
absolute total care™
wellcare™

Meeting Overview

Health Plan Updates

01— Medicare-Medicaid Plan (MMP) to Dual Special Needs Plan DSNP

02— Payment Integrity Solutions

03— Prior Authorizations Updates
- Medicaid
- Marketplace

04— Health Insurance Mobile App

05— Behavioral Health Claim Processing Update

06— Eligibility
- Absolute Total Care Provider Portal
- Wellcare Medicare Advantage Provider Portal
- Availity Essentials: New Multi-Payer Portal

07— Annual Provider Training Requirements

08— Medical Clinical Policies

09— Payment Policies

10— Claims 411

11— PaySpan

12— Risk Adjustment
- Clinical Documentation Improvement (CDI)

13— Quality Improvement
- Partnership for Quality
- CPT II and HCPCS

14— CAHPS

15— Accessibility and Availability Standards

16— Case Management

17— Provider Resources

18— Appendix
- 2026 Medicaid Member ID Card
- 2026 D-SNP Member ID Card
- 2026 Medicare HMO Member ID Card
- 2026 Medicare PPO Member ID Card
- 2026 Medicare PDP Classic and Value Script Member ID Card

Poll Question

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

absolute total care™

Health Plan Updates

absolute total care™

Medicare-Medicaid Plan (MMP) to Dual Special Needs Plan (DSNP)

absolute total care™

Medicare-Medicaid Plan (MMP) to an aligned Dual Special Needs Plan (DSNP)

Effective, January 1, 2026, we will launch an aligned Dual Special Needs Plan (D-SNP) in South Carolina. As directed by CMS, our current Medicare-Medicaid Plan (MMP), Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan) will sunset on December 31, 2025, and members will be automatically transitioned into the new aligned D-SNP, Wellcare Absolute Total Care Dual Align (HMO D-SNP).

Like the MMP, this new plan is designed for individuals who qualify for both Medicare and Medicaid, allowing their benefits to be coordinated and managed by a single healthcare organization.

Key Information Providers Should Know

To help you prepare for this transition, we invite you to explore the tools and resources available at go.wellcare.com/ATC. From there, you can click on "For Providers" to access:

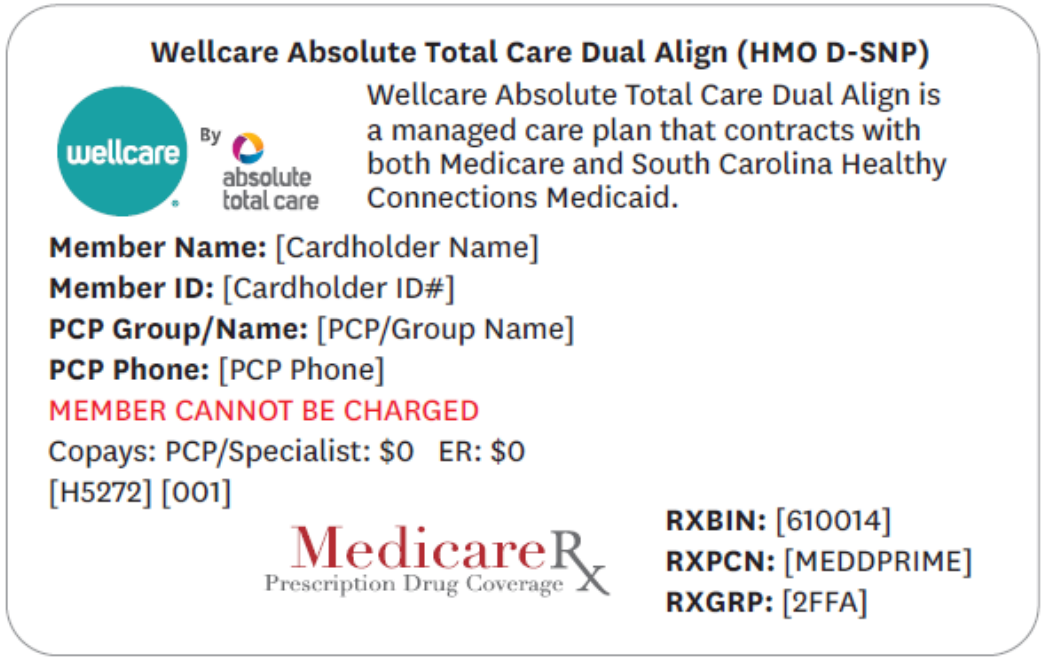
- A link to register for the secure provider portal at go.wellcare.com/ATC
- The Provider Manual and Quick Reference Guide(s)
- Frequently Asked Questions (FAQ) for this transition

If you have additional questions about this change, your Provider Engagement Account Manager is here to help. You can also reach out to Provider Services at: 1-833-998-5401.

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

2026 Medicare Dual Align HMO D-SNP ID Card

Plan Name: Wellcare Absolute Total Care Dual Align (HMO D-SNP)
Contract (PBP) Number: H5272-001
Brand Name: Wellcare By Absolute Total Care



Wellcare Absolute Total Care Dual Align (HMO D-SNP)

Wellcare Absolute Total Care Dual Align is a managed care plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid.

Member Name: [Cardholder Name]
Member ID: [Cardholder ID#]
PCP Group/Name: [PCP/Group Name]
PCP Phone: [PCP Phone]
MEMBER CANNOT BE CHARGED
Copays: PCP/Specialist: $0 ER: $0
[H5272] [001]

MedicareRx Prescription Drug Coverage

RXBIN: [610014]
RXPCN: [MEDDPRIME]
RXGRP: [2FFA]

Member Services / Nurse Advice Line	[1-833-998-5063] (TTY: 711)
Behavioral Health	[1-833-998-5063] (TTY: 711)
Vision: [Centene Vision Services]	[1-855-659-6665] (TTY: 711)
Dental: [Liberty Dental]	[1-866-544-4362] (TTY: 711)
Transportation: [ModivCare]	[1-877-682-9029] (TTY: 711)
Provider Services / Pharmacy Prior Auth	[1-833-998-5401] (TTY: 711)
Pharmacist Only	[1-833-750-4244] (TTY: 711)

Send Claims To: [Wellcare By Absolute Total Care Attn: Claims P.O. Box 9700 Farmington, MO 63640-0700] Payor ID: [68069]
Part D Claims: [Wellcare By Absolute Total Care Attn: Medicare Part D Member Reimbursement P.O. Box 31577 Tampa, FL 33631-3577]
FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room
Website: [go.wellcare.com/ATC]

Payment Integrity Solutions

absolute total care™

Updates regarding Payment Integrity Solutions

Effective 2/1/2026

For claims received on or after *2/1/2026, providers may receive written requests for medical record submission prior to payment based on the areas outlined below. These requests will come from Optum and will contain instructions for providing the documentation. Should the requested documents not be returned, the claim(s) will be denied. Providers will have the ability to dispute findings through Optum directly in the event of a disagreement.

Editing Area	Description
Trauma Activation with No Ambulance Service	This analytic will identify outpatient claims with revenue codes for trauma response (Rev 681 – 689) when there are no claims in history for ambulance services with HCPCS codes between A0021 and A0999 for the same member on the same date of service.
High Dollar Hardware	This analytic identifies outpatient claims billing high dollar pass-through payment for hardware with code C1713 (anchors/screws).
Unsupported Lab Tests on High Dollar Claims	This analytic reviews high dollar lab claims with at least 5 lines and a payment greater than $500 that are potentially unsupported by an order from a qualified healthcare professional.
Cross-coder Outpatient Facility Surgical Claims	This analytic identifies outpatient facility claims with surgical procedure codes that do not match the professional claim codes for similar services provided to the same patient on the same date of service. Records will be reviewed to ensure coding/documentation guidelines are met.
Digital Spike Analysis	This analytic will target when a Digital Spike Analysis of EEG (95957) is billed in addition to the primary EEG procedure to verify the required additional time and extra work was done to support the billing of this code.
Upcoding of Incision and Drainage Codes	This analytic identifies claims billing incision and drainage (I&D) procedure codes that are suspected to be non-incision or lower-level incision and drainage which may have been incorrectly submitted to achieve additional reimbursement, reviewing simple I&D procedure codes 10060, 10080, 10140 and complicated/multiple I&D procedure codes 10061, 10081
Misbilling of Third Order Selective Catheter Placement	This algorithm targets codes for arterial selective catheter placement of the third order for placement above the diaphragm (36217) and below the diaphragm (36247) when claim details suggest that a first or second order arterial branch above the diaphragm or below the diaphragm was more likely the location of the procedure. Records will be reviewed to determine if the coding guidelines required to bill arterial selective catheter placement of the third order are met.
Cross-coder Professional vs. Outpatient Facility Surgery Claims	This analytic identifies professional claims with surgical procedure codes that do not match the outpatient facility claim codes for similar services provided to the same patient on the same date of service. Records will be reviewed to ensure coding/documentation guidelines are met

Associated Code for EOP	Description
Absolute Total Care Medicaid: EXbo	MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED
Ambetter from Absolute Total Care: EXbo	MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED
Wellcare By Absolute Total Care: EXbo	MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED
Wellcare of South Carolina Medicare: CPIMR	MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED

*Impacts Medicare, Medicaid and Marketplace

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

Prior Authorizations Updates

absolute total care™

Medicaid Prior Authorizations Updates

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

absolute total care | Healthy Connections

Important Prior Authorization Updates

Effective Feb. 1, 2026

As part of our ongoing work to improve the prior authorization (PA) process for both providers and members, Absolute Total Care wants to share some important updates to our PA requirements. Our goal is to reduce administrative burden, simplify submission and approval processes, and facilitate timely access to appropriate, high-quality care.

Code change details can be found below. These changes may include:

- Removing PA requirements based on criticality of review and clinical need.
- Creating a more uniform set of prior authorization requirements across our markets and lines of businesses, including adding and changing some PA requirements, to simplify processes, reduce confusion for providers, and support future efforts to expand real-time responses to requests.

If you have questions about specific prior authorization codes or how these changes affect your practice, your Provider Engagement Account Manager is here to help. You can also reach out to Provider Services at 1-866-433-6041.

Service Category	PA Rule	Services	Procedure codes
Behavioral Health	PA Required	Substance Abuse Treatment	H0004, H2022, H2027
		Therapy	H2019
		Treatment Services	90867, 90868, H0036
	No PA Required	Treatment Services	97157
Cardiovascular	PA Required	Heart Surgery	93656
DME Services	PA Required	Nutritional Services	B4158, B4159, B4160, B4161
		Wheelchairs	E1004
Drug Codes	PA Required	Injections	J3241
	No PA Required	Medications	J2469
Home Services	PA Required	Other Services	S5165
	No PA Required	Home Management	S9211
Laboratory	PA Required	Urinalysis	G0481, G0482, G0483
Other Medical Services	PA Required	Other Services	A4554
Physical Medicine	PA Required	Orthotic and Prosthetic	Q4101, Q4121, Q4160, Q4186, Q4195, Q4196
Surgery Procedures	PA Required	Cardiovascular System	33285, 37243, 92928
		Female Genitalia	58662
		Male Genitalia	54360
	No PA Required	Vascular	36471
Transportation Services	PA Required	Medical Transportation	A0428, A0436

Important Prior Authorization Updates

Effective Feb. 1, 2026

As part of our ongoing work to improve the prior authorization (PA) process for both providers and members, Ambetter from Absolute Total Care wants to share some important updates to our PA requirements. Our goal is to reduce administrative burden, simplify submission and approval processes, and facilitate timely access to appropriate, high-quality care.

Code change details can be found below. These changes may include:

- Removing PA requirements based on criticality of review and clinical need.
- Creating a more uniform set of prior authorization requirements across our markets and lines of businesses, including adding and changing some PA requirements, to simplify processes, reduce confusion for providers, and support future efforts to expand real-time responses to requests.

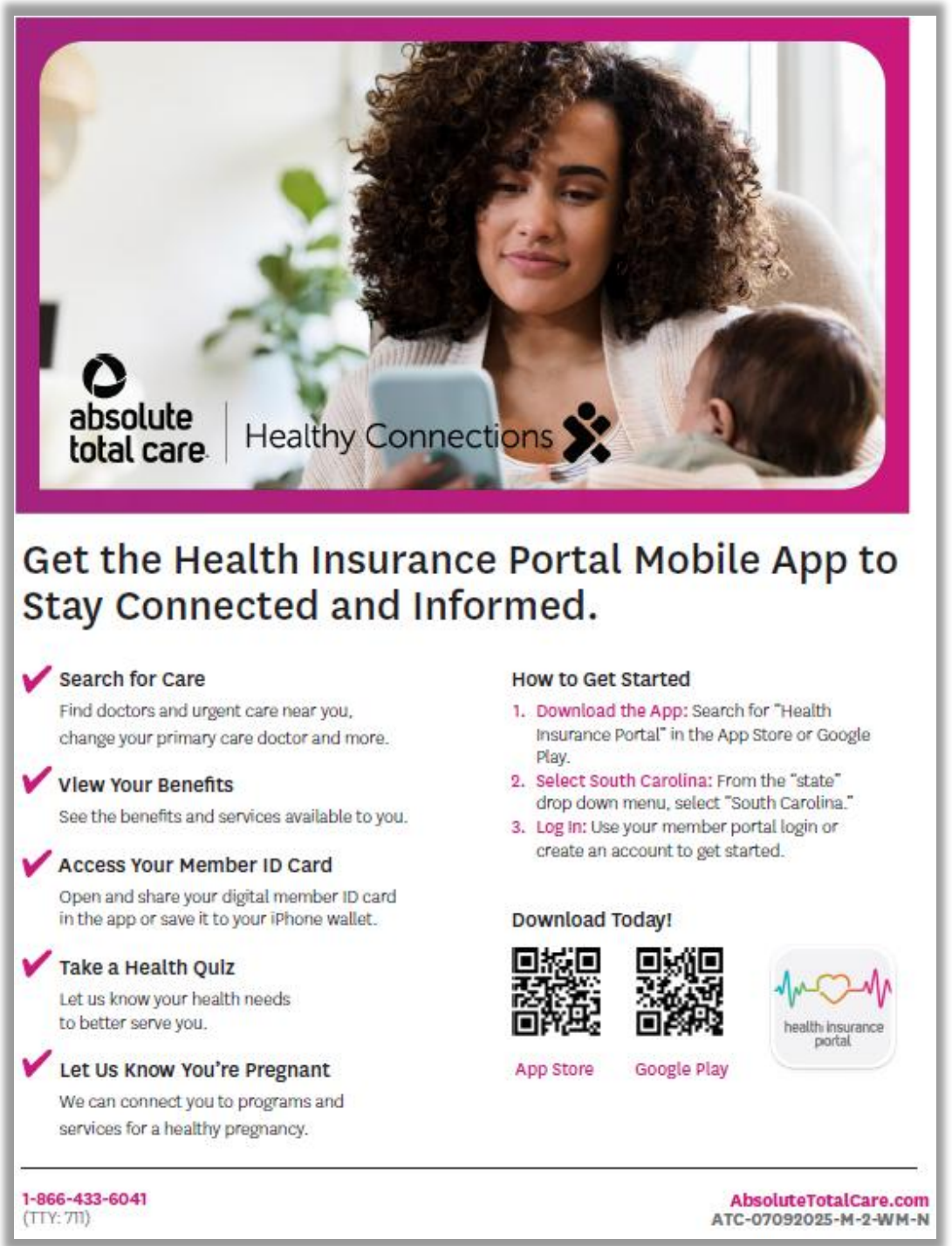
If you have questions about specific prior authorization codes or how these changes affect your practice, your Provider Engagement Account Manager is here to help. You can also reach out to Provider Services at 1-833-270-5443.

