Centene Corporation® (Centene) will provide Medicaid managed care services to members in South Carolina as Absolute Total Care (ATC). Centene and its wholly owned health plans have a long and successful track record offering Medicaid managed care services. For more than 20 years, Centene has provided comprehensive managed care services to the Medicaid population and currently operates health plans in 24 states. ATC will serve our South Carolina members consistent with our core philosophy that quality healthcare is best delivered locally.

ATC is a South Carolina licensed Health Maintenance Organization / Managed Care Organization (MCO) contracted with the South Carolina Department of Health and Human Services (SCDHHS) to serve Medicaid and other government services program members. ATC has developed the expertise to work with Medicaid members to improve their health status and quality of life. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. ATC will accomplish this goal by partnering with primary care providers (PCPs) who manage the healthcare of ATC members.

ATC’s goals are as follows:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. ATC provides all medically necessary care required by the SCDHHS MCO Policy and Procedure Manual. We hope that you will assist ATC in reaching these goals and we look forward to your active participation.

The purpose of this Provider Manual is to assist ATC providers in delivering medical care to ATC members. This manual serves as a guide pertaining to ATC’s policies and procedures when rendering medical services to our members. This is a supplement to your agreement with ATC and includes information on billing, quality, credentialing and compliance requirements set forth by any statutory, regulatory, contractual, and/or accreditation entities. Any revisions to this manual that result in a policy change will be implemented 30 days after notice is provided by mail, fax, electronic mail or provider post bulletins. Up-to-date information may be found by visiting our website at absolutetotalcare.com.
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CONTACT INFORMATION

How to reach us:

Absolute Total Care
1441 Main Street, Suite 900
Columbia, SC 29201
Provider and Member Services: 1-866-433-6041
Administrative Offices: 1-803-933-3638

Vendor Contacts:

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Contact Number</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cenpatico Behavioral Health</td>
<td>1-866-433-6041</td>
<td>Behavioral health services</td>
</tr>
<tr>
<td>National Imaging Associates (NIA) <a href="http://www.radMD.com">www.radMD.com</a></td>
<td>1-866-433-6041</td>
<td>Authorizations for CT, PET, MRI</td>
</tr>
<tr>
<td>NurseWise</td>
<td>1-866-433-6041</td>
<td>24-hour nurse triage service</td>
</tr>
<tr>
<td>OptiCare Vision</td>
<td>1-866-433-6041</td>
<td>Routine vision services</td>
</tr>
<tr>
<td>PaySpan</td>
<td>1-877-331-7154</td>
<td>835 vendor for EFT/ERA transactions</td>
</tr>
<tr>
<td>Envolve Pharmacy Solutions</td>
<td>1-800-460-8988</td>
<td>Pharmacy Benefit Manager</td>
</tr>
</tbody>
</table>
**AVAILABILITY**

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

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

**ACCESSIBILITY**

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

**24-HOUR ACCESS**

You are responsible to maintain sufficient facilities and personnel to provide covered physician services and ensure services are available as needed 24 hours a day, 365 days a year. An after-hours telephone number must be provided to all members. The after-hours number must connect the member to an answering service, a call center system, a recording that directs the caller to another number to reach you or your authorized medical practitioner or a system that automatically transfers the call to another telephone line that is answered by a person who will contact you.

A hospital may be used for the 24-hour telephone coverage requirement if the 24-hour access is not answered by the emergency department staff. You will establish a communication and reporting system with the hospital and the PCP must review the results of all hospital-authorized services.

ATC will monitor physicians’ offices through scheduled and unscheduled visits and call coverage verification.

