# Medicare-Medicaid Provider Manual

Absolute Total Care (Medicare-Medicaid Plan) is a Coordinated and Integrated Care Organization (CICO) contracted with the Centers for Medicare & Medicaid Services (CMS) and South Carolina Healthy Connections Medicaid to coordinate medical services to Medicare-Medicaid (dual eligible) members in South Carolina.

Absolute Total Care's main goals are to:

- Improve health outcomes;
- Coordinate necessary care to dual eligible members;
- Reduce avoidable emergency department visits and hospital readmissions; and
- Increase access to home- and community-based services.

All of our programs, policies, and procedures are designed with these objectives in mind. These objectives mirror and support the objectives of the CMS and South Carolina Healthy Connections Medicaid guidelines to provide covered healthcare services to low-income and elderly members. This manual will be updated and revised, as needed, based on CMS, South Carolina Healthy Connections Medicaid, and Absolute Total Care guidelines.

Absolute Total Care takes the privacy and confidentiality of our members' health information seriously. We have processes, policies, and procedures that comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and CMS regulations.

Our goal is to reinforce the relationship between our members and their primary care provider (PCP). We want our members to benefit from their PCP having the opportunity to deliver high-quality care using contracted clinicians, hospitals, and specialists. The PCP is responsible for coordinating our members' health services, maintaining a complete medical record for each member under their care, and ensuring continuity of care. The PCP advises the member about their health status; medical treatment options, which include the benefits or consequences of treatment or non-treatment; and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.

Absolute Total Care encourages our PCPs to provide health education to all of our members or their representatives. This Provider Manual offers information on preventive care, member benefits, disease and care management programs, and clinical practice guidelines. It also provides the needed information for member education and promotion of member compliance with treatment directives and self-directed care.

If a PCP is unable to provide treatment to a member, including counseling and referral services, because of religious or moral reasons, they should contact Provider Services at 1-855-735-4398.

We appreciate your partnership in achieving our objectives.

# How to Reach Us

Absolute Total Care
1441 Main Street, Suite 900
Columbia, SC 29201

Provider and Member Services:
1-855-735-4398
mmp.absolutetotalcare.com

Hours of Operation: Monday through Friday, 8 a.m. to 8 p.m.

Claims Submission Address:
P.O. Box 3060
Farmington, MO 63640

**Vendor Contacts**

| Vendor | Contact Number | Service |
|---|---|---|
| CVS (Pharmacy) | 1-855-735-4398 | Pharmacy Claims Administrator |
| Envolve Pharmacy Solutions (Prescribers) | 1-855-735-4398 | Pharmacy Benefits Manager |
| National Imaging Associates (NIA) www.radMD.com | 1-855-735-4398 | Authorizations for CT, PET, MRI |
| Nurse Advice Line | 1-855-735-4398 | 24-hour Nurse Triage Service |
| Envolve Vision | 1-855-735-4398 | Routine Vision Services |
| PaySpan | 1-877-331-7154 | 835 Vendor or EFT/ERA Transactions |

**Healthy Connections Prime Contacts**

| Vendor | Contact Number | Service |
|---|---|---|
| Maximus www.scchoices.com/Member/MemberHome.aspx | 1-877-552-4642 | Enrollment Processor |
| South Carolina Department of Health and Human Services www.scdhhs.gov/prime | 1-800-726-8774 | Program Administrator |

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# Marketing Guidelines

Absolute Total Care will follow CMS and South Carolina Healthy Connections Medicaid guidelines. Absolute Total Care and providers with whom they have a relationship (contractual or otherwise) that assist members with plan selection will ensure that providers' assistance results in plan selection that is always in the best interest of the member. Providers that have entered into co-branding relationships with Absolute Total Care must also follow these guidelines.

Absolute Total Care will not conduct sales activities in healthcare settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.

Absolute Total Care will not conduct sales presentations, distribute and accept enrollment applications, or solicit members in areas where patients primarily receive healthcare services or are waiting to receive healthcare services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities in healthcare settings extends to activities planned in healthcare settings outside of normal business hours.

Absolute Total Care will only schedule appointments with members residing in long-term care facilities (including nursing homes, assisted living facilities, and board and care homes) upon request by the member. Absolute Total Care may use providers to make available or distribute plan marketing materials as long as the provider or the facility distributes or makes available marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available or distribute plan marketing materials they should do so if Absolute Total Care indicates that the provider must accept future requests from other plans with which they participate. Absolute Total Care may also provide materials for providers to display in common areas such as the provider's waiting room. Additionally, Absolute Total Care may provide materials to long-term care facilities to place in admission packets announcing all plan contractual relationships.

For more information on CMS marketing guidelines, visit http://cms.gov.

# Quality Improvement (QI)

Absolute Total Care conducts an ongoing QI Program. Absolute Total Care's QI Program includes a Chronic Care Improvement Program and QI Projects. The QI Program is evaluated at least annually concerning its impact and effectiveness.

The goal of the QI Program is to achieve sustained improvement in aspects of clinical care and non-clinical services through ongoing measurement and intervention. This can be expected to have a beneficial effect on health outcomes and member satisfaction.

The QI Program:

- Incorporates information from Member Services, Claim Disputes & Appeals, Medical Management, Credentialing, Provider Services, Claims, and Marketing.
- Designates a senior official responsible for QI administration.
- Has a committee that evaluates the effectiveness of the QI Program.
- Has an annual evaluation of its QI Program which:
    - Assesses both progress in implementing the QI strategy and the extent to which the strategy is in fact promoting the development of an effective QI Program;
    - Considers whether activities in Absolute Total Care's Work Plan are being completed on a timely basis or whether commitment of additional resources is necessary;
    - Includes recommendations for needed changes in program strategy or administration. These recommendations are forwarded to and considered by the designated committee; and
    - Encourages Absolute Total Care's providers to participate in CMS and South Carolina Healthy Connections Medicaid QI initiatives.

Absolute Total Care corrects all significant systematic problems that come to its attention through internal surveillance, complaints, or other mechanisms. To accomplish this, Absolute Total Care:

- Has a mechanism for assessing the severity of identified problems; and
- Takes timely and specific action to correct identified problems, depending on the severity and impact of the identified problems.

The scope of the QI Program is comprehensive; it addresses both the quality and safety of clinical care and the quality of service provided to Absolute Total Care members is defined by CMS and South Carolina Healthy Connections Medicaid. Absolute Total Care incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its QI activities, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, and ancillary services. Absolute Total Care's Quality Assessment and Performance Improvement (QAPI) Program monitors the following:

- Acute and chronic care management;
- Compliance with member confidentiality laws and regulations;
- Compliance with preventive health and clinical practice guidelines;
- Continuity and coordination of care;
- Employee and provider cultural competency;
- Marketing practices;
- Member enrollment and disenrollment;
- Member grievance system;
- Member satisfaction;
- Patient safety;
- Provider and Absolute Total Care's after-hours telephone accessibility;
- Provider appointment availability and accessibility;
- Provider network adequacy and capacity; and
- Provider satisfaction.

# Quality

**How can providers help to improve the quality and care provided to Medicare beneficiaries?**

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Continue to talk to patients and document interventions regarding topics such as:
  - Fall prevention;
  - Bladder control; and
  - The importance of physical activity.
- Create office practices to identify non-compliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes and properly document medical charts for all members.
- Review member listing of gaps in care. This listing is available on our secure web portal.
- Identify opportunities for you or your office to have an impact.

**Healthcare Effectiveness Data and Information Set (HEDIS)**

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of cost differences.

As federal and state governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. CMS uses HEDIS rates to evaluate the effectiveness of a managed care plan's ability to demonstrate an improvement in preventive health outreach to its members.

**HEDIS Rate Calculations**

HEDIS rates are calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include annual mammogram, Body Mass Index Assessment, cholesterol management, colorectal cancer screenings, use of disease modifying anti-rheumatic drugs of members with rheumatoid arthritis, osteoporosis screening for female members having suffered a fracture, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10, and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review (MRR) include diabetic HbA1c and LDL lab results, eye exams and nephropathy, and controlling high blood pressure.