Service Category	PA Rule	Services	Procedure codes
DME Services	No PA Required	Wheelchairs	E1140, K0739
Home Services	No PA Required	Social Services	S9127
Surgery Procedures	PA Required	Cardiovascular System	92928
		Digestive System	43281, 43282, 49329
		Male Genitalia	55866
		Musculoskeletal System	28300, 28308
	No PA Required	Vascular	36476, 36483

Health Insurance Portal Mobile App

absolute total care™

Health Insurance Portal Mobile App

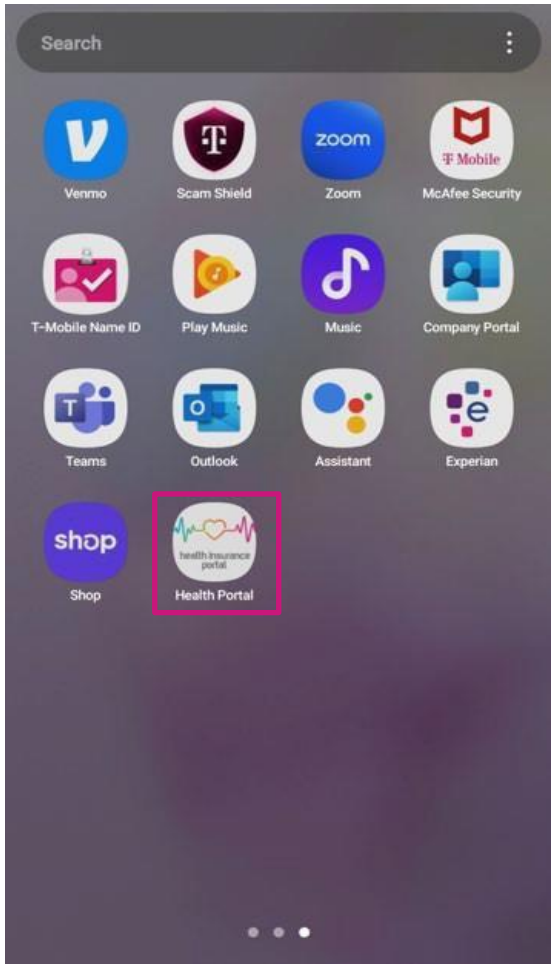


absolute total care | Healthy Connections

Member Mobile App User Guide

Steps to Using the Absolute Total Care Medicaid Health Insurance Portal App

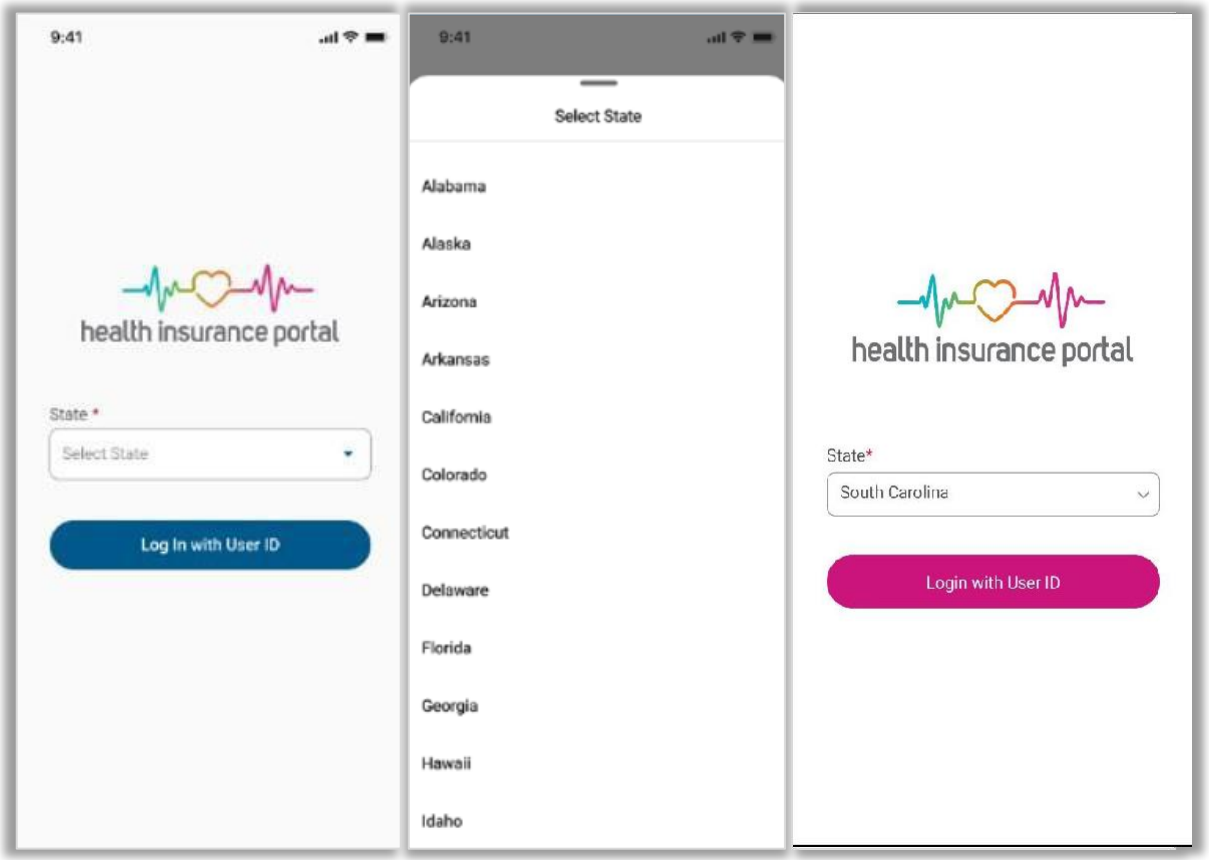
Step 1: OPEN. Open the mobile app by clicking on the "Health Insurance Portal" icon.



absolute total care | Healthy Connections

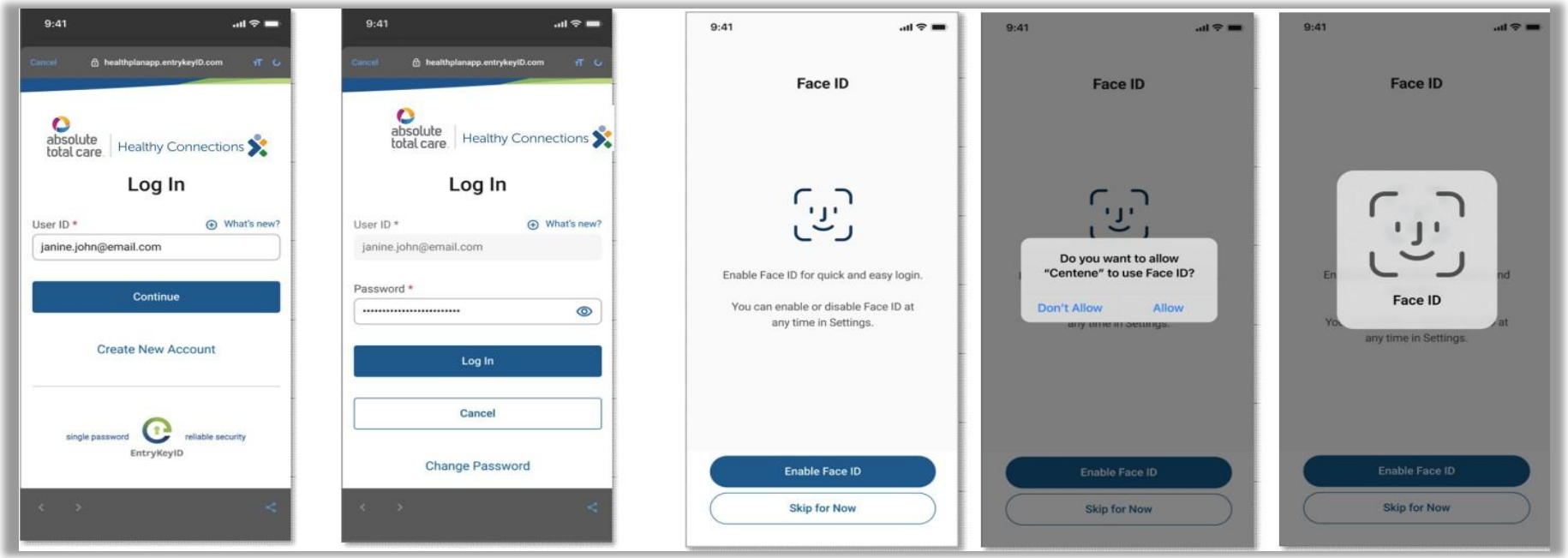
Member Mobile App User Guide

Step 2: LOG IN. Click on the dropdown arrow to search for your "State" (South Carolina). Once you have selected "South Carolina" as your State, click on "Log In with User ID."



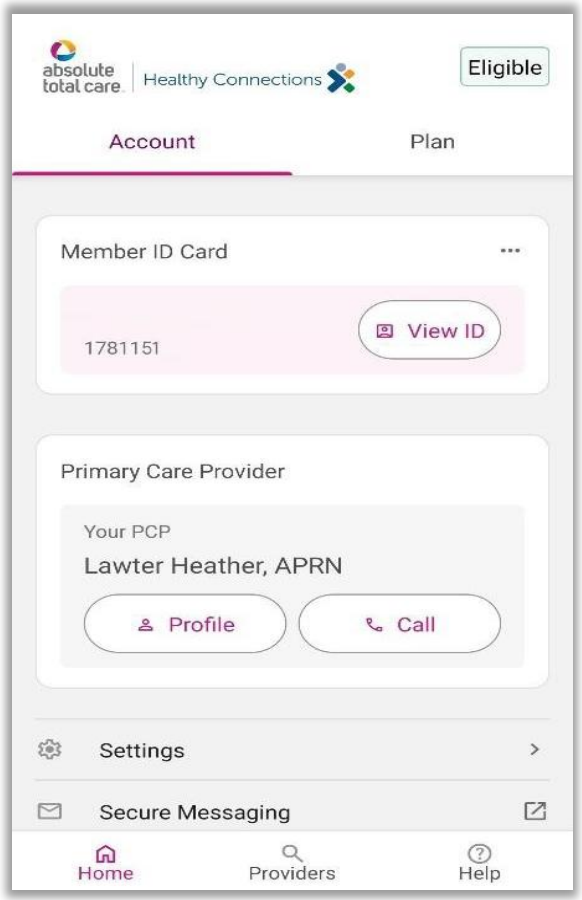
Member Mobile App User Guide

Step 2a: LOG IN. Enter your email address in the "User ID" box and click "Continue." Enter your "Password" and click "Log In." Next, you will have the option to" as a log in option. Here, you can select "Enable Face ID" or "Skip for Now." use "Biometrics



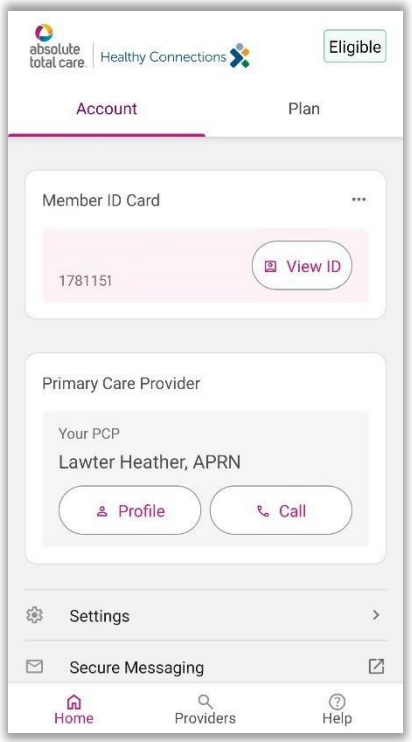
Member Mobile App User Guide

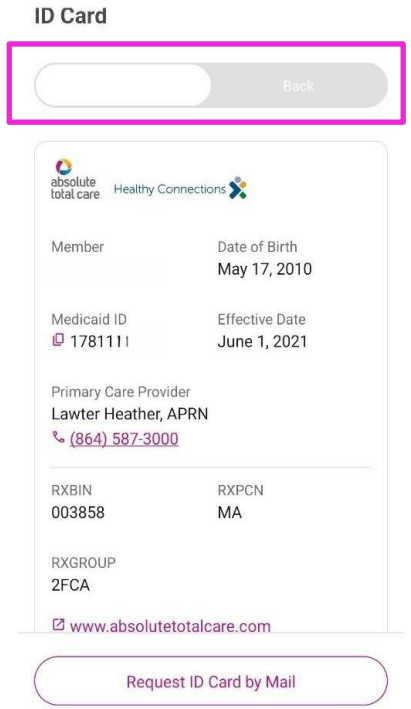
Step 3: HOMEPAGE/ACCOUNT. The homepage screen will appear with the following options: Member ID Card and Primary Care Provider.

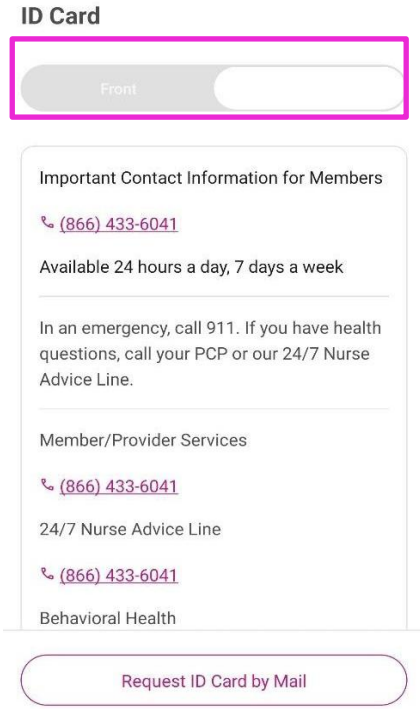


Member Mobile App User Guide

Step 4: MEMBER ID CARD. If you click on the "View ID" button next to your member name, you will be directed to your Absolute Total Care ID card. You will be able to view the "Front" and "Back" of your ID card.

