Table of Contents

Chapter 1: Welcome to Absolute Total Care 8
Key Contacts and Important Phone Numbers 9
Medicaid in South Carolina 10
About Absolute Total Care 10
Guiding Principles 10
Informational Tools for Providers 12
Website 12
Availity Essentials 12
Secure Provider Portal 13
Member Benefits 13

Chapter 2: Member Eligibility 14
Eligibility Determination 14
Managed Care Enrollment 14
Member ID Card 15
Verifying Member Eligibility 15
Methods to Verify Eligibility 15
Preferred Method 15
Other Methods 15
Newborn Enrollment 16
Dual Eligible Enrollment 16

Chapter 3: Credentialing and Recredentialing 17
Credentialing and Recredentialing Overview 17
Credentialing Requirements for 18
Requirements for Practitioners 18
Certification and Licensing Requirements 20
Credentialing Committee 22
Recredentialing 23
Practitioner and Provider Credentialing Rights 23
Right to Appeal Adverse Credentialing Determinations 24
Practitioner Addition to Existing Practice 24
Demographic Updates 24

Chapter 4: Utilization Management and Prior Authorization 26
Utilization Management Program Overview 26
Utilization Management Contact Information 27
Utilization Management Criteria 27
Clinical Practice Guidelines 28

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Medical Necessity 28
Routine Services 29
Urgent Services 29
Emergency Services 29
Post-Stabilization Care Services 30
Observation Bed Guidelines 31
Referrals 31
Second Opinions 32
Services Requiring Prior Authorization 32
Clinical Criteria Requirements 33
Submitting Prior Authorization Requests 33
Timeframes for Requests and Notifications 34
Timeliness of Decisions 36
Standard Pre-Service Authorization Determination 36
Urgent or Expedited Pre-Service Determination 36
Concurrent Review Determination 36
Retrospective Review Determination 36
Peer-to-Peer Process 36
Evolent Authorizations 37
Continuity of Care 37
Continuity of Care for New Members 38
Continuity of Care Following Provider Termination 38
New Technology 38

Chapter 5: Provider Requirements for Pregnant Members and Newborns 40
Notice of Pregnancy 40
Pregnancy-Related Care by Maternity Providers 40

Chapter 6: Provider Requirements for Treating Children and Youth 42
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services and Standards 42
Vaccines and Immunizations 44
Vaccines for Children Program 45

Chapter 7: Covered Benefits and Services 46
Core Benefits and Services Covered by Absolute Total Care 46
Additional Services Covered by Absolute Total Care 60
My Health Pays™ Rewards 62
Services Covered by Medicaid Fee-for-Service 62
Services Not Covered by Absolute Total Care 64

Chapter 8: Member Grievances and Appeals 66
Member Rights for Grievances and Appeals 66
Member Grievances Process 66
Member Appeals Process 67

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Medicaid State Fair Hearing 69
Continuation of Benefits 70
Assistance with Grievances and Appeals 70
Appointment of Authorized Representative 70
Ombudsman 71
Trending of Grievances and Appeals 71

Chapter 9: Case Management 72
Case Management Program Overview 72
Integrated Medical and Behavioral Health Approach 72
Identification of Members for Care Management 73
Care Management Process 73
Care Management Levels for Members 74
Care Coordination 74
Care Management 74
Complex Care Management 75
Intensive Care Management 75
Targeted Case Management 75
Foster Care Management 76
Case Management for Dual Members 76
Condition-Specific Programs 76
Asthma Program 76
Diabetes Program 77
Emergency Room (ER) Diversion Program 77
Lead Case Management Program 77
Perinatal/High Risk Obstetrical Program 77

Chapter 10: Quality Improvement Program 79
Quality Improvement Program Description 79
Quality Improvement Program Goals and Scope 80
Working with our Providers 81
Interaction with Functional Areas 82
Quality Improvement and Utilization Management Committee and Sub-Committees 83
Quality Improvement and Utilization Committee and Sub-Committees Overview 83
Quality Improvement and Utilization Management Committee 83
Credentialing Committee 84
Joint Oversight Committee 84
Peer Review Committee 84
Member Advisory Committee 85
HEDIS Steering Committee 85
Quality Improvement Activities 85
Monitoring Patient Safety/Quality of Care 85
Monitoring Provider Access and Availability 85
Monitoring Quality Outcomes 86

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Performance Improvement Projects 89

Chapter 11: Fraud, Waste and Abuse 91
Fraud, Waste and Abuse (FWA) 91
Special Investigations Unit 91
Provider Implementation of FWA Safeguards 91
False Claims Act 92
Health Care Laws 92
Direct Reporting of Fraud, Waste and Abuse 93
Authority and Responsibility 93

Chapter 12: Provider Rights and Responsibilities 94
Provider Bill of Rights 94
Provider Responsibilities 94
Provider Programs and Accountabilities 97
PCPs and the Patient-Centered Medical Home 97
Coordination Between Physical 98
Identifying and Reporting Abuse or Neglect 99
Telemedicine 99
Ordering, Referring, and Prescribing (ORP) Provider Enrollment Requirements 100

Chapter 13: Provider Administration 101
Provider Services and Supports 101
Access and Availability 101
Availability 102
Accessibility 102
24-Hour Access 103
Appointment Access Standards 103
Provider Office Standards 104
PCP Administration 105
Member Panel Capacity for PCPs 105
Referrals by PCPs 105
Nurse Practitioners as a PCP 105
Member PCP Change Request 106
Member Dismissal from a Panel 106
Unable-to-Locate Members 107
Provider Training 107
Provider Training Overview 107
New Provider Orientation 108
Required Training 108
Additional Training and Education 108
Provider Termination 109
Enrollment and Marketing Guidelines 109
Medical Records 109

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Medical Records Documentation 110
Medical Records Audits 111
Record Accessibility Policy 111
Medical Record Requests 111
Medical Record Release 112
Medical Records Transfer for New Members 112
Cultural Competency 112
Cultural Competency Overview 112
Preparing Cultural Competency Development 113
Provider Assistance with Cultural Competency Needs 114
Interpreter and Translation Services 114
Provider Assistance with Public Health Services 115
Additional Reporting Requirements 115

Chapter 14: Member Administration 117
Member Rights 117
Member Responsibilities 119
Advance Directives 120

Chapter 15: Pharmacy Program 121
Pharmacy Benefit 121
Pharmacy Policy 121
Pharmacy Prior Authorization 122
340B Medications 122
Over-the-Counter (OTC) Medications 123
Injectables and Oral Anti-Cancer Drugs 123
72-Hour Emergency Supply Policy 123
Continuity of Care/Transition of Care 123
Pain Management Safety and Resources 123
Exclusions 124

Chapter 16: Claims Coding and Billing 126
Risk Adjustment 126
Provider Billing Information 127
Required Provider Information 127
Changes in Billing Information 127
Coordination of Benefits 127
Processing by Other Insurance 127
Coordination of Benefits Processing 128
Encounter Versus Claim 128
Claim Submission 129
Claim Payment Process 130
Claims Payment: EFT and ERA 130
Billing Forms 130

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Verification Procedures 131
Clean Claim vs. Unclean Claim 132
Upfront Rejection vs. Denial 132
Upfront Rejection 132
Denial 133
Timely Submission 134
Electronic Claim Submission 134
Electronic Claim Submission Overview 134
Electronic Payor ID Numbers 134
Electronic Claim Flow Description 135
Online Claim Submission 135
Paper Claim Submission 136
Address for Filing Paper Claims 136
Edit Requirements 136
Acceptable Forms and Font 136
Imaging Requirements 137
Clinical Lab Improvement Act (CLIA) 138
EDI 138
Web 138
Paper Claims 139
Corrected Claims, Requests 139
Definitions 139
Corrected Claim Process 139
Process for Corrected Claims and Reconsiderations 140
Process for Provider Disputes 141
Billing the Member 143
Member Acknowledgement Statement 143
Balance Billing Prohibition 143

Chapter 17: Code Editing 145
Code Editing Overview 145
CPT and HCPCS Coding Structure 145
Level I HCPCS Codes 145
Level II HCPCS Codes 145
Miscellaneous/Unlisted Codes 146
Temporary National Codes 146
HCPCS Code Modifiers 146
International Classification of Diseases (ICD-10) 146
Revenue Codes 147
Edit Sources 147
Code Editing and the Claims Adjustment Cycle 148
Code Editing Principles 148
Unbundling 149
Frequency and Lifetime Edits 150

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Duplicate Edits 151
National Coverage Determination Edits 151
Invalid Revenue to Procedure Code Editing 151
Assistant Surgeon 151
Co-Surgeon/Team Surgeon Edits 151
Add-on and Base Code Edits 151
Missing Modifier Edits 151
Administrative and Consistency Rules 152
Prepayment Clinical Validation 152
Modifier 59 152
Modifier 25 153
Payment and Coverage Policy Edits 154
Claim Reconsiderations 154
Third-Party Liability 154

Definitions 156

Revision Log 169

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Chapter 1: Welcome to Absolute Total Care

Absolute Total Care appreciates your partnership as we work together to improve the lives of our members, your patients. We are here to support you, and we have many resources available to help.

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

Please consider using AbsoluteTotalCare.com as your first stop for information. It's easy to navigate and is updated frequently.

For important updates, please visit our For Providers page and Provider News articles.

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Key Contacts and Important Phone Numbers

Absolute Total Care provides a 24-hour help line to respond to requests for prior authorization. In addition, Absolute Total Care Provider Services staff are available Monday through Friday from 8 a.m. to 6 p.m. Eastern to answer provider questions and respond to provider complaints, emergencies and notifications. Absolute Total Care Member Services staff are available Monday through Friday from 8 a.m. to 8 p.m. Eastern to assist members. Calls received after business hours are routed directly to the nurse advice line.

After regular business hours, the provider services line is answered by an automated system. The line can provide callers with information about operating hours and a prompt to leave a voicemail. After-hours eligibility checks can be conducted in the Secure Provider Portal or in Availity. The following are key services that you may have questions about and the phone number for that service:

Contact	Phone Number	Fax/Web/Email
Provider Services	1-866-433-6041	
Member Services		
Interpreter Services		
Medical Inpatient and Outpatient Prior Authorizations		1-866-912-3606
Concurrent Review/Clinical Information		1- 866-653-6349
Medical Records /Face Sheets / Census Reports		1-866-653-6349
Notification of Pregnancy		1-866-653-6961
Behavioral Health Prior Authorizations		Inpatient: 1-833-493-3349 Outpatient: 1-833-493-3350
Appeals and Grievances		1-866-918-4457
Care Management		1-833-418-3676
24/7 Nurse Advice Line		
Peer to Peer		Medicaidp2p@centene.com
Centene Vision		CenteneVision.com
Transplants	1-866-447-8773	1-866-753-5659 or 1-833-414-1668
Centene Pharmacy Services	1-800-460-8988	
Pharmacy Prior Authorization	1-866-399-0928	1-833-982-4001
AcariaHealth Specialty Pharmacy Services	1-800-511-5144	
Evolent	1-866-312-9729	RadMD.com 1-800-784-6864

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PaySpan	1-877-331-7154	

Medicaid in South Carolina

The Medicaid program, as established by Title XIX of the Social Security Act, as amended, promotes quality health care to low-income, disabled and elderly individuals by utilizing state and federal funds to reimburse providers for covered health services. This care includes diagnosis, treatment and management of illnesses and disabilities.

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan for Medical Assistance.

Managed care organizations: The managed care model is a fully capitated plan that provides a core benefit package like the one provided under the current Medicaid program. These models usually include additional services and benefits above the core Medicaid benefit package.

About Absolute Total Care

Absolute Total Care, a wholly-owned subsidiary of Centene Corporation, is a South Carolina licensed Health Maintenance Organization/Managed Care Organization (MCO) contracted with the South Carolina Department of Health and Human Services (SCDHHS) to provide Medicaid managed care – including behavioral health — to members in all South Carolina counties. For more than 40 years, Centene has provided comprehensive managed care services to Medicaid populations and operates health plans throughout the United States.

Under its current contract with SCDHHS, Absolute Total Care provides full-risk managed care services to Medicaid beneficiaries within South Carolina. Absolute Total Care members can receive full MCO benefits up to age 65. In January 2026, Absolute Total Care expanded coverage to Medicaid members aged 18 and older receiving full Medicare and Medicaid benefits (duals), or are in a nursing facility, and/or members enrolled in either the Community Choices, HIV or Ventilator Dependent waiver.

Absolute Total Care will serve our South Carolina members consistent with our core philosophy that quality healthcare is best delivered locally. Absolute Total Care utilizes an integrated model of care that incorporates both physical health and behavioral health. Absolute Total Care's mission is to improve the health of the community, one person at a time.

Guiding Principles

Absolute Total Care's top priority is the promotion of high-quality care and outcomes through preventive healthcare and evidence-based care of chronic conditions. Absolute Total Care works to accomplish this goal by partnering with primary care providers (PCPs), who oversee the healthcare of Absolute Total Care members and work toward Absolute Total Care's mission to

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transform the health of the community, one person at a time.

Using an integrated model of care, Absolute Total Care partners with behavioral health providers, specialists and ancillary providers as part of a whole-person philosophy to healthcare.

Absolute Total Care is committed to the philosophy of providing appropriate treatment at the least restrictive level of care that meets the member's needs. Individualized consideration and evaluation of each member's treatment needs are required for optimal medical necessity determination.

To attain those goals, Absolute Total Care follows these guiding principles:

- Embrace a culture of diversity
- Forge local partnerships to enable meaningful, accessible healthcare
- Foster open, consistent and two-way communication
- Foster teamwork
- Innovate and encourage challenges to the status quo
- Operate at the highest ethical standards
- Remove barriers to accessing care
- Treat people with kindness, respect and dignity
- Treat the whole person

Absolute Total Care believes quality healthcare is best delivered locally, and that successful managed care is delivered via appropriate, medically necessary services rendered in the appropriate setting – not by eliminating such services. As such, it is committed to providing access to high-quality, culturally sensitive healthcare services by building a collaborative partnership with PCPs, specialists, behavioral health providers, ancillary providers, and facilities.

Absolute Total Care's programs, policies and procedures are designed to:

- Encourage quality, continuity and appropriateness of medical and behavioral health care
- Ensure access to primary and preventive care services
- Ensure access to services to manage chronic conditions and provide other needed care
- Ensure care is delivered in the best and least-restrictive setting to achieve optimal outcomes
- Ensure member and provider satisfaction
- Provide coverage of benefits in a cost-effective manner

Absolute Total Care allows open provider and member communication regarding appropriate treatment alternatives. Absolute Total Care does not penalize providers for discussing medically necessary, appropriate care or treatment options with members.

All Absolute Total Care programs, policies and procedures are designed to minimize administrative responsibilities in the management of care, enabling providers to focus on the health needs of their patients.

Absolute Total Care conducts its business affairs in accordance with the standards and rules of ethical business conduct and abides by all applicable federal and state laws. Absolute Total Care takes the privacy and confidentiality of members' health information seriously and its processes, policies and procedures comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy law requirements. For questions regarding these privacy practices, please contact the privacy officer at 1-866-433-6041.

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Absolute Total Care follows the Section 1557 nondiscrimination provision of the federal Affordable Care Act (ACA). Sex discrimination includes, but is not limited to, discrimination based on an individual's sex, including pregnancy, medical related conditions, termination of pregnancy, gender identity and sex stereotypes. The law prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs or activities.

Informational Tools for Providers

Absolute Total Care uses the following tools to inform providers of new programs, requirements and policies:

- Communications sent via mail, email or fax
- Provider News
- Provider Newsletter
- New Provider Orientation
- Provider Town Halls
- Provider Quick Reference Guide
- Website
- Availity Essentials to validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources
- Secure Provider Portal to verify member eligibility, manage claims and authorizations
- Web-based materials, including provider directory, provider manual and other provider resources, including policies and procedures on AbsoluteTotalCare.com
- Web-based trainings
- Workshops led by certified trainers on a variety of specialized topics, including behavioral health

Website

Providers can visit Provider Resources to learn more about Absolute Total Care policies, processes, trainings and quality programs. In addition, providers may:

- Access payment and clinical policies
- Access frequently used forms
- Access provider webinar schedules
- Access the most recent Provider Manual
- Access billing and claims reference guides
- Access Find a Provider directories
- Access vendor information
- Complete required trainings using the Provider Training website
- Access the link for Availity Essentials to see gaps in care; including HEDIS
- Register and access Absolute Total Care's Secure Provider Portal
- Sign up for electronic funds transfers (EFT) via PaySpan
- Utilize the Provider Engagement Account Manager link to identify the Provider Engagement Account Manager assigned to your practice, group or facility

Availity Essentials

Availity Essentials allows providers and their office staff to verify member eligibility and benefits,

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submit claims, check claim status, submit authorizations, and more. Providers can find additional functionality in the Health Plan's payer space on Essentials as they become available and use the heart icon to add apps to My Favorites in the top navigation bar. Users can also save provider information in Availity Essentials and auto-populate it to save time and prevent errors.

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 Providers when our current secure portal is retired.

We encourage you to use Availity Essentials for transactions. If you already work in Essentials, you can log in to your existing Essentials account to access these tools today.

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.

Secure Provider Portal

Absolute Total Care allows providers and their office staff to register for the Secure Provider Portal. On the secure site, providers can use tools that make obtaining and sharing information seamless. Through the secure site, providers can:

- Contact Absolute Total Care securely and confidentially
- Submit claims and check claim status
- Submit claim reconsiderations
- Resubmit claim adjustment and reconsideration for payments online
- Submit prior authorization requests
- Submit attachments for claims and resubmitted claims for payment reconsiderations and primary payer information for secondary payment
- Update certain provider information such as phone number and address
- View and print enrollee eligibility
- View patient list
- Submit referrals to case management
- Complete the provider notification of pregnancy
- View disease management and case management indicators
- View eligibility history for all products
- View provider analytics and pay-for-performance reports

Member Benefits

Absolute Total Care provides an extensive menu of benefits and additional services. Additional services are extra benefits or services we provide at no cost to members. In addition, some covered services require prior authorization. To see a list of benefits and additional services as well as those services requiring prior authorization, go to AbsoluteTotalCare.com.

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Chapter 2: Member Eligibility

Eligibility Determination

Medicaid eligibility in South Carolina is determined by the South Carolina Department of Health and Human Services (SCDHHS) or the Social Security Administration (SSA), which determines eligibility for individuals receiving Supplemental Security Income (SSI). SCDHHS determines Medicaid eligibility for:

- Children
- Pregnant women and infants
- Parents and caretaker relatives of children
- Former foster care individuals
- Aged, blind or disabled (ABD) individuals
- Individuals in Nursing Facilities and/or Receiving Home and Community-Based Waiver Services

Managed Care Enrollment

Until the actual date of enrollment with Absolute Total Care, the health plan is not financially responsible for services the prospective member receives. In addition, Absolute Total Care is not financially responsible for services members receive after coverage is terminated. However, Absolute Total Care is responsible for anyone who is an Absolute Total Care member at the time of a hospital inpatient admission and changes health plans during that confinement.

Member Enrollment for the South Carolina Healthy Connections Managed Care Program is limited to certain Medicaid Members who:

- Are not in a limited benefit category.
- Are not participating in a wavier program except for the following Home and Community Bases wavier programs:
    - Community Choices (CLTC)
    - HIV/AIDs (HIVA)
    - Mechanical Vent Dependent (VENT)
- Are not participating in the Program for All Inclusive Care (PACE) program
- Do not have HMO third party coverage except for those health plans administered by Medicare.
- Are not otherwise excluded from participation based on federal requirements or state laws or policies.

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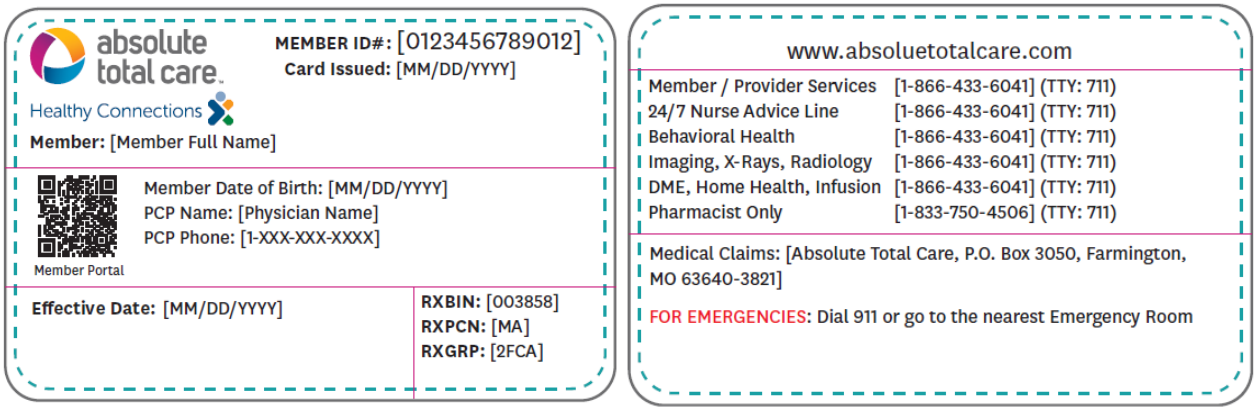
Member ID Card

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

Sample Identification Card



Verifying Member Eligibility

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

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

Methods to Verify Eligibility

Preferred Method

Providers are asked to verify member eligibility by using Availity Essentials or the Absolute Total Care Secure Provider Portal. Using either portal, registered providers can quickly check member eligibility by using member name and date of birth or Medicaid ID number and date of birth.

Other Methods

Providers may call provider services at 1-866-433-6041. For the member, they will need to provide the Member ID or last four SSN along with the member DOB.

If the secure portal or IVR lines are unavailable during regular business hours, providers may call the Provider Services number and speak to a representative.

Providers will be asked to supply the member's name and date of birth or the member's

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Medicaid identification number and date of birth.

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

Newborn Enrollment

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

Providers are encouraged to refer the mother to Absolute Total Care to select a PCP for their newborn. If the mother does not select a PCP after delivery, a PCP will automatically be assigned to the newborn. To make a PCP selection for the newborn, members should contact Member Services at 1-866-433-6041 (TTY: 711) or they can select a PCP in the Secure Member Portal or in the mobile app.

All providers are also encouraged to direct the mother to her county caseworker to ensure the newborn is officially deemed eligible for the Medicaid Program. Frequently, Absolute Total Care receives a claim(s) for a newborn prior to the state sending the member's eligibility information. It is imperative for providers to obtain a newborn's Medicaid ID number prior to billing for services. Without a Medicaid ID number on the claim, the claim will be denied.

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

Dual Eligible Enrollment

Medicaid members that are enrolled in Absolute Total Care's Medicare Dual Special Needs Plan (D-SNP), Wellcare By Absolute Total Care, will be mandatorily assigned into Absolute Total Care's corresponding Medicaid Managed Care Plan. Medicaid members that are enrolled in a Medicare product that is either fee for service or not of the same parent organization as the Medicaid Managed Care Plan will be assigned through the South Carolina Healthy Connections Medicaid assignment process if the Medicaid member does not choose a Medicaid Managed Care Plan.

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Chapter 3: Credentialing and Recredentialing

Credentialing and Recredentialing Overview

Absolute Total Care has established rigorous standards for the selection and evaluation of licensed independent practitioners and organizational providers to offer a high-quality network of experienced, licensed providers and facilities that are safe, clean and offer exceptional care. The application process focuses on the review and verification of each practitioner's license, education, certification/accreditation, experience, and quality-of-care attributes.

For consideration to participate in the Absolute Total Care network, each practitioner or provider must meet the minimum qualifications outlined by the South Carolina Department of Health and Human Services (SCDHHS), the National Committee for Quality Assurance (NCQA) and Absolute Total Care.

The Absolute Total Care Credentialing Department is responsible for verifying information from all medical and behavioral health practitioners and providers seeking to contract with Absolute Total Care.

Practitioners may include physicians, advanced registered nurse practitioners, physician assistants, podiatrists, chiropractors, social workers, counselors, psychologists and therapists (occupational, physical and speech).

All practitioners must fulfill the requirements for South Carolina licensure/certification and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession, as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor Licensing and Regulation (SCLLR). All practitioners must also be in compliance with all federal, state, and local laws.

Providers may include the following: hospitals, free-standing surgical centers, urgent care centers, diagnostic radiology centers, federal qualified health centers, community mental health centers, substance use treatment facilities, long-term rehabilitation centers, skilled nursing facilities, home health agencies, durable medical equipment providers, hospice facilities, and other services.

Absolute Total Care's partners and vendors are responsible for credentialing pharmacists and vision practitioners. Some practitioners and providers that are considered delegated entities follow Absolute Total Care's policies and perform their own credentialing under the auspices of an Absolute Total Care delegation contract with oversight by Absolute Total Care.

Once a practitioner or provider submits an application, the credentialing staff takes up to forty-five (45) calendar days to complete the credentialing process. Once the application is completed, Absolute Total Care's Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting. Recredentialing is performed at least every 36 months.

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Note: All practitioners and providers must be enrolled in the South Carolina Healthy Connections Medicaid Program. Practitioners and providers must be contracted and credentialed before accepting or treating members. PCPs are not permitted to accept member assignments until they are fully credentialed.

The process for practitioners involves several steps, including:

- Verification of the practitioner's license, Drug Enforcement Administration registration number, education, training, board certifications and hospital privileges
- Determination of any malpractice history, sanctions or exclusions, legal actions and Medicare opt-out status, if applicable
- Verification of the practitioner's Social Security number, Level 2 background check and unsanctioned ownership of the practice
- Confirmation of work history

The process for credentialing providers includes:

- Verification of the facility's license and accreditation with appropriate governing bodies
- Determination that the facility is in good standing with state, federal and regulatory agencies
- Verification of unsanctioned ownership of the facility

All participating practitioners and providers are required to go through the recredentialing process every 36 months. The recredentialing evaluation requires the verification of many of the same primary sources required in the initial credentialing process, as well as a summation of all practitioners' performance measured against current utilization and quality standards.

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

Credentialing Requirements for Practitioners and Providers

The credentialing and recredentialing processes ensure participating practitioners and providers meet the criteria established by Absolute Total Care, government regulations and the standards of accrediting bodies. To maintain a current profile, practitioners and providers are required to promptly notify Absolute Total Care of any relevant changes to their credentialing information.

Requirements for Practitioners

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

- Complete signed and dated Absolute Total Care Standardized Credentialing Form or have a Council for Affordable Quality Health Care (CAQH) Provider ID with current and complete information. The application must include the following:
    - Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions and/or felony convictions; lack of current illegal substance and/or alcohol abuse; mental and

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physical competence and ability to perform the essential functions of the position, with or without accommodation; encouraged to report Practitioner race, ethnicity and language.

