wellcare With absolute total care

Healthy Connections

Wellcare With Absolute Total Care

Provider Manual

2027

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Partners in Quality Care

Dear Provider Partner,

At Wellcare, we deeply value your commitment to delivering compassionate, high-quality care to our members — your patients. Your role is essential in helping us serve individuals who rely on both Medicare and Medicaid, many of whom face complex health and social challenges.

Together, we ensure our members receive the coordinated care they need to live healthier, more fulfilling lives.

We are committed to quality — and that means supporting you with the tools, resources, and programs that help remove barriers to care. Whether it's identifying care gaps, navigating benefits, or addressing social needs, we're here to work alongside you and your team.

As part of our partnership, we also recognize and reward your efforts to close care gaps and improve outcomes. Your dedication makes a meaningful difference.

The enclosed D-SNP Provider Manual is your guide to working with Wellcare. We encourage you to explore the highlighted sections, which reflect our shared goal of delivering integrated, person-centered care.

Thank you for being a trusted Wellcare provider partner.

Sincerely,

Wellcare

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2027 D-SNP(DUALS) PROVIDER MANUAL REVISION TABLE

Date	Section	Sub-Header	Comments
1/1/2027	2: Member Benefit Information	Member Eligibility and Enrollment Exclusions from Enrollment Sample Member ID Card Special Supplemental Benefits for the Chronically Ill (SSBCI) Emergency Services Member Grievance	Updated age; Updated list; Updated member ID card sample; Added section; Clarified language; Updated language
1/1/2027	3: Provider Functions and Responsibilities	Provider Credentialing/Re-Credentialing	Updated language
1/1/2027	4: Utilization Management	UM Decisions Prior Approval Requirements/ Precertification CMS Interoperability APIs — Provider Overview Care Coordination	Updated language; Added weblink and updated instructions; Added section; Added training link
1/1/2027	5: Billing and Claims Payment	Retroactive Adjustments	Added new section
1/1/2027	7: Compliance and Regulatory Requirements	FRAUD, WASTE & ABUSE (FWA) Program	Updated language

SECTION 1: GENERAL INFORMATION

Welcome to the Wellcare With Absolute Total Care Provider Manual. This manual is a comprehensive resource for healthcare Providers participating in our Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP), administered by Centene Corporation. Our HIDE-SNP product is designed to deliver seamless, coordinated care to individuals eligible for both Medicare and Medicaid, ensuring access to the full spectrum of covered services.

Within this manual, Providers will find essential information on policies, procedures, and best practices that support high-quality, integrated care. Our goal is to empower Providers with the tools and guidance needed to improve health outcomes and enhance Member experience. We value our partnership with you and remain committed to supporting your efforts in delivering exceptional care to our Members.

BACKGROUND

In May 2022, the Centers for Medicare & Medicaid Services (CMS) finalized regulatory requirements directing states participating in the Medicare-Medicaid Financial Alignment Initiative to end their demonstration programs by December 31, 2025, or transition to an integrated Dual Eligible Special Needs Plan (D-SNP) model.

In response to this guidance, the South Carolina Department of Health and Human Services (SCDHHS) has transitioned its existing Financial Alignment Initiative Medicare-Medicaid Plan program to a HIDE-SNP. A HIDE-SNP is a type of Medicare Advantage plan specifically designed to serve individuals who are dually eligible for both Medicare and Medicaid. It offers coordinated delivery of Medicare and Medicaid benefits - including behavioral health services – through a single managed care organization.

HIDE-SNP Program Commitment and Transition Pillars

Wellcare With Absolute Total Care, in partnership with the SCDHHS, is committed to enhancing care delivery for low-income seniors and individuals with disabilities who are dually eligible for Medicare and Medicaid. This commitment will be upheld through the implementation of a HIDE-SNP, with the primary goal of ensuring continuity of benefits and maintaining high standards of care.

To support a smooth and effective transition, Wellcare With Absolute Total Care has adopted the Integrated Care Transition Pillars developed under the CMS Medicare-Medicaid Coordination Office (MMCO) framework, supported by the Resources for Integrated Care (RIC) initiative. These pillars serve as guiding principles for delivering high-quality, person-centered, and equitable care under the HIDE-SNP model.

Integrated Care Transition Pillars

- **Foster Integration and Continuity:** Wellcare With Absolute Total Care's HIDE-SNP program is designed to integrate Medicare and Medicaid services, improving access and care quality for dually eligible individuals. The model bridges gaps between physical health, behavioral health, and long-term services and supports (LTSS). Upon enrollment, Members will maintain access to their existing

Providers and services – without changes in amount, scope, or duration – until a comprehensive assessment is completed.

- **Reduce Racial and Ethnic Disparities:** The Wellcare With Absolute Total Care HIDE-SNP program uses a data-driven approach to identify and address health disparities. The HIDE-SNP model emphasizes culturally and linguistically appropriate services, ensuring equitable access to care for individuals with limited English proficiency and those from diverse backgrounds. These efforts align with broader state and federal health equity initiatives.
- **Improve Care Delivery:** The HIDE-SNP uses a person-centered care model that prioritizes the holistic needs of each Member. Care coordination will be central, ensuring seamless transitions across care settings and Providers. Interdisciplinary care teams will support individualized care planning and service delivery.
- **Promote Self-Determination:** Wellcare With Absolute Total Care's HIDE-SNP empowers Members to take an active role in directing their care, particularly in LTSS. The program supports flexible, enrollee-directed care models that respect individual preferences, values, and goals.
- **Build a Culture of Quality:** Continuous quality improvement is embedded throughout the HIDE-SNP program. The Plan uses integrated data systems to monitor performance, identify gaps, and improve outcomes. Key focus areas include care coordination, person-centered planning, health equity, and value-based payment reform.

Program Launch and Implementation

The HIDE-SNP program launched on January 1, 2026, with initial implementation in select South Carolina counties, as confirmed by SCDHHS. During the early implementation phase, LTSS remains carved out, with coordination maintained between HIDE-SNP plans and state-contracted LTSS Providers to ensure continuity and alignment of care.

HOW TO USE THIS MANUAL

The Wellcare With Absolute Total Care Provider Manual is a digital resource designed to provide comprehensive, easy-to-navigate guidance for participating Providers. The manual is organized into clearly defined sections, each supported by a master Table of Contents and section-specific Tables of Contents for more precise navigation.

To efficiently locate information:

- Start with the primary Table of Contents to identify the relevant section or topic.
- Note the corresponding Section Number.
- Navigate to that section and review its section-specific Table of Contents.
- Locate the page number for the topic you are seeking and proceed directly to that page.

This manual is available digitally at wellcare.absolutetotalcare.com. A printed copy may be requested by contacting Provider Services.

Updates and Revisions

The Wellcare With Absolute Total Care Provider Manual is a living document, updated regularly to reflect changes in policies, procedures, and program requirements. Minor revisions may be communicated to Providers through routine outreach or informational updates.

In the event of significant changes, a revised version of the manual will be issued and will replace any previous editions. Providers are encouraged to reference the most current version, which is always available on the Wellcare With Absolute Total Care website at wellcare.absolutetotalcare.com.

KEY CONTACT INFORMATION

To support Providers in delivering high-quality care, Wellcare With Absolute Total Care offers dedicated resources for assistance with clinical, administrative, and operational needs. The following contacts are available to help with questions related to claims, authorizations, pharmacy, and more.

Please refer to the table below for the most commonly used contact information:

wellcare With absolute total care	Wellcare With Absolute Total Care P.O. Box 10050 Van Nuys, CA 91410-0050 Phone: 1-833-998-5401 (TTY: 711) Hours of Operation: Monday-Friday, 8am-8pm EST wellcare.absolutetotalcare.com	
Department	**Phone Number**	**Website**
Member Services	1-833-998-5063	N/A
24-Hour Nurse Advice Line		
Behavioral Health		
Provider Services	1-833-998-5401	
Centene Pharmacy Services		www.centenepharmacy.com
Pharmacy Prior Authorizations		N/A
Express Scripts, Inc. (ESI) Pharmacy Helpdesk	1-833-750-4244	

wellcare With absolute total care.	Wellcare With Absolute Total Care P.O. Box 10050 Van Nuys, CA 91410-0050 Phone: 1-833-998-5401 (TTY: 711) Hours of Operation: Monday-Friday, 8am-8pm EST wellcare.absolutetotalcare.com	
Department	**Phone Number**	**Website**
CARES Hotline for Behavioral Health Crisis	1-800-345-9049	N/A
Vision: Centene Vision Services	1-855-659-6665	
Dental: Liberty Dental	1-866-544-4362	
Non-Emergency Transportation: ModivCare	1-877-682-9029	
Interpreter Services	1-800-977-7522	
Fraud, Waste, & Abuse	1-866-685-8664	
Ethics & Compliance	1-800-345-1642	
Payspan	1-877-331-7154, Option 1	www.payspanhealth.com

SECTION 2: MEMBER BENEFIT INFORMATION

MEMBER ELIGIBILITY AND ENROLLMENT

To enroll in a Wellcare With Absolute Total Care, individuals **must:**

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Have full Medicaid benefits (QMB+, SLMB+, FBDE)
- Be 18 years of age or older
- Permanently reside in the Wellcare With Absolute Total Care service areas
- Not be enrolled in hospice
- Be a U.S. citizen or lawfully present in the United States

EXCLUSIONS FROM ENROLLMENT

The following populations are excluded from enrollment in the program:

- Individuals with partial Medicaid eligibility (e.g., SLMB, QI, QDWI)
- Individuals without full Medicaid coverage (e.g., spend-down status)
- Individuals under the age of 18
- Individuals with HMO third party coverage with the exception of those health plans administered by Medicare
- Individuals with elected hospice services
- Individuals who are incarcerated
- Individuals with presumptive Medicaid Eligibility
- Individuals disenrolled from Medicaid managed care due to special circumstances
- Individuals enrolled in the State's Developmental Disability Home and Community Based Waivers.
- Individuals must be enrolled in the South Carolina Medicaid Managed Care Organization (MCO) ABSOLUTE TOTAL CARE, INC. that exclusively aligns with the Contractor (Centene Medicaid)
- Individuals with the following Full-Benefit Dual Eligible categories into this Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP): QMB+, SLMB+ and FBDE
- Community Supports (CS) Waiver
- SC Head and Spinal Cord Injury (HASCI) Waiver
- SC Intellectual disability and Related Disabilities (ID/RD) Waiver
- SC Medically Complex Children Waiver
- PACE
- Are not otherwise excluded from participation based on federal requirements or state laws or policies

NON-DISCRIMINATION STATEMENT

Wellcare With Absolute Total Care will accept all eligible Members regardless of:

- Race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family status.
- Furthermore, we will not limit, or condition coverage of plan benefits based on any factor that is related to the Member's health status, including but not limited to:
  - Medical condition
  - Claims history
  - Receipt of healthcare
  - Medical history
  - Genetic information
  - Evidence of insurability or disability

MEMBER RIGHTS AND RESPONSIBILITIES

Members of Wellcare With Absolute Total Care may have the following rights and responsibilities, in accordance with applicable federal and state laws, regulations, and the terms of the health plan contract:

Access to Information

1. Members may request and receive information about the health plan, including:
   a. Member rights and responsibilities
   b. Participating Providers and their qualifications
   c. Grievance and appeal procedures
   d. Covered benefits and services
2. Provider information – such as location, qualifications, and availability – is accessible via the online Provider directory or by contacting Member Services.
3. Members may request information about the plan's structure, operations, and benefits, and can expect responses to reasonable inquiries.
4. Plan rules, benefits, and available options may be explained to Members, with interpreter services made available when needed.

Language and Disability Services

5. Members may access, at no cost:
   a. Language assistance services, including qualified interpreters and translated written materials
   b. Auxiliary aids for effective communication, such as large print documents, audio materials, or accessible electronic formats
6. When available and upon request, the plan may assist in identifying Providers who speak the Member's preferred language

Dignity, Privacy, and Nondiscrimination

7. Members are to be treated with respect and dignity, with consideration for their right to privacy.

8. The plan is expected to comply with applicable laws regarding the confidentiality of personal health information. Members have the right to authorize or decline the release of their personal health information, consistent with those laws.
9. Members are protected from discrimination based on race, color, national origin, religion, sex, age, marital status, disability, sexual orientation, genetic information, source of payment, and other classifications protected by law.
10. Members may not be subjected to restraint or seclusion as a form of coercion, discipline, convenience, or retaliation.
11. Members should be able to exercise their rights without fear of negative consequences from the plan, its Providers, or the state.