**Who conducts medical record reviews (MRRs) for HEDIS?**

Absolute Total Care may contract with an independent MRR vendor to conduct the HEDIS MRR on its behalf. MRR audits for HEDIS are usually conducted March through May each year. Prompt cooperation with the MRR process is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Absolute Total Care that allows them to collect PHI on our behalf.

**How can providers improve their HEDIS scores?**

- *Understand the specifications* established for each HEDIS measure.
- *Submit claims and encounter data for each and every service rendered.* All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Absolute Total Care. Claims and encounter data is the most efficient way to report HEDIS.

- *Submit claims and encounter data correctly, accurately, and on time.* If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- *Ensure chart documentation reflects all services provided.* Keep accurate chart/medical record documentation of each member service and document conversations/services.
- *Submit claims and encounter data using CPT codes related to HEDIS measures* such as diabetes, eye exam, and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical records review, please contact the QI Department at 1-855-735-4398.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey**
The CAHPS survey is a member satisfaction survey that is included as part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA-certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well the plan is meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the QI Program including monitoring of practitioner access and availability. CAHPS survey material that may reflect on the service of providers includes:

- Whether the member received an annual flu vaccine;
- Whether members perceive they are getting needed care including specialists and prescriptions; and
- How quickly members were able to get appointments and care.

**Medicare Health Outcomes Survey (HOS)**
The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather data to help target QI activities and resources, monitor health plan performance and reward top-performing health plans, and help Medicare beneficiaries make informed healthcare choices. Absolute Total Care must participate in the Medicare HOS. Medicare HOS questions that may reflect on the service of providers include:

- Whether the member perceives their physical or mental health is maintained or improving;
- Whether the member has seen their physician and discussed starting, increasing, or maintaining their level of physical activity; and
- If the provider has discussed fall risks and bladder control with the member.

# Network Participation

The enrollment, credentialing and re-credentialing processes exist to ensure that participating providers meet and maintain compliance with the criteria established by Absolute Total Care, as well as government regulations and standards of accrediting bodies. **Failure of an applicant to provide adequate information to meet all criteria may result in termination of the application process.**

**If a practitioner/provider already participates with Absolute Total Care in the Medicaid, Medicare, and/or Marketplace product, the practitioner/provider will NOT be separately credentialed for the MMP.**

**Note: In order to maintain a current provider profile, providers are required to notify Absolute Total Care of any relevant changes to their credentialing information in a timely manner but in no event later than 10 days from the date of the change.** Providers must submit at a minimum the following information when applying for participation with Absolute Total Care:

- A completed, signed, and dated Absolute Total Care Standardized Credentialing Form or Council for Affordable Quality Healthcare (CAQH) Provider Data Form. The application must include the following:
  - Signed attestation of the correctness and completeness of the application;
  - History of loss of license or clinical privileges;

    - Disciplinary actions or felony convictions, lack of current illegal substance or alcohol abuse, mental and physical competence; and
    - Ability to perform the essential functions of the position, with or without accommodation.
- A copy of current malpractice insurance policy fact sheet that includes expiration dates, amounts of coverage, and provider's name
- A copy of current State Controlled Substance certificate (if applicable)
- A copy of current Drug Enforcement Agency (DEA) Registration Certificate for South Carolina and in the state where care is being provided
- A copy of W-9
- A copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted Medical License to practice in the state of South Carolina (applicable to Organizational Providers)
- Evidence of specialty/board certification (if applicable)
- If practitioner is not board certified, proof of highest level of education (copy of certificate or letter certifying formal post-graduate training)
- Willingness to submit to a Site Visit Evaluation (applicable to PCPs and OB/GYNs)
- A copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Ability to demonstrate enumeration by National Plan and Provider Enumeration System (NPPES), depicting the provider's unique National Provider Identifier (NPI)
- A copy of current written protocol and name of supervising physician is required for all nurse practitioners
- A Disclosure of Ownership and Financial Interest Statement, version 1514

Absolute Total Care will review for the following information:

- Current, unrestricted state licensure to practice, if a license is required to practice;
- Education and training or board certification;
- Reports of malpractice settlements via the National Practitioner Data Bank (NPDB);
- Current DEA Registration;
- Hospital privileges in good standing at a participating Absolute Total Care hospital;
- Gaps of six months or greater within the past five years of work history;
- Medicare/Medicaid-specific exclusions or determination of disbarment, suspension, or other exclusion from participation in federal procurement activities via Office of Inspector General (OIG), System of Award Management (SAM),CMS Medicare Preclusion List, and South Carolina Excluded Providers List (SC EPLS);
- Potential fraudulent activity by ensuring provider is not listed on the Social Security Administration's Death Master File;
- Proof of professional liability coverage in an amount accepted by Absolute Total Care; and
- Proof of collaborative agreement, protocols, or other written authorization with a licensed physician.

Providers must be credentialed and contracted prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed and have an executed contract.

Once the application is completed, the Absolute Total Care Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting. Re-credentialing is performed at least every 36 months from the date of the initial credentialing decision or most recent recredentialing decision. The purpose of this process is to identify any changes in the practitioner's/provider's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/provider's ability to perform services under the contract. This process includes all practitioners, facilities, and ancillary providers previously credentialed and currently participating in the network.

Absolute Total Care shall ensure that providers receive 30 days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

# Reporting

Absolute Total Care is required to maintain a health information system that collects, analyzes, and integrates all data necessary to aggregate, evaluate, and report certain statistical data related to cost, utilization, quality, and other data requested by CMS. As an Absolute Total Care provider, you are required to submit all data necessary to fulfill these requirements in a timely manner. You are required to certify, in writing, that the data submission to Absolute Total Care is complete, accurate, and truthful. This includes all data, including encounter data, medical records, or other information required by CMS.

**Physician/Provider Profiling**

As part of its incentive strategies, Absolute Total Care will systematically profile the quality of care delivered by high-volume PCPs to improve provider compliance with clinical practice guidelines and clinical performance indicators. The profiling system is developed with Absolute Total Care network physicians and providers to ensure the process has value to physicians, providers, members, and Absolute Total Care.

Absolute Total Care's QI Committee will work with network providers to build useful, understandable, and relevant analyses and reporting tools to improve care and compliance with clinical practice guidelines. This collaborative effort helps to establish the foundation for physician and provider acceptance of results leading to continuous QI activities that yield performance improvements.

Profiles will include a multidimensional assessment of a PCP's performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to the target population. Additional assessment, at Absolute Total Care's discretion, may include such elements as availability of extended office hours, member complaint rates, and compliance with medical record standards.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Absolute Total Care in publications such as newsletters, bulletins, press releases, and recognition in Absolute Total Care Provider Directories.

Interventions will be implemented to address practitioners' performance that is out of range (outliers) from their peers, and such interventions may include, but are not limited to, provider education, sharing of best practices or documentation tools, assistance with barrier analysis, development of corrective action plans, ongoing medical record reviews, and potential termination of network status when recommended improvements are not made. Providers identified as significantly outside the norm will be re-measured.

# Member Eligibility

The dual eligible demonstration will be available to individuals who meet the following criteria:

- Enrolled in Medicare Part A and B and are receiving full Medicaid benefits
- Age 65+
- Not in an institution (at time of enrollment)
- Not enrolled in a PACE program (Program of All-Inclusive Care for the Elderly)
- Non-Department of Disabilities Special Needs (Non-DDSPN) waiver
- Not enrolled in Hospice (at time of enrollment)
- Not receiving end-stage renal disease (ESRD) services

You should always verify member eligibility prior to delivering services. It is very important to ask the member for a copy of the health plan ID card and some other form of identification, such as a driver's license or photo ID.

Absolute Total Care's card replaces the member's original red, white and blue Medicare card and their Medicaid Fee-for-Service (FFS) ID card. See the below sample Absolute Total Care member ID card.

**Member ID Card**




**Eligibility May be Verified in Three Ways**

1. The secure web portal found at mmp.absolutetotalcare.com.
    a. If you are already a registered user of the web portal, you do not need a separate registration.
    b. If you are not currently a registered user, registration is a quick process. There is a video on our registration page which will walk you through the process should you experience any difficulties.
2. 24/7 Interactive Voice Response System at 1-855-735-4398.
3. Provider Services at 1-855-735-4398.