- Copy of current malpractice insurance policy fact sheet that includes expiration dates, amounts of coverage and provider's name
- Copy of current Federal Drug Enforcement Administration (DEA) Certificate
- Copy of current State Controlled Substance Certificate for South Carolina
- W-9 Form
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable)
- Copy of current unrestricted state license to practice in South Carolina
- Evidence of Specialty/Board Certification (if applicable)
- Proof of highest level of education (certificate or letter certifying formal post-graduate training) if practitioner is not board certified
- Copy of CLIA Certificate (if applicable)
- Ability to demonstrate enumeration by National Plan and Provider Enumeration System (NPPES), depicting the provider's unique NPI
- Nurse practitioners: current written protocol and name of preceptor (supervising) physician

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

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

Absolute Total Care verifies the following information submitted for credentialing and recredentialing purposes:

- Current, unrestricted state license to practice, if license is required to practice
- Education and training and/or board certification
- Reports of malpractice settlements via the National Practitioner Data Bank (NPDB)
- Current DEA Registration
- Hospital privileges in good standing at a participating Absolute Total Care hospital, if applicable
- Justification of gaps of six months or greater within the past five years of work history
- Medicare/Medicaid-specific exclusions and/or determination if disbarment, suspension, or other exclusion from participation in federal procurement activities via Office of Inspector General (OIG), System of Award Management (SAM), South Carolina Excluded Providers List(SC EPLS) and South Carolina Termination for Cause

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List
- Potential fraudulent activity by ensuring provider is not listed on the Social Security Administration's Death Master File
- Proof of professional and/or general liability coverage in an amount accepted by Absolute Total Care
- Proof of collaborative agreement, protocols, or other written authorization with a licensed physician (if applicable)

Certification and Licensing Requirements

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

Ambulance Transportation
- Must be licensed by the South Carolina Department of Public Health.

Ambulatory Surgical Center
- Must be surveyed and licensed by the South Carolina Department of Public Health and certified by CMS.

Certified Nurse Midwife/Licensed Midwife
- A certified nurse midwife must be licensed to practice as a registered nurse by the Board of Nursing under the South Carolina Department of Labor, Licensing and Regulations and certified as a nurse midwife by the Division of Competency Assessment.
- A certified nurse midwife must be licensed by the South Carolina Department of Public Health.
- A certified nurse midwife's services are limited by practice protocol.

Certified Registered Nurse Anesthetist (CRNA)/Anesthesiologist Assistant (AA)
- The Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse
- Anesthetists must license a CRNA to practice as a registered nurse in South Carolina in which he or she is rendering services and currently certified.
- A CRNA is authorized to perform anesthesia services only and may work independently or under the supervision of an anesthesiologist.
- An AA must be licensed to practice as an AA in South Carolina.

Dispensing Physician
- Must be licensed by the Board of Medical Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

End-Stage Renal Disease (ESRD) Clinic
- Must be surveyed and licensed by the South Carolina Department of Public Health and certified by CMS.

Federally Qualified Health Center (FQHC)
- Must have a Notice of Grant Award under 319, 330, or 340 of the Public Health Services Act and be certified by CMS.
- Provider's billing laboratory procedures must have a CLIA Certificate.

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Home Health

- Must be surveyed and licensed by the South Carolina Department of Public Health and certified by CMS.

Inpatient/Outpatient Hospital

- Must be surveyed and licensed by the South Carolina Department of Public Health and certified by CMS

Infusion Center

- There are no licensing requirements or certification for infusion centers.

Laboratory Certification

- In accordance with federal regulations, all laboratory-testing facilities providing services must have a CLIA Certificate of Waiver or a Certificate of Registration with CLIA identification number.
- Laboratories can only provide services that are consistent with their type of CLIA certification.

Long-Term Care Facility/Nursing Home

- Must be surveyed and licensed under state law and certified as meeting the Medicaid and Medicare requirements of participation by the South Carolina Department of Public Health.

Mail-Order Pharmacy

- Must be licensed by the appropriate state board.
- A special non-resident South Carolina permit number is required of all out-of-state providers. The Board of Pharmacy, under the South Carolina Department of Labor, Licensing and Regulations, issues such permits.
- Be enrolled in the South Carolina Medicaid program and receive official notification of enrollment.

Mammography Services

- The United States Department of Health and Human Services, Public Health Services and Food and Drug Administration must certify facilities providing screening and diagnostic mammography services.

Medical Professional

- Individual medical professionals must all have a current unrestricted license and be certified to practice by the appropriate board/licensing body. Medical professionals include, but are not limited to physicians, physician assistants, podiatrists, chiropractors, social workers, counselors, psychologists, private therapists and audiologists.

Nurse Practitioner and Clinical Nurse Specialist

- A registered nurse must complete an advanced formal education program and be licensed and certified by the South Carolina Board of Nursing under the South Carolina Department of Labor, Licensing and Regulations, or the appropriate medical board in South Carolina.
- Services are limited by practice protocol.

Pharmacy

- Permit must be issued by the Board of Pharmacy under the South Carolina Department of Labor, Licensing and Regulations.

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- Out-of-state pharmacies must be enrolled with the South Carolina Medicaid program to be reimbursed for any prescriptions dispensed to South Carolina Medicaid beneficiaries. Non-resident pharmacies (i.e., pharmacies located outside of South Carolina) whose primary business is filling mail-order prescriptions must have a special permit issued by the South Carolina Board of Pharmacy to engage in the sale, distribution, or dispensing of legend drugs or devices in South Carolina. This special non-resident South Carolina permit is required to be eligible for Medicaid participation

Physician Assistant

- A health professional that performs such tasks as approved by the State Board of Medical Examiners in a dependent relationship with a supervising physician or under direct personal supervision of the attending physician.

Physiology Lab

- Providers must be enrolled with Medicare.

Podiatrist

- Must be licensed by the Board of Podiatry Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

Portable X-ray

- Must be surveyed by the South Carolina Department of Public Health and certified by CMS.

Rural Health Center (RHC)

- Must be surveyed and licensed by the South Carolina Department of Public Health and certified by CMS.
- Providers billing laboratory procedures must have a CLIA Certificate.
- Laboratories can only provide services that are consistent with their type of CLIA certificate.

Stationary X-ray

- South Carolina Department of Public Health registration.

Credentialing Committee

The credentialing committee is responsible for establishing the criteria for practitioner and provider participation and termination; and direction of the credentialing procedures, including provider participation, denial and termination. The committee bases decisions solely on business needs, completeness of the applicant's file, and review of any sanctions or malpractice history, as applicable, and not on race, ethnic/national identity, gender, age, or sexual orientation, or the types of procedures or plan in which the provider specializes.

Committee meetings are held at least monthly, no less than ten times yearly.

Failure by the applicant to adequately respond to requests for additional information within 30 days of submission will result in discontinuation of the application process. Applicants wishing to be reconsidered for participation must resubmit all updated documentation.

In between credentialing cycles, Absolute Total Care conducts provider performance monitoring activities on all network practitioners/providers. This monthly inquiry is designed to monitor any new adverse actions taken by regulatory bodies against practitioners/providers between

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credentialing cycles. Additionally, Absolute Total Care reviews monthly reports released by the state Office of Inspector General to identify any network practitioners/providers who have been newly sanctioned or excluded from participating in Medicare or Medicaid.

Recredentialing

To comply with accreditation standards, Absolute Total Care conducts the recredentialing process for practitioners and providers at least every three years from the date of the initial credentialing decision.

The process identifies any changes in the practitioner's licensure, sanctions, certification, competence or health status, which may affect the ability to perform services the practitioner is under contract to provide. It also includes a review of provider-specific performance data, including information from member complaints/grievances and other quality improvement activities.

Additionally, between credentialing cycles, a practitioner or provider may be requested to supply current proof of any credentials such as state licensure, malpractice insurance, DEA registration or a copy of certificate of cultural competency training, which may expire before the next review process.

A provider's accreditation, licensure, Medicaid eligibility, inspection reports and complaint, grievance or quality of care/services trends may be reviewed between credentialing cycles.

A practitioner or provider's agreement may be terminated at any time if Absolute Total Care's board of directors or the credentialing committee determines the practitioner, or provider no longer meets credentialing requirements.

Practitioner and Provider Credentialing Rights

All providers and practitioners participating with Absolute Total Care have the right to review information obtained by Absolute Total Care to evaluate their credentialing/recredentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank and malpractice insurance carriers, as well as the South Carolina State Board of Medical Examiners and South Carolina State Board of Nursing for nurse practitioners. This does not allow a practitioner to review references, personal recommendations, or other information that is peer-review protected.

Should a practitioner believe any of the information used in the credentialing/recredentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to Absolute Total Care's Credentialing Department. Upon receipt of this information, the practitioner will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to Absolute Total Care. Absolute Total Care's Credentialing Committee will then include this information as part of the credentialing/recredentialing process.

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

Right to Appeal Adverse Credentialing Determinations

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

All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation with Absolute Total Care.

The Credentialing Committee will review the reconsiderations at the next regularly scheduled meeting but in no case later than sixty (60) days from the receipt of the additional documentation. If a hearing cannot be scheduled within six months due to the unavailability of the provider or practitioner or their representative, the request for the hearing is considered withdrawn. The committee will send the applicant a written response to his/her request within sixty (60) days of the final decision.

Practitioner Addition to Existing Practice

A contracted medical or behavioral health practice that would like to add a practitioner should email all relevant documentation to SouthCarolinaPDM@centene.com. Providers are encouraged to utilize the Provider Profile Sheet, available on our website under the Forms section of the Provider Resources tab. This document enables providers to submit requests to add multiple practitioners simultaneously and is applicable across all lines of business. The credentialing department will confirm receipt of the email and request any additional information if necessary.

What Are My Next Steps?

- Once your email is received, you will receive an automated email acknowledging your request from SouthCarolinaPDM@centene.com.
- Once the credentialing process is completed, the Credentialing Specialist emails the confirmation w/approval letters and the effective date to the initial requester (via email).

Demographic Updates

Providers should email all demographic changes to SouthCarolinaPDM@Centene.com. To request these changes, Providers are encouraged to use the Provider Profile Sheet, available on our website under the Forms section of the Provider Resources tab.

Additionally, the Secure Provider Portal offers a self-service option for Account Managers to update

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practice information under the “Manage Practice” tab.

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Chapter 4: Utilization Management and Prior Authorization

Utilization Management Program Overview

The purpose of the Absolute Total Care Utilization Management (UM) Program is to promote fair, impartial, and consistent utilization decisions and coordination of physical and behavioral health care for the health plan members. Through defined structures and processes, including assignment of responsibility to appropriate individuals, the UM Program serves to:

- Objectively and consistently monitor and evaluate the delivery of high quality and cost-effective services.
- Make evidence-based decisions that take into consideration medical necessity, appropriateness, and availability of benefits.
- Ensure confidentiality of personal health information; and
- Initiate process improvement activities to enhance UM practices.
- Utilization management decisions are made without bias or discrimination against gender identity, sexual orientation, culture, language, race, age, or other protected classes.

The goals of the UM Program are to optimize a member's health status, sense of well-being, productivity, and access to quality health care, and aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

The UM Program seeks to advocate for appropriate utilization of resources and achieves UM goals through the following program components: 24-hr nurse triage, prior authorization/precertification, second opinion, concurrent review, complex discharge planning, ambulatory review, and retrospective review for medical and behavioral health care services. Additional program components implemented to achieve the program’s goals include:

- Monitoring trends of service approvals, denials, terminations, reductions, and suspensions to identify opportunities to address over and underutilization, improve processes and provide targeted staff and provider training.
- Building and maintaining interactive relationships with practitioners and providers to promote appropriate practice standards.
- Referral to hospital discharge planners and dialogue with the primary care physician (PCP) to determine post-charge and ongoing care needs. The PCP is responsible for assuring appropriate utilization of services along the continuum of care.
- Monitor all member discharge plans from physical and behavioral health inpatient admissions to ensure that they include the member, member’s caregiver and applicable

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providers and promote continuity with existing behavioral health therapeutic relationships.

Utilization Management Contact Information

The UM department is staffed Monday through Friday from 8 a.m. to 6 p.m. Eastern (excluding holidays).

Providers should call Provider Services at 1-866-433-6041 and select the prompt for authorization. After hours, weekends and holidays, please contact 1-866-433-6041 for urgent and emergent access to the UM Department for clinical determinations. Authorization requests can also be faxed to:

- Medical Authorization: 1-866-912-3606
- Outpatient Behavioral Health Authorization: 1-833-493-3350
- Inpatient Behavioral Health Authorization: 1-833-493-3349

Utilization Management Criteria

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

Practitioners also can discuss any medical UM denial decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. Absolute Total Care's Medical Director may be contacted by calling the UM Department at 1-866-433-6041 and asking for the medical director. Absolute Total Care delegates UM reviews to approved delegates, vendors, medical director specialists, or other appropriate entities. Please refer to and pay careful attention to all communications and written correspondence such as RFI (requests for information) or denial notices for contact information and instructions to discuss the determination, schedule a peer-to-peer (P2P), submit requested or additional information. Failure to follow instructions may result in delay,

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denial, misplaced, misrouted, or other similar adverse decision actions. A Care Manager may also coordinate communication between the medical director and the requesting practitioner.

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

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

Clinical Practice Guidelines

Absolute Total Care adopts preventive and clinical practice guidelines from evidence-based sources to provide acute, chronic and behavioral health services relevant to member health needs or for identified opportunities for improvement. The criteria in the clinical guidelines are used to ensure consistency with all decisions relating to utilization management, member education, and covered services.

Absolute Total Care adopts practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in a field
- Are adopted in consultation with providers
- Consider the needs of the members

Guidelines are presented to the quality improvement committee for appropriate physician review and adoption. They are updated at least annually or upon significant new scientific evidence or changes in national standards.

Providers may view Absolute Total Care's preventive and chronic condition management on our Practice Guidelines web page. If you would like more information or want to request a paper copy, please contact Provider Services at 1-866-433-6041.

Medical Necessity

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

- Essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid Managed Care Member.
- Are provided in the appropriate setting and at the appropriate level of care for the

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treatment of Member's medical condition.

- Are provided in accordance with objective and evidence-based criteria and standards of medical practice.

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

Routine Services

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

Urgent Services

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

Urgent care provided in an urgent care facility does not require prior authorization.

Emergency Services

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

Absolute Total Care covers emergency services furnished by a qualified individual provider or entity, regardless of network participation, that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services and needed to evaluate or stabilize an emergency medical condition. An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

During an episode of emergency care, Absolute Total Care does not require prior authorization, regardless of whether the member obtains a service within or outside Absolute Total Care's network. The facility should verify member eligibility as soon as possible after the member presents to the ER.

The PCP plays a major role in educating Absolute Total Care members about appropriate and inappropriate use of hospital emergency rooms. The PCP is responsible for following up on members who receive emergency care from other providers.

In emergency medical conditions the facility should use its best efforts to contact the PCP, or in the case of a pregnant woman, the member's OB. The facility should document all attempts to

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contact the PCP, or the obstetrician, and determinations made on appropriate care. At no time should emergency services be withheld or delayed.

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

Absolute Total Care covers any medically necessary duration of a stay in a non-participating facility resulting from a medical emergency until Absolute Total Care can safely transport the member to a participating facility. The attending emergency physician or treating provider is responsible for determining when the member is sufficiently stabilized for transfer.

Post-Stabilization Care Services

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

Absolute Total Care covers:

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

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- Transfer of a member presenting for emergency care to another medical facility.

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

- A Plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- A Plan physician assumes responsibility of the member's care through transfer;
- A Plan representative and the treating physician reach agreement concerning the member's care; or
- The member is discharged.

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

Observation Bed Guidelines

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

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

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

Referrals

A referral is considered a request to Absolute Total Care for authorization of services as listed on the prior authorization list. PCPs are not required to issue paper referrals but are expected to direct the member's care and assist with obtaining a prior authorization for referrals to

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certain services and all non-emergent, out-of-network practitioners as noted on the prior authorization list.

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition or when requested by any member of the member's health care team, including the member, parent and/or guardian, or a social worker exercising a custodial responsibility, may request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available. The second opinion is provided at no cost to the members.

Discharge Planning

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

Services Requiring Prior Authorization

Providers should refer to the Pre-Auth Check Tool to look up a service code to determine if prior authorization is needed. Under the Provider Resources section of our website, providers can find Inpatient and Outpatient Authorization Forms and specific service requirements and medical necessity criteria. Criterion used in decision-making is available upon request to the provider, member, or member's authorized representative by contacting the UM Department.

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

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

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

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experimental, investigational, or cosmetic procedures.

Prior authorization is not a guarantee of payment. Payment of claims is subject to all of the terms and conditions of the member's benefit plan, including but not limited to, member eligibility, benefit coverage at the time the services are provided and any pre-existing condition exclusions referenced in the member's benefit plan as well as provider contracts, correct coding and billing practices.

Clinical Criteria Requirements

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

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

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

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

Consistent with 438.3(i) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

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

Submitting Prior Authorization Requests

Prior authorization requires the provider to make a formal medical necessity determination request to the plan before the service may be rendered. The preferred and easiest method for submitting

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authorization requests is through Availity Essentials or the Secure Provider Portal. Providers should refer to the Pre-Auth Check Tool to look up a service code to determine if prior authorization is needed.

Absolute Total Care's Utilization Management Department hours of operation are 8 a.m. to 6 p.m. (EST), Monday through Friday (excluding holidays). Providers can call Provider Services at 1-866-433-6041 and select the prompt for authorization. After hours, weekends and holidays, please contact 1-866-433-6041 for urgent and emergent access to the UM Department for clinical determinations.

Fax Number Reference Guide	Fax Number
Absolute Total Care Medicaid Face Sheets	**866-653-6349**
Absolute Total Care Medicaid Inpatient Requests	**866-653-6349**
Absolute Total Care Medicaid Medical Records	**866-653-6349**
Absolute Total Care Medicaid Prior Authorization	**866-912-3606**
Absolute Total Care Medicaid Census Report	**866-653-6349**
Absolute Total Care Pharmacy Buy & Bill Prior Authorizations	**855-865-9469**
Absolute Total Care Inpatient Behavioral Health PA	**833-493-3349**
Absolute Total Care Outpatient Behavioral Health PA	**833-493-3350**
Absolute Total Care Transplants	**866-535-6974 or 833-414-1668**

Providers can find Inpatient and Outpatient Authorization Forms under the Provider Resources section of our website.

Timeframes for Requests and Notifications

Scheduled Inpatient Admission

Providers are required to notify Absolute Total Care **within 10 calendar days** prior to the proposed admission date for all pre-service, non-emergent, non-urgent elective, or scheduled inpatient admissions except for normal newborn deliveries. Approved authorizations for scheduled procedures and services are separate and applicable only to the specific procedure(s) and service(s) indicated by the CPT or HCPCS code(s) authorized, and not for the actual inpatient hospital admission.

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Inpatient facilities are required to notify Absolute Total Care **within one (1) business day** following the actual date of admission. Facilities should follow the Notification of Inpatient Admission (NOA) and authorization processes when a member is admitted to obtain an "IP" authorization for the admission. Inpatient authorization and notification is not required for in-network facilities if a member is admitted for observation level of care (LOC) of less than 48 hours.

- This requirement includes admission to any level of acute or sub-acute care, skilled nursing facilities, rehabilitation admissions, transplant services including pre- and post-transplant services and all other inpatient facility type admissions. This requirement also includes different levels of care within, in, or between facilities (i.e., transfer from acute to rehab or transfer to a different facility).

Emergent or Urgent Inpatient Admissions

Inpatient facilities are required to notify Absolute Total Care within one (1) business day following the actual date of admission for all emergent or urgent inpatient admissions. Clinical admission information must be provided. Facilities should follow the Notification of Inpatient Admission (NOA) and authorization processes when a member is admitted to obtain an "IP" authorization for the admission.

Newborn Deliveries

Notification of newborn delivery must be called in by the next business day after delivery.

- Absolute Total Care covers newborn or infant transfers to the original or lower level of care facility regardless of the reason for transfer.
- Prior authorization is not required for back transfers to the originating facility.
- Absolute Total Care covers medically necessary transfers designated by the attending physician.

Observation Stays

Inpatient facilities must notify the UM Department and provide clinical information for observation stays that **exceed 48 hours**.

Non-Inpatient Prior Authorization

All non-inpatient 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.

Out-of-Network and Out-of-State Providers and Services

Absolute Total Care realizes that there may be times when a member needs care from a provider who is not in Absolute Total Care's network or out-of-state. All services, excluding emergency and urgent care, always require prior authorization for any non-participating, out-of-network and/or out-of-state facility provider. Absolute Total Care will approve medical services if these services:

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

Based on Absolute Total Care's contract with SCDHHS, services provided by an out-of-network provider for which Absolute Total Care has adequate network coverage may be reimbursed at a

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rate below the Medicaid fee schedule.

Timeliness of Decisions

The Absolute Total Care UM Department responds to requests for authorization within established timeframes as determined by NCQA guidelines and SCDHHS requirements.

Standard Pre-Service Authorization Determination

Standard prior authorization requests should be submitted for medical necessity review at least **10 calendar days** before the scheduled service delivery date or as soon as the need for service is identified. Prior authorization decisions for non-urgent services shall be made within **7 calendar days** of receipt of the request for services. An extension may be granted for an additional **14 calendar days** if the member, the member's authorized representative, or the provider requests an extension or if Absolute Total Care can justify a need for additional information and the extension is in the member's best interest.

Urgent or Expedited Pre-Service Determination

In the event the provider indicates, or Absolute Total Care determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Absolute Total Care will make an expedited authorization determination and provide notice within **72 hours** of receiving the request through 12/31/2026, and within **48 hours** of receiving the request on and after 1/1/2027. All such requests must be indicated as **urgent** when submitting to Absolute Total Care. An extension may be made up to **14 calendar days** if the member, the member's authorized representative, or the provider requests an extension or Absolute Total Care justifies a need for additional information and the extension is in the member's best interest.

Concurrent Review Determination

Absolute Total Care makes determinations for urgent concurrent within **72 hours** of receipt of the request for services. A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by Absolute Total Care.

Retrospective Review Determination

Medical necessity of post-service decisions (retrospective review), if granted, and subsequent provider notification occurs no later than 30 calendar days from receipt of request.

Peer-to-Peer Process

The Peer-to-Peer Process (P2P) is available to any provider who receives a medical necessity denial. The intent of the P2P is to discuss the denial decision. Authorizations that are administratively denied or because no clinical information was submitted with the request are NOT eligible for a P2P.

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P2P must be requested within five (5) business days of the initial notification of the denial. Absolute Total Health has two (2) business days to acknowledge P2P requests.

To request a P2P, email Medicaidp2p@centene.com fax 1-866-918-4457, or call 1-866-433-6041.

The following information is needed to be considered a valid P2P request:

- Provider Name
- Provider Phone Number
- Member Name
- Member DOB
- Authorization #
- Caller's Contact Information
- Provider's available date(s) and time(s). Availability must be within 7 calendar days from the date we receive a valid P2P request.

Absolute Total Care will make every attempt to accommodate requested times; however, this may not be possible for narrow windows. Therefore, we recommend a minimum of a 2-hour window on at least 2 different days.

If the Absolute Total Care Medical Director returns the P2P request and leaves a message, the provider has one (1) business day to return the call, or the denial will be upheld, and the provider will need to file an appeal (with the written consent from the member).

Evolent Authorizations

Absolute Total Care has contracted with Evolent (formerly NIA) to provide utilization management for the services below. Evolent provides an interactive website, which should be used to obtain on-line authorizations.

- Complex imaging, MRA, MRI, PET, CT scans
- Interventional Pain Management
- Musculoskeletal Services
- Outpatient rehabilitative and habilitative physical medicine services including PT, OT, and Speech services in the outpatient office and outpatient hospital setting*
- Cardiac-related Procedures
- Oncology/supportive drugs for members age 18 and older

The program includes management of prior authorization. This program is consistent with industry-wide efforts ensuring that services provided to our members are consistent with nationally recognized clinical guidelines. Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of your claim. Please visit the Evolent website or Absolute Total Care website for more information.

Continuity of Care

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Continuity of Care for New Members

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

If a network provider cannot provide the same or clinically equivalent services without disrupting care to the member, Absolute Total Care approves the services without regard of network status until one or more of the following occurs: the service(s) are no longer medically necessary, or; service(s) can be initiated and continued by a network provider without disrupting care to the member; or clinically equivalent service(s) can be provided and obtained by a network provider without disrupting care to the member.

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

Continuity of Care Following Provider Termination

Providers who terminate their affiliation with Absolute Total Care have a responsibility to provide medically necessary care for members at least 90 days following their termination date.

Absolute Total Care permits members to continue receiving medically necessary services from a not-for-cause terminated provider and continues to process provider claims for at least ninety (90) days or until members select another provider.

Absolute Total Care must issue prior authorization for continuity of care when a provider is terminated.

New Technology

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

When a request is made for coverage with a new technology, which has not been reviewed by the Clinical Policy Committee, Absolute Total Care's Medical Director will review all information and make a one-time determination within two business days of receipt of all information. This new technology request will then be reviewed at the next regular meeting of the Clinical Policy Committee. If you need a new technology benefit determination or have an individual case review

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for new technology, please contact Provider Services at 1-866-433-6041. SCDHHS will be notified in writing thirty (30) days following any material change to the Population Health and Clinical Operations Program.

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Chapter 5: Provider Requirements for Pregnant Members and Newborns

Notice of Pregnancy

Practitioners should submit a notice of pregnancy (NOP) form to Absolute Total Care within thirty (30) days, or earlier, if possible, of the member's first prenatal visit and identify the estimated date of confinement and delivery facility.

The NOP form may be accessed and submitted electronically via the Secure Provider Portal. Once in the portal, click on the "Assessments" tab. The NOP Form can also be found our website under Provider Resources. Fax the completed NOP Form to 1-866-653-6961.

This information is used to identify members eligible to join the Start Smart for Your Baby® maternity case management program. The program's care managers educate pregnant members; address barriers (particularly those that contribute to poor birth outcomes); arrange appointments; and link members to community resources, such as the Women, Infants and Children (WIC) program.

Practitioners are encouraged to refer any pregnant members who may benefit from the Start Smart for Your Baby® program by calling 1-866-433-6041 Monday through Friday from 8 a.m. to 5 p.m. Eastern and selecting the case management prompt.