Participation in Care

12. Members are encouraged to participate in decisions about their healthcare, including the right to:
    a. Accept or refuse recommended treatment
    b. Discuss treatment options with their Providers, including potential risks, benefits, and alternatives
13. Members may receive healthcare services in accordance with applicable laws and Wellcare With Absolute Total Care's agreement with the state.
14. Members may have access to a network of Providers, including primary care providers, specialists, hospitals, and American Indian/Alaska Native Providers when appropriate.
15. Members may access emergency services when medically necessary, regardless of network status or prior authorization.

Grievances, Appeals, and Involvement

16. Members may voice concerns or submit grievances and appeals regarding their care or plan services.
17. Members may request and review their medical records and request corrections as permitted by law.
18. Members may receive decisions related to service authorization, benefit coverage, and prescription drugs, including notification of appeal rights.
19. Members may recommend improvements to the plan's policies and procedures.
20. Members may participate in plan governance and operations, consistent with applicable rules and program structure.

Final Protections

21. Members are generally not responsible for bills, cost-sharing, or copayments for services covered by the plan, including those provided by American Indian/Alaska Native Providers, when consistent with applicable program guidelines.

Reasonable Accommodations

22. The plan and its contracted Providers are expected to provide reasonable accommodations for Members with disabilities, as required by law.
    a. Members may be informed annually – and as needed – about their rights to accommodations via the Member handbook.
    b. Providers are informed of these requirements through the Provider manual.

c. Members may request accommodations through their care coordinator, who can help assess needs and provide available options.
d. The Utilization Management team reviews accommodation requests and determines whether they can be provided.
e. Members may appeal decisions regarding accommodations through the appeals process outlined in plan policy.

23. Receive basic information about the plan, orally as well as in writing, upon request, about the organization of Wellcare With Absolute Total Care including but not limited to Member rights and responsibilities, participating Providers, grievance, and appeal procedures, and covered services. This information is made accessible to all Members including those with limited English proficiency or reading skills, with diverse cultural ethnic background, and with physical and mental disabilities.

MEMBER BENEFITS AND SERVICES

Wellcare With Absolute Total Care offers a comprehensive benefit package to Members who are eligible for Medicare and full Medicaid benefits. Covered services are based on medical necessity and must meet professionally accepted standards of care. The plan integrates Medicare and Medicaid benefits, including behavioral health, and preventive care.

Covered services may include:

- Primary and specialty care provider visits
- Hospital inpatient and outpatient services
- Emergency and urgent care services
- Ambulance and emergency medical transportation
- Behavioral health services, including outpatient therapy and psychiatric care
- Prescription drugs (Medicare Part D and Medicaid-covered medications)
- Dental services
- Vision services, including eye exams and eyeglasses
- Hearing services, including hearing aids
- Durable Medical Equipment (DME) and medical supplies
- Home health care -
- Skilled nursing facility care
- Rehabilitative therapies (physical, occupational, and speech therapy)
- Preventive services, including immunizations and screenings
- Family planning and reproductive health services
- Podiatry and chiropractic care
- Transportation to medical appointments (non-emergency medical transportation)
- Care coordination and case management
- Second medical opinions, when requested

Additional Notes

- Members are not responsible for co-pays on Medicaid-covered services.
- Prior authorization may be required for out-of-network services, except in the case of emergencies.
- Members have the right to receive care from Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Interpreter services and materials in alternative formats (e.g., large print, braille, or audio) are available at no cost to Members.
- Wellcare With Absolute Total Care will implement any changes to covered services as directed by SCDHHS, in alignment with updates to the South Carolina Medicaid program.

Non-Covered Services

While Wellcare With Absolute Total Care provides a wide range of integrated Medicare and Medicaid benefits, certain services are excluded from coverage under South Carolina Medicaid and/or Medicare. These services are not reimbursable and will not be covered by the plan unless required by law or authorized under special circumstances. For a complete list of non-covered services, refer to Chapter 4 of the Wellcare With Absolute Total Care Member Handbook, otherwise known as the Evidence of Coverage.

Services Not Covered by the Plan include:

- Elective abortions, except in case of rape, incest, or when the life of the pregnant person is endangered
- Experimental or investigational treatments, drugs, or equipment not approved by CMS or SCDHHS
- Cosmetic surgery or procedures performed solely for aesthetic purposes
- Infertility treatments and related medications
- Erectile dysfunction medications (unless medically necessary and covered under Medicare Part D)
- Services not deemed medically necessary by the plan or state guidelines

LTSS and Other Services Managed Outside the Plan

Certain services are administered outside of the HIDE-SNP benefit package by state-contracted Providers or through waiver programs. These services are not directly managed by Wellcare With Absolute Total Care but are essential to supporting Members' long-term care needs. Providers are expected to assist Members in accessing these services through appropriate referrals and coordination with state agencies or designated Provider networks.

- Adult day health care
- Companion services
- Home-delivered meals
- Minor home adaptations
- Personal and attendant care
- Personal emergency response systems
- Private duty nursing
- Certain nutritional supplements

- Specialized medical equipment and supplies
- Institutional and in-home respite care

Wellcare With Absolute Total Care Providers play a key role in helping Members navigate these resources by facilitating referrals, sharing relevant clinical information, and collaborating with external care teams to ensure continuity and alignment of services.

Provider Support

Providers should contact Member Services at **1-833-998-5063** for assistance with:

- Referrals to state-administered services
- Clarification of benefit coverage
- Coordination with LTSS or waiver program Providers

Member ID Cards

Each Wellcare With Absolute Total Care Member receives a personalized Member ID card upon enrollment. This card serves as proof of coverage and contains essential information that Providers should verify prior to delivering services.

Key Information on the Member ID Card

- Member name and identification number
- Plan name and coverage type
- Contact information for Member Services
- Pharmacy, Vision, and Dental benefit details (if applicable)

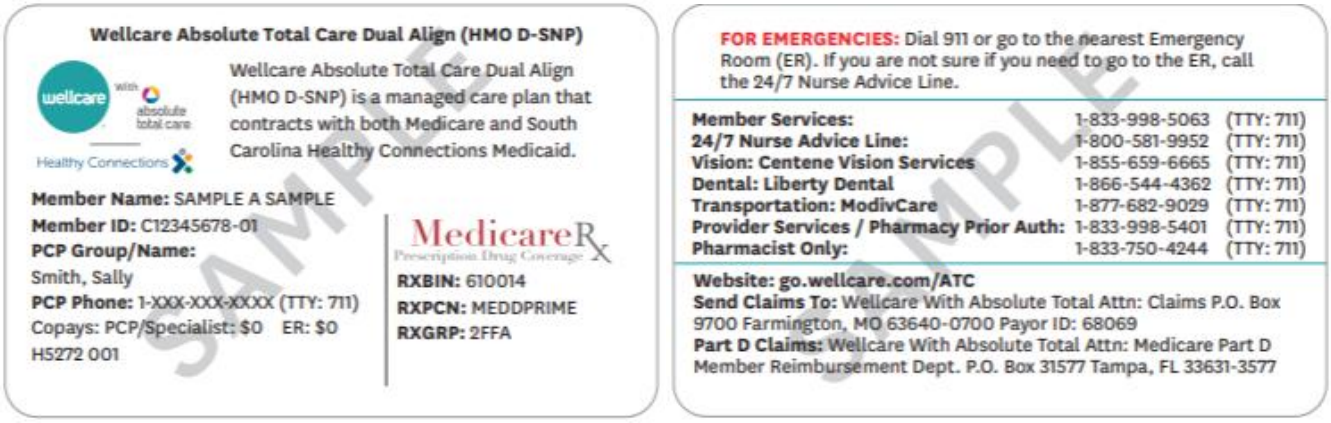
Provider Responsibilities

Providers are expected to:

- Verify Member eligibility and benefits using the information on the ID card and the secure Provider Portal.
- Confirm the Member's identity at the time of service.
- Use the Member ID number for all claims submissions and prior authorization requests.

Note: Possession of a Member ID card does not guarantee eligibility. Always verify current coverage through the Provider Portal or by contacting Provider Services.

Sample Member ID Card



Special Supplemental Benefits for the Chronically Ill (SSBCI)

Overview

Special Supplemental Benefits for the Chronically Ill (SSBCI) are supplemental benefits available to eligible members enrolled in a Wellcare With Absolute Total Care plan that offers SSBCI and who meet CMS-defined eligibility requirements.

Members are continuously reviewed through Wellcare With Absolute Total Care's automatic eligibility process using available claims, medical records, clinical assessments, and other approved clinical information. This automated process is the primary pathway used to determine SSBCI eligibility.

Provider Attestation Process

Provider attestation is an alternative qualification pathway for SSBCI benefits primarily intended for newly enrolled members when sufficient claims or clinical data may not yet be available to determine eligibility through the automatic eligibility process.

Members should schedule an in-person office visit or contact their healthcare provider to request that an attestation be submitted. A healthcare provider who is familiar with the member's medical history may attest whether the member meets all required SSBCI eligibility criteria.

Providers should visit the Wellcare With Absolute Total Care SSBCI Provider Attestation Portal to complete the online attestation. Providers with questions regarding the attestation process or who may require additional support with submitting an attestation should contact Provider Services using the phone number listed in the applicable Provider Manual or the phone number listed on the back of the member's ID card.

Please note: Provider attestation is for provider use only. Members cannot self-attest for SSBCI eligibility.

SSBCI Eligibility Requirements

To qualify for SSBCI benefits, members must meet **all three** CMS-defined eligibility criteria:

- Has one or more qualifying chronic conditions that is life threatening or significantly limits overall health or function
- Has a high risk of hospitalization or other adverse health outcomes
- Requires intensive care coordination

A diagnosis of a qualifying chronic condition alone does not qualify a member for SSBCI benefits. In addition to having one or more qualifying chronic conditions, eligibility for SSBCI may be demonstrated through one or more of the following:

- History of hospitalization or emergency department visits, and/or
- Frequent use of outpatient services or specialty care, and/or
- Evidence of poor disease control or medication adherence, and/or
- Non-medical social needs that impact health outcomes

Provider Instructions for Submitting an Attestation

Providers should follow these steps to submit an SSBCI attestation:

1. Access the Wellcare With Absolute Total Care SSBCI Provider Attestation portal at wellcare.ssbci.rrd.com
2. Review the eligibility criteria and evaluate whether the member meets all required SSBCI eligibility criteria
3. Complete and submit the electronic provider attestation
4. If applicable, submit a claim including the appropriate diagnosis coding consistent with the member's documented chronic condition(s) and services provided

Providers should complete the attestation based on their clinical judgment and evaluation of the member, certifying whether the member meets all required SSBCI eligibility criteria.

Determination Process & Member Notification

Once an attestation is submitted:

- The attestation will be reviewed as part of the SSBCI eligibility determination process
- The member will receive written notification of the determination within 10 business days
- Members determined eligible will receive information regarding available SSBCI benefits and how to access those benefits

- Members not meeting eligibility requirements will receive notification explaining the determination and appeal rights

Submission of a provider attestation does not guarantee approval. Eligibility determinations are based on the member meeting all applicable SSBCI eligibility requirements.

PHARMACY BENEFIT MANAGEMENT

Wellcare With Absolute Total Care utilizes a Pharmacy Benefit Manager (PBM) to administer Member pharmacy benefits. Prior to authorizing any drug benefit, each Member's eligibility is determined. The PBM provides Wellcare With Absolute Total Care with a pharmacy network, pharmacy claims management, and adjudication services.

In accordance with the requirements set forth by SCDHHS, the Wellcare With Absolute Total Care's Drug List includes drugs covered under Medicare Part D and some prescription and over-the counter (OTC) drugs and products covered under Healthy Connections Medicaid. The formulary is designed to cover the vast majority of therapeutic conditions. However, should a specific medication not listed on the formulary be deemed medically necessary for a Member, a medical necessity exception may be requested through the prior authorization (PA) process. Additionally, certain specialized medications on the drug formulary require a PA before they can be dispensed.

The drug formulary is accessible on the Prescriber Portal. This formulary should be consulted when prescribing medications for Wellcare With Absolute Total Care Members. Medicaid Members have coverage for both prescription and specific over-the-counter medication.

While we encourage prescribing within the formulary, we recognize that situations arise where a formulary alternative is not available. Drugs requiring Prior Authorization are identified in the formulary with a PA designation.

Wellcare With Absolute Total Care requires adherence to the following Prior Authorization procedures for obtaining medically necessary non-formulary/non-covered drug products:

To receive a non-formulary/non-preferred medication, the Provider must submit a prior authorization request. Using the form on our website located at wellcare.absolutetotalcare.com or through covermymeds.com.