# Member Benefits

Absolute Total Care will cover all current/traditional Medicare FFS benefits (including primary and acute care, Part D, and skilled nursing facility services) and current Medicaid FFS (including nursing facilities and behavioral health services and home- and community- based waiver services) subject to eligibility verification, medical necessity determination and prior authorization requirements. The table below represents the covered benefits offered. This table may not be all-inclusive. Should you have questions regarding benefits, you may call Provider Services at 1-855-735-4398.

**Services and Items Covered by Healthy Connections Prime**

| | |
|---|---|
| • Abdominal Aortic Aneurysm Screening<br>• Alcohol Misuse Screening and Counseling<br>• Ambulance Services<br>• Annual Wellness Visit<br>• Bone Mass Measurement<br>• Breast Cancer Screening (Mammograms)<br>• Cardiac (Heart) Rehabilitation Services<br>• Cardiovascular (Heart) Disease Risk Reduction Visit (Therapy for Heart Disease)<br>• Cardiovascular (Heart) Disease Testing<br>• Cervical and Vaginal Cancer Screening<br>• Chiropractic Services<br>• Colorectal Cancer Screening<br>• Counseling to Stop Smoking or Tobacco Use<br>• **Dental Services***<br>• Depression Screening<br>• Diabetes Screening<br>• Diabetic Self-management Training, Services, and Supplies | • Medical Nutrition Therapy<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Medicare Part B Prescription Drugs<br>• **Non-emergency Medical Transportation***<br>• Nursing Home Care<br>• Nursing Home Transition Services<br>• Obesity Screening and Therapy to Keep Weight Down<br>• Outpatient Diagnostic Tests and Therapeutic Services and Supplies (e.g., Lab Tests, X-rays, and Imaging)<br>• Outpatient Hospital Services<br>• Outpatient Mental Health Care<br>• Outpatient Rehabilitation Services (Physical, Occupational, and Speech Therapy)<br>• Outpatient Substance Abuse Services<br>• Over-the-Counter Items Not Covered Under Medicare Part D<br>• Outpatient Surgery<br>• Palliative Care<br>• Partial Hospitalization Services<br>• Physician/Provider Services, Including Doctor's Office |

| | |
|---|---|
| • Durable Medical Equipment and Related Supplies<br>• Emergency Care<br>• Family Planning Services<br>• Health and Wellness Education Programs<br>• Home Health Agency Care<br>• HIV Screening<br>• Hospice Care<br>• Immunizations<br>• Incontinence Supplies<br>• Infusion Therapy<br>• Inpatient Hospital Care | Visits and Specialist Services<br>• Podiatry Services<br>• Prostate Cancer Screening Exams<br>• Prosthetic Devices and Related Supplies<br>• Pulmonary Rehabilitation Services<br>• Sexually Transmitted Infections (STIs) Screening and Counseling<br>• Skilled Nursing Facility Care<br>• Targeted Case Management (TCM)<br>• Telemedicine<br>• Urgently Needed Care<br>• Vision Care<br>• "Welcome to Medicare" Preventive Visit<br>• Inpatient Mental Health Care<br>• Inpatient Services Covered During a Non-covered Inpatient Stay<br>• Kidney Disease Services (e.g., Dialysis), Supplies, and Training |

*** Services covered by Healthy Connections Medicaid, not Healthy Connections Prime.**

In addition to the table above, Absolute Total Care also offers the following value-added benefits:

- **Hearing:** Free hearing exams and up to $1,250 towards the purchase of hearing aids.
- **Over-the-Counter Supplies:** Certain over-the-counter and personal wellness items shipped free to the member's home from our mail order pharmacy.
- **Health Club Membership:** Up to $250 reimbursement per year for a health club membership fee.

# Member Orientation

Once the enrollment application is processed, each new member will receive a letter from Absolute Total Care stating the effective date of coverage and a packet of information about our program.

The following documents are provided to the new members:

- Member ID card
- Welcome letter
- A comprehensive integrated formulary
- Information about how to access or receive the pharmacy/provider directory
- Summary of Benefits (SB)
- Member Handbook (Evidence of Coverage, EOC)

Members are encouraged to select a health-plan contracted PCP. For all members in Care Management, a Care Management Team will work with the member's PCP or facility personnel to address the needs of the member, coordinate needed healthcare and services, and ensure the member accesses their preferred health service benefits.

Members receive various pieces of information through mailings and face-to-face contact. Many of these materials are printed in English and Spanish. These materials include, but are not limited to:

- Nurse Advice Line information (our 24/7 nurse advice line); and
- Emergency room information.

Providers interested in receiving these materials may contact Provider Services at 1-855-735-4398.

# Enrollment Process

All enrollment and disenrollment related transactions, including enrollments from one Coordinated and Integrated Care Organization (CICO), also called a Medicare-Medicaid Plan (MMP), to a different CICO, will be processed by Maximus. Eligibility and enrollment are determined by the state or its enrollment broker/vendor based on CMS and South Carolina Healthy Connections Medicaid qualifying criteria.

# Voluntary Disenrollment

A member may terminate their participation with Absolute Total Care. Disenrollment from CICOs and enrollment from one CICO to a different CICO shall be allowed on a month-to-month basis any time during the year; however, coverage will continue through the end of the month.

**Note: It is very important to verify member's eligibility prior to rendering services.**

# Member Rights and Responsibilities

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

Absolute Total Care members have certain rights and protections designed to:

- Protect members when they get healthcare.
- Make sure members get the healthcare services that the law says they can get.
- Protect members against unethical practices.
- Protect members' privacy.
- Be treated with dignity and respect at all times.
- Be protected from discrimination. Every company or agency that works with Medicare must obey the law, and can't treat members differently because of their race, color, national origin, disability, age, religion, or sex.
- Have personal and health information kept private.
- Get information in a way the member understands from Medicare, healthcare providers, and, under certain circumstances, contractors.
- Get understandable information about Medicare to help members make healthcare decisions, including:
    - What's covered;
    - What Medicare pays;
    - How much members have to pay; and
    - What to do if the member wants to file a complaint or appeal.
- Have questions about Medicare answered.
- Have access to doctors, specialists, and hospitals.
- Learn about treatment choices in clear language that the member can understand, and participate in treatment decisions.
- Get healthcare services in a language the member understands and in a culturally-sensitive way.
- Get emergency care when and where the member needs it.
- Get a decision about healthcare payment, coverage of services, or prescription drug coverage.
    - When a claim is filed, the member gets a notice from Medicare, South Carolina Healthy Connections Medicaid or Absolute Total Care letting them know what it will and won't cover.
    - If the member disagrees with the decision of their claim, they have the right to file an appeal.
- Request a review (appeal) of certain decisions about healthcare payment, coverage of services, or prescription drug coverage.
    - If the member disagrees with a decision about their claims or services, they have the right to appeal.

- File complaints (sometimes called “grievances”), including complaints about the quality of the member’s care.

# Member Prescription Drug Plan Rights

A member has the following rights related to the prescription drug coverage:

- To request a coverage determination or appeal to resolve differences with the plan.
- To file a complaint (called a “grievance”) with the plan.
- To have the privacy of heath and prescription drug information protected.
  - Medications
  - Other needs that form the basis of our integrated, holistic care plan

# Member Appeals

An appeal is a request for review of an adverse action. An appeal may be requested by a member, member representative or their physician. Appeals can be initiated verbally, but before being acted on, Absolute Total Care must receive written documentation that includes the reason for the appeal and the evidence that explains why the member needs the service. If a member representative or doctor is acting on behalf of the member, written consent is required.

Appeal information can be mailed or faxed. See the contact information below.

If the service is again denied, the denial decision will have the written instructions regarding additional appeal rights such as requesting a State Fair Hearing and how the member may exercise their additional appeal rights.