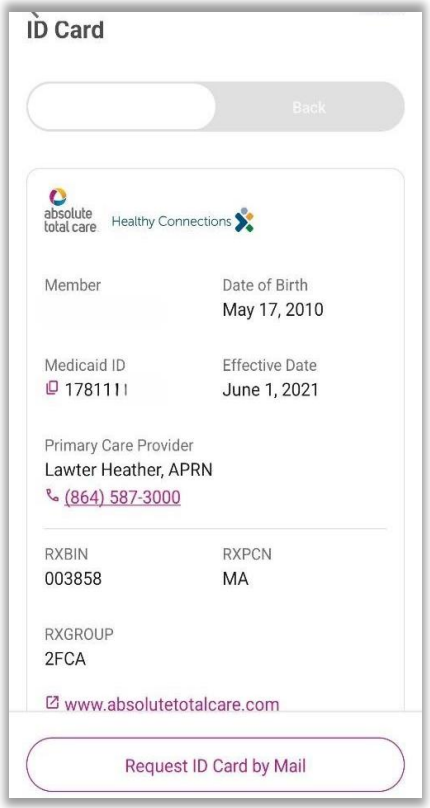




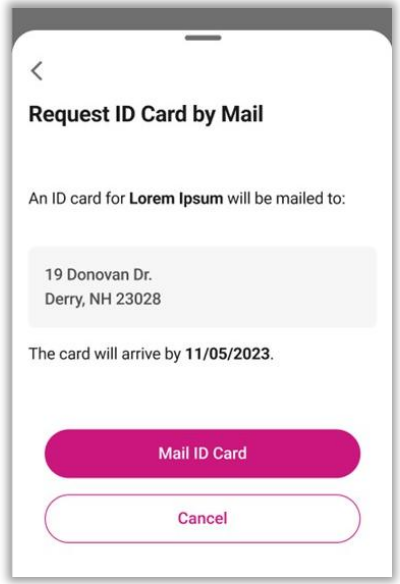


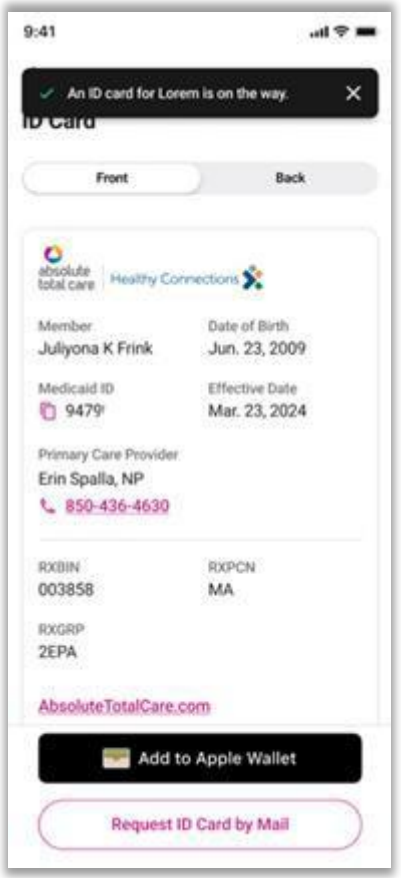
Member Mobile App User Guide

Step 5a: REQUEST YOUR ID CARD. To have your ID card printed and shipped to you, click on "Request ID Card by Mail." After verifying your mailing address, select "Mail ID Card."



Step 5b: ADD YOUR ID CARD TO YOUR DEVICE. To save your ID card to your cellphone device, select "Add to Apple Wallet," select "Mail ID Card."



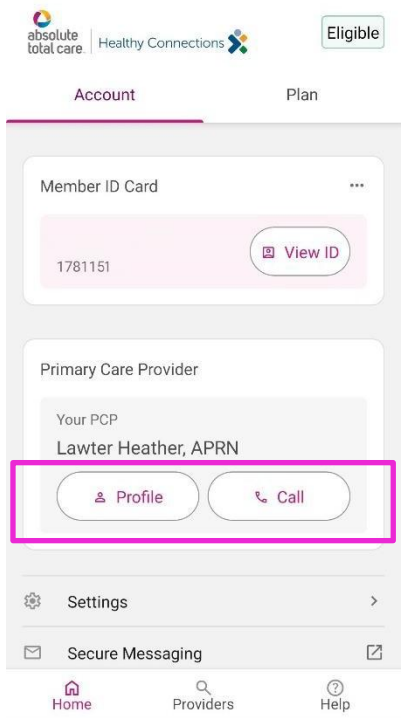


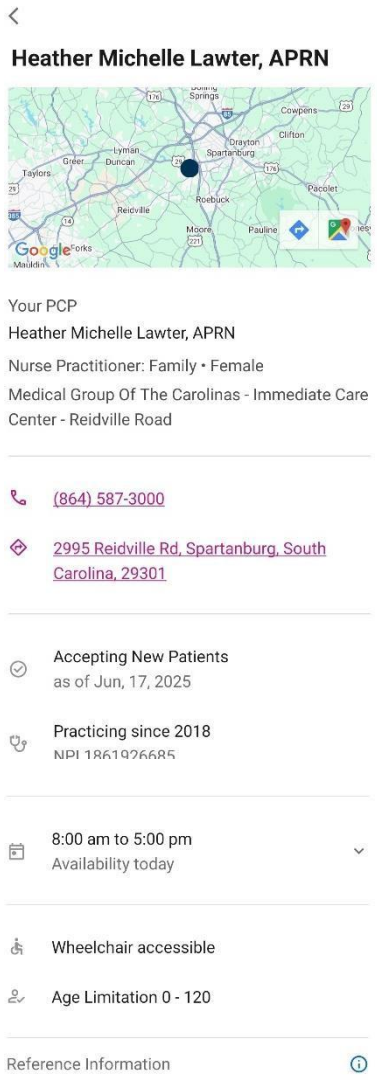
absolute total care | Healthy Connections

Note: The option to save to your cell phone is not available on Android devices.

Member Mobile App User Guide

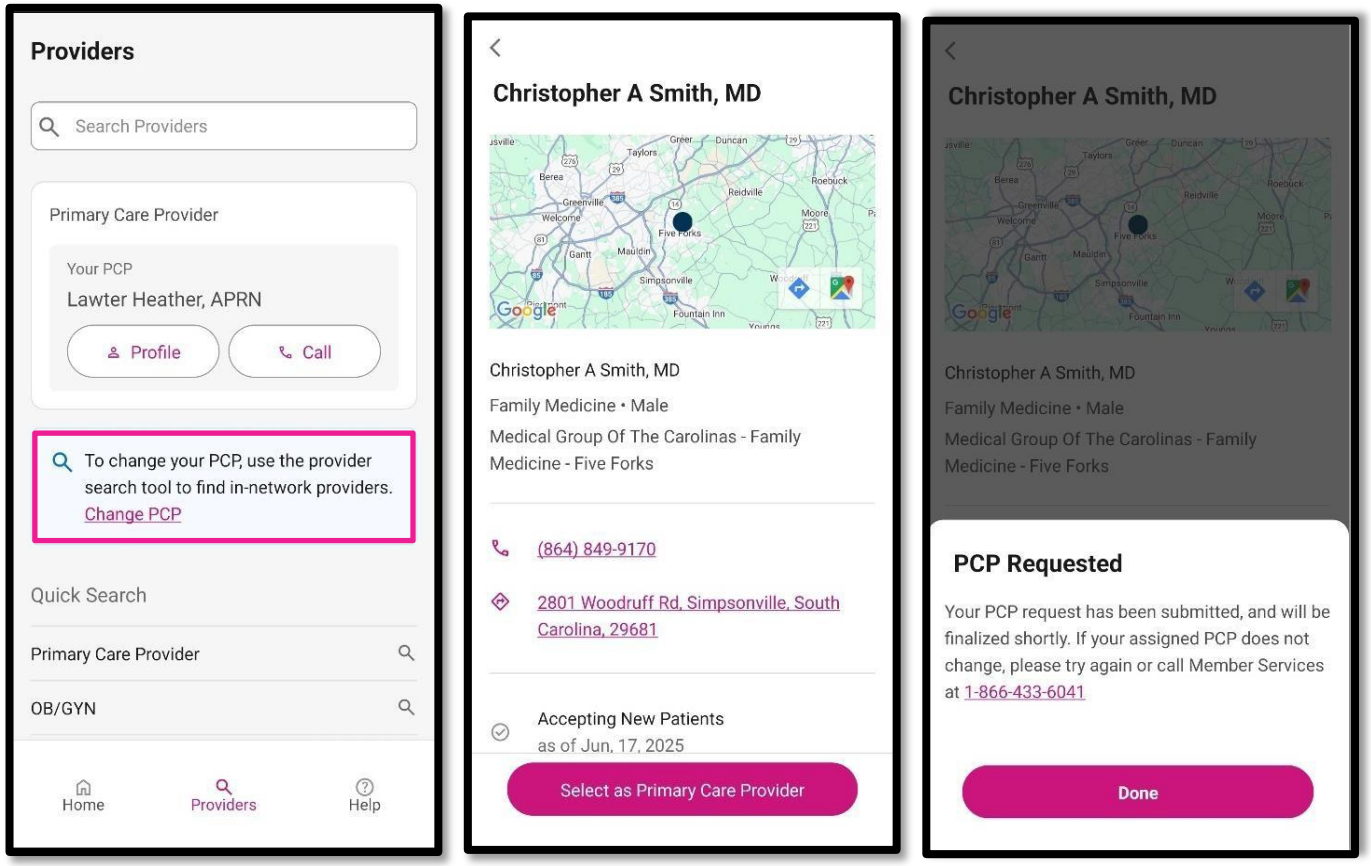
Step 6: PRIMARY CARE PROVIDER. Here, you will be able to view your Primary Care Provider (PCP). You can click on "Profile" to view full details or "Call" to call the provider directly from your device.





Member Mobile App User Guide

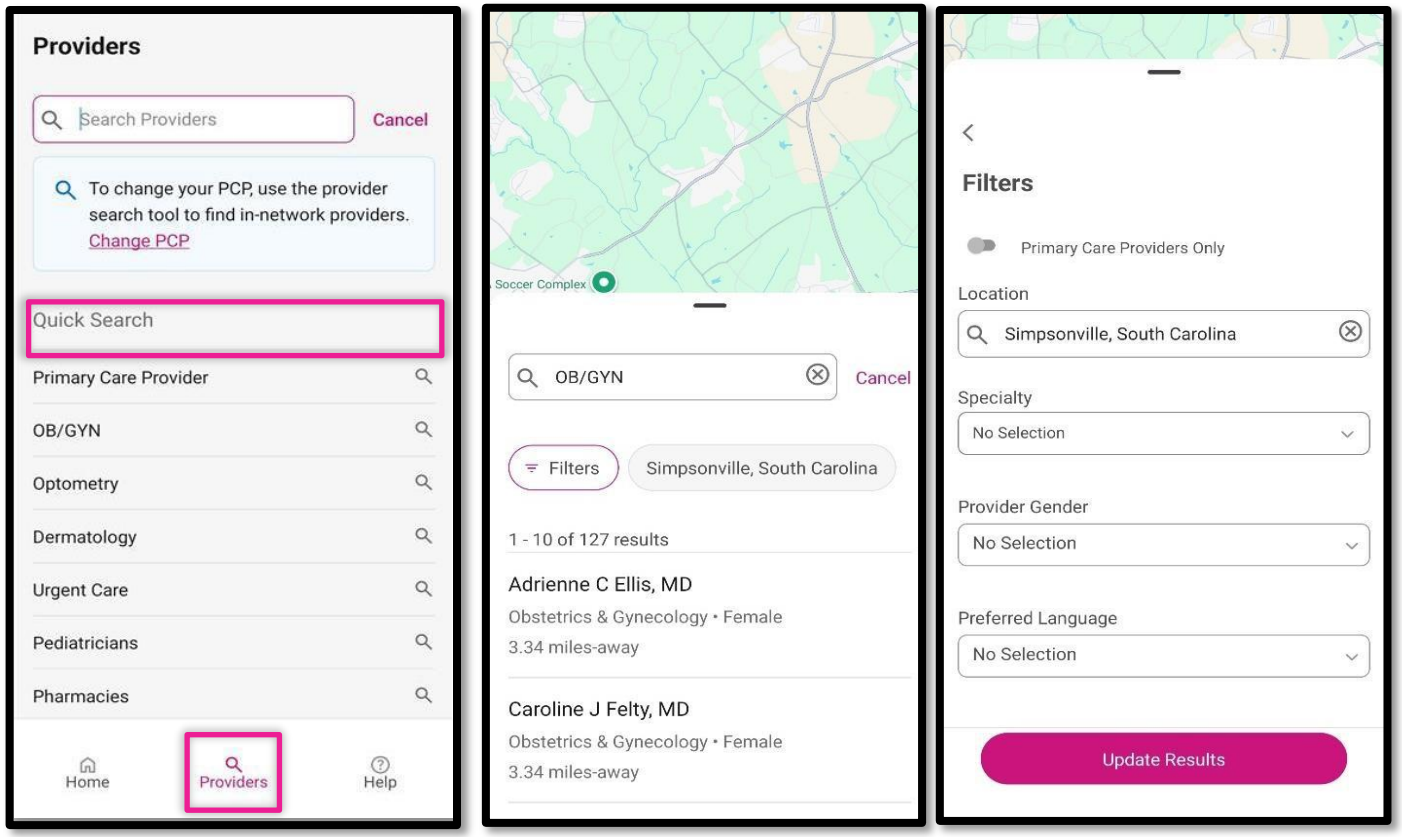
Step 7: CHANGE MY PRIMARY CARE PROVIDER (PCP). Here you will have the option to change the PCP assigned to you by clicking "Change PCP" which will open up the Find a Provider search tool. Once you have found a new provider in the search tool, you can click "Select as Primary Care Provider."



Note: When updating your PCP, you will see a dialog message box about your changes.