1. The Pharmacy Services reviewer may request that the Provider submit additional clinical information by fax to process the request.
2. If the request is approved, pharmacy services will notify the Provider via fax and enter the necessary authorization into the claims processing system for dispensing at a participating pharmacy network Provider.
3. The Provider may contact Pharmacy Services by telephone at **1-833-998-5401** with any questions or concerns.

MEMBER SELF-REFERRALS

Family Planning

Family planning services include any medically approved method – such as diagnostic evaluation, medications, supplies, devices, and related counseling – used to voluntarily prevent or delay pregnancy, or to detect and treat sexually transmitted diseases (STDs). These services must be provided continuously to individuals of childbearing age, including sexually active minors, who choose to avoid pregnancy, or wish to manage the number and timing of their children.

Infertility treatment is not covered under the family planning benefit.

All Wellcare With Absolute Total Care Members have the right to choose any qualified family planning Provider, whether in-network or out-of-network. Primary Care Providers (PCPs) should support Members by providing family planning services or assisting them in locating and selecting a family planning Provider, as requested.

Members seeking additional information or assistance with family planning referrals may contact Member Services at 1-833-998-5063.

Women's Health

Female Members aged eighteen (18) and older may self-refer to any in-network OB/GYN for routine annual examinations and preventive screenings, including Pap smears, chlamydia testing, and mammograms. Members may also self-refer to an in-network OB/GYN of their choice for prenatal and perinatal care.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

FQHCs are essential community-based Providers that deliver comprehensive healthcare services. All Wellcare With Absolute Total Care Members have access to FQHCs when these services are available within their community. The Member Handbook outlines each Member's right to seek care from an FQHC within their service area.

For more information or assistance accessing an FQHC, Members may contact Member Services at 1-833-998-5063.

NON-EMERGENCY TRANSPORTATION

Wellcare With Absolute Total Care ensures that non-emergency transportation and travel expenses are readily available and accessible for Members requiring medically necessary care. This service supports access to medical appointments, examinations, and treatments as determined necessary by the Member's primary care Provider.

Non-emergency transportation is available to support Members' access to medically necessary care. Covered services include, but not limited to:

- End Stage Renal Disease treatment (hemodialysis)
- Prenatal and preventive care

- Mental health services
- Prescription pickup
- Durable Medical Equipment (DME) supplies

Wellcare With Absolute Total Care partners with a transportation agency that maintains a Provider network capable of servicing the entire geographic area in which Members reside.

For more information on how to access non-emergent transportation services, Members should consult their Member Handbook or contact Member Services at **1-833-998-5063**.

Accessing Non-Emergent Transportation Services

To schedule non-emergent transportation, the Member, their primary care Provider (PCP), or a Wellcare With Absolute Total Care representative may call the transportation vendor at **1-877-682-9029** or contact Member Services at **1-833-998-5063** for assistance.

The non-emergent transportation vendor will provide services for the following individuals:

- Members: All Wellcare With Absolute Total Care Members for covered outpatient services.
- Parents or Legal Guardians: May accompany minor or legally incapacitated Members to appointments.
- Other Family Members: Transportation for additional individuals (e.g., siblings) may be permitted, depending on circumstances and vendor policies.

Transportation is provided to and from participating Providers. In cases where medically necessary services are only available from a non-participating Provider, transportation may be arranged as directed by Wellcare With Absolute Total Care.

EMERGENCY SERVICES

Wellcare With Absolute Total Care provides coverage for emergency services in accordance with applicable Medicare and Medicaid requirements. When Healthy Connections Medicaid covers emergency services not included under Medicare - or covers them at a greater amount, duration, or scope – Wellcare With Absolute Total Care will provide those services through Medicaid as outlined in our contract.

- **Emergency Care Access**: Emergency services are available to Members twenty-four (24) hours a day, seven (7) days a week. Members will be screened and stabilized without prior authorization in accordance with the Emergency Medical Treatment and Labor Act (EMTALA), using the prudent layperson standard.
- **Medicare-Covered Emergency Services**: Wellcare With Absolute Total Care covers appropriate cost sharing for emergency services and medical screenings provided under Medicare, including:
    - Out-of-network or out-of-area emergency services delivered in a hospital emergency department.
    - Emergency care received without prior notice to the PCP or plan.

- Emergency transportation and professional services necessary to evaluate or stabilize an emergency medical condition.

- Post-Stabilization Care: Wellcare With Absolute Total Care ensures coverage for post-stabilization services in alignment with 42 CFR §422.214 and §422.113. Cost-sharing coverage is provided under the following conditions:
  - Services are pre-approved by a plan Provider or representative.
  - Services are delivered within one hour of a pre-approval request to maintain the Members' stabilized condition without explicit prior approval.
  - Wellcare With Absolute Total Care fails to respond within the regulatory timeframe (1 hour) to a request for authorization.
  - No plan representative is available at the time of the authorization request.
  - A disagreement occurs between the treating provider and the plan representative, and the provider cannot consult with a plan provider in a timely manner.
- Medical Screening and Stabilization: Hospitals providing emergency services must conduct a medical screening exam to determine if an emergency condition exists. If one is found, the provider must stabilize the Member before discharge or transfer. Emergency services must continue until the Member is clinically stabilized.
- Medicaid Coverage: For services not covered under Medicare but included under Medicaid, Wellcare With Absolute Total Care will ensure those services are provided as part of the Member's benefits.
- Authorization Requirements After Stabilization: If additional care (e.g., hospitalization or specialty services) is needed following an emergency room visit, prior authorization may be required for non-emergent services following stabilization, consistent with 42 CFR 422.113 and 438.114.
- Coverage Ends When:
  - A Wellcare With Absolute Total Care provider assumes responsibility for the Member's care.
  - The Member is transferred under the care of a plan-approved provider.
  - An agreement is reached between the treating provider and the plan.
  - The Member is discharged.

Definitions

Emergency Medical Condition

An emergency medical condition is defined as a medical condition manifesting acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, with average knowledge of health and

medicine, could reasonably expect that the absence of immediate medical attention would result in one or more of the following:

- Placing the health of the individual (or a pregnant woman and her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services

Emergency services are defined as covered inpatient and outpatient services that:

- Are provided by a qualified Provider in accordance with federal requirements under Title 42; and
- Are necessary to evaluate or stabilize an emergency medical condition.

Post-stabilization Care Services

Post-stabilization care services are defined as medically necessary services provided after a Member has been stabilized, and are intended to:

- Maintain the stabilized condition; or
- Improve or resolve the Member's condition, consistent with 42 CFR §438.114(e).

Plan Coverage and Financial Responsibility

The Plan covers and reimburses emergency services regardless of whether the Provider is contracted with the Plan.

The Plan will not deny coverage for emergency services under the following circumstances:

- The Member experienced an emergency medical condition, even if the absence of immediate medical attention would not have led to the outcomes described above; or
- A Plan representative directed the Member to seek emergency care.

The Plan does not:

- Restrict what qualifies as an emergency condition based solely on diagnosis or symptom lists;
- Deny emergency service claims due to lack of notification to the Member's Primary Care Provider or the Plan, within ten (10) calendar days of treatment.

Members **cannot** be held financially liable for any screening or treatment needed to diagnose or stabilize an emergency medical condition.

The attending emergency provider, or the Provider treating the Member, is solely responsible for determining when the Member is stabilized for discharge or transfer. This determination is binding on the Plan if:

- It adheres to generally accepted medical standards; and

- The services are covered under the Plan's contract.

Post-stabilization Authorization and Coverage

The Plan is financially responsible for post-stabilization services provided by contracted or non-contracted Providers when:

- Services are pre-approved by a Plan Provider or representative;
- Services are initiated within one hour of a request for pre-authorization, even if pre-approval is not yet obtained;
- The Plan fails to respond within one hour, cannot be reached, or if the Plan and the treating Provider cannot reach agreement on care and no Plan Provider is available for consultation.

In such cases, the treating Provider must be given the opportunity to consult with a Plan provider, and care may proceed until such consultation occurs or until one of the criteria outlined in 42 CFR §422.113(c)(3) is met.

Cost Sharing

Members may not be charged more for post-stabilization services than they would have paid had the services been obtained through a contracted Provider. For the purposes of cost-sharing, post-stabilization services begin upon inpatient admission.

End of Plan Financial Responsibility

Wellcare With Absolute Total Care's financial responsibility for post-stabilization care services ends when any of the following occurs:

- A Plan-affiliated provider with hospital privileges assumes responsibility for the Member's care;
- A Plan-affiliated provider assumes care through transfer;
- The Plan and the treating Provider reach agreement on care; or
- The Member is discharged.

24 HOUR NURSE ADVICE LINE

Wellcare With Absolute Total Care offers a 24-Hour Nurse Advice Line as a resource to support Members in making informed healthcare decisions. This service is intended to supplement, not replace, the care and guidance of the Members' Primary Care Provider (PCP).

The Nurse Advice Line offers:

- General health information
- Guidance on appropriate levels of care
- Assistance understanding health care benefits
- Information on treatment options and available resources

This service is available to Members at no cost 24 hours a day, 7 days a week, 365 days a year via the Nurse Advice Line at **1-833-998-5063 (TTY: 711).**

Providers should encourage Members to utilize the Nurse Advice Line for non-emergency medical questions or concerns, especially outside of regular office hours.

Wellcare With Absolute Total Care monitors Member grievances and appeals as part of its quality oversight and compliance responsibilities. The grievance and appeal processes outlined below are in accordance with state and federal regulations and apply to all Wellcare With Absolute Total Care Members.

MEMBER GRIEVANCE

A grievance is defined as any expression of dissatisfaction about matters other than an "action" (i.e., a denial, reduction, or termination of a service), which would be subject to the appeal process. Examples of grievances may include:

- Delays in obtaining timely appointments or referrals
- Concerns regarding Provider or staff behavior
- Alleged violations of Member rights
- Issues related to the quality of care or services received

Grievances may be filed by the Member, their authorized representative, or a Provider acting on the Member's behalf. Members may contact Wellcare With Absolute Total Care Member Services at **1-833-998-5063** to file a grievance.

Wellcare With Absolute Total Care offers both informal and formal grievance processes. Informal grievances are typically resolved during the initial interaction with Member Services.

Formal grievances should be submitted to:

Wellcare With Absolute Total Care
Appeals & Grievances Medicare Operations
Grievance Department
P.O. Box 10052
Van Nuys, CA 91410

Upon receipt of a formal grievance, Wellcare With Absolute Total Care will send written acknowledgment within five (5) business days and issue a resolution within thirty (30) calendar days of receipt. In cases involving clinical urgency, Wellcare With Absolute Total Care will request a response from the Provider or facility within 24 hours. For standard grievances, Provider responses are expected within seven (7) calendar days to support timely resolution.

Providers are expected to cooperate fully with Wellcare With Absolute Total Care in the investigation and resolution of Member grievances, including responding to information requests within designated timeframes. Failure to respond may impact the resolution process or be escalated for contractual review.

Members will receive written notification of the grievance outcome, which will include the resolution determination and any next steps, if applicable.

Member Appeals

An appeal is a formal request from the Member, their authorized representative, or Provider to review a decision made by Wellcare With Absolute Total Care to deny, reduce, delay, or terminate a requested service or payment. Examples include:

- Denial of a service based on medical necessity
- Denial of payment for a service already received
- Termination or reduction of a previously authorized service

Non-Urgent Pre-Service Appeal

Members have sixty (60) calendar days to file an appeal from the date of the denied service. All written or verbal communication by a Member regarding dissatisfaction with a decision to deny, reduce, delay, or terminate a clinical service based on medical necessity or on benefit determination is to be considered an appeal.

A Provider or other authorized representative of the Member such as family Member, friend, or attorney may file an appeal on the Member's behalf with the Member's written permission. The Member must submit written permission to Wellcare With Absolute Total Care for an authorized representative to appeal on their behalf.

Members have the right to appeal an adverse benefit determination. Appeals may be submitted to the Wellcare With Absolute Total Care Appeals Department or by phone through Member Services at 1-833-998-5063. If submitted in writing, the appeal should include a valid phone number for follow-up and confirmation of receipt.

Appeals should be mailed to:

Wellcare With Absolute Total Care
Member Appeals & Grievances Medicare Operations
Appeals Department - Medical
P.O. Box 10052
Van Nuys, CA 91410 - 0052

Within three business days of receiving a Member's appeal, Wellcare With Absolute Total Care will notify the Member of all the information that is required to process the request. Appeals are reviewed and resolved within thirty (30) calendar days from the date of receipt for items or services and seven (7) calendar days for Part B drugs. This timeframe may be extended by fourteen (14) calendar days if it is in the Member's best interest. Appeals are reviewed by a qualified clinical peer reviewer holding the same or similar specialty as the treating Provider. The reviewer will not be the same individual who made the initial determination to deny, reduce, or terminate services.