**Part C – Medical**

- **Standard Appeal:** Pre- and post-service, decision within 15 calendar days
- **Expedited Appeal:** 72 hours

**Part D – Drug**

- **Standard Appeal:** Decision within seven calendar days
- **Expedited Appeal:** 72 hours

**Send Member Medicare Service (Part C) and Medication (Part D) appeals to:**
Absolute Total Care
Medicare Grievance & Appeals
7700 Forsyth Blvd.
St. Louis, MO 63105

Phone: 1-855-735-4398
Fax: 1-844-273-2671

**Send Member Medicaid Service Appeals to:**
Absolute Total Care (Medicare-Medicaid Plan)
Attn: Appeals and Grievances -Medicare Operations
7700 Forsyth Blvd
St. Louis, MO 63105

Phone: 1-855-735-4398
Fax: 1-844-273-2671

**Appeal Rights*:* Contracted Providers**
In accordance with the Medicare managed care regulations, contracted providers DO NOT have Medicare appeal rights for payment disputes. However, Absolute Total Care has a review process to address any contracted

provider claim issues. Requests for contracted provider claim reviews must be received by Absolute Total Care within 60 days from the date of the Explanation of Payment (EOP). A copy of the EOP and supporting justification or documentation (such as medical records) must be submitted with the review request.

**Appeal Rights: Non-Contracted Providers**
In accordance with the Medicare managed care regulations, non-contracted providers have Medicare appeal rights. Medicare appeal rights apply to any claims for which Absolute Total Care has denied payment. All requests for payment appeals must include a completed and signed "Waiver of Liability" (WOL) statement. Absolute Total Care cannot begin the appeals process until a completed and signed WOL is received. Requests for appeals that do not include a WOL will be issued a Notice of Dismissal of Appeal Request. Requests for payment appeals must be filed within 60 calendar days of the EOP. A copy of the EOP and any other supporting documentation (such as medical records when applicable) must be submitted with the appeal request. Absolute Total Care must make a decision regarding the appeal within 60 calendar days from the date the appeal request was received.

Requests sent to the wrong address will be returned to the submitter. Requests should be submitted to the following address:

Absolute Total Care
Grievance and Appeals Department
P.O. Box 3060
Farmington, MO 63640

# Member Complaints

A complaint is a grievance or dispute, other than one that constitutes an organization determination (prior authorization determination), where the member is expressing dissatisfaction with the manner in which a health plan or delegated entity provides healthcare services.

A complaint may be requested by a member or the member's authorized representative at any time, regardless of when the issue with the health plan or the provider occurred.

A complaint is either called in, mailed, or faxed. See the contact information below. We will review the complaint and work with the member to identify a mutually beneficial outcome.

**Standard Complaint:** Most complaints are answered in 30 calendar days. If we need more information and the delay is in the member's best interest, or if you ask for more time, we can take up to 14 more calendar days to answer a complaint.

**Fast Complaint:** Within 24 hours

**Send Member Grievances to:**
Absolute Total Care (Medicare-Medicaid Plan)
Attn: Appeals and Grievances
7700 Forsyth Blvd.
St. Louis, MO 63105

Phone: 1-855-735-4398 from 8 a.m. to 8 p.m., Monday through Friday.
Fax: 1-844-273-2671

# Provider Responsibilities

Providers must comply with each of the items listed below:

- To help or advocate for members to make decisions within their scope of practice about their relevant or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments;
    - Provide information regarding the nature of treatment options;
    - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered; and
    - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.
- To treat members with fairness, dignity, and respect.
- To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental, or physical disability/condition including pregnancy or hospitalization, or the expectation for frequent or high cost care.
- To maintain the confidentiality of members' PHI, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service.
- To provide members with an accounting of the use and disclosure of their PHI in accordance with HIPAA.
- To allow members to request restriction on the use and disclosure of their PHI.
- To provide members, upon request, access to inspect and receive a copy of their PHI, including medical records.
- To provide clear and complete information to members – in a language they can understand – about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.
- To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- To allow a member who refuses the request to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- To respect members' advance directives and include these documents in their medical record.
- To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- To allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- To follow all state and federal laws and regulations related to patient care and rights.
- To participate in Absolute Total Care data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- To review clinical practice guidelines distributed by Absolute Total Care.
- To comply with the Absolute Total Care Medical Management program as outlined herein.
- To disclose overpayments or improper payments to Absolute Total Care.
- To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- To obtain and report to Absolute Total Care information regarding other insurance coverage the member has or may have.
- To give Absolute Total Care timely, written notice if the provider is leaving/closing a practice.
- To contact Absolute Total Care to verify member eligibility and benefits, if appropriate.
- To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.

- To provide members with information regarding office location, hours of operation, accessibility, and translation services.
- To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
- To provide hours of operation to Absolute Total Care members which are no less than those offered to other Medicare patients.

# Appointment Availability

The following standards are established regarding appointment availability:

- **A full-time practice** is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.
- **Routine appointments and physicals** should be available within four weeks of the request.
- **Primary care urgent appointments (non-life threatening)** should be available within one week of the request.
- **Urgent care** should be available within 24 hours.
- **Urgent specialty care** should be available within 24 hours of referral.
- **Referrals to specialists** should be made within four weeks of the request.
- **Emergency care** should be received immediately and be available 24 hours a day.
- **Persistent symptoms** must be treated no later than the end of the following working day after initial contact with the PCP.
- **Non-urgent care appointment for sick visit** should be available within 72 hours of the request.
- **Provider visits** to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work within 10 days of request.
- **Behavioral healthcare** must be provided immediately for emergency services, within 24 hours of the request for urgent care, and within 10 days of the request for routine care. Additional behavioral healthcare appointment availability timeframes can be found in the Behavioral Health section of this manual.

# Telephone Arrangements

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering member telephone calls and inquiries on a timely basis;
- Prioritizing appointments;
- Scheduling a series of appointments and follow-up appointments as needed by a member;
- Identifying and rescheduling broken and no-show appointments;
- Identifying special member needs when scheduling an appointment (e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally deficient);
- Response time for telephone call-back waiting times:
    - After-hours telephone care for non-emergent, symptomatic issues within 30 to 45 minutes
    - Same day for non-symptomatic concerns
    - Crisis situations within 15 minutes
- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours. Protocols should be in place to provide coverage in the event of a provider's absence; and
- After-hours calls should be documented in a written format, in either an after-hour call log or some other method, and transferred to the patient's medical record.

**Note: If after-hours urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care or emergency center to notify the facility.**

Absolute Total Care will monitor appointment and after-hours availability on an ongoing basis through the QI Program.

# Cultural Competency

Absolute Total Care views cultural competency as the measure of a person's or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community, within an organization, and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency Program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of healthcare delivery, cultural competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender, or ethnic groups and accommodating the patient's culturally-based attitudes, beliefs, and needs within the framework of access to healthcare services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices that are important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Absolute Total Care is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of Absolute Total Care's Cultural Competency Program, providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them;
- Medical care is provided with consideration of the member's primary language, race, or ethnicity as it relates to the member's health or illness;
- Office staff routinely interacting with members has been given the opportunity to participate in, or has participated in, cultural competency training;
- Office staff responsible for data collection makes reasonable attempts to collect race- and language-specific information for each member. Staff will also explain race categories to a member in order to assist the member in accurately identifying their race or ethnicity;
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on healthcare;
- Office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area; and
- An appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act (ADA) including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

# Americans with Disabilities Act (Disability Awareness)

Absolute Total Care strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504, which require that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and

- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services.

The term "disability" means, with respect to an individual:

1. A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
2. A record of such an impairment; or
3. Being regarded as having such impairment.

If an individual meets any one of these three tests, he or she is considered to be an individual with a disability for purposes of coverage under the ADA.

**General Requirements**

§ 35.130 General prohibitions against discrimination include:

1. No qualified individual with a disability shall on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
2. 
    a. A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability:
        i. Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;
        ii. Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
        iii. Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;
        iv. Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;
        v. Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;
        vi. Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;
        vii. Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.
    b. A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.
    c. A public entity may not, directly or through contractual or other arrangements, use criteria or methods of administration:
        i. That has the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;
        ii. That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
        iii. That perpetuates the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same state.

d. A public entity may not, in determining the site or location of a facility, make selections:
    i. That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
    ii. That has the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
e. A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.
f. A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
g. A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
h. A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.