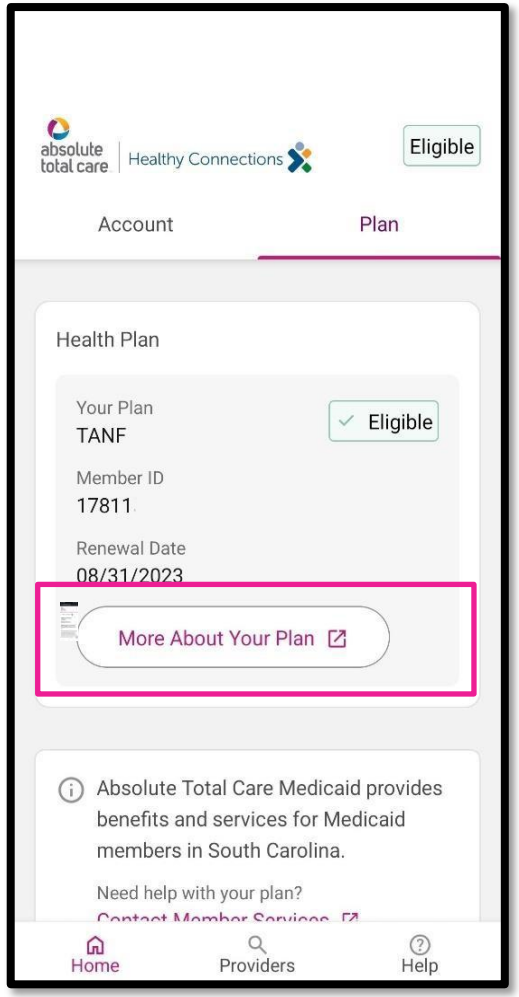
Member Mobile App User Guide

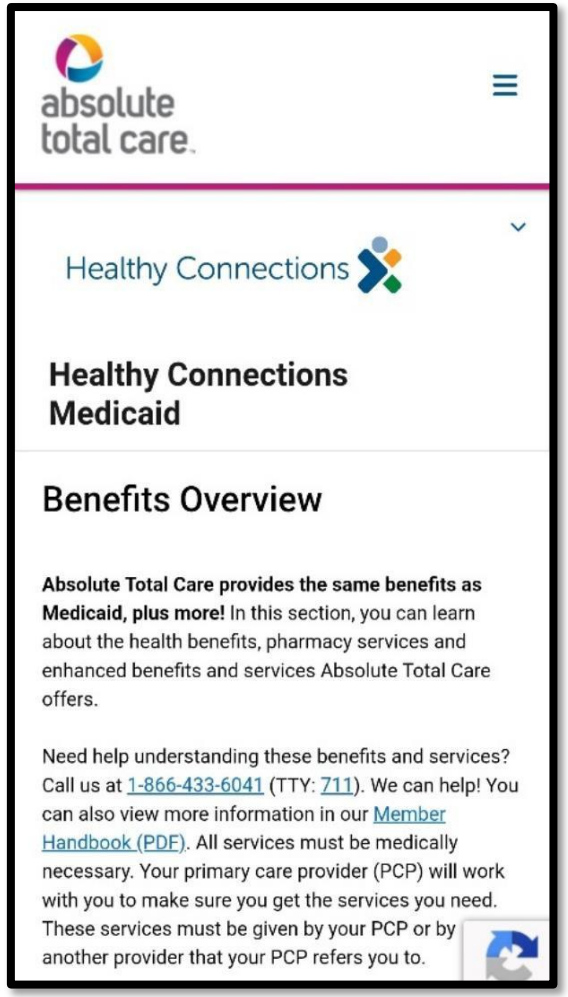
Step 8: FIND A PROVIDER. Clicking on the "Providers" icon at the bottom will direct you to search for providers. Click on any provider category under "Quick Search" to look for a health-care provider the same way you can on the Absolute Total Care website.



Member Mobile App User Guide

MORE ABOUT YOUR PLAN. Click "Plan" from your homepage screen, then select "More About Your Plan" where you will be directed to view your benefits on Absolute Total Care's website.





Behavioral Health Claims Processing Change

absolute total care™

Behavioral Health Claim Processing Change

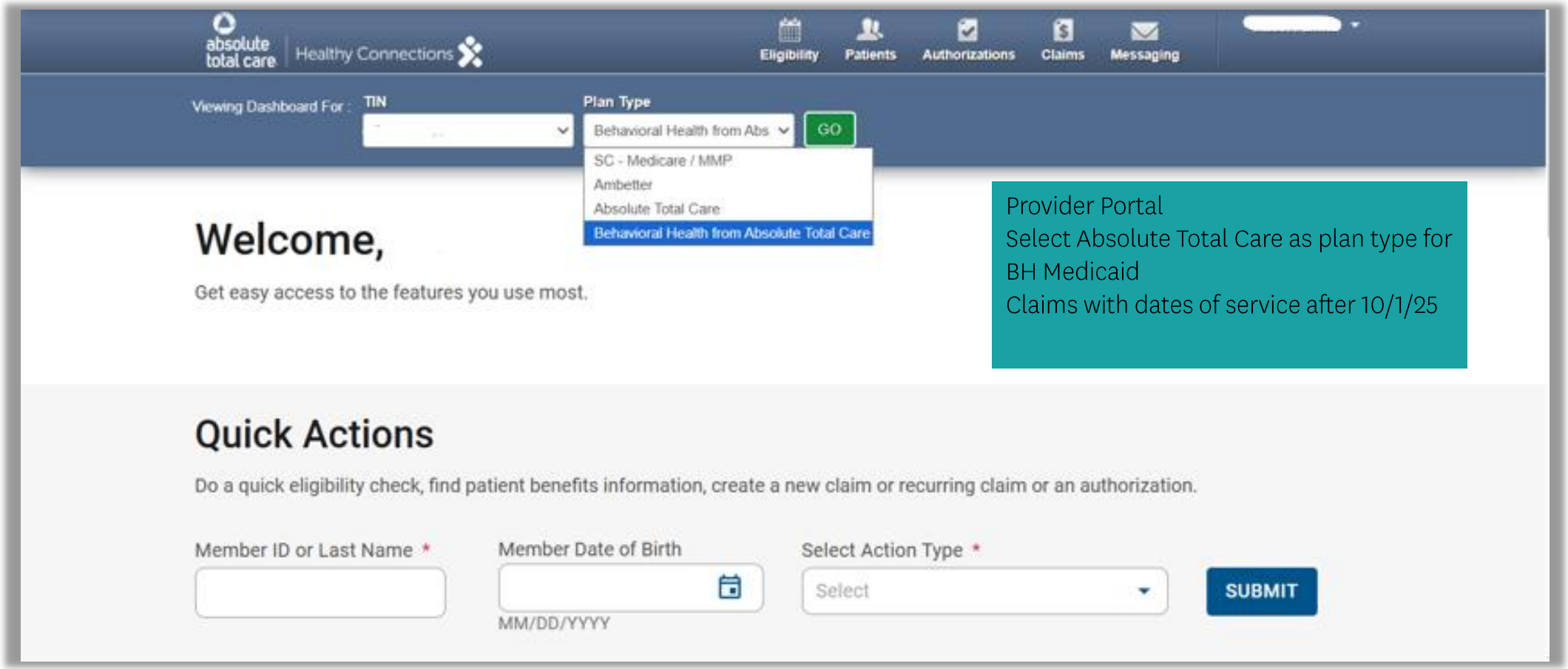
Effective for Dates of Service on or After October 1, 2025

	Dates of service before October 1, 2025	Dates of service on or after October 1, 2025
Initial Claim	Absolute Total Care P.O. Box 7001 Farmington, MO 63640-3818	Absolute Total Care PO Box 3050 Farmington, MO 63640-3821
Claim Adjustments and Reconsiderations	Absolute Total Care Attn: Adjustments/Reconsiderations PO Box 7001 Farmington, MO 63640-3811	Absolute Total Care Attn: Adjustments/Reconsiderations PO Box 3050 Farmington, MO 63640-3821
Provider Disputes	Absolute Total Care Provider Disputes PO Box 6000 Farmington, MO 63640-3821	Absolute Total Care Provider Disputes PO Box 3050 Farmington, MO 63640-3821
Payor ID	68068	68068
Note: *This information is specific to Medicaid only.*		

absolute total care™

Behavioral Health Claim Processing Change

Effective for Dates of Service on or After October 1, 2025



Provider Portal
Select Absolute Total Care as plan type for BH Medicaid
Claims with dates of service after 10/1/25

Eligibility

absolute total care™

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)

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

absolute total care | Healthy Connections

Absolute Total Care (Medicaid)
1-866-433-6041

ambetter. FROM absolute total care

Ambetter from Absolute Total Care (Marketplace)
1-833-270-5443

wellcare PRIME by absolute total care | Healthy Connections PRIME

Wellcare Prime (Medicare -Medicaid Plan)
1-855-735-4398
(Ends 12/31/2025)

wellcare™

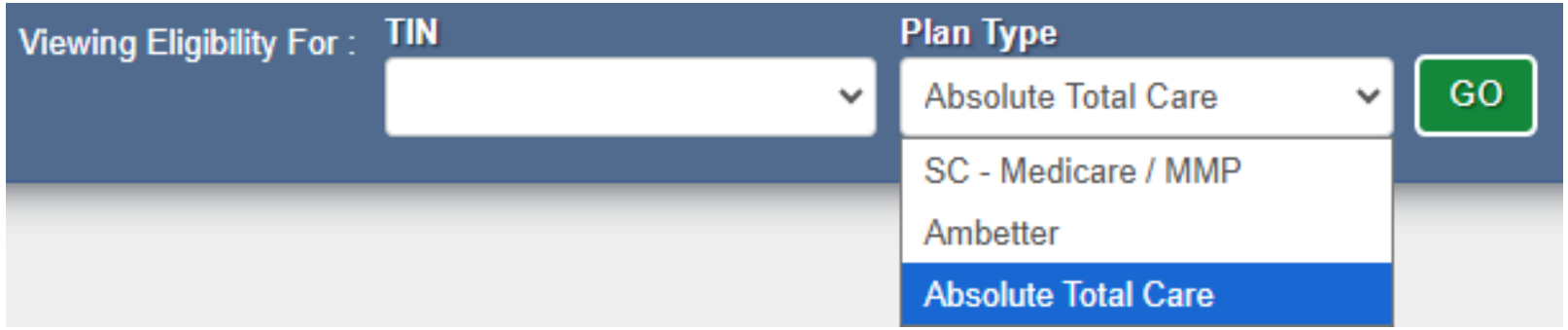
Wellcare Medicare Advantage
1-866-270-5223

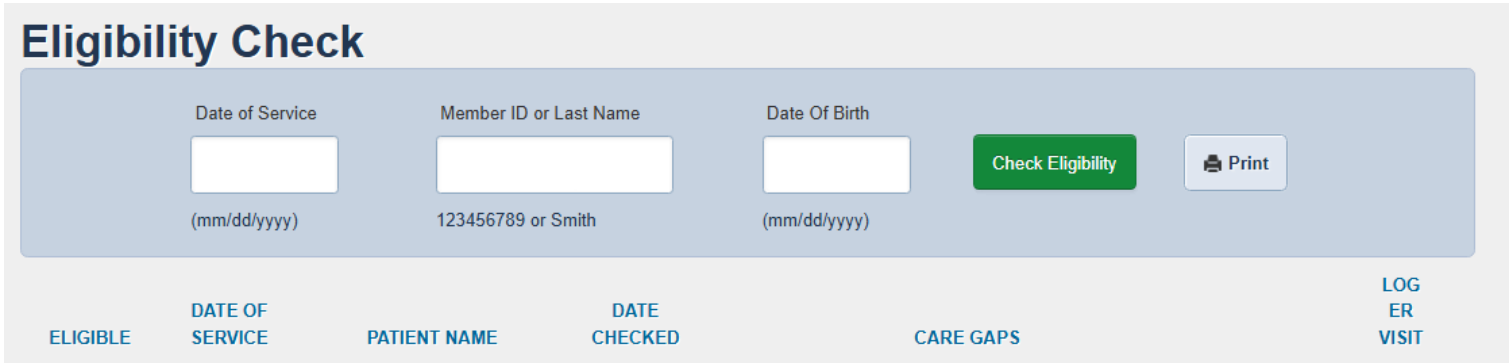
wellcare By absolute total care

Wellcare By Absolute Total Care Dual Align (HMO D-SNP)
1-833-998-5401
(Effective 1/1/2026)

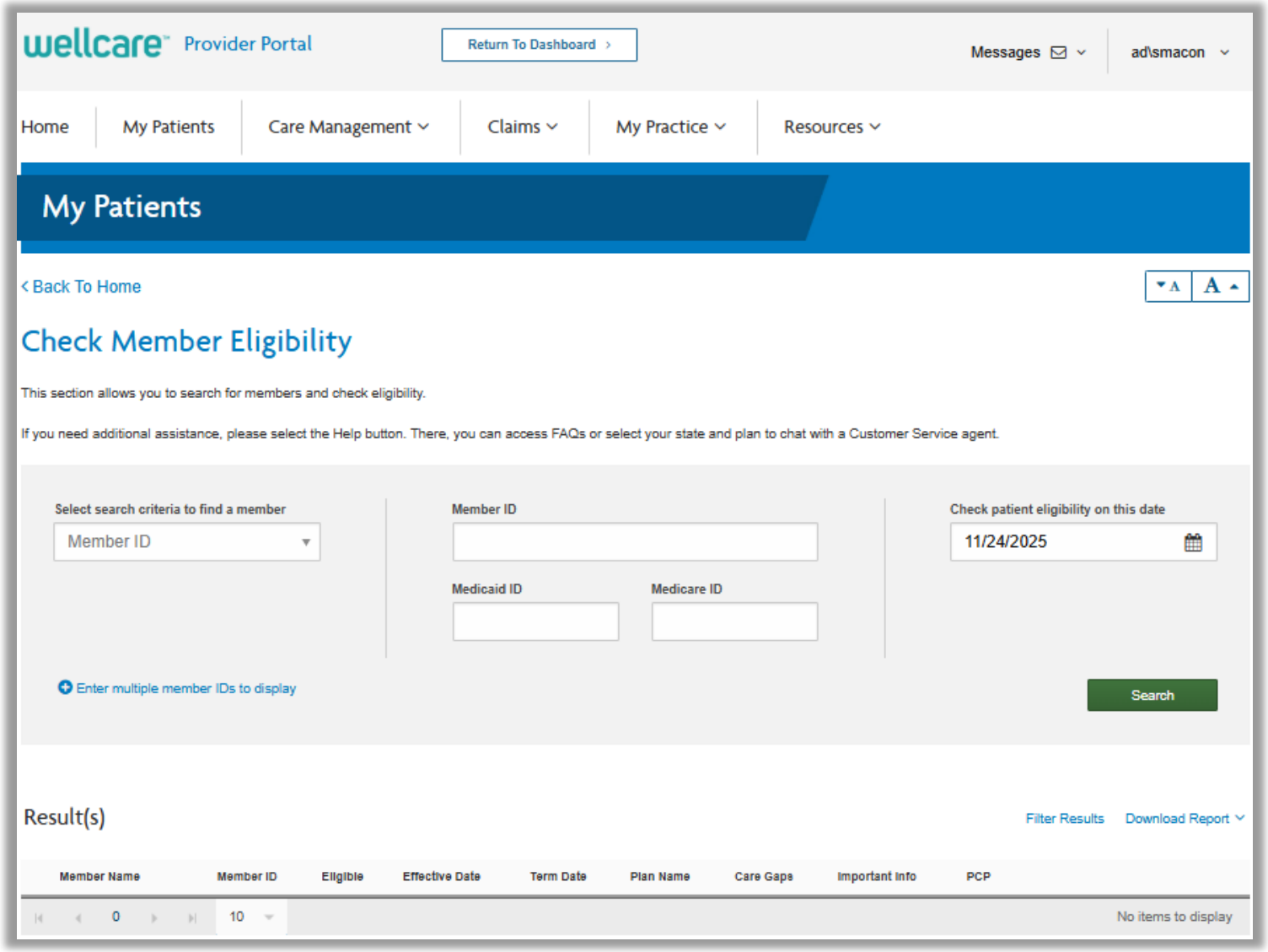
absolute total care™

Absolute Total Care Provider Portal





Wellcare Provider Portal



Availity Essentials: New Multi-Payer Portal

Comprehensive Administrative Tools
Availity Essentials offers tools to validate eligibility, submit claims and check claim status efficiently.

Integration with Health Plans
The platform supports multiple health plans like **Absolute Total Care** and **Wellcare** for streamlined processes.

Reduced Administrative Burden
Centralized functionalities minimize errors and improve workflow, enhancing provider satisfaction.