**APPOINTMENT ACCESS STANDARDS**

The following schedule should be followed regarding appointment availability:

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine visits with PCP</td>
<td>Within four (4) weeks</td>
</tr>
<tr>
<td>Routine visits with Unique Specialist</td>
<td>Within twelve (12) weeks</td>
</tr>
<tr>
<td>Urgent or non-emergency visits</td>
<td>Within forty-eight (48) hours</td>
</tr>
<tr>
<td>Emergent or emergency visits</td>
<td>Immediately upon presentation at a service delivery site</td>
</tr>
<tr>
<td>Twenty-four (24) hour PCP coverage</td>
<td>24 hours a day, 7 days a week or triage system approved by ATC</td>
</tr>
<tr>
<td>Office wait time for scheduled routine appointments</td>
<td>Not to exceed forty-five (45) minutes</td>
</tr>
</tbody>
</table>
ATC will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement (QI) Program.

**REFERRALS**
A PCP referral is not required for a member to see an ATC network specialist. However, ATC recommends that members always check with their PCP before going to a see a specialist. PCPs should refer members to the appropriate specialist for care.

**MEMBER PANEL CAPACITY**
All PCPs reserve the right to state the number of members they are willing to accept into their panel. ATC **DOES NOT** guarantee that any provider will receive a set number of members. If a PCP wants to make a change to their panel capacity, the PCP must contact the ATC Provider Relations Department at 1-866-433-6041. A PCP shall not refuse to treat members as long as the physician has an open panel status with ATC.

PCPs must notify ATC at least 45 days in advance of an inability to accept additional Medicaid-covered persons under ATC agreements. ATC prohibits all providers from intentionally segregating members from fair treatment and any covered services provided to other non-Medicaid members.

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

**Absolute Total Care**
ATTN: Provider Data Management
1441 Main Street, Suite 900
Columbia, SC 29201

**CHANGING PCP**
**PCP Transfers:**
In order to maintain continuity of care, ATC encourages members to build collaborative relationships with their PCP. Members may request to change their PCP at any time by calling our Member Services Department at 1-866-433-6041, completing the PCP Change Request on our website at absolutetotalcare.com in the Member Portal, or by mailing in the completed PCP Change Form located in the Member To-Do-List booklet. PCP change requests will be processed generally on the same business day or by the next business day. Members will receive a new ID card within fourteen (14) days.

**CONTRACT TERMINATION**
Refer to your ATC contract for specific information about terminating from ATC’s network of providers. The request will be reviewed based on the termination section in your contract agreement. All requests for termination must be in writing and signed on the provider’s letterhead and addressed to:
ADVANCE DIRECTIVES

ATC is committed to a member’s awareness of advance directives and their rights to execute them. ATC is equally committed to ensuring that its PCPs and staff understand and comply with their member responsibilities under federal and state law regarding advance directives.

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

ATC recommends to its PCPs that:

- At the first point of contact with the member, the PCP’s office should ask if the member has executed an advance directive and the member’s response should be documented in the medical record.
- For those members with an executed advance directive during the first point of contact, the PCP’s office should request a copy of the advance directive and document the request and delivery in the member’s medical record.
- An advance directive should be included as a part of the member’s medical record, including mental health directives.
- If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician (if applicable). Discussion should be documented in the medical record.
- If an advance directive has not been executed, the first point of contact within the office should ask the member if they desire more information about advance directives.
- If the member requests further information, member advance directive education/information should be provided.
- Member Services and MemberConnections® representatives will assist members with questions regarding advance directives; however, no employee of ATC may serve as witness to an advance directive, or as a member’s designated agent or representative.

You may obtain a copy online at http://aging.sc.gov/legal/pages/advancedirectives.aspx.
ATC’s QI Department will monitor compliance with this provision during medical record review.
If you have any questions regarding advance directives, contact:

Provider Services Department
Telephone: 1-866-433-6041
Web address: absolutetotalcare.com
PROVIDER ASSISTANCE WITH PUBLIC HEALTH SERVICES

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

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

ADDITIONAL REPORTING REQUIREMENTS

ATC, in accordance with its contract with SCDHHS, must report the existence of certain information regarding its membership. For example, if a member is involved in an accident or becomes injured, this information should be shared with ATC. This includes any incidents that occur prior to a member’s coverage with ATC. To report this type of information, please call our Member Services Department at 1-866-433-6041. Please be prepared to supply as many details as possible including the date and cause of the accident, the injuries sustained by the member and whether or not any legal proceedings have been initiated. In addition, you must immediately report the death of an ATC member.

