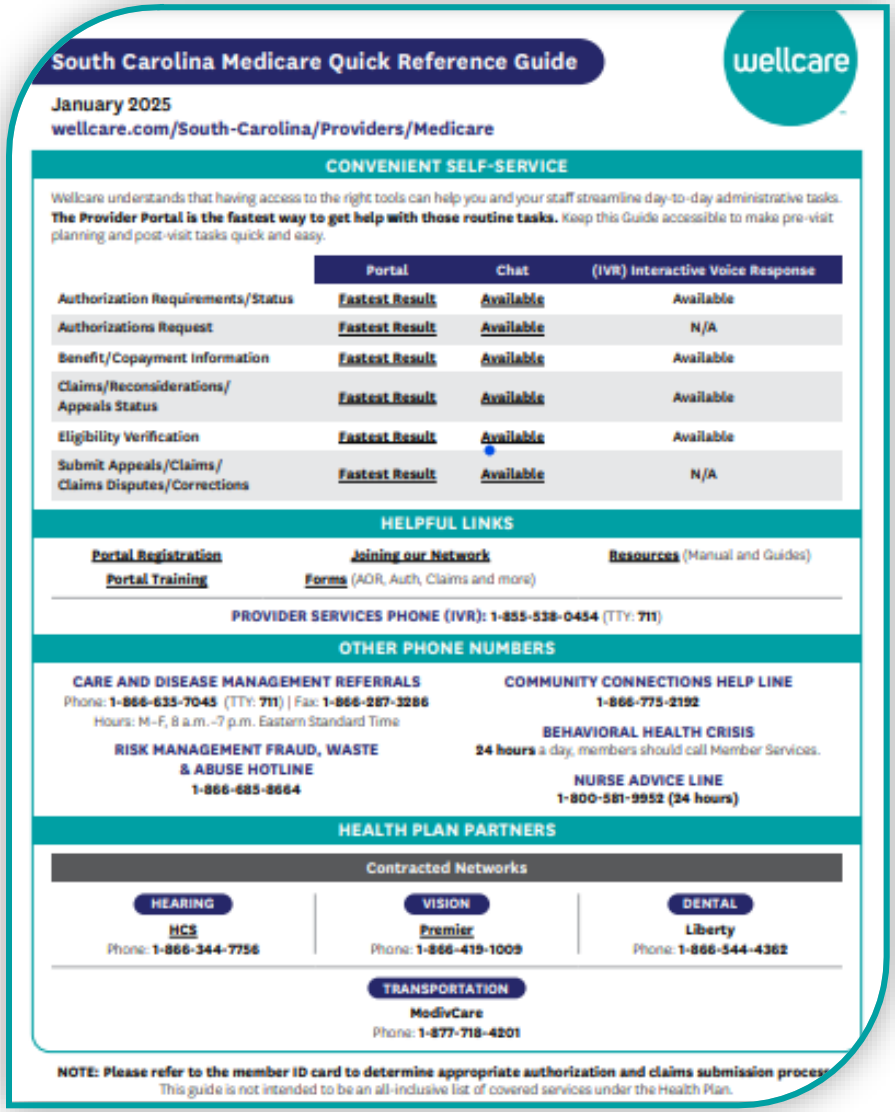
Program Overview for Eligible Participating Medicare Members[1]

- Financial benefits to all Medicare members[1] in 2025 include an elimination of the coverage gap and capping the **maximum out-of-pocket (OOP) prescription costs at $2,000 annually** — which beneficiaries can spread across the plan year.
- M3P participants will pay **$0 at the pharmacy** for covered Part D drugs and be billed monthly for any cost-sharing they incur while in the program. Importantly, this will help them manage prescription costs by enabling them to spread their monthly payments over time.
- Payment *might change* every month as additional prescriptions are filled.
- The program is **voluntary**, and **eligible** members can choose to opt-in to the program during the **annual enrollment period** and **throughout the plan year**. Members can conveniently opt-in via online, by phone, or mail.
  - Online: express-scripts.com/mppp.
  - Phone: **1-833-750-9969**
  - Mail: Express Scripts Medicare
    Prescription Payment Plan
    P.O. Box 2
    St. Louis, MO 63166
- **Existing members** will receive additional information in their **Annual Notice of Change.**
- New members will receive additional information within 10 days of confirmed enrollment.

