



• Absolute Total Care
• and Wellcare
Q1 2026 Virtual Provider Town Hall



Q1, 2026 ATC & Wellcare Meeting Overview

Health Plan Updates

01— **Dual Eligibility Products **NEW****

02— Ambetter Eligibility

03— Prior Authorizations Updates

Payment Integrity Solutions

04— Eligibility

- **Absolute Total Care Provider Portal**
- **Wellcare Medicare Advantage Provider Portal**
- **Availity Essentials: New Multi-Payer Portal**

05— Annual Provider Training Requirements

06— Provider Training: Compliance Program and Fraud, Waste, and Abuse

07— **Annual Provider Training Requirements**

08— Payment and Clinical Policies

09— Claims 411

10— PaySpan

11— Risk Adjustment

- **Clinical Documentation Improvement (CDI)**

12— Quality Improvement

- **Partnership for Quality**
- **CPT II and HCPCS**

13— CAHPS

14— Accessibility and Availability Standards

15— Case Management

16— Provider Satisfaction Survey

17— Appendix

- **Health Insurance Mobile App**
- **2026 Medicaid Member ID Card**
- **2026 D-SNP Member ID Card**
- **2026 Medicare HMO Member ID Card**
- **2026 Medicare PPO Member ID Card**
- **2026 Medicare PDP Classic and Value Script Member ID Card**
- **2026 Ambetter Member ID Card**
- **Payment Integrity**

Poll Question

What area do you support in your organization / practice?



Billing / Claims Payment / Revenue Cycle

Community Relations

Direct Patient Care

Medical Management

Network Development / Contracting

Pharmacy

Pre-cert / Authorizations / Referrals

Dual-Eligibility Products

Dual Eligibility Products



Wellcare By Absolute Total Care implemented a new Aligned Integrated Plan (AIP) 1/1/26 for members that are enrolled in both Medicare and Medicaid. This is an exciting evolution of our product offerings for these members, and we want to ensure that our provider partners are aware of the key details of this change.

What is an AIP?



An Applicable Integrated Plan (AIP) delivers Medicare and Medicaid coverage through a single health insurance product.

AIPs streamline the insurance experience for both members and providers.



Is All Duals Coverage AIP?







The AIP product offering from Wellcare By Absolute Total Care is new in 2026.

All Wellcare By Absolute Total Care dual eligible members will be covered by an AIP plan.

Coverage from other payers may include a mix of AIP and non-AIP coverage for dual eligible members.

Member Alignment Overview



Logo	Plan Name & ID	Plan Type	Enrollment
 By 	H5272-SC-000 Wellcare Absolute Total Care Dual Liberty (HMO-POS) – New	HIDE DSNP	Members have Medicare and Medicaid and are enrolled in the ATC HID DSNP and ATC Medicaid Plan
	Absolute Total Care HCC Medicaid MCO	Aligned Dual Member	
Various	Other Medicare	MAPD, CO-DSNP, Medicare FFS / PDP	Dual members have Medicare and Medicaid and are enrolled in the ATC Medicaid Plan Medicare payor is Primary and for Medicare coverage the members can be enrolled in a MAPD or CO-DNSP with other carriers or in Medicare FFS with or without a PDP Plan
	Absolute Total Care HCC Medicaid MCO	Unaligned Dual Member	
	Absolute Total Care HCC Medicaid MCO	Non-Dual Member	Members have Medicaid and could have other commercial insurance as Primary

About Dual-Eligible Members



- Dual-eligible members may be more vulnerable and have more complex care needs than members who are enrolled in only Medicare or Medicaid.
- Factors that can lead to dual-eligibility include:
 - Demographic data including age
 - Income level
 - Disability status
 - Diagnosed clinical conditions
 - Social determinants of health
- Awareness of which factors apply to your dual-eligible patients is critical to understanding their care needs.

Clinical Best Practices

- Engage the patient
 - Outreach to members without visit, or in need of follow-up care
 - Encourage regular preventive care
 - Initiate needed screenings and routine monitoring
 - Keep track of medication adherence
- Take advantage of value-added services such as:
 - Dental/vision coverage
 - Hearing exams/hearing aids
 - Transportation benefits
 - Telehealth
 - Fitness programs
 - Meal programs
 - In-home support



Operational Best Practices



Eligibility Verification		
	Aligned AIP	Unaligned*
	Single, integrated ID card. Primary ID will be the Medicare ID. Providers will not need the Medicaid ID number.	Separate Member IDs and ID cards for Medicare and Medicaid. Provider must scan both member IDs cards.
Authorizations		
	Aligned AIP	Unaligned*
Authorization Submission	Providers will submit a single authorization with a unified process, single review and decision.	Providers will submit authorizations for Medicare covered benefits to Medicare carrier as applicable; Providers will submit authorizations for Medicaid only benefits (not covered by Medicare) to Absolute Total Care Medicaid plan.
Authorization Inquiry	Authorization status inquiries will be combined into a single view using the single auth #	Authorization status inquiries for Medicare covered benefits should be viewed under the Medicare carrier as applicable; Medicaid only benefits (not covered by Medicare) can be obtained using the Availity or the Absolute Total Care secure portal.
Authorization Appeal	Providers will submit a single appeal with a unified process, single review and decision.	Authorization appeals are submitted to the Medicare carrier for Medicare benefits; Authorization appeals are submitted to Absolute Total Care for Medicaid only benefits

*Absolute Total Care Medicaid members with primary Medicare coverage other than the HIDE DSNP Aligned AIP H5272. Absolute Total Care Medicaid coordinates cost share on claims and covers State Medicaid only benefits only.

Operational Best Practices, cont.



Claims		
	Aligned AIP	Unaligned*
Claims Submissions	Providers will submit one claim for both Medicare and Medicaid and will get one claim number for reference	Provider must submit claims to the Medicare carrier and subsequently to Absolute Total Care with the primary carrier EOP; Primary EOP is not required for claims for Medicaid only benefits (not covered by Medicare)
Claims Inquiry	Claim status inquiries will be combined into a single view using the single claim number	Claim status inquiries must be reviewed with the Medicare carrier and with Absolute Total Care using the applicable claim numbers and/or Member IDs
Claims Appeal	Provider will submit a single appeal and will have a single claim number for status inquiries	Provider appeals are submitted to the Medicare carrier for Medicare benefits; Provider appeals are submitted to Absolute Total Care for Medicaid only benefits (not covered by Medicare) and COB claims.
Payments and EOPs		
	Aligned AIP	Unaligned*
	Providers will receive a single EOP with the detail for both Medicare and Medicaid payment amounts	Providers will receive a payment and EOP from the Medicare carrier and Absolute Total Care (providers must submit the claim to Absolute Total Care with the primary carrier EOP; Primary EOP is not required for claims for Medicaid only benefits (not covered by Medicare)

*Absolute Total Care Medicaid members with primary Medicare coverage other than the HIDE DSNP Aligned AIP H5272. Absolute Total Care Medicaid coordinates cost share on claims and covers State Medicaid only benefits only.

Key Information Providers Should Know



Explore the tools and resources available at go.wellcare.com/ATC. From there, you can click on “For Providers” to access:

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




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

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5104452_NA6PCARNEWE
H5272_SCWC2025_PROVDUALS-Notification

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



Aligned Dual Special Needs Plan (DSNP)



 Telehealth Virtual Visits with a Provider Explore Telehealth Benefits	 Dental Benefits to Make You Smile Explore Dental Benefits	 Wellcare Spendables® Card Added Perks for D-SNP members Explore Wellcare Spendables
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Member Perks

As a Wellcare By Absolute Total Care member, extra benefits are included with member's plan.

 My Wellcare Rewards It pays to make healthy choices Explore Wellcare Rewards	 Over-the-Counter (OTC) Benefits Allowance for Everyday Items Explore OTC Benefits
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2026 Medicare Dual Align HMO D-SNP ID Card

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

Contract (PBP) Number: H5272-001

Brand Name: Wellcare By Absolute Total Care

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



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

Member Name: [Cardholder Name]

Member ID: [Cardholder ID#]

PCP Group/Name: [PCP/Group Name]

PCP Phone: [PCP Phone]

MEMBER CANNOT BE CHARGED

Copays: PCP/Specialist: \$0 ER: \$0
[H5272] [001]



RXBIN: [610014]

RXPCN: [MEDDPRIME]

RXGRP: [2FFA]



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

Send Claims To: [Wellcare By Absolute Total Care Attn: Claims P.O. Box 9700 Farmington, MO 63640-0700] Payor ID: [68069]

Part D Claims: [Wellcare By Absolute Total Care Attn: Medicare Part D Member Reimbursement P.O. Box 31577 Tampa, FL 33631-3577]

FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room

Website: [go.wellcare.com/ATC]



FROM



Ambetter from Absolute Total Care

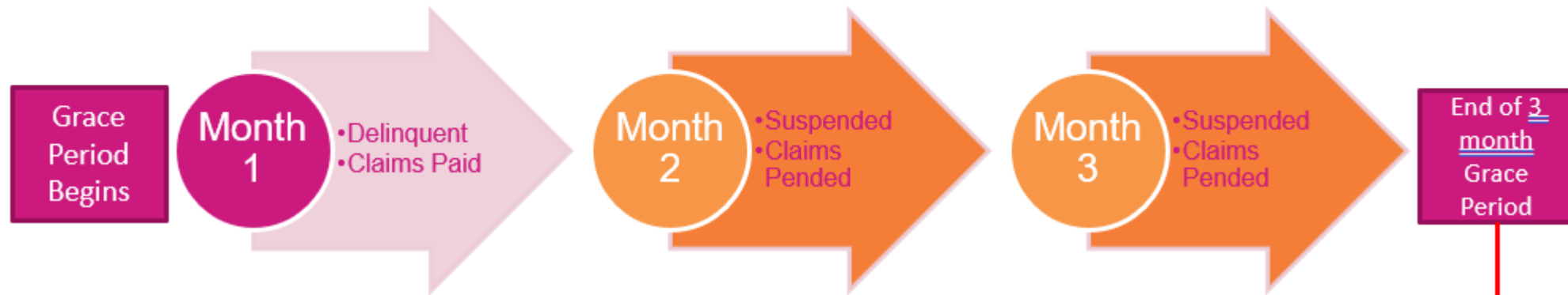
My Health Pays Rewards Program

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

Marketplace-Ambetter/Ambetter Health

Member Eligibility and Grace Period

Eligible for 3-month grace period

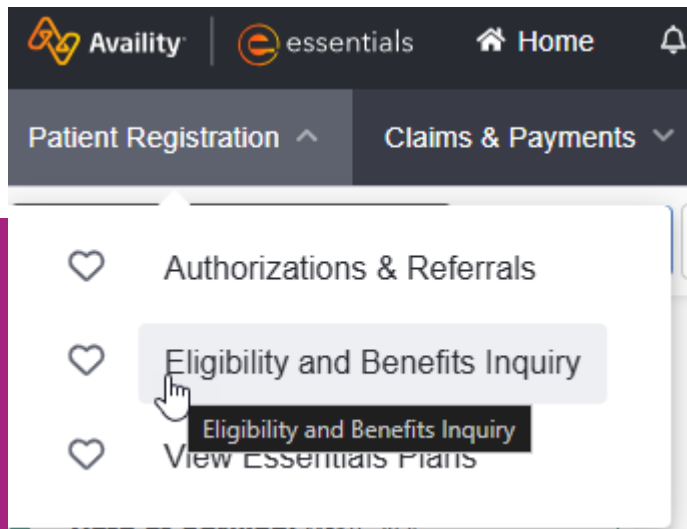


If the subscriber does not pay **all** outstanding premium amounts owed by the end of the grace period, the coverage will be terminated for nonpayment retroactively to the last day of the first month of grace period

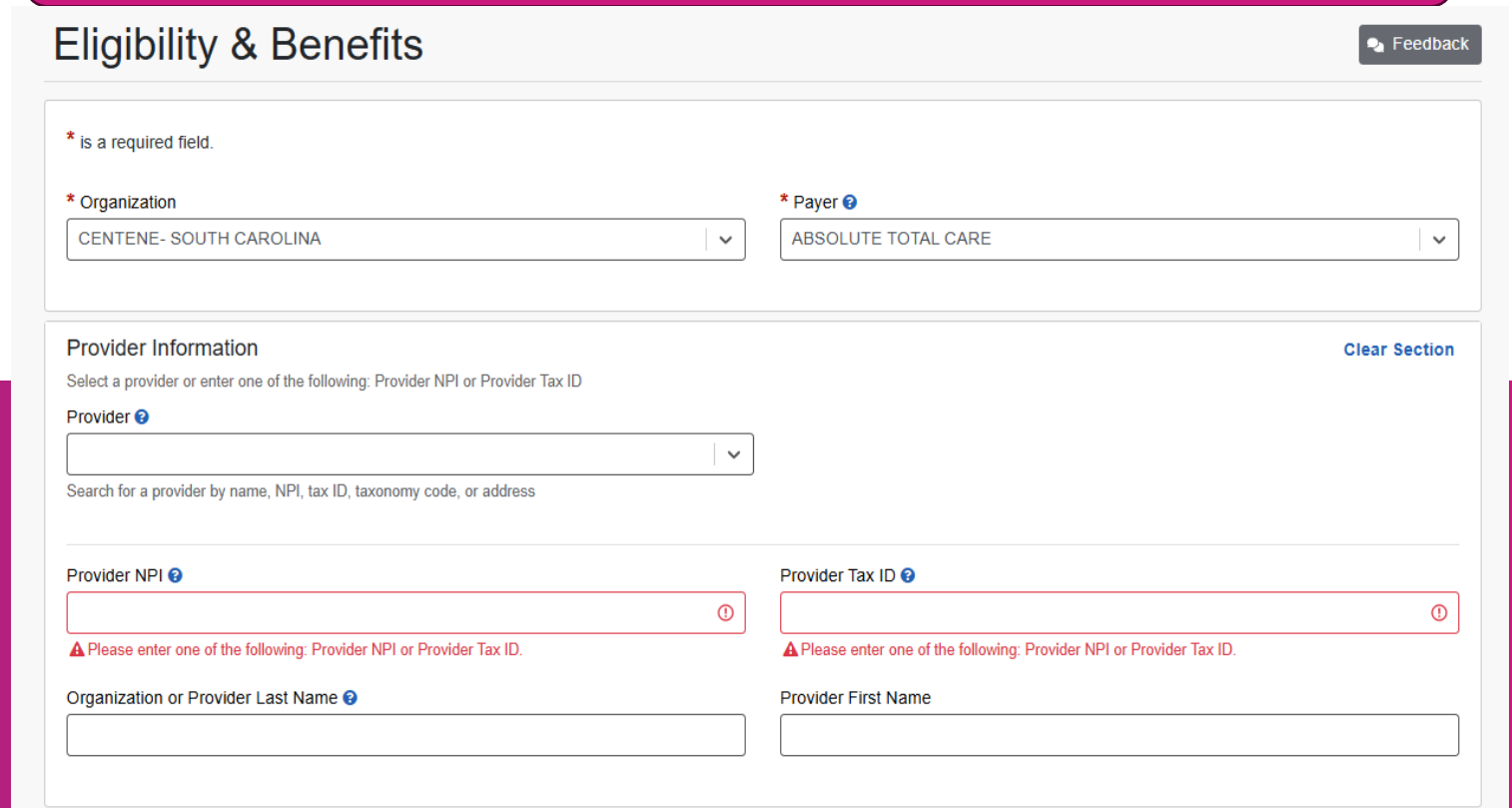
Marketplace-Ambetter/Ambetter Health Member Eligibility and Grace Period

If claims are pending for “EXLZ - PEND: NO- PAYMENT OF PREMIUM”, follow these steps to review member eligibility in Availity Essentials for additional information.