Pregnancy-Related Care by Maternity Providers

Absolute Total Care has adopted nationally recognized clinical practice guidelines from the American Academy of Family Physicians on prenatal care and related issues, including preconception care, folic acid, medication safety, nausea, vomiting, pregnancy complications and prenatal screening. Additionally, Absolute Total Care has adopted the American Congress of Obstetricians and Gynecologists guidelines for deliveries before 39 weeks.

Maternity providers are encouraged to follow these recommendations:

- Complete a pregnancy test and note results
- Complete a preterm delivery risk assessment by week 28
- Complete the notification of pregnancy form via the secure provider portal within 30 days of the first prenatal visit for incentive reward
- Discuss arrangements for delivery (especially for high-risk members), family planning and contraception alternatives, and the importance of timely childhood checkups for infants
- Discuss nutritional concerns and/or make referrals for:

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  - Breastfeeding and/or breast milk substitutes
  - Individualized nutritional counseling
  - Nutritional assessment
  - Nutritional care plan
- Document referrals and follow up appointments made during pregnancy
- Schedule return prenatal visits at least every four weeks until week 32; every two weeks until week 36; and every week thereafter until delivery; unless the member's condition requires more frequent visits, and document attempts to reschedule missed appointments
- Screen for tobacco use and offer counseling and treatment
- Schedule post-partum visit between 7-83 days after delivery

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Chapter 6: Provider Requirements for Treating Children and Youth

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

EPSDT is a program of comprehensive preventive health services available to Absolute Total Care recipients through the month of their 21st birthday. The program provides eligible members with physical, mental, vision, hearing, dental services and other screening/tests that are needed to treat and prevent health problems and conditions. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services. Absolute Total Care's EPSDT Program ensures that all medically necessary Medicaid covered services and screenings are provided either directly, through subcontracting or by referral.

EPSDT services include the following:

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

Standards for proving EPSDT services are in accordance with the South Carolina Department of Health and Human Services (SCDHHS) EPSDT program, which has adopted the American Academy of Pediatrics (AAP) / Bright Futures Recommendations for Preventive Pediatric Health Care (also referred to as the Bright Futures / AAP Periodicity Schedule) and are also described and included in the SCDHHS MCO Contract and SCDHHS Provider Manuals.

PCPs and pediatricians are responsible for performing these child health check-ups in their entirety according to the "Bright Futures" periodicity schedule to ensure children have routine health screenings combined with appropriate diagnosis, treatment, referrals and follow up. This schedule is available on the Absolute Total Care Practice Guidelines web page.

The components of these visits are as follows:

- **Comprehensive Health and Developmental History** Including assessments of both physical and mental health development.
- **Comprehensive Unclothed Physical Examination**.

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- **Appropriate Immunizations** According to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.
- **Blood Lead Screening** For children from the ages of six months through 72 months. A Lead Screening Questionnaire should be completed at the time of each routine office visit for children in this age group. All children are considered at-risk and must be screened for lead poisoning. CMS requires that all children receive a screening blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 5ug/dl obtained by capillary specimen must be confirmed using a venous blood sample.
- **Anemia Screening and Laboratory Test** As indicated, as well as is appropriate for age and risk factors (including a hematocrit or hemoglobin test performed between six and nine months of age and at least once during adolescence for menstruating females).
- **Blood Pressure** should be measured on children ages three and over at each screening.
- **Anticipatory Guidance/Health Education** Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms for the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- **Vision Screening** Vision should be assessed at each screening. In infants, the history and subjective findings of the ability to regard and reach for objects, the ability to demonstrate an appropriate social smile and to have age-appropriate interaction with the examiner is sufficient. At ages four and older, objective measurement using the age-appropriate Snellen Chart, Goodlite Test, or Titmus Test should be done and recorded. If needed, a referral should be made to an ophthalmologist or optometrist.
- **Dental Screening** A general assessment of the dental condition (teeth and/or gums) is obtained on all children, including fluoride treatments. Children with their first tooth eruption and age two and older should be referred to a dentist.
- **Topical Fluoride Varnish** The best practices of the American Academy of Pediatrics recommend that children up to three years old who are at high risk for dental caries should receive fluoride varnish application in their PCPs office during their EPSDT visit two times per year (once every six months) and in their dental home two times per year (once every six months). T. The PCP will bill procedure code 99188 for the application of topical fluoride varnish to Absolute Total Care on the CMS 1500 Claim Form.
- **Hearing Screening** A hearing test is required appropriate to the child's age and educational level. For the child under age four, hearing is determined by whatever method is normally used by a provider, including, but not limited to, a hearing kit. For the child over four, an audiometer, if available, is recommended. If needed, an appropriate referral should be made to a specialist. It is recommended that high-risk neonates be evaluated with objective measures, such as brain stem evoked response testing, prior to discharge from the hospital nursery.
- **Other Necessary Healthcare States** must provide other necessary healthcare, diagnosis services, treatment and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

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- **Periodic Screening** EPSDT beneficiaries are eligible to receive 20 screenings in 21 years of life. Screening ranges are determined according to age of the child and, in some circumstances, when last screened. EPSDT visits are recommended at the ages listed below.

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

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

Comprehensive periodic screenings must be performed according to the time frames identified in the periodicity schedule. In addition, a child may receive a child health check-up whenever it is medically necessary or requested by the child, the child's parent or the child's caregiver. If a child is diagnosed as having a medical problem, the child should be referred to and treated by the appropriate provider, such as a specialist, dentist, or physical therapist.

Preventive health and EPSDT services are a major principle on which Absolute Total Care is based, measured, and held accountable. Absolute Total Care will send reminders of the need for a well-child examination to all EPSDT-eligible members. A copy of Absolute Total Care's EPSDT Program description can be found at absolutetotalcare.com in the Provider Manuals and Forms section.

Vaccines and Immunizations

Absolute Total Care encourages all members who are 18 years or younger to be immunized by their PCP or pediatricians unless medically contraindicated or against parental religious beliefs. Providers shall report all immunizations to the Statewide Immunization Online Network (SIMON) administered by South Carolina Department of Public Health (SCDPH).

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

PCPs and pediatricians are required to:

- Provide immunizations in accordance with the "recommended childhood immunization schedule for the United States" or when medically necessary
- Provide for the simultaneous administration of all vaccines for which a member under the age of 21 years is eligible at the time of each visit

PCPs and pediatricians may follow only true contraindications established by the Advisory

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Committee on Immunization Practices ("ACIP"), unless:

- In making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate; or
- The requirement is not in compliance with South Carolina law, including laws relating to religious or other exemptions

The South Carolina Vaccines for Children (VFC) program provides routine vaccines and immunizations to children from birth through age 18 years who meet program eligibility, at no cost to the member or practitioners.

Vaccines for Children Program

Absolute Total Care requires contracted practitioners who administer vaccines to children to participate in South Carolina's Vaccines for Children (VFC) program. The South Carolina VFC program provides routine vaccines to children from birth through age 18 years who meet program eligibility, at no cost to the member or practitioners, and eliminates the practitioners' need to refer children to the local state health department. Absolute Total Care does not reimburse for vaccines that are covered under this program but will pay the administrative fee.

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

If a PCP does not routinely administer immunizations as part of their practice, the PCP may refer the child to the member's local state health department but must maintain a current record of the child's immunization status.

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Chapter 7: Covered Benefits and Services

Absolute Total Care members are entitled to all the benefits and services provided under the South Carolina Medicaid Program, plus more.

Core Benefits and Services Covered by Absolute Total Care

Core benefits and services include but are not necessarily limited to the following:

Ambulance Transportation

Prior Authorization Required for Some Services

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

Ancillary Medical Services

Prior Authorization Not Required

Services include, but are not limited to, anesthesiology, pathology, radiology, emergency medicine, inpatient dental facility charges, outpatient dental facility charges, and ambulatory surgical center charges for dental services.

Assertive Community Treatment (ACT) Services

Prior Authorization Required

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

Audiological Services

Prior Authorization Required

Audiological services include diagnostic, screening, preventive and/or corrective services provided to individuals with hearing disorders or for the purpose of determining the existence of a hearing disorder by or under the direction of an audiologist. A physician or other Licensed Practitioner of the Healing Arts (LPHA), within the scope of his or her practice

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under state law, must refer individuals to receive these services. Audiological services involve testing and evaluation of hearing-impaired children ages 20 years and younger who may or may not be improved with medication or surgical treatment. This includes services related to hearing aid use.

Autism Spectrum Disorder (ASD) Services

Prior Authorization Required

Services provided to eligible Medicaid beneficiaries ages 0 to 21 to treat ASD that must be recommended by a Licensed Psychologist, Developmental Pediatrician, or a Licensed Psycho-Educational Specialist (LPES) within his or her scope of practice under the South Carolina State law to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficacy of the individual. These services shall be provided in the Member's home, clinical setting, or other settings as authorized in the applicable section of the SCDHHS Services Provider Manual.

BabyNet Services

Prior Authorization Not Required

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

Bariatric Surgery

Prior Authorization Required

Bariatric surgery for morbid obesity is a covered service for members who meet guidelines for medical necessity.

Behavioral Health Evaluation

Prior Authorization Not Required

A maximum of one outpatient evaluation every six months is allowed for adult and child members.

Behavioral Health Office Visit

Prior Authorization Required for Some Services

Covered when rendered by a psychiatrist, physician assistant or nurse practitioner.

Behavioral Health Services

Prior Authorization Required for Some Services

All inpatient and outpatient behavioral health services including South Carolina Office Department of Behavioral Health and Developmental Disabilities (BHDD), Psychiatric Residential Treatment Services (PRTF), Autism Spectrum Disorder (ASD) and Rehabilitative Behavioral Health Services (RBHS) are authorized and provided by behavioral health clinicians.

Birthing Centers

Prior Authorization Required for Some Services

Absolute Total Care will cover obstetrical and newborn services provided by a birthing center

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licensed by SCDPH and enrolled in the Medicaid program.

Biopharmaceuticals (Specialty Injectables)

Prior Authorization Required

Specialty medications designed to treat complex diseases that includes self-injectable drugs, medications that require special distribution and/or are at limited supply, and certain oral oncology medications.

Chiropractic Services

Prior Authorization Not Required

Chiropractic services are available to all recipients. Chiropractic services are limited to manual manipulation of the spine to correct subluxation. Absolute Total Care's Chiropractic Network is Health Network Solutions (HNS). An HNS provider must render all chiropractic services. Limits: Six visits per year July 1 – June 30.

Circumcisions

Prior Authorization Required for Some Services

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

Communicable Disease Services

Prior Authorization Not Required

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

Diabetic Shoes

Prior Authorization Not Required

Absolute Total Care covers one pair per year and three inserts per year.

Diabetic Supplies

Prior Authorization Required for Some Services

Covered supplies include insulin pumps, test strips, lancets and pen needles. Quantity limits may apply.

Disease Management

Prior Authorization Not Required

Absolute Total Care offers interventions designed to improve and maintain the health of our members. Disease management services include the coordination, monitoring, and education of

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members to maximize appropriate self-management of chronic diseases. Members may attend classes and receive specific disease management bulletins and treatment updates, appointment reminder cards and informational mailings. Refer to ***Chapter 9: Case Management*** to learn more about Absolute Total Care disease management programs and how to refer members.

Dermatology Services

Prior Authorization Required for Some Services

Medically necessary visits and treatments for dermatological services are covered by Absolute Total Care. The acne diagnosis codes (L70.0 - L70.9, L73.0) are covered only when the patient is 18 years of age or younger (non-covered beginning on the 19th birthday), and the acne condition is infected, cystic or pustular. The keloid scar diagnosis L91.0 is covered only in severe cases with pain, intractable itching, or interference with range of movement. Services provided for cosmetic reasons are non-covered.

Developmental Evaluation Services

Prior Authorization Not Required

Medically necessary comprehensive neuro-developmental and psychological developmental, evaluation and treatment services for members between the ages of 0 through the month of their 21st birthday who have developmental delays and have been referred by a physician or other Licensed Practitioner of the Healing Arts (LPHA). These members have or are suspected of having a developmental delay, behavioral or learning disability, or other disabling condition. These services are provided only at the following Developmental Evaluation Centers:

- Department of Pediatrics at the Greenville Hospital in Greenville
- University School of Medicine, University of South Carolina in Columbia
- Medical University of South Carolina in Charleston

Durable Medical Equipment (DME)

Prior Authorization Required for Some Services

Equipment and supplies that provide therapeutic benefits and/or enables an individual to perform certain tasks s/he would otherwise be unable to undertake due to certain medical conditions and/or illnesses. DME equipment and supplies are primarily and customarily used for medical reasons and appropriate and suitable for use in the home.

The attending physician has the responsibility of determining the type or model of equipment and length of time the equipment is needed through a written necessity statement. Approval for Absolute Total Care coverage of products requiring prior authorization is patient-specific and is determined according to certain established criteria. Luxury and deluxe models are restricted if standard models are appropriate. Repairs to medical equipment are covered if reasonable. Prior authorization may be required for some DME.

Absolute Total Care follows SCDHHS DME rental guidelines:

- Capped rental equipment cannot initially be purchased. A capped rental item is only considered purchased when it has been rented for a maximum of 10 months. Some examples of capped rental equipment include manual hospital beds with mattress side rails, respiratory assist devices, insulin pumps, and standard manual wheelchairs.

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

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

Prior Authorization Not Required

EPSDT is a program of comprehensive preventive health services available to Absolute Total Care recipients through the month of their 21st birthday. The program provides eligible members with physical, mental, vision, hearing, dental services and other screening/tests that are needed to treat and prevent health problems and conditions. EPSDT services are offered in addition to medically necessary services available to all Medicaid members. Absolute Total Care's EPSDT Program ensures that all medically necessary Medicaid covered services and screenings are provided either directly, through subcontracting or by referral. Refer to ***Chapter 6: Provider Requirements for Treating Children and Youth*** for more information on the program and requirements.

Emergency Care

Prior Authorization Not Required

Absolute Total Care covers emergency services furnished by a qualified individual provider or entity, regardless of network participation, that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services and needed to evaluate or stabilize an emergency medical condition. An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

Enteral/Parenteral Nutrition Therapy

Prior Authorization Required for Some Services

Nutrition therapy provided via tube and sole source of nutrition for clients with chronic disease, growth problems, medically diagnosed anemias, elevated blood lead or other nutritional disorders.

End Stage Renal Disease (ESRD) Services

Prior Authorization Required for Some Services

Absolute Total Care covers ESRD services as the primary sponsor during the waiting period required by Medicare for eligibility determination. Once a determination of Medicare eligibility is received from the Social Security Administration Absolute Total Care will not

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cover ESRD services as the primary sponsor for any Medicare-covered services from the effective date of the Medicare eligibility. When it has been determined that the member is ineligible for Medicare coverage, Absolute Total Care will continue to cover ESRD services as the primary sponsor.

The ESRD facility, as the primary provider, is responsible for ensuring a Medicare application is made on behalf of the beneficiary and is encouraged to complete and submit the CMS Form 2728 within the first 30 days of the member's receipt of ESRD treatments. If a member is denied Medicare coverage, a copy of the Medicare denial letter must be faxed immediately to Absolute Total Care's ESRD Program Coordinator at 1-883-418-3676.

Family Planning Services

Prior Authorization Not Required

Covered services including examination, assessments, diagnostic procedures, health education, counseling, and traditional contraceptive drugs, supplies, and preventive contraceptive methods. All family planning services should be provided on a voluntary and confidential basis to all members, including those that are less than 18 years of age.

Members should be encouraged to receive family planning services through their PCP or by appropriate referral to promote the integration of these services with their total plan of care. Members have the freedom to receive family planning services from any appropriate Medicaid provider without any restrictions.

Fluoride Rinse and Varnish

Prior Authorization Not Required

Fluoride rinse and varnish is covered as part of EPSDT as recommended by the American Academy of Pediatrics.

Hearing Aids and Accessories

Prior Authorization Required

Absolute Total Care only covers hearing aids and hearing aid accessories for members aged 20 years and younger with prior authorization.

Home Health Care

Prior Authorization Required

Services delivered in a person's place of residence, excluding nursing homes and institutions, a doctor's office, outpatient clinic, an adult day center, or in another type of outpatient facility and include intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and physician-ordered supplies. These services cannot be restricted to a requirement that the individual be homebound. The use of a homebound requirement under the Medicaid home health benefit violates federal regulatory requirements at 42 CFR Section 440.230(c) and Section 440.240(b). These services have a limitation of 50 visits per member per year (July 1 through June 30).

Home Infusion Therapy Infusion Centers

Prior Authorization Required for Some Services

Services to provide medications, equipment, and supplies for members to receive

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intravenous or subcutaneous treatments at home, which are administered by a healthcare professional, family member, or the patient themselves.

Hysterectomies

Prior Authorization Required

Medically necessary, hysterectomies must meet the following requirements:

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

Laboratory and X-ray Services

Prior Authorization Required for Some Services

Services include laboratory and X-ray services, including genetic testing services ordered by a physician and provided by independent laboratories and portable and free-standing x-ray facilities. Quest Laboratory, Laboratory Corporation of America (LabCorp) and in-network local and regional laboratories are our preferred clinical laboratories. For a list of in-office laboratory testing covered by Absolute Total Care, please refer to the Physician's Office Lab Testing Payment Policy found on our on the Payment Policy page. CT, PET and MRI scans require prior authorization through Evolent. Evolent can be reached by calling 1-866-312-9729.

Inpatient Hospital Services

Prior Authorization Required

Services may include, but are not limited to, a full range of necessary diagnostic and therapeutic care including surgical, dental, medical, behavioral health, general nursing, radiological and rehabilitative services in emergency or non-emergency conditions provided under the direction of a Physician and are furnished to a patient who is admitted to an acute

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care medical facility for a period of time. Additional inpatient hospital services would include room and board, miscellaneous hospital services, medical supplies, and equipment. Medicaid will pay for a semi-private room only when it is medically necessary to have a private room. The need for this care must be medically necessary and is reviewed by the UM Department throughout the admission for appropriate level of care.

Inpatient Physician Visits

Prior Authorization Not Required

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

Maternity Services

Prior Authorization Required for Some Services

Maternity care benefits and services include prenatal, delivery, postpartum services, and nursery charges for a normal pregnancy or complications related to the pregnancy.

Newborn Hearing Screenings

Prior Authorization Not Required

Included in the Core Benefits when provided to newborns in an inpatient hospital.

Non-Elective Abortions

Prior Authorization Required

Covered according to applicable federal and state laws and regulations. All non-elective abortions, including spontaneous, missed, incomplete, septic and hydatidiform mole abortions, require only that the medical records verify such a diagnosis. Legible medical records should be included with all non-elective abortion claims and should include admission history and physical, discharge summary, pathology report, operative report and physician progress notes unless otherwise noted below.

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

OB Ultrasounds

Prior Authorization Not Required

Ultrasound imaging used in determining gestational age, fetal number, viability, and placental location and other medically necessary diagnostic purposes in obstetrics is covered. Refer to Ultrasounds in Pregnancy policy located on the Payment Policy page on our website for applicable limits.

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Oncology Services

Prior Authorization Required

Absolute Total Care will pay for medically necessary oncology and hematology services. All oncology-related chemotherapeutic drugs and supportive agents will require prior authorization from Evolent before being administered in a physician's office, outpatient hospital, or ambulatory setting. Evolent services are for in-network oncology/hematology providers submitting requests for members who are not pregnant and are 18 years of age and older. Log in to the Evolent Provider Web Portal or call 1-888-999-7713 to complete an authorization request. This process applies to the Medical Benefit (Buy and Bill Request).

Orthopedic, Musculoskeletal, Interventional Pain Management and Spinal Surgery Services

Prior Authorization Required

Absolute Total Care will pay for medically necessary orthopedic and spinal surgery services. Orthopedic and spinal surgery services require prior authorization through Evolent by phone (1-866-312-9729), fax (800-784-6864) or Evolent Provider Web Portal. The secure portal is the preferred and fastest method for submitting a prior authorization request.

Orthotics and Prosthetics

Prior Authorization Required for Some Services

Braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body.

Outpatient Services

*Prior Authorization Required for Some Services**

Emergency and non-emergency preventive, diagnostic, therapeutic, rehabilitative, surgical, mental health, facility services for dental and Emergency Services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding twenty- four (24) hours. Outpatient or ambulatory care facilities include hospital outpatient departments, diagnostic and treatment centers, ambulatory surgical centers, emergency rooms, End Stage Renal Disease (ESRD) clinics, pediatric HIV clinics, Intensive Outpatient Programs (IOP), and Partial Hospitalization Programs (PHP). **Emergency care does not require prior authorization for any participating or non-participating provider.*

Podiatry Services

Prior Authorization Is Required

Members may receive medically necessary podiatry care from an in-network PCP or a podiatrist.

Power Wheelchairs

Prior Authorization Is Required

Covered every seven years. Limited accessories are covered.

Primary Care After-Hours Services

Prior Authorization Not Required

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

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

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

Psychiatric Services

Prior Authorization Required for Some Services

Services including assessment, treatment plan development and modification and therapy services are covered for all members.

Physician Services

Prior Authorization Required for Some Services

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

Prescription Drugs

Prior Authorization Required for Some Services

Prescription drug benefits are managed through Absolute Total Care and administered by Absolute Total Care's pharmacy benefit manager. Absolute Total Care uses a Comprehensive Drug List (CDL) which includes all drugs on the SCDHHS Single Preferred Drug List, effective July 1, 2024, as well as additional drugs. This is a list of prescription drugs approved by Absolute Total Care for use by our members. Please reference *Chapter 15: Pharmacy Program* for additional details.

Rehabilitative Therapies for Children—Non-Hospital Based

Prior Authorization Required

Non-hospital-based services available to members aged 20 years and younger with special needs (e.g., sensory impairments, Intellectual Disability/Related Disabilities (ID/RD), physical disabilities, developmental disabilities and delays) and to members of any age who are enrolled in the Intellectual Disability/Related Disabilities (ID/RD) waiver and the Head and Spinal Cord Injury Waiver. For services to be covered, the member must have an Individualized Family Service Plan (IFSP), an Individualized Education Plan (IEP), or a valid treatment plan and be referred by either the South Carolina Department of Disabilities and Special Needs, SCDHEC, the South Carolina School for the Deaf and the Blind, or a local Education Agency (School District). Frequency limits: combined total of 105 hours (420 units) per year (July 1 through June 30). Authorization is required through Evolent when services are rendered in an outpatient setting. Initial evaluations do not require authorization.

Rehabilitative Therapy

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Prior Authorization Required

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

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

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

Rehabilitative Therapy Services for Members Over Age 20 If members are over 20 years old, reimbursement is allowed for physical, occupational, and speech therapies performed under the following guidelines. The member's record must substantiate at least one of the following requirements for therapy:

- The attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay and therapy continues on an outpatient basis until that plan of treatment is concluded.
- The attending physician prescribes therapy as a direct result of outpatient surgery.
- The attending physician prescribes therapy to avoid an inpatient hospital admission.
- Therapy provided in an inpatient and observation status, acute rehab hospital inpatient, home health, assisted living, and inpatient and outpatient skilled nursing facility settings require prior authorization from Absolute Total Care. Prior authorization is required through Evolent when services are rendered in an outpatient setting.

School-Based Mental Health Services

Prior Authorization Required for Some Services

Services to increase access to mental health assessment, intervention and treatment services by empowering health clinicians to render treatment onsite in South Carolina's public schools. Prior authorization may be required prior to rendering services. Services that are covered include:

- Diagnostic Assessment – initial and follow up
- Service Plan Development
- Crisis Management
- Individual Psychotherapy
- Family Psychotherapy
- Group Psychotherapy

The following professionals may be reimbursed for providing these services in the school

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setting:

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

Screening Brief Intervention and Referral to Treatment (SBIRT)

Prior Authorization Not Required

SBIRT is an evidenced based, integrated and comprehensive approach to the identification, intervention and treatment of substance (drug and alcohol) usage, domestic violence, depression and tobacco use in pregnant women to include 12 months postpartum. This initiative is a collaboration between SCDHHS, Absolute Total Care (and all South Carolina Medicaid managed care plans) and state agencies to include the South Carolina Department of Public Health (DPH).

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

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

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

Sterilizations

Prior Authorization Required

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

- Sterilization shall mean any medical procedure, treatment, or operation done for the purpose of rendering an individual permanently incapable of reproducing.
- The individual to be sterilized shall give informed consent not less than 30 calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery) but not more than 180 calendar days before the date of the

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sterilization. A new Consent for Sterilization Form (Form HHS-687) is required if 180 calendar days have passed before the surgery is provided.

- The completed Consent for Sterilization Form (Form HHS-687) cannot be obtained while the patient is in the hospital for labor, childbirth, abortion, or under the influence of alcohol or other substances that affect the patient's state of awareness.
- The individual to be sterilized is at least 21 years old at the time consent is obtained.
- The individual to be sterilized is mentally competent.
- The individual to be sterilized is not institutionalized (i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed).
- The individual has voluntarily given informed consent on the approved Consent for Sterilization Form (Form HHS-687).

Substance Use Services

Prior Authorization Required for Some Services

Absolute Total Care covers substance abuse services including alcohol and other drug abuse treatment services provided by private Opioid Treatment Providers, the Office of Substance Use Services (OSUS), and other licensed and qualified South Carolina Medicaid Network Providers. There are three basic types of OSUS services that are available through the statewide service-delivery system: Prevention, Intervention, and Treatment.

Therapeutic Abortions

Prior Authorization Required

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

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

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

Diagnosis codes to be used only to report therapeutic abortions are O04.5; O04.6; O04.7;

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O04.80; O04.81; O04.82; O04.83; O04.84; O04.85; O04.86; O04.87; O04.88; O04.89; Z33.2.

Tobacco Cessation Services

Prior Authorization Not Required

Absolute Total Care covers all FDA-approved, rebated, tobacco cessation medications to include bupropion for tobacco use, bupropion SR tab (Zyban), Varenicline (Chantix), and nicotine replacement therapies in gum, lozenge, nasal spray, inhaler, and patch dosage forms. General benefit edits related to day supply limits apply. Limits related to age, quantity, or number of quit attempts are not more restrictive than the FDA labeling.

Transplant and Transplant-Related Services

Prior Authorization Required

Absolute Total Care covers all medically necessary transplant services, including the transplant event, testing, and other pre-transplant care, hospital stay for the transplant itself, and the care after the transplant including doctor visits, testing, and medications.

Providers should contact Absolute Total Care Central Transplant Unit (CTU) at 1-866-447-8773 for assistance with all transplant cases. All other prior authorization, pharmacy, and inpatient admission notification, and authorization guidelines remain.

