Managed Care Incontinence Supplies Carve-In Information and FAQ

Background: On January 1, 2026, Healthy Connections Medicaid members who are 18 years of age and older were carved into to Medicaid Managed Care service delivery model for coverage of Medicaid State Plan services. This includes:

- Medicaid members who are dually enrolled in Medicare and Medicaid
- Medicaid members enrolled in the HIV/AIDS Waiver
- Medicaid members enrolled in the Mechanical Ventilator Dependent (Vent) Waiver
- Medicaid members enrolled in the Community Choices Waiver
- Medicaid members who reside in a nursing facility *(medical services only)*

Continuity of Care Period: The transition from Medicaid Fee-for-Service (FFS) to Medicaid Managed Care delivery model includes a 180-day continuity of care period for Healthy Connections Medicaid members. During the continuity of care period, Absolute Total Care will honor all previous prior authorizations and ensure there is no break in access to service or covered medical supplies for members. Absolute Total Care will pay claims at 100% of the applicable Medicaid FFS rate, unless a contractually negotiated rate exists, for authorized services for Healthy Connections Medicaid members covered by Absolute Total Care during the continuity of care period regardless of the providers' network status.

Prior Authorization: Absolute Total Care will honor all previous prior authorizations for incontinence supplies during the 180-day Continuity of Care period. Prior Authorization is required after the 180-day Continuity of Care period and for any new patients receiving incontinence supplies. Providers should refer to the Pre-Auth Check Tool to look up a service code to determine if prior authorization is needed.

Eligibility

How do I check eligibility?

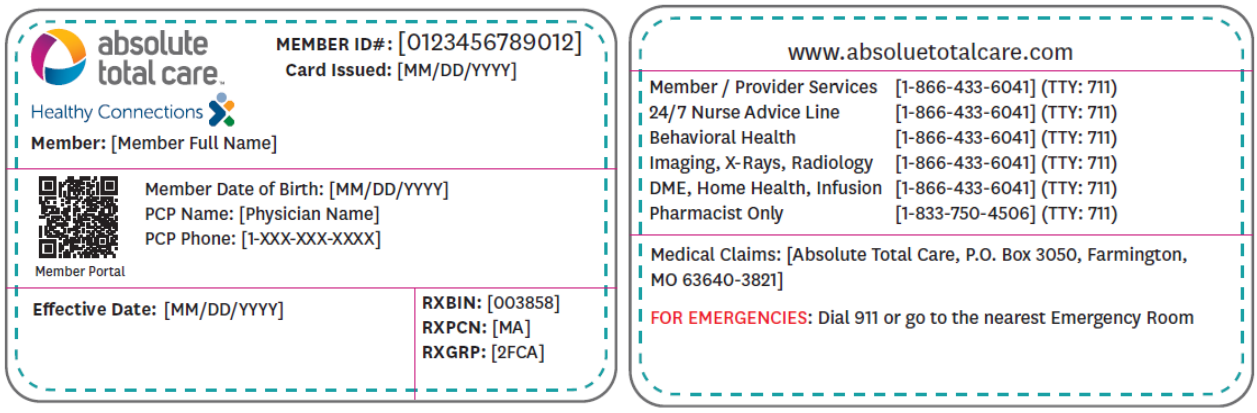
- Providers can login to Availity Essentials or the Secure Provider Portal to verify eligibility and verify benefits. Availity Essentials is the preferred option.
- Providers may also call provider services at 1-866-433-6041. You will be asked to supply the member's name and date of birth or the member's Medicaid identification number and date of birth.
- You can confirm eligibility by using these options if the required member identifiers are provided.

How are members notified of enrollment into Absolute Total Care?

- Members are mailed a New Member Welcome Packet and Member ID card within 14 calendar days of receipt of enrollment from SCDHHS. If a member has not received their information, please encourage the member to contact Absolute Total Care Member Services to update their mailing address on file. Members can also update their mailing address using the Secure Member Portal or Mobile App.

How can I identify an Absolute Total Care member?

- Members will present with a Member ID card that displays the logo for Absolute Total Care logo and plan information. Below is an example of the Absolute Total Care ID card:



Prior Authorization

How do I submit Prior Authorization requests?