1. Log in to Availity Essentials.
2. From the top menu, open Patient Registration (drop-down).
3. Select Eligibility and Benefits Inquiry



On the Eligibility screen, enter the required provider details (either Provider NPI or Provider TIN is required)



Eligibility & Benefits Feedback

* is a required field.

* Organization: CENTENE- SOUTH CAROLINA | * Payer: ABSOLUTE TOTAL CARE

Provider Information Clear Section

Select a provider or enter one of the following: Provider NPI or Provider Tax ID

Provider: [Dropdown]

Search for a provider by name, NPI, tax ID, taxonomy code, or address

Provider NPI: [Field] ⓘ ⚠ Please enter one of the following: Provider NPI or Provider Tax ID.

Provider Tax ID: [Field] ⓘ ⚠ Please enter one of the following: Provider NPI or Provider Tax ID.

Organization or Provider Last Name: [Field] | Provider First Name: [Field]

Marketplace-Ambetter/Ambetter Health Member Eligibility and Grace Period

Enter the required member information (member ID/name, DOB, date(s) of service, etc.). Once all required information has been entered, click **SUBMIT**

Patient Information

Single Patient

* Patient ID [?](#)

* Patient Last Name Suffix

* Patient First Name * Date of Birth

Patient's Relationship to Subscriber [?](#)

Service Information

* As of Date [?](#)

* Benefit / Service Type [?](#)
 [clear](#)

Submit another patient

Marketplace-Ambetter/Ambetter Health Member Eligibility and Grace Period

Review Member Status. If premium payment is delinquent, the status will show “Active: Pending Investigation”

The screenshot displays a web interface for reviewing member status. At the top, there is a navigation bar with dropdown menus for 'Clinical', 'My Providers', 'Payer Spaces', 'More', and 'Reporting', along with a 'Keyword Search' field. Below the navigation, a 'Status' dropdown is set to 'Status'. A blue button labeled '+ New Request' is visible on the right. The main content area shows a transaction summary for 'Date of Service Mar 9, 2026', with fields for 'Transaction ID', 'Transaction Time Mar 9, 3:55 PM', and 'Customer ID'. Action buttons for 'Edit', 'Print', and 'Feedback' are present. The member's status is 'Active - Pending Investigation', which is highlighted with a red box. Other fields include 'Date of Birth', 'Gender', and 'Relationship to Subscriber Self'. Below this, a list of member details is shown, including Member ID, Plan Name, Plan Number, Plan Network Name, Plan Network ID, Plan Begin Date (Jan 1, 2026), Plan End Date (Dec 31, 2026), and Date of Last Update (Mar 9, 2026). The 'absolute total care' logo is displayed, and the payer is identified as 'Ambetter from Absolute Total Care'. A section for 'Other or Additional Payer Information' states 'No additional payer information provided.' At the bottom, a dropdown for 'Provider Information' is partially visible.

Marketplace-Ambetter/Ambetter Health Member Eligibility and Grace Period

Scroll down the screen to “Plan Maximums and Deductibles” and review the additional details shown there (this is where the non-payment/pended context is typically reflected)

▶ Provider Information

▼ Care Reminders

No reminders for this member.

FILTER BY NETWORK

Out of Network

In Network

All Networks

Plan Maximums and Deductibles

▼ Health Benefit Plan Coverage- 30

Active - Pending Investigation

Plan / Product: Everyday Bronze


- This members premium payment is delinquent. Claims will be pended. If the members full premium is not received within the grace period, coverage will end and pending claims will be denied.
- To determine if a prior authorization is required, please check the health plan's website.

If you have questions or need further assistance, reach out to your Provider Engagement Account Manager.

Marketplace-Ambetter/Ambetter

Ambetter / Ambetter from Absolute Total Care
Network name: PREMIER

Ambetter Health (ICHA)
Network name: SOLUTIONS



REFERRAL NOT REQUIRED


PREMIER

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

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

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

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



REFERRAL NOT REQUIRED

SOLUTIONS

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

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

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

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

AmbetterHealth.com/SC

Member/Provider Services: 1-833-270-5443
(Relay 711)

24/7 Nurse Line: 1-833-270-5443

Numbers below for providers:

Pharmacist Only: 1-833-750-4237

EDI Payor ID: 68069

[Centene Vision Services: 1-833-724-9353]

[Centene Dental Services supported by

United Concordia: 1-833-605-6320]

Medical Claims Address:

Ambetter from
Absolute Total Care
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

AMB25-SC-C-00060

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AmbetterHealth.com

Member/Provider Services: 1-833-543-3145
(TTY 711)

24/7 Nurse Line: 1-833-543-3145

Numbers below for providers:

Pharmacist Only: 1-833-750-4237

EDI Payor ID: 68069

[Centene Vision Services: 1-833-724-9353]

[Centene Dental Services supported by

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Medical Claims Address:

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Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

AMB25-SC-C-00060

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Prior Authorizations Updates

Medicaid Managed Care Incontinence Supplies

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

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

Continuity of Care Period: The transition from Medicaid Fee-for-Service (FFS) to Medicaid Managed Care delivery model includes a 180-day continuity of care period for Healthy Connections Medicaid members. During the continuity of care period, Absolute Total Care *will honor all previous prior authorizations* and ensure there is no break in access to service or covered medical supplies for members. Prior Authorization is required after the 180-day Continuity of Care period and for any new patients receiving incontinence supplies. Providers should refer to the [Pre-Auth Check Tool](#) to look up a service code to determine if prior authorization is needed.

Medicaid Prior Authorizations Updates

Important Prior Authorization Updates

Effective Feb. 1, 2026



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

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

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

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

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

Important Prior Authorization Updates

Effective Feb. 1, 2026



FROM



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

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

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

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

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

Evolut Prior Authorizations Updates

Effective 4/1/2026

The following codes for **Radiology and Diagnostic Cardiology** for Medicaid will no longer require PA and will be removed from the Evolut Utilization Review Matrix.

Modality	Allowable Billing Group	CPT
CT ORBIT/EAR/FOSSA WITH O DYE	70480,70481,70482	70480
CT MAXLOFCE AREA; W/O CONTRAST MATL	70487,70488, 70486, 76380	70486
DIAGNOSTIC COMPUTED TOMOGRAPHY THORAX W/O CNTRST	71250, 71260, 71270, 71271	71250
CT UPPER EXTREMITY WITH O DYE	73200, 73201, 73202	73200
MRI UPPR EXTREMITY WITH OAND WITH DYE	73218, 73219, 73220	73220
CT LOWER EXTREMITY WITH O DYE	73700, 73701, 73702	73700
MRI FETAL SNGL/1ST GESTATION	74712, 74713	74712
CARDIAC MRI MORPHOLOGY & FUNCTION W/O CONTRAST	75557, 75559, 75561, 75563	75557
CT HRT WITH 3D IMAGE CONGEN	75573	75573
MRI BREAST WITHOUT CONTRAST MATERIAL UNILATERAL	77046, 77047, 77048, 77049	77046
CT BONE MINERL DENSITY STUDY 1/> SITS AXIAL SKE	77078	77078
MRI BONE MARROW BLOOD SUPPLY	77084	77084
GATED HEART PLANAR SINGLE	78472, 78473, 78494	78472
ECHOCRDGRPHY RL TM W/2D W/WO M-MODE, TRANSESOPHAGEAL	93312, 93313, 93314, 93315, 93316, 93317, 93318	93312

Evolut Prior Authorizations Updates

Effective 4/1/2026

The following codes for **Cardio** for Medicaid will no longer require PA and will be removed from the Evolut Utilization Review Matrix.

Modality	Impacted CPT
ANGIOGRAPHY	36218, 36253, 36254, 75580, 75736, 76937
BYPASS GRAFT IN-SITU VEIN	35583, 35585, 35587, 35621, 35646, 35654, 35656, 35661, 35666, 35671
BYPASS GRAFT VEIN	35556, 35558, 35566, 35571
CARDIAC CATHETERIZATION	93451, 93505, 93563, 93565, 93566, 93567, 93568, 93571, C1759
CONGENITAL HEART DISEASE SURGERY	33820
CORONARY ARTERY DISEASE SURGERY	33215, 33217, 33223, 33405, 35305, 35884, 93580, 93583, 93650, C1732, C1895
DEVICE IMPLANTATION/ELECTRICAL CARDIOVERSION	33202, 33218, 33220, 33222, 33224, 33225, 33226, 33227, 33228, 33229, 33233, 33234, 33235, 33236, 33271, 33274, 33275, 33286, 92960, 92961, C1722, C1760, C1785, C1882, C1900, C2621
DEVICE MONITORING	93292, K0606
ELECTROPHYSIOLOGY STUDIES (EPS)	93662, C1730
EXCISION EXPLORATION REPAIR REVISION	35700, 35881, 35883
INTERRUPTION/LIGATION/STRIPPING ETC.	37765, 37766
INTERVENTIONAL CARDIOLOGY	33418, 92987, 92997, 93581, 93590, 93591
INTERVENTIONAL RADIOLOGY	36836, 36837
PULMONARY VALVE SURGERY	33475, 33477
REPAIR/EXCISION FOR ANEURYSM OCCLUSIVE DISEASE ETC.	35001, 35011, 35141, 35151
TAVR	33361, 33362, 33363, 33364, 33365, 33366, 33369
THERAPEUTIC SERVICES	93745
THROMBOENDARTERECTOMY	35301, 35302, 35303, 35351, 35355, 35371, 35372
TRICUSPID VALVE SURGERY	33465

Evolut Prior Authorizations Updates

Effective 4/1/2026

The following codes for Cardio for Medicare will no longer require PA and will be removed from the Evolut Utilization Review Matrix.

Modality	Impacted CPT
ANGIOGRAPHY	36218, 36253, 36254, 75580, 75736, 76937
BYPASS GRAFT IN-SITU VEIN	35583, 35585, 35587, 35621, 35646, 35654, 35656, 35661, 35666, 35671
BYPASS GRAFT VEIN	35556, 35558, 35566, 35571
CARDIAC CATHETERIZATION	93451, 93459, 93460, 93505, 93563, 93565, 93566, 93567, 93568, 93571, C1759
CONGENITAL HEART DISESE SURGERY	33820
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TAVR	33361, 33362, 33363, 33364, 33365, 33366, 33369
THERAPEUTIC SERVICES	93745
THROMBOENDARTERECTOMY	35301, 35302, 35303, 35351, 35355, 35371, 35372
TRICUSPID VALVE SURGERY	33465



Evolut Prior Authorizations Updates

Effective 4/1/2026

The following codes for **Radiology and Diagnostic Cardiology** for Medicare will no longer require PA and will be removed from the Evolut Utilization Review Matrix.

Modality	Allowable Billing Group	CPT
CT ORBIT/EAR/FOSSA WITH O DYE	70480,70481,70482	70480
CT MAXILOFCE AREA; W/O CONTRAST MATL	70487,70488, 70486, 76380	70486
CT SOFT TISSUE NECK WITH O DYE	70490, 70491, 70492	70490
MRI IMAGING BRAIN; INCLUDING BRAIN STEM; WITHOUT CONTRAST MATERIAL	70551, 70552, 70553	70551
MRI- SPINAL CANAL AND CONTENTS, CERVICAL; WITHOUT CONTRAST MATERIAL	72141, 72142, 72156	72141
MRI, SPINAL CANAL AND CONTENTS, THORACIC; WITHOUT CONTRAST MATERIAL	72146, 72147, 72157	72146
MRI- SPINAL CANAL AND CONTENTS, LUMBAR; WITHOUT CONTRAST MATERIAL	72148, 72149, 72158	72148
MRI PELVIS WITH DYE	72195, 72196, 72197	72196
CT UPPER EXTREMITY WITH O DYE	73200, 73201, 73202	73200
MRI UPPR EXTREMITY WITH OAND WITH DYE	73218, 73219, 73220	73220
MRI JOINT UPR EXTREM WITH O DYE	73221, 73222, 73223	73221
CT LOWER EXTREMITY WITH O DYE	73700, 73701, 73702	73700
CT ABDOMEN WITH O DYE	74150, 74160, 74170	74150
MRI ABDOMEN WITH O DYE	74181, 74182, 74183, S8037	74181
MRI FETAL SNGL/1ST GESTATION	74712, 74713	74712
CARDIAC MRI MORPHOLOGY & FUNCTION W/O CONTRAST	75557, 75559, 75561, 75563	75557
CT HRT WITH 3D IMAGE	75572	75572
CTA HRT CORNRY ART/BYPASS GRFTS CONTRST 3D POST	75574	75574
MRI BREAST WITHOUT CONTRAST MATERIAL UNILATERAL	77046, 77047, 77048, 77049	77046
CT BONE MINERL DENSITY STUDY 1/> SITS AXIAL SKE	77078	77078
MRI BONE MARROW BLOOD SUPPLY	77084	77084
GATED HEART PLANAR SINGLE	78472, 78473, 78494	78472
ECHOCRDRGRPHY RL TM W/2D W/WO M-MODE, TRANSESOPHAGEAL	93312, 93313, 93314, 93315, 93316, 93317, 93318	93312

Evolut Prior Authorizations Updates

Effective 4/1/2026

The following codes for **Cardio** for Marketplace will no longer require PA and will be removed from the Evolut Utilization Review Matrix.

Modality	Impacted CPT
ANGIOGRAPHY	36218, 36253, 36254, 75580, 75736, 76937
BYPASS GRAFT IN-SITU VEIN	35583, 35585, 35587, 35621, 35646, 35654, 35656, 35661, 35666, 35671
BYPASS GRAFT VEIN	35556, 35558, 35566, 35571
CARDIAC CATHETERIZATION	93451, 93505, 93563, 93565, 93566, 93567, 93568, 93571, C1759
CONGENITAL HEART DISEASE SURGERY	33820
CORONARY ARTERY DISEASE SURGERY	33215, 33217, 33223, 33405, 35305, 35884, 93452, 93580, 93583, 93650, C1732, C1895
DEVICE IMPLANTATION/ELECTRICAL CARDIOVERSION	33202, 33218, 33220, 33222, 33224, 33225, 33226, 33227, 33228, 33229, 33233, 33234, 33265, 33236, 33271, 33274, 33275, 33286, 92960, 92961, C1722, C1760, C1785, C1882, C1900, C2621
DEVICE MONITORING	93292, K0606
ELECTROPHYSIOLOGY STUDIES (EPS)	93662, C1730

Modality	Impacted CPT
EXCISION EXPLORATION REPAIR REVISION	35700, 35881, 35883
INTERRUPTION/LIGATION/STRIPPING ETC.	37765, 37766
INTERVENTIONAL CARDIOLOGY	33418, 92987, 92997, 93581, 93590, 93591
INTERVENTIONAL RADIOLOGY	36836, 36837
PULMONARY VALVE SURGERY	33475, 33477
REPAIR/EXCISION FOR ANEURYSM OCCLUSIVE DISEASE ETC.	35001, 35011, 35141, 35151
TAVR	33361, 33362, 33363, 33364, 33365, 33366, 33369
THERAPEUTIC SERVICES	93745
THROMBOENDARTERECTOMY	35301, 35302, 35303, 35351, 35355, 35371, 35372
TRICUSPID VALVE SURGERY	33465

Evolut Prior Authorizations Updates

Effective 4/1/2026

The following codes for **Radiology and Diagnostic Cardiology** for **Marketplace** will no longer require PA and will be removed from the Evolut Utilization Review Matrix.