- Transplant services will not be reimbursed unless coordinated by Absolute Total Care's Care Manager;
- Transplant care coordination ensures members receive all medically necessary services before and after the transplant, including necessary pharmacy services; and
- Coordinated Care Managers also address potential barriers and ensure that all state guidelines and protocols, including in-state and out-of-state evaluations, transportation, and other service guidelines are followed to prevent disruptions in needed care and services for these vulnerable, high-risk members.

Vaccines/Immunizations (Adult)

Prior Authorization Not Required

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

Vaccines/Immunizations (Children)

Prior Authorization Not Required

Vaccines and immunizations are covered for individuals 0 – 18 years of age in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) vaccine recommendations guidelines. Since immunizations are a required component of EPSDT screening services, contracted practitioners who administer

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vaccines to children are required to participate in South Carolina's Vaccines for Children (VFC) program. Ages 18 and younger. Refer to ***Chapter 6: Provider Requirements for Treating Children and Youth*** for additional information on vaccines and immunizations for children.

Vision Care

Prior Authorization Not Required

Medically necessary eye exams are covered for all members. Members under 21 get an eye exam and one complete pair of glasses (frame and lenses) once every 12 months.

Additional Services Covered by Absolute Total Care

Absolute Total Care provides additional services for Absolute Total Care members that provide additional benefits beyond the SCDHHS covered services. The additional services below exceed SCDHHS benefits and are designed to improve members' well-being, encourage responsible and prudent use of healthcare benefits, and enhance the cost effectiveness of the South Carolina Medicaid Program. Some Members may not qualify for some of the additional services listed.

90-Day Medication Supply

Members can receive a 90-day supply of medicines to help control high blood pressure, diabetes, and high cholesterol for select medications. View the 90-Day Supply Medication List (PDF) to see the list of eligible medications.

Breast Pump

New moms can receive an electric breast pump at no cost. Members are eligible to request the breast pump 12 weeks before delivery and up to 30 days after delivery (within 90 days for NICU babies). Members can call 1-877-394-1860 for more information or complete the Breast Pump Member Request Form. Limit one per calendar year.

Cell Phone Program

The SafeLink program provides free talk, text and data for qualifying Absolute Total Care members. This program provides communication with members' primary care provider, Care Manager, and certain family members instrumental in their care, and our 24/7 nurse advice line. Members can enroll in the program today by visiting the SafeLink website.

General Education Diploma (GED) Testing

Absolute Total Care provides vouchers for members over the age of 16 to take the GED Exam at no cost.

Housing Assistance

Absolute Total Care assists qualifying members in locating temporary or permanent housing accommodations, accessing community resources and will deliver a Welcome Kit on or near member's move-in day at no cost.

Over-the-Counter (OTC) Benefit

Absolute Total Care provides members with a $15 quarterly allowance, up to $60 annually, of

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OTC products per household. No prescription is required, and items are mailed to the home. Unused funds at the end of each quarter do not carry over.

Ordering is easy! And members can choose from hundreds of items, including children's health products, first aid supplies, pain relievers and more. For a full list of eligible OTC items, view our OTC Benefit Brochure available online under Benefits Overview.

Members can place an order by the following methods:

- Order online on the CVS website.
- Call CVS at 1-888-628-2770 (TTY: 711) Monday to Friday, from 9 am to 8 pm.
- Shop at any OTC Health Solutions® (OTCHS) enabled CVS store. To find the closest participating location, visit the CVS website.

Postpartum Meals

Absolute Total Care provides qualifying birth parents who have a delivery on record 14 free, home-delivered postpartum meals.

Reading Skills Development Program

Absolute Total Care provides books and tutoring sessions to qualified members (Pre-K - fifth grade) to improve reading skills at no cost.

Safe Sleep Kit

Absolute Total Care provides a safe sleep kit for high-risk members who are engaged in Case Management at no cost.

Smoking Cessation

Absolute Total Care provides smoking cessation counseling and medications at no cost.

Sports Activity Fee

Absolute Total Care covers the sports activity fee for members 5-18 years old. Members can receive up to $50 annually through the My Health Pays rewards program. This benefit covers the program activity/registration fee only.

Sports Physical

Absolute Total Care covers one sports physical with a qualified provider per year for members 5-18 years old.

Start Smart for Your Baby® Educational Program

Absolute Total Care provides pregnancy and postpartum educational information to qualifying members at no cost. Refer to ***Chapter 9: Case Management*** to learn more about Absolute Total Care Start Smart for Your Baby® educational program and how to refer members.

Substance Use Disorder Program

Absolute Total Care provides a substance use disorder program for at-risk members at no cost.

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Suicide Prevention Program

Absolute Total Care provides a suicide prevention program for at-risk members at no cost.

My Health Pays™ Rewards

Members can earn My Health Pays™ reward dollars for completing healthy activities like screenings, preventive care, and more. Absolute Total Care adds the reward dollars earned directly to the member's My Health Pays™ Visa® Prepaid Card which is mailed to the member after completing their first healthy activity. Members can keep earning My Health Pays™ rewards by completing more healthy activities.

Members can use My Health Pays™ rewards to help pay for everyday items at Walmart*, utilities, transportation, telecommunications, childcare services, education and rent. Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.

For more information about Absolute Total Care's Member Rewards Program, visit our My Health Pays™ Rewards webpage.

*This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A Inc. and may not be used to buy alcohol, tobacco, or firearms products. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

Services Covered by Medicaid Fee-for-Service

Absolute Total Care does not cover all Medicaid benefits and services. Some services are covered by Medicaid Fee-for-Service and are called "carved-out benefits." Contact Provider Services at 1-866-433-6041 for any questions you have about these services. You can also contact SCDHHS toll-free at 1-888-549-0820. Medicaid Fee-for-Service covered services include:

Community Long Term Care Waiver Services

In-home or community-based support services that assist persons with long-term care needs to remain at home. The Community Choices (CC) waiver is designed to serve Medicaid-eligible participants who are aged eighteen (18) or older, have long term care needs, and meet nursing home level of care. To avoid or delay costly nursing home admission, participants can access the services necessary to receive care at home through careful assessment, service planning, care coordination and monitoring.

Dental Services

Routine and emergency dental services are available to those Members under the age of twenty-one (21). Limited dental services are available to those Members aged twenty-one (21) and over. The dental Program for all Members is administered by SCDHHS's dental broker, DentaQuest. DentaQuest tollfree number is 1-888-307-6553.

HIV/AIDS Waiver Services

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The Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver is designed to serve Medicaid-eligible participants with HIV/AIDS, regardless of age, who choose to live at home but have long term care needs and are at risk for hospitalization.

Hospice Services

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

Institutional Long-Term Care

Institutional long-term care services in a long-term care facility are covered upon approval by CLTC and reimbursed by Medicaid Fee-For Service.

Mechanical Ventilator Dependent (VENT) Waiver Services

The Mechanical Ventilator Dependent (Vent) waiver is designed to serve Medicaid-eligible participants aged 21 or older who are dependent on mechanical ventilation at least six (6) hours per day and have long term care needs. Participants can receive services to supplement care in their home to avoid or delay costly nursing home admission, through careful assessment, service planning and service coordination.

Non-Emergency Transportation Services

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

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

Targeted Case Management (TCM)

Services that assist individuals with specialized needs gain access to needed medical, social, educational, and other services to include a systematic referral process to the service with documented follow-up. TCM services are available to alcohol and substance abuse individuals, children in foster care, mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with intellectual disabilities or a related disability, individuals with head or spinal cord injury or a related disability, children and adults with sickle cell disease and adults in need of protective services. Patients who are dually diagnosed with complex social and medical problems may require TCM services from more than one Case Management Provider. Absolute Total Care will assist with referrals and coordinating health care for members that require TCM services that avoid duplication and ensure that the members' needs are adequately met.

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Services Not Covered by Absolute Total Care

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

- Abortions (elective) except in the case of rape, incest, or when medically necessary to save the mother's life (must have supporting SCDHHS Abortion Statement Form signed by physician and medical documentation)
- Acne treatment for members who are 19 years of age and older
- Acupuncture and biofeedback services
- Care for the treatment of obesity unless medically necessary
- Care provided by any provider, when the insured has other primary coverage at the time of the episode of care
- Care or supplies that are not medically necessary
- Comfort items in the hospital (e.g., TV or telephone)
- CLTC Waiver Home and Community Based Services (covered by Medicaid Fee-for-Service)
- Cosmetic surgery and procedures
- Court-ordered testing
- Dental services (covered by Medicaid Fee-for-Service/DentaQuest)
- Experimental care, such as drugs and supplies, not covered by Medicaid
- Experimental or investigational procedures, technologies, or supplies
- Gender affirming care
- Hospice care covered by Medicaid Fee-for-Service
- Infertility services
- Non-emergency medical transportation (covered by Medicaid Fee-for-Service/ModivCare)
- Paternity testing
- Reversal of sterilization services
- Routine adult vision services and hardware
- Services to find cause of death
- Sex therapy or marriage therapy
- Shots to travel outside of the country
- Institutional long-term care
- Sterilization of a person who is age 21 years or younger, mentally incompetent, or institutionalized

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

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Chapter 8: Member Grievances and Appeals

Member Rights for Grievances and Appeals

Federal law requires Medicaid managed care organizations to have internal grievance and appeal procedures under which Medicaid members, or a person or a provider acting as their authorized representatives, may challenge denial of coverage or payment for medical assistance. These procedures must include an opportunity to file a grievance and/or an appeal and the right to seek a Medicaid State fair hearing upon completion of the internal Absolute Total Care appeal process.

A member can give permission for a person or a provider to act on their behalf in writing by completing and submitting the Appointment of Authorized Representative Form found under Member Resources on our website or as an attachment in the notification letter members receive with denial notices. They also may craft their own letter appointing their provider as their representative in the grievance or appeal.

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

If the grievance or appeal requires additional medical records, providers are expected to respond within one (1) business day of receiving the request to ensure member grievances or appeals are completed within the established grievance and appeal time frames.

Absolute Total Care shall retain grievance and appeal records and reports for a period of at least ten (10) years from the date the appeal or grievance has been resolved. If any litigation, claim negotiation, audit or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until the completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later.

For more information and forms, visit the Absolute Total Care Grievances and Appeals web page.

Member Grievances Process

A grievance is an expression of dissatisfaction about any matter other than “an adverse benefit determination.” For example, a member may file a grievance regarding issues such as:

- The behavior of a doctor or his/her staff
- Wait times to be seen while in a doctor’s office
- Unclean facilities

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Absolute Total Care will send a letter to the member confirming receipt of the grievance within **five (5) calendar days**. We will try to reach a resolution right away. If not, we will send a written decision within **ninety (90) calendar days** from receipt of the grievance. Absolute Total Care may extend the time frame to resolve the grievance up to **fourteen (14) calendar days** if the member or the member's authorized representative requests additional time or Absolute Total Care can demonstrate that there is a need for additional information that is in the member's best interest. If the time frame is extended, Absolute Total Care will make a reasonable effort to give the member prompt oral notice of the delay. Absolute Total Care will give the Member written notification within **two (2) calendar days**, including the reason for the additional time to resolve the issue as well as information on their right to file a grievance if they disagree with the decision.

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

A Member Grievance can be filed verbally or in writing at any time by:

- Call Member Services at 1-866-433-6041.
- Mail, email, or fax a completed Member Grievance Form under "Forms" on the Member Handbook and Forms resources page or written letter telling us why they are not satisfied. The information should include the Member's first and last name; Member's Absolute Total Care member ID number; Member's address and telephone number; and the reason for the grievance.
- In person at the address below:

Mail/In Person: Absolute Total Care Grievance and Appeals Coordinator
100 Center Point Circle, Suite 100
Columbia, SC 29210
Fax: 1-866-918-4457
Email: atc-appeals_grievances@centene.com

Member Appeals Process

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

- The denial or limited authorization of a requested service, including determinations based onthe type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the state.

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- The failure of an MCO, PIHP, or PAHP to act within the time frames provided in § 438.408(b)(1)and (2) regarding the standard resolution of grievances and appeals.
- For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise their right, under § 438.52(b)(2)(ii), to obtain services outside the network.
- The denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities.

There are two kinds of member appeals.

Standard Appeal: Absolute Total Care will provide a written decision within **thirty (30) calendar days** from the date the request was received.

Expedited Appeal: If a decision on an appeal is required immediately due to the member's physical or mental health needs, or that could seriously jeopardize the member's life or ability to attain, maintain, or regain maximum function, and which cannot wait with the standard resolution time, an expedited appeal may be requested. Absolute Total Care's decision on the expedited resolution will be provided within **seventy-two (72) hours** of the receipt of the request. Expedited requests do not require a member's written consent for the providers to appeal on the member's behalf.

If the request for an expedited appeal is denied, Absolute Total Care will make efforts to contact the member and provider promptly by telephone. In addition, the member and provider will be sent a written notice within **two (2) calendar days**. Absolute Total Care will follow the standard appeal time frame and provide a written decision within **thirty (30) calendar days** from the original appeal request.

Extension of an Appeal: Absolute Total Care may extend the time frame to resolve a standard or an expedited appeal up to **fourteen (14) calendar days** if the member or the member's authorized representative requests an extension, or Absolute Total Care can demonstrate that there is a need for additional information that is in the member's best interest. If the time frame is extended, Absolute Total Care will make a reasonable effort to give the member prompt oral notice of the delay. Absolute Total Care will give the Member written notification within **two (2) calendar days**, including the reason for the additional time to resolve the issue as well as information on their right to file a grievance if they disagree with the decision.

An appeal may be filed in writing or verbally within sixty (60) calendar days from the date on the Adverse Benefit Determination Notice. The Adverse Benefit Determination Notice will explain the action Absolute Total Care has taken, explain the appeals process, and include a copy of the Appeal Form. Information on the appeals process and a copy of the Appeal Form can also be found on our website at absolutetotalcare.com. Requests for an appeal that are received without the member's written consent cannot be processed. General consents signed by the member such as consent of financial liability, consent for treatment, or consent to disclose PHI do not meet compliance standards for appeals. It is recommended that the Appointment of Authorized Representative form be used. However, in cases that form is not used, or the provider utilizes their own form, the written consent must specifically authorize a person or facility to act as an authorized representative for the member and include, at a minimum, the member's name, DOB, date and signature. Software that

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allows electronic or remote signing of documents, such as DocuSign, are acceptable only when they can be authenticated by including a unique signature ID (usually below or beside the name).

A Member Appeal may be filed verbally or in writing within sixty (60) calendar days from the date on the Adverse Benefit Determination Notice by:

- Calling Member Services at 1-866-433-6041.
- Mail, email, or fax a completed Member Appeal Form located under "Forms" on the Member Handbook and Forms resources page or written letter telling us why they are not satisfied. Information should include the Member's first and last name; Member's Absolute Total Care member ID number; Member's address and telephone number; and the reason for the grievance.
- In person, at the address below:

Mail/In Person: Absolute Total Care Grievance and Appeals Coordinator
100 Center Point Circle, Suite 100
Columbia, SC 29210
Fax: 1-866-918-4457
Email: atc-appeals_grievances@centene.com

Absolute Total Care will send a letter informing the Member of the appeals receipt. Members also have the right to present evidence and testimony and make legal and factual arguments regarding their appeal in person, in writing, or by telephone. Members also have the right to receive, at no charge and upon oral or written requests, any evidence and documents regarding their appeal or review in person at Absolute Total Care's office address listed above.

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

During the appeal process, the member has the right to keep getting the service that is scheduled to be reduced, suspended or terminated until a final decision is made as long as the appeal request is made within ten (10) days of the date of the denial letter.

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

Medicaid State Fair Hearing

If the member is not satisfied with the final appeal decision, the member or the member's authorized representative may file an appeal directly to SCDHHS Division of Appeals and Hearings. Medicaid fair hearings may be requested at any time up to 120 days following the date on the Adverse Benefit Determination Notice. The member must exhaust the Absolute Total Care appeal process first.

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

South Carolina Department of Health and Human Services
Division of Appeals and Hearings (Suite 901)

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P.O. Box 8206
Columbia, SC 29202-8206
Telephone: 1-803-898-2600

Continuation of Benefits

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

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

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

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

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

Assistance with Grievances and Appeals

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

Appointment of Authorized Representative

Absolute Total Care allows for a provider or another person to act on behalf of the member with the member's written consent. The authorized representative can file a grievance or an appeal or request a State Fair Hearing, with the exception that a provider cannot request continuation of

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benefits. A member can give written consent for a provider, another person, or an attorney to act on their behalf by completing and submitting the Appointment of Authorized Representative Form found under "Forms" on the Member Handbook and Forms resources page. A copy of the completed Authorized Representative Form will need to be attached when an authorized provider or person files a grievance, an appeal, or requests a State Fair Hearing on behalf of a member. Requests that are received without the member's consent cannot be processed.

Ombudsman

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

Trending of Grievances and Appeals

Absolute Total Care documents the reasons for every grievance and appeal and uses the data to identify opportunities for internal process improvement and provider re-education. The credentialing department also uses this information as part of its recredentialing process.

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Chapter 9: Case Management

Case Management Program Overview

Absolute Total Care adheres to the Case Management Society of America (CMSA) definition of case management: "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes."

Absolute Total Care also abides by the principles of case management practice, as described in CMSA's "Standards of Practice for Case Management 2022."

The case management program and tools used to manage care are developed using evidence-based clinical practice guidelines and preventive health guidelines adopted by Absolute Total Care.

The mission of Absolute Total Care's case management program is to:

- Assist members in achieving optimum health, functional capability, and quality of life through improved management of their wellness, disease, or condition.
- Assist members in determining and accessing available benefits and resources.
- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals.
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.

Case management staff are available Monday through Friday from 8 a.m. to 5 p.m. Eastern at 1-866-433-6041. After-hours calls go to the 24-hour nurse advice line.

Integrated Medical and Behavioral Health Approach

Absolute Total Care's case management program is structured on an interdisciplinary approach that allows for the input of staff, members, caregivers and treating providers. Absolute Total Care staff may include physical health and behavioral health care managers, social workers, pharmacists, health coaches, and the medical director.

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

Absolute Total Care's Care Managers support the physician by tracking adherence with the care management plan, and facilitating communication between the member, the member's managing

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

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

Identification of Members for Care Management

Absolute Total Care uses a population-based algorithm that uses claims, authorizations, admission, hospital discharge and transfer data, social determinates of health data and information from our care management assessments to identify members for case management programs. To assist in the identification of eligible members for screening and engagement into care management, including complex care management data is refreshed daily and identifies members deemed as having physical, behavioral health or psycho-social/SDOH (social determinants of health) high needs, with utilization patterns and behaviors that are impactable, based on multiple data science models. The data indicates the recommended level of physical health care management, or behavioral health care management, to facilitate the assignment to the appropriate care team and primary care manager. Absolute Total Care makes every effort to conduct an initial screen, of each enrollee needs within 90 days of the effective date of enrollment.

Additional care management and clinical program reports (e.g., state/CMS enrollment process, Notification of Pregnancy forms, etc.) may also be used to identify members for outreach and further appraisal for care management. Members are also identified as potential candidates for care management through multiple referral avenues that help minimize the time between the need for and initiation of care management services. Direct referrals are considered high priority and are forwarded to the care management team as expediently as possible for further evaluation of needs.

Practitioners may make referrals to case management through the Secure Provider Portal or by calling 1-866-433-6041.

Care Management Process

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

- Screen and identify members who potentially meet the criteria for high-risk care management
- Assessment of member risk factors to determine the need for care management.
- Obtain acceptance from the member to participate in care management.
- Notify the member's PCP of the member's enrollment in Absolute Total Care's Care Management Program.
- Develop and implement a person-centered individualized care plan that accommodates the

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specific cultural and linguistic needs of the member.
- Establishment of treatment objectives and monitoring of outcomes.
- Referrals and assistance to promote timely access to providers and community-based organizations.
- Active coordination of care linking members to providers, medical services, residential, social, and other support services where needed.
- Ongoing monitoring and revision of the care plan as required by the members' changing conditions.
- Continuity and coordination of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/care management activities.
- Track plan outcomes
- Follow-up post discharge from care management
- Addressing the member's right to decline participation in the care management program or disenroll at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all care management procedures in compliance with applicable accreditation standards, specific contractual requirements, HIPAA, state, and federal law.
- Foster Care: Communication with South Carolina Department of Social Services (SCDSS) case worker

Care Management Levels for Members

Members are stratified into case management levels and may move through those stratification levels or move to a higher or lower level of intervention as their conditions change.

Absolute Total Care encourages all PCPs and practitioners who believe a patient would benefit from such a program to call Member Services at 1-866-433-6041 or make a referral through the Secure Provider Portal.

Care Coordination

Care coordination is appropriate for members with several uncomplicated issues/issues related to social drivers of health such as housing, transportation, food insecurity, emergency utilization, finances, etc., with need for referrals to community-based organizations or assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-licensed staff under the direction of a licensed care manager or other designee; licensed staff may help if minor medical or behavioral health concerns arise.

Care Management

Care management is appropriate for members who need a moderate level of support based on physical or behavioral health or multiple/complicated psychosocial needs and/or unusually high utilization of services based on their condition. Members may have complex conditions or multiple co-morbidities and need additional support to coordinate care or more effectively manage their conditions. Services included at this level of case management include coordination

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of care, identification of goals, identification of interventions, and tracking of progress meeting goals.

Complex Care Management

Complex management is a high level of care management services for members with highly complex needs and/or limited supports, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Services are more intensive at this level of care management and include coordination of care, identification of goals, identification of interventions, and tracking of progress meeting goals. Members have prevalent chronic conditions requiring targeted education, medication adherence support, health coaching, and/or other interventions to ensure access to recommended care.

Intensive Care Management

A more intensive type of intervention in comparison to a standard or traditional Care Management / disease management program where the activities used help ensure the patient can reach his/her care goals. A more frequent level of interaction–direct and indirect contact, more time spent with the member and caregivers. This may include the use of special technology and/or devices, such as telemonitoring devices. Intensive care management uses face-to-face visits, telephone, telehealth, office, and clinic visits to meet the members in the least restrictive setting.

Targeted Case Management

Absolute Total Care recognizes that some members require additional assistance to address medical, social, educational, and other identified needs. Absolute Total Care provides Targeted Case Management services to members including, but not limited to, those with alcohol and substance concerns, children transitioning into foster care service, adults diagnosed with chronic mental illness, children experiencing an emotional disturbance, children in juvenile justice system, individuals with sensory impairments, individuals with developmental delays, or a related disability, individuals with head or spinal cord injury or a related disability, children and adults with sickle cell disease, and adults in need of protective services. Absolute Total Care's Case Management team works collaboratively with health care providers by making appropriate referrals for medical education, legal, and rehabilitation services to ensure members' health care needs are adequately met. The Care Management team is responsible for following up with coordinating agencies after a referral is made to confirm referral receipt and coordinate the member's care to ensure the member is receiving care that is accessible, and medically necessary. Absolute Total Care recognizes that individuals who are dually diagnosed with complex social and medical/behavioral concerns may require Targeted Case Management services from more than one provider and collaborates with the Targeted Case Management provider to ensure the member's health care needs are met.

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Foster Care Management

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

Absolute Total Care encourages all PCPs and physicians to call Member Services at 1-866-433-6041 to refer a member to care management when a member is identified that meets the criteria for a chronic or complex condition.

Case Management for Dual Members

For aligned dual-eligible members enrolled in our HIDE SNP and Absolute Total Care Healthy Connections Medicaid plan, we implement a single, integrated assessment and risk stratification process that complies with both the Medicaid MCO contract and CMS D-SNP Model of Care requirements. Aligned dual members are assigned to a single Care Coordinator or Case Manager responsible for conducting the assessments and developing a single plan of care for all their Medicaid and Medicare services to ensure a seamless member experience. For non-aligned duals, our stratification process will include coordination with the member's Medicare Advantage or D-SNP plans, as applicable.

Condition-Specific Programs

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

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

Practitioners who believe their patients would benefit from such a program may send a case management referral through the Secure Provider Portal or call 1-866-433-6041.

Asthma Program

The Asthma Disease Management Program targets members with asthma who are overusing rescue

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medications, having repeated visits to the ER, or being admitted to the hospital with a primary diagnosis of asthma. A Care Manager will contact members/caregivers and provide additional education. The Care Manager coordinates care with the member's PCP. The goals of this program include increasing positive clinical outcomes for the member and controlling the asthma to improve the quality of life for the member.

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

Diabetes Program

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

Emergency Room (ER) Diversion Program

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

- Empower members towards achievement of optimum health, functional capability and quality of life through improved management and understanding of their disease or condition
- Assist members in accessing available and appropriate benefits and resources
- Work collaboratively with members, family, significant others, providers and community organizations to develop goals and assist/empower members in achieving those goals
- Assist members by facilitating timely coordination of appropriate services in the most appropriate settings
- Maximize benefits and resources through oversight and cost-effective UM
- Decrease medically unnecessary admissions and/or readmissions for the same or similar diagnosis
- Decrease non-emergent ER usage
- Increase PCP usage

Lead Case Management Program

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

Perinatal/High Risk Obstetrical Program

Pregnancy, labor, and delivery account for a large portion of care provided to Absolute Total Care

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

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

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

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

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

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

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Chapter 10: Quality Improvement Program

Quality Improvement Program Description

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

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

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

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

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Committee, and the Member and Provider Satisfaction Work Groups.

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

Network practitioners and providers are contractually required to cooperate with all quality improvement activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in Absolute Total Care's quality improvement programs. Practitioner and provider contracts, or a contract addendum, also require that practitioners and providers allow Absolute Total Care the use of their performance data for quality improvement activities.

The evaluation considers the following:

- Coordination between physical health and behavioral health services
- Credentialing and recredentialing
- Cultural competency
- Delegated entity oversight
- Member and provider satisfaction
- Member complaints, grievances and appeals
- Outcomes of case management
- Practitioner appointment availability and access
- Performance measures, including Healthcare Effectiveness Data and Information Set (HEDIS), potentially preventable events, birth outcomes, transition of Comprehensive members from a facility to the community and state-defined measures
- Potentially preventable admission, readmission and emergency department events
- Birth outcomes
- Preventive health and chronic condition guidelines, including behavioral health
- Quality improvement studies
- Utilization management, including pharmacy

Quality Improvement Program Goals and Scope

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

Absolute Total Care's Quality Program priorities and goals support the Centene Corporation mission of Transforming the Health of the Community, one person at a time. It is reinforced by our values of Accountability, Courage, Curiosity, Trust, and Service. At Absolute Total Care, we believe that we

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must treat the whole person, not just the physical body. We will treat people with kindness, respect, and dignity to empower healthy decisions. We have a responsibility to remove barriers and make it simple to get well, stay well, and be well. We believe local partnerships enable meaningful, accessible healthcare. At Absolute Total Care we know healthier individuals create more vibrant families and communities. We successfully provide high quality, whole health solutions for our diverse membership by recognizing the significance of the many different cultures our members represent and by forming partnerships in communities that bridge social, ethnic and economic gaps.