3. Nothing in this part prohibits a public entity from provided benefits or services, to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
4. A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
5. Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.
6. Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
7. A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.
8. A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

# Long-Term Services and Supports (LTSS)

LTSS are a means to provide medical and non-medical services to seniors and people with disabilities in need of sustained assistance. These services aid individuals with activities of daily living. Activities of daily living include eating, grooming, dressing, toileting, bathing, and transferring. These services are covered benefits when authorized under the Medicare-Medicaid product.

# Prior Authorization

To see a list of services that require prior authorization please visit our website at mmp.absolutetotalcare.com and use the Pre-Auth Tool or call the Authorization Department with questions. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment. We will suspend the need for prior authorization requests during an emergency/disaster where providers are unable to reach Absolute Total Care for an extended period and when, acting in good faith, providers need to deliver services to our members.

Absolute Total Care does not reward providers, employees who perform utilization reviews, or other individuals for issuing denials of authorization. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve benefit coverage. Absolute Total Care affirms that utilization management decision-making is based on appropriateness of care and service and the existence of coverage. Absolute Total Care does not reward practitioners or other individuals for issuing denials of service or care. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Note: All out-of-network services require prior authorization excluding emergency room services, urgent care when the PCP is not available, and out-of-area dialysis. The preferred method for submitting authorizations is through the secure web portal at mmp.absolutetotalcare.com. The provider must be a registered user on the secure web portal. If a provider is already registered for the secure web portal for one of our other products, no further registration is required. If the provider is not already a registered user on the secure web portal and needs assistance or training on submitting prior authorizations, the provider should contact his or her dedicated Provider Relations Specialist.

Other methods of submitting the prior authorization requests are as follows:

- Call the Medical Management Department at 1-855-735-4398. Our Nurse Advice Line can assist with authorizations after normal business hours.
- Fax prior authorization requests utilizing the prior authorization fax forms posted on our website. Our fax number is 1-844-503-8866.
    - Faxes will not be monitored after hours and will be responded to on the next business day. Please contact our 24/7 Nurse Advice Line at 1-855-735-4398 for after-hour urgent admissions or inpatient notifications or requests.

**Medical Necessity**

Medically necessary services are generally accepted medical practices provided in light of conditions present at the time of treatment. These services are:

- Essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, causes suffering or pain, causes physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a member;
- Provided at an appropriate facility and at the appropriate level of care for the treatment of the member's medical condition; and
- Provided in accordance with generally accepted standards of medical practice.

The criteria used to determine medical necessity includes but is not limited to:

| | |
|---|---|
| Medical Services | InterQual® Adult Guidelines |
| Behavioral Health Services | InterQual® Adult Guidelines |
| High Tech Imaging | Internally developed criteria by National Imaging Associates (NIA). Criteria developed by representatives in the disciplines of radiology, internal medicine, nursing and cardiology. |
| Substance Use Disorder Services | Based upon the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. The criteria are available at www.asam.org. |

There must be no other effective and more conservative or substantially less costly treatment, service, and setting available. In keeping with CMS and South Carolina Healthy Connections Medicaid policies and procedures, Absolute Total Care shall not cover experimental, investigational, or cosmetic procedures.

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

- Member's name and ID number;
- Physician's name and telephone number;
- Hospital name, if the request is for an inpatient admission or outpatient services;
- Reason for admission – primary and secondary diagnoses, surgical procedures, surgery date;
- Relevant clinical information – past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed;
- Admission date or proposed surgery date, if the request is for an inpatient admission;
- Requested length of stay, if the request is for an inpatient admission; and
- Discharge plans, if the request is for an inpatient admission.

If more information is required, the Registered Nurse or licensed practical nurse will notify the caller of the specific information needed to complete the authorization process.

# Individualized Care Plan (ICP)

Absolute Total Care strives to work with the provider community to ensure members' individual needs are met leveraging our care coordination approach. An ICP is developed with input from all parties involved in the member's care. The ICP includes:

- Goals and objectives;
- Specific services and benefits to be provided; and
- Measurable outcomes.

Members receive monitoring, service referrals, and condition-specific education. Care coordinators and PCPs work closely together with the member and their family to prepare, implement, and evaluate the ICP. Absolute Total Care disseminates evidence-based clinical guidelines and conducts studies to:

- Measure member outcomes; and
- Monitor quality of care.

# Interdisciplinary Care Team (ICT)

The care coordinators will coordinate the member's care with the ICT. The ICT includes the health plan, member and caregiver, external practitioners, and vendors involved in the plan for the member's care, all of which is dependent on who the member chooses to attend.

- **Inpatient Care:** Care coordinators will coordinate with facilities to assist members with the appropriate level of care and develop an appropriate discharge plan. Absolute Total Care will then notify the PCP of the transition of care and anticipated discharge date to ensure members receive the appropriate follow-up care.
- **Transition of Care:** Managing transition of care for discharged members may include, but is not limited to, face-to-face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan.
- **Provider ICT Responsibilities:** Provider responsibilities include accepting ICT meeting invitations on members, when possible; maintaining copies of the ICP, ICT work sheets, and transition of care notifications in the member's medical record; and collaborating with our care coordinators, ICT, and members or caregivers.

**How to Identify LTSS Needs**

LTSS are covered services in the Medicare-Medicaid product. Services include eating, grooming, dressing, toileting, bathing, transferring, meal planning and preparation, managing finances, shopping for food or other essential

items, performing essential household chores, communicating by phone or by other media, as well as participating in the community. Members may qualify for these services through an eligibility assessment conducted by South Carolina Healthy Connections Medicaid or its designee.

Additionally, upon enrollment with Absolute Total Care, members will complete a HRA. This HRA will be provided to the member's PCP. Should you identify members who are not currently receiving LTSS and may benefit from these services, please contact Absolute Total Care's Care Management Department at 1-855-735-4398.

**How to Identify Behavioral Health Needs**
Common behavioral health needs include, but are not limited to, depression, anxiety, and alcohol and/or drug abuse. PCPs will be provided with the member's HRA to assist with identifying behavioral health needs. Should you identify members who are not currently receiving behavioral health services and may benefit from these services, please contact Absolute Total Care's Care Management Department at 1-855-735-4398.

The table below reflects services that require prior authorization. This is not an all-inclusive list. For a complete list of prior authorization requirements, please visit our website at mmp.absolutetotalcare.com.

| Service | Description |
|---|---|
| **All out-of-network practitioners and providers rendering service to dually eligible members are required to obtain a prior authorization before rendering services.** | |
| Ambulance | • Fixed-wing Aircraft<br>• Non-emergent |
| Behavioral Health Services (Includes Substance Use Disorder) | • Inpatient Psychiatric<br>• Partial Hospitalization<br>• Intensive Outpatient Therapy<br>• Psychological Testing<br>• Neuropsychological Testing<br>• Electroconvulsive Therapy<br>• Substance Use Disorder Treatment/Rehabilitation |
| Cosmetic Procedures | Includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member (Medicare Definition). |
| Durable Medical Equipment (DME) | Includes <u>but not limited to:</u><br>• Custom Wheelchairs<br>• Power Wheelchairs<br>• Hearing Aids<br>• BIPAP<br>• CPAP<br>• Hospital Bed/Mattress<br>• Lift Devices, Including Hoyer<br>• Infusion Pumps<br>• Oxygen<br>• TENS Units<br>• Ventilators<br>• Wound Vacuum (Negative Pressure) Devices<br>• Bone Growth Stimulator<br>• Vagus Nerve Stimulator |