CULTURAL COMPETENCY OVERVIEW

Cultural competency within the ATC Network is defined as “A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural differences, similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members.”

ATC is committed to the development, strengthening and sustaining of healthy PCP/member relationships. Members are entitled to dignified, appropriate and quality 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.

ATC, as part of the credentialing process, will evaluate the cultural competency level of its PCPs and provide access to training and toolkits to assist PCPs in developing culturally competent and culturally proficient practices.
Network providers must ensure the following:

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

ATC is committed to helping providers develop a culturally competent practice. For information on ATC’s Cultural Competency Plan, please review the Plan on our website at absolutetotalcare.com or you can request a hard copy by calling ATC’s Provider Services Department at 1-866-433-6041.

**PREPARING CULTURAL COMPETENCY DEVELOPMENT**

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. ATC is committed to helping you reach this goal. Take into consideration the following as you provide care to the ATC membership:

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

**MEDICAL RECORDS**

ATC providers must keep accurate and complete medical records. Such records will enable you to render the highest quality healthcare service to members. They will also enable ATC to review the quality and appropriateness of the services rendered. To ensure the member’s privacy, medical records should be kept in a secure location. ATC requires you to maintain all records for members for at least ten (10) years for adult patients and at least thirteen (13) years for minors. See the Member Rights Section of this manual for policies on member access to medical records.
REQUIRED INFORMATION

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member’s participating provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary and emergency care, prepared in accordance with all applicable SCDHHS rules and regulations and signed by the medical professional rendering the services. PCPs must maintain complete medical records for members in accordance with the following standards:

- Patient’s name, Medicaid Identification number and date of birth;
- Personal/biographical data is present (i.e. address, employer, home/work telephone number, sex, age, marital status, next of kin, responsible party (parent or guardian), cultural/linguistic needs, physical impairments, etc.);
- All entries must be legible and dated;
- All entries bear author identification, which may be a handwritten signature, unique electronic identifier or initials. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials;
- Significant illnesses and/or medical conditions are documented on the problem list;
- Medication, allergies and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented. Medication List should include instructions to the member regarding dosage, initial date of prescription and number of refills;
- An up-to-date immunization record is established for pediatric members (under 19 years of age) or an appropriate history is documented in adult members’ charts;
- Evidence that preventive screening and services are offered in accordance with ATC’s practice guidelines;
- Appropriate subjective and objective information pertinent to the member’s presenting complaints is documented in the History and Physical (H + P);
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, surgeries and/or illnesses, discharge summaries, after-hours encounters, and ED encounters and follow-up; for children and adolescents (under 19 years of age), include past medical history relating to prenatal care, birth, any operations and/or childhood illnesses and a complete History and Physical (H + P);
- Working diagnosis is consistent with findings;
- Treatment plan is appropriate for diagnosis;
- Documented treatment prescribed, therapy prescribed and drug(s) administered or dispensed;
- Signed and dated required consent forms;
- Unresolved problems from previous visits are addressed in subsequent visits;
- Laboratory and other studies ordered as appropriate;
• Abnormal lab and imaging study results have explicit notations in the record for follow up plans. All entries should be initialed by the PCP to signify review;

• Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere;

• Health teaching and/or counseling is documented;

• For patients ten years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times, a substance abuse history should be queried);

• Documentation of failure to keep an appointment;

• Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed;

• Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem; and

• Documentation and/or evidence of conversation regarding advance directives, if completed.

MEDICAL RECORDS RELEASE

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

Written authorization is required for the transmission of the medical record information of a current or former ATC member to any provider rendering services to an ATC member.