Modality	Allowable Billing Group	CPT
CT ORBIT/EAR/FOSSA WITH O DYE	70480,70481,70482	70480
CT MAXILOFCE AREA; W/O CONTRAST MATL	70487,70488, 70486, 76380	70486
DIAGNOSTIC COMPUTED TOMOGRAPHY THORAX W/O CNTRST	71250, 71260, 71270, 71271	71250
MRI PELVIS WITH DYE	72195, 72196, 72197	72196
CT UPPER EXTREMITY WITH O DYE	73200, 73201, 73202	73200
MRI UPPR EXTREMITY WITH OAND WITH DYE	73218, 73219, 73220	73220
CT LOWER EXTREMITY WITH O DYE	73700, 73701, 73702	73700
MRI FETAL SNGL/1ST GESTATION	74712, 74713	74712
CARDIAC MRI MORPHOLOGY & FUNCTION W/O CONTRAST	75557, 75559, 75561, 75563	75557

Modality	Allowable Billing Group	CPT
CT BONE MINERL DENSITY STUDY 1/> SITS AXIAL SKE	77078	77078
GATED HEART PLANAR SINGLE	78472, 78473, 78494	78472
ECHOCRDGRPHY RL TM W/2D W/WO M-MODE, TRANSESOPHAGEAL	93312, 93313, 93314, 93315, 93316, 93317, 93318	93312

Payment Integrity Solutions

Effective 4/1/2026

We are committed to continuously evaluating and improving Payment Integrity Solutions as required by State and Federal governing entities. There are changes to the existing review criteria as of 4/1/2026:

Description of Changes	Lines of Business
<p>Reimbursement for bundled weekly OTP services submitted for the same patient by the same provider that include both toxicology testing codes (80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659) and Medication-Assisted Treatment (MAT) codes (G2067, G2068, G2069, G2073, G2074, G2075) will be reviewed for incorrect coding based on the following scenarios.</p> <p>Scenario 1: Claims billed with codes 80305, 80306, 80307, G0480, G0481, G0482, G0483 will deny if another claim is previously received/paid for codes G2067, G2068, G2069, G2073, G2074, G2075 within 7 calendar days for the same patient and the same provider.</p> <p>Scenario 2: Claim billed with codes G2067, G2068, G2069, G2073, G2074, G2075 will be denied if another claim is previously received/paid for codes 80305, 80306, 80307, G0480, G0481, G0482, G0483 within 7 calendar days for the same patient and the same provider.</p> <p>Regardless of whether these services are billed on the same or separate claims, only the first claim received will be reimbursed. Subsequent claims will be denied.</p>	Marketplace & Medicare



Important Prior Authorization Updates

Effective 4/1/2026



****NEW****

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

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

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

If you have questions about specific prior authorization codes or how these changes affect your practice, please reach out to your local Provider Engagement Account Manager.

Service Category	PA Rule	Services	Procedure codes
DME Services	No PA Required for PAR providers	Beds	E0185
		Orthotic & Prosthetic	L1951
		Supplies and Devices	E0486
Drug Codes	No PA Required for PAR providers	Medications	J1096
Genetic Analysis	No PA Required for PAR providers	Genetic Testing	81240, 81256
Imaging Services	No PA Required for PAR providers	Nuclear Medicine	77002
Physician Services	No PA Required for PAR providers	Other Services	G3002
Skin Procedures	PA Required	Muscle Flap Procedures	15734, 15736, 15738
Surgery Procedures	No PA Required for PAR providers	Surgery-Nervous System	64718, 64719
Vision Services	No PA Required for PAR providers	Vision Evaluation	92004

Medicaid Provider Enrollment



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. Please note...Primary Care Physicians (PCPs) are not permitted to accept member assignments until they are fully credentialed.

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 enroll online through the SCDHHS website by visiting www.scdhhs.gov and navigating to Providers >> Become a Medicaid Provider >> Apply Online.

Medical Records Requests from SCDHHS

“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 Provider Manual to ensure correct documentation and proper signature is provided”

Medical Records Requests from SCDHHS Cont.

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 Records Requests from SCDHHS Cont.

“Medicaid providers must make records accessible and available for review during a provider’s normal business hours or as otherwise directed, with or without advance notice by authorized entities and staff as described in this section. An authorized entity may either copy, accept a copy, or may request original records. Any requested record(s) is deemed inaccessible if not available within two (2) hours of the request when requested by an authorized entity. The health record shall be accessible at the provider’s service address as documented by the SCDHHS provider enrollment record. It is the responsibility of the provider to transport/send records to the place of service location as documented by the SCDHHS provider enrollment record.”

Medical Records Requests from SCDHHS Cont.

The following must be provided for the dates of service that is requested:

- 1. Documentation of Evidence-Based Practice Services**
- 2. Consent Form(s)**
- 3. Evidence of Authorization (if applicable)**
- 4. Documentation justifying Medical Necessity**
- 5. Signed Treatment Plan(s)**
- 6. Treatment Progress Documentation**
- 7. Clinical Services Notes that support billed claims**
- 8. Coordination of Care Documentation**
- 9. Discharge/Transition Plan (if applicable)**

For more information, please contact your Provider Engagement Account Manager

Eligibility

Eligibility

- Member eligibility should be checked each month and each time prior to rendering services for all lines of business.
- Eligibility can be verified through [Absolute Total Care Provider Portal](#), [Wellcare Provider Portal](#), [Availity Essentials](#) or the Interactive Voice Response (IVR)
- IVR is available 24 hours a day, seven days a week



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



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

wellcare™

Wellcare Medicare Advantage
1-866-270-5223

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



Absolute Total Care Provider Portal



absolute total care | Healthy Connections 

 Manage Practice  Eligibility  Patients  Authorizations  Claims  Messaging



Viewing Eligibility For : TIN Plan Type

Eligibility Check

(mm/dd/yyyy) (mm/dd/yyyy)

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS	LOG ER VISIT
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My Patients

[< Back To Home](#)



Check Member Eligibility

This section allows you to search for members and check eligibility.

If you need additional assistance, please select the Help button. There, you can access FAQs or select your state and plan to chat with a Customer Service agent.

Select search criteria to find a member

Member ID

Member ID

Medicaid ID Medicare ID

Check patient eligibility on this date

11/24/2025

[+ Enter multiple member IDs to display](#)

[Search](#)

Result(s)

[Filter Results](#) [Download Report](#)

Member Name	Member ID	Eligible	Effective Date	Term Date	Plan Name	Care Gaps	Important Info	PCP
No items to display								

Availity Essentials: Multi-Payer Portal



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



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



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



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



New Accounts:

The Availity Administrator registers and manages user accounts and must have the legal authority to sign agreements. Visit [Register and Get Started with Availity Essentials](#) for training.



Existing Accounts:

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



Contact Info:

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

Annual Provider Training Requirements

Annual Provider Training Requirements

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



Cultural Competency

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



Person-Centered Planning

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



Fraud, Waste & Abuse

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



General Compliance

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



Model of Care (MOC)

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



Annual Provider Training Requirements

Required Training	Training Location
General Compliance	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html
Fraud, Waste and Abuse	https://cmsnationaltrainingprogram.cms.gov/resources
Model of Care (MOC)	https://www.wellcare.com/south-carolina/providers/medicare/training
Person-Centered Planning	https://www.absolutetotalcare.com/providers/resources/provider-training.html
Cultural Competency	https://www.absolutetotalcare.com/providers/resources/provider-training.html https://www.ahrq.gov/sdoh/clas/index.html

Provider Training Attestation



Home Find a Provider Login Careers Contact Language

absolute total care.

For Members For Providers Get Insured

For Providers

- Login
- Become a Provider
- Pre-Auth Check
- Integration Information
- Pharmacy
- Provider Resources**
- Provider Manuals and Forms
- Provider Training**
- Provider Training Attestation
- Special Supplemental Benefits for Chronically Ill (SSBCI)
- Eligibility Verification
- Grievances and Appeals
- Incentives Statement
- Integrated Care
- Prior Authorization
- National Imaging Associates (NIA)
- Behavioral Health
- Fraud, Waste, and Abuse
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Provider Training Attestation

Absolute Total Care contracted providers are required to complete certain training within 90 days of contracting and annually thereafter. Complete and submit this form to verify training completion.

Please check applicable training selections below to confirm completion *

- General Compliance (CMS)
- Fraud, Waste, and Abuse (CMS)
- Model of Care (MOC)
- Person-Centered Planning
- Cultural Competency
- Other

Provider Group * County *

Provider TIN(s) - Please include all Tax ID Numbers that you are representing when completing this form: *

Contact Information

Phone * Email *

Form Completed By * Title *

Date *



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

Provider Training: Compliance Program and Fraud, Waste, and Abuse

What is Compliance?

Compliance is an organization's responsibility to act in accordance with applicable laws, regulations, policies, procedures, and other explicit standards.

Compliance is important for many reasons, but most importantly, it ensures funds are used appropriately to provide quality services to your community.

Organizations create or have a compliance program to implement compliance plans and institute internal controls.

While the fundamental elements of a compliance program are generally the same, the specific components of a compliance program depend on the organization's size and needs.

Your Role in Healthcare Provider Compliance

- **When you drive compliance, you ensure that the business you conduct is within the boundaries of the law, and guides your practice in acting ethically, legally and responsibly.**
- **When you make ethical decisions and commit to doing the right thing, you build trust with your patients, managed care organizations, stakeholders, and regulators.**
- **All of us must:**
 - ❖ **Act fairly and honestly**
 - ❖ **Act with integrity, transparency, and accountability**
 - ❖ **Adhere to high ethical standards in all of your practices**
 - ❖ **Comply with all applicable laws, regulations, State Medicaid and CMS requirements**
 - ❖ **Report suspected violations**
 - ❖ **Do the right thing!**



Provider Responsibilities

As a health care provider, you are responsible for:

- **being a vital part of the effort to prevent, detect, and report noncompliance, fraud, waste, and/or abuse identified;**
- **complying with all applicable statutory, regulatory, Medicaid and Medicare healthcare program requirements, including adopting and implementing an effective compliance program;**
- **reporting any violations of laws that you may be aware of; it is your obligation and duty to report; and**
- **following your organization's Code of Conduct, a tool that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.**



Effective Compliance Programs consist of 7 Elements:



**Written Standards,
Policies, and Procedures**



**Compliance Leadership
and Oversight**



Training and Education



**Effective Lines of
Communication**



**Enforcement of
Disciplinary Standards**



**Risk Assessment,
Auditing, and
Monitoring**



**Responding to Detected
Offenses and
Developing Corrective
Action Initiatives**

7 Elements of Compliance Programs

- 1. Written Policies, Procedures, and Standards of Conduct**
 - These articulate the organization's commitment to comply with all applicable Federal and State standards and describe the compliance expectations according to the Standards of Conduct.
 - Entities should assess how their operations may present risk areas specific to them and design policies and procedures that address these risks.
- 2. Compliance Officer, Compliance Committee, and High-Level Oversight.**
 - The organization must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated and resolved by the compliance program.
 - The organization's senior management and governing body must be engaged and exercise reasonable oversight of the organization's compliance program.
- 3. Effective Training and Education**
 - This covers the elements of the compliance plan as well as preventing, detecting and reporting suspected or actual Fraud, Waste and Abuse.
 - Tailor training and education to the different employees and their responsibilities and job functions.

7 Elements of Compliance Programs

4. Effective Lines of Communication

- Make effective lines of communication accessible to all.
- Ensure Confidentiality and provide methods for anonymous and good-faith issues reporting at all organizational levels.
- Having “effective lines of communication” means that several avenues to report compliance concerns are available.

5. Well-Publicized Disciplinary Standards

- The organization must enforce standards through well-publicized disciplinary guidelines.

6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks

- Conduct routine monitoring and auditing of the Organization’s operations to evaluate compliance with Federal and State requirements as well as the overall effectiveness of the compliance program.

7. Procedures and System for Prompt Response to Compliance Issues

- The Organization must use effective measures to respond promptly to non-compliance, undertake appropriate corrective action, and report to government agencies, as required.

A Provider's Compliance Responsibilities and Awareness

As a provider you should be aware of high-risk areas to ensure your part in maintaining compliance. This includes, but is not limited to:

Beneficiary Notices

Billing practices

Conflicts of Interest

Monthly Exclusion Screening

Documentation Requirements

Ethics

Formulary Administration

HIPAA

Quality of Care

Non-Compliance & Impact

What is Non-Compliance

Non-compliance is conduct that does not conform to regulations, laws, State, and Federal health care program requirements or to the Absolute Total Care's ethical and business policies.

Effects of noncompliance:

Damage to the patient:

- **Delayed services**
- **Denial of benefits**
- **Difficulty in using providers of choice**
- **Hurdles to care**

Damage to everyone:

- **Higher insurance copayments**
- **Higher premiums**
- **Lower benefits for individuals/employers**
- **Lower profits**



Fraud, Waste & Abuse Overview

Healthcare Fraud, Waste and Abuse

A compliance program contains measures to prevent, detect and correct FWA. We all have a role to play in detecting FWA. Be alert for suspicious activities and report anything you notice.

Compliance programs are designed to ensure that we meet all legal, regulatory and business requirements, both domestic and international. They reflect our commitment to reduce the potential for non-compliance with these requirements.

Fraud, Waste and Abuse Definitions

Fraud is the intentional deception or misrepresentation an individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes “reckless disregard” of the facts with the intent to receive an unauthorized payment. This party may also conceal facts in order to receive reimbursement for which they are not entitled.

For the purposes of this training, fraud is intentionally submitting false information (including situations in which you should have known the information was false) to get money or a benefit.