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| | **To determine if other DME codes require prior authorization, please visit our website at mmp.absolutetotalcare.com and use the Pre-Auth Tool.** |
| Experimental/Investigational Services/Clinical Trial | Any item or service potentially considered investigational, experimental, or as part of a clinical trial must be authorized in advance. |
| Genetic Counseling and Testing | Genetic testing is a type of medical test that identifies changes in chromosomes, genes, or proteins. Prior authorization is required. |
| Home Health Services | • Home IV Infusion<br>• Occupational Therapy<br>• Physical Therapy<br>• Speech Therapy<br>• Skilled Nursing Visits<br>• Social Work Visits<br>• Home Health Aide |
| Hospice | Home or Inpatient |
| Infertility | Includes the following:<br>• Drug Therapy<br>• Testing<br>• Treatment |
| Inpatient Admission: Elective or Scheduled | • Acute Inpatient Hospital<br>• Inpatient Rehabilitation Hospital<br>• Long-Term Acute Care Hospital<br>• Skilled Nursing Facility |
| Orthotics/Prosthetics | **To determine if orthotic/prosthetic codes require prior authorization, please visit our website at mmp.absolutetotalcare.com and use the Pre-Auth Tool.** |
| Observation Stay | Prior authorization required. |
| Outpatient therapy performed at free-standing facility or outpatient hospital | • Occupational Therapy (OT)<br>• Physical Therapy (PT)<br>• Speech-Language Therapy (ST) |
| Pain Management | • Facet Injections<br>• Trigger Point Injections<br>• Epidural Injections<br>• Median Branch Block<br>• Radio Frequency Ablation<br>Authorization required, unless being performed as part of a surgery. |
| Medicare Part B Drugs | Please see Medicare Part B Prior Authorization List |
| Radiology: visit www.radmd.com | • MRI<br>• PET<br>• CT |
| Sleep Studies | • Diagnostic and Treatment (Including Surgery) |
| Surgeries, Regardless of Place of Service | • Abortion<br>• Bariatric Surgery<br>• Blepharoplasty |

| | |
|---|---|
| | • Breast Augmentation (Except Following Mastectomy)<br>• Breast Reduction<br>• Cochlear Implant<br>• Diagnostic Left Heart Catheter<br>• Excision of Lesion<br>• Facial Osteotomy<br>• Hysterectomy<br>• Joint Replacements<br>• Mastectomy for Gynecomastia<br>• Oral Surgery (Temporomandibular Joint Surgery)<br>• Otoplasty<br>• Reconstructive and Plastic Surgery<br>• Rhinoplasty<br>• Sacral Nerve Neuromodulation<br>• Scar Revision<br>• Septoplasty<br>• Spinal Surgeries Including Fusion, Stabilization, and Discectomy<br>• Uvulopalatopharyngoplasty/ Uvulopharyngoplasty<br>• Veins (Ablation, Ligation, Stripping, and Sclerotherapy) |
| Transplants | All transplant evaluations and procedures, including but not limited to, evaluation, transplant consult visits, HLA typing, donor search, and transplant procedure. |

# Pharmacy

The covered pharmacy services for Absolute Total Care members vary based on the plan benefits. Information regarding the member's pharmacy coverage can be best found via our secure web portal. Additional resources available on the website include the Absolute Total Care Preferred Drug List (PDL), the Envolve Pharmacy Solutions (Pharmacy Benefit Manager) Provider Manual, and Medication Request/Exception Request forms.

The Absolute Total Care PDL is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The PDL provides instruction on the following:

- Which drugs are covered, including restrictions and limitations;
- The Pharmacy Management Program requirements and procedures;
- An explanation of limits and quotas;
- How prescribing providers can make an exception request; and
- How Absolute Total Care conducts generics substitution, therapeutic interchange, and step-therapy.

The Absolute Total Care PDL does not:

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

The Absolute Total Care PDL will be approved initially by the Absolute Total Care Pharmacy and Therapeutics (P&T) Committee, led by the pharmacist and medical director, with support from community-based PCPs and specialists. Once established, the PDL will be maintained by the P&T Committee, using quarterly meetings, to ensure that Absolute Total Care members receive the most appropriate medications. The Absolute Total Care PDL contains

those medications that the P&T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the committee will review the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the committee. Copies of the PDL are available on our website, mmp.absolutetotalcare.com. Providers may also call Provider Services at 1-855-735-4398 for a hard copy of the PDL.

The majority of prescriptions will be covered based on the Medicare Formulary. In addition, Absolute Total Care will assist with the following:

- Transitions of prescription drugs
- Out-of-network coverage
- Quality assurance
- Utilization management (prior authorization requirements)
- Exceptions and appeals
- Locating a pharmacy near you
- Information about any formulary changes
- Specialty pharmacy

# Transition Policy

Under certain circumstances, Absolute Total Care can offer a temporary supply of a drug if the drug is not on the formulary or is restricted in some way. To be eligible for a temporary supply, members must meet the requirements below:

1. The drug the member has been taking is no longer on the Absolute Total Care formulary or the drug is now restricted in some way.
2. The member must be in one of the situations described below:
    - **The member was enrolled the plan last year:** We will cover a temporary supply of the drug during the first 90 days of the calendar year. This temporary supply will be for up to 30 days of medication at a retail pharmacy and at a long-term care pharmacy, up to 31 days. If the prescription is written for fewer days, we will allow multiple fills to provide up to the maximum 30 days of medication allowed. You must fill the prescription at a network pharmacy. Long-term care pharmacies may provide the prescription drug in small amounts at a time to prevent waste.
    - **The member is new to the plan:** We will cover a temporary supply of the drug during the first **180 days** of membership in the plan. This temporary supply will be for up to 30 days of medication at a retail pharmacy and at a long-term care pharmacy, up to 31 days. If the prescription is written for fewer days, we will allow multiple fills to provide up to the maximum 30 days of medication allowed. You must fill the prescription at a network pharmacy. Long-term care pharmacies may provide the prescription drug in small amounts at a time to prevent waste.
    - **A member has been in the plan for more than 90 days and lives in a long-term care facility and needs a supply right away:** We will cover one 31-day supply, or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply. Throughout the plan year, a member may have a change in treatment setting because of the type of level of care that is required. Such transitions may include, but are not limited to:
        - Members who are discharged from a hospital or skilled nursing facility from a home setting.
        - Members who are admitted to a hospital or skilled nursing facility from a home setting.
        - Members who transfer from one skilled nursing facility to another and are served by a different pharmacy.
        - Members who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefits.
        - Members who give up Hospice Status.
        - Members discharged from chronic psychiatric hospitals with highly individualized drug regimes.

For these changes in treatment settings, Absolute Total Care will cover as much as a 31-day temporary supply of a Part D-covered drug when the prescription is filled at a pharmacy. If a member has changed treatment settings multiple times within the same month, an exception or prior authorization can be requested for approval for continued coverage of the drug. We will review these requests for continuation of therapy on a case-by-case basis when the member is on a stabilized drug regimen that, if changed, is known to have risks.

# Prior Authorization Requirements

Absolute Total Care has a team of providers and pharmacists to create tools to help provide quality coverage to Absolute Total Care members. The tools include, but are not limited to: prior authorization criteria, clinical edits, and quantity limits. Some examples include:

- **Age Limits:** Some drugs require a prior authorization if the member's age does not meet the manufacturer, Food and Drug Administration (FDA), or clinical recommendations.
- **Quantity Limits:** For certain drugs, Absolute Total Care limits the amount of the drug we will cover per prescription or for a defined period of time.
- **Prior Authorization:** Absolute Total Care requires prior authorization for certain drugs. Prior authorization may be required for drugs that are on the formulary or drugs that are not on the formulary and were approved for coverage through our exceptions process. This means that approval will be required before the prescription can be filled. If approval is not obtained, Absolute Total Care may not cover the drug.
- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the generic version, unless the brand name drug was requested. If the brand name drug is approved, the member may be responsible for higher copay or the difference in cost between the brand and generic medications.

Prior authorization may be requested by calling us at 1-855-735-4398 or completing the prior authorization fax form found on our website at mmp.absolutetotalcare.com.

# General Billing Guidelines

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with Absolute Total Care for payment of covered services.