Some of the activities included in the quality improvement program are:

- Case management programs to promote improved member outcomes
- Compliance with all applicable regulatory requirements and accreditation standards
- Improvement in member satisfaction scores
- Improvement in potentially preventable events, birth outcomes, transition of Comprehensive members from a facility to the community
- Improvement in processes that enhance clinical efficiency, promote effective utilization of health care resources and focus on improved outcome management
- Integration of quality improvement activities across Absolute Total Care's functional areas
- Monitoring of, and collaboration with, the contracted network to continuously improve the quality of care and services members receive
- Protection of member's rights and responsibilities

The scope of the Quality Program is comprehensive and addresses both the quality and safety of clinical care and the quality of service provided to Absolute Total Care's members including medical, behavioral health, and vision care as applicable to the health plan's benefits. Absolute Total Care incorporates all demographic groups, lines of business, benefit packages, care settings and services in its quality improvement activities. Areas addressed by the Quality Program include preventive health; emergency care; acute and chronic care; population health management; health disparity reduction; behavioral health; episodic care; ancillary services; CLAS; continuity and coordination of care; patient safety; social determinants of health; and administrative, member, and network services as applicable.

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

The quality improvement program evaluation includes a summary of all quality improvement activities that were noted in the annual quality improvement work plan. These findings are used in developing the following year's annual quality improvement program description.

The quality improvement evaluation is reviewed and approved by Absolute Total Care's Quality Improvement and Utilization Management Committee and Board of Directors. A short summary of HEDIS and CAHPS results is available to providers and members at AbsoluteTotalCare.com.

Working with our Providers

Absolute Total Care works with network providers to build useful and relevant analyses and

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reporting tools that are understandable and utilizes feedback through local peer comparisons to improve care. This collaborative effort helps to establish a foundation that supports continuous quality improvement activities that yield performance improvements.

To reach quality goals, Absolute Total Care offers useful reports and robust clinical support. In addition, Absolute Total Care aligned these quality goals with network performance and employed a focused strategy based on strong partnerships with network providers. Absolute Total Care continues to review data to identify network provider performance and opportunities to support providers in improving member care.

Absolute Total Care provides reports to providers that reflect how they are impacting quality of care and appropriate utilization of services. The reports are structured to reflect:

- Meaningfulness to the provider
- Relevance to the populations served
- Information to assist the provider in impacting care

Specific provider quality standards that are measured include: member access to care, member satisfaction, utilization of services, quality of care and service (including HEDIS and non-HEDIS measures), pharmacy utilization and other relevant measures, as applicable.

Interaction with Functional Areas

The Quality Improvement Department maintains strong working relationships with key functional areas within the health plan such as Provider Network Services, Member Services, Utilization Management, Regulatory Compliance and Grievance and Appeals. Quality Improvement is integrated throughout Absolute Total Care and represents a strong commitment to quality of care and services for members.

- **Provider Network Services**, such as Provider Services and Contracting and the Quality Improvement Department work together to verify that clinical materials distributed to providers are understandable and useful and that providers understand the members' rights and responsibilities and treat enrolled members accordingly. These departments also coordinate efforts for appropriate access and availability through ongoing monitoring.
- **Members Services, Care Management and the Quality Improvement** staff collaborate in relation to Member Satisfaction Survey activities, to include performance improvement projects. The Quality Improvement, Member Services and Care Management departments work collaboratively to maintain performance data related to EPSDT outreach activities and any other Quality Improvement activities related to member services functions, including call center functions, are tracked, trended and used as a tool to identify opportunities for performance improvement, as appropriate.
- **Utilization Management Department** provides utilization management, care management and disease-focused services to enrolled members. Utilization Management staff identifies and refers quality concerns to the Quality Improvement Department for investigation and recommends benefit enhancements and participates in Quality Improvement activities and projects.
- **Regulatory Compliance and the Quality Improvement Department** work together to ensure that Absolute Total Care's initiatives comply with state contract and

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accreditation requirements for National Committee for Quality Assurance (NCQA).

- **Grievance and Appeals coordinator(s) and Provider Services** work closely with the Quality Improvement Department to ensure that:
  - Any grievance related to a quality-of-care issue is promptly investigated;
  - Grievances and second-level reviews of grievances and administrative reviews are handled timely;
  - Data collection and reporting is compliant with relevant contractual and regulatory requirements; and
  - Reporting to appropriate Quality Improvement committees occurs.

Quality Improvement and Utilization Management Committee and Sub-Committees

Quality Improvement and Utilization Committee and Sub-Committees Overview

Quality and equity are integrated throughout Absolute Total Care and represent our strong commitment to delivering equitable, quality care, behavioral health care and services to members. The Board of Directors is the governing body designated for oversight of the Quality Program and has delegated authority and responsibility for the development and implementation of the Quality Program to the Quality Improvement Committee.

Absolute Total Care's various committees, subcommittees and ad-hoc committees assist in the planning, decision making, intervention and assessment of results to support its quality improvement program.

Quality Improvement and Utilization Management Committee

The Quality Improvement and Utilization Management Committee (QIUMC) is a senior management-led committee accountable to the Board of Directors. The committee reports Quality Improvement and Utilization Management program activities, findings, recommendations, actions, and results to the Board of Directors at least annually. QIUMC is supported by the Credentialing Committee, Member Advisory Committee, Joint Oversight/Enterprise Delegation Oversight Committee, and HEDIS Steering Committee. The Peer Review Committee functions as an ad hoc subcommittee that assists in assessing the appropriateness of clinical care.

The QIUMC and the Board of Directors review and approve the Quality Improvement Program and Utilization Management Program descriptions at least annually. The committee provides oversight and strategic direction for both programs and is responsible for reviewing and approving medical necessity criteria, clinical protocols, and utilization management policies and procedures.

To fulfill its responsibilities, the committee oversees and promotes:

- A comprehensive, plan-wide system of ongoing, objective, and systematic monitoring and evaluation of the quality, appropriateness, and efficiency of care and services.
- Education and communication to members, providers, practitioners, and staff regarding

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Quality Improvement, Utilization Management, and Credentialing programs.

- Identification, evaluation, and resolution of process and system issues that may affect quality, access, service, or utilization.
- Identification of opportunities to improve member outcomes, health care delivery, and member experience.
- Monitoring and analysis of relevant data to detect and address patterns of potential or actual underutilization, overutilization, and inappropriate utilization of services.
- Oversight of activities related to potentially preventable events, birth outcomes, transitions of members from facility settings to the community, care coordination, and the appropriate use of health care services and resources.
- Monitoring member and practitioner/provider satisfaction with the Utilization Management process.

The committee meets quarterly and coordinates the annual review and revision of the Utilization Management Program description, work plan, and annual program evaluation. The committee reviews performance against established goals and objectives, evaluates the effectiveness of improvement initiatives, and recommends actions to address identified opportunities. Findings and recommendations are incorporated into the Quality Improvement and Utilization Management programs and reported to the Board of Directors through established governance processes.

Credentialing Committee

The Credentialing Committee is responsible for the development and annual review of the credentialing program description and its associated policies and procedures. The CC has the responsibility for credentialing and re-credentialing physicians, non-physician practitioners, facilities, and other practitioners in the ATC network and to oversee the credentialing process to ensure its compliance with regulatory and accreditation requirements. The CC shall ensure network providers; facilities and practitioners are qualified, properly credentialed, and available for access by ATC members.

Joint Oversight Committee

The Joint Oversight Committee provides guidance to and oversight of operations affecting the scope of functions of delegated vendors, subcontractors, and Centene specialty companies that provide services to the health plan membership. The Joint Operations Committee monitors delegate/vendor compliance with the delegation service agreement and regulatory requirements, identifies issues and opportunities for improvement, and develops mitigation plans as appropriate.

Peer Review Committee

The Peer Review Committee is an ad-hoc committee of the QIC and responsible for reviewing alleged inappropriate or aberrant services by a practitioner/provider, including potential quality of care incidents, adverse events, and sentinel events where initial investigation indicates a significant potential or significant, severe adverse outcome has occurred or other cases as

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deemed appropriate by the Medical Director.

Member Advisory Committee

The Member Advisory Committee is a group of members, parents, guardians, member advocacy groups, and health plan staff as appropriate, who meet quarterly via virtual meetings where information is shared, and reports are reviewed on a variety of quality and service issues. The Member Advisory Committee represents the geographic, cultural and racial diversity of our membership across the state and provides the health plan with feedback regarding satisfaction with care, problem identification, and suggestions for improving the service delivery system. Absolute Total Care uses the feedback to identify barriers and interventions, both short-term and long-term, to ensure members are served adequately, equally and with the highest level of satisfaction.

HEDIS Steering Committee

The HEDIS® Steering Committee is the committee responsible for monitoring and improving quality scores and overseeing the quality performance of the Health Plan. The committee reviews monthly rate trending, identifies data concerns, and communicates initiatives to senior leadership. The committee directs member and provider initiatives to improve quality scores.

Quality Improvement Activities

Monitoring Patient Safety/Quality of Care

Patient safety is a key focus of Absolute Total Care's quality improvement program. Monitoring and promoting patient safety is integrated throughout many activities across Absolute Total Care but primarily through identification of potential and/or actual quality-of-care events.

A potential quality-of-care issue may be any alleged act or behavior that:

- May be detrimental to the quality or safety of patient care
- Is not compliant with evidence-based standard practices of care
- Signals a potential sentinel event, up to and including death of a member

Employees (including PHCO staff, member services staff, provider services staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, state partners, Medical Directors, or the Board of Directors may inform the Quality Department of potential quality of care issues and/or critical incidents. Potential quality of care issues requires investigation of the factors surrounding the event to determine their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Potential quality of care issues and critical incidents received by the Quality Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Monitoring Provider Access and Availability

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Accessibility

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

Access

Absolute Total Care follows standards set by SCDHHS for the numbers and geographic distribution of PCPs, specialists, hospitals and other providers while taking into consideration the special and cultural needs of its members.

Absolute Total Care analyzes provider accessibility at least annually to identify and address any deficiencies in the number and distribution of various types of practitioners and providers.

Availability

Absolute Total Care establishes appointment wait times for various types of visits. At least quarterly, Absolute Total Care assesses compliance with established appointment wait times for PCPs, specialists and behavioral health care providers to identify and address any deficiencies.

Monitoring Quality Outcomes

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a set of standardized performance measures developed by The National Committee for Quality Assurance (NCQA) to allow comparison across health plans. Purchasers and consumers use HEDIS® scores to distinguish between health plans based on comparative quality instead of cost differences. HEDIS® reporting is a required part of the SCDHHS contract. Through HEDIS®, Absolute Total Care is accountable for the timeliness and quality of healthcare services (e.g., acute, preventive and mental health) delivered to its diverse membership.

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

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

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

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as ‘pay for performance’ and ‘quality bonus funds.’ These programs incentivize providers with an increased premium based on the scoring of such quality indicators used in HEDIS®.

How are HEDIS® rates calculated?

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

Who conducts the Medical Record Reviews for HEDIS®?

Absolute Total Care has experienced HEDIS® staff who conduct the HEDIS® medical record review. Medical record review audits for HEDIS® occur annually in quarters one and two. You may receive a call from a medical record review representative if your patients fall into the HEDIS® samples for Absolute Total Care. Your prompt cooperation with the medical record review representative is greatly needed and appreciated.

Absolute Total Care may request records for HEDIS® and/or contract with medical records review vendors to offer the provider community medical record correspondence options. These options include confidential fax, traditional mail, secure email, or onsite retrieval by qualified staff. These various options allow you, as the provider, to choose the most convenient method for your practice.

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

How can I improve my HEDIS® score?

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

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

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

CAHPS® is a member satisfaction survey included as a part of HEDIS® and NCQA

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

The CAHPS® survey focuses on three population cohorts:

- Adult
- Child
- Child with Chronic Conditions

Composite scores summarize member responses in the following key areas:

- Getting Needed Care
- Getting Care Quickly
- Rating of Health Plan
- Rating of Health Care Quality

The results of this survey are used to develop interventions to improve members' perception of those listed composites.

Visit Consumer Assessment of Healthcare Providers and Systems (CAHPS®) to learn more and review Absolute Total Care's CAHPS® Provider Resource Guide.

Provider Satisfaction Surveys

Absolute Total Care conducts an annual Provider Satisfaction Survey to assess provider experiences with our services, including claims processing, communications, utilization management, and provider support. The survey is administered by an independent vendor to ensure objectivity and confidentiality. Participants are randomly selected based on criteria established by Absolute Total Care, and all responses remain anonymous.

We strongly encourage providers to complete the survey promptly, as the feedback collected is analyzed and used to guide provider-focused quality improvement initiatives. In addition to the annual survey, other feedback tools may be utilized throughout the year. Your participation is essential in helping us enhance our services and strengthen our partnership with you.

Feedback on Aggregate Results

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

At least quarterly, a Provider Engagement Account Manager meets with PCPs and bi-annually with high volume specialists to review policies, guidelines, indicators, medical record standards and provide feedback on audit/study results. These sessions are also an opportunity for providers to suggest revisions to existing materials and recommend priorities for further initiatives. When a guideline, indicator, or standard is developed in response to a documented quality of care deficiency, Absolute Total Care disseminates the materials through an in-service training program to upgrade providers' knowledge and skills.

Absolute Total Care's Medical Director and Pharmacist conduct special training and meetings to

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assist physicians and other providers with quality improvement and service improvement efforts.

Feedback on Physician Specific Performance

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

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

Performance Improvement Projects

Absolute Total Care's QIUMC reviews and adopts an annual Quality Program Description and Quality Improvement Work Plan based on managed care Medicaid appropriate industry standards. The QIUMC adopts traditional quality, risk, and utilization management approaches to problem identification with the objective of identifying improvement opportunities. As part of this approach, the Chief Medical Officer, in conjunction with the Quality Improvement Department, determines the scope and frequency of quality improvement initiatives (e.g., clinical and non-clinical performance improvement projects and focus studies). Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or the service. Once a quality improvement topic is selected, the Quality Improvement Department, in conjunction with specific functional areas as appropriate, will present the proposed QI initiative to the QIUMC for approval. The QIUMC will select those initiatives that have the greatest potential for improving health outcomes, or the quality of service delivered to the plan's members and network providers. While topics are typically selected based on identified opportunities for improvement, SCDHHS may require Absolute Total Care to conduct a Performance Improvement Project addressing a specific topic or area of concern.

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

The development and selection of clinical performance improvement projects are the responsibility of the QIUMC due to its clinical representation. The QIUMC continues to monitor the progress of clinical performance improvement projects. Absolute Total Care's Quality Program allows for continuous performance of quality improvement activities through analysis,

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evaluation and improvement in the delivery of healthcare provided to all members and has established mechanisms to track issues over time.

Quality Improvement Work Plan

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

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

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

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Chapter 11: Fraud, Waste and Abuse

Fraud, Waste and Abuse (FWA)

Special Investigations Unit

Absolute Total Care is committed to preventing, detecting, identifying and reporting suspected cases of fraud, waste, and abuse and has a Fraud, Waste and Abuse Program that complies with all state and federal laws. Absolute Total Care, in conjunction with its parent company Centene Corporation, operates a Special Investigations Unit (SIU) to detect, investigate and prosecute fraud, waste and abuse (FWA). Absolute Total Care routinely conducts audits to ensure compliance with billing regulations and uses code editing software to perform systematic audits during the claims payment process. To better understand this system, please review the Claims Coding and Billing section of this manual.

The SIU performs prepayment and retrospective audits, which in some cases may result in taking actions against providers who commit fraud, waste and/or abuse. These actions include but are not limited to:

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

Some of the most common FWA practices include:

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

Providers who suspect or witness inappropriate billing or inappropriate services for a member are encouraged to call the anonymous and confidential FWA hotline at 1-866-685-8664 or contact the compliance officer by phone at 1-866-796-0530 or by email at atc.compliance@centene.com.

Provider Implementation of FWA Safeguards

Federal program payments may not be made for items or services furnished or prescribed

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by an excluded provider or entity. Plans may not use federal or state funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee, contractor or subcontractor excluded by the Office of the Inspector General (OIG) or General Services Administration (GSA).

Absolute Total Care will review the OIG's "List of Excluded Individuals and Entities (LEIE)" and the GSA's "Excluded Parties List (EPLS)" now known as "System for Award Management (SAM)," as well as SCDHHS's listing of suspended and terminated providers before hiring or contracting any new employee, temporary employee, volunteer, consultant, governing body member or subcontractor, and monthly thereafter.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the federal government. The Act prohibits the following:

- Knowingly presenting or causing to be presented a false claim for payment or approval
- Knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim
- Conspiring to commit any violation of the False Claims Act
- Falsely certifying the type or amount of property to be used by the government
- Certifying receipt of property on a document without completely knowing that the information is true
- Knowingly buying government property from an unauthorized officer of the government
- Knowingly making, using or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the government

For more information regarding the False Claims act visit the Centers for Medicare and Medicaid Services website.

Health Care Laws

Absolute Total Care instructs and expects all its providers, contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Anti-kickback statute
- State and federal False Claims Acts
- Qui Tam lawsuits (Whistleblower Protection Act)
- Health Insurance Portability and Accountability Act (HIPAA)
- Physician self-referral law (Stark Law)
- Social Security Act
- U.S. criminal codes

Absolute Total Care requires all providers, contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all Absolute Total Care members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering,

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failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or enrollees' medication fraud.

FWA Training is available on the Absolute Total Care website that providers may download in PDF format. Absolute Total Care also offers FWA training in provider orientation materials.

State and federal regulations require mandatory compliance and FWA training to be completed by contractors and subcontractors, as well as their employees, within 30 days of hire/contracting and annually thereafter. Training records must be maintained and readily available at the request of Absolute Total Care's compliance officer, SCDHHS, CMS or agents of both agencies.

Providers or their employees who have not taken compliance and/or FWA training may do so by visiting Absolute Total Care's website.

Direct Reporting of Fraud, Waste and Abuse

Providers may report suspected or confirmed fraud, waste or abuse in the state Medicaid program through the following channels:

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

Absolute Total Care Fraud, Waste and Abuse Hotline: 1-866-685-8664 (All calls are confidential.)
Mail: Absolute Total Care Compliance Department
100 Center Point Circle, Suite 100 Columbia, SC 29210
Email: atc.compliance@centene.com

Authority and Responsibility

Absolute Total Care's Compliance Officer has the overall responsibility and authority to carry out the provisions of the compliance program – especially measures of prevention, detection, reduction, correction and reporting of fraud, waste, abuse and any other non- compliance related issues – and is committed to sanctioning and prosecuting suspected fraud, waste or abuse.

Absolute Total Care's provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations, at the providers' own expense.

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Chapter 12: Provider Rights and Responsibilities

Provider Bill of Rights

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

A healthcare professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his or her patient for the following:

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

Provider Responsibilities

Contracted providers are responsible for providing and managing healthcare services for Absolute Total Care members as determined by medical necessity criteria. In addition, practitioners and providers are responsible to:

***Notify Absolute Total Care in writing of any of these changes*:**

- Changes in practice ownership, name, address, phone, national provider identifier (NPI) or federal tax identification numbers
- The addition or departure of a physician to the practice

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- Loss or suspension of the provider's license to practice
- Practice bankruptcy or insolvency
- Suspension, exclusion, debarment or other sanction from a state or federally funded health care program
- Indictment, arrest or conviction for a felony or any criminal charge related to the practice
- Material changes in cancellation or termination of liability insurance
- The closing of a practice to new patients and vice versa
- When terminating affiliation with Absolute Total Care

***Not bill or balance bill members*:** Providers have a responsibility not to bill or balance bill Medicaid recipients for covered services regardless of whether they believe the amount of money they have been or will be paid by Absolute Total Care is appropriate or sufficient. Providers also may not bill members for failure to appear for a scheduled appointment.

***Provide 24/7 coverage*:** PCPs and specialists must provide access to covered medical services 24 hours a day, seven days a week. In practice, this means member telephone calls should be answered by an answering service that is able to connect the member to someone who can render a clinical decision or reach the PCP or treating behavioral health practitioners for a clinical decision.

***Inform members about advance directives*:** Providers have a responsibility to inform Absolute Total Care members about their right to have an advance directive and provide written information on state law about members' rights to accept or refuse treatment and the provider's own policies regarding advance directives. Providers must document in the members' medical record any results of a discussion on advance directives and include a copy of the advance directive in the patient file if a member has or completes one.

***Maintain medical records*:** Providers have a responsibility to have policies that address medical record protocols. Policies should include maintaining a single, permanent medical record for each patient that is available at each visit; protecting patient records from destruction, tampering, loss or unauthorized use; maintaining medical records in accordance with state and federal regulations; and maintaining a current patient signature of consent for treatment. Medical records should be complete and legible and follow standard practices.

***Provide care*:** Providers have a responsibility to provide care within their scope of practice, in accordance with Absolute Total Care's access, availability, quality and participation standards and in a culturally competent manner. Providers also should identify any member who requires translation, interpretation or sign language services and call Absolute Total Care to arrange for such services.

***Participate in quality improvement programs*:** Providers have a responsibility to participate with Absolute Total Care in quality improvement initiatives and other activities associated with meeting regulatory requirements and upholding contractual obligations.

***Not discriminate*:** Providers have a responsibility to provide optimal care to members without

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regard to age, race, gender, religious background, national origin, disability, sexual orientation, source of payment, veteran status, claims experience, social status, health status or marital status.

***Supply members with complete and accurate information*:** Providers have a responsibility to give members complete and accurate information concerning a diagnosis, treatment plan, or prognosis in terms they can understand (eliminating both language and cultural barriers) and without regard to plan coverage; to inform members of non-covered treatments or services and their cost prior to rendering them; and to advise members of their right to contact Absolute Total Care if they have concerns about a non-covered service or wish to file a grievance or appeal.

Maintain confidentiality: Providers have a responsibility to keep members' protected health information (PHI) strictly confidential in compliance with Health Insurance Portability and Accountability Act (HIPAA) standards and to provide necessary member PHI to Absolute Total Care, also in compliance with HIPAA standards, when required for payment, treatment, quality assurance, regulatory, data collection and reporting activities. Providers are responsible for contacting the Absolute Total Care Compliance Department when a HIPAA violation occurs.

***Submit claims*:** Providers have a responsibility to submit complete and accurate claims for their services that conform to Medicaid requirements within the time frames outlined in their contract and to provide Absolute Total Care with supporting documentation when required to support a claim.

***Participate in utilization management*:** Providers have a responsibility to conform to Absolute Total Care's referral and prior authorization policies and procedures as they relate to services provided and to cooperate with utilization management staff in providing the necessary documentation or medical information.

***Provide continuity of care following provider termination*:** Providers who are terminating their affiliation with Absolute Total Care have a responsibility to provide medically necessary care for members at least 90 days following their termination date. Absolute Total Care permits members to continue receiving medically necessary services from a non-for-cause terminated provider and continues to process provider claims for at least 90 days or until members select another provider.

***Report any adverse or critical incidents*:** Providers are responsible for reporting to Absolute Total Care any critical or adverse incidents that negatively impact the health, safety or welfare of a member. Such incidents may include abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement, or major medication errors.

***Report Abuse, Neglect or Exploitation*:** Providers are responsible for immediately reporting knowledge or reasonable suspicion of abuse, neglect or exploitation of a child, aged person or disabled adult to the South Carolina Department of Social Services hotline at 1-888-CARE4US (1-888-227-3487). Providers are also responsible for ensuring that staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect,

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and exploitation. Providers should refer victims of domestic violence to call the National Domestic Violence Network hotline at 1-800-799-7233 or use the text and chat features at thehotline.org to seek information about local domestic violence programs and shelters in South Carolina.

Participate in training: Providers are responsible for participating in training as mandated by regulatory authorities and/or Absolute Total Care.

Provider Programs and Accountabilities

PCPs and the Patient-Centered Medical Home

Absolute Total Care is committed to supporting its network providers in achieving recognition as Patient Centered Medical Homes (PCMH) and will promote and facilitate the capacity of primary care practices to function as medical homes by using systematic, patient-centered, and coordinated care management processes. In alignment with the vision of U.S. Department of Health and Human Services (DHHS), it is Absolute Total Care's goal to have all its primary care providers recognized as a PCMH by an accrediting agency. Absolute Total Care will support providers in obtaining NCQA's Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) recognition.

The purpose of the PCMH program is to promote and facilitate a medical home model of care that will provide better healthcare quality, improve self-management by members of their own care, and reduce avoidable costs over time. Absolute Total Care will actively partner with our providers, with community organizations, and with groups representing our members to increase the numbers of providers who are recognized as a PCMH (or are committed to becoming recognized) and who achieve the meaningful use of health information technology (HIT).

Absolute Total Care has dedicated resources to ensure its providers achieve PCMH recognition with a technical support model that will include:

- Readiness survey of contracted providers.
- Education in the process of becoming certified.
- Resource tools and best practices.

From an information technology perspective, we will be offering several HIT applications for our network providers who are either a recognized PCMH or are committed to becoming a National Committee for Quality Assurance (NCQA) accredited medical home. Our Secure Provider Portal offers tools that will help support PCMH accreditation elements.

These tools include:

- Online care gap notification.
- Member Panel Roster including member detail information.
- Trucare service plan.
- Health record.

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- Provider overview report.

For more information on PCMH recognition and best practice models, please visit the Patient-Centered Medical Home page on our website.

Coordination Between Physical and Behavioral Health

Continuity and coordination of behavioral and medical care includes communication between medical and behavioral health professionals, appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care, appropriate use of psychotropic medications, management of treatment access and follow-up for members with coexisting medical and behavioral disorders, primary or secondary preventive behavioral healthcare program implementation and special needs for members with severe and persistent mental illness.

PCPs treating members with identified behavioral health needs are responsible for consulting with behavioral health/substance use disorder providers about the member's medical condition, mental status, psychosocial functioning and family situations when making referrals or during treatment, using all available communication methods to coordinate treatment with documentation of those methods in the member's medical record.

Likewise, behavioral health practitioners are asked to refer members with known or suspected untreated physical health problems or disorders to their PCP for examination and treatment to preserve continuity of care. With appropriate written consent from the member, behavioral health practitioners are responsible for keeping the PCP apprised of the member's treatment status and progress in a consistent and reliable manner to meet the requirements set forth in 42 CFR Part 2, when applicable. If the member requests this information not be given to the PCP, the provider must document this refusal in the member's treatment record and, if possible, offer the reason.