The complete definition has three primary components:

- Intentional dishonest action or misrepresentation of fact
- Committed by a person or entity
- With knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit

Waste includes practices that, directly or indirectly, result in unnecessary costs to federally funded programs, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

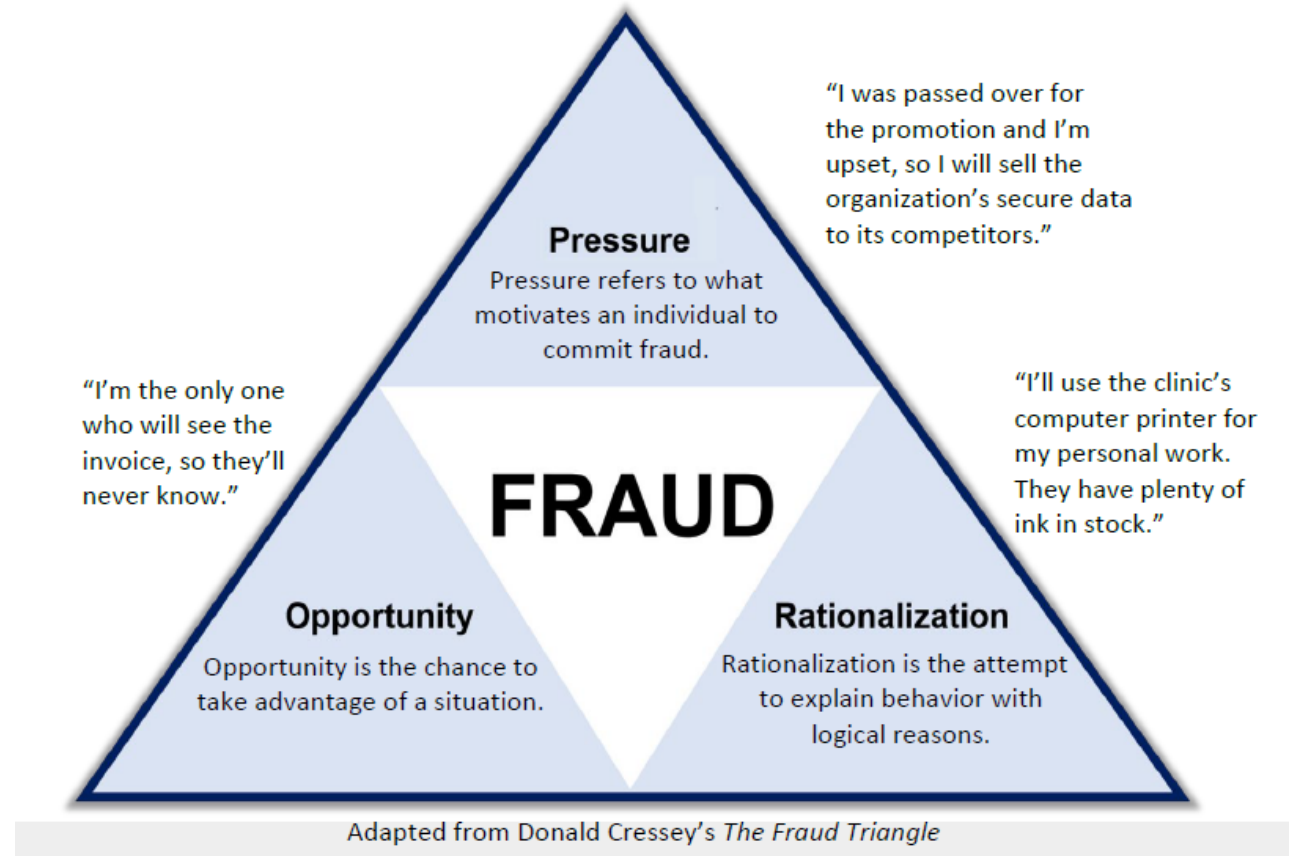
- Prescribing more prescriptions than necessary
- Conducting excessive and/or unnecessary laboratory tests
- Scheduling and billing unnecessary office visits

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to federally funded programs. Abuse involves paying for items or services when there is no legal entitlement to that payment resulting in:

- Unnecessary costs to the healthcare system,
- Improper payment,
- Payment for services that fail to meet professionally recognized standards of care, or
- Services that are medically unnecessary.

The Fraud Triangle

- The Fraud Triangle illustrates the three elements that are present in environments where fraud occurs.
- What Can My Organization Do To Prevent Fraud?
- Your organization can establish a compliance program to proactively avoid the vulnerabilities in The Fraud Triangle. Additionally, your organization can identify issues early and, as part of your compliance program, build robust internal controls to prevent them.



What are Some Examples of Health Care Fraud?

Below are a few examples of fraud that can happen with health care providers:

- Submitting false claims, such as claims for services that were not provided;
- Inflating costs reported on cost reports;
- Diverting prescription drugs;
- Offering or receiving kickbacks for patient referrals; and
- Providing medically unnecessary care.

Health Care Fraud Enforcement and Other Standards: Overview of Certain Federal Laws



False Claims Act

The False Claims Act (FCA) ([31 U.S.C. §§ 3729-3733](#)) allows the Federal Government to recover damages and penalties from entities that knowingly submit, or knowingly cause to be submitted, false or fraudulent claims to the Federal Government, including to Medicare or Medicaid.

Basically, the FCA protects the Government from being overcharged, mischarged, or sold shoddy goods or services. The FCA defines "knowingly" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information.

The FCA prohibits filing a claim for an item or service that was not actually provided as claimed. Every time you submit a claim, you are, essentially, certifying that all the criteria for payment for that item or service on that claim have been met.

The ACA also expanded the range of health plan business subject to the FCA and compliance must now be a significant concern in "non-government" lines of business (ex. Commercial insurance). Under Section 1313 of the Affordable Care Act, payments made by, through or in connection with an Exchange are subject to the FCA if the payments include any federal funds.

False Claims Act Continued

Depending on the circumstances, some examples of potential False Claims Act violations in the health care fraud context include:

Upcoding,

Billing for unnecessary services,

Billing for services or items that were not provided'

Billing for services performed by an excluded individual.

Failure to return overpayments may lead to liability under the False Claims Act. Under section 1128J(d) of the Social Security Act, persons who have received an overpayment from a Federal health care program must report and return the overpayment within 60 days of the date the overpayment was identified. Failure to do so may make the overpayment a false claim.

Violation of the False Claims Act may lead to exclusion from Federal health care programs, along with Criminal fines, Imprisonment, and Civil legal action for penalties and damages

Federal Anti-Kickback Statute

- The Federal Anti-Kickback Statute (AKS) ([42 U.S.C. § 1320a-7b\(b\)](#)) is a criminal law that prohibits the knowing and willful exchange, offer to exchange, solicitation, or receipt of anything of value in an effort to influence, induce, or reward the referral of Federal health care program business, including the referral for Medicare, Medicaid, or IHS items and services, and arranging for or recommending such items and services.
- Examples of improper kickback relationships include the following:
 - A diagnostic lab offers a nurse practitioner \$100 for each Medicare referral.
 - An oncologist takes family vacations paid for by a pharmaceutical company in exchange for prescribing the company's drug in lieu of alternatives.
 - A medical equipment company and a physician agree that the physician can establish a rent-free office in a space owned by the medical equipment company if the physician refers Medicaid patients to the company.
- It is important to understand that submitting a claim to Medicare, Medicaid, or another Federal health care program that was the result of a kickback scheme, in addition to violating the criminal AKS, can also lead to liability under the False Claims Act (FCA).



Stark Law

- The Prohibition on Certain Physician Referrals ([42 U.S.C. § 1395nn](#)) is frequently referred to as the “Stark Law,” after Peter Stark, the former member of congress credited for the law’s enactment.
- The Stark Law prohibits physicians from referring Medicare and Medicaid patients for “designated health services” (e.g., inpatient and outpatient hospital services, home health care services, clinical laboratory services, physical therapy, speech therapy, etc.) to entities with which the physician or an immediate family member has a financial relationship (ownership, investment, or compensation).
- Additionally, the entities are prohibited from presenting or causing to be presented claims to Medicare or Medicaid (or billing another individual, entity, or third-party payer) for those referred services.
 - For example, under the Stark Law, a general physician is prohibited from referring a patient to a physical therapy office that is owned by his wife unless an exception applies.
 - As another example, a physician who is an employee of a hospital, and refers patients to that hospital, may not be paid above fair market value by the hospital.

Civil Monetary Penalties Law

- The Civil Monetary Penalty Law (CMPL) ([42 U.S.C. § 1320a-7a](#)) protects the Government from a variety of improper conduct, including the submission of false claims related to HHS grant programs, Federal contracts, or Federal health care programs.
- The Office of Inspector General (OIG) has the authority to seek penalties and exclusion from Federal health care programs against an individual or entity based on a wide variety of prohibited conduct related to Federal health care programs, HHS grants, and HHS contracts. The amount of civil monetary penalties imposed by the Government depends on the conduct but can be up to \$20,000 per claim for the submission of false claims. In addition to that amount, the Government may seek to recover up to three times the amount of damages, or loss to the program.

These violations include, but are not limited to:

- Submitting false claims;
- Violating Medicare assignment provisions or the physician agreement;
- Providing false or misleading information expected to influence a decision to discharge a patient;
- Failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency condition or in labor;
- Making false statements on applications or contracts to participate in a Federal health care program.



Exclusion Provisions

- The OIG can exclude health care providers from Federal health care programs if the provider has committed certain acts such as fraud or patient abuse.
- OIG has authority ([42 U.S.C. § 1320a-7](#)) to exclude an individual or entity from participation as a provider or supplier in Federal health care programs, including Medicare, Medicaid, and IHS, among others.
- The effect of an OIG exclusion is that no Federal health care program payment may be made for any items or services furnished (1) by an excluded person or (2) at the medical direction or on the prescription of an excluded person. The exclusion and the payment prohibition continue to apply to an individual even if he or she changes from one health care profession to another while excluded. This payment prohibition applies to all methods of Federal health care program payment, whether from itemized claims, cost reports, fee schedules, capitated payments, a prospective payment system, other bundled payment, or other payment system and applies even if the payment is made to a State agency or a person that is not excluded.
- There are two general types of exclusion:
 - **Mandatory Exclusions**
 - Mandatory exclusions are exclusions that OIG *must* impose. Conduct that would result in a mandatory exclusion includes criminal convictions relating to Medicare or Medicaid fraud, patient abuse or neglect, and felony convictions related to controlled substances.
 - **Permissive Exclusions**
 - Permissive exclusions are exclusions that OIG, in its discretion, *may* impose. Conduct that could result in a permissive exclusion includes misdemeanor offenses related to health care fraud, misdemeanor offenses related to controlled substances, loss of professional license in certain circumstances, and defaulting on student loans.
- **The Effects of Exclusion**
 - The effect of exclusion is that no payment shall be made by Medicare, Medicaid, IHS, or any other Federal health care program for services furnished, ordered, or prescribed by a person or entity who is excluded. This prohibition on payment applies even when the excluded person would only indirectly receive payment, for example, when a hospital bills Medicare for services provided by an excluded nurse.

Criminal Health Care Fraud Statute

- The Criminal Health Care Fraud Statute is primarily found in [18 U.S. Code § 1347](#), which makes it a crime to knowingly and willfully execute a scheme to defraud a healthcare benefit program.
- This statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for health care benefits, items, or services to either:
 - Defraud any health care benefit program
 - To obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program

Conviction under the statute doesn't require proof the violator knew the law or had specific intent to violate it.

An Example of an Identified Liability

Submission of Accurate Claims

Common and longstanding risks associated with claim preparation and submission include duplicate billing, insufficient documentation, and false or fraudulent cost reports.

*Note that the Federal Government is aware of the difference between a fraudulent claim and an innocent, erroneous claim. Even though billing errors do not rise to the level of fraud, providers should return payments received for claims submitted in error.

Legal Consequence Awareness

Healthcare FWA is on the rise. Anti-fraud and abuse laws protect insurers, their employees and members, as well as public health benefit programs and taxpayer dollars.

Legal Consequences

There are legal consequences for committing fraud, waste and abuse. The actual consequence depends on the violation. The following are potential penalties:

- **Civil Monetary Penalties**
- **Criminal Conviction/Fines**
- **Civil Prosecution**
- **Imprisonment**
- **Loss of Provider License**
- **Exclusion from Federal Healthcare programs**

Preventing Fraud, Waste, and Abuse What Are My Responsibilities?

- **You play an important role in preventing, detecting, and reporting potential FWA.**
 - **You must comply with all applicable statutory, regulatory, and other requirements, including adopting and using an effective compliance program.**
 - **You have a duty to report any compliance concerns and suspected or actual violations.**
 - **You have a duty to follow your organization's code of conduct that describes your and your organization's commitment to standards of conduct and ethical rules of behavior.**

How Do I Prevent Fraud, Waste, and Abuse?

Look	Look for suspicious activity
Conduct	Conduct yourself in an ethical manner
Ensure	Ensure accurate and timely data and billing
Ensure	Ensure coordination with other payers
Know	Know FWA policies and procedures, standards of conducts, laws, regulations, and CMS guidance
Verify	Verify all information you receive.

Reporting FWA

With your help, we can increase the detection and prevention of fraud, waste, and abuse to improve the quality, safety, and value of Health and Human Services (HHS) programs. If you suspect fraud, waste, or abuse, you may report the information that suggests dishonest or illegal activities involving HHS programs.

One method of reporting fraud, waste, or abuse is to contact the OIG Hotline. OIG protects certain current and former HHS employees; HHS employment applicants; and HHS contractors, subcontractors, personal services contractors, grantees, and subgrantees who disclose information to OIG through mechanisms such as the OIG hotline.

Another method of reporting is to self-disclose if you suspect the law or program requirements have been violated. OIG's Health Care Fraud Self-Disclosure Program provides a framework for disclosing, coordinating, evaluating, and resolving potential violations of law.

***Please reach out to your Compliance Officer for specific guidance on reporting FWA in your organization**

Where to Report

Absolute Total Care

- **Phone:** Absolute Total Care Fraud and Abuse Hotline 1-866-685-8664 (all calls are confidential)
- **Mail:**
Absolute Total Care
Compliance Department
100 Center Point Circle
Columbia SC 29210
- **Email:** ATC.Compliance@centene.com

South Carolina Department of Health and Human Services

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

Federal

- **Medicare**
- **Phone:** 1(800)-447-8477 TTY
- **Fax:** 1800-223-8164
- **Online:** [OIG.HHS.gov/fraud/report-fraud](https://oig.hhs.gov/fraud/report-fraud)
- **Mail:** U.S. Department of Health and Human Services
ATTN: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

Resources

- The [OIG Hotline Operations](#) website accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs.
- The [OIG Compliance Resources](#) Portal includes educational materials such as compliance toolkits, videos, podcasts, and advisory opinions.
- The OIG [General Compliance Program Guidance](#)
- The OIG [HEAT Provider Compliance Training](#)
- The [OIG Fraud Information](#) website includes information such as OIG's Consumer Alerts; criminal, civil, or administration legal actions; a tips and complaints Hotline; and a list of fugitives wanted for health care fraud, abuse, or child support obligations. The website also details OIG's areas of focus including grant and contract fraud. Additionally, the website gives information about OIG's Whistleblower Protections, Fraud Risk Indicators, State False Claims Act reviews, and Operation Care that helps protect the health and well-being of HHS beneficiaries, including residents in long-term care facilities such as nursing homes.
- [General Questions Regarding Certain Fraud and Abuse Authorities](#)
- MEDICAID INTEGRITY PROGRAM - [EDUCATIONAL RESOURCES](#) - The resources on these pages cover important topics in Medicaid program integrity.
- CMS Laws against Health Care Fraud [Fact Sheet](#)
- CMS [Combating Medicare Parts C & D Fraud, Waste, and Abuse Training](#)
- [South Carolina Department of Health and Human Services](#) – To report fraud call (1-888-364-3224) or follow the link to report online. This website also offers lists of [South Carolina Medicaid Excluded/Terminated Providers \(updated: 08/14/2025\)](#) and [LEIE - List of Excluded Individuals and Entities](#)
- The South Carolina Office of Inspector General is charged with investigating and detecting fraud, waste, abuse, mismanagement, misconduct, violations of state or federal law, and wrongdoing in the Executive Branch. To report fraud, waste, abuse, mismanagement, or misconduct within or involving a state agency, call the SC Office of Inspector General at 1-855-723-7283 (1-855-SC-Fraud), or visit the [SC Office of Inspector General's website](#) to file a complaint online.