[1]Excludes plans that solely charge $0 cost sharing for Part D covered drugs. See your plan's Evidence of Coverage for more details.

Questions or Concerns?
As always, we encourage you to use the resources on Medicare.gov/prescription-payment-plan *or* to contact your **Provider Services team.**

Medicare Quick Reference Guide



South Carolina Medicare Quick Reference Guide

January 2025
wellcare.com/South-Carolina/Providers/Medicare

CONVENIENT SELF-SERVICE

Wellcare understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks. **The Provider Portal is the fastest way to get help with those routine tasks.** Keep this Guide accessible to make pre-visit planning and post-visit tasks quick and easy.

	Portal	Chat	(IVR) Interactive Voice Response
Authorization Requirements/Status	Fastest Result	Available	Available
Authorizations Request	Fastest Result	Available	N/A
Benefit/Copayment Information	Fastest Result	Available	Available
Claims/Reconsiderations/ Appeals Status	Fastest Result	Available	Available
Eligibility Verification	Fastest Result	Available	Available
Submit Appeals/Claims/ Claims Disputes/Corrections	Fastest Result	Available	N/A

HELPFUL LINKS

Portal Registration | Portal Training | Joining our Network | Forms (AOR, Auth, Claims and more) | Resources (Manual and Guides)

PROVIDER SERVICES PHONE (IVR): 1-855-538-0454 (TTY: 711)

OTHER PHONE NUMBERS

CARE AND DISEASE MANAGEMENT REFERRALS
Phone: 1-866-635-7045 (TTY: 711) | Fax: 1-866-287-3286
Hours: M–F, 8 a.m.–7 p.m. Eastern Standard Time

RISK MANAGEMENT FRAUD, WASTE & ABUSE HOTLINE
1-866-685-8664

COMMUNITY CONNECTIONS HELP LINE
1-866-775-2192

BEHAVIORAL HEALTH CRISIS
24 hours a day, members should call Member Services.

NURSE ADVICE LINE
1-800-581-9952 (24 hours)

HEALTH PLAN PARTNERS

Contracted Networks

HEARING
HCS
Phone: 1-866-344-7756

VISION
Premier
Phone: 1-866-419-1009

DENTAL
Liberty
Phone: 1-866-544-4362

TRANSPORTATION
ModivCare
Phone: 1-877-718-4201

NOTE: Please refer to the member ID card to determine appropriate authorization and claims submission proces
This guide is not intended to be an all-inclusive list of covered services under the Health Plan.

CLAIM SUBMISSION INFORMATION

SUBMISSION INQUIRIES
EDI team: EDIBA@centene.com or call Provider Services.

PREFERRED EDI CLEARINGHOUSE
Availity: 1-800-282-4548.
Web portal for direct data entry (DDE) claims:
availity.com/Essentials-Portal-Registration.

PAYER IDs: 14163 (CH – Chargeable)
59354 (RF – Reporting only)

Visit our Claims page to locate detailed claims information, addresses, claim forms and guidelines.

Timely Filing guidelines: 180 days from date of service.

EFT
Register: payspanhealth.com or call 1-877-331-7154.
Email: providersupport@payspanhealth.com.