Contracted behavioral health practitioners and providers should include all the following information in their report to the PCP:

- A copy or summary of the intake assessment
- Member's completion of treatment
- Results of an initial psychiatric evaluation and the initiation of and major changes in psychotropic medication(s) within 14 days of the visit or medication order
- Results of functional assessments
- Written notification of member's noncompliance with treatment plan (if applicable)

Practitioners should exercise caution in conveying information regarding substance use disorders, which is protected under separate federal law.

For assistance with identifying network providers, or for care management support for a member, providers should call Provider Services at 1-844-477-8313 Monday through Friday from 8 a.m. to 8 p.m. Eastern.

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Identifying and Reporting Abuse or Neglect

Absolute Total Care providers are responsible for immediately reporting knowledge or reasonable suspicion of abuse, neglect or exploitation of a child, aged person or disabled adult to the South Carolina Department of Social Services hotline at 1-888-CARE4US (1-888-227-3487). Providers are also responsible for ensuring that staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect, and exploitation. Providers should refer victims of domestic violence to call the National Domestic Violence Network hotline at 1-800-799-7233 or use the text and chat features at thehotline.org to seek information about local domestic violence programs and shelters in South Carolina.

Absolute Total Care and state law requires reporting by any person if they have "reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse." Providers are to report any suspected child abuse or neglect immediately to children's services in the appropriate county. Reporting can be done anonymously.

Telemedicine

Telemedicine is defined as the practice of healthcare delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis or treatment. Any practitioner licensed within their scope of practice can perform this service for services approved by SCDHHS to be provided via telemedicine. South Carolina Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between a patient and a practitioner. Telecommunication equipment and telemedicine operations must meet the technical safeguards required by 45 CFR § 164.312, where applicable. Providers must include modifier GT on the CMS-1500 claim form.

The following are the requirements for providers to bill for telemedicine:

- Two-way, real time interactive communication between patient and physician at the distant site
- Audio and video interaction with patient
- Technology used is compliant with HIPAA privacy requirements
- Patient must be informed and provide consent to the use of telemedicine
- Patient must have the choice of whether to access services through a face-to-face visit or telemedicine
- Document the choice for telemedicine in the patient's medical record

Absolute Total Care will not reimburse providers for:

- Telephone conversations
- Chart review
- Electronic mail messages
- Facsimile transmissions

All Absolute Total Care referral, notification and prior authorization requirements apply. Providers may furnish and receive payment for covered, eligible telemedicine services, when provided at a Distant Site, in accordance with this policy and the provider's scope of practice.

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Ordering, Referring, and Prescribing (ORP) Provider Enrollment Requirements

To comply with the Patient Protection and Affordable Care Act and 42 CFR §455.410, the Centers for Medicare & Medicaid Services (CMS) requires all providers, including out-of-state providers, who order, refer, or prescribe services for Medicaid recipients to enroll in the South Carolina Medicaid program, even if they do not bill Medicaid directly. This requirement applies to professional, pharmacy, and institutional claims.

Enrollment Requirement

Providers must maintain a current, valid Medicaid enrollment record for ordered, referred, or prescribed services to be paid. Any provider who orders, refers, or prescribes services for a Medicaid member must have an active SCDHHS provider identification number, including out-of-state providers and retail pharmacists. Providers may enroll online through the SCDHHS website at www.scdhhs.gov/orp and should select the “Ordering/Referring” enrollment type. Providers enrolling only as an Ordering/Referring provider need to enroll with SCDHHS only and are not required to contract directly with Absolute Total Care.

Affected Services

Covered services include, but are not limited to, pharmaceuticals, clinical laboratory services, therapy services, imaging, home health services, and durable medical equipment (DME).

Claim Impact

Providers must include the ordering or referring physician’s NPI on all claims.

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Chapter 13: Provider Administration

Provider Services and Supports

Our locally based Provider Engagement Model is a tailored, responsive connection built on mutual respect. We have an open line of two-way communication and help our providers with all the tools necessary to provide timely, accessible, quality care. Through our Provider Engagement Model, providers receive hands-on contracting, onboarding, and quality improvement support. Absolute Total Care has various departments and support systems to assist medical and behavioral health practitioners and providers in treating Absolute Total Care members. Those departments include the following:

- Provider Engagement – This team provides initial and ongoing engagement and training to educate providers and provide tools, information, and support they need to deliver high-quality care. This team also serves as provider advocates to resolve provider issues and practice-level and operational needs as they arise. Locate your Provider Engagement Account Manager by using the Find Your Provider Engagement Account Manager tool.
- Provider Quality – This team is dedicated to supporting providers' performance improvement efforts on key quality initiatives and performance indicators. They collaborate with providers to identify barriers to performance and implement rapid-cycle quality improvement initiatives to close gaps and enhance member outcomes.
- Provider Contracting – This team provides support for providers from contracting through initial credentialing and can be reached at ATC_Contracting@centene.com.
- Provider Services – This team is available by calling 1-866-433-6041 Monday through Friday from 8 a.m. to 6p.m. EST, to field provider concerns, troubleshoot authorizations, obtain translation services, and assist with any other needs that may occur.

Access and Availability

All providers are responsible for providing appointments to Absolute Total Care members within a reasonable amount of time based on the nature of the visit. Practitioners unable to offer an appointment within the time frames listed below should refer the member to Absolute Total Care Member Services which can be reached by calling 1-866-433-6041 (TTY:711) Monday through Friday from 8 a.m. to 8 p.m. Eastern Time (ET) for rescheduling with an alternate provider who is able to meet the access standards and the member’s needs.

Adherence to these standards is monitored via telephone auditing. Providers not in compliance with the standards may be required to implement corrective actions set forth by Absolute Total Care.

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Availability

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

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

Accessibility

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

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24-Hour Access

PCPs and specialist providers are required to maintain sufficient access to needed health care services on an ongoing basis and must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours; and
- A member must be able to access their provider after normal business hours and on weekends; this may be accomplished through the following:
    - A covering physician.
    - An answering service.
    - A triage service or voicemail message that provides a second phone number that is answered.
    - If the provider's practice includes a high population of Spanish speaking members, it is recommended that the message be recorded in both English and Spanish.
- Examples of unacceptable after-hours coverage include, but are not limited to:
    - Calls received after-hours are answered by a recording telling callers to leave a message.
    - Calls received after-hours are answered by a recording directing patients to go to an emergency room for any services needed.
    - Not returning calls or responding to messages left by patients' after-hours within 30 minutes.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can render a clinical decision or reach the PCP or specialist provider for a clinical decision. Whenever possible, PCP, specialist providers, or a covering professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Appointment Access Standards

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

Primary Care Provider (PCP) Appointment Access Standards	
Appointment Type	**Access Standard**
Routine visits for established patients	Within 15 business days
Urgent, 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, seven days a week by direct access or through arrangement with a triage system
Office wait time for scheduled routine appointments	Not to exceed 45 minutes

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Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment
Specialty Care Provider Appointment Access Standards *(OB-GYNs, Oncologists, Retail Pharmacy, Autism Services)*	
Appointment Type	**Access Standard**
Routine visits for established patients	Within 15 business days
Urgent, 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, seven days a week by direct access or through arrangement with a triage system
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
Behavioral Health Provider Appointment Access Standards	
Appointment Type	**Access Standard**
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
Urgent, 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, seven days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment
Other Required Specialty Care Provider Appointment Access Standards	
Appointment Type	**Access Standard**
Routine visits for non-symptomatic care	Within four and a maximum of twelve weeks for unique specialists
Urgent medical condition visits	Within 48 hours of referral or notification of the PCP
Emergent or emergency visits	Immediately upon referral
Indian Member Referrals	Allow for Indian Health Care provider referrals of an Indian member

Provider Office Standards

Absolute Total Care requires all office spaces to be professional, clean, free of clutter and

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physically safe. In addition, offices must have visible signage, a separate waiting area with adequate seating, a fully confidential telephone line, and clean restrooms.

Offices also must be compliant with the Americans for Disabilities Act (ADA) and have locked cabinets behind locked doors for storage of patient medical records, prescription pads, and sample medications.

PCP Administration

Member Panel Capacity for PCPs

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Absolute Total Care does not guarantee that any provider will receive a defined number of members.

If a PCP declares a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact their assigned Provider Engagement Account Manager with the requested changes.

PCPs shall notify Absolute Total Care at least 45 days in advance of their inability to accept additional Medicaid-covered persons under Absolute Total Care agreements. Absolute Total Care prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

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

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

Referrals by PCPs

PCPs are to coordinate healthcare services and are encouraged to refer a member to the appropriate network provider when medically necessary care is needed that is beyond their scope. However, a PCP referral is not required for a member to see an Absolute Total Care network provider, and members may self-refer for all services, including referrals to specialists and behavioral health providers. Prior authorization may be required for some services. Except for emergency and family planning services, services must be obtained through network providers unless prior authorization for out-of-network providers is obtained.

Nurse Practitioners as a PCP

Absolute Total Care may utilize nurse practitioners to provide healthcare services under the following conditions:

Nurse practitioners are able to perform the healthcare services allowed within the parameters of the South Carolina Nurse Practice Act (S.C. Code Ann. §§40-33-5 et seq., Absolute Total Care must:

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- Validate nurse practitioner status;
- Confirm the nurse practitioner's ability to provide the allowed services as evidenced by written protocols; and
- Verify that there is a process in place to accommodate medically necessary hospital admissions.

Supervising physicians (preceptors) for practices staffed only by nurse practitioners must also be enrolled in the MCO's network and must have an active license. Absolute Total Care must:

- Authenticate the formal relationship between the nurse practitioner and supervising physician (i.e., preceptor); and
- Contract with any off-site supervising physician who is not already enrolled in Absolute Total Care's network.

Note: If the supervising physician will not enroll, the nurse practitioner-only practice cannot be enrolled into or, if already enrolled, cannot remain in Absolute Total Care's network.

Members shall not be automatically assigned to a nurse practitioner; however, members may choose a nurse practitioner to provide the healthcare services allowed with their scope of services.

Member PCP Change Request

To maintain continuity of care, Absolute Total Care encourages members to build collaborative relationships with their PCP. Members may request to change their PCP at any time by calling Member Services at 1-866-433-6041, in the Member Mobile App or in the Secure Member Portal. PCP change requests will generally be processed on the same business day or by the next business day. Absolute Total Care will issue an updated ID card to members within 7 calendar days.

Member Dismissal from a Panel

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

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

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

All requests to remove a member from a panel must be made in writing and contain detailed documentation and sent via certified mail to:

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

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

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

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

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

Unable-to-Locate Members

PCPs who have made three documented, unsuccessful attempts to contact members in their panel may request member removal from their panel. The PCP must provide pertinent member information and all documentation regarding attempts to contact the member to their Absolute Total Care Provider Engagement Account Manager.

Provider Training

Provider Training Overview

Absolute Total Care offers comprehensive training programs designed to educate and assist physical and behavioral health providers in meeting the unique needs of our members. These programs emphasize the appropriate exchange of medical information to support coordination of care. Training courses are developed to maintain compliance with SCDHHS requirements and all applicable state and federal laws while placing an emphasis on promoting high standards of care. Absolute Total Care's Provider Engagement department plays a key role in facilitating provider education and supporting initiatives that improve HEDIS® compliance rates for plan members.

Educational content includes, but is

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not limited to:

- Medicaid Managed Care Program policies and procedures
- Member benefits and services
- Additional services and member incentives
- Access and availability standards
- Care management programs
- Continuity and coordination of care
- Authorization or referral processes
- Clinical and payment policies
- Appeals, grievances and provider disputes
- Material rule changes
- Reporting or notification requirements
- Claims and billing guidelines
- Quality initiatives
- State and federal regulations
- Transition of Care/Discharge planning

The Provider Resource Center on our website features access to online training and assistance modules for live, instructor-led training, specialized webinars, self-guided training, assistance modules, and documents.

New Provider Orientation

The onboarding process for contracted providers begins with our comprehensive New Provider Orientation, designed to ensure a consistent understanding of program requirements, operational protocols, and compliance expectations. Orientation is delivered through multiple training modalities to accommodate provider preferences and operational needs. The primary format is webinar-based, offering flexibility and accessibility. Additionally, the assigned Provider Engagement Account Manager may conduct in-person orientations at provider offices upon request. Providers must complete this training within 30 business days of becoming effective with Absolute Total Care.

Required Training

In addition to initial training, network providers are required to complete the following training sessions found on our website on the Provider Resource Center:

- **General Compliance Training** – Within the first 30 days of joining the network and annually thereafter
- **Fraud, Waste and Abuse Training** – Within the first 30 days of joining the network and annually thereafter
- **Culturally and Linguistically Appropriate Services (CLAS) Training** – Within the first 30 days of joining the network and annually thereafter
- **Model of Care Training*** – Within the first 90 days of joining the network and annually thereafter

**As applicable. For providers serving dual-eligible members*

Additional Training and Education

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Absolute Total Care understands providers have diverse schedules and learning preferences, so we offer training in multiple formats, including live sessions, recorded webinars, written guides, and on-demand access through our website. This flexible, multi-modal approach allows our providers to engage with training materials at their convenience, ensuring they have the knowledge and resources to navigate our systems, meet compliance requirements, and deliver high-quality care.

Absolute Total Care offers a variety of clinical and behavioral health training opportunities to providers to promote practitioner opportunities to enhance skills, expand the use of evidence-based practices and support their ability to provide quality services to members. Training occurs at various times throughout the year and may be offered in real-time both in-person and via webinars.

The Provider Resource Center on our website provides easy access to training, assistance modules, and documents.

Provider Termination

Providers should refer to their Absolute Total Care contract for specific information about terminating from Absolute Total Care's network of providers. Any request to terminate a provider contract should be sent to the Absolute Total Care Contracting Department. The request will be reviewed based on the termination section in your contract agreement. All requests for termination must be in writing and signed on the provider's letterhead and addressed to:

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

Enrollment and Marketing Guidelines

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

Medical Records

Absolute Total Care providers are required to maintain accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to

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members. They will also enable Absolute Total Care to review the quality and appropriateness of the services rendered. Medical records should be stored in a secure location to protect member privacy. Absolute Total Care requires providers to maintain all records for members for at least 10 years for adult patients and at least 13 years for minors. Refer to the Member Rights section of this manual for policies on member access to medical records.

Medical Records Documentation

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

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

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

Each visit must include the following items:

- Date
- Purpose of visit
- Diagnosis or medical impression
- Objective finding
- Assessment of patient's findings
- Plan of treatment, diagnostic tests, therapies and other prescribed regimens
- Medications prescribed
- Health education provided

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- Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials
- Medication allergies
- Legible and organized documentation

Medical Records Audits

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

Record Accessibility Policy

Providers must have and maintain a health record system that ensures that the record can be accessed and retrieved immediately. Access to all records concerning services and payment, shall be allowed to SCDHHS, the State Auditor's Office (SAO), the South Carolina Attorney General's Office (SCAG), HHS, Government Accountability Office (GAO), and/or their designees, for the purpose of reviewing, copying, and reproducing documents during normal business hours. SCDHHS will accept electronic records and clinical notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §§ 26-6-10 et seq). and the Health Insurance Portability and Accountability Act (HIPAA) electronic health record requirements. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended.

Medical Record Requests

As a condition of participation in the Medicaid program, providers are required to document, maintain, and provide immediate access to original health records that fully disclose the medical necessity for treatment and the extent of services provided to Medicaid patients [Social Security Act 1902(a)(27), 1902(a)(57), and 1902(a)(58); 42 CFR 431.107], including associated audit trails.

Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the provider into a reasonably usable form that allows the ability to review the record. When submitting documentation for claims, providers must follow the specific guidelines outlined within each SCDHHS Provider Manual to ensure correct documentation and proper signature is provided.

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Medical Record Release

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

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

Medical Records Transfer for New Members

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

Cultural Competency

Cultural Competency Overview

Absolute Total Care is a quality-driven organization that adopts continuous quality improvement that includes culturally and linguistically sensitive services as a core business strategy for the entire health plan. Guided by the concept of cultural humility that acknowledges the complexity of identities and the evolving and dynamic nature of an individual's experience and needs (e.g., social, cultural, linguistic). Absolute Total Care employs a system perspective that values differences and is responsive to diversity at all levels. Cultural humility is community-focused, and family-oriented, valuing the differences and integration of cultural attitudes, beliefs, and practices. These core components are integrated into diagnostic and treatment methods throughout the health care system to support the delivery of culturally relevant and competent care.

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

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

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provided in an accessible and responsive manner to all members.

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

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

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

Network providers must ensure that:

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

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

Preparing Cultural Competency Development

The road to developing a culturally competent practice begins with the recognition and

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acceptance of the value of meeting the needs of your patients. Absolute Total Care is committed to helping you reach this goal. Take into consideration the following as you provide care to Absolute Total Care's membership:

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

Provider Assistance with Cultural Competency Needs

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

Interpreter and Translation Services

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

- Having individuals available who are trained professional interpreters for languages other than English and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with members as needed.
- Providing Language Line services at no cost to members, that will be available 24 hours a day, seven days a week in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.
- In-person interpreter services are made available when Absolute Total Care is notified in advance of the member's scheduled appointment to allow for a more positive encounter between the member and provider; telephonic services are available for those encounters involving urgent/emergent situations, as well as non-urgent/emergent appointments as requested.
- Providing TTY access for members who are hearing impaired through 711.
- Absolute Total Care, nurse advice line, provides 24-hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line.
- Providing or making available Member Services and health education materials in

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alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee.

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

Provider Assistance with Public Health Services

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

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

Additional Reporting Requirements

Absolute Total Care, in accordance with its contract with SCDHHS, must report on the existence of certain information regarding its membership. For example, if a member is involved in an accident or becomes injured, this information should be shared with Absolute Total Care. This includes any incidents that occur prior to a member's coverage with Absolute Total Care. To report this type of information, please call Member Services at 1-866-433-6041. Please be prepared to supply as many details as possible including the date and cause of the accident, the injuries sustained by the member, and whether any legal proceedings have been initiated. In addition, you must immediately report the death of an Absolute Total Care member.

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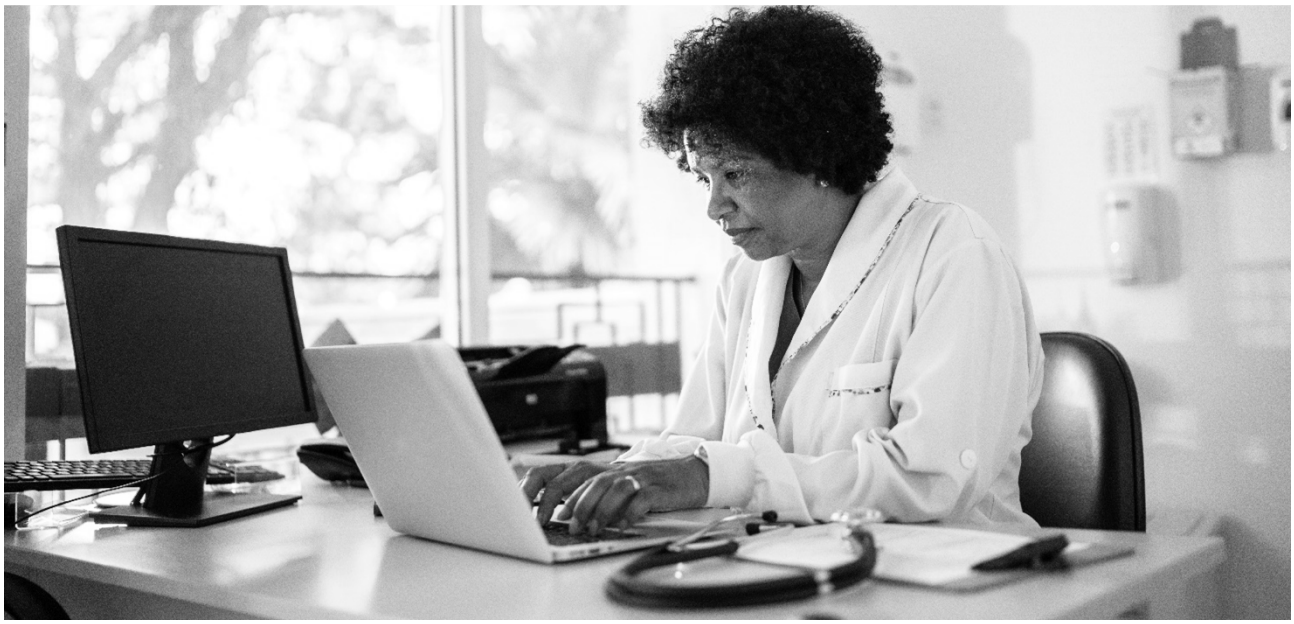

Domestic Violence

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

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

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

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Chapter 14: Member Administration

Member Rights

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

- To be treated with respect and with due consideration for his or her dignity and the right to privacy and non-discrimination as required by law.
- To participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
- To request and receive a copy of their medical records and request that their medical records be amended or corrected.
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information including enrollment notices, information materials, instructional materials, available treatment options and alternatives in a manner and format that may be easily understood.
- To receive assistance from both SCDHHS and Absolute Total Care in understanding the requirements and benefits of the health plan.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- To receive information about the basic features of managed care, which populations may or may not enroll in the program, and Absolute Total Care's responsibilities for coordination of care in a timely manner to make an informed choice.
- To receive information on the following:
    - *Benefits covered.*
    - *Procedures for obtaining benefits, including any authorization requirements*
    - *Cost-sharing requirements if any.*
    - *Service area.*

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- *Names, locations, telephone numbers of non-English language speaking Absolute Total Care providers, including at a minimum, PCPs, specialists and hospitals.*
- *Any restrictions on the member's freedom of choice among network providers.*
- *Providers that are not accepting new patients.*
- *Benefits not offered by Absolute Total Care but available to members and how to obtain those benefits, including how transportation is provided.*

- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
- To receive information on the grievance, appeal, and State Fair Hearing procedures.
- To receive detailed information on emergency and after-hours coverage, including, but not limited to:
  - *What constitutes an emergency medical condition, emergency services and post-stabilization services.*
  - *That emergency services do not require prior authorization.*
  - *The process and procedures for obtaining emergency services.*
  - *The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.*
  - *The right to use any hospital or other setting for emergency care.*
  - *Post-stabilization care services rules in accordance with federal guidelines.*
- To expect their medical records and care be kept confidential as required by law.
- To receive Absolute Total Care's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
- To exercise these rights without adversely affecting the way Absolute Total Care, its providers, or SCDHHS treat the member.
- To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law.
- To receive timely access to care, including referrals to specialists when medically necessary without barriers.
- To choose a PCP and to change to another PCP.
- To choose a person to act on their behalf.
- To voice grievances or file appeals about Absolute Total Care decisions that affect their privacy, benefits, or the care provided.
- To make recommendations regarding Absolute Total Care's member rights and responsibilities policy.
- To file for a State Fair Hearing with SCDHHS.
- To make an advance directive, such as a living will.
- To receive information about Absolute Total Care, its benefits, its services, its practitioners, providers, member rights and responsibilities.
- To have a candid discussion about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

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- To get a second opinion from a qualified healthcare professional.
    - *You have the right to a second opinion about your care.*
    - *This means talking to a different provider about an issue to see what they have to say. The second provider is able to give you their point of view. This may help you decide if certain services or methods are best for you. If you want to hear another point of view, tell your PCP.*
    - *Choose an Absolute Total Care contracted provider to give you a second opinion. There is no charge to you. Your PCP or Member Services can help you find a provider. If you are unable to find a provider in Absolute Total Care's network, we will help you find a provider outside the network. There is no charge to you if you need a second opinion from a provider outside the network.*
    - *Any tests that are ordered for a second opinion must be given by a provider in Absolute Total Care's network. Your PCP will look at the second opinion and help you decide on a treatment plan that will work best for you.*

Member Responsibilities

- As a recipient of Medicaid and a member in a Plan, members have certain responsibilities. Absolute Total Care members have the responsibility:
- To inform Absolute Total Care of the loss or theft of their ID card.
- To present their ID card when using healthcare services.
- To be familiar with Absolute Total Care procedures to the best of their ability.
- To call or contact Absolute Total Care to obtain information and have questions clarified.
- To provide information (to the extent possible) that Absolute Total Care and its practitioners and providers need to provide care.
- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with their practitioners/providers.
- Make every effort to keep a scheduled appointment or cancel an appointment in advance of when it is scheduled.
- To inform their provider of reasons they cannot follow the prescribed treatment of care recommended.
- To understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To access preventive care services.
- To follow the policies and procedures of the SCDHHS Medicaid Plan.
- To be honest with providers and treat them with respect and kindness.
- To get regular medical care from their PCP before seeing a specialist.
- To follow the steps of the appeal process.
- To notify SCDHHS, Absolute Total Care and providers of any changes that may affect their membership, healthcare needs or access to benefits. Some examples may include:
    - *If they have a baby.*
    - *If their address changes.*
    - *If their telephone number changes.*
    - *If they or one of their children are covered by another health plan.*

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    - *If they have a special medical concern.*
    - *If their family size changes.*
- To keep all their scheduled appointments, be on time for those appointments and cancel 24 hours in advance if they cannot keep an appointment.

Advance Directives

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

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

Absolute Total Care recommends to its PCPs that:

- At the first point of contact with the member, the PCP's office should ask if the member has executed an advance directive, and the member's response should be documented inthe medical record.
- For those members with an executed advance directive during the first point of contact,the PCP's office should request a copy of the advance directive and document the request and delivery in the member's medical record.
- An advance directive should be included as part of the member's medical record,including mental health directives.
- If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician (if applicable). Discussionshould be documented in the medical record.
- If an advance directive has not been executed, the first point of contact within the officeshould ask the member if they desire more information about advance directives.
- If the member requests further information, member advance directive education andinformation should be provided.

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

Providers and members may obtain a copy of an advance directive online at caringinfo.org.

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

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Chapter 15: Pharmacy Program

Pharmacy Benefit

Prescription drug benefits are managed through Absolute Total Care and are administered by Absolute Total Care's pharmacy benefit manager. Absolute Total Care uses a Comprehensive Drug List (CDL) which includes all drugs on the SCDHHS Single Preferred Drug List, effective July 1, 2024, as well as additional drugs. Some drugs, even though they are listed on the CDL, may have special limitations, such as quantity limits and age restrictions. Others may require the member to try and fail other preferred medications first. Non-CDL drugs may be requested through the prior authorization process. Some drugs are excluded from the pharmacy benefits, including but not limited to medications such as those for infertility, medications not participating in CMS's Medicaid Drug Rebate Program, gender dysphoria agents, and those used for cosmetic purposes. The CDL is available to providers on the Pharmacy page on the Absolute Total Care website. Most drugs are allowed up to a 31-day supply, select medications for diabetes, cholesterol or hypertension may be available for a 90-day supply.