- Providers can login to Availity Essentials or the Secure Provider Portal submit prior authorization requests. Availity Essentials is the preferred option.
- Providers may also complete the Outpatient Prior Authorization Form and fax to 1-866-912-3606.
- Standard prior authorization requests should be submitted for medical necessity review at least 10 calendar days before the scheduled service delivery date or as soon as the need for service is identified.
- Urgent requests will be reviewed within 72 hours from the time the request has been received. Per the ATC Provider Manual Urgent is defined as “Services furnished to treat a medical condition that requires attention within 48 hours. If the condition is left untreated for 48 hours or more, it could develop into an emergency condition.
- Non-urgent requests will be reviewed within 7 calendar days from the time the request has been received.

What needs to be submitted with a Prior Authorization request for Incontinence Supplies?

- To submit an incontinence supply prior authorization, you must provide a Physicians Order/Prescription, Certificate of Incontinence (COI), and recent clinical notes (within 6 months) documenting the diagnosis and daily supplies/quantity needed. The certificate of incontinence must be signed by the physician within a year and requested quantity of supplies is within the Medicaid FFS parameters.
- Providers may also complete the Outpatient Prior Authorization Form and fax to 1-866-912-3606.

What is the authorization period for incontinence supplies?

- Authorizations are typically approved for up to 30 days, and each authorization will include specific start and end dates. If the authorization period expires and services are still needed, it is necessary to submit a new authorization request.

Is Absolute Total Care confirming proper terminations are in place with previous supplier before Absolute Total Care transitions a member to another provider?

- We will honor previous prior authorizations during the 180-day Continuity of Care period regardless of network participation status. Non-participating providers will be notified in advance if a member chooses to move to an in-network provider before the end of the 180-day Continuity of Care period. For all members using non-

participating providers, they will be given the option to choose from in-network providers and will be transitioned to an in-network provider at the conclusion of the 180-day Continuity of Care period.

Claim Submission and Payment

Where do I submit claims?

- Providers can login to Availity Essentials or the Secure Provider Portal to submit and manage claims. Availity Essentials is the preferred option.
- Paper claims can be submitted to:
  Absolute Total Care
  Attn: Claims Department
  PO Box 3050
  Farmington, MO 63640-3821

What is Absolute Total Care's Payor ID?

- Absolute Total Care's Payor ID is 68069.

What information needs to be included on claims?

- Providers are to use standardized claim forms whether filing on paper or electronically. The appropriate CMS billing form for paper and EDI claim submissions for durable medical equipment (DME) on a CMS 1500 form. Information commonly required of a clean claim on a CMS 1500 form includes:
  - Full member name
  - Member date of birth
  - Member identification number
  - Member gender
  - Appropriate Clinical Laboratory Improvement Amendments (CLIA) number for all laboratory services
  - Complete service level information, including:
  - Date of service
  - Diagnosis
  - Place of service
  - Procedural coding (appropriate CPT-4, ICD-10 codes)
  - Charge information and units
  - Servicing provider's name and address
  - Provider's NPI
  - Provider's federal tax identification number
  - Information on other coverage *(if applicable)*
- Additional information on claim requirements can be found in the Absolute Total Care Medicaid Provider Manual online.

Can I submit paper claims?

- Absolute Total Care encourages all providers to submit claims electronically. Providers who choose not to submit claims electronically may submit claims directly to Absolute Total Care via paper. Absolute Total Care only accepts the most current CMS 1500 paper claims forms. Other claim form types will be rejected and returned to the provider.
- All paper claim forms must be completed with Times New Roman font in either 10 or 12 point, typed using blue or black ink, and on the required original red-and-white version to ensure clean acceptance and processing.

Black-and-white forms or handwritten forms will be rejected and returned to the provider. To reduce document handling time, providers should not use highlights, italics, bold text or staples for multiple page submissions.

- Submit all claims in a 9" x 12" or larger envelope to:
  Absolute Total Care
  Attn: Claims Department
  PO Box 3050
  Farmington, MO 63640-3821

How long does it take for Absolute Total Care pay claims?

- Absolute Total Care pays clean claims within 30 days of receipt, with an average processing time of 12 to 15 days.

Should I register for PaySpan?

- Absolute Total Care partner's with PaySpan to provide 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. For more information and to register, visit the PaySpan page on our website.
- Providers that chose not to register with PaySpan will receive payment via Virtual Credit Card (VCC) through Zelis. VCC payments work like any other credit card payment. Providers follow the same process as taking a credit card payment from a patient. Here's how it works:
  - A printed Explanation of Payment includes a 16-digit card number.
  - The provider enters the card number and the full amount of the payment into the credit/debit point-of-sale terminal before the expiration date.
  - Funds are received in the same timeframe as other credit card payments.
  - There is no need to enroll to receive VCC payments as they are processed under the merchant agreement with the provider's existing banking partner.
  - Note the merchant/banking partner charges fees for the payment transaction. These fees are in lieu of the check clearing fees being paid.