MEDICAL RECORDS TRANSFER FOR NEW MEMBERS

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

MEDICAL RECORDS AUDITS

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

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, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap or result in illness or infirmity of a member;

• Are provided in the appropriate setting and at the appropriate level of care for the treatment of member’s medical condition; and

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

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

The ATC Medical Management Department hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 6:00 p.m. For PAs during business hours, the provider should contact:

Medical Management/Utilization Management
Telephone: 1- 866-433-6041
Fax: 1-866-912-3606
Web address: absolutetotalcare.com

For after-hours and holidays, please contact 1-866-433-6041 for urgent and emergent access to the Utilization Management Department for clinical determinations.

CLINICAL CRITERIA REQUIREMENTS

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

• Member’s name and ID number;
• Physician’s name and telephone number;
• Facility name, if the request is for an inpatient, Skilled Nursing Facility (SNF), Long Term Care (LTC) facility admission or outpatient services;
• Reason for service – 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;
• Date of service, admission date or proposed surgery date, if the request is for an inpatient admission;
• Requested length of stay, if the request is for an inpatient admission;
• Discharge plans, if the request is for an inpatient admission;
• For obstetrical (OB) admissions, the date and method of delivery, estimated date of confinement and information related to the newborn or neonate;
• Clinical reason for a delivery prior to thirty-nine (39) weeks gestation.
If more information is required, the Medical Management team (Medical Director, RN or LPN) will notify the requestor of the specific information needed to complete the authorization process.

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

Consistent with 42 CFR 438.3(i) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee.

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

**UTILIZATION MANAGEMENT CRITERIA**

ATC has adopted utilization review criteria developed by McKesson InterQual Products. Specialists representing a national panel from community-based and academic practices develop InterQual appropriateness criteria. InterQual criteria cover medical and surgical admissions, outpatient procedures and ancillary services. Additional criteria is established, periodically evaluated and updated with appropriate involvement from physician and other clinical members of the Clinical Policy Committee. InterQual and other clinical criteria is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. **Criteria are used for the approval of medical necessity. When the requested service does not meet medical necessity benefit provisions, protocols or evidence-based medicine, the Medical Director will review and use this information in his or her determination and/or in the rendering of a denial decision. The member, member’s representative or provider may obtain a copy of the actual benefit provision, guideline, protocol or other criterion (on which the denial decision was based) upon request to the Medical Management Department at 1-866-433-6041.**

Practitioners also have the opportunity to discuss any medical UM denial decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. ATC’s Medical Director may be contacted by calling ATC’s main toll-free phone number and asking for the Medical Director. An ATC Care Manager may also coordinate communication between the Medical Director and the requesting practitioner.

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

**Absolute Total Care**  
ATTN: Grievance and Appeals Department  
1441 Main Street, Suite 900  
Columbia, SC 29201  
Telephone: 1-866-433-6041  
Fax: 1-866-918-4457
CONCURRENT REVIEW

The ATC Medical Management Department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital’s Utilization and Discharge Planning Departments and when necessary, the member’s attending physician. An inpatient stay will be reviewed as indicated by the member’s diagnosis and response to treatment. The review will include evaluation of the member’s current status, proposed care plan, discharge plans, and any subsequent diagnostic testing or procedures. All requested clinical information (medical records) is required to be received by the date/time indicated from the concurrent review nurse. Information not received will result in a denial due to ATC’s inability to determine medical necessity.

The ATC Medical Management Department may contact the member’s admitting physician’s office or PCP’s office prior to the discharge date established during the authorization process to check on the member’s progress and to make certain the member receives medically necessary follow up services.