MAIL PAPER CLAIMS TO:
Wellcare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

PHARMACY SERVICES

PHARMACY SERVICES Phone: 1-855-538-0454

Rx BIN	Rx PCN	Rx GRP
610014	MEDIMPACT	2FFA
610014	MAC	2FHU (MA only)

MAIL ORDER
Express Scripts® Phone: 1-833-750-0201 (TTY: 711)
24 hours a day, 7 days a week

SPECIALTY PHARMACY
AcariaHealth™
Phone: 1-866-458-9246 (TTY: 1-855-516-5636)
Monday–Thursday, 8 a.m. to 7 p.m., Friday, 8 a.m. to 6 p.m. ET.
Fax: 1-866-458-9245

AcariaHealth™ Pharmacy #26, Inc.
8715 Henderson Rd.
Tampa, FL 33634

MEDICAL ONCOLOGY SERVICES
New Century Health Phone: 1-888-999-7713

MEDICATION APPEALS Fax: 1-866-388-1766
Submit a Medication Appeal Request form with supporting documentation by fax or mail within 60 days from the date of the denial notice.

Wellcare
Attn: Pharmacy Appeals Department
P.O. Box 31383
Tampa, FL 33631-3383

COVERAGE DETERMINATION REQUESTS
Fax: 1-866-388-1767
Electronic Prior Authorization (ePA):
account.covermymeds.com

Access the Pharmacy page for Pharmacy related information and forms, including:
- Coverage Determination Request Form and exceptions
- Other Request forms such as injectible Infusion
- Formulary
- Express Scripts Mail Order Service
- Home Infusion/Enteral Services
- and more

PRIOR AUTHORIZATION (PA)

A Pre-Auth Needed tool is available to determine if prior authorization is required. Detailed Prior Authorization list and important PA information can be found in the Prior Authorization Guide. Most current information can be found within the Pre-Auth tool.
For fastest results, submit requests online using the associated PA forms.

Medical Fax: 1-833-562-7172
Behavioral Health Fax: Outpatient **1-855-710-0160** | Inpatient **1-855-710-0159**
Pharmacy Medical Requests Fax: 1-888-871-0564

***Urgent* Authorization Requests and Admission Notifications: Call 1-855-538-0454 and follow the prompts.**
Notification is required for Inpatient Hospital admissions **by the next business day** (except normal maternity delivery admissions). Phone authorizations must be followed by a fax submission of clinical information.

Wellcare does not accept handwritten, faxed or replicated claim forms. Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

Network Development and Participation

absolute total care

Network Development and Participation

Network Participation

- The enrollment, credentialing and recredentialing processes exist to ensure that participating providers meet and remain compliant to the criteria established by Absolute Total Care.
- These processes also ensure that providers remain compliant with government regulations and standards of accrediting bodies

Network Development

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

Network Development and Participation

To initiate the credentialing process for a new practitioner at ATC, providers are required to submit a Provider Data (Add) Form along with a Current W-9 to SouthCarolinaPDM@centene.com.

- The process takes about 60 days to complete. For follow-ups before receiving the Welcome Letter, email SouthCarolinaPDM@centene.com.
- Recredentialing occurs every 36 months.
- To update existing participating providers and locations, email the Provider Data Form (Update) to SouthCarolinaPDM@centene.com. (Examples: terminations, new hires, location closures, etc.)

To enroll a new practitioner with Wellcare, providers need to submit a completed Provider Profile Sheet along with a Current W-9 to atcnetworkrelations@centene.com.

- The process takes roughly 60 days to complete.
- Recredentialing occurs every 36 months.
- Providers can update existing participating providers and locations by emailing their assigned representatives or at atcnetworkrelations@centene.com.

Claims 411 – Did You Know?

absolute total care

Claims Adjustments, Reconsiderations and Disputes

- Submitted when a provider disagrees with how a clean or adjusted claim was processed.

Reconsideration

- Requests to change the initial claim.

Claim adjustments

- Submitted when a provider has received an unsatisfactory response to a previous reconsideration request.

Disputes

Claims Adjustments, Reconsiderations and Disputes

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

MARKETPLACE		
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission **(NEW)**	**180 days**	**180 days**
Claim Adjustment	**60**	**60**
Claim Reconsideration	**60**	**60**
Claim Dispute	**60**	**60**
Decision Timeframes	Par	Non-Par
Appeal Decision	**30**	**30**
Dispute Decision	**30**	**30**
Mailing Address		
P.O. Box 5010 Farmington, MO 63640-5010		

Effective 7/1/24

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

* From date of service

** Waiver of Liability required

*** From date of last processed claim

Claims Submission

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

- Claims submitted at the local office will not be accepted.
- Follow the applicable procedure based on your line of business.