Where can I find the fee schedule and how often is the fee schedule updated?

- Absolute Total Care pays according to the Medicaid allowed codes and fee schedule. Updates to billing-related codes or fee schedules become effective on the date that is the latter of the first day of the month following 30 days after publication by SCDHHS or the effective date of such code/fee updates, as determined by such governmental agency. Claims processed prior to the Code/Fee Change Effective Date will not be reprocessed to reflect any code updates.
- Fee schedules can be found online by visiting www.scdhhs.gov and navigating to Providers >> Fee Schedules.

Accessing Digital Tools

How do I access Availity Essentials?

- Availity Essentials is available to participating and non-participating providers at no charge to the provider.
- Absolute Total Care encourages you to use Availity Essentials for transactions such as verifying member eligibility and benefits, submitting claims, checking claim status, submitting authorizations, and more.
- With an active Availity Essentials account, providers will have immediate access to new health plans and features as soon as they become available.
- If you already work in Availity Essentials, you can log in to your existing Essentials account.
- 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 need additional assistance with your registration, please call Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday, 8 a.m. – 8 p.m. EST.

How do I access the Secure Provider Portal?

- If you are a contracted provider, you can register now to use the Secure Provider Portal.
- If you are a non-contracted provider, you will be able to register after you submit your first claim. To enter our Secure Provider Portal, select that you are a Medical Provider and click submit. After creating an account within the Absolute Total Care Secure Provider Portal, you can:
- The user manual is available on the secure portal, after you successfully complete the log in process.
- The Secure Provider Portal will be retired at undetermined date in the future and providers will be notified in advance. Availity Essentials is the preferred tool as it will be in the digital option in the future, but both are available options at this time.

Network Participation

I am currently a contracted provider with Absolute Total Care; will I have to sign a new contract to continue seeing my patients enrolled into Absolute Total Care?

- Providers contracted with Absolute Total Care do not need to do anything additional to provide services for patients enrolled in Absolute Total Care Medicaid Managed Care Plan. Providers are encouraged to visit absolutetotalcare.com/providers for manuals, forms, and resources related to claims submission, eligibility, prior authorization, and more. If you have additional questions about participation status, contact your Provider Engagement Account Manager or Provider Services at 1-866-433-6041.

How do I join the Absolute Total Care provider network?

- Providers interested in joining the Absolute Total Care provider network should submit a request to the Network Development and Contracting Department via email at atc_contracting@centene.com.

How long does the process take to become a participating provider?

- Approximately 60 days from receipt of executed agreement and credentialing application.

What credentialing and recredentialing?

- Credentialing verifies that providers possess the necessary education, training, licensure, and experience to deliver quality care. Providers must submit a complete credentialing application with, at a minimum, Current General Liability Insurance Policy Fact Sheet that includes expiration dates and amounts of coverage, other applicable current state/federal/licensures (i.e., CLIA, DEA, South Carolina Controlled Substance Certificate, Pharmacy, or Department of Health), copy of current accreditation/certification by a nationally recognized accrediting body or site evaluation results by a government agency if not accredited, attestation of current professional liability coverage in the minimum amounts of $1,000,000 per occurrence and $3,000,000 aggregate, copy of current CMS Certification, if applicable, W-9 Form and ability to demonstrate enumeration by NPPES, depicting the provider's unique NPI. Recredentialing occurs every 36 is based on the initial credentialing date, and Absolute Total Care will notify providers when it is due.

Other

Did wavier services transition to MCOs on January 1, 2026, for the population that was carve-in?

- Waiver services will continue to be authorized through the FFS delivery model. However, for dates of service on and after January 1, 2026, claims for medical services, also referred to as "State Plan services" for members who are enrolled in the three waiver programs should be submitted to the managed care organization (MCO) in which the member is enrolled. Additional information can be found online by visiting www.scdhhs.gov and navigating to Partners >> Managed Care >> Managed Care Carve-In.

What training resources are available?

- Providers can find additional resources, such as the Provider Manual and Provider News, and training by visiting the For Providers page at absolutetotalcare.com.

Who do I contact with questions?

- Please contact Provider Services at 1-866-433-6041 or the Provider Engagement Account Manager for Durable Medical Equipment providers.