DISCLAIMER

This course was prepared as a service and is not intended to grant rights or impose obligations.

The information provided is only intended to be a general summary. It is not legal advice nor a substitute for independent review of the applicable laws, statutes, or regulations.

We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents and consult independent legal counsel.

Payment and Clinical Policies

Medical Clinical Policies

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

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

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

Payment Policies

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

Key Sources of Payment Rules

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

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

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

Claims 411

Claims Adjustments, Reconsiderations, and Disputes

Requests to change the initial claim.

Claim adjustments



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

Reconsideration



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

Disputes



Claims Submission Time Frames

MEDICAID		
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	365 days	365 days
Claim Adjustment	365	365
Claim Dispute	60*	60*
Decision Timeframes	Par	Non-Par
Dispute Decision	30	30
Mailing Address		
Absolute Total Care ATTN: Claims Department P.O. Box 3050 Farmington, MO 63640-3821		
Behavioral Health Claims Absolute Total Care ATTN: Claims Department P.O. Box 7001 Farmington, MO 63640-3818		

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

Wellcare by Absolute Total Care		
Submission Timeframes	Par	Non-Par
Claim Initial	365 days	365 days
Claim Resubmission	180 days	365 days
Claim Adjustment	60*	365*
Claim Appeal***	120*	60*
Decision Timeframes	Par	Non-Par
Appeal Decision	60	60
Dispute Decision	30	30
Mailing Address		
Wellcare by Absolute Total Care ATTN: Claims Department P.O. Box 9700 Farmington, MO 63640-0700		

- * From date of EOP
- ** Waiver of Liability required
- *** Additional required information found in Provider Manual

Claims Submission



IMPORTANT

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

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

Claims Submission Guidelines



Form Field	Requirements	CMS-1500 (Professional)	UB-04 (Institutional)
Billing provider name, address and NPI	Enter the name, address, and 10-character NPI ID and taxonomy of the billing entity	Box 33	Box 1
Subscriber (name, address, DOB, sex, and member ID required)	Enter the subscriber's Health Plan ID exactly as it appears on the member's current ID card.	Subscriber box 1a, 4, 7, 11	Box 58 and 60
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	Enter the member's Health Plan ID exactly as it appears on the member's current ID card.	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11

Form Field	Requirements	CMS-1500 (Professional)	UB-04 (Institutional)
Attending provider with NPI	Enter the 10-character NPI ID and taxonomy for the attending practitioner.	N/A	Box 76
Rendering provider	Enter the 10-character NPI ID and taxonomy for the individual practitioner who rendered the service (this can be blank if a sole proprietor and that NPI is entered as the Billing Provider).	NPI in Box 24J	Box 56
Service facility information	Enter the name, address, and 10-character NPI ID and taxonomy where the patient service was delivered (this can be blank only if provider is a sole proprietor).	Box 32	Box 1

Taxonomy Guide



IMPORTANT

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

CMS 1500

PAPER SUBMISSION:

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

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT (Rank) Ptn	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To												
MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER						
												ZZ	208U00000X
												NPI	REQUIRED

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()	
SIGNED	DATE	a. NPI	b.	a. REQUIRED	b. ZZ208U00000X

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. ZZ	208U00000X
		17b. NPI	REQUIRED

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

CMS 1500 Electronic Submission:

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

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

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

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

Taxonomy Guide, continued



IMPORTANT

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

UB-04

PAPER SUBMISSION:

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

80 REMARKS	81CC a	B3	282N00000X	
	b			
	c			
	d			

ELECTRONIC SUBMISSION:

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

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



Wellcare Medicare Advantage

Provider Timeframes, Claim Adjustments and Disputes

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

*From date of service

**Waiver of Liability required

***From date of last processed claim

Mailing Address
<p>Wellcare ATTN: Claims Department P.O. Box 31372 Tampa, FL 33631-3372</p>

Claims Submission – Wellcare Medicare Advantage



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

CLAIM SUBMISSION INFORMATION	
<p>SUBMISSION INQUIRIES EDI team: EDIBA@centene.com or call Provider Services.</p> <p>PREFERRED EDI CLEARINGHOUSE Availity: 1-800-282-4548. Web portal for direct data entry (DDE) claims: availity.com/Essentials-Portal-Registration.</p> <p>PAYER IDs: 14163 (CH - Chargeable) 59354 (RF - Reporting only)</p> <p>Visit our Claims page to locate detailed claims information, addresses, claim forms and guidelines.</p>	<p>Timely Filing guidelines: 180 days from date of service.</p> <p>EFT Register: payspanhealth.com or call 1-877-331-7154. Email: providersupport@payspanhealth.com.</p> <hr/> <p> MAIL PAPER CLAIMS TO: Wellcare Attn: Claims Department P.O. Box 31372 Tampa, FL 33631-3372</p>

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



Effective 1/1/2026



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

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

Common Claim Rejections and Denials



Common Claim Rejections

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

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

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

Common Claim Denials

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

****For rejection inquiries, reach out to the EDI team @ EDIBA@centene.com**

Top Rejections and Causes



IMPORTANT

- ❑ Claim REJECTIONS occur BEFORE claims are entered into the system and processed. This is usually due to a technical issue or inaccurate formatting. **For rejection inquiries, reach out to the EDI team @ EDIBA@centene.com for assistance.**

Incorrect Member Details

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

Member Inactive at Time of Service

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

Incorrect Claim Form

- ❑ File claims based on CMS guidelines or Contractual agreement

Missing Taxonomy

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

IMPORTANT

- ❑ Claim REJECTIONS occur BEFORE claims are entered into the system and processed. This is usually due to a technical issue or inaccurate formatting. Carefully read the rejection error message or letter and follow the best practices below. For rejection inquiries reach out to the EDI team @ EDIBA@centene.com for assistance.

Verify Member Eligibility and Benefits

- ❑ Validate coverage for service date
- ❑ Review payer ID or plan information

Review Claims Processing Data

- ❑ Rendering provider NPI and Taxonomy codes
- ❑ Billing provider TIN and Group NPI
- ❑ Review DOS is populated

ACT IMMEDIATELY

- ❑ Review all errors and resubmit within 24-72 hours
- ❑ ALWAYS submit the claim as a “NEW” claim. Due to initial submission being rejected, there is not a claim on file to correct

Monitor, Analyze and Audit

- ❑ Monitor to confirm successful claim submission
- ❑ Establish an audit process for claim submission to capture rejections timely

Top Denials and Explanations



IMPORTANT

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

Duplicate Claim Service

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

Timely Filing

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

Coordination of Benefits (COB)

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

No Authorization on file that Matches Service(s) Billed

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

Preventing “Duplicate Claim” Denials



IMPORTANT

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

How it happens...

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

Why it matters...

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

Best Practices

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

Preventing “Timely Filing” Denials



IMPORTANT

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

How it happens...

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

Why it matters...

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

Best Practices

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

Preventing “Coordination of Benefits (COB)” Denials

IMPORTANT

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

How it happens...

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

Why it matters...

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

Best Practices

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

Preventing “No Authorization on File” Denials



IMPORTANT

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

How it happens...

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

Why it matters...

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

Best Practices

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

Electronic Funds Transfer

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

PAYSPAN®

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

PaySpan®

- Providers can register using PaySpan's enhanced provider registration process at <http://www.payspanhealth.com/>.
- Providers can access additional resources by clicking Need More Help on the PaySpan® homepage or link directly to <https://www.payspanhealth.com/nps/Support/Index>.
- PaySpan® Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 1-877-331-7154 or on the web at <https://www.payspanhealth.com/>.

PaySpan®

Paper Checks with PaySpan

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

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

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

Risk Adjustment

Risk Adjustment

CONTINUITY OF CARE (COC) INCENTIVE PROGRAM

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

CLINICAL DOCUMENTATION IMPROVEMENT PROGRAM

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



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

Clinical Documentation Improvement (CDI) Webinar Series

January through November
2026

Join Centene Corporation's CDI Webinar Series designed to enhance your understanding of:

- Risk Adjustment methodologies
- Accurate and compliant documentation practices
- Coding strategies aligned with regulatory standards

Who Should Attend? Providers, non-physician practitioners, coders, billers, and administrative staff involved in clinical documentation and coding.

💡 *Advance registration is required. Utilize the corresponding registration link provided for each topic to register (links are unique to each webinar). You may download a copy of these pages for access as well.*

SCAN ME for registration and additional dates!



OR Click link below for registration and additional dates!

[2026 Webinars Registration Page - Google Slides](#)

If you have questions or need assistance with registration, email us at: CDIWebinars@centene.com

Quality Improvement

2026 Partnership For Quality Program



Partnership for Quality (P4Q) Bonus Program

The 2026 Partnership for Quality Program has been extended to all South Carolina Product lines: Absolute Total Care, Ambetter and Wellcare.

Absolute Total Care understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because Absolute Total Care recognizes these important partnerships, we are pleased to offer the 2026 Partnership for Quality (P4Q) Bonus Program, which rewards PCPs for improving quality and closing gaps in care.

The measurement period is Jan. 1 to Dec. 31, 2026. Absolute Total Care must receive all claims/encounters by January 31, 2027.



Primary care providers can earn additional compensation by addressing preventive care activities and closing care gaps for our members.



P4Q Program Instructions

- 1 Contact patients to schedule an appointment. At the visit, order appropriate tests and preventive screenings, as applicable. Take action to help patients complete all preventive care and close care gaps by **December 31, 2026**.
- 2 Upon completion of the examination, document care, treatment and diagnosis in the patient's medical record. Submit all applicable diagnosis codes on claims, encounter files and/or approved NCQA supplemental electronic flat files containing all relevant ICD-10, CPT and CPT II codes by **January 31, 2027**.
- 3 Review and counsel on results of tests and screenings with patients.

Measure	P4Q Amount per Member	P4Q Amount per Clinical Priority Member	Combined P4Q and Clinical Priority Member Earning Potential	Common Ways to Close the Gap
Annual Preventive Visit (APV)	\$25	\$25	\$50	Annual Wellness Visit and/or Routine Physical Exam
Breast Cancer Screening (BCS)	\$50	\$10	\$60	Mammogram
Controlling High Blood Pressure (CBP)	\$100	\$25	\$125	Documented blood pressure reading
Colorectal Cancer Screen (COL)	\$50	\$10	\$60	Fit kit, colonoscopy, CT colonography
Diabetes - Dilated Eye Exam (EED)	\$25	\$10	\$35	Comprehensive eye exam or retinal screening with proper diagnosis codes

Measure	P4Q Amount per Member	P4Q Amount per Clinical Priority Member	Combined P4Q and Clinical Priority Member Earning Potential	Common Ways to Close the Gap
Diabetes HbA1C \leq 9 (GSD)	\$100	\$25	\$125	Blood test
Kidney Health Evaluation for Patients with Diabetes (KED)	\$50	\$10	\$60	Urine screening and blood test
Medication Adherence - Blood Pressure Medications	\$35	N/A	\$35	Medication regimen
Medication Adherence - Diabetes Medications	\$35	N/A	\$35	Medication regimen
Medication Adherence - Statins	\$35	N/A	\$35	Medication regimen
Osteoporosis Management in Women with Fracture (OMW)	\$50	\$10	\$60	BMD, osteoporosis medication therapy or long-acting osteoporosis medications
Statin Therapy for Patients with CVD (SPC)	\$35	\$10	\$45	Medication regimen
Statin Use in Persons with Diabetes (SUPD)	\$35	\$10	\$45	Medication regimen
Medication Reconciliation Post Discharge (TRC)	\$50	\$10	\$60	Medication reconciliation encounter/intervention: 99483, CPT II Code 1111F

Absolute Total Care

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

Ambetter

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

CPT II and HCPCS Billing



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

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

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



How does this help you, our Providers?

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



What measures do these codes apply to?

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



CPTII Codes and HCPCS Billing PRO_91371E_Approved_01112022.pdf

What measures do these codes apply to?

Controlling Blood Pressure

- **Blood pressure results**

A1C levels

Diabetic Retinal Eye Exams

Care of Older Adults

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

Medication Reconciliation Post Discharge

- **Medication List and Review after hospital discharge**

Electronic Medical Record (EMR) System



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



Reduce provider office staff activities regarding HEDIS Hybrid chart chase requests



Decrease and avoid duplication of over utilization or retrieval efforts



Lead to improved HEDIS performance reporting

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

Supplemental Data Feed

Monthly Supplemental Data Feed

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

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



Close care gaps



Improve our HEDIS scores



Potential Compensation



Reduces request for medical records

CAHPS[®]

**Consumer Assessment of Healthcare
Providers and Systems**

Quality Rating Systems and CAHPS

MEDICAID

Rating System: HPR (Health Plan Rating System)

What role does CAHPS play?

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

MEDICARE AND MMP

Rating System: Star Ratings

What role does CAHPS play?

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

MARKETPLACE

Rating System: QRS (Quality Rating System)

What role does CAHPS play?

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

Survey Detail by Product

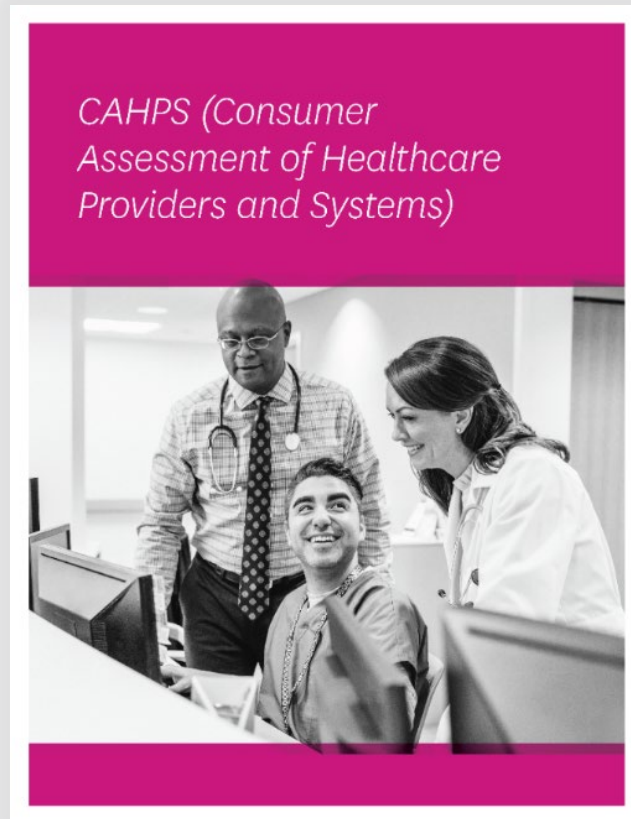


- The CAHPS survey is conducted annually however, the timeline varies slightly by product.
- The image provided reflects a breakdown of each product, important timeframes/deadlines, survey type, survey length, and sample size.