Enhanced Patient Care Support
Accurate and efficient administrative processes contribute to better patient care outcomes.

New Accounts:
The Availity Administrator registers and manages user accounts and must have the legal authority to sign agreements. Visit Register and Get Started with Availity Essentials for training.

Existing Accounts:
Log in to enjoy full functionality. Add apps to My Favorites and save provider information for faster transactions.

Contact Info:
Availity Client Services: **1-800-AVAILITY (282-4548),** Mon–Fri, 8 AM–8 PM EST. For general questions: Contact Provider Services or Provider Engagement Administrator

Annual Provider Training Requirements

absolute total care™

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/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html
Fraud, Waste and Abuse	https://cmsnationaltrainingprogram.cms.gov/resources
Model of Care (MOC)	https://www.wellcare.com/south-carolina/providers/medicare/training
Person-Centered Planning	https://www.absolutetotalcare.com/providers/resources/provider-training.html
Cultural Competency	https://www.absolutetotalcare.com/providers/resources/provider-training.html https://www.ahrq.gov/sdoh/clas/index.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

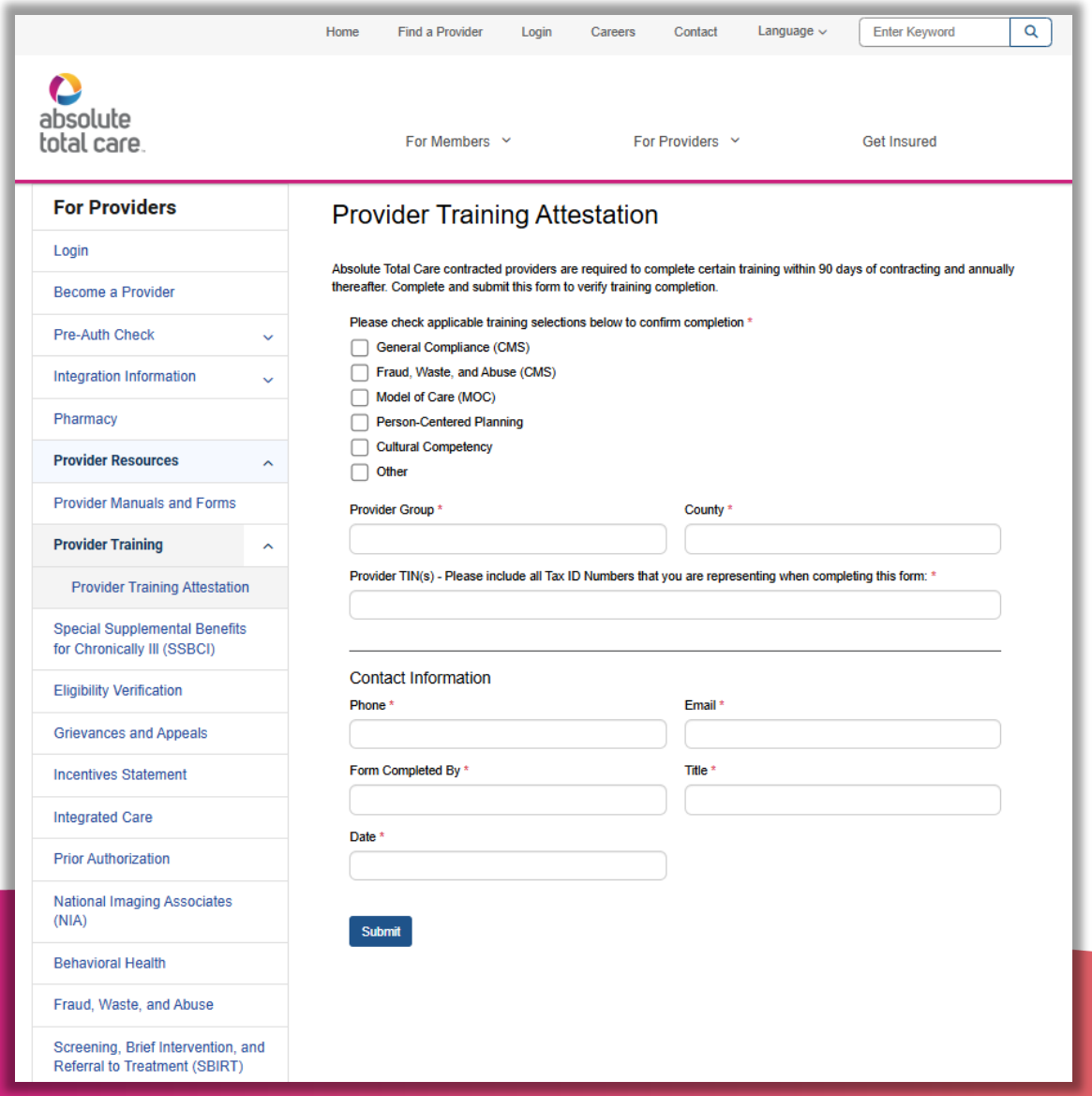
(Ambetter) Antidepressant Medication Management, Follow-Up After Hospitalization for Mental Illness, and Initiation and Engagement of Substance Use Disorder Treatment: Optimizing the AMM, FUH, and IET HEDIS® Measures (Absolute Total Care)

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

Payment and Clinical Policies

absolute total care™

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.

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/clinical-payment-policies.html
- https://www.absolutetotalcare.com/providers/resources/behavioral-health-clinical-policies.html
- https://www.wellcare.com/south-carolina/providers/clinical-guidelines

absolute total care™

Payment Policies

Healthcare claims payment policies are guidelines designed to support the administration of payment rules based on generally accepted principles of correct coding. These policies help determine whether healthcare services are appropriately coded for reimbursement.

Key Sources of Payment Rules

1. Centers for Medicare & Medicaid Services (CMS):
   - *Publication 100-04*: Claims Processing Manual for physicians and non-physician practitioners.
   - *National Correct Coding Initiative (NCCI)*:
     - Procedure-to-procedure coding combination edits.
     - Medically unlikely edits (MUEs).
2. American Medical Association (AMA):
   - *Current Procedural Terminology (CPT) Guidance*: Standards for reporting medical procedures and services.
3. Health Plan Clinical Policies:
   - Based on medical necessity and appropriateness of care.
4. State-Specific Reimbursement Guidance:
   - Additional rules and edits based on local regulations.

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

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

Wellcare Medical Clinical Policies 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:

February 9, 2026:

- MC.CP.MP.31 Cosmetic and Reconstructive Procedures
- MC.CP.MP.107 Durable Medical Equipment and Orthotics and Prosthetics Guidelines
- MC.CP.MP.108 Allogeneic Hematopoietic Cell Transplants for Sickle Cell Anemia and β-Thalassemia
- MC.CP.MP.166 Sacroiliac Joint Interventions for Pain Management
- MC.CP.MP.247 Transplant Service Documentation Requirements
- MC.CP.MP.250 Lantidra (donislecel) Allogeneic Pancreatic Islet Cellular Therapy

November 1, 2025:

- CC.PP.206 Skilled Nursing Facility Leveling
- MC.CP.MP.184 Home Ventilators
- MC.CP.MP.185 Skin Substitutes for Chronic Wounds of the Lower Extremities
- MC.CP.MP.247 Transplant Service Documentation Requirements
- MC.CP.MP.249 Allogeneic Hematopoietic Progenitor Cell Therapy
- MC.CP.MP.181 Polymerase Chain Reaction Respiratory Viral Panel Testing (Retired)
- MC.CP.MP.209 Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing (Retired)

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

Claims 411

absolute total care™

Claims Adjustments, Reconsiderations, and Disputes

Requests to change the initial claim.

Claim adjustments

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

Reconsideration

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

Disputes

Claims Adjustments, Reconsiderations and Disputes

Submission Timeframes

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	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		

MMP (WELLCARE PRIME)		
Submission Timeframes	Par	Non-Par
Claim Initial/resubmission	365 days	365 days
Claims Adjustment	365 days*	365 days*
Claim Reconsideration	365 days*	365 days*
Claim Appeal	60 days	60 days**
Claim Dispute	60 days	60 days
Decision Timeframes	Par	Non-Par
Appeal Decision	30 days	60 days
Dispute Decision	30 days	30 days
Mailing Address		
P.O. Box 3030 Farmington, MO 63640		

* From date of service

** Waiver of Liability required

*** From date of last processed claim

MMP Ends
12/31/2025

absolute total care

Claims Submission

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

Line of Business	Electronic Claim Submission	Paper Claim Submission
Medicaid	Secure Provider Portal: www.AbsoluteTotalCare.com/login Or ***EDI Payer Numbers- (Medical):*** 68069-Emdeon/WebMD/Envoy/PayerPath 42772-Relay Health/McKesson 68055 – Allscripts/Payerpath/Practice Insights ***EDI Payer Numbers- (Behavioral Health):*** 68068 – Emdeon/WebMD/Envoy/Availity 68068 – Relay Health/McKesson 68059 – Allscripts/Payerpath/Practice Insights	***Absolute Total Care (Medical and Behavioral Health)*** P.O. Box 3050 Farmington, MO 63640-3821 Behavioral Health ***(before 10/1/2025)*** P.O. Box 7001 Farmington, MO 63640-3811
Marketplace ***MMP (Wellcare Prime) (ends 12/31/2025)***	Secure Provider Portal: www.AbsoluteTotalCare.com/login Or EDI Payer Numbers- (Medical): 68069-Emdeon/WebMD/Envoy/PayerPath	Ambetter from Absolute Total Care P.O. Box 5010 Farmington, MO 63640-5010
Wellcare Absolute Total Care Dual Align (HMO D-SNP) *****Effective 1/1/2026*****	Secure Provider Portal: www.AbsoluteTotalCare.com/login Or EDI Payer Numbers- (Medical): 68069-Emdeon/WebMD/Envoy/PayerPath	Wellcare by Absolute Total Care Attn: Claims P.O. Box 9700 Farmington, MO 63640-0700

Claims Submission Guidelines

Form Field	Requirements	CMS-1500 (Professional)	UB-04 (Institutional)
Billing provider name, address and NPI	Enter the name, address, and 10-character NPI ID and taxonomy of the billing entity	Box 33	Box 1
Subscriber (name, address, DOB, sex, and member ID required)	Enter the subscriber's Health Plan ID exactly as it appears on the member's current ID card.	Subscriber box 1a, 4, 7, 11	Box 58 and 60
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	Enter the member's Health Plan ID exactly as it appears on the member's current ID card.	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11
Attending provider with NPI	Enter the 10-character NPI ID and taxonomy for the attending practitioner.	N/A	Box 76
Rendering provider	Enter the 10-character NPI ID and taxonomy for the individual practitioner who rendered the service (this can be blank if a sole proprietor and that NPI is entered as the Billing Provider).	NPI in Box 24J	Box 56
Service facility information	Enter the name, address, and 10-character NPI ID and taxonomy where the patient service was delivered (this can be blank only if provider is a sole proprietor).	Box 32	Box 1

Taxonomy Guide

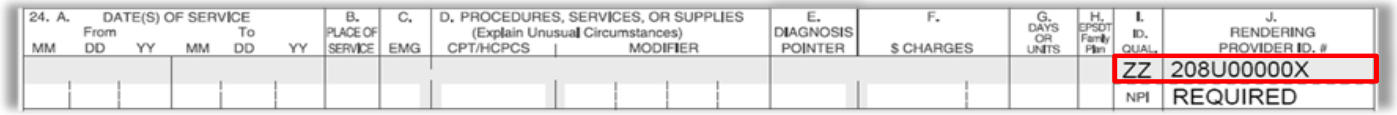
IMPORTANT

- Taxonomy codes are 10-digit federally established numbers which health care providers use to identify their unique specialty areas.
- Taxonomy Code Example: 282N00000X

CMS 1500

PAPER SUBMISSION:

Rendering – Box 24i should contain the qualifier "ZZ." Box 24j (shaded area) should contain the taxonomy code.



Billing – Box 33b should contain the qualifier "ZZ" along with the taxonomy code.

Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of "ZZ" along with the taxonomy code in the next column.

PROVIDERS ARE REQUIRED TO SUBMIT CLAIMS WITH THE CORRECT TAXONOMY CODE AND QUALIFIER CONSISTENT WITH THE PROVIDER'S SPECIALTY TO ENSURE APPROPRIATE CLAIM ADJUDICATION. THE **CLAIM WILL BE REJECTED** IF THE TAXONOMY CODE IS INCORRECT OR OMITTED FROM THE CLAIM.

Taxonomy Guide

CMS 1500 Electronic Submission:

Rendering – Loop 2310B PRV01 “PE” = Referring PRV02 = “ZZ” qualifier PRV03 = 10 character taxonomy code

Billing – Loop 2000A-PRV01 “BI” PRV02 = “ZZ” qualifier PRV03 = 10 character taxonomy

Referring –If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of “ZZ” along with the taxonomy code.

PROVIDERS ARE REQUIRED TO SUBMIT CLAIMS WITH THE CORRECT TAXONOMY CODE AND QUALIFIER CONSISTENT WITH THE PROVIDER’S SPECIALTY TO ENSURE APPROPRIATE CLAIM ADJUDICATION. THE **CLAIM WILL BE REJECTED** IF THE TAXONOMY CODE IS INCORRECT OR OMITTED FROM THE CLAIM.

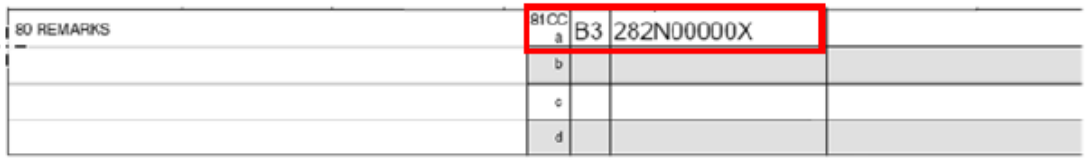
Taxonomy Guide

IMPORTANT

- UB-04 Submissions
- Taxonomy Code Example: 282N00000X

UB-04	PAPER SUBMISSION:

Billing – Box 81CCa should contain the qualifier of "B3" in the left column and the taxonomy code in the middle column.



80 REMARKS	81CC a	B3	282N00000X	
	b			
	c			
	d			

ELECTRONIC SUBMISSION:

Billing - Loop 2000A - PRV01 "BI" = "Billing"; PRV02 – "PXC" qualifier; PRV03 = 10 character taxonomy code

PROVIDERS ARE REQUIRED TO SUBMIT CLAIMS WITH THE CORRECT TAXONOMY CODE AND QUALIFIER CONSISTENT WITH THE PROVIDER'S SPECIALTY TO ENSURE APPROPRIATE CLAIM ADJUDICATION. THE ***CLAIM WILL BE REJECTED*** IF THE TAXONOMY CODE IS INCORRECT OR OMITTED FROM THE CLAIM.