Wellcare Provider Timeframes, Claim Adjustments and Disputes

Type	Par	Non-Par
Initial Claim/Resubmission	180*	180*
Claim Payment Dispute	90*	90*
Claim Payment Policy Dispute	30***	30***
Appeal (Medical)	90	60**

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

Claims Submission - Wellcare

CLAIM SUBMISSION INFORMATION

SUBMISSION INQUIRIES
EDI team: **EDIBA@centene.com** or call Provider Services.

PREFERRED EDI CLEARINGHOUSE
Availity: **1-800-282-4548**.
Web portal for direct data entry (DDE) claims:
availity.com/Essentials-Portal-Registration.

PAYER IDs: 14163 (CH – Chargeable)
59354 (RF – Reporting only)

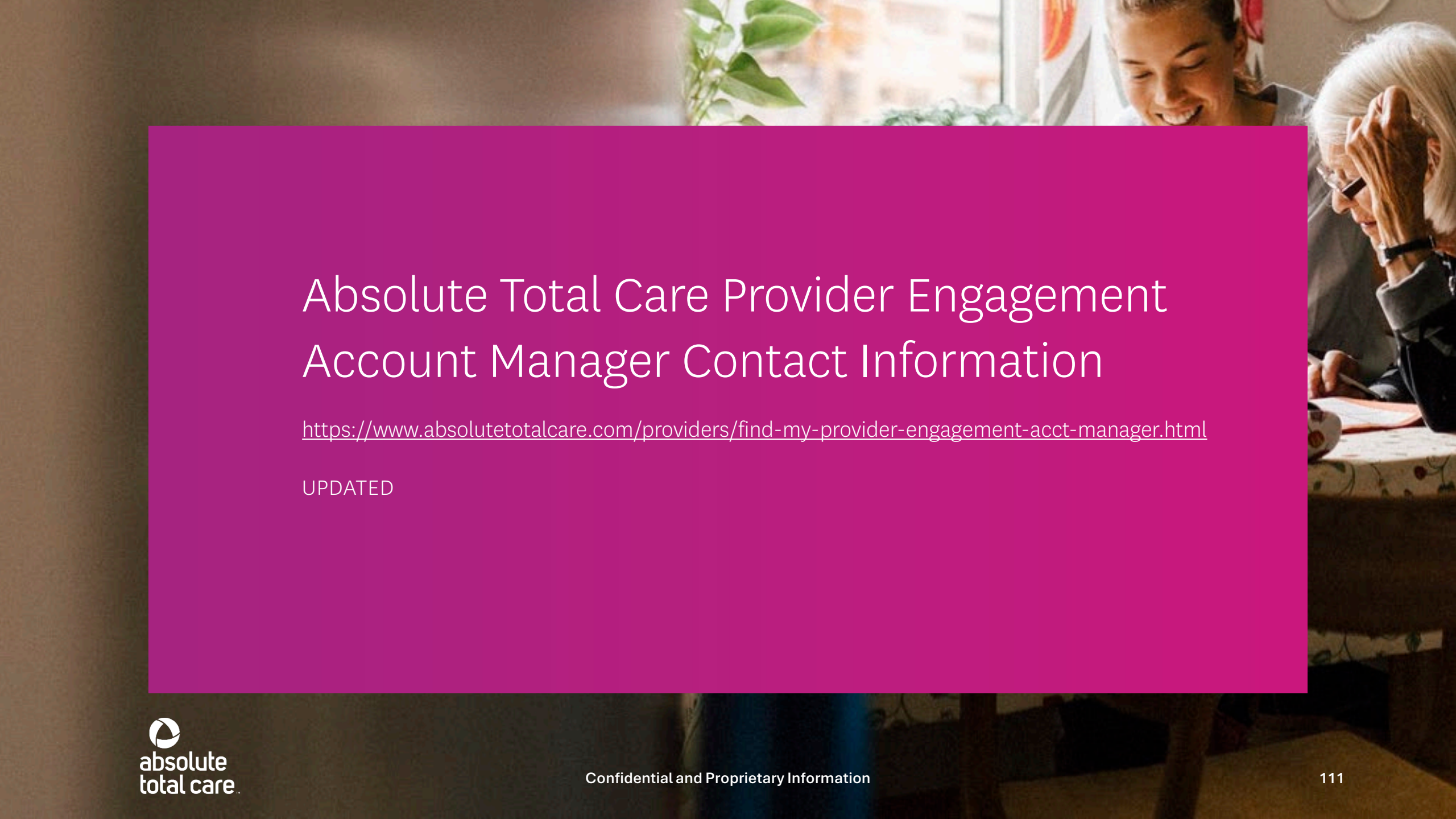
Visit our **Claims** page to locate detailed claims information, addresses, claim forms and guidelines.