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

CAHPS® Provider Resource Guide

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



CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL
[Patient Care Manager](#)
[Provider Feedback Guide](#)

CAHPS (Consumer Assessment of Healthcare Providers and Systems)

Every year, a random sample of about 100,000 patients is surveyed about their experience with their doctors, nurses, and health plan. It is with their responses that we ensure that patients are satisfied, not only with the health care services but also with their health care experience.

CAHPS surveys allow patients to evaluate the aspects of care delivery that matter the most to them. At HEALTH PLAN, we are committed to partnering with our providers to deliver an outstanding patient experience.

As a provider, you are the most critical component of that experience. We want to ensure that you know exactly how your patients are evaluating your care. Please take a moment to review and to familiarize yourself with some of the key topics included in the survey.

CAHPS MEASURE: GETTING NEEDED CARE

The Getting Needed Care measure assesses the extent to which patients receive the care, tests, or treatment they needed. It also assesses how often they were able to get a specialist appointment, scheduled when needed.

Incorporate the following into your daily practice:

- Doctors should help coordinate specialty appointments for urgent cases
- Encourage patients and caregivers to view results on the patient portal when available
- Inform patients of what work items are needed after hours
- Offer appointments or referrals via text and/or email

CAHPS MEASURE: GETTING CARE QUICKLY

The Getting Care Quickly measure assesses how often patients get the care they needed as soon as they requested and how often special treatment was needed. It includes:

Incorporate the following into your daily practice:

- Ensure a few appointments each day are available to accommodate urgent visits
- Offer appointments with a nurse practitioner or physician assistant for short-notice appointments
- Maintain an effective triage system to assist patients, both on-line and over the phone, with urgent care
- Keep patients informed if there is a longer wait time than expected and give them an option to reschedule

CAHPS/HOS Provider Resource Guide

CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL
[Patient Care Manager](#)
[Provider Feedback Guide](#)

CAHPS MEASURE: CARE COORDINATION

The Care Coordination measure assesses providers' assistance with managing the disparate and confusing health care system, including access to medical records, timely follow-up on test results, and education on prescription medications.

Incorporate the following into your daily practice:

- Ensure there are open appointments for patients recently discharged from a facility
- Integrate PCIT and specialty practices through EMR or fax to get reports promptly
- Ask patients if they have seen any other providers, discuss visits to specialty care as needed
- Encourage patients to bring in their medications to each visit

CAHPS MEASURE: HOW WELL DOCTORS COMMUNICATE

The How Well Doctors Communicate measure assesses patients' perception of the quality of communication with their doctor. Consider using the Teach-Back Method to ensure patients understand their health information.

What is Teach-back?

- A way to ensure you – the healthcare provider – have explained information clearly. It is not a test or quiz of patients
- Asking a patient (or family member) to explain in their own words what they need to know or do in a caring way
- A way to check for understanding and, if needed, to explain and check again
- A research-based health literacy intervention that improves patient-provider communication and patient health outcomes

CAHPS MEASURE: RATING OF HEALTH CARE QUALITY

The CAHPS measure asks patients to rate the overall quality of their health care on a 0-10 scale.

Incorporate the following into your daily practice:

- Encourage patients to make their routine appointments for checkups or follow-up visits as soon as they can – weeks or even months in advance
- Ensure that open care gaps are addressed during medical visits
- Make use of the provider portal when requesting prior authorizations

CAHPS/HOS Provider Resource Guide

Provider Focus Quick Tips



Getting Care Quickly

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



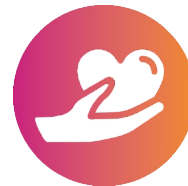
Rating of Health Care

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



Getting Needed Care

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



Care Coordination

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

Accessibility and Availability Standards

Accessibility and Availability



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



Availability is defined as the extent to which Absolute Total Care contracts with the appropriate type and number of practitioners and providers necessary to meet the needs of its members within defined geographical areas.

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

Access Standards - Medicaid



Primary Care Provider (PCP) Appointment Access Standards	
Routine Visits for established patients	Within 15 business days
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24-hour coverage	24 hours a day, 7 days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment

Specialty Care Provider Appointment Access Standards *NEW*	
Obstetrics & Gynecology (OB/GYNs), Oncologists, Retail Pharmacy and Autism Services	
Routine Visits for established patients	Within 15 business days
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24-hour coverage	24 hours a day, 7 days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment

Access Standards - Medicaid



Behavioral Provider Appointment Access Standards	
Initial visit for routine care	Within 10 business days
Follow-Up routine care for established patients	Within 15 business days
Care for a non-life-threatening emergency	Within 6 hours or referred to the emergency room or behavioral health crisis unit
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24 Hour coverage	24 hours a day, 7 days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in Appointments/non-urgent	Should be seen if possible or schedules for an appointment

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

Access Standards – Wellcare by Absolute Total Care



Primary Care and Specialist Appointment Type	Access Standard
PCP-Urgent	Within 24 hours
PCP-Non-urgent	Within 7 business days
PCP-Regular and routine	Within 30 business days
All specialists (including high volume and high impact) - Urgent	Within 24 hours
All specialists (including high volume and high impact) - Non-Urgent	Within 30 business days
Behavioral health provider - Urgent care	48 hours
Behavioral health provider – Initial routine care	Within 10 business days
Behavioral health provider – Non-life-threatening emergency	Within 6 hours
Behavioral health provider – Initial routine care follow-up	Within 10 business days
In-office wait times for all standards	Not to exceed 15 minutes

Access Standards – Medicare Advantage



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

Access Standards - Ambetter



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

Case Management

Case Management Services

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



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

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

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

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

Provider Satisfaction Survey

Provider Satisfaction Survey



Save the Date
APRIL 2026



**PROVIDER
SATISFACTION
SURVEY**

Our annual provider satisfaction survey will launch April 2026 and we hope you'll take a moment to share your feedback.

This survey serves as the foundation for key improvement initiatives that we undertake each year, and your feedback is critical to making sure we address the issues that are important to you.

We look forward to learning about how we can continue to improve your experience in doing business with us. Please keep an eye out for our survey in the coming weeks.

Checking Medication Coverage Is Easy

Key Pharmacy Goals to Improve Provider Satisfaction

Our goals

- Simplify access to medication coverage and formulary information
- Use electronic tools and provider resources
- Make prior authorization requirements easy to find

Why this matters

- Supports continuity of care
- Encourages evidence-based prescribing
- Reduces delays and administrative burden

Preferred Drug List (PDL) Identify preferred medications and therapeutic alternatives 🙌

Benefit Search Tool (Prior Authorizations) Quickly confirm if prior authorization is required 🙌

Preferred drug list

<https://www.absolutetotalcare.com/providers/pharmacy.html>



Medical Benefit Search tool (for prior authorizations)

<https://www.absolutetotalcare.com/providers/preauth-check.html>



2025 Press Ganey Human Experience Pinnacle of Excellence Award



Absolute Total Care receives 2025 Press Ganey Human Experience Pinnacle of Excellence Award

Absolute Total Care through a press release announced that it has been named a 2025 Human Experience (HX) Pinnacle of Excellence Award[®] winner by [Press Ganey](#), the global leader in healthcare experience solutions and services. This award is part of Press Ganey's annual ranking of the top health plans, hospitals and health systems in the country, according to performance in a variety of experience metrics.

As a winner of the Press Ganey HX Pinnacle of Excellence Award[®], Absolute Total Care has earned recognition for ranking in the top 5% of health plans nationwide, delivering exceptional member experience over a minimum of two consecutive years in Highest overall CAHPS ratings.

This prestigious honor reflects Absolute Total Care's unwavering commitment to understanding and prioritizing the voices of its members. Press Ganey partners with over 85% of U.S. health plans in its mission to advance member experience, reduce friction points, and create a seamless healthcare journey.



https://www.prnewswire.com/news-releases/absolute-total-care-receives-2025-press-ganey-human-experience-pinnacle-of-excellence-award-302682939.html?tc=eml_cleartime



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



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

absolutetotalcare.com



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



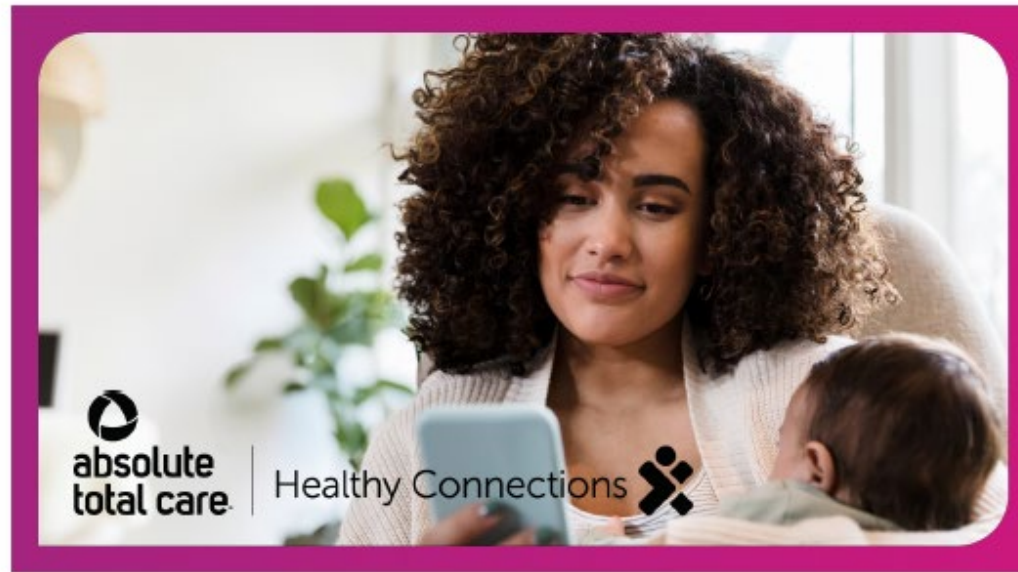
Absolute Total Care is committed to giving our providers the tools & support you need.

wellcare.com/medicare

Appendix

Health Insurance Portal Mobile App

Health Insurance Portal Mobile App



Get the Health Insurance Portal Mobile App to Stay Connected and Informed.

- ✓ **Search for Care**
Find doctors and urgent care near you, change your primary care doctor and more.
- ✓ **View Your Benefits**
See the benefits and services available to you.
- ✓ **Access Your Member ID Card**
Open and share your digital member ID card in the app or save it to your iPhone wallet.
- ✓ **Take a Health Quiz**
Let us know your health needs to better serve you.
- ✓ **Let Us Know You're Pregnant**
We can connect you to programs and services for a healthy pregnancy.

How to Get Started

1. **Download the App:** Search for "Health Insurance Portal" in the App Store or Google Play.
2. **Select South Carolina:** From the "state" drop down menu, select "South Carolina."
3. **Log In:** Use your member portal login or create an account to get started.

Download Today!



App Store



Google Play



1-866-433-6041
(TTY: 711)

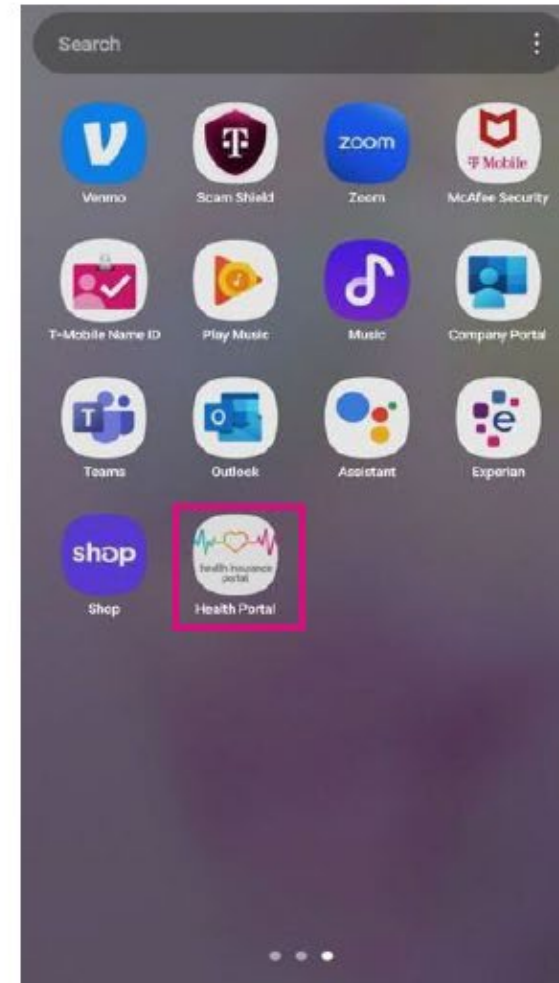
AbsoluteTotalCare.com
ATC-07092025-M-2-WM-N



Member Mobile App User Guide

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

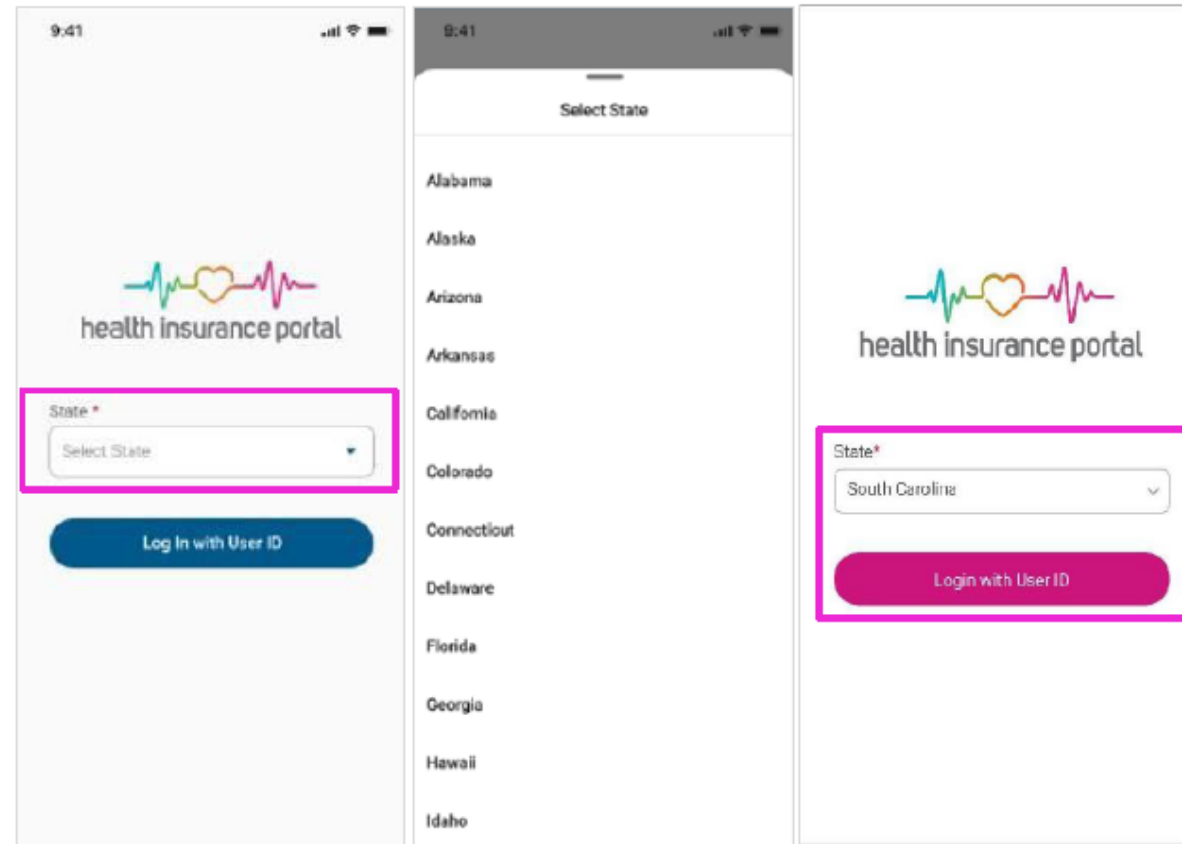
Step 1: **OPEN.** Open the mobile app by clicking on the “Health Insurance Portal” icon.