Wellcare Medicare Advantage
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 Medicare Advantage

IMPORTANT

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

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

Wellcare By Absolute Total Care Dual Align (HMO D-SNP)
Provider Timeframes, Claim Adjustments and Disputes

Effective 1/1/2026

IMPORTANT

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

Wellcare Absolute Total Care Dual Align (HMO D-SNP) effective 1/1/2026		
Submission Timeframes	***Par***	***Non-Par***
Claim Initial/Resubmission	365 days	365 days
Claim Reconsideration	365 days	365 days
Claim Appeal	60 days	60 days
Claim Dispute	60 days	60 days
Decision Timeframes	***Par***	***Non-Par***
Appeal Decision	30 days	60 days
Dispute Decision	30 days	30 days

Claims Submission
Wellcare By Absolute Total Care
Dual Align (HMO D-SNP)

Effective 1/1/2026

IMPORTANT

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

CLAIM SUBMISSION INFORMATION	
SUBMISSION INQUIRIES EDI team: EDIBA@centene.com or call Provider Services ***PREFERRED EDI CLEARINGHOUSE*** Availity: Web portal for direct data entry (DDE) claims: ***Availity.com/Essentials-Portal-Registration*** ***Secure Provider Portal:*** www.AbsoluteTotalCare.com/login ***PAYER ID*** 68069-Emdeon/WebMD/Envoy/PayerPath	***Timely Filing guidelines:*** 365 days from date of service ***EFT*** Register: payspanhealth.com or call 1-877-331-7154 Email: providersupport@payspanhealth.com ***MAIL PAPER CLAIMS TO:*** Wellcare by Absolute Total Care Attn: Claims P.O. Box 9700 Farmington, MO 63640-0700

Common Claim Rejections and Denials

absolute total care™

Common Claim Rejections

- ❑ Incorrect Member details
- ❑ Member Inactive
- ❑ Incorrect Claim Form
- ❑ Taxonomy Missing

A rejection occurs BEFORE the claim has cleared entry into the system for processing

Claim denials happen AFTER the claim has been processed and is denied

Common Claim Denials

- ❑ Timely Filing
- ❑ Duplicate Claim
- ❑ Coordination of Benefits (COB)
- ❑ No Authorization on File that Matches Service(s) Billed

Top Rejections and Causes

IMPORTANT

- Claim REJECTIONS occur BEFORE claims are entered into the system and processed. This is usually due to a technical issue or inaccurate formatting.

Incorrect Member Details

- Misspelled Names
- Inaccurate DOB
- Incorrect Member ID
- Incorrect Line of Business

Member Inactive at Time of Service

- Eligibility should be verified often and prior to rendering services.

Incorrect Claim Form

- File claims based on CMS guidelines or Contractual agreement

Missing Taxonomy

- Providers are required to submit claims with the correct Taxonomy code and qualifier consistent with provider's specialty

Top Denials and Explanations

IMPORTANT

- A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

Duplicate Claim Service

- A duplicate claim is a claim submitted more than once for the same service, DOS, Provider and member – without any changes or corrections

Timely Filing

- Timely Filing is the maximum amount of time allowed between the DOS and the date a claim was submitted

Coordination of Benefits (COB)

- COB is the process used to determine the order in which multiple insurance plans pay for the services

No Authorization on file that Matches Service(s) Billed

- Due to either the prior authorization was not obtained or approved authorization does not match the billed services to include CPT/HCPCS, Provider, location or date

Preventing “Duplicate Claim” Denials

- A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

How it happens...

- System Errors
- Miscommunication
- Resubmitted before initial claim is processed

Why it matters...

- Unnecessary denials
- Reimbursement delays
- Increased administrative work
- Audit trigger/Compliance risk
- Resolving duplicates time is better spent improving patient care and operations

Best Practices

- Verify claim status before resubmitting
- Modify/correct claim as needed
- Refer to the reconsideration and dispute process
- Keep staff trained and up to date on procedures and guidelines

Preventing “Timely Filing” Denials

IMPORTANT

- A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

How it happens...

- Filing claim past the Timely Filing guidelines outlined per the line of business or individual provider agreement

Why it matters...

- Faster claim processing
- Reduces lost revenue
- Increased administrative work
- Billing efficiency

Best Practices

- Submit claims immediately after rendering services
- Implement software alerts and tracking to monitor deadlines
- Keep detailed records of submission attempts and confirmations
- Conduct regular billing audits and train staff on guidelines

Preventing “Coordination of Benefits” (COB) Denials

IMPORTANT

- A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

How it happens...

- Missing COB information or updates
- Incorrect Primary/Secondary insurance designation
- Claim submitted to secondary payer without primary EOB
- Member did not notify payer of coverage changes
- Duplicate or overlapping coverage records

Why it matters...

- Faster claim processing
- Reduces lost revenue
- Increased administrative work

Best Practices

- Verify eligibility and coverage each visit
- Ask member about other insurance
- Update COB details with payers regularly
- **Submit claims in correct order: Primary first, then secondary**
- **Include primary EOB when billing secondary payer**
- Train staff on COB workflows and guidelines

Preventing “No Authorization on File” Denials

IMPORTANT

- A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

How it happens…

- Approved Prior Authorization does not match the billed service to include CPT/HCPC Codes, Provider, location or requested date(s)
- Provider failed to obtain Prior Authorization

Why it matters…

- Faster claim processing
- Reduces lost revenue
- Increased administrative work

Best Practices

- Regularly review Prior Auth requirements
- Verify Authorization details prior to rendering services
- Confirm approved authorization details prior to submitting claim
- Update authorization request *immediately,* if needed, prior to filing claim
- ***Authorization number must be included on the submitted claim*** (CMS 1500 BOX 23, UB-04 BOX 63)

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/.

absolute total care™

PaySpan®

Paper Checks with PaySpan

Payspan payments that were issued via check are now processed through the Zelis Payments Network. Providers will receive the electronic payments as Automated Clearing House (ACH), honoring the provider's choice to enroll in ACH+.

ACH+ is a service offered by some financial platforms that speeds up the delivery of electronic payments, allowing suppliers to receive funds as quickly as a credit card transaction, but without the associated higher fees and credit card processing requirements. It utilizes the existing (ACH) network to provide faster, non-card electronic payments for businesses, eliminating the delays and costs of traditional methods like checks.

If a provider has questions about how payment was disbursed, how to access funds, the Zelis portal, etc., call center representatives can direct them to Zelis Provider Services via 1-877-828-8770 or ClientService@zelispayments.com.

Risk Adjustment

absolute total care™

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 contact your Provider Engagement Account Manager for more information regarding these programs.

absolute total care™

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.

Link to Prerecorded 2025 Webinars:

https://centene.qumucloud.com/view/fYzA4SnMBWU600pfrBXHvd

CDI 2026 Webinar Series:
Stronger Documentation. Smarter Coding. Better Outcomes.

Join us for engaging sessions that enhance your documentation and coding expertise.

- ✓ Learn practical risk adjustment strategies through real-world case studies.
- ✓ Strengthen documentation to capture the full scope of each patient's conditions.
- ✓ Master the ICD-10-CM coding guidelines to ensure precise compliant coding.
- ✓ Build confidence to document and code with accuracy that supports better outcomes.

Live sessions built for providers, no-physician practitioners, coders, billers and support staff, because great documentation and coding starts with a great team!

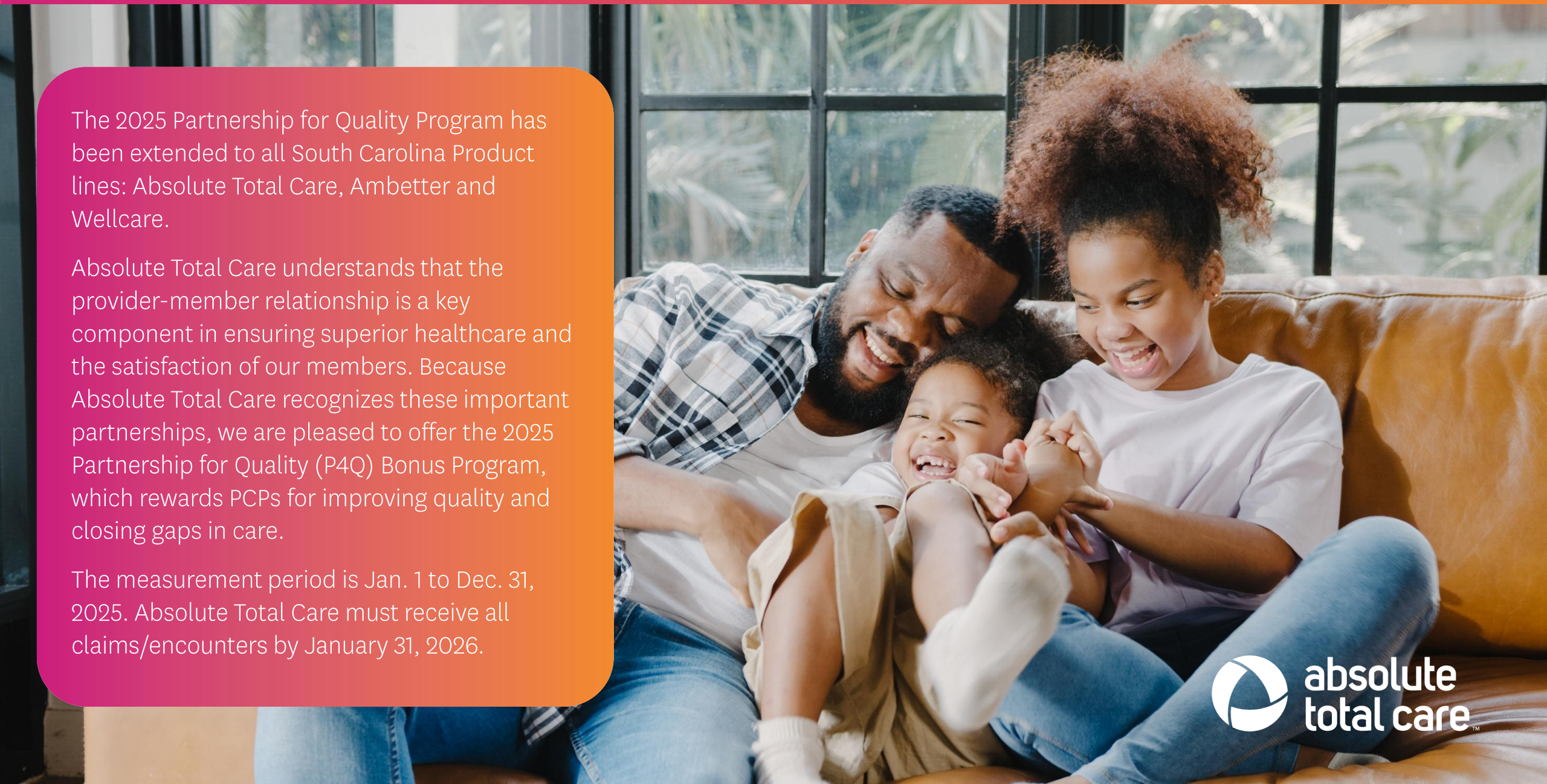
Register here!

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

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.

absolute total care™

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

absolute total care™

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

absolute total care™

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).

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

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

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.

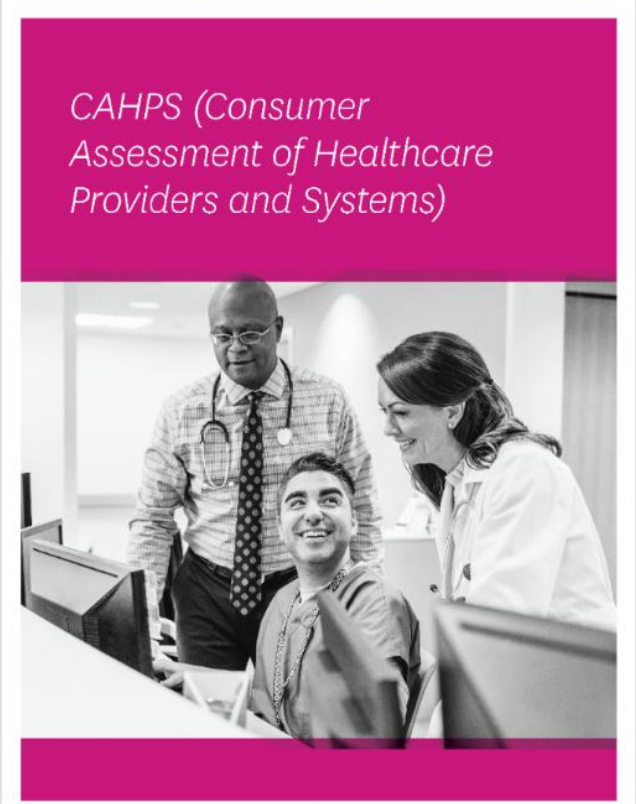
Survey Detail by Product

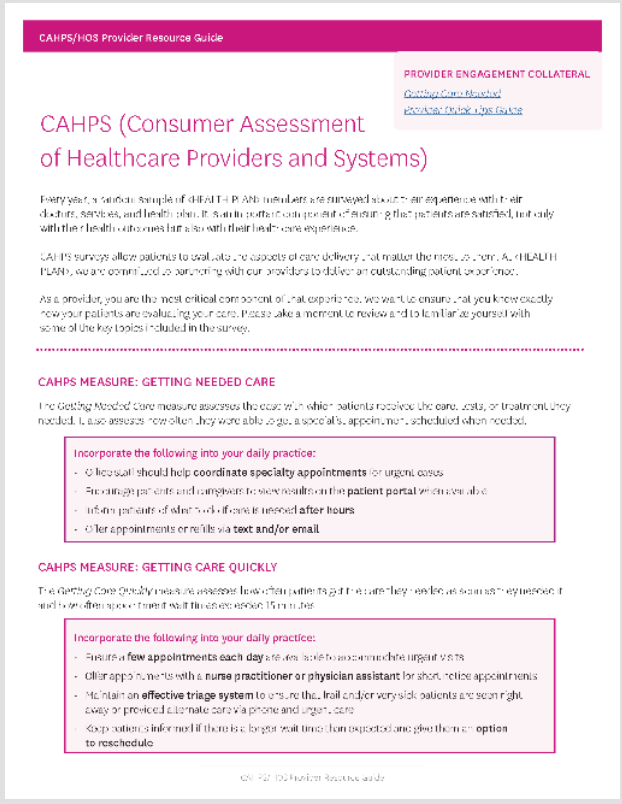
- The CAHPS survey is conducted annually however, the timeline varies slightly by product.
- The image provided reflects a breakdown of each product, important timeframes/deadlines, survey type, survey length, and sample size.