Wellcare With Absolute Total Care will provide written notification of the appeal decision to the Member and any other Provider directly involved in the appeal.

Expedited Appeals

A Member or their Provider may call Member Services at **1-833-998-5063** to file an expedited appeal if they think that their situation is clinically urgent and reviewing the appeal in the standard timeframe could:

- Seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the Member's medical condition
- Would subject the Member to severe pain that cannot be adequately managed without the care or treatment

If an appeal is deemed urgent, the Member must obtain written confirmation from their Provider by attesting that the standard appeal timeframe could seriously jeopardize the Member's life, health, or ability to regain maximum function.

Upon receipt of the expedited appeal, Wellcare With Absolute Total Care will notify the Member within twenty-four (24) hours if additional information is required. A decision will be rendered within seventy-two (72) hours of receiving the expedited request.

The outcome will be communicated verbally to the Member and any other Provider involved in the appeal, followed by written notification.

Note: Wellcare With Absolute Total Care prohibits any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.

External Review of an Appeal (Non-Expedited)

If Wellcare With Absolute Total Care affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals), in whole or in part, Wellcare With Absolute Total Care will submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. For standard pre-service appeals, the IRE has 30 days from receipt of the appeal to issue a final determination. For retrospective reconsideration appeals, the IRE has 60 days from receipt of the appeal to issue a final determination.

Once a final determination has been made, the IRE will notify the Member and Wellcare With Absolute Total Care. If the IRE agrees with Wellcare With Absolute Total Care, the IRE will provide the Member with further appeal rights. If the IRE reverses the initial denial, the IRE will notify the Member or representative in writing of the decision. Wellcare With Absolute Total Care will also notify the Member or Member's representative in writing that the services are approved along with an authorization number.

External Review of an Appeal (Expedited)

If Wellcare With Absolute Total Care reverses its initial action and/or the denial, it will notify the Member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision. If Wellcare With Absolute Total Care affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals) (in whole or in part), Wellcare With Absolute Total Care will submit a written explanation for a final determination with the complete case file to the independent review

entity (IRE) contracted by CMS. The IRE has 72 hours from receipt of the case to issue a final determination. Wellcare With Absolute Total Care will notify the Member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the Member and Wellcare With Absolute Total Care. If the IRE agrees with Wellcare With Absolute Total Care, the IRE will provide the Member with further appeal rights. If the IRE reverses the initial denial, the IRE notifies the Member or representative in writing of the decision.

SECTION 3: PROVIDER FUNCTIONS AND RESPONSIBILITIES

PRIMARY CARE/MANAGED CARE PROGRAM

Wellcare With Absolute Total Care utilizes a Primary Care Provider (PCP) Patient-Centered Medical Home system. In this system, the PCP is responsible for the comprehensive management of each Member's health care. This may include, but is not limited to, ensuring that all medically necessary care is made available and delivered, facilitating the continuity of Member health care, promoting, and delivering the highest quality health care per Wellcare With Absolute Total Care standards.

Wellcare With Absolute Total Care Providers are responsible for knowing and complying with all Wellcare With Absolute Total Care network policies and procedures. Implementation of Wellcare With Absolute Total Care policies will facilitate the Plan's periodic reporting of HMO data to State and the Federal agencies.

Primary Care Provider (PCP) Roles and Responsibilities

Each Wellcare With Absolute Total Care Member selects a PCP who is responsible for coordinating the Member's total healthcare. PCPs are required to work 20 hours per week per location, and be available 24 hours a day, seven days a week.

Female Members will have direct access to women's health specialists to provide women's routine and preventative health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist.

Except for required direct access benefits or self-referral services, all covered health services are either delivered by the PCP or are referred/approved by the PCP and/or Wellcare With Absolute Total Care.

All Providers must offer hours of operation that are no less than the hours of operation offered to commercial Members or comparable to Medicaid fee-for service (FFS) if the Provider serves only Medicaid Members.

Specialty Care Provider Roles and Responsibilities

Wellcare With Absolute Total Care recognizes that the specialty Provider is a valuable team Member in delivering care to Wellcare With Absolute Total Care Members. Key specialty Provider roles and responsibilities include, but are not limited to:

- Rendering services requested by the PCP by referral
- Communicating with the PCP regarding the findings in writing
- Obtaining prior authorization from the PCP and plan before rendering any additional services not specified on the original referral form
- Confirming Member eligibility and benefit level prior to rendering services

- Providing the consultation report to the PCP within sixty (60) days of the consultation date
- Providing the lab or radiology Provider with:
    - The PCP and/or corporate prior authorization number
    - The Member's ID number

Hospital Roles and Responsibilities

Wellcare With Absolute Total Care recognizes that the hospital is a valuable team Member in delivering care to Wellcare With Absolute Total Care Members. Essential hospital responsibilities include, but are not limited to:

- Coordination of discharge planning with Wellcare With Absolute Total Care Medicare Utilization Management staff
- Coordination of mental health/substance abuse care with the appropriate state agency or Provider
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent Member information to Wellcare With Absolute Total Care and to the PCP
- Communication of all hospital admissions to the Wellcare With Absolute Total Care Medicare Utilization Management staff within one business day of admission
- Issuing all appropriate service denial letters to identified Members

Ancillary/Organization Provider Roles and Responsibilities

Wellcare With Absolute Total Care recognizes that the ancillary Provider is another valuable team Member in delivering care to Wellcare With Absolute Total Care Members. Critical ancillary Provider responsibilities include, but are not limited to:

- Confirming Member eligibility and benefit level before rendering services
- Being aware of any limitations, exceptions, and/or benefit extensions applicable to Wellcare With Absolute Total Care Members
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent Member information to Wellcare With Absolute Total Care and to the PCP

APPOINTMENT STANDARDS

All participating Providers are required to comply with Wellcare With Absolute Total Care's standards for appointment availability and in-office wait times. These standards are established to ensure that Members receive timely access to medically necessary services based on the urgency of their clinical needs.

Wellcare With Absolute Total Care continuously monitors Provider adherence to these standards through various oversight mechanisms. Providers found to be out of compliance may be subject to corrective action plans, up to and including contract review.

Type of Appointment	Access Standard
Primary Care	
PCP - Urgent	≤ 24 hours
PCP – Non-urgent	≤ 7 business days
PCP – Regular and Routine	≤ 30 business days
PCP – After-hours Care	24 hours per day, 7 days per week
Specialty Care	
All Specialists (including High Volume and High Impact) – Urgent	≤ 24 hours
All Specialists (including High Volume and High Impact) – Regular and Routine	≤ 30 business days
Behavioral Health Care	
Behavioral Health Provider – Urgent Care	≤ 48 hours
Behavioral Health Provider – Initial Routine Care	≤ 10 business days
Behavioral Health Provider – Non-Life-threatening Emergency	≤ 6 hours
Behavioral Health Provider – Routine Care follow-up	≤10 business days

Note: In-office wait times for all standards shall not exceed 15 minutes.

Telephone Arrangements

PCPs must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week. To ensure access and availability, PCPs must provide one of the following after-hours services:

- A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP

- Answering system with option to page the provider for a return call within a maximum of 30 minutes
- A medical professional who will answer after-hours calls and provide the Member with access to the PCP or on-call provider within a maximum of 30 minutes

CONFIDENTIALITY AND ACCURACY OF MEMBER RECORDS

Medical records and other health and enrollment information of a Member must be managed under established procedures that:

- Safeguard the privacy of any information that identifies a particular Member
- Respect Member rights to access, amend errors in, request confidentiality for, or an accounting of disclosures of the Member's health information
- Identify when and to whom Member information may be disclosed
- Safeguard the privacy of any information that identifies a particular Member
- Secure information through robust controls designed to maintain the confidentiality, integrity, and availability of medical records and to protect against threats or hazards to the security or integrity of such information and any uses or disclosures of such information that could violate the law.
- Maintain such records and information in a manner that is accurate and timely, ensure timely access by Members to the records and information that pertain to them for what purpose(s) the information will be used within the organization, and identify when and to whom Member information may be disclosed

In addition to the obligation to safeguard the privacy and security of any information that identifies a particular Member, the health plan and all participating Providers are each obligated to abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and Member information. First tier and downstream Providers must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)) and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, within requested time frames, and maintain records a minimum of 10 years.

OBLIGATIONS OF RECIPIENTS OF FEDERAL FUNDS

Providers participating in Wellcare With Absolute Total Care plans are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including but not limited to Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act, the Anti-Kickback Statute, and HIPAA laws.

At minimum, Wellcare With Absolute Total Care can check the SCDHHS health professions website monthly for excluded Providers. At minimum, Wellcare With Absolute Total Care can check the OIG List of Excluded Individual Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM)

[the successor to the Excluded Parties List System (EPLS)] for its Providers at least monthly, before contracting with the Provider, and at the time of a Provider's credentialing and recredentialing. If a Provider is terminated or suspended from the SCDHHS Medicaid Program, Medicare, or another state's Medicaid program, or is the subject of a state or federal licensing action, the Integrated Community Organizations (ICO) shall terminate, suspend, or decline a Provider from its Provider Network as appropriate.

Upon notice from SCDHHS or CMS, Wellcare With Absolute Total Care cannot authorize any Providers who are terminated or suspended from participation in the South Carolina Medicaid Program, Medicare, or from another state's Medicaid program, to treat Members and shall deny payment to such Providers for services provided.

Wellcare With Absolute Total Care must notify CMS and SCDHHS on a quarterly basis when a Provider fails credentialing or recredentialing because of a program integrity reason, or Adverse Action reason, or, effective no sooner than January 1, 2018, an Adverse Benefit Determination reason, and shall provide related and relevant information to CMS and SCDHHS as required by CMS, SCDHHS, state or federal laws, rules, or regulations.

Wellcare With Absolute Total Care is prohibited from issuing payment to a Provider or entity that appears in the List of Excluded Individuals/Entities as published by the Department of Health and Human Services Office of the Inspector General or in the List of Debarred Wellcare With Absolute Total Care as published by the General Services Administration (with the possible exception of payment for emergency services under certain circumstances).

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at http://exclusions.oig.hhs.gov.
- The General Services Administration List of Debarred Wellcare With Absolute Total Care Providers can be found at www.sam.gov.
- More information on the Preclusion List can be found at Preclusion List | CMS.

OSHA TRAINING

Employee training and annual in-service education must include:

- Universal precautions
- Proper handling of blood spills
- HBV and HIV transmission and prevention protocol
- Needle stick exposure and management protocol
- Bloodborne pathogen training
- Sharps handling
- Proper disposal of contaminated materials

- Information concerning each employee's at-risk status

At-risk employees must be offered the Hepatitis B vaccination free of charge. Each employee file of an at-risk employee must contain informed consent or informed refusals for Hepatitis B vaccines. Personal protective equipment must be provided to each at-risk employee.

Necessary equipment must be provided for the administration of mouth-to-mouth resuscitation.

Documents to be posted in the facility are:

- Pharmacy Drug Control license issued by the State of South Carolina if dispensing drugs other than samples
- Section 17757a from the Board of Pharmacy (if dispensing drugs other than samples)
- Controlled Substances License from State of South Carolina and the Federal DEA
- CLIA certificate or waiver
- Medical Waste Management certificate
- X-ray equipment registration
- R-H 100 notice
- Radiology protection rules

PROVIDER CREDENTIALING/RE-CREDENTIALING

The provider's credentialing and re-credentialing processes require that all providers keep the Wellcare With Absolute Total Care's Provider Services department is updated with changes in credentials. In conjunction with this, providers should respond promptly to any requests to update information so that all credentialing files can be maintained appropriately.

Practitioners have the following rights during the credentialing process: All information received during the credentialing process that is not peer-protected can be forwarded to the applicant upon written request to the Credentialing Department. Wellcare With Absolute Total Care is not required to reveal the source of the information if the information is not obtained to meet the credentialing verification requirements or if disclosure is prohibited by law. Upon written request to the Credentialing Department, any practitioner has the right to be informed in writing or verbally of their credentialing status.

Wellcare With Absolute Total Care will notify providers of any material discrepancies between credentialing verification data and the information submitted by the provider during the credentialing process, giving them the opportunity to correct erroneous information. Notification will include the time frame for making the correction and includes the contact information for submitting the correction/explanation which must be submitted in writing before the due date stated on the notification.

The provider must inform Wellcare With Absolute Total Care in writing of their intent to correct any erroneous information.

Wellcare With Absolute Total Care re-credentials each provider in the network at least every three years. Approximately six months prior to the provider's three-year anniversary date, the provider will be notified of the intent to re-credential. All necessary forms will be sent for completion. In certain instances, a site visit will also be scheduled.