In addition to drugs available from a retail pharmacy, Absolute Total Care covers specialty injectable drugs or pharmaceuticals that can be administered in a physician's office or member's home. These injectable drugs do not include immunizations provided in the PCP's office. AcariaHealth is the preferred provider of biopharmaceuticals and specialty injectables for Absolute Total Care.

Pharmacy Policy

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

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

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

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Pharmacy Prior Authorization

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

Prior Authorization Telephone: 1-866-399-0928

Prior Authorization Fax: 1-833-982-4001

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

340B Medications

Pharmacy Benefit Effective with dates of service on or after July 1, 2019, the following policy will apply regarding the submission of claims for drugs purchased through the 340B Program, as described in Section 340B of the Public Health Act of 1992. When submitting Medicaid claims, an amount not to exceed the 340B ceiling price plus an enhanced 340B dispensing fee should be submitted in the usual and customary field.

Effective January 1, 2026, all 340B designated pharmacies under the Absolute Total Care Medicaid health plan must declare a claim as either 340B or non-340B by providing the appropriate code in the Submission Clarification Code (SCC) field. Each claim must include one of the following:

• If the claim is being filled with 340B stock, the pharmacy must include an SCC 20 designation.

• If the claim is being filled with non-340B stock, then the pharmacy must include an SCC 02 designation.

• If a claim is submitted without an SCC 02 or SCC 20, the claim will be rejected with the following reject code and secondary message:

- o Reject 70 – SCC 20 or 02 Reqd. Resubmit with SCC 20 if 340B claim or resubmit with SCC 02 if not 340B.

This edit will apply to all claims at 340B pharmacies for all NDCs without exception. Member Prior Authorizations will not be able to override this edit.

Medical Benefit on or after **April 1, 2026**, a "TB" modifier will be required on all 340B medical claims (CMS-1500 or UB-04 claim form). When submitting Medicaid claims, an amount not to exceed the 340B ceiling price plus an enhanced 340B dispensing fee should be submitted in the usual and customary field.

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Over-the-Counter (OTC) Medications

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

In addition, Absolute Total Care offers an enhanced OTC benefit, which may include first aid supplies, cold/cough medications, eye drops, toothpaste, pain relievers, vitamins, and personal care items.

Injectables and Oral Anti-Cancer Drugs

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

72-Hour Emergency Supply Policy

State and federal law require that a pharmacy dispense a 72-hour emergency supply of medicine to any member awaiting prior authorization determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour emergency supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour emergency supply of medication, whether the prior authorization request is ultimately approved or denied.

Absolute Total Care Pharmacy Benefit Manager programming allows for an automated dispensing of a 72-hour supply of a medication without the pharmacist having to place a call to the pharmacy services help desk if the pharmacy requires further assistance for any reason, they may call Pharmacy Services at 1-866-399-0928.

Continuity of Care/Transition of Care

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

Transition of Health Records

Providers furnishing services to Members must maintain and share a member's health record in accordance with professional standards (42 CFR 438.208(b)(5).

Pain Management Safety and Resources

Safe and appropriate opioid prescribing and utilization is a shared priority across the healthcare

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community. Absolute Total Care requires providers to follow its prescription policies, State and Federal regulatory guidance, and adhere to established best practices and patient safety protocols. Our prescription policies are designed to reduce the risk of misuse or abuse of high-risk chronic pain medications. Providers are expected to offer education and support to members regarding opioid safety and pain management, as needed, and continue to assess the use of opioid treatment to determine if tapering or discontinuation is a viable possibility. Providers may utilize the following information to assist in opioid pain management treatment decisions.

Pain Management:

Non-opioid Treatment:

Nonopioid Therapies for Pain Management | Overdose Prevention | CDC

Opioid Treatment**:**

https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

Opioid Tapering: Talking With Patients about Treatment Changes from CDC:

https://www.youtube.com/watch?v=xn47OxHBlgk

Tapering Off Opioids:

http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

http://www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext

Opioid Conversion Calculator

Opioid Conversion Calculator for Morphine Equivalents

CDC Overdose Prevention and Resource Page

https://www.cdc.gov/overdose-prevention/index.html

https://www.cdc.gov/overdose-prevention/communication-resources/index.html

Exclusions

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

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

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- Erectile dysfunction products prescribed to treat impotencies.

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Chapter 16: Claims Coding and Billing

Risk Adjustment

Risk adjustment is a process used by state Medicaid agencies to account for expected differences in cost of treatment of members who have varying health status.

Accurate calculation of risk adjustment requires specificity in diagnostic coding. Providers should always document and code according to CMS and State regulations and follow all applicable coding guidelines for ICD-10-CM, CPT and HCPCs code sets. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity by assigning the most precise ICD code that most fully explains the symptom or diagnosis
- Ensure medical record documentation is clear, concise, consistent, complete, legible and meets CMS and State signature guidelines (each encounter must stand alone)
- Submit claims and encounter information in a timely manner
- Alert Absolute Total Care of any erroneous data submitted and follow Absolute Total Care's policies to correct errors in a timely manner
- Provide medical records as requested and within fifteen days of request
- Provide ongoing training to staff regarding appropriate use of ICD coding for reporting diagnoses

Accurate and thorough diagnosis coding is imperative to Absolute Total Care's ability to manage members, comply with risk adjustment data validation and audit requirements. Claims submitted with inaccurate or incomplete data may require retrospective chart review.

Fee Schedule and Code Updates

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

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

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

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Provider Billing Information

Required Provider Information

Physicians, other licensed health professionals, facilities and ancillary providers contract directly with Absolute Total Care for payment of covered services. Providers should confirm with Provider Engagement or the practice's dedicated Provider Engagement Account Manager that the following information is current:

- Provider name (as noted on current W-9 form)
- National provider identifier (NPI)
- Group national provider identifier (NPI), if applicable
- Tax identification number (TIN)
- Billing name and address (as noted on current W-9 form)
- Physical name and address (if different)

Changes in Billing Information

Providers should notify Absolute Total Care at least 60 days but no later than 30 days in advance of changes pertaining to billing information.

If the change in billing information affects the address to which the end of the year 1099 IRS form is to be mailed, providers are required to submit a new W-9 form.

Providers may not use a claim form or 277 electronic file to make changes to their TIN or billing address.

- All W-9s should be e-mailed to SouthCarolinaPDM@centene.com.
- W-9s should be sent to Absolute Total Care each time the payment address changes.

If Absolute Total Care does not have the updated W-9 information, this could lead to a misdirection of payment.

Coordination of Benefits

Processing by Other Insurance

Before seeking reimbursement for a service from Absolute Total Care, providers should determine if their Absolute Total Care patients have any other medical insurance, including Medicare, Veterans Administration and commercial insurance. If so, providers should submit the claim to that insurance as Medicaid is the payer of last resort.

Providers may check eligibility and identify if a member has other insurance through the Absolute Total Care Secure Provider Portal. This is particularly important if a member has Medicare coverage through a managed care plan or Medicare fee for service.

If the needed service is covered by Medicare, the provider must first process the payment through the Medicare payer and follow applicable authorization rules. For covered Medicare services, the provider does not need to obtain an authorization from Absolute Total Care. If a balance remains

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following the Medicare payment, the provider may submit the Medicare evidence of payment to Absolute Total Care for consideration of additional payment under the member's Medicaid benefits with the appropriate additional authorization, if applicable, and up to the Medicaid-allowed amount

For Absolute Total Care Medicaid members also enrolled in Wellcare With Absolute Total Care, our aligned integrated Dual Special Needs Plan (D-SNP), Wellcare With Absolute Total Care will process claims through a single payment process that reflects Medicare and Medicaid coverage.

If the needed service is a not a covered Medicare benefit or the benefit limit has been exhausted, the provider should follow the Absolute Total Care prior authorization requirements and applicable billing procedures. For benefits that have been exhausted, the provider must send the explanation of benefits (EOB) that specifies the benefit exhaustion.

This entire process also applies to other applicable medical insurance carriers.

Coordination of Benefits Processing

To ensure the proper processing of claims requiring coordination of benefits, Absolute Total Care recommends that providers validate the membership number and supplementary or primary carrier information for every claim.

Absolute Total Care requires that 837I COB be submitted at the claim level loop (2300), 837P at the detail level (2400) for all COB transactions.

All sum of paid amount (AMT02 in loop 2320) and all line adjustment amounts (CAS in 2320 and 2340) must equal the total charge amount (CLM). Additionally, the service charge amount must equal the value of all drug charges (sum of CTP03 and CTP04 in 2410).

If the claim was adjudicated by another payer identified in the 2330B loop, the "AMT payer paid amount" or "AMT remaining patient liability" fields must be completed.

Primary and secondary coverage for the same claim will not be processed simultaneously. Claims that contain both primary and secondary coverage must be broken down into two claims. Submitters should file the primary coverage first and submit the secondary coverage after the primary coverage claim has been processed. Submitters can be assured that the primary coverage claim has been processed upon receipt of the EOP or ERA. A secondary coverage claim that is submitted prior to the processing of its preceding primary coverage claim will be denied based on the need for primary insurance information.

Encounter Versus Claim

Providers are required to submit an encounter or claim for each service rendered to an Absolute Total Care member.

- If you are the PCP for an Absolute Total Care member and receive a monthly capitation amount for services, you must file a "proxy claim" (also referred to as an "encounter") on a CMS 1500 Claim Form for each service provided. Since you will receive a pre-payment in the form of capitation, the "proxy claim" or "encounter" is paid at zero-dollar amounts. It is mandatory that your office submits encounter data. Absolute Total Care utilizes encounter reporting to evaluate all aspects of

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quality and UM, and it is required by the state of South Carolina and CMS.

- A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as a CMS 1500 or CMS 1450 (UB-04) Claim Form. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim.

Claim Submission

In general, Absolute Total Care follows CMS billing requirements for paper, electronic data interchange (EDI) and secure web-submitted claims. Absolute Total Care is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials. Claims will be rejected or denied if not submitted correctly.

The appropriate CMS billing forms for paper and EDI claim submissions are CMS 1450 (UB-04) for facilities and CMS 1500 for professionals.

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

- All documentation must be legible.
- PCPs and all participating providers must submit claims or encounter data for every member visit, even though they may receive a monthly capitation payment.
- Providers must ensure that all data and documents submitted to Absolute Total Care are accurate, complete, and truthful to their best knowledge, information and belief.
- All claims and encounter data must be submitted on either Claim Form CMS 1500, CMS 1450 (UB-04), or by electronic media in an approved format.
- Review and retain a copy of the error report that is received for claims that have been submitted electronically, then correct any errors and resubmit them with your next batch of claims.
- Providers must submit all claims and encounters within 365 days of the date of service.
- Coordination of Benefits' claims must be submitted with the appropriate primary payer's EOP information.
- Any provider for covered services must never bill Absolute Total Care members unless the criterion listed under the Billing the Member section of this Provider Manual is met.
- In a workers' compensation case for which Absolute Total Care is not financially responsible, the provider should directly bill the employer's workers' compensation carrier for payment.

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Claim Payment Process

Absolute Total Care will adjudicate 90% of clean claims within 10 days of receipt, 95% of clean claims within 15 days of receipt, and 99% of clean claims within 30 days of receipt. Absolute Total Care sends providers written notification via an explanation of payments for each claim that is paid or denied, including reason(s) for the denial, the date the contractor received the claim, and a reiteration of the outstanding information required from the provider to adjudicate the claim.

It is the provider's responsibility to cross-check their submitted claims audit report to processed claims EOPs from Absolute Total Care. This information is available at absolutetotalcare.com but requires registration to access the Secure Provider Portal.

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

Claims Payment: EFT and ERA

Absolute Total Care partners with specific vendors 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. Providers can enroll online after they receive their completed contract or have submitted a claim.

More information is available on the visit the Absolute Total Care PaySpan Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA) web page.

Billing Forms

Providers are to use standardized claim forms whether filing on paper or electronically. For paper filing, providers are to submit claims for all services except hospital services on a CMS 1500 form. Information commonly required of a clean claim on a CMS 1500 form includes:

- Full member name
- Member's date of birth
- Member identification number
- Appropriate NDC number for all J-Codes
- 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

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- Provider's federal tax identification number
- Billing and rendering provider taxonomy
- All mandatory fields must be complete and accurate.

Submit claims for hospital-based inpatient and outpatient services as well as swing bed services on a CMS 1450 (UB-04) Claim Form.

Verification Procedures

All claims filed with Absolute Total Care are subject to verification procedures. These include, but are not limited to, the following:

- All required fields are completed on an original CMS 1500 claim form, CMS 1450 (UB-04) claim form, EDI electronic claim format or claims submitted on the secure provider portal, individually or batched.
- All claim submissions are subject to 5010 validation procedures based on CMS industry standards.
- Claims must contain the CLIA number when CLIA-waived or CLIA-certified services are provided.
  - Paper claims must include the CLIA certification in Box 23 when CLIA-waived or CLIA-certified services are billed
  - For EDI submitted claims, the CLIA certification number must be placed in X12N 837 (5010 HIPAA version) loop 2300 (single submission); REF segment with X4 qualifier or X12N 837 (5010 HIPAA version); loop 2400 REF segment with X4 qualifier (both laboratory services for which CLIA certification is required and non- CLIA covered laboratory tests)
- All diagnosis, procedure, modifier, location (place of service), revenue, type of admission and source of admission codes are valid for:
  - Member age, date of birth and gender for the date of service billed
  - Bill type
  - Date of service
  - Provider type and/or provider specialty billing
- All diagnosis codes must be to the highest number of available digits
- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable, including quantity and type with type limited to the following list:
  - F2 – International unit
  - GR – Gram
  - ME – Milligram
  - ML – Milliliter
  - UN – Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM
  - On a CMS 1500 claim form, principal diagnosis criteria is fixed to all procedure codes billed and the applicable pointers. If a procedure points to a diagnosis that is not valid as a primary diagnosis code, the service line may deny.
  - Inpatient facilities are required to submit a "present on admission" (POA) indicator. Inpatient claims will be denied (or rejected) if the POA indicator is missing or invalid. Providers should reference CMS billing guidelines regarding POA for more information

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and for excluded facility types. Valid 5010 POA codes are N (No), Y (Yes) or left blank.

- Interim Billing Requirements – The Plan requires that hospital providers billing first-time claims for interim inpatient stays that exceed 100 consecutive days use Inpatient Type of Bill Code 0112 Interim. For each subsequent inpatient hospital billing, the previous interim claim is voided by being recouped and replaced with the new claim type of bill code 0117.
- Member is covered by Absolute Total Care in the dates of service submitted for reimbursement.
- Services were provided by a participating provider or, if provided by a non-participating provider, authorization was received to provide services to the eligible member. (This guideline excludes services from an out-of-network provider for an emergency medical condition; however, authorization requirements apply for post- stabilization services.)
- Third party coverage was clearly identified, and appropriate COB information was included with the claim submission.

Clean Claim vs. Unclean Claim

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

Unclean claims are submitted claims that require further investigation or development beyond the information contained therein. Errors or omissions in claims will result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, unclean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

To obtain clean claim submission protocols and standards, including instructions and all information required for a clean or complete claim, visit the Absolute Total Care PaySpan Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA) web page.

Upfront Rejection vs. Denial

Upfront Rejection

An upfront rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in CMS 837 companion guide (PDF) available on the CMS website.

Common causes for upfront rejections include but are not limited to:

- Unreadable information (Ink is faded, too light, too bold, bleeding into other characters or beyond the box, or too small)

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- Missing member date of birth
- Missing member name or identification number
- Missing provider name, taxpayer identification number (TIN) or national practitioner identification (NPI) number
- Missing attending provider information from Loop 2310A on institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form
- Date of service is not prior to the received date of the claim (future date of service)
- Date of service occurred before member's effective date
- Missing date of service or date span from required fields, e.g., "Statement From" or "Service From" dates
- Invalid bill type
- Missing, invalid or incomplete diagnosis code
- Missing service line detail
- Missing admission type (Inpatient facility claims – CMS 1450 (UB-04), field 14
- Missing patient status (Inpatient facility claims – CMS 1450 (UB-04), field 17
- Missing or invalid occurrence code/date
- Missing or invalid revenue code
- Missing or invalid CPT/procedure code
- Missing CLIA number in Box 23 or a CMS 1500 for CLIA or CLIA waived service
- Incorrect form type
- Missing billing and rendering provider taxonomy

Upfront rejections will not enter the claims adjudication system, so there will be no explanation of payment (EOP) for these claims. Instead, the provider will receive a letter or a rejection report if the claim is submitted electronically.

Denial

If all edits pass and the claim is accepted, it is entered into the system for processing. If the claim has been billed with invalid or inappropriate information, the claim will be denied. An EOP will then be sent to the provider with denial reasons.

Common Billing Errors

To avoid rejected claims or encounters always remember to:

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

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Timely Submission

Providers must submit claims in a timely manner as indicated in the following table.

Initial Claim	Corrected Claim or Reconsideration	Provider Dispute*	Coordination of Benefits**
365 days from the date of service	365 days from the date of service	60 days from the date of the EOP	365 days from the date of service

*If a contracted or non-contracted provider is not satisfied with the outcome of a previous adjustment request or request for reconsideration, the provider may submit a provider dispute to Absolute Total Care.

**Providers have up to 24 months to resubmit claims for Member's Medicare retroactive eligibility.

Electronic Claim Submission

Electronic Claim Submission Overview

Providers are encouraged to participate in Absolute Total Care's electronic claims/encounter filing program. Absolute Total Care can receive ANSI XS12N 837 professional, institutional or encounter transactions. In addition, Absolute Total Care can generate an ANSI X12N 835 electronic remittance advice known as an explanation of payment (EOP).

For more information on electronic filing, contact Absolute Total Care's Electronic Transactions (EDI) department by calling 1-800-225-2573, ext. 25525, or send an email to EDIBA@centene.com.

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Absolute Total Care can receive coordination of benefits (COB) or secondary claims electronically. Absolute Total Care follows the 5010 X12 HIPAA companion guides for requirements on submission of COB data. A list of applicable clearinghouses is available on our website.

Electronic Payor ID Numbers

Absolute Total Care EDI Payer Numbers - Electronic Claims (Medical):

- 68069 – Emdeon/WebMD/Envoy/Availity
- 42772 – Relay Health/McKesson
- 68055 – Allscripts/Payerpath/Practice Insights

Absolute Total Care EDI Payer Numbers- Electronic Claims (Behavioral Health):

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- 68068 – Emdeon/WebMD/Envoy/Availity
- 68068 – Relay Health/McKesson
- 68059 – Allscripts/Payerpath/Practice Insights

Electronic Claim Flow Description

To send claims electronically to Absolute Total Care, all EDI claims must first be forwarded to one of Absolute Total Care's clearinghouses. This can be completed via direct submission to a clearinghouse or through another EDI clearinghouse. Once the clearinghouse receives the transmitted claims, it then validates them against their proprietary specifications and plan-specific requirements.

Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. Providers should review this error report daily to identify any claims that were not transmitted to Absolute Total Care. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Absolute Total Care, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Absolute Total Care by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are upfront rejected and sent back daily to the clearinghouse. The clearinghouse in turn forwards the upfront rejection back to its trading partner – either the intermediate EDI clearinghouse or provider. Providers should review this report of rejected claims daily as these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily. Because the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Absolute Total Care.

For assistance in resolving submission issues reflected on either the acceptance or claim status reports, providers should contact the clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Providers should clearly mark the claim as a corrected claim per the instructions provided in the corrected claim section.

Online Claim Submission

Providers who have internet access and choose not to submit claims via EDI or on paper may submit claims directly to Absolute Total Care by using the Secure Provider Portal. Providers must request access to the secure site by registering for a username and password.

Once registered for the Secure Provider Portal, providers may file first-time claims individually

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or submit first-time batch claims. Providers also have the capability to find, view, and correct any previously processed claims.

Detailed instructions for submitting via the Secure Provider Portal are also stored on the website. Providers must login to the secure site for access to this manual.

Paper Claim Submission

Address for Filing Paper Claims

Absolute Total Care encourages all providers to submit claims electronically. Paper submissions are subject to the same edits as electronic and web submissions.

The mailing address for first-time **medical claims**:

Absolute Total Care
Attn: Claims Department
P.O. Box 3050
Farmington, MO 63640-3821

The mailing address for first-time **behavioral health claims** for **dates of service before October 1, 2025**:

Absolute Total Care
Attn: Claims Department
P.O. Box 7001
Farmington, MO 63640-3818

The mailing address for first-time **behavioral health claims** for **dates of service on or after October 1, 2025**:

Absolute Total Care
Attn: Claims Department
P.O. Box 3050
Farmington, MO 63640-3821

Edit Requirements

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. If a paper claim has been rejected, providers should submit the rejection letter with the corrected claim.

Acceptable Forms and Font

Absolute Total Care only accepts the most current CMS 1500 and CMS 1450 (UB-04) paper claims forms. Other claim form types will be rejected and returned to the provider.

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All paper claim forms must be completed with Times New Roman font in either 10 or 12 point 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.

Imaging Requirements

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

Do:

- Use the correct P.O. Box number.
- Submit all claims in a 9” x 12” or larger envelope.
- Type all fields completely and correctly.
- Use black or blue ink only.
- Submit all claims on a proper and current form (CMS 1500 or CMS 1450 (UB-04) Claim Form).

Don’t:

- Submit handwritten claim forms.
- Use red ink on claim forms.
- Circle any data on claim forms.
- Add extraneous information to any claim form field.
- Use a highlighter on any claim form field.
- Submit photocopied claim forms (black and white).
- Submit carbon-copied claim forms.
- Submit claim forms via fax.

Hospital Claims

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

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

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

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

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accordance with this policy. Once charges are reviewed and validated, the outlier portion of the reimbursement will be released, and the total claims payment will have been adjudicated.

Forensic Review Process

- DRG+Outlier are paid and one line which doesn't impact payment is denied EXm3 Itemized Bill Required for Claim Review.
- 6Degrees, our delegated vendor, will also send a request for the itemized bill and the patient's medical records.
- 6Degrees reviews the claim and records and informs the Claims Department of the results of the review highlighting exceptions.
- The claim is adjusted based on the exceptions. You will be sent a second letter informing you of the status of the exceptions.

Emergency Room (ER) Claims

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

Clinical Lab Improvement Act (CLIA) Billing Instructions

Clinical Lab Improvement Act (CLIA) numbers are required for CMS 1500 claims where CLIA-certified or CLIA-waived services are billed. If the CLIA number is not present, the claim is rejected.

EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4.

If a claim is submitted with both laboratory services for which CLIA certification or a waiver is required and a non-CLIA covered laboratory test, in the 2400 loop for the appropriate line, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

Consult the 5010 implementation guides for the appropriate loops to enter the CLIA number. If a claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided.

Web

Complete box 23 by using the CLIA certification or waiver number as the prior authorization

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number for those laboratory services for which CLIA certification or waiver is required.

Paper Claims

If a claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided in Box 23.

An independent clinical laboratory that elects to file a paper claim form shall file a CMS 1500 claim form for a referred laboratory service (as it would any laboratory service). The line-item services must be submitted with a modifier of 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims – one claim for non-referred tests and another for referred tests.

If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP code shall be reported in item 32 on the CMS 1500 claim form to show where the service (test) was performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Corrected Claims, Requests for Reconsideration, and Provider Disputes

Definitions

The definition of a corrected claim is when a provider needs to change information on a previously submitted initial claim.

The definition of a request for reconsideration is when a provider disagrees with the original claim outcome, such as payment amount or denial reason, and resubmits additional information for review. Requests related to a code edit or authorization denial require medical records and must accompany the request for reconsideration.

The definition of a provider dispute is when a contracted or non-contracted provider is not satisfied with the outcome of a previous adjustment request or request for reconsideration. In-network providers may also dispute Absolute Total Care's policies, procedures, rates, contract disputes, and any aspects of Absolute Total Care's administrative functions.

Corrected Claim Process

Providers must indicate the correction in one of the following ways:

- Submit a corrected claim via the secure provider portal and follow instructions on the portal for submitting a corrected claim

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- Submit a corrected claim electronically via a clearinghouse:
  - For institutional claims (UB): Field CLM05-3=7 and ref*8 = original claim number
  - For professional claims (CMS): Field CLM05-3=7 and ref*8 = original claimnumber
- Submit a corrected paper claim by mail:
  - Upon submission of a corrected paper claim, the original claim number must be typed in field 22 of the CMS 1500 claim form for professional claims and in field 64 of the CMS 1450 (UB-04) for institutional claims with the corresponding frequency codes in field 22 of the CMS 1500 claim form for professional claims and in field 4 of the CMS 1450 (UB-04) for institutional claims

Process for Corrected Claims and Reconsiderations

Providers have **365 calendar days from the date of service** to file a timely corrected claim or reconsideration request via EDI, on the Secure Provider Portal at absolutetotalcare.com (the preferred and fastest method) or by mail to the address below. Requests submitted via mail must include a completed Provider Claim Adjustment/Reconsideration Form, which can be found on our website at absolutetotalcare.com, along with all supporting documentation.

Medical Claim Adjustments and Reconsiderations

Submit claim adjustments and reconsiderations to the following address:

Absolute Total Care
Attn: Adjustments/Reconsiderations
P.O. Box 3050
Farmington, MO 63640-3821

Behavioral Health Claim Adjustments and Reconsiderations

Dates of service before October 1, 2025, submit claim adjustments and reconsiderations to the following address:

Absolute Total Care
Attn: Adjustments/Reconsiderations
P.O. Box 7001
Farmington, MO 63640-3818

Dates of service on or after October 1, 2025, submit claim adjustments and reconsiderations to the following address:

Absolute Total Care
Attn: Adjustments/Reconsiderations
P.O. Box 3050
Farmington, MO 63640-3821

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If the request for reconsideration is related to a code audit, code edit, or authorization denial, supporting documentation must accompany the request for reconsideration.

Reconsiderations should be submitted by completing the Provider Claim Adjustment/Reconsideration Form. All formal requests for reconsideration/dispute must include the appropriate form. Reconsideration/disputes received with a missing or incomplete form will not be processed and returned to sender.

Absolute Total Care shall process and finalize all claim adjustment and reconsideration requests to a paid or denied status normally within 30 business days of receipt of the adjustment or reconsideration request. When the request for reconsideration results in an overturn of the original decision, the provider will receive a revised explanation of payment (EOP). If the original decision is upheld, the provider will receive either a revised EOP or a letter detailing the decision.