	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]



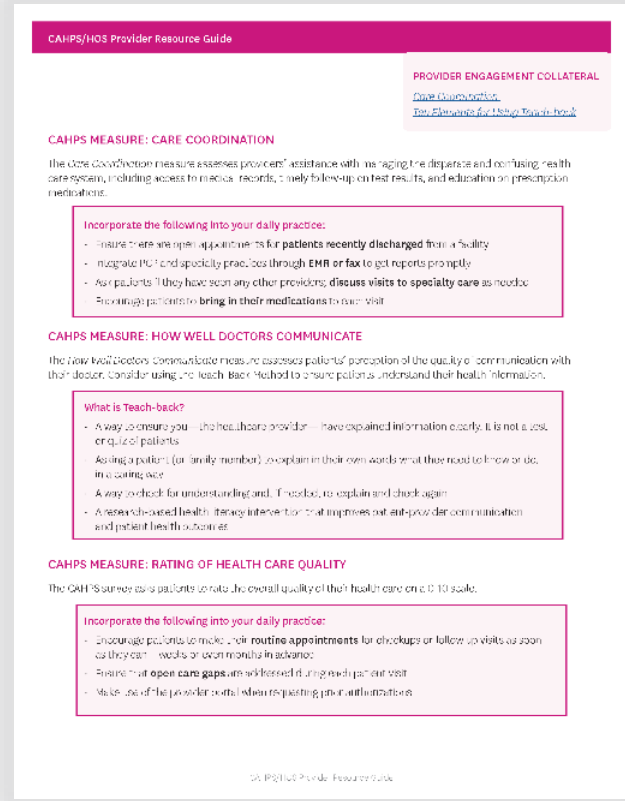

CAHPS/HOS Provider Resource Guide

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 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.

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.

Accessibility and Availability Standards

absolute total care™

Accessibility and Availability

Accessibility is defined as the extent to which a member can obtain needed services in a timely and convenient manner. This includes both telephone access and the ease of scheduling appointments, when 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.

absolute total care™

Access Standards - Medicaid

Primary Care Provider (PCP) Appointment Access Standards	
Routine Visits for established patients	Within 15 business days ***NEW***
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 Access Standards ***NEW*** Obstetrics & Gynecology (OB/GYNs), Oncologists, Retail Pharmacy and Autism Services	
Routine Visits for established patients	Within 15 business days
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

Access Standards - Medicaid

Behavioral Provider Appointment Access Standards	
Initial visit for routine care	Within 10 business days
Follow-Up routine care for established patients	Within 15 business days
Care for a non-life-threatening emergency	Within 6 hours or referred to the emergency room or behavioral health crisis unit
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 schedules for an appointment

Other Required Specialty Care Provider Appointment Access Standards ***NEW***	
Routine Visits for non-symptomatic care	Within 4-12 weeks
Urgent medical condition visits	Within 48 hours
Emergent or emergency visits	Immediately upon referral
Indian Medial Referrals	Allow for Indian Health Care provider referrals of an Indian member

Access Standards
Wellcare By Absolute Total Care

Primary Care and Specialist Appointment Type	Access Standard
PCP-Urgent	Within 24 hours
PCP-Non-urgent	Within 7 business days
PCP-Regular and routine	Within 30 business days
All specialists (including high volume and high impact) - Urgent	Within 24 hours
All specialists (including high volume and high impact) - Non-Urgent	Within 30 business 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	Within 6 hours
Behavioral health provider – Initial routine care follow-up	Within 10 business days
In-office wait times for all standards	Not to exceed 15 minutes

Access Standards
Medicare Advantage

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) - Non-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 or instructions on how to reach a physician
	24 hours a day, 7 days a week

Case Management

absolute total care™

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

absolute total care™

Case Management Referrals

absolute total care | Healthy Connections

Medicaid (Healthy Connections)
1-866-433-6041

ambetter. FROM absolute total care

Ambetter from Absolute Total Care
(Marketplace)
1-833-270-5443

wellcare By absolute total care.

Wellcare By Absolute Total Care
Dual Aligned
1-833-998-5401

wellcare™

Wellcare (Medicare Advantage)
1-866-635-7045

absolute total care™

absolute total care™

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

Appendix

absolute total care™

Absolute Total Care Healthy Connections (Medicaid)

2026 MEMBER ID CARD OVERVIEW

Front of Member ID Card

Member Information

- Member Full Name
- Member Date of Birth
- Member ID# (required for claims)
- Effective Date (benefits begin)

Primary Care Provider

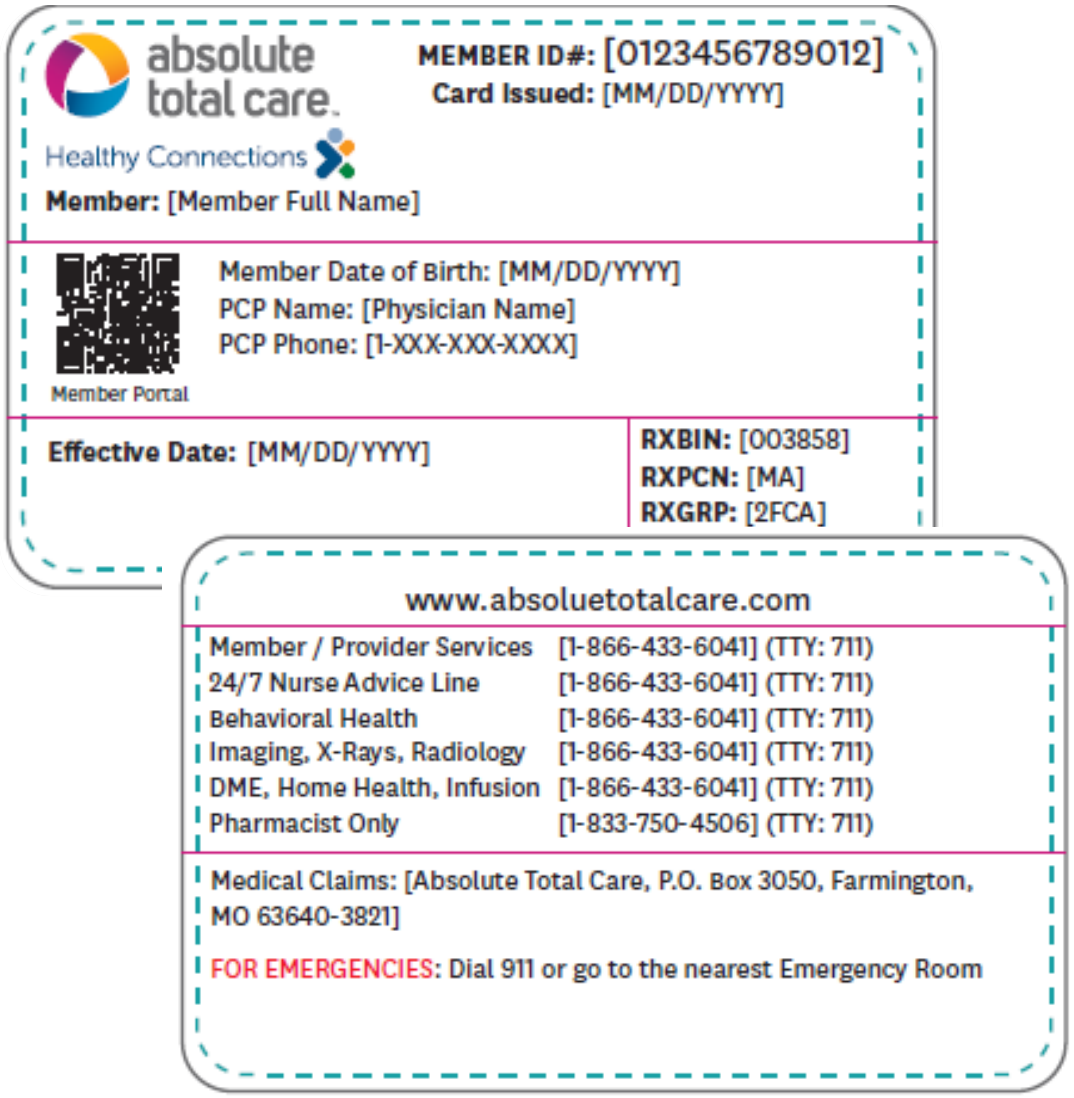
- PCP Name
- PCP Phone Number

Digital Access

- Member Portal QR Code

Pharmacy Processing

- RXBIN / RXPCN / RXGRP



Back of Member ID Card

Support & Assistance

- Member/Provider Services
- 24/7 Nurse Advice Line
- Behavioral Health

Specialty & Home-Based Care

- Imaging, X-rays, Radiology
- DME, Home Health, Infusion

Pharmacy Support

- Pharmacy Help Desk (pharmacists only)

Administrative Information

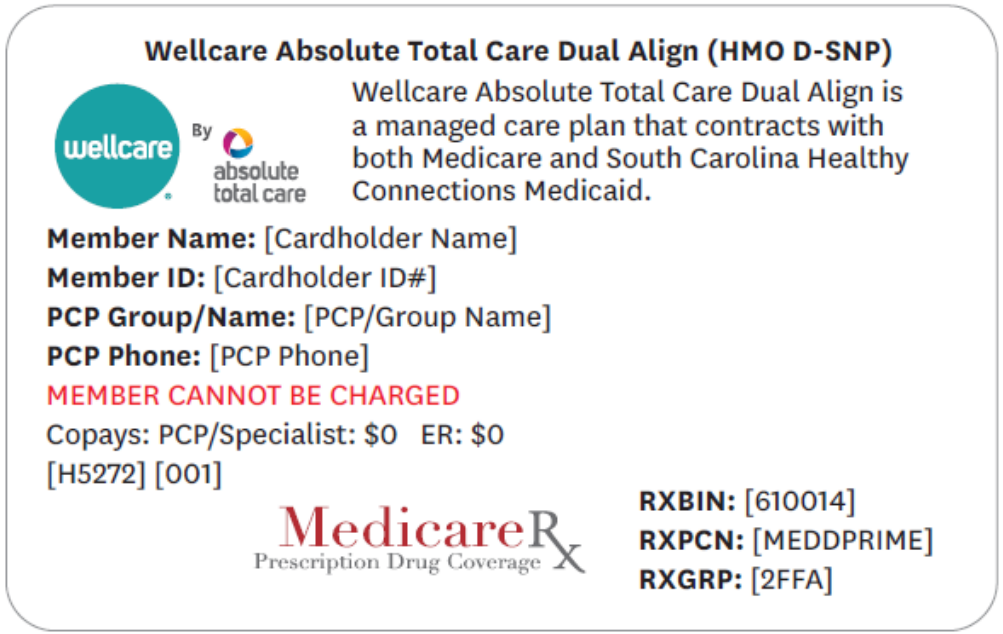
- ATC Billing Address
- ATC Website

absolute total care | Healthy Connections

Medicare Dual Align HMO D-SNP

2026 MEMBER ID CARD OVERVIEW

Plan Name: Wellcare Absolute Total Care Dual Align (HMO D-SNP)
Contract (PBP) Number: H5272-001
Brand Name: Wellcare By Absolute Total Care



Wellcare Absolute Total Care Dual Align (HMO D-SNP)

Wellcare Absolute Total Care Dual Align is a managed care plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid.

Member Name: [Cardholder Name]
Member ID: [Cardholder ID#]
PCP Group/Name: [PCP/Group Name]
PCP Phone: [PCP Phone]
MEMBER CANNOT BE CHARGED
Copays: PCP/Specialist: $0 ER: $0
[H5272] [001]

MedicareRx Prescription Drug Coverage

RXBIN: [610014]
RXPCN: [MEDDPRIME]
RXGRP: [2FFA]

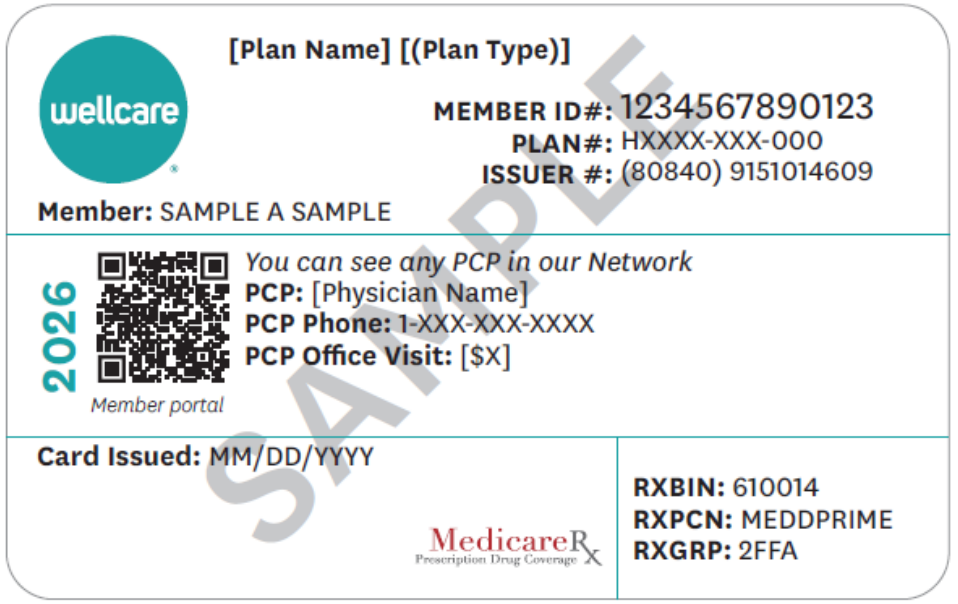
Member Services / Nurse Advice Line	[1-833-998-5063] (TTY: 711)
Behavioral Health	[1-833-998-5063] (TTY: 711)
Vision: [Centene Vision Services]	[1-855-659-6665] (TTY: 711)
Dental: [Liberty Dental]	[1-866-544-4362] (TTY: 711)
Transportation: [ModivCare]	[1-877-682-9029] (TTY: 711)
Provider Services / Pharmacy Prior Auth	[1-833-998-5401] (TTY: 711)
Pharmacist Only	[1-833-750-4244] (TTY: 711)

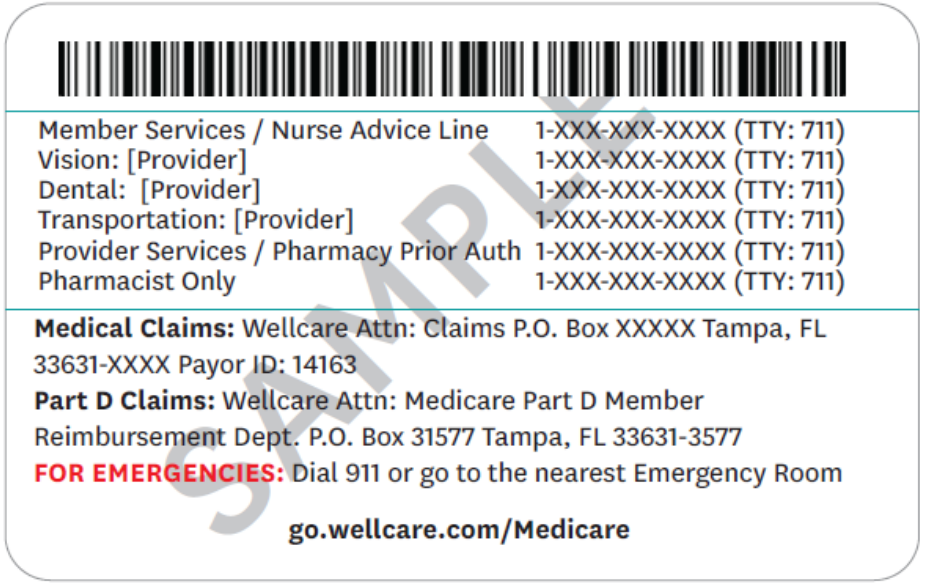
Send Claims To: [Wellcare By Absolute Total Care Attn: Claims P.O. Box 9700 Farmington, MO 63640-0700] Payor ID: [68069]
Part D Claims: [Wellcare By Absolute Total Care Attn: Medicare Part D Member Reimbursement P.O. Box 31577 Tampa, FL 33631-3577]
FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room
Website: [go.wellcare.com/ATC]