Additionally, the provider re-credentialing process includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data, and member transfer rates.

All individuals or entities that furnish services to, or order, refer, or certify the need for services provided to individuals eligible under South Carolina Medicaid must be enrolled in the South Carolina Medicaid program.

Appeals Process

Wellcare With Absolute Total Care maintains a formal appeal process for any provider or applicant who is denied new or continued participation in the provider network.

When an Applicant receives a non-approval notice, the affected practitioner has 30 calendar days from receipt of the notice to file a written request for reconsideration. The request must include additional supporting documentation in favor of the applicant's consideration for network participation and should be directed to the Wellcare With Absolute Total Care Quality Medical Director via Provider Services. To submit a reconsideration request or obtain further instructions, please contact Provider Services at 1-833-998-5401.

Failure to deliver the request within 30 calendar days constitutes a waiver of reconsideration rights by the affected practitioner.

The request is presented to the Credentialing Committee at the next regularly scheduled meeting but in no case later than sixty (60) calendar days from the receipt of additional information. The Committee may recommend:

- Support of the original denial recommendation by the Credentialing Committee and closure of the file; OR
- Support of the applicant's ability to meet the plan minimum participation criteria and approval of the applicant for inclusion in the plan practitioner network.

The Medical Director/Credentialing Committee Chair, or designee, notifies the applicant in writing within thirty (30) calendar days of the Credentialing Committee decision.

When a practitioner's current participation status is being suspended, restricted or terminated based on issue of quality of care or service, the plan offers and informs the practitioner of their right to a formal appeal hearing. Information about the appeal process and where to submit the request is included within the notification letter. The request for the appeal hearing must be submitted in writing to the Credentialing contact listed on the notification letter within thirty (30) calendar days of the date of the notice. Failure to

deliver the request within 30 calendar days constitutes a waiver of hearing rights and the Credentialing Committee's proposed decision becomes final.

In the event a practitioner requests a hearing pursuant to this Policy and Procedure, the plan appoints an Appeals Committee on an ad hoc basis. The Appeals Committee conducts hearings regarding proposed decisions from the Credentialing Committee to suspend, restrict or terminate the network participation of practitioners. The Appeals Committee is comprised of a minimum of three (3) network practitioners, including at least one who is in the same specialty as the practitioner under review

SECTION 4: UTILIZATION MANAGEMENT

The objective of Wellcare With Absolute Total Care's Utilization Management (UM) program is to ensure that the medical services provided to Members are medically necessary and/or appropriate and are in conformance with the health plan benefits. To guide the decision-making process, UM applies systematic evaluations to appropriate medical necessity criteria and considers circumstances unique to the Member.

Access to the Utilization Management Staff

For Utilization Management inquiries, you may call during normal business hours Monday-Friday, 8 a.m. to 5 p.m. at 1-833-998-5401. The Provider portal is available 24/7 for status authorization requests and to submit new requests.

UTILIZATION MANAGEMENT DECISIONS

Utilization decisions are based on appropriate care and service, as well as the Member's eligibility. Wellcare With Absolute Total Care does not specifically reward our Providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

Utilization management clinical staff uses plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by Wellcare With Absolute Total Care medical directors. In certain circumstances, external review of service requests is conducted by qualified, licensed Providers with the appropriate clinical expertise.

Providers should refer directly to Medicare coverage policies for information on Medicare coverage policies and determinations. The two most common types of Medicare coverage policies are National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

National Coverage Determinations (NCDs) and The Centers for Medicare and Medicaid Services (CMS) explain NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals.

LCDs provide guidance to the public and Provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

In coverage situations where there are no NCDs, LCDs, or guidance in Medicare manuals, Wellcare With Absolute Total Care may utilize current literature review, Optum, Inc.'s InterQual criteria, and input from practicing providers and medical experts in the relevant field. The organization also considers government agency policies, standards adopted by national accreditation organizations, and its own Medical Management policies for clinical decision making. Additionally, Wellcare With Absolute Total Care may adopt coverage policies from other MA Organizations within its service area to guide its determinations.

Wellcare With Absolute Total Care's Medical Necessity Guidelines are based on current literature review, consultation with practicing Providers and medical experts in their particular field, government agency policies, and standards adopted by national accreditation organizations. It is the responsibility of the attending Provider to make all clinical decisions regarding medical treatment. These decisions should be made consistently with accepted principles of professional medical practice and in consultation with the Member.

Copies of the criteria utilized in decision-making are available free of charge upon request by calling the Utilization Management department at 1-833-998-5401. In certain circumstances, an external review of service requests is conducted by qualified, licensed Providers with the appropriate clinical expertise.

Utilization management decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the Member's eligibility and benefits at the time the services are rendered.

Previously approved prior authorizations can be updated for changes in dates of service, CPT/HCPCS codes, or provider within 30 days of the original date of service prior to claim denial.

Classifying Your Prior Authorization Request

Standard Organization Determination (Non-urgent Preservice Request): Standard organization determinations are made as expeditiously as the Member's health condition requires, but no later than seven (7) calendar days after Wellcare With Absolute Total Care receives the request for service.

Expedited Organization Determination (Urgent/Expedited Preservice Request): Expedited organization determinations are service requests are made when the Member or the Provider believes that waiting for a decision under the standard timeframe could place the Member's life, health, or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receiving the Member's or Provider's request. An extension may be granted for an additional fourteen (14) calendar days if the Member requests an extension or if Wellcare With Absolute Total Care justifies a need for additional information and documentation on how the delay is in the interest of the Member.

Requests for expedited review will require Provider attestation confirming the clinical urgency of the request.

Inpatient Review

Our nurse reviewers are assigned to follow Members at specific acute care facilities to promote collaboration with the facility's review staff and management of the Member across the continuum of care. Wellcare With Absolute Total Care's nurse reviewers assess the care and services provided in an inpatient setting and the Member's response to the care by applying InterQual® criteria. Together, with the facility's staff, Utilization Management's clinical staff coordinates the Members' discharge needs.

Wellcare With Absolute Total Care's nurse reviewers' interface with the hospital/facility discharge planners to:

- Obtain and identify the Member's discharge planning needs
- Facilitate the transition of the Member from one level of care to another level of care

- Obtain clinical information and facilitates the authorization of post discharge services, such as DME, home health services, and outpatient services

Providers must notify Wellcare With Absolute Total Care within one business day of admission.

Prior Approval Requirements/ Precertification

Wellcare With Absolute Total Care offers multiple methods to submit authorization requests. For the most efficient and timely service—use of Wellcare With Absolute Total Care's Online Prior Authorization (PA) Form is the preferred method of submitting requests. For additional information regarding PA refer to the Pre-Auth Check webpage.

1. **Authorization Requirements:** Refer to the Pre-Auth Check Tool to confirm PA necessity.
2. **Online Submission**: The Wellcare With Absolute Total Care Online PA Form can be accessed by visiting the secure Provider Portal or Availity Essentials.
3. **Fax Submission**: Refer to Utilization Management's referral type fax numbers. Please include pertinent clinical documentation with the request if indicated
4. **Phone Submission**: Many authorizations cannot be processed via phone, as clinical review and supporting documentation are required. Requests should only be submitted via the phone for services related to pending hospital discharges or expedited pre-certification requests.

Wellcare With Absolute Total Care	
Type of Request	Fax Number
Inpatient Admissions	1-844-503-8866
Post-Acute Admissions	
Pre-Service Standard Requests	
Pre-Service Expedited Requests (Phone)	1-833-998-5401
Part B	1-844-941-1331
Part D (prescription drugs)	1-866-388-1767
Behavioral Health Inpatient Admissions	1-833-325-1830
Behavioral Health Outpatient Services	1-833-325-1827

When submitting a Prior Authorization request, please include the following information:

- Member's name and date of birth
- Member's identification number
- Requesting Provider & NPI Number
- Servicing Provider & NPI Number

- Servicing Facility & NPI Number
- Place of Service
- Date(s) of service
- Procedure Code(s)
- ICD-10 Diagnosis Code(s)

Decision Timeframes – Prior Authorizations			
Review Type	Make Decision	Written/Verbal Notification	Written Notification (Denials)
Pre-Service Non-urgent	Within 7 days of receipt of the request	Within 7 days of receipt of the request	Within 7 days of receipt of the request
Pre-Service Urgent	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request
Urgent Concurrent	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 72 hours of the decision

CMS INTEROPERABILITY APIS — PROVIDER OVERVIEW

In support of federal CMS interoperability requirements, Wellcare With Absolute Total Care offers a set of standardized application programming interfaces (APIs) that support improved data sharing between providers, health plans, and members. Two of these - the **Prior Authorization API** and the **Provider Access API** - are designed specifically to reduce administrative burden, streamline clinical workflows, and strengthen care coordination through the secure, electronic exchange of information within participating EHR/EMR systems.

Prior Authorization API

Providers whose EHR/EMR vendor has connected to the Prior Authorization API may be able to check authorization requirements, identify required documentation, submit prior authorization requests, and receive status updates and decisions electronically within their existing clinical workflow. These capabilities bring greater transparency to the process and support more efficient prior authorization processing for medical items and services.

Provider Access API

Providers whose EHR/EMR vendor has connected to the Provider Access API may be able to retrieve eligible patient claims, clinical, and prior authorization information to support treatment and care coordination.

Access is generally limited to providers with an active treatment relationship and remains subject to applicable member consent and privacy requirements.

Additional Interoperability APIs

CMS interoperability requirements also include the **Patient Access API**, which allows members to share their health information with third-party applications; the **Payer-to-Payer API**, which supports electronic data exchange when members change plans or are covered by more than one health plan; and the **Provider Directory API**, which makes provider directory information available to third-party applications.

For detailed educational materials, implementation guidance, a list of connected EHR/EMR vendors, and frequently asked questions, providers are encouraged to visit the wellcare.absolutetotalcare.com.

CLINICAL INFORMATION

Clinical information should be provided at the time of submission of the request. The Provider or facility is responsible for ensuring services are authorized prior to service delivery authorization. Wellcare With Absolute Total Care provides a reference number on all authorizations. To ensure a timely decision, make sure all supporting clinical information is included with the initial request:

Clinical information includes relevant and current information regarding the Members:

- History of presenting problem
- Physical assessment
- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Member's response to treatment

Clinical Practice Guidelines

Wellcare With Absolute Total Care encourages the use of evidence-based Clinical Practice Guidelines (CPGs) by all participating Providers.

Whenever possible, Wellcare With Absolute Total Care adopts preventive and clinical practice guidelines that are:

- Published by nationally recognized organizations (e.g., The Centers for Disease Control (CDC), U.S. Preventive Services Task Force (USPSTF), and The Agency for Healthcare Research and Quality (AHRQ)),
- Endorsed by government institutions, or

- Developed through statewide collaboratives or consensus among healthcare professionals in the relevant field.

These guidelines are reviewed and selected with the needs of the South Carolina HIDE-SNP population in mind. This includes individuals who are dually eligible for Medicare and Medicaid, and who may require:

- Home and community-based services (HCBS),
- Behavioral health support, and
- Management of chronic and complex conditions.

The goal is to support whole-person, integrated care that improves health outcomes, promotes independence, and aligns with the principles of the Model of Care for HIDE-SNPs.

SERVICES REQUIRING PRIOR AUTHORIZATION

The list below provides Wellcare With Absolute Total Care's general Prior Authorization requirements. This list is not all inclusive and is subject to change. Providers will be given 60-day advance notice to additions to the Prior Authorization list. Please verify requirements at the time of the request.

Wellcare With Absolute Total Care Utilization Management verifies benefit eligibility and medical necessity for select services at the time of the request and is not a guarantee of coverage or payment. Payment is determined by the Members' eligibility and benefits at the time of service.

Claims payment is also based on the appropriateness, accuracy, and presence of codes submitted on the claim as determined by Centers for Medicare. Providers should verify code requirements using the most current Medicaid and Medicare guidelines. Codes that are not listed on the applicable Medicaid fee schedule may not be payable by Wellcare With Absolute Total Care.