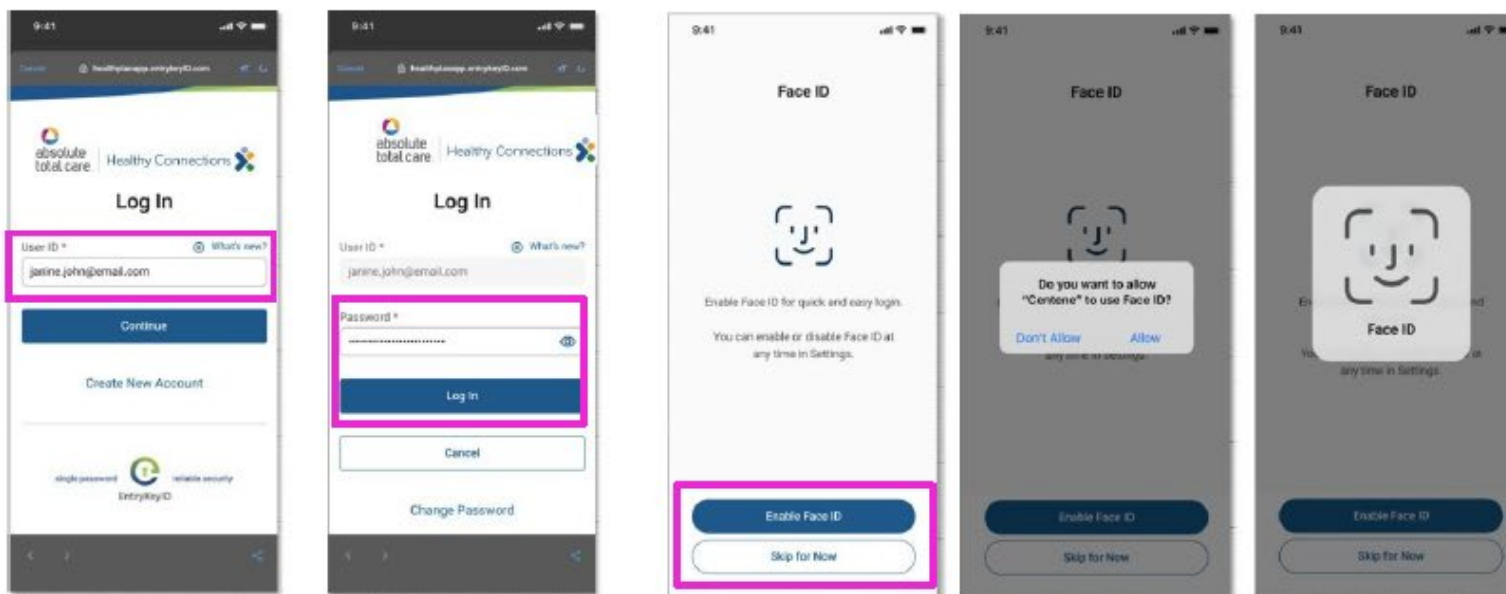
Member Mobile App User Guide

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



Member Mobile App User Guide

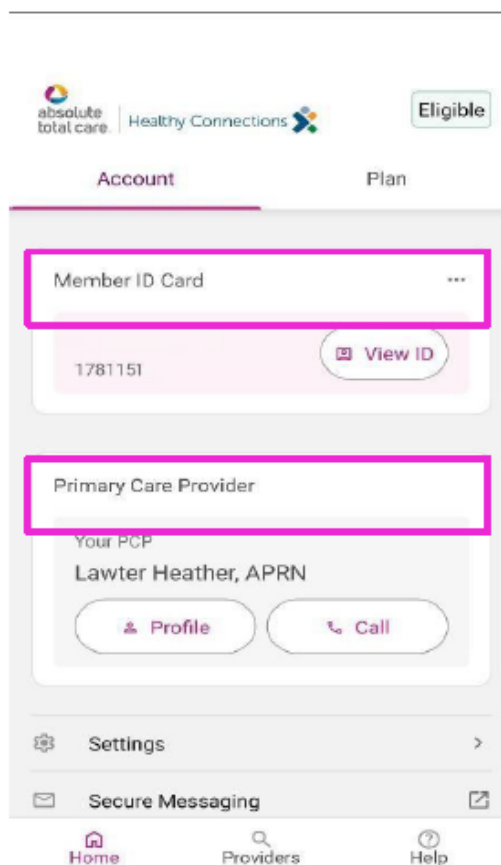
Step 2a: LOG IN. Enter your email address in the “User ID” box and click “Continue.” Enter your “Password” and click “Log In.” Next, you will have the option to “Enable Face ID” as a log in option. Here, you can select “Enable Face ID” or “Skip for Now.” use “Biometrics



Member Mobile App User Guide



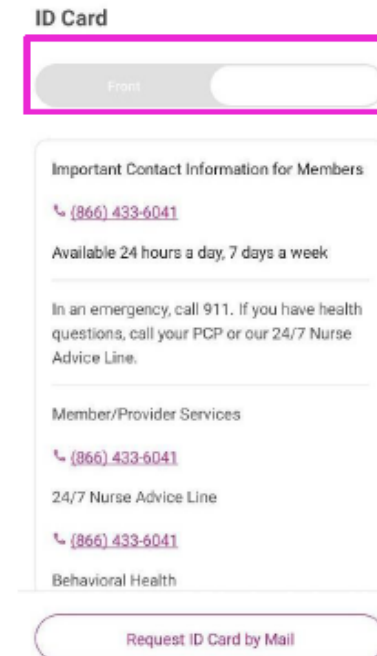
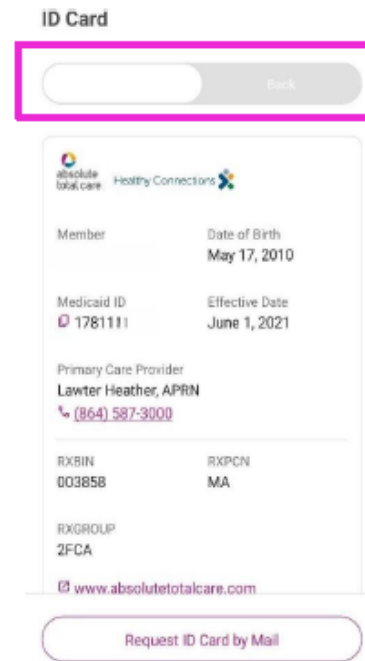
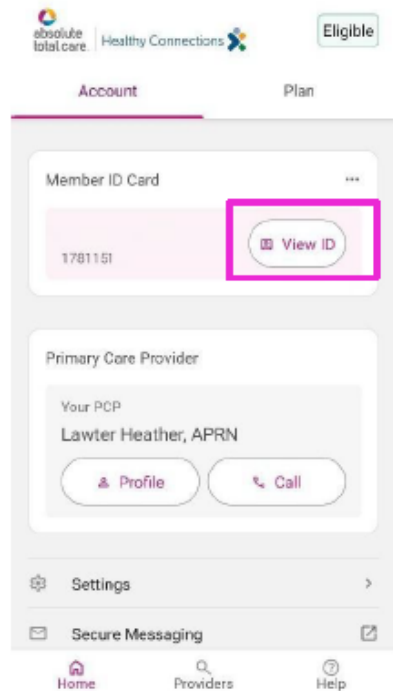
Step 3: **HOME PAGE/ACCOUNT.** The homepage screen will appear with the following options: **Member ID Card** and **Primary Care Provider**.



Member Mobile App User Guide



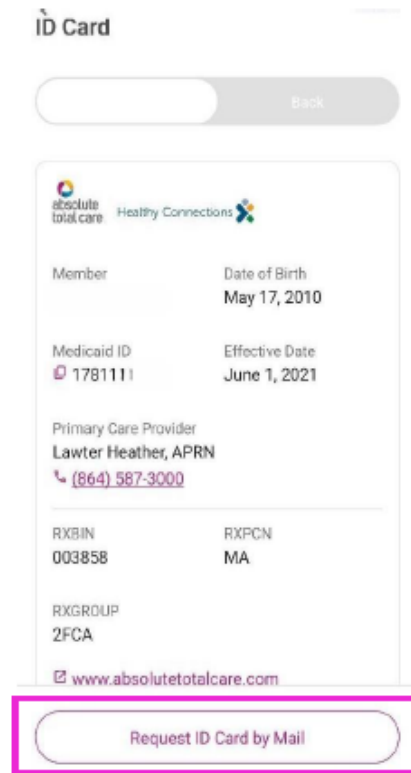
Step 4: **MEMBER ID CARD.** If you click on the “View ID” button next to your member name, you will be directed to your Absolute Total Care ID card. You will be able to view the “Front” and “Back” of your ID card.



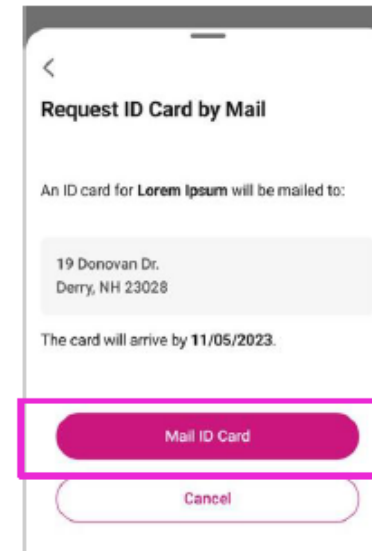
Member Mobile App User Guide



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



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

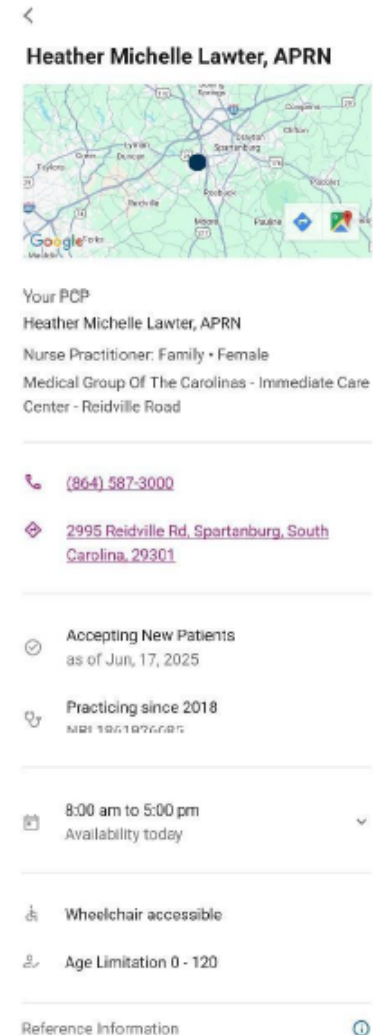
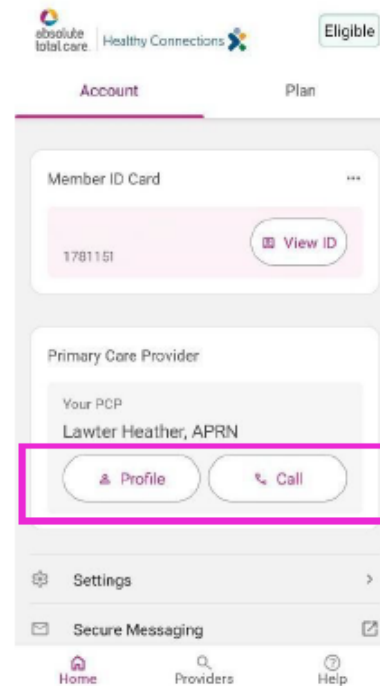


Note: The option to save to your cell phone is not available on Android devices.



Member Mobile App User Guide

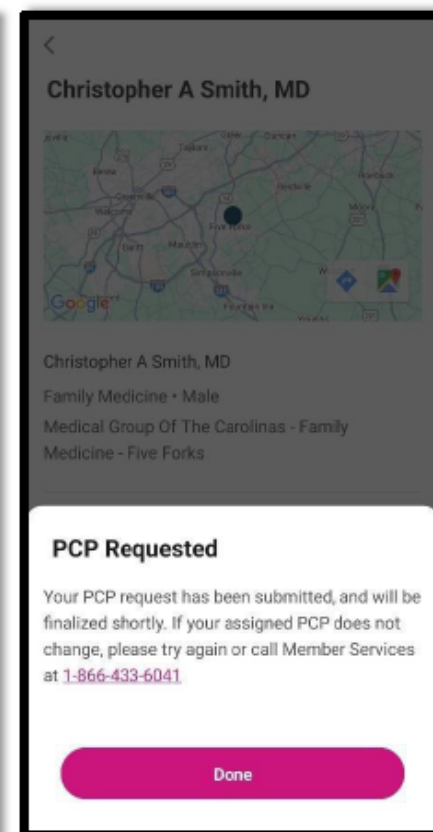
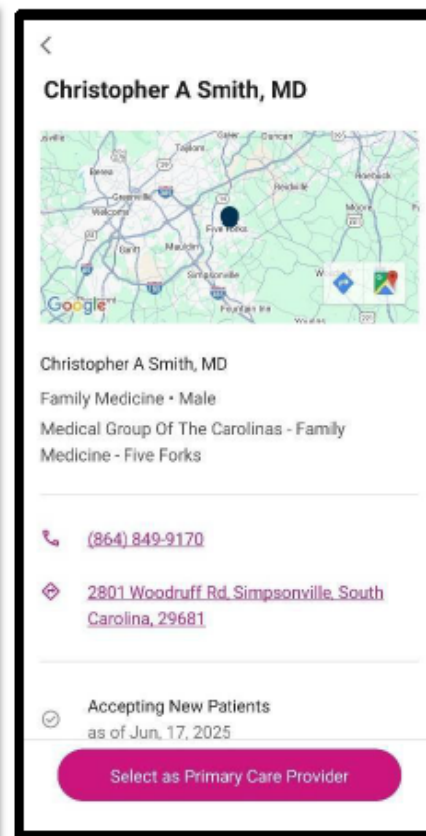
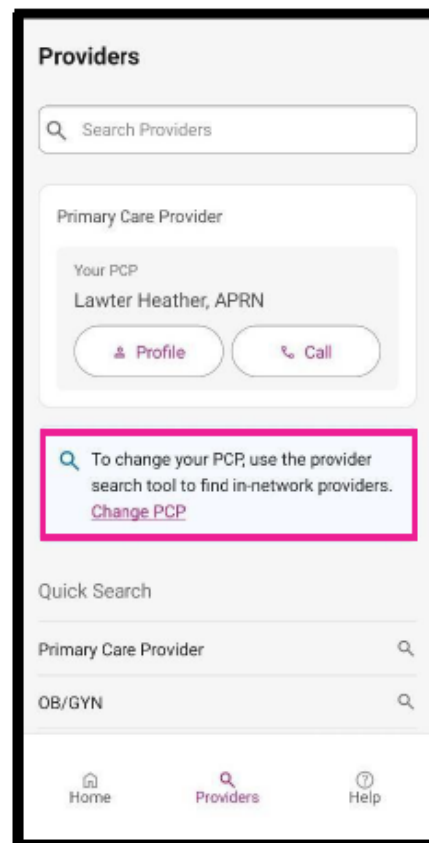
Step 6: **PRIMARY CARE PROVIDER.** Here, you will be able to view your Primary Care Provider (PCP). You can click on **“Profile”** to view full details or **“Call”** to call the provider directly from your device.