Wellcare (Medicare HMO 4847)

2026 MEMBER ID CARD OVERVIEW

Brand Name: Wellcare	
Plan Name	***Contract (PBP) Number***
Wellcare Simple (HMO-POS)	H4847-001
Wellcare Assist (HMO-POS)	H4847-005
Wellcare Giveback (HMO-POS)	H4847-007
Wellcare Patriot Giveback (HMO-POS)	H4847-006

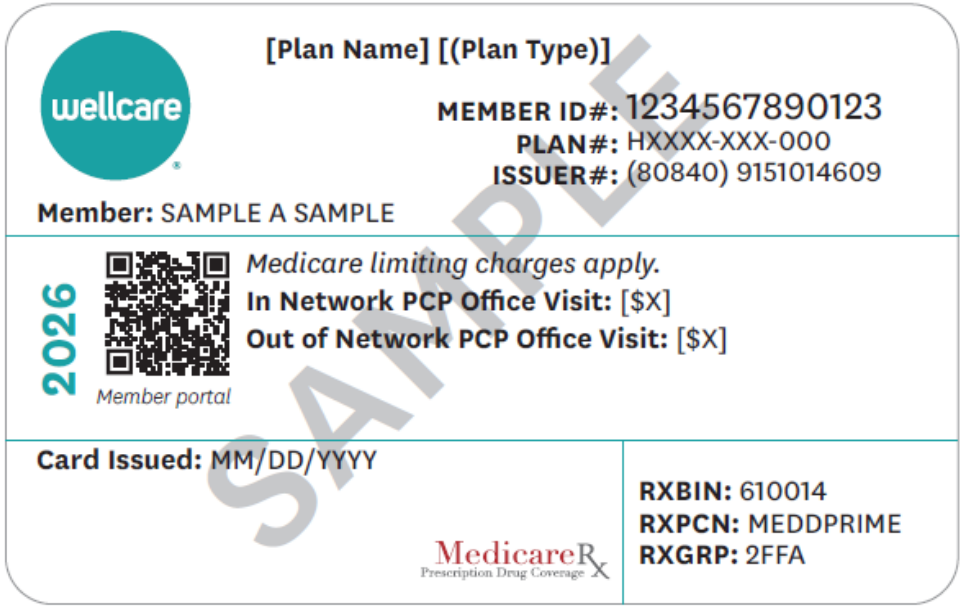


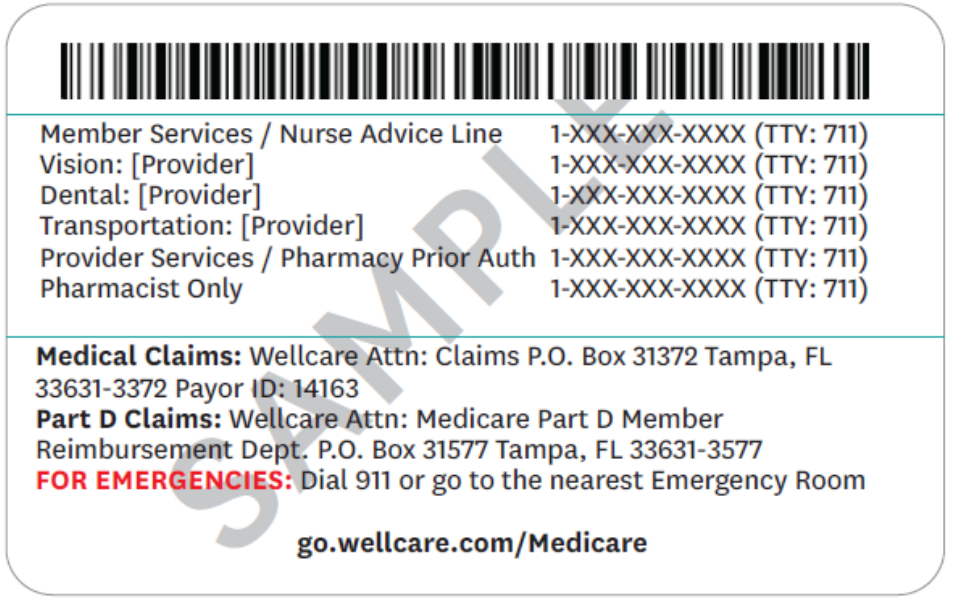


Wellcare (Medicare PPO H7326)

2026 MEMBER ID CARD OVERVIEW

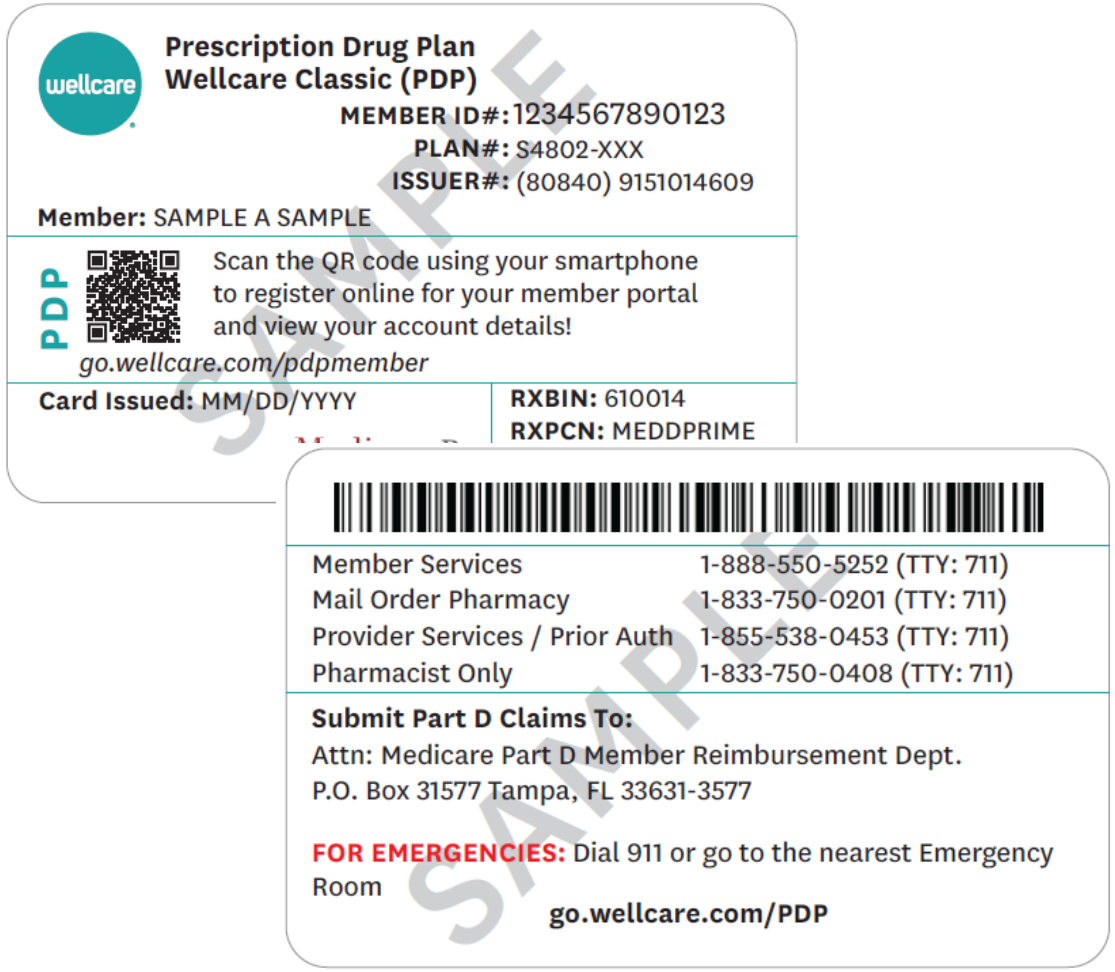
Brand Name: Wellcare	
Plan Name	***Contract (PBP) Number***
Wellcare Simple Open (PPO)	H7326-001
Wellcare Assist Open (PPO)	H7326-007

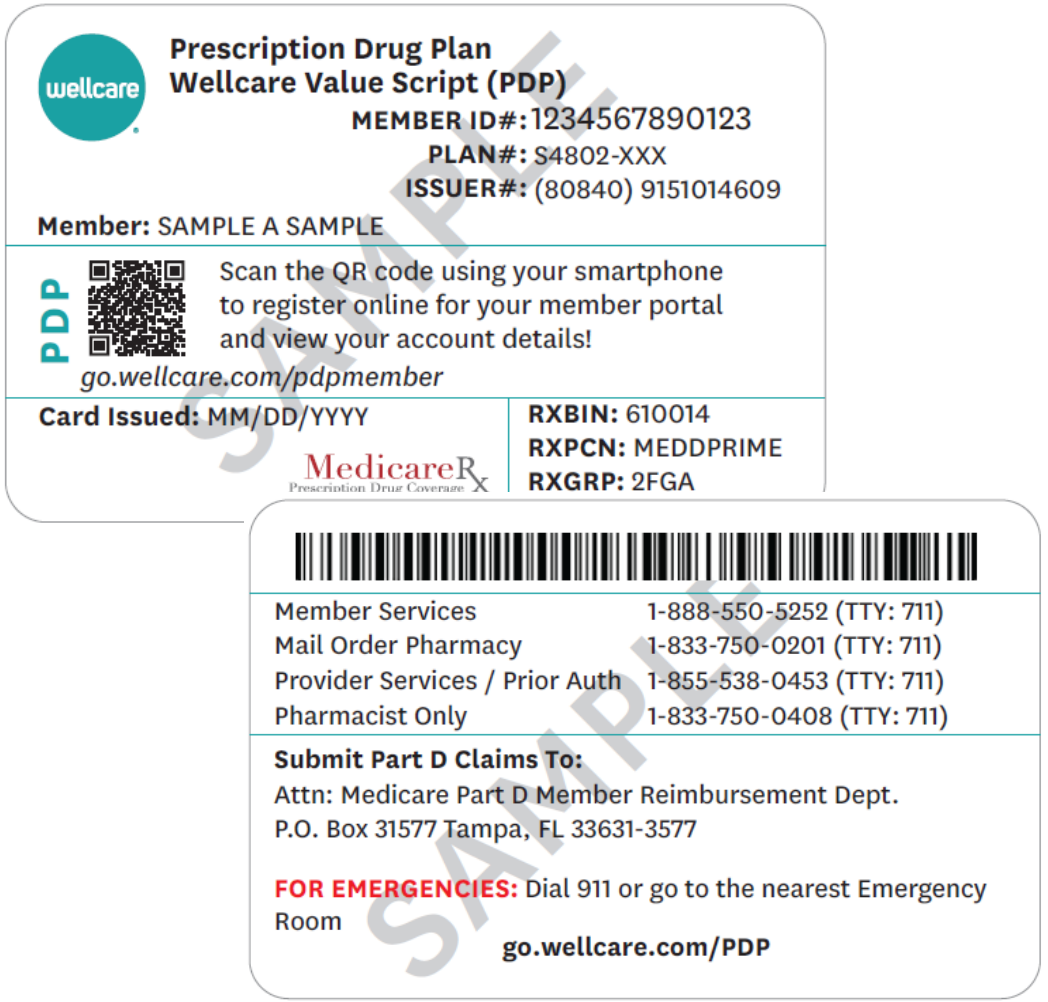




PDP-Classic and Value Script

2026 MEMBER ID CARD OVERVIEW

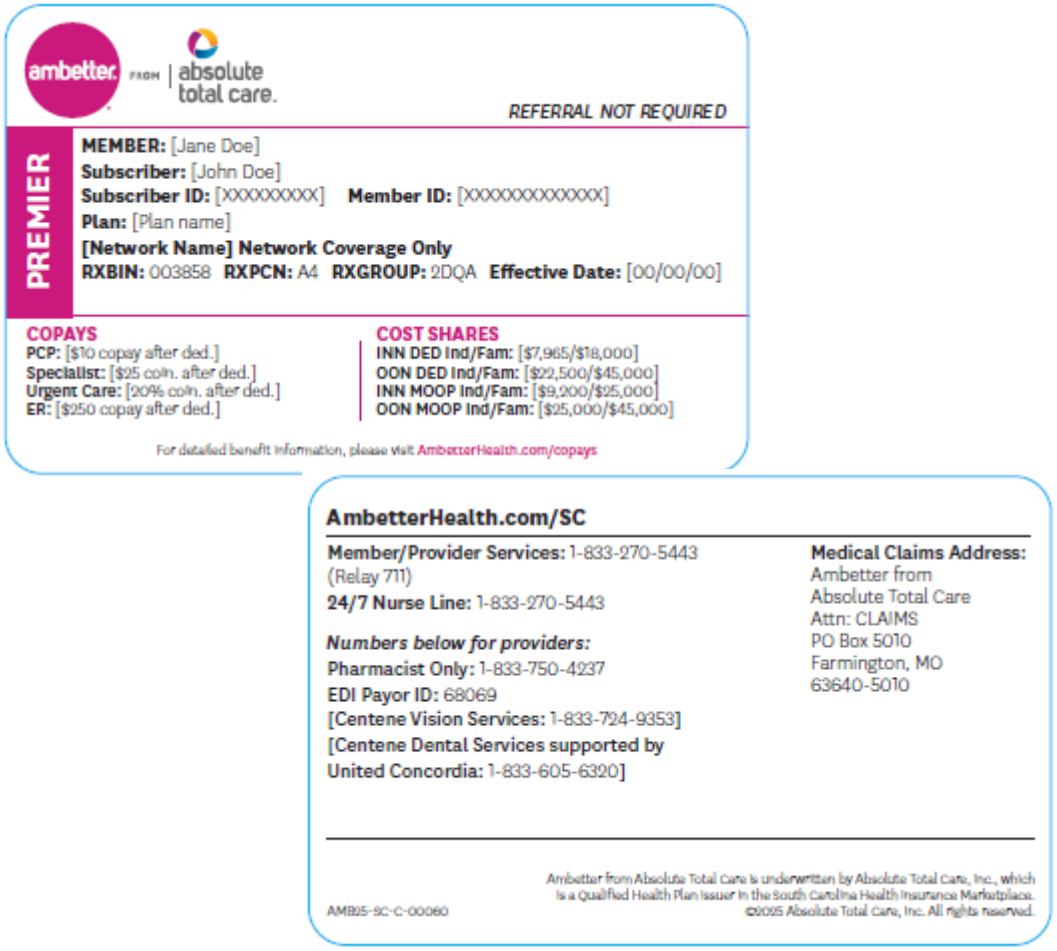




Marketplace Ambetter/Ambetter Health

2026 MEMBER ID CARD OVERVIEW

Ambetter / Ambetter from Absolute Total Care
Network name: PREMIERE



Ambetter Health (ICHRA)
Network Name: SOLUTIONS

absolute total care™