Inpatient Services

- All inpatient admissions (Emergent and Elective)
- Long-Term Acute Care (LTACH) admissions
- Acute Rehabilitation admissions
- Skilled nursing facilities (SNF) admissions

Durable Medical Equipment (DME)[1]

- DME items are covered according to the SCDHHS Medicaid Fee Schedule and are subject to applicable prior authorization requirements
- Insulin pumps for DM type 1

[1] *This list is not all inclusive and is subject to change.*

- Hearing aids

Certain Outpatient Services/Treatments/Procedures

- Chiropractic Services
- Nutritional Counseling
- Hyperbaric oxygen therapy
- Genetic Testing
- Home Health/Skilled Nursing Visits
- Back Surgeries
- Ambulance Transportation Non-Emergent
- Dental Anesthesia in Facility
- Hysterectomy
- Spinal Surgeries
- Varicose Vein Surgery
- Breast Reduction
- Septoplasty
- Rhinoplasty
- Experimental and Investigational procedures

MENTAL HEALTH OUTPATIENT VISITS FOR MEMBERS WITH MILD-TO-MODERATE BEHAVIORAL HEALTH CARE NEEDS

Wellcare With Absolute Total Care covers mental health inpatient and outpatient services for Members. You may contact our Behavioral Health staff at 1-833-998-5063 to assist a Member with the following services:

- Locating a behavioral health Provider
- Scheduling behavioral health appointments
- Locating community groups and self-help groups

SPECIALTY NETWORK ACCESS TO CARE

Referrals to Specialists may be considered when an appropriate in-network specialist is not available, or when a second opinion is requested following consultation or treatment by an in-network specialist. Specialist referrals may be utilized when an in-network specialist is not available, or to seek another opinion subsequent to consultation/treatment with an in-network specialist.

As a PCP, you may request a referral to one of the health care public entities via Wellcare With Absolute Total Care's Provider Portal at wellcare.absolutetotalcare.com, fax or by calling Wellcare With Absolute Total Care at 1-833-998-5401. Wellcare With Absolute Total Care's staff will forward the information and authorization

to the central referral office of the public entities. Wellcare With Absolute Total Care will fax you a copy of the approved referral notification form along with contact information to the public entity.

Services that DO NOT require prior authorization (regardless of contract status) include:

- Emergency services
- Post stabilization services
- Women's Health
- Family Planning Services
- Long-Acting Reversible Contraception (LARCs)
- Other services based on state requirements

You may access the most recent Authorization Requirements on the Online Prior Authorization form under the Prior Authorization Requirements link.

DENIALS AND RECONSIDERATIONS

Denials based on medical necessity may only be issued by a Wellcare With Absolute Total Care Medical Director. When a denial occurs, the requesting Provider will be notified via phone to discuss the decision.

In addition to verbal communication, a written denial notice is:

- Faxed to the requesting Provider, and
- Mailed to the Member.

The denial notice includes the following:

- The specific reason(s) for the denial,
- A reference to the applicable benefit provision and/or clinical guideline used to make the decision,
- Instructions on how to request a free copy of the benefit provision and/or guideline,
- A clear description of the Members' appeal rights, and
- Step-by-step instructions for submitting an appeal.

MODEL OF CARE OVERVIEW

Wellcare With Absolute Total Care's Model of Care (MOC) is designed to support a complex population with diverse medical, behavioral, and social needs. The Care Coordination model integrates medical, hospital, behavioral health, and coordinates LTSS with state-contracted Providers. Community-based resources are also leveraged to promote independent and healthy living.

Central to Wellcare With Absolute Total Care's Model of Care is the Interdisciplinary Care Team (ICT), which supports whole-person, coordinated care for Members with complex needs. The ICT may include the Member, their chosen supports, primary care Provider (PCP), care manager, behavioral health specialist, and other clinical or social service professionals.

While LTSS are carved out of the HIDE-SNP benefit package in South Carolina, the ICT collaborates with state-contracted LTSS Providers and agencies to ensure continuity of care. This coordination helps align medical, behavioral, and social supports with the Member's goals, preferences, and service needs.

The Provider network reflects this integrated philosophy, consisting of medical professionals, behavioral health specialists, LTSS Providers, and community-based organizations committed to evidence-based, collaborative, and person-centered care.

Wellcare With Absolute Total Care continuously refines its Model of Care through quality improvement initiatives, incorporating data-driven insights and Member feedback to ensure it meets the evolving needs of the dual-eligible population. These efforts have been recognized at both the state and national levels.

Care Coordination

Wellcare With Absolute Total Care's Care Coordination program offers personalized case management for Members with complex or high-risk conditions. The program is designed to improve health outcomes through proactive care planning and service coordination.

Eligible Members include those with:

- Asthma
- Diabetes
- Congestive heart failure
- Cardiovascular disease
- Complex or catastrophic illness
- High emergency room utilization
- Maternity care needs

Care Coordinators may contact Providers to:

- Participate in Members' ICT meeting
- Coordinate and/or update a Member's plan of care
- Confirm diagnoses or test results
- Identify care gaps or non-compliance issues
- Address behavioral health needs or social determinants of health

Referrals to Care Coordination may be submitted via the secure Wellcare With Absolute Total Care Provider Portal using the "Notify CM" button, or by calling **1-833-998-5401**.

Provider Action: Integrated Care Team (ICT)

Providers identified as part of a Member's ICT are encouraged to actively participate in the care planning process. The ICT collaborates with the Member and their supports to ensure care is coordinated, person-centered, and aligned with the Member's unique goals, preferences, and needs.

Medicare Model of Care Self-Study Program: https://www.wellcare.com/en/providers/model-of-care-training

EVOLENT

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Wellcare With Absolute Total Care contracts with Evolent to provide prior authorization services and utilization management for advanced imaging and radiology services. Evolent focuses on radiation awareness designed to assist Providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MRI/MRA
- PET

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization;
- It is the responsibility of the ordering provider to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

To reach Evolent and obtain authorization, please call **1-866-510-9460** and follow the prompt for radiology authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Wellcare With Absolute Total Care contracts with Evolent, to provide a cardiac imaging program to promote health care quality for Members with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a Member's diagnosis or treatment - and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. Evolent also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve the Members' health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize Members' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each Member
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed
- Quality assessment of imaging Providers to ensure the highest technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for Members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through Evolent:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call **1-866-510-9460** and follow the prompt for radiology and cardiac authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

Physical Medicine Program

To help ensure that physical medicine services (physical, speech, and occupational therapy) provided to our Members are consistent with nationally recognized clinical guidelines, Wellcare With Absolute Total Care has partnered with Evolent to implement a prior authorization program for physical medicine services. Evolent provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Wellcare With Absolute Total Care Members.

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by Evolent's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at

the time of the evaluation and for any ongoing care is required through Evolent. Home Health Providers submitting claims using codes other than the designated CPT codes for the initial evaluation should request an authorization within the Wellcare With Absolute Total Care retro authorization guidelines. There is no need to send Member records in advance. Evolent will contact the Provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under the agreement between Wellcare With Absolute Total Care and Evolent, Wellcare With Absolute Total Care oversees the Evolent Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the Member will receive notice of the coverage decision.

Should you have questions, please contact Wellcare With Absolute Total Care Provider Services at **1-833-998-5401**.

Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering provider to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission are still required through Wellcare With Absolute Total Care. To obtain authorization through Evolent, visit RadMD.com or call **1-866-510-9460**.

Musculoskeletal (MSK) Management Program

The MSK program currently requires prior authorization for non-emergent outpatient, interventional spine pain management services (IPM), and will be expanded to include spinal cord stimulators, and inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries for our Members. The decision to implement this latest program is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Under the terms of this agreement:

- We will oversee the MSK program and continue to be responsible for claims adjudication and medical policies.
- Evolent will manage IPM services, and inpatient and outpatient MSK surgeries through the existing contractual relationships with us.

It is the responsibility of the ordering provider to obtain prior authorization for all IPM procedures and MSK surgeries managed by Evolent. Evolent does not manage prior authorization for emergency MSK surgery cases that are admitted through the emergency room or for MSK surgery procedures outside of those procedures listed above. The ordering provider must obtain prior authorization with Evolent prior to performing the surgery/procedure. Facility admissions do not require a separate prior authorization. However, the facility should ensure that an Evolent prior authorization has been obtained prior to scheduling the surgery/procedure.

MSK surgeries other than those outlined above will continue to follow prior authorization requirements for hospital admissions and elective surgeries as outlined for the Wellcare With Absolute Total Care HIDE-SNP line of business.

SECTION 5: BILLING AND CLAIMS PAYMENT

OVERVIEW

Wellcare With Absolute Total Care's Claims Department is structured to ensure accurate and timely processing of Provider claims. A dedicated toll-free telephone number, **1-833-998-5401**, is available for Providers to contact a representative with claims-related inquiries.

CLEAN CLAIM SUBMISSION

Wellcare With Absolute Total Care only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) Claim Forms whether filing on paper or electronically. Other claim form types will be upfront rejected and returned to the Provider.

Professional Providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional Providers complete the CMS 1450 (UB-04) Claim Form. Wellcare With Absolute Total Care does not supply claim forms to Providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10- or 12- point Times New Roman font and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten forms and nonstandard will be upfront rejected and returned to the Provider. To reduce document handling time, do not use highlights, italics, bold text, or staples for multiple page submissions. If you have questions regarding what type of forms to complete, contact Provider Services.

IMPORTANT STEPS TO SUCCESSFUL SUBMISSION OF CLAIMS

The following information must be included on every claim, paper or electronic:

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for providers or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard, and handwritten claim forms will be rejected back to the Provider.
3. Enter the Provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
4. Providers must include their taxonomy code (e.g., 207Q00000X for Family Practice) and corresponding ID qualifier in this section for correct processing of claims.

5. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Locations (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
6. Ensure all Diagnosis and Procedure Codes are appropriate for the age and sex of the Member.
7. Ensure all Diagnosis Codes are coded to their highest number of digits available.
8. Ensure Member is eligible for services during the time which services are provided.
9. Ensure Provider receives authorization to provide services to the eligible Member, when appropriate.
10. Ensure an authorization is given for services that require prior authorization by Wellcare With Absolute Total Care.

If electronic Claim submission is not possible, all hard copy (CMS-1500, CMS-1450 {UB-04}) claims must be submitted by mail to the address listed below.

Wellcare With Absolute Total Care
P.O. Box 9700
Farmington, MO 63640-0700

When submitting paper Claims:

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for providers or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard, and handwritten claim forms will be rejected back to the Provider.
3. Ensure Provider receives authorization to provide services to the eligible Member, when appropriate.
4. Ensure an authorization number is listed on the claim for services that require prior authorization by Wellcare With Absolute Total Care.

CLAIMS BILLING REQUIREMENT

Sample forms for the CMS 1500 and the UB-04 forms are provided at the back of the manual. In order to receive reimbursement in a timely manner, please ensure each claim:

1. Uses the data elements of UB-04 (UB-04 Version 050) or CMS 1500 as appropriate http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf
2. If the facility is Medicaid-enrolled ASC, bill using the ASC X12 837 5010 professional claim format when submitting electronic claims. Paper claims must be billed on CMS 1500 paper form.
3. It is submitted within 365 days of the date the service was performed

4. Identifies the Member (Member ID assigned by Wellcare With Absolute Total Care, address, and date of birth)
5. Identify the plan (plan name and/or Member ID number)
6. Lists the date (mm/dd/yyyy) and place of service
7. If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if Wellcare With Absolute Total Care requires prior authorization
8. Includes additional documentation based upon services rendered as reasonably required by Wellcare With Absolute Total Care Medical Policies: https://www.absolutetotalcare.com/Providers/resources/clinical-payment-policies.html
9. Is certified by Provider that claim:
    - Is true, accurate, prepared with the knowledge and consent of Provider
    - Does not contain untrue, misleading, or deceptive information
    - Identifies each attending, referring, or prescribing Provider, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim
10. Is a claim for which the Provider has verified the Member's eligibility and enrollment in Wellcare With Absolute Total Care before the claim was submitted
11. Is not a duplicate of a claim submitted within 45 days of the previous submission
12. Is submitted in compliance with all of Wellcare With Absolute Total Care's prior authorization and claims submission guidelines and procedures
13. Is a claim for which the Provider has exhausted all known other insurance resources for the Medicaid line of business (Medicaid is the payer of last resort)
14. Is submitted electronically if the Provider has the ability to submit claims electronically

Providers may submit and check the status of claims electronically via the secure Wellcare With Absolute Total Care Provider Portal. To gain access to the Provider Portal, please register with the link provided below.

Submit claims via the Provider Portal or Availity Essentials at Availity Essentials.

Note: For fastest, most accurate processing, EDI is the preferred method.