OBSERVATION BED GUIDELINES

In the event that a member’s clinical symptoms do not meet the criteria for an inpatient admission, but the treating physician believes that allowing the member to leave the hospital would likely put the member at serious risk, the member may be admitted to the facility for an observation period. Observation Bed Services are those services furnished on a hospital’s premises, including use of a bed and periodic monitoring by a hospital’s nurse or other staff. Observation admissions must be authorized by ATC’s Utilization Management Department. These services are reasonable and necessary to:

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

An observation may last up to a maximum of 72 hours. In those instances that a member begins their hospitalization in an observation status and the member is changed to an inpatient admission, all incurred observation charges and services will be rolled into the acute reimbursement rate, or as designated by the contractual arrangement with ATC, and cannot be billed separately. It is the responsibility of the hospital to notify ATC of the inpatient admission. Providers should not substitute outpatient observation services for medically appropriate inpatient hospital admissions.

DISCHARGE PLANNING

Discharge planning activities must be initiated upon admission. The ATC Medical Management Department will coordinate the discharge planning efforts with the hospital’s Utilization and Discharge Planning Departments and, when necessary, the member’s attending physician/PCP to ensure that ATC members receive appropriate post-hospital discharge care.

PRIOR AUTHORIZATION

For the most up to date list of services that require authorization, visit our website at absolutetotalcare.com and use our online prior authorization tool. Criterion used in decision-making is available upon request to the provider, member or member’s authorized representative by contacting the Utilization Management Department.
Inpatient:

- All pre-service, non-emergent, non-urgent elective or scheduled inpatient admissions (except for normal newborn deliveries) require the physician’s office to call within ten calendar days prior to the proposed admission date, and the hospital to notify ATC within one business day following the actual date of admission.

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

  2. LTC facility at the skilled or intermediate levels of care (benefit restriction of first 90 days only).

- For all emergent or urgent inpatient admissions: the hospital must notify the Utilization Management Department within one business day following the date of admission; clinical admission information must be provided.

- Newborn deliveries must be called in by the next business day after delivery.

- For all observation stays the hospital must notify the Utilization Management Department within one business day after the date observation status began, and clinical information must be provided.

Services, excluding emergency and urgent care, may require prior authorization at any non-participating, out-of-network or out of state facility, vendor or provider.

Non-Inpatient:

This is not an all-inclusive list. For a complete listing of non-inpatient services requiring prior authorization, please visit the ATC website at absolutetotalcare.com.

Standard Service Authorization – Prior Authorization decisions for non-urgent services shall be made within 14 calendar days of receipt of the request for services. An extension may be granted for an additional 14 calendar days if the member, the member’s authorized representative or the provider requests an extension or if ATC can justify a need for additional information and the extension is in the member’s best interest.

Expedited Service Authorization – In the event the provider indicates, or ATC determines, that following the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function, ATC will make an expedited authorization determination and provide notice within 72 hours of receiving the request. All such requests must be indicated as URGENT when submitting to ATC. An extension may be made for an additional 48 hours if the member, the member’s authorized representative or the provider requests an extension or if, within 24 hours of
receiving the request, ATC justifies a need for additional information and the extension is in the member’s best interest.

**Abortions:**
Abortions are covered according to applicable Federal and State laws and regulations.

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

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

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

The following diagnosis codes are to be used in reporting therapeutic abortions:

- Diagnosis codes in the 635 range should be used ONLY to report therapeutic abortions performed on or before September 30, 2015.

- Diagnosis codes to be used only to report therapeutic abortions performed on or after October 1, 2015 are O04.5; O04.6; O04.7; O04.80; O04.81; O04.82; O04.83; O04.84; O04.85; O04.86; O04.87; O04.88; O04.89; Z33.2.

**Non-Elective Abortions:** All non-elective abortions, including spontaneous, missed, incomplete, septic, hydatidiform mole, etc., require only that the medical record verify such a diagnosis. Legible medical records should be included with all non-elective abortion claims and should include admission history and physical, discharge summary, pathology report, operative report, physician progress notes, etc. unless otherwise noted below.

The following diagnosis codes are to be used in reporting non-elective abortions:

- The appropriate other diagnosis codes (e.g., 630, 631, 632, 634, 636, and 637) should be reported for non-elective abortions on or before September 30, 2015.