Timely Filing guidelines: 180 days from date of service.

EFT
Register: **payspanhealth.com** or call **1-877-331-7154**.
Email: **providersupport@payspanhealth.com**.

MAIL PAPER CLAIMS TO:
Wellcare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

- Claims submitted at the local office will not be accepted.
- Follow the appropriate procedure for your line of business to submit your claim.



Absolute Total Care Provider Engagement Account Manager Contact Information

https://www.absolutetotalcare.com/providers/find-my-provider-engagement-acct-manager.html

UPDATED

ATC Provider Engagement Territory Assignment

Effective 2/1/2025

absolute total care

Provider Engagement Account Managers

Adria Felder
(803) 315-8405
Adria.Felder@Centene.com

Providers & Groups

- Ambulatory/EMS providers
- Health Network Solutions [HNS] Chiropractor Network
- Long Term Acute Care (LTAC) Rehabilitation Facilities
- Skilled Nursing Facilities
- Condor Health
- Encompass Health Rehab
- PACs
- PruittHealth- SNFs
- Regency Hospital
- **Speech Therapy, Physical Therapy, & Occupational Therapy**

Anna Truesdale
(803) 427-3260
Anna.Truesdale@Centene.com

Federally Qualified Health Centers

- Affinity Health Centers
- Beaufort Jasper Hampton Comprehensive Health Centers
- CARE - Net of Lancaster
- Care Team Plus, CareSouth Carolina
- Carolina Health Centers
- Christ Community Health Centers
- Community Medicine Foundation dba North Central
- Family Health Center
- Eau Claire Cooperative
- Family Health Centers
- Fetter Healthcare Network
- Foothills Community Health Care
- Genesis Health Centers
- Greenwood Family Practice Healthcare Partners of SC
- Hope Health, Inc
- Little River Medical Centers
- Low Country Health Care Systems
- Neighborhood Improvement Project
- New Horizon Family Health Services
- ReGenesis Health Centers
- Rosa Clark Medical Center
- Rural Health Services dba Margaret J. Weston Community HC
- Sandhills Medical Foundation
- St. James-Santee Family Health Services
- Tandem Health

S. Brandi Crosby
(843) 518-3918
shunta.crosby@Centene.com

Counties & Provider Groups

- Beaufort
- Berkeley
- Charleston
- Colleton
- Dorchester
- Hampton
- Jasper
- Border GA-Savannah
- Beaufort Memorial Hospital
- Hampton Regional Medical Center
- Liberty Doctors
- Medical University of SC*

Kisha Thomas
(803) 904-6430
Kisthomas@Centene.com

Providers & Groups

- Dialysis Centers
- Independent Ambulatory Surgery Centers (ASCs)
- DaVita Kidney Care
- Dialysis Clinic, Inc (DCI)
- Fresenius Medical Care Greenville
- Dialysis Clinic, LLC Spartanburg Ambulatory Surgery Center
- US Renal Care