Submit all initial claims for payment to:

Wellcare With Absolute Total Care
ATTN: Claims Department
P.O. Box 9700
Farmington, MO 63640-0700

TAXONOMY CODES

Taxonomy Codes are designed to categorize the type, classification, and/or specialization of healthcare Providers. Wellcare With Absolute Total Care requires all claims, both paper and electronic, to include the taxonomy code of the rendering Provider. The taxonomy code included on the claim must also match the taxonomy code Wellcare With Absolute Total Care has on file for the rendering Provider. To submit or update this information, please complete the Provider enrollment form located on our website.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) & FREESTANDING RURAL HEALTH CLINIC (RHC)

FQHCs and RHCs are important community Providers, and all Wellcare With Absolute Total Care Members have access to them if the Member resides in a community where FQHC services are available. The Member Handbook outlines the Member's rights to access a FQHC in their service area. FQHC and RHC Billing Requirements:

- Claims must be billed using the group National Provider Identifier (NPI).
- Behavioral health (BH) claims must include the appropriate BH modifier.
- All claims must be submitted on a UB-04 claim form.

ELECTRONIC CLAIMS SUBMISSION

Providers using electronic submission shall submit all claims to Wellcare With Absolute Total Care or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider's NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the Member's medical record prior to the initial submission of any claim.

In-network Providers may submit claims through Absolute Total Care Secure Provider Portal or Availity Essentials.

Clearinghouses

The preferred method for submitting claims is electronically. This can be done through clearinghouses or via the online Provider Portal.

If you are re-submitting a claim for a status or a correction, please indicate "Status" or "Claims Correction" on the claim.

Wellcare With Absolute Total Care is currently accepting electronic claims from the following clearinghouses:

Availity Essentials

- **Customer Support: 1-800-282-4548**
- **Claim Types:** Professional/Facility
- **Payer ID:** 68069

*Providers are responsible for ensuring they receive a confirmation file for claims submitted via EDI.

Wellcare With Absolute Total Care may add new clearinghouses partners periodically. Providers should contact Provider Services at **1-833-998-5401** to verify whether their current clearinghouse is included in the approved list. It is the Providers' responsibility to ensure receipt of a confirmation file for all claims submitted via EDI.

PAYSPAN® ELECTRONIC PAYMENTS & REMITTANCE

Overview

PaySpan® is Wellcare With Absolute Total Care's preferred secure electronic payment solution that allows providers to receive claim payments and remittance information electronically. Through PaySpan, providers can access payment details quickly, streamline reimbursement processes, and reduce administrative burden associated with paper checks and mailed EOBs.

Benefits to Providers

- **Faster Payments:** Receive claim payments via EFT (Electronic Funds Transfer), reducing delays associated with paper checks.
- **Convenient Online Access:** View remittance information (835s/EOBs) online, download reports, and reconcile payments in real time.
- **Customizable Preferences:** Choose how and when payments are received, including grouping, notification settings, and reporting formats.
- **Enhanced Security:** EFT reduces risk of lost, stolen, or misdirected checks.
- **Improved Administrative Efficiency:** Streamlined payment workflows allow billing teams to reduce manual posting and improve cash flow management.

Enrollment

Providers who have not yet enrolled in PaySpan must complete the online registration process. During enrollment, providers will:

- Verify TIN/NPI credentials
- Provide banking information for EFT
- Set up user accounts and security preferences (To be tailored per market if needed.)

Providers should have their most recent payment or provider information available to complete registration.

Existing PaySpan providers will be required to add the Wellcare With Absolute Total Care's line of business to their existing account using their TIN. Failure to register the new line of business may result in providers receiving paper checks.

How to Access PaySpan

Providers may log in to PaySpan's secure portal at: www.payspanhealth.com

Support & Assistance

For enrollment assistance, password resets, or technical questions, providers may contact PaySpan Customer Service:

- PaySpan Support: 1-877-331-7154
- Email: providersupport@payspanhealth.com
- Hours: Monday–Friday, 8 a.m. to 8 p.m. EST

For questions related to claim payment amounts or adjudication decisions (not system access), providers should contact the applicable Provider Services phone number on the member's ID card.

PAPER CLAIMS SUBMISSION

To facilitate processing and to minimize chances for rejection or error in payment, it is required that paper claims be typewritten or computer printed. The recommended font to use for computer generated claims is 12-point Times New Roman font. Do not print in italics, bold or script. Handwritten claims and photocopied claims are not accepted. Paper claims information must be submitted within the confines of each item box.

Claims must be legibly signed and dated in ink by the Provider or his or her authorized representative. Any claim that is not properly signed or that has the certification statement altered will be rejected. A rubber signature stamp or other substitute is not acceptable. An authorized representative may only be a trusted employee over whom the Provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the Provider. Such a representative must be designated specifically and must sign the Provider's name and his or her own initials on each certification statement. This responsibility cannot be delegated to a billing service. It is mandatory that claims for services be submitted only on original billing forms. Photocopies or other facsimile copies cannot be accepted for payment purposes.

TIMELY FILING OF CLAIMS

A claim must be submitted within 365 days from DOS.

CORRECTED CLAIMS

A corrected claim should be submitted when a Provider needs to change information on a previously submitted initial claim.

If you are replacing or voiding/cancelling a UB-04 claim, please use the appropriate bill type of 137 or 138. If you are replacing or voiding/cancelling a CMS 1500 claim, please complete box 22. For replacement or corrected claim, enter resubmission code 7 on the left side of item 22 and enter the original claim number of the claim you are replacing on the right side of item 22. If submitting a void/cancel claim, enter resubmission code 8 on the left side of item 22 and enter the original claim number of the paid claim you are voiding/cancelling on the right side of item 22. If you do not follow these corrected claim form submission processes the claim will deny for a duplicate claim submission.

Claim Resubmissions

Resubmit claim information to address previously submitted claims that had missing, invalid or incomplete claim information as follows:

- **Contracted Providers:** Resubmit invalid/incomplete claims within 180 days of service via EDI or mail to the address below.
- **Non-Contracted Providers:** Resubmit within 365 days of service via EDI or mail to the address below.

Wellcare With Absolute Total Care
PO Box 9700
Farmington, MO 63640-0700

Claim Adjustments

Resubmit claim information to correct a billing error in the initial claim submission or to request claim reprocessing due to a previously partially paid claim as follows:

- **Contracted Providers:** Request corrections or reprocessing within 60 days of service or correspondence (as confirmed by the Explanation of Payment (EOP) date via EDI or mail to the address below:
- **Non-Contracted Providers:** Request a claim adjustment within 365 days of service via EDI or mail to the address below:

Wellcare With Absolute Total Care
PO Box 9700
Farmington, MO 63640-0700

APPEAL RIGHTS

- **Contracted Providers:** In accordance with the Medicare managed care regulations, contracted providers DO NOT have Medicare appeal rights for payment disputes. However, Wellcare With Absolute Total Care will review claim requests. Requests must be submitted within 120 days from the date of the EOP and include a copy of the EOP and supporting justification or documentation such as medical records.
- **Non-Contracted Providers:** In accordance with the Medicare managed care regulations, non-contracted providers have Medicare appeal rights for denied claims. Wellcare With Absolute Total

Care will make a decision within sixty (60) calendar days from the date the request is received. Appeals must be mailed to the address below within sixty-five (65) calendar days of the EOP along with:

- Completed CMS Waiver of Liability (WOL) statement. Wellcare With Absolute Total Care cannot begin the appeals process without a completed and signed WOL, and requests for appeals that do not include a WOL will be issued a Notice of Dismissal of Appeal request.
- Supporting documentation, such as medical records, should be mailed to:

Wellcare With Absolute Total Care
PO Box 9700
Farmington, MO 63640-0700

PAYMENT DISPUTE RIGHTS

- **Contracted Providers:** See Appeal Rights section.
- **Non-Contracted Providers:** Medicare payment disputes apply to any claim for which the provider contends the amount paid by Wellcare With Absolute Total Care for a covered service is less than the amount that would have been paid by original Medicare or for which Wellcare With Absolute Total Care's decision to pay for a different service than the billed service (down-coding). Payment disputes cannot apply to denials resulting in zero payment made and must be handled by the appeals process described above. Wellcare With Absolute Total Care must make a decision within 30 days from the date of dispute receipt. Payment disputes must be mailed to the address below within 120 days of the EOP.

  Mail to:

  Wellcare With Absolute Total Care
  PO Box 9700
  Farmington, MO 63640-0700

Requests sent to the wrong address will not be returned to the submitter. For more information, visit our website at wellcare.absolutetotalcare.com or call **1-833-998-5401**.

OVERPAYMENTS

Providers are required to promptly notify Wellcare With Absolute Total Care upon identification of any overpayment. Identified overpayments must be returned to the Plan within sixty (60) calendar days, accompanied by written documentation detailing the reason for the overpayment.

RETROACTIVE ADJUSTMENTS

Should CMS Risk Adjustment activity retroactively increase or decrease payments, including Risk Adjustment Data Validation (RADV), and for adjustments made by CMS to Health Plan's monthly payments based upon changes in eligibility, capitation payments to Providers shall be retroactively adjusted on a proportional basis.

Wellcare may contract with a vendor to conduct premium enhancing activities. Any fees resulting from premium enhancing activities conducted by Wellcare's vendor will be charged back to Provider during the period when the premium changes are realized. The vendor will sign a HIPAA compliant Business Associate Agreement with Wellcare that allows it to collect PHI on our behalf.

REIMBURSEMENT GUIDELINES, PAYMENT POLICES AND CODING GUIDANCE

Member Billing

Pursuant to Law, Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payor is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Wellcare With Absolute Total Care to the Provider. Providers may not bill Wellcare With Absolute Total Care DSNP Members for covered services, also known as "balance billing," regardless of whether they believe the amount they were paid or will be paid by Wellcare With Absolute Total Care is appropriate or sufficient. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable Patient Liability towards covered Medicaid services such as Nursing Facility.

Post-Service Provider Appeals

Wellcare With Absolute Total Care offers a Post-Service claim appeal process for disputes related to denial of payment for services rendered to Wellcare With Absolute Total Care Members. This process is available to all Providers, regardless of whether they are in or out of network.

What Types of Issues Can Providers Appeal?

The appeals process is in place for two main types of issues:

- Post-Service Provider Appeal: An appeal of services that were denied or reduced because they did not meet a specific criteria, policy or guideline and have a denied authorization on file. For example, the Provider disagrees with a determination made by Wellcare With Absolute Total Care, such as combining two stays as a 15-day readmission. In this case, the Provider should send additional information (such as medical records) that support the Provider's position.
- Administrative Appeal: An appeal by a Provider of a claim/service denied for failure to authorize services according to timeframe requirements. In this case, the Provider must explain the circumstances and why the Provider feels an exception is warranted in that specific case.

A Provider's lack of knowledge of a Member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to a Member being ineligible on the date of service or due to non-covered benefits.

How to File a Post-Service Provider Appeal

Providers may submit a post-service appeal in one of three ways:

1. Login to the Provider Portal to submit an appeal. This is the preferred method for a quicker turnaround time.
2. Via mail by filling out the Appeal Cover Letter form and sending documentation to support your position, such as medical records, to the following address:

Wellcare With Absolute Total Care
Attn: Appeals Department
P.O. Box 9700
Farmington, MO 63640-0700

Timeframe for Filing a Post-Service Provider Appeal

Provider appeals must be submitted within 180 days from the date of the EOP.

Response to Post-Service Provider Appeals

Wellcare With Absolute Total Care typically responds to a Post-Service Provider Appeal within thirty (30) calendar days from the date of receipt. Providers will receive a letter with the decision and rationale.

For Medicare-covered services, there is one level of Provider appeal, and all determinations are final.

For Medicaid-covered services, Providers may have additional appeal rights, including the option to request a State Fair Hearing or review by a Medicaid Independent Review Entity (IRE), depending on the nature of the service and the appeal.

Medical Records

All medical records requested by Wellcare With Absolute Total Care are to be provided at no cost from the Provider. This includes administrative fees, copying fees, paper fees, and fees delegated from a third-party vendor.

Medical records should be provided to Wellcare With Absolute Total Care within ten (10) business days of request, unless otherwise agreed. To help ease the burden on Providers, accommodations can be arranged for individuals designated by Wellcare With Absolute Total Care to assist in extracting medical records for this request. Electronic access to medical records should be arranged wherever possible.