Process for Provider Disputes

If a contracted or non-contracted provider is not satisfied with the outcome of a previous adjustment request or request for reconsideration, the provider may submit a formal dispute to Absolute Total Care within **sixty (60) calendar days from the receipt of notice of an adverse action**.

Providers may contact Absolute Total Care with concerns in-person or by telephone, email, or in writing and will receive instruction on how to file a formal provider dispute. However, to be classified as a provider dispute these concerns must be submitted in writing and include the Provider Dispute Form and supporting documentation.

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

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

- Adverse benefit determinations and actions related to pre-service and/or concurrent authorization determinations for which the provider is not acting as an authorized representative of the member as defined by SCDHHS.

  *Note: Appeals related to a provider acting as an authorized representative of the Medicaid member are processed as a member grievance or appeal in accordance with SCDHHS regulations and Absolute Total Care's policies and procedures.

- Denials, rejections, or nonpayment of rendered services not covered or approved for

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reimbursement by SCDHHS and Absolute Total Care

- Denials and payment adjustments for National Correct Coding Initiative (NCCI)
- Rejection, denial, or nonpayment of services not billed on a “clean claim” as defined by this manual.

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

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

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

Medical Claim Disputes

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

Behavioral Health Claim Disputes

Dates of service before October 1, 2025, submit claim adjustments and reconsiderations to the following address:

Absolute Total Care
Provider Disputes
P.O. Box 6000
Farmington, MO 63640-3821

Dates of service on or after October 1, 2025, submit claim adjustments and reconsiderations to the following address:

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

If a provider has a question or is not satisfied with the information, they have received related to

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a claim, they can contact Provider Services at 1-866-433-6041.

Billing the Member

Absolute Total Care only reimburses services that are medically necessary and covered through Medicaid. Carved out services outlined earlier in this manual should be billed to the state Medicaid Fee- For-Service Program. Providers may not bill Medicaid recipients for covered services, regardless of whether they believe the amount they were paid or will be paid by Absolute Total Care is appropriate or sufficient. A provider may only bill an Absolute Total Care member if the provider obtains written consent from the member as outlined in the Member Acknowledgment Statement section of this Provider Manual.

Member Acknowledgement Statement

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

A member acknowledgement statement must include all the following:

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

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

Balance Billing Prohibition

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

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

- Members cannot be billed for the difference between the provider's usual and customarycharge and the provider's contracted rate.
- Members cannot be billed for the difference between the amount billed by the provider andthe amount paid by Absolute Total Care.
- Absolute Total Care members cannot be billed, nor can any deposits be collected from Absolute Total Care members.
- If a member does not keep a scheduled appointment, you are not permitted to bill themember or Absolute Total Care for the missed appointment.

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Chapter 17: Code Editing

Code Editing Overview

Absolute Total Care uses HIPAA-compliant clinical claims editing software for physician and outpatient facility coding verification. The software detects, corrects and documents coding errors on provider claim submissions prior to payment. The software contains clinical logic that evaluates medical claims against principles of correct coding using industry standards and government sources. These principles are aligned with a correct coding "rule." When the software edits a claim that does not adhere to a coding rule, a recommendation known as an "edit" is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code editing software is a useful tool to ensure provider compliance with correct coding, a fully automated code editing software application will not wholly evaluate all clinical patient scenarios. Consequently, Absolute Total Care uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors.

Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers 25 and 59 for clinical scenarios that justify payment above and beyond the basic service performed.

Moreover, Absolute Total Care may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the Healthcare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding.

Current procedural terminology (CPT) codes belong to the Level I subset and comprise the terminology used to describe medical terms and procedures performed by healthcare professionals. CPT codes are published by the American Medical Association (AMA) and are updated (added, revised and deleted) annually.

Level I HCPCS Codes

This code set comprises CPT codes that are maintained by the AMA. CPT codes are a five-digit uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.

Level II HCPCS Codes

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The Level II subset of HCPCS codes are used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment (DME), orthotics and prosthetics, CWSP behavioral health assessments, etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated annually.

Miscellaneous/Unlisted Codes

The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided.

Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records along with the initial claims' submission. If the records are not received, the provider will receive a denial indicating that medical records are required.

Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered.

Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

Temporary National Codes

These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H, and T code ranges.

HCPCS Code Modifiers

Providers use modifiers to include additional information about the HCPCS codes billed. Occasionally certain procedures require more explanation because of special circumstances. For example, modifier 24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10)

International Classification of Diseases-10 (ICD-10) is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). Healthcare providers use ICD-10 codes to classify diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external

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causes of injury or diseases.

The code set in the base classification allows for more than 14,400 different codes and permits the tracking of many new diagnoses compared to ICD-9. By using optional sub-classifications, the number of codes can be expanded to over 16,000.

With the transition to ICD-10, in the United States, ICD-9 codes are segmented into ICD-10-CM and ICD-10-PCS codes. The "CM" in ICD-10-CM codes stands for clinical modification.

ICD-10-CM codes were developed by the Centers for Disease Control and Prevention (CDC) in conjunction with the National Center for Health Statistics (NCHS) for outpatient medical coding and reporting in the United States.

The "PCS" in ICD-10-PCS codes stands for the procedural classification system. ICD-10-PCS is a separate medical coding system from ICD-10-CM, containing an additional 87,000 codes for use only in United States inpatient, hospital settings. The procedure classification system (ICD-10-PCS) was developed by CMS in conjunction with 3M Health Information Management (HIM).

Revenue Codes

These codes represent the location where a member had services performed, or the type of services received. These codes are billed by institutional providers on the CMS 1450 (UB-04) claim form. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims' editing software application contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied.

The software applies edits that are based on the following sources:

- CMS National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits include column 1/column 2, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments.
- CMS Claims Processing Manual
- Public domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons)
- CMS Medicaid NCCI Policy Manual
- State provider manuals, fee schedules, periodic provider updates (bulletins/transmittals)
- CMS coding resources such as HCPCS coding manual, national physician fee schedule, provider benefit manual, claims processing manual, Medicare Learning Network (MLN) and provider transmittals
- AMA resources, including:
  - CPT Manual

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- AMA website
- Principles of CPT Coding
- Coding with Modifiers
- CPT Assistant
- CPT Assistant Archives
- CPT Insider's View
- CPT Procedural Code Definitions
- HCPCS Procedural Code Definitions

- Billing guidelines published by specialty provider associations
  - Global maternity package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
  - Global service guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims
- Absolute Total Care policies and provider contract considerations

Code Editing and the Claims Adjustment Cycle

Code editing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

The software makes the following recommendations depending upon the code edit applied:

- **Deny:** Code editing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- **Pend:** Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- **Replace and pay:** Code editing recommends the denial of a service line, and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim, and a new line is added to reflect the software's recommendations. For example, if an incorrect CPT code is billed for the member's age, the software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing as the original billing remains on the claim.

Code Editing Principles

The following principles are not an all-inclusive list of available code editing principles but, rather, a sample of edits applied to practitioner and/or outpatient facility claims.

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Unbundling

CMS National Correct Coding Initiative

CMS developed the correct coding initiative to control erroneous coding and help prevent inaccurate claim payment. CMS National Correct Coding Initiative (NCCI) edits consist of Procedure to Procedure (PTP) edits for physicians and hospitals and Medically Unlikely Edits for professionals and facilities.

CMS offers a more complete explanation of the unbundling initiative on its website.

Procedure to Procedure Practitioner and Hospital Edits

CMS has designated certain combinations of codes that should not be billed together. CMS developed Procedure to Procedure (PTP), also known as Column I/Column II, edits to detect incorrect claims submitted by medical providers. The column I procedure code is the most comprehensive code, and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component of the column I code. While these codes should not typically be billed together, there are circumstances when an NCCI modifier may be appended to the column II code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

PTP practitioner edits are applied to claims submitted by physicians, non-physician practitioners, and ambulatory surgical centers (ASC). The PTP hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers, and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits for Practitioners, DME Providers and Facilities

Medically unlikely edits (MUEs) reflect the maximum number of units that a provider would bill for a single member on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information, and clinical judgment.

Code Bundling Rules Not Sourced to CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules concerning the proper use of codes in their area of expertise. These rules are published and available for use by the public. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

When two or more procedure codes are used to report a service and a more comprehensive procedure code should have been used, the less comprehensive code is denied with an unbundling edit.

Mutually Exclusive Editing

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These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest relative value unit (RVU) is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules concerning payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a thirty (30) day global surgical period. Procedures assigned a thirty (30) day global surgery period are designated as major procedures. Evaluation and management services for a major procedure (30-day period) that are reported one-day preoperatively, on the same date of service or during the 30-day post-operative period, are not recommended for separate reimbursement.

Global Maternity Editing

Global periods for maternity services are classified as “MMM” when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days). Certain procedures are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (Three-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days of the date of an inpatient admission, up to and including the date of admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered bundled into the inpatient admission and, therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule assesses situations where a provider has billed two or more procedure codes when a single, more comprehensive code should have been billed to represent all the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There also

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are codes that are allowed a limited number of times on a single date of service, over a given period or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period or during a member's lifetime. Code editing will trigger a frequency edit when the procedure code is billed more than the established guidelines allow.

Duplicate Edits

Code editing evaluates prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate of the prospective claim. The software also determines if another provider was paid for the same procedure for the same member on the same date of service. Finally, the software analyzes multiple services within the same range of services performed on the same day.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Invalid Revenue to Procedure Code Editing

This code editing rule identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

This code editing rule evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

CMS and State guidelines define whether an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co-surgeon or team surgeon.

Add-on and Base Code Edits

These code editing rules look for claims in which the add-on CPT code was billed without the primary service CPT code. If the primary service code is denied, then the add-on code is also denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one when an add-on code should have been used to describe the additional services rendered.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service performed in a facility setting. The technical

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component is typically performed by the facility and not by the physician.

Administrative and Consistency Rules

The code editing rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim.

Examples include the following:

- Procedure code invalid rules: Evaluates claims for invalid procedure, revenue and diagnosis codes
- Deleted codes: Evaluates claims for procedure codes which have been deleted
- Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers' affecting payment. Examples are modifiers 24, 25, 26, 57, 58 and 59.
- Age rules: Identifies procedures inconsistent with member's age
- Incomplete/invalid diagnosis codes: Identifies diagnosis codes that are incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Absolute Total Care's clinical validation services includes reviews of modifiers 25 and 59. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1."

Furthermore, specialty organization edits may also be considered for override when they are billed with these modifiers.

When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier 25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier 59).

Absolute Total Care's clinical validation team uses the information on the prospective claim and claims history to determine whether it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifier 59

The National Correct Coding Initiative (NCCI) states that the primary purpose of modifier 59 is to indicate that procedures or non-evaluation and management (E/M) services that are not usually reported together are appropriate under the circumstances. The CPT manual defines modifier 59 as follows: "Modifier 59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day."

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Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers routinely assign modifier 59 when billing a combination of codes that will result in a denial due to unbundling. Modifier 59 is often misused when related to the portion of the definition that allows its use to describe "different procedure or surgery." NCCI guidelines state that providers should not use modifier 59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier 59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions on the same organ. However, it does not include treatment of contiguous structures of the same organ.

Absolute Total Care uses the following guidelines to determine if modifier 59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates diagnostic testing was performed on multiple body sites or areas that would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters, or those unusual circumstances are present that support modifier 59 were used appropriately.

To avoid incorrect denials, providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating the areas of the body that were treated.

Modifier 25

In the NCCI policy manual, both CPT and CMS specify that by using a modifier 25 the provider is indicating that a "significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service." Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that: "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure." For example, osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.

The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a

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minor surgical procedure.

Absolute Total Care uses the following guidelines to determine whether modifier 25 was used appropriately. The clinical nurse reviewer will recommend reimbursement for the E/M service if any one of the following conditions are met:

- The E/M service is the first time the provider has seen the patient or evaluated a major condition.
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of service
- A provider bills supplies/equipment on the same date that are unrelated to the procedure performed but would require an E/M service to determine the patient's need.

To avoid incorrect denials, providers should assign all applicable diagnosis codes that support additional E/M services.

Payment and Coverage Policy Edits

Payment and coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective edits.

Clinical and payment policies are posted on the provider website when appropriate.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence.

Claim Reconsiderations Related to Code Editing and Other Editing

Claim reconsiderations resulting from claim editing are handled per the provider claims reconsideration process outlined in this manual. When submitting claims reconsiderations, providers should submit medical records, invoices and all related information to assist with the reconsideration review.

Providers who disagree with a code edit or other edit and request claim reconsideration should submit medical documentation (medical record) related to the reconsideration. If medical documentation is not received, the original code edit or other edits will be upheld.

Third-Party Liability

Third-party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and

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worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

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

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

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Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes Beneficiary practices that result in unnecessary cost to the Medicaid Program. See 42 CFR 455.2.

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

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

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

Adverse Benefit Determination: An Adverse Benefit Determination is:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered Benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the Claim does not meet the definition of a "Clean Claim" at 42 CFR §447.45(b) of this chapter is not an Adverse Benefit Determination.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of Absolute Total Care to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.
- For a resident of a rural area with only one MCO, the denial of a Member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.
- The denial of a Member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities. See 42 CFR 438.400.

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

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

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

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

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

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

Authorized Representative: An individual or organization granted authority to act responsibly on behalf of a potential Member or Member's in accordance with 42 CFR 435.923. For Eligibility and Appeal purposes, an Authorized Representative is also an individual granted authority to act via SCDHHS Form 1282, Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications Reviews and Appeals, who is acting for the potential Member or Member with the potential Member's or Member's knowledge and consent and who has knowledge of his circumstances.

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

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

Benefit or Benefits: The health care services for which Members may be eligible to receive.

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

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

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

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

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

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

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

Claim: A bill for services, a line item of services, or all services for one Member within a bill. See 42 CFR 447.45

Clean Claim: Claims that can be processed without obtaining additional information from the Provider of the service or from a Third Party. It does not include a Claim from a Provider who is under investigation for Fraud or Abuse, or a Claim under review for Medical Necessity. See 42 CFR 447.45.

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

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

Compliance Committee: An organized group of executive and senior management officials, on the Board of Directors and at the senior management level, charged with overseeing Absolute Total Care's Compliance Program and its compliance with the requirements under the Contract.

Compliance Officer: The individual, who on behalf of the Contractor, is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Medicaid Managed Care Organization Contract and who reports directly to the Chief Executive Officer (CEO) and the Board of Directors.

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

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

Coordination-Only Dual Special Needs Plan (C0-DSNP): CO D-SNPs, or Coordination-Only Dual Eligible Special Needs Plans, are a type of Medicare Advantage plan designed for individuals who qualify for both Medicare and Medicaid. They must hold contracts with state Medicaid agencies and coordinate care for dually eligible individuals. CO D-SNPs differ from other types of D-SNPs in that they do not have the same level of integration as Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) or Highly Integrated Dual Eligible Special Needs Plans

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(HIDE SNPs).

Copayment: Any cost-sharing payment for which the Member is responsible.

Core Benefits: A schedule of health care Benefits, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible, provided to Members enrolled in the Absolute Total Care Plan as specified under the terms of the Medicaid Managed Care Organization Contract.

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

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

Critical Incident: A Critical Incident is, at a minimum, verbal, physical, sexual, psychological, or emotional abuse; neglect; exploitation including financial exploitation; misuse or unauthorized use of restrictive interventions or seclusion; a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect. (See 42 CFR § 441.302(a)(6)(i)(A)).

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

Days: Calendar Days unless otherwise specified.

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

Dual Eligibles: Individual(s) that are enrolled in both Medicaid and Medicare Programs who receive benefits from both programs.

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

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

- Early: Assessing and identifying problems early
- Periodic: Checking children's health at periodic, age-appropriate intervals
- Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

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- Diagnostic: Performing diagnostic tests to follow up when a risk is identified, and
- Treatment: Control, correct or reduce health problems found.

States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on federal guidelines. See 42 CFR 440.40(b).

Emergency Medical Condition: Medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. See 42 CFR 438.114.

Emergency Services: Covered inpatient and Outpatient Services that are as follows: furnished by a Provider that is qualified to furnish these services and needed to evaluate or stabilize an Emergency Medical Condition. See 42 CFR 438.114.

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

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

Evidence of Coverage: The term which describes services and supplies provided to Medicaid Members, which includes specific information on Benefits, coverage limitations and services not covered.

Excluded Services: Medicaid services not included in the Absolute Total Care's Core Benefits and reimbursed fee-for-service by SCDHHS.

Exclusion: Items or services furnished by a specific Provider who has defrauded or abused the Medicaid Program will not be reimbursed under Medicaid. See 42 CFR 455.2.

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

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

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

Fraud: An intentional deception or misrepresentation made by a person with the knowledge

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that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes under applicable federal or State law. See 42 CFR 455.2.

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

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. See 42 CFR 438.400.

Grievance and Appeal System: Refers to the overall system that includes Grievance process, Appeals process, and Member access to state fair hearing as defined in 42 CFR 438.400.

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

Health Insurance Plan: A Health Insurance Plan means a package of covered health care items and services offered to individuals, together with the payment terms applicable to those items and services. The Plan specifies the scope of benefits, the reimbursement amounts or cost-sharing obligations and ensures access to a contracted provider network within the designated service area.

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

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

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

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

Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP): A D-SNP offered by a Medicare Advantage organization that provides coverage, consistent with SCDHHS policy, of long-term services and supports or behavioral health services under a capitated contract that meets one of the following arrangements: (1) the capitated contract is between the Medicare Advantage organization and SCDHHS; or (2) the capitated contract is between the Medicare Advantage organization’s parent organization (or another entity that is owned and controlled by its parent organization) and SCDHHS; and (3) has received CMS designation as a HIDE-SNP.

Home and Community Based Services (HCBS): Services delivered to persons with long-term

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care needs that allow them to remain in a community-based environment, as authorized in an approved 1915(c) Waiver or 1915(i) State Plan.

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

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

Hospital Outpatient Services: Hospital outpatient services is treatment received at a hospital or its departments by a patient who has not been formally admitted as an inpatient by a physician. These services are diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished by or under the direction of a physician or dentist to an outpatient in an institution licensed and certified as a hospital.

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

Improper Payment: Per 42 CFR 431.958, an improper payment in any payment that is made in error or in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements: to an ineligible Recipient; for ineligible goods or services; for goods or services not received (except for such payments where authorized by law); that duplicates a payment; or that does not account for credit for applicable discounts.

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

In Network Provider: A Provider that is under contract with Absolute Total Care to render services to the Absolute Total Care's Members.

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

Indian Health Care Provider (IHCP): A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). See 42 CFR 438.14(a).

Indian Managed Care Entity (IMCE): A MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service. See 42 CFR 438.14(a).

Inmate of a Public Institution: Pursuant to 42 CFR § 435.1010, an Inmate of a public institution is defined as "a person living in a public institution", and a public institution is

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defined as “an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.”

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

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

Limited English Proficiency: Potential Members and Members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient and may be eligible to receive language assistance for a particular type of service, Benefit, or encounter. See 42 CFR 438.10(a).

List of Excluded Individuals/Entities (LEIE): A database accessible to the general public, maintained by the United States Health and Human Services Office of Inspector General, that provides information about parties excluded from Medicare, Medicaid, and all other federal health care programs. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusion.asp.

Long-term Services and Supports (LTSS): Services and supports provided to Beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the Beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider- owned or controlled residential setting, a nursing facility, or other institutional setting. See 42 CFR 438.2.

Managed Care Organization (MCO): An entity that has, or is seeking to qualify for, a Comprehensive Risk Contract that is: a federally qualified HMO that meets the advance directive requirements of 42 CFR Part 489 Subpart I; or any public or private entity that meets the advance directives requirements and is determined by the Secretary of United States Health and Human Services to also meet the following conditions: makes the services it provides to its Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Beneficiaries within the area serviced by the entity; and meets the solvency standards of 42 CFR §438.116. This includes any of the entity’s employees, affiliated Providers, agents, or contractors. See 42 CFR 438.2.

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

Medicaid Managed Care Program: The program administered by the Department under the 1932(a) State Plan Authority (SSA Sec. 1932. [42 U.S.C. 1396u-2] State Option to Use Managed Care).

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

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

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

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and Procedures.

Medicare: A federal health insurance program for people sixty-five (65) or older, and certain younger individuals with disabilities, and certain individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant) authorized by Title XVIII of the Social Security Act.

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

Member: A person who is currently enrolled with a SCDHHS approved MCO.

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

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

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

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

Negative PDL Change: Any of the following changes: removal of a drug or therapeutic drug class from a Single Preferred Drug List (formulary); increasing the cost-sharing/co-pay status of a drug on the Single Preferred Drug List(formulary) subsequent to a change in step therapy; adding or making more restrictive utilization management requirements on a drug or therapeutic drug class, including: Prior Authorization requirements, quantity limits, and step therapy requirements.

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

Network Provider: A Provider of healthcare services or products which includes, but is not limited to, an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved and enrolled by the Department, licensed and/or credentialed which accepts payment in full for providing benefits to Members.

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

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

Non-Participating Provider: A Provider licensed to practice who has not

contracted with or is not employed by Absolute Total Care or Healthy Connections Medicaid to provide health care services.

Overpayment: Any payment made to a Network Provider by a MCO to which the Network Provider is not entitled to under Title XIX of the Social Security Act or any payment to a MCO, by the Department to which the MCO is not entitled to under Title XIX of the Act. See 42 CFR

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438.2 (2024, as amended).

Pharmacy Benefit: Covered outpatient drugs that are billed through a pharmacy point of sale system.

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

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

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

Prevalent Non-English Language: A non-English language determined to be spoken by a significant number or percentage of potential Members and Members that are Limited English Proficiency. See 42 CFR 438.10

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

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

Program: The method of provision of Title XIX services to South Carolina Beneficiaries as provided for in the South Carolina State Plan for Medical Assistance and Department regulations.

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

Protected Health Information (PHI): As defined in 45 CFR §160.103.

Provider: Any individual or entity furnishing Medicaid services under a Provider agreement with Absolute Total Care or the Medicaid agency. See 42 CFR 400.203. These may include the following: any individual, group, Physicians (e.g. Primary Care Providers and Specialists) or entity (e.g. hospitals, ancillary Providers, outpatient center (free standing or owned) clinics and laboratories) furnishing Medicaid services under an agreement with the SCDHHS; or for the Medicaid Managed Care Program, any individual, group, Physicians (e.g. Primary Care Providers and Specialists) or entity (e.g. hospitals, ancillary Providers, clinics, outpatient

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centers (free standing or owned) and laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.

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

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

Provider Incentives: Provider Incentives are those incentives paid by Absolute Total Care to qualified Providers for achieving designated goals.

Provider Network: Providers with which a Managed Care Plan contracts or makes arrangements to furnish covered health care services to Members.

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

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

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

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

Recoupment: Any formal action by the State or its fiscal agent to initiate recovery of an Improper Payment Overpayment without advance official notice by reducing future payments to a Provider. See 42 CFR 433.304.

Redetermination: The process of reviewing and confirming that individuals still meet the program's eligibility requirements, typically on an annual basis.

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

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

Screen or Screening: Assessment of a member's physical or mental condition to determine

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evidence or indications of problems and the need for further evaluation or services.

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

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

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

Single Preferred Drug List (sPDL): A list of outpatient drugs covered under the Pharmacy Benefit that health care payors use to encourage providers to prescribe certain drugs over others. The sPDL is not a comprehensive list of all medications covered by Medicaid.

Social Security Act: Title 42, United States Code, Chapter 7, as amended.

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

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

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

South Carolina State Plan for Medical Assistance (State Plan): The comprehensive written commitment by the Department, submitted under section 1902(a) of the Social Security Act, to administer or supervise the administration of the Medicaid Program in accordance with federal requirements.

Specialist: A healthcare professional with advanced training who treats only certain parts of the body, certain health conditions, or certain age groups, and who is distinct from a Primary Care Provider.

Special Enrollment Period (SEP): An enrollment period that allows a person to enroll in health

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coverage or switch plans outside of the annual open Enrollment period, or during open Enrollment for an earlier coverage start date.

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

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

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

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

Suspension of Payment for Credible Allegation: All Medicaid payments to a Provider are suspended after the SCDHHS determines there is a Credible Allegation of Fraud for which an investigation is pending under the Medicaid Program against an individual or entity unless the SCDHHS has good cause to not suspend payments or to suspend payment only in part. See 42 CFR 455.23.

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

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

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

Urgent Care: Medical conditions that require attention within forty-eight (48) hours. If the condition is left untreated for forty-eight (48) hours or more, it could develop into an emergency condition.

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

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Revision Log

Effective Date	Section Header	Change
9/15/2026	Key Contacts and Important Phone Numbers	Updated Member Services hours of operations; Pharmacy Prior Authorization phone number
9/15/2026	Timeliness of Decision	Updated Urgent or Expedited Pre-Service Determination language
9/15/2026	Vaccines and Immunizations	Updated language to the Statewide Immunization System Online Network (SIMON)
9/15/2026	Core Benefits and Services Covered by Absolute to Total Care - Developmental Evaluation Services	Updated language to add medically necessary
9/15/2026	Core Benefits and Services Covered by Absolute to Total Care - Rehabilitative Therapy	Updated language to remove approval by sponsoring agency
9/15/2026	Core Benefits and Services Covered by Absolute to Total Care - School-Based Mental Health Services	Updated language to add Prior authorization required for some services
9/15/2026	Core Benefits and Services Covered by Absolute to Total Care - Vaccines/Immunizations (Adult)	Updated language to add recombinant zoster vaccine
9/15/2026	Additional Services Covered by Absolute Total Care – 90-Day Medication Supply	Added language
9/15/2026	Quality Improvement Program Description	Updated Quality Improvement Committee (QIC) to Quality Improvement and Utilization Management Committee (QIUMC)
9/15/2026	Quality Improvement and Utilization Management Committee	Updated language
9/15/2026	Performance Improvement Projects	Updated language to include additional requirements
9/15/2026	Ordering, Referring, and Prescribing (ORP) Provider Enrollment Requirements	Added language
9/15/2026	Member PCP Change Request	Updated language
9/15/2026	Record Accessibility Policy	New section
9/15/2026	Medical Record Requests	New section
9/15/2026	Pharmacy Benefit	Updated language to add 90-day supply
9/15/2026	340B Medications	Updated language
9/15/2026	Provider Billing Information – Required Provider Information	Updated language
9/15/2026	Billing Forms	Updated language
9/15/2026	Upfront Rejection vs. Denial	Updated language
9/15/2026	Timely Submission	Added language
9/15/2026	Definitions	Updated and added definitions

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