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

Counties & Provider Groups

- Cherokee
- Greenville
- Lancaster
- Laurens
- Spartanburg
- Union
- York
- Border-North Carolina
- Carolina Neurology & Spine
- Doctor's Care
- OrthoCarolina

Margaretta Jones
803-465-5106
Margaretta.Jones@Centene.com

Providers & Groups

- Durable Medical Equipment & Home Health (statewide)
- Amedysis
- Intrepid Home Health
- Medical Services of America
- Palmetto Infusion
- PruittHealth- Home Health
- Interim Healthcare
- **Non-facility Lab (Example: LabCorp, Quest, etc)**
- **York Pathology**

Neshelle Miller
(803) 972-1460
Neshelle.Miller@Centene.com

Counties & Provider Groups

- Aiken
- Allendale
- Bamberg
- Barnwell
- Calhoun
- Edgefield
- Lexington
- Newberry
- Saluda
- Orangeburg
- Border Georgia counties (Augusta)
- Newberry Internal
- Tapestry Telehealth

Porsha Lewis
(803) 873-8691
Porsha.Lewis@Centene.com

Counties & Provider Groups

- Chester
- Fairfield
- Kershaw
- Lee
- Richland
- Sumter
- Carolina Pediatrics Columbia
- Nephrology
- Oak Street Physicians
- SC House Calls
- Southern Medical Mgmt
- Sumter Pediatrics
- Tenet Health***

Sarah Wilkinson
(843) 344-0009
Sarah.Wilkinson@Centene.com

Counties & Provider Groups

- Chesterfield
- Clarendon
- Darlington
- Dillon
- Florence
- Georgetown
- Horry
- Marion
- Marlboro
- Williamsburg
- Carolina Pines Medical Center
- Conway Medical Center
- Tidelands

ATC Provider Engagement Territory Assignment

Effective 2/1/2025

absolute total care

Senior Provider Engagement Account Managers

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

Behavioral Health

Including school districts, Department of Alcohol and Other Drug Abuse Services (DAODAS), SC Department of Mental Health (SCDMH), etc.

Janet Kimbrough
(803) 873-4454
Janet.H.Kimbrough@Centene.com

Provider Groups

Bon Secours St Francis
CenterWell Senior Primary Care (formerly Partners in Primary Care)
Preferred Care of Aiken
Spartanburg Regional Health/Regional HealthPlus

Regina Meade
(803) 351-9065
Regina.Meade@Centene.com

Counties & Provider Groups

Abbeville
Anderson
Greenwood
McCormick
Oconee
Pickens

Aiken Regional Medical Ctr
Augusta University (AU)
Piedmont Augusta (formerly University Hospital)
Foundation Medicine
Allergy Partners
Pearl Health
OASIS Health
Pinner Clinic

Tracey Snowden
(803) 606-5328
Tracey.D.Snowden@Centene.com

Provider Groups

Abbeville Medical Center
AnMed Health
Atrium Health
Newberry Hospital
Self Regional
SC Oncology Associates (SCOA)

Tonya Carpenter
(864) 492-5669
Tonya.S.Carpenter@Centene.com

Provider Groups

**HCA Healthcare
Lexington Medical Center
McLeod Health
Palmetto Primary Care Physician
Prisma Health
Roper St. Francis Healthcare
SC Pediatric Alliance

Management

Jennifer Helms
Vice President, Operations
Jennifer.B.Helms@Centene.com

SaBrina Macon
Director, Provider Relations
SaBrina.C.Macon@Centene.com

Kristen Graham
Manager, Provider Relations
Kristen.Graham@Centene.com

Please note list above highlights VIP groups; list not all inclusive.
Send inquiries to: ***ATCNetworkRelations@centene.com***

**Medical University of South Carolina, Providence Hospital, Kershaw Medical Center, The Regional Medical Center*
***HCA Healthcare: Colleton Medical Center, Summerville Medical Center, Trident Medical Center, Grand Strand Health*
****Tenet: (East Cooper Medical Center, Piedmont Medical Center, Hilton Head Hospital, Coastal Carolina Hospital*