Procedure

All practitioners in the network must comply with the following:

1. Medical record documentation must include at least the following elements:

a. All services provided directly by the practitioner

b. All ancillary services and diagnostic tests ordered by the practitioner

c. All diagnostic and therapeutic services for which the Member was referred to by the practitioner (e.g., home health nursing reports, specialty Provider reports, hospital discharge reports, and physical therapy reports)

2. The essential documentation elements for the medical record include:

    a. History and physicals

    b. Allergies and adverse reactions, or no known drug allergies (NKDA), are prominently noted

    c. Problem lists of significant illnesses and medical conditions, with date of onset

    d. Medications (current medications, changes, discontinuation, and reported reactions)

    e. Working diagnoses are consistent with findings

    f. Treatment plans are consistent with diagnoses

    g. Preventive services/risk screenings

    h. There is no evidence that the Member is placed at inappropriate risk by a diagnostic or therapeutic procedure

3. The Medical Record Keeping standard checks for the following:

    a. Presence of an organized medical record system (i.e., dividers by type of service such as lab reports/test, consults, etc.)

    b. The medical record is a unit record (bound and organized)

    c. Entries in the medical record are legible, signed and dated

    d. The medical record is available to the practitioner (attending and covering) at every visit and retrievable for review for ten years

    e. Member information is kept confidential by ensuring that the records are stored securely, and only authorized personnel have access to the records. Fax machines should be in an area that is not accessible by other Members to ensure confidentiality

    f. Acknowledgement of receipt of privacy notice in record (If not in individual records, there is a central file with acknowledgement of receipt of notice)

Note: Corrective action plans are requested of all Providers whose compliance falls below stated levels (80%). Reassessment is subsequently completed within 6 months to verify improved performance and compliance.

A focused medical record review is performed annually as part of the continuous quality improvement activities of Wellcare With Absolute Total Care. In addition, an individual practitioner medical record review may be performed, when the apparent lack of compliance with the above standards is discovered during a utilization management or QI activity.

SECTION 6: REPORTING REQUIREMENTS

CORPORATE REPORTING REQUIREMENTS

Member encounter information should be reported on submitted claims forms (CMS 1500; UB-04) by stamping or clearly designating on the claims form "ENCOUNTER."

Practices will be monitored for accurate and complete encounter reporting. The data that Wellcare With Absolute Total Care submits to CMS and SCDHHS requires your compliance with this requirement.

Other reporting requirements or data collection may be added, as data collection requirements are dynamic. PCP offices will be notified in writing of any additional reporting requirements.

ENCOUNTER REPORTING REQUIREMENTS

In order to assess the quality of care, determine utilization patterns and access to care for various healthcare services, qualified health plans are required to submit encounter data containing detail for each Member encounter reflecting all services provided by the Providers of the health plan. The State will determine the minimum data elements of the encounter reporting. A format consistent with the formats and coding conventions of the CMS 1500 and UB-04 will be used initially. PCPs will submit their encounter data monthly to Wellcare With Absolute Total Care, who must submit to CMS and SCDHHS. Both Wellcare With Absolute Total Care and Provider agree that all information related to payment, treatment, or operations will be shared between both parties and all medical information relating to individual Members will be held confidential.

As part of Wellcare With Absolute Total Care's contract with Providers, it is required that Provider Preventable Conditions (PPCs) associated with claims be reported to Wellcare With Absolute Total Care. PPCs address both hospital and non-hospital conditions identified by the state for non-payment. PPCs are broken into two distinct categories: Health Care-Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). HCACs are conditions/secondary diagnosis codes identified when not present on an inpatient admission. OPPCs are conditions occurring in any healthcare setting that could have been prevented through the application of evidence-based guidelines.

Medicare requires all delegated vendors, delegated Providers, and capitated Providers to submit encounter data to Centene, even if they are reimbursed through a capitated arrangement.

This section is intended to give Providers necessary information to allow them to submit encounter data to Centene. If the encounter data does not meet the requirements set forth in Centene's government contracts for timeliness of submission, completeness or accuracy, federal and state agencies (for example, CMS) have the ability to impose significant financial sanctions on Centene.

SECTION 7: COMPLIANCE AND REGULATORY REQUIREMENTS

FRAUD, WASTE & ABUSE (FWA) PROGRAM

Purpose and Commitment

Wellcare With Absolute Total Care is committed to the prevention, detection, investigation, and reporting of suspected **fraud, waste, and abuse (FWA)** in accordance with applicable **federal and state laws, regulations, and contractual requirements**. FWA impacts the healthcare system broadly and may result in significant and unnecessary costs to publicly funded programs.

Wellcare With Absolute Total Care has developed an aggressive, proactive fraud waste and abuse ("FWA") program designed to collect, analyze and evaluate data in order to identify suspected fraud, waste and abuse.

Detection tools have been developed to identify patterns of health care service use, including over utilization, unbundling, up-coding, misuse of modifiers, services not rendered and other common schemes

Through its parent company, **Centene Corporation (Centene)**, Wellcare With Absolute Total Care maintains a dedicated **Special Investigations Unit (SIU)** and an established FWA program designed to:

- Collect, analyze, and evaluate data to identify potential FWA patterns
- Conduct audits and investigations to assess billing and documentation compliance
- Implement corrective actions, recover overpayments when appropriate, and refer matters to regulatory or law enforcement agencies as required

Definitions (42 CFR §455.2 and HHS Definitions)

For purposes of this manual:

- **Fraud**: An intentional deception or misrepresentation made with knowledge that the deception could result in an unauthorized benefit to the individual or another party. This includes any act that constitutes fraud under applicable federal or state law.
- **Waste**: The overutilization of services or practices that result in unnecessary costs, including consumption or expenditures without adequate return.
- **Abuse**: Provider practices inconsistent with sound fiscal, business, or medical practices that result in unnecessary costs to Medicare and/or Medicaid, reimbursement for services not medically necessary, or services that fail to meet professionally recognized standards of care. Abuse also includes member practices that result in unnecessary program costs.

Examples of FWA and Improper Billing Practices

Common FWA and improper billing practices may include, but are not limited to:

- Billing for services **not rendered**
- **Duplicate billing** (billing the same service more than once)
- **Unbundling** or fragmenting codes
- **Upcoding** services
- Billing **add-on codes without required primary CPT codes**
- Use of **exclusion codes**
- Misuse of modifiers
- Diagnosis and/or procedure codes **inconsistent with the member's age**
- **Excessive units** or frequency
- **Overutilization** or medically unnecessary services
- Misuse of benefits (including inappropriate use of identification cards)

Providers are cautioned that unbundling, upcoding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD-CM), Providers' Current Procedural Terminology (CPT) Health Care Common Procedure Coding System, (HCPCS) and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be maintained consistent with contractual and regulatory obligations.

Federal and state regulatory agencies, law enforcement and Wellcare With Absolute Total Care vigorously investigate incidents of suspected FWA. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure and/or civil and/or criminal prosecution, fines and other penalties.

PROVIDER RESPONSIBILITIES AND COOPERATION REQUIREMENTS

Reporting

Providers, including Provider employees and /or Provider sub-contractors, must report to Wellcare With Absolute Total Care any suspected fraud, waste or abuse, misconduct or criminal acts by any Provider, including Provider employees and/or Provider sub-contractors, or by Wellcare With Absolute Total Care Members. If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the

member may be involuntarily disenrolled from Wellcare With Absolute Total Care, with appropriate state and regulatory approval.

Cooperation with Audits and Investigations

Participating providers are obligated to cooperate fully with Centene SIU, and applicable oversight agencies. This includes, as required:

- Producing requested medical records and related documentation timely
- Making staff and/or subcontractor personnel available for interviews and consultation
- Making offices and facilities available for onsite visits
- Cooperating with investigative processes, including hearings, trials, and other proceedings when applicable

Documentation Standards

Quality care and appropriate payment depend on **accurate, complete, and legible medical record documentation**. Documentation must support:

- The service(s) billed
- The level of service reported
- Medical necessity, where applicable
- Compliance with all relevant CMS, state, contractual and Wellcare With Absolute Total Care documentation and billing requirements

SPECIAL INVESTIGATIONS UNIT (SIU)

Our Special Investigations Unit (SIU) proactively monitors for potential FWA and investigates allegations of fraud, waste, and abuse. Staff includes full-time investigators, clinical investigators, data analysts, management support, administrative staff, and legal personnel.

FWA DETECTION AND MONITORING

Wellcare With Absolute Total Care uses multiple methods to identify potential billing irregularities, including:

- Claims analytics and code editing tools during claims processing
- Pattern recognition for potential overutilization, unbundling, upcoding, and modifier misuse
- Retrospective audits and investigations
- Prepayment Reviews

Reviews may incorporate, as applicable:

- CMS guidelines
- Federal and state regulations/guidance
- Local Coverage Determinations (LCDs)
- National Coverage Determinations (NCDs)
- Specialty-specific billing and coding guidance
- Wellcare With Absolute Total Care clinical and billing policies
- Contractual requirements

When clinically appropriate, review may include assessment by a clinician of like specialty.

Post-Payment (Post-Processing) Claims Audits/Investigations

Overview

A post-payment audit/investigation is a review of clinical documentation for claims previously submitted. Reviews are conducted to ensure payment is supported by proper documentation, consistent with the services rendered.

Medical Record Requests and Timeframes

Wellcare With Absolute Total Care will request medical, behavioral health, dental, vision, or pharmacy records to initiate an investigation:

- Medical records will be requested for a defined review period.
- Providers must submit requested records within the timeframe stated in the request.
- If no response is received, a **second and final request** may be issued.
- Records must be received within the timeframe specified in the second request.

As a reminder, HIPAA permits the use or disclosure of protected health information (PHI) for treatment, payment, and health care operations (TPO) without the member's or patient's consent or authorization. See 45 C.F.R. § 164.506.

Failure to Submit Records / Insufficient Documentation

If a provider:

- Fails to respond to the second and final request, **or**
- Submits records that do not document the services billed,

Consistent with applicable law, regulation, and provider agreement terms, Wellcare With Absolute Total Care may recover all amounts paid for the services in question.

Findings Communication, Overpayments, and Recovery

Findings Results Letter

Upon completion of an investigation, Wellcare With Absolute Total Care may issue a Proposed Action Letter (PAL) that includes:

- A summary of the review findings and outcome.
- A complete list of the claims reviewed, including the determination for each claim line.
- Documentation of the sources used to make claim-line determinations.
- Any applicable recovery amount and the basis for it.
- Notice of appeal rights

Overpayment Methodology

If documentation does not support the payment, Wellcare With Absolute Total Care will seek recovery of identified claim payments. Depending on the scope of review, overpayments may be calculated using:

- **Claim-by-claim** review, and/or
- **Extrapolation methodology** may be used to estimate overpayment amounts through statistical sampling, consistent with program integrity methods used in Medicare and Medicaid oversight.

Appeal of Overpayment

Providers may contest the findings, the amount of the overpayment, or the methodology used to identify the overpayment by filing an appeal within 120 calendar days of the date of receipt of the PAL with supporting documentation.

Instructions for filing an appeal are provided in the initial PAL and include:

- A complete and accurate explanation of the issues being refuted. Supporting materials, medical records, or other documentation to challenge the findings.
- An appeal letter as necessary, outlining any contractual, regulatory, factual or other basis of disagreement with the findings and/or overpayment amount.

If the provider does not contest the overpayment, repay the amount due, or contact Wellcare With Absolute Total Care within thirty calendar days of receiving the PAL to arrange payment, Wellcare With Absolute Total Care will offset the overpayment against future claims submitted for by the provider.

Required FWA Training and Screening Requirements

Providers and their employees/contractors must comply with applicable CMS rules and regulations related to compliance training and education, including FWA training requirements. Providers and their employees must complete FWA training:

- Within 90 days of contracting, and
- Annually thereafter, as applicable (e.g., consistent with requirements referenced under § 423.504).

Exclusion / Preclusion Screening (Medicare Networks)

For Medicare lines of business, providers are required to check:

- OIG/GSA Exclusion lists, and
- The CMS Preclusion List

Prior to hiring/contracting and monthly thereafter for staff, volunteers, temporary employees, consultants, directors, and contractors who meet applicable requirements, consistent with references including:

- The Act §1862(e)(1)(B)
- 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6)
- 1001.1901

Medicare payment may not be made for items or services furnished or prescribed by a precluded or excluded provider/entity.

Reporting Suspected Fraud, Waste, or Abuse

Wellcare With Absolute Total Care encourages prompt reporting of suspected FWA. Reports may be made anonymously and are treated as confidential to the extent permitted by law.

Fraud, Waste, and Abuse Hotline: **1-866-685-8664**
Corporate Compliance/Ethics Hotline (as applicable): **1-800-345-1642**
Email (if applicable): Special_Investigations_Unit@centene.com

All reports are reviewed and investigated as appropriate.

False Claims Act (Overview)

The False Claims Act establishes liability when a person or entity improperly receives or avoids payment to the federal government. Prohibited conduct includes, but is not limited to:

- Knowingly presenting (or causing to be presented) a false claim for payment or approval
- Knowingly making or using a false record or statement material to a false or fraudulent claim
- Conspiring to violate the False Claims Act
- Knowingly making or using false statements to avoid or decrease an obligation to pay the government

For additional information, providers may reference CMS resources (e.g., www.cms.hhs.gov).



wellcare.absolutetotalcare.com