It is important that providers ensure Absolute Total Care has accurate billing information on file. Please confirm with your Provider Relations Department that the following information is current in our files:

- **Provider Name** (as noted on current W-9 form)
- **Provider National Provider Identifier (NPI)**
- Physical location address (as noted on current W-9 form)
- Billing name and address (if different)
- **Tax Identification Number (TIN)**

Providers must bill with their NPI number in box 24J. Absolute Total Care will return or reject claims when billing information does not match the information that is currently in our files. **Claims missing the above requirements in bold will be returned** with a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be entered into the system.

We recommend that providers notify Absolute Total Care in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a provider's TIN or addresses are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member's contract on the date of service.

- Referral and prior authorization processes were followed.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

# Timely Filing

Providers must submit all claims and encounters within 365 days from the date of service, unless Absolute Total Care or its vendors created the error.

Absolute Total Care must comply with state and federal requirements mandating provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR 434.6(a)12 (2011, as amended) and 42 CFR 447.26 (2011, as amended).

**All requests for reconsideration or adjustments to processed claims must be received within 365 calendar days from the date of service.**

**Failure to obtain authorization**
Providers may NOT bill members for services when the provider fails to obtain an authorization and the claim is denied.

# No Balance Billing

Federal law prohibits Medicare providers from billing Qualified Medicare Beneficiaries (QMBs) for Medicare cost-sharing, including deductibles, coinsurance, and copays under any circumstances. Providers can use CMS HIPAA Eligibility Transaction System (HETS) eligibility data to verify a beneficiary's QMB status and exemption from cost-sharing charges. Do not bill Absolute Total Care members for any deductibles, coinsurance, or copays with the exception of allowable copays for durable medical equipment, home health care, and dental care. Billing Absolute Total Care members is a violation of your provider agreement. Provider reimbursement from Absolute Total Care constitutes payment in full regardless of the type of service.

# Imaging Requirements for Paper Claims

Absolute Total Care uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

**Do's**

- **Do** use the correct P.O. Box number.
- **Do** submit all claims in a 9" x 12" or larger envelope.
- **Do** type all fields completely and correctly.
- **Do** use black or blue ink only.
- **Do** submit on a proper and current form (CMS 1500 or UB 04).

**Don'ts**

- **Don't** submit handwritten claim forms.
- **Don't** use red ink on claim forms.
- **Don't** circle any data on claim forms.
- **Don't** add extraneous information to any claim form field.
- **Don't** use highlighter on any claim form field.
- **Don't** submit photocopied claim forms (black and white).
- **Don't** submit carbon copied claim forms.
- **Don't** submit claim forms via fax.

# Claims Filing Instructions

Network providers are encouraged to participate in Absolute Total Care's Electronic Claims/Encounter Filing Program. The plan has the capability to receive an ANSI X12N 837 professional, institution, or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an EOP.

Submit electronic claims using the following EDI numbers:

EDI payer number: 68069

For EDI assistance contact:

Absolute Total Care
C/O Centene EDI Department
Phone: 1-800-225-2573, extension 25525
Email: EDIBA@centene.com

You are required to follow HIPAA 5010 format for claim submissions. Absolute Total Care's timely filing is within 365 days from the date of service.

Monitor your error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. You are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Submit paper claims to:

Absolute Total Care
Medicare Claims
P.O. Box 3060
Farmington, MO 63640

**Claim Resubmissions*:* Contracted and Non-Contracted Providers**
For claim resubmissions, including a response to an invalid or incomplete claim submission and/or a claim resubmission with previously missing claim information, submitters have 365 days from the date of service to file a timely resubmission request via EDI or to the following address:

Absolute Total Care
Medicare Claims
P.O. Box 3060
Farmington, MO 63640

**Claim Adjustments**
For claim adjustments that include a correction to a billing error in the initial claim submission or to request claim reprocessing due to a previously partially paid claim:

**Contracted Providers*:*** Submitters have 365 calendar days from the date of the service (as confirmed by the EOP) to request processing of a claim adjustment via EDI or to the address below:

**Non-Contracted Providers:** Submitters have 365 calendar days from the date of service to request processing of a claim adjustment via EDI or to the following address:

Absolute Total Care
Medicare Adjustments
P.O. Box 3060

Farmington, MO 63640

# Coordination of Benefits for Medicare and Medicaid

Claims for Absolute Total Care members will be automatically "crossed-over." You will receive one remit (EOP/ERA) and payment (check/ERA) for the Medicare claim adjudication. The Medicare EOP will show EX 30 (alpha) to indicate the claim will be "crossed-over" to process for the Medicaid benefits. Once "crossed-over" you will receive one remit (EOP/ERA) and payment for the Medicaid claim adjudication. Members will receive one EOB showing both Medicare and Medicaid payments.

# Payment Dispute Rights

**Contracted Providers**
Refer to the Contracted Providers section under the Appeal Rights section.

**Non-Contracted Providers**
In accordance with the Medicare managed care regulations, non-contracted providers have Medicare payment dispute rights. Medicare payment dispute rights apply to any claims for which the provider contends the amount paid by Absolute Total Care for a covered service is less than the amount that would have been paid by Original Medicare. Medicare payment dispute rights also apply to any claims for which there is a disagreement between the non-contracted provider and Absolute Total Care regarding Absolute Total Care's decision to pay for a different service than the billed service (often referred to as down-coding of claims). Requests for payment disputes must be filed within 120 calendar days of the date of this EOP. Absolute Total Care must make a decision regarding the payment within 30 calendar days from the date of the payment dispute was received.

Requests sent to the wrong address will be returned to the submitter. Requests should be submitted to the following address:

Absolute Total Care (Medicare-Medicaid Plan)
Attn: Provider Disputes
P.O. Box 3060
Farmington, MO 63640

Payment disputes are subject to review by CMS, as Medicare-Medicaid Plan organizations such as Absolute Total Care are required to pay non-contracted providers the same amount the provider would have received had the provider billed original Medicare. The non-contracted provider payment dispute process cannot be used to challenge payment denials by Absolute Total Care that result in zero payment being made. Payment denials may be appealed as described in the noncontracted provider appeal rights section.

**Note: Additional information about the appeals and payment dispute process can be found on our website at mmp.absolutetotalcare.com/ or by calling Provider Services at 1-855-735-4398.**

# Risk Adjustments and Correct Coding

Risk adjustment is critical and a requirement defined in CFR 42 (Section 42 of the Code of Federal Regulations) and the Medicare Modernization Act that will help ensure the long-term success of the program. Accurate calculation of risk adjustment requires accuracy, documentation completeness, and specificity in diagnostic coding. Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-9 CM, CPT, DSM-IV, and HCPCS code sets. Services rendered after October 1, 2015 are required, per CMS, to be billed using ICD-10 and DSM-V coding guidelines. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity, when applicable and defensible through chart audits and medical assessments;

- Code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care, treatment, or management;
- Ensure that medical record documentation is clear, concise, consistent, complete, and legible and meets CMS signature guidelines (each encounter must stand alone);
- Submit claims and encounter information according to the requirements specified in your contract or this provider manual;
- Alert us of any erroneous data submitted and follow our policies to correct errors as set forth in your contract or this provider manual; and
- Provide ongoing training to your staff regarding appropriate use of ICD coding for reporting diagnoses.

# Home- and Community-Based Services (HCBS)

Absolute Total Care is responsible for payment to the HCBS providers within seven days of the submitted services. South Carolina Healthy Connections Medicaid will continue to authorize these services using the Phoenix and Call Care systems. All disputes concerning services authorized and payments for services are handled by South Carolina Department of Health and Human Services (SCDHHS). Please contact SCDHHS for assistance.

Contact Absolute Total Care for any questions related to the status of your payment.

# Compliance

Absolute Total Care's Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the Compliance Program.

Absolute Total Care is committed to identifying, investigating, sanctioning, and prosecuting suspected fraud and abuse.

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

# First Tier and Downstream Providers

Through written agreement, we may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 438.230 to First Tier, downstream, and delegated entities. These functions and responsibilities include, but are not limited to, contract administration and management, claims submission, claims payment, credentialing and re-credentialing, network management, and provider training. We oversee and are accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities' performance is inadequate. We will ensure written agreements which specify these responsibilities by use and the delegated entity are clear and concise. Agreements will be kept on file for reference.