Member Mobile App User Guide



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

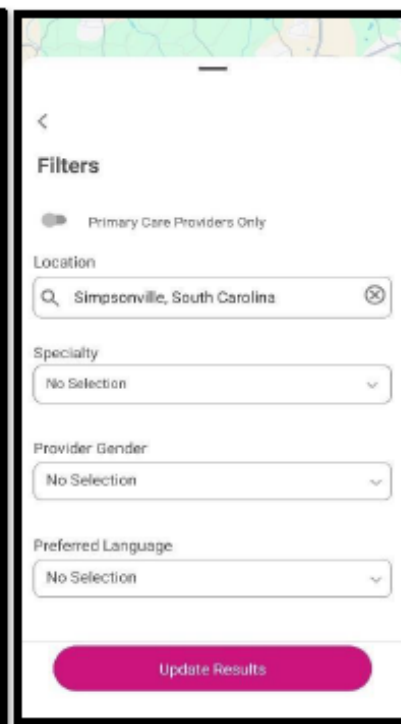
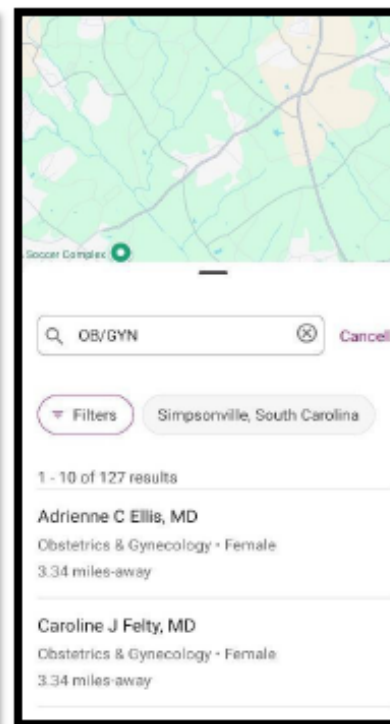
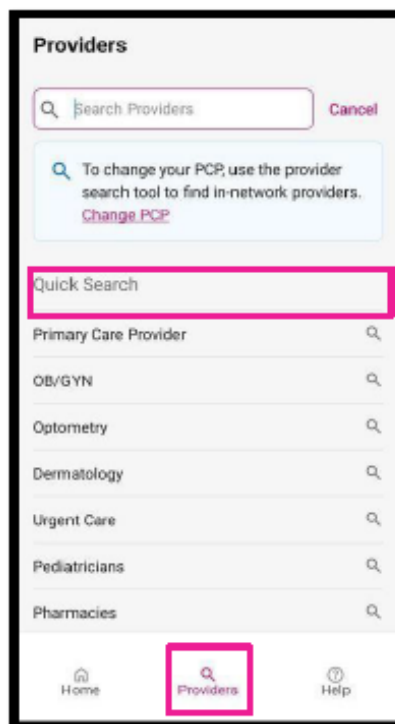


Note: When updating your PCP, you will see a dialog message box about your changes.

Member Mobile App User Guide



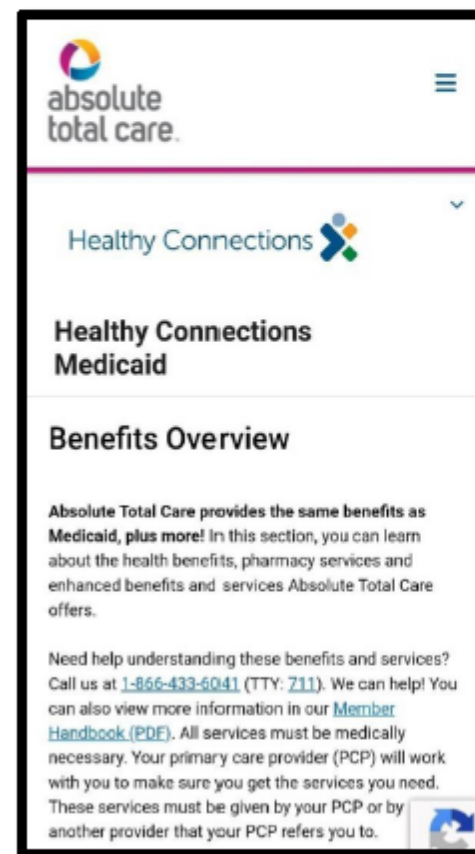
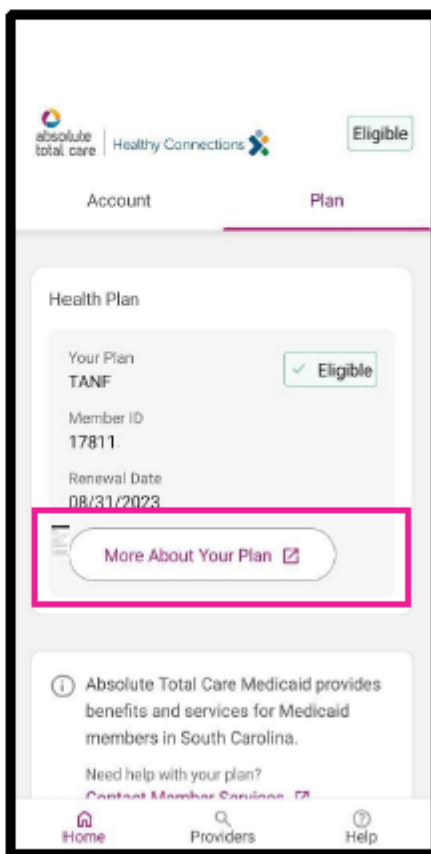
Step 8: **FIND A PROVIDER.** Clicking on the “Providers” icon at the bottom will direct you to search for providers. Click on any provider category under “Quick Search” to look for a health-care provider the same way you can on the Absolute Total Care website.



Member Mobile App User Guide






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



ID Card Samples

2026 Medicaid ID Cards

 Healthy Connections 	MEMBER ID#: [0123456789012] Card Issued: [MM/DD/YYYY]
Member: [Member Full Name]	
 Member Portal	Member Date of Birth: [MM/DD/YYYY] PCP Name: [Physician Name] PCP Phone: [1-XXX-XXX-XXXX]
Effective Date: [MM/DD/YYYY]	RXBIN: [003858] RXPCN: [MA] RXGRP: [2FCA]

www.absolutotalcare.com	
Member / Provider Services	[1-866-433-6041] (TTY: 711)
24/7 Nurse Advice Line	[1-866-433-6041] (TTY: 711)
Behavioral Health	[1-866-433-6041] (TTY: 711)
Imaging, X-Rays, Radiology	[1-866-433-6041] (TTY: 711)
DME, Home Health, Infusion	[1-866-433-6041] (TTY: 711)
Pharmacist Only	[1-833-750-4506] (TTY: 711)
Medical Claims: [Absolute Total Care, P.O. Box 3050, Farmington, MO 63640-3821]	
FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room	

Medicare Dual Align HMO D-SNP 2026 ID CARD



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

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



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

Member Name: [Cardholder Name]
Member ID: [Cardholder ID#]
PCP Group/Name: [PCP/Group Name]
PCP Phone: [PCP Phone]

MEMBER CANNOT BE CHARGED

Copays: PCP/Specialist: \$0 ER: \$0
[H5272] [001]



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




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

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

Medicare HMO 4847 ID Card



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



[Plan Name] [(Plan Type)]


MEMBER ID#: 1234567890123

PLAN#: HXXXX-XXX-000

ISSUER #: (80840) 9151014609

Member: SAMPLE A SAMPLE

2026



You can see any PCP in our Network

PCP: [Physician Name]

PCP Phone: 1-XXX-XXX-XXXX

PCP Office Visit: [\$X]


Member portal


Card Issued: MM/DD/YYYY

RXBIN: 610014

RXPCN: MEDDPRIME

RXGRP: 2FFA





Member Services / Nurse Advice Line

Vision: [Provider]

Dental: [Provider]

Transportation: [Provider]

Provider Services / Pharmacy Prior Auth

Pharmacist Only

1-XXX-XXX-XXXX (TTY: 711)

1-XXX-XXX-XXXX (TTY: 711)

1-XXX-XXX-XXXX (TTY: 711)

1-XXX-XXX-XXXX (TTY: 711)

1-XXX-XXX-XXXX (TTY: 711)

1-XXX-XXX-XXXX (TTY: 711)

Medical Claims: Wellcare Attn: Claims P.O. Box XXXXX Tampa, FL 33631-XXXX Payor ID: 14163

Part D Claims: Wellcare Attn: Medicare Part D Member Reimbursement Dept. P.O. Box 31577 Tampa, FL 33631-3577


FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room

go.wellcare.com/Medicare

Medicare PPO H7326 ID card



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




[Plan Name] [(Plan Type)]

MEMBER ID#: 1234567890123
PLAN#: HXXXX-XXX-000
ISSUER#: (80840) 9151014609

Member: SAMPLE A SAMPLE

2026




Medicare limiting charges apply.


In Network PCP Office Visit: [\$X]
Out of Network PCP Office Visit: [\$X]

Member portal

Card Issued: MM/DD/YYYY

RXBIN: 610014
RXPCN: MEDDPRIME
RXGRP: 2FFA





Member Services / Nurse Advice Line	1-XXX-XXX-XXXX (TTY: 711)
Vision: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Dental: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Transportation: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Provider Services / Pharmacy Prior Auth	1-XXX-XXX-XXXX (TTY: 711)
Pharmacist Only	1-XXX-XXX-XXXX (TTY: 711)

Medical Claims: Wellcare Attn: Claims P.O. Box 31372 Tampa, FL 33631-3372 Payor ID: 14163

Part D Claims: Wellcare Attn: Medicare Part D Member Reimbursement Dept. P.O. Box 31577 Tampa, FL 33631-3577

FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room

go.wellcare.com/Medicare

PDP-Classic and Value Script ID cards



wellcare Prescription Drug Plan
Wellcare Classic (PDP)

MEMBER ID#: 1234567890123
PLAN#: S4802-XXX
ISSUER#: (80840) 9151014609

Member: SAMPLE A SAMPLE

PDP  Scan the QR code using your smartphone to register online for your member portal and view your account details!
go.wellcare.com/pdpmember


Card Issued: MM/DD/YYYY	RXBIN: 610014 RXPCN: MEDDPRIME RXGRP: 2FGA
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MedicareRx
Prescription Drug Coverage

wellcare Prescription Drug Plan
Wellcare Value Script (PDP)

MEMBER ID#: 1234567890123
PLAN#: S4802-XXX
ISSUER#: (80840) 9151014609

Member: SAMPLE A SAMPLE

PDP  Scan the QR code using your smartphone to register online for your member portal and view your account details!
go.wellcare.com/pdpmember

Card Issued: MM/DD/YYYY	RXBIN: 610014 RXPCN: MEDDPRIME RXGRP: 2FGA
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MedicareRx
Prescription Drug Coverage



Member Services	1-888-550-5252 (TTY: 711)
Mail Order Pharmacy	1-833-750-0201 (TTY: 711)
Provider Services / Prior Auth	1-855-538-0453 (TTY: 711)
Pharmacist Only	1-833-750-0408 (TTY: 711)

Submit Part D Claims To:
Attn: Medicare Part D Member Reimbursement Dept.
P.O. Box 31577 Tampa, FL 33631-3577

FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room
go.wellcare.com/PDP



Member Services	1-888-550-5252 (TTY: 711)
Mail Order Pharmacy	1-833-750-0201 (TTY: 711)
Provider Services / Prior Auth	1-855-538-0453 (TTY: 711)
Pharmacist Only	1-833-750-0408 (TTY: 711)

Submit Part D Claims To:
Attn: Medicare Part D Member Reimbursement Dept.
P.O. Box 31577 Tampa, FL 33631-3577

FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room
go.wellcare.com/PDP

Marketplace Ambetter/Ambetter Health Member ID Card



Ambetter / Ambetter from Absolute Total Care
Network name: PREMIERE

Ambetter Health (ICHRA)
Network name: SOLUTIONS

REFERRAL NOT REQUIRED

PREMIER

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

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

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

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

REFERRAL NOT REQUIRED

SOLUTIONS

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

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

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

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

AmbetterHealth.com/SC

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

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

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

Ambetter from Absolute Total Care is underwritten by Absolute Total Care, Inc., which is a Qualified Health Plan issuer in the South Carolina Health Insurance Marketplace. ©2025 Absolute Total Care, Inc. All rights reserved.

AMB25-SC-C-00060

AmbetterHealth.com

Member/Provider Services: 1-833-543-3145
(TTY 711)
24/7 Nurse Line: 1-833-543-3145

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

Medical Claims Address:
Ambetter Health
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

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AMB25-SC-C-00060

Payment Integrity Solutions

Updates regarding Payment Integrity Solutions

Effective 2/1/2026

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

*Impacts Medicare, Medicaid, & Marketplace.

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

Cross-coder Professional vs. Outpatient Facility Surgery Claims	This analytic identifies professional claims with surgical procedure codes that do not match the outpatient facility claim codes for similar services provided to the same patient on the same date of service. Records will be reviewed to ensure coding/documentation guidelines are met
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Associated Code for EOP	Description
Absolute Total Care Medicaid: EXbo	MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED
Ambetter from Absolute Total Care: EXbo	MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED
Wellcare By Absolute Total Care: EXbo	MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED
Wellcare of South Carolina Medicare: CPIMR	MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED





Wellcare Medical Clinical Policies Updates

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

February 9, 2026:

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

November 1, 2025:

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




absolute
total care

Healthy Connections 

Thank You.

Confidential and Proprietary Information