# Fraud, Waste, and Abuse (FWA)

Absolute Total Care takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a FWA Program that complies with the federal and state laws. Absolute Total Care, in conjunction with its parent company, Centene, operates a fraud, waste, and abuse unit. Absolute Total Care routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic during the claims payment process. The Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against providers who commit fraud, waste, and/or abuse. These actions include, but are not limited to:

- Remedial education and training to prevent the billing irregularity;
- More stringent utilization review;
- Recoupment of previously paid monies;

- Termination of provider agreement or other contractual arrangement;
- Civil and/or criminal prosecution; and
- Any other remedies available to rectify.

Some of the most common FWA practices include:

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

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA Hotline at 1-866-685-8664. Absolute Total Care takes all reports of potential FWA very seriously and investigates all reported issues.

**Office of Inspector General (OIG)/General Services Administration (GSA) Exclusion**

As a provider in our network, the plan's expectation is that you will check the exclusions list as outlined below for all your staff, volunteers, temporary employees, consultants, Board of Directors, and any contractors that would meet the requirements as outlined in The Act §1862(e)(1)(B), 42 CFR §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 1001.1901.

**Providers' Implementation of FWA Safeguards to Identify Excluded Providers and Entities**

Medicare payment may not be made for items or services furnished or prescribed by an excluded provider or entity. Plans shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee or FDR excluded by the Department of Health and Human Services (DHHS), OIG, or the GSA. Absolute Total Care will review the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties List(EPLS) prior to hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or First Tier, Downstream, or Related entities (FDR), and monthly thereafter.

If anyone is identified, providers are required to notify Absolute Total Care immediately so that, if needed, Absolute Total Care can take appropriate action. Providers may contact the Absolute Total Care Compliance Officer at 1-855-735-4398.

**FWA Program Compliance Authority and Responsibility**

The Absolute Total Care Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the Compliance Program. Absolute Total Care is committed to identifying, investigating, sanctioning, and prosecuting suspected FWA. The Absolute Total Care provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations.

**False Claims Act**

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

1. Knowingly presenting, or causing to be presented, a false claim for payment or approval;
2. Knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. Conspiring to commit any violation of the False Claims Act;
4. Falsely certifying the type or amount of property to be used by the government;

5. Certifying receipt of property on a document without completely knowing that the information is true;
6. Knowingly buying government property from an unauthorized officer of the government; and
7. Knowingly making, using, or causing to be made or used, a false record to avoid or decrease an obligation to pay or transmit property to the government.

For more information regarding the False Claims Act, please visit www.cms.hhs.gov.

# South Carolina Omnibus Adult Protection Act

The Omnibus Adult Protection Act is the statute in South Carolina that provides the protection of vulnerable adults from abuse, neglect, and exploitation. The Act is found in Title 43, Chapter 35 of the South Carolina Code of Laws. Persons age eighteen or older who meet the definition of a vulnerable adult under the statute are protected from abuse, neglect, or exploitation. Vulnerable adults can live in private homes, in the community, or in facilities.

If suspected abuse, neglect, or exploitation of a vulnerable adult occurs in a facility, reports of your suspicions should be made to the State Long-Term Care Ombudsman at 1-800-868-9095. Reports of incidents in facilities operated by or contracted for operation by the South Carolina Department of Mental Health or South Carolina Department of Disabilities and Special Needs must be reported to the South Carolina Law Enforcement Division (SLED) at 1-866-200-6066.

If suspected activity occurs in a private home or in the community, report your suspicions to your local county Department of Social Services or to the State Department of Social Services at 1-803-898-7601. Reports can be made to local law enforcement for any location.

# Medicare Regulatory Requirements

As a Medicare contracted provider, you are required to follow Medicare regulations and CMS requirements. Some of these requirements are found in your provider agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- You may not discriminate against Medicare members in any way based on health status.
- You must ensure that members have adequate access to covered health services.
- You may not impose cost-sharing on members for influenza vaccinations or pneumococcal vaccinations.
- You must allow members to directly access screening mammography and influenza vaccinations.
- You must provide female members with direct access to women's health specialists for routine and preventative healthcare.
- You must comply with the plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- Absolute Total Care will provide you with at least 60 days written notice of termination if electing to terminate our agreement without cause, or as described in your participation agreement if greater than 60 days. You agree to notify the health plan according to the terms outlined in your provider agreement.
- You will ensure that your hours of operation are convenient to the member and do not discriminate against the member for any reason. You will ensure necessary services are available to member 24 hours a day, seven days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Medicare members without CMS approval of the materials or forms.
- Services must be provided to members in a culturally competent manner, including members with limited reading skills, limited English proficiency, hearing or vision impairments and diverse cultural and ethnic backgrounds.

- You will work with plan procedures to inform our members of healthcare needs that require follow up and provide necessary training in self-care.
- You will document in a prominent part of the member's medical record whether the member has executed an advance directive.
- You must provide services in a manner consistent with professionally recognized standards of care.
- You must cooperate with Absolute Total Care to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make an informed choice about their Medicare coverage.
- You must cooperate with the health plan in notifying members of provider contract terminations.
- You must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- You must comply with any plan medical policies, QI programs and Medical Management procedures.
- You must cooperate with Absolute Total Care in disclosing quality and performance indicators to CMS.
- You must cooperate with Absolute Total Care's procedures for handling grievance appeals and expedited appeals.
- You must fully disclose to all members before providing a service, if you feel the service may not be covered by the plan. The member must sign an agreement of this understanding. If they do not, the claim may be denied and the provider will be liable of the cost of the service.

# Behavioral Health

**Continuity of Care Coordination**

When members are newly enrolled and have been previously receiving behavioral health services, Absolute Total Care will make best efforts to maximize the transition of members' care through providing for the transfer of pending prior authorization information for at least 180 days, and work with the member's provider to honor those existing prior authorizations.

**Coordination and Communication between Behavioral Health Providers and PCPs**

Absolute Total Care encourages PCPs to consult with their members' behavioral health (mental health and/or substance use disorder) provider(s). In many cases, the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required. We encourage all service providers to coordinate care with a member's entire treatment team, including, but not limited to, PCPs and the behavioral health provider. Additionally, Absolute Total Care will offer trainings to PCPs and behavioral health providers focused on the concepts of integrated care, cross training in medical, behavioral and substance use disorders, and screening tools.

Network providers should communicate and coordinate with the member's PCP and with any other behavioral health providers whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered to the member. Examples of some of these items to be communicated include:

- Prescription medication;
- Results of health risk screenings;
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment;

- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse); and
- The member's progress toward meeting the goals established in their treatment plan.

A form to be used in communicating with the PCP and other behavioral health providers is located on our websites at mmp.absolutetotalcare.com. Network providers can identify the name and contact information for a member's PCP by performing an eligibility inquiry on the Absolute Total Care secure web portal or by contacting Provider Services at 1-855-735-4398. Network providers report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the network provider's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner.

**The following information should be included in the report to the PCP:**

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

**Prior Authorization Requirements**

All non-participating providers require authorization for all services, including traditional outpatient therapy services. The following services require prior authorization for participating providers:

| | |
|---|---|
| Behavioral Health Services Includes Substance Use Disorder (Department of Alcohol and Other Drug Abuse Services – DAODAS) Services | • Inpatient Psychiatric<br>• Detoxification<br>• Residential Treatment Programs (SUD Only)<br>• Partial Hospitalization Program (PHP)<br>• Intensive Outpatient Therapy (IOP)<br>• Psychological Testing<br>• Neuropsychological Testing<br>• Electroconvulsive Therapy (ECT)<br>• Alcohol and/or Drug Treatments<br>• Day Treatment<br>• Vivitrol Injections |
| Community Support Services: Behavioral Health | • Peer Support Service<br>• Behavior Modification<br>• Family Support<br>• Care Management<br>• Psychosocial Rehabilitation |

Participating network providers are not required to obtain authorization for specific outpatient therapy services. For a comprehensive listing of covered behavioral health and substance use disorder billing codes, including authorization requirements, please refer to the Covered Services and Authorization Guidelines section of the manual.