For dates of service on or before September 30, 2015, the following diagnosis codes do not require documentation: 630, 631, 632, 656.4(0,1,3), 658.1 (0,1,3), and 658.2 (0,1,3).

- The appropriate other diagnosis codes (e.g., O01.0; O01.1; O01.9 O02.0; O02.1; O02.81; O02.89; O02.9; O03.0; O03.1; O03.2; O03.30; O03.31; O03.32; O03.33; O03.34; O03.35; O03.36; O03.37;
O03.38; O03.39; O03.4; O03.5; O03.6; O03.7; O03.80; O03.81; O03.82; O03.83; O03.84; O03.85; O03.86; O03.87; O03.88; O03.89; O03.9) should be reported for non-elective abortions on or after October 1, 2015.

For dates of service on or after October 1, 2015, the following diagnosis codes do not require documentation: O01.0; O01.1; O01.9 O02.0; O02.1; O02.81; O02.89; O02.9; O36.4XX0, O36.4XX1, O36.4XX2, O36.4XX3, O36.4XX4, O36.4XX5, O36.4XX9, O42.00, O42.019, O42.90, O42.919, O42.011, O42.012, O42.013, O42.02, O42.911, O42.912, O42.913, O42.92, O42.10, O42.111, O42.112, O42.113, O42.119, O42.12.

Hysterectomies:
Medically necessary hysterectomies must meet the following requirements:

a) The member or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.

b) The member or her representative, if any, must sign and date an acknowledgment of receipt of Consent for Sterilization Form (DHHS Form 1723) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

c) The Consent for Sterilization Form is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.

d) The acknowledgment form is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required.

e) Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

f) Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

g) All prior approval requests for hysterectomies must be submitted with the Consent for Sterilization Form for review. There is a 30 day wait period from the date the Consent for Sterilization Form is signed before the surgery is performed. For urgent and emergent hysterectomy cases the 30 day wait is not required, however the reason for the emergency must be provided by the provider.

Sterilizations:
Non-therapeutic sterilization must be documented with a completed Consent for Sterilization Form (DHHS Form 1723), which will satisfy federal and state regulations. Sterilization requirements include the following:
a) Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing.

b) The individual to be sterilized shall give informed consent not less than 30 calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. A new Consent for Sterilization Form is required if 180 calendar days have passed before the surgery is provided.

c) The completed Consent for Sterilization Form cannot be obtained while the patient is in the hospital for labor, childbirth, abortion or under the influence of alcohol or other substances that affects the patient’s state of awareness.

d) The individual to be sterilized is at least 21 years old at the time consent is obtained.

e) The individual to be sterilized is mentally competent.

f) The individual to be sterilized is not institutionalized: i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed.

g) The individual has voluntarily given informed consent on the approved Consent for Sterilization Form (DHHS Form 1723).

Transplant Related Services:
The following services are covered by ATC and require coordination with the ATC Care Manager:

- Corneal transplants
- Pre-transplant services 72 hours prior to pre-admission
- Post-transplant follow-up services
- Post-transplant pharmaceutical services

Providers should contact the ATC Care Management Department at 1-866-433-6041 for assistance with all potential or impending transplant cases. Transplant services covered by ATC will not be reimbursed unless coordinated by the ATC Care Manager.

All other transplant services remain a benefit of the Medicaid Fee-For-Service program.

Developmental Evaluation Services:
Developmental Evaluation Services are defined as medically necessary comprehensive neuro-developmental and psychological developmental, evaluation and treatment services for members between the ages of 0 to 21 years. These members have or are suspected of having a developmental delay, behavioral or learning disability, or other disabling condition. These services are for facilitating correction or amelioration of physical, emotional and/or mental illnesses and other conditions, which if left untreated, would negatively impact the health and quality of life of the member. Contact the ATC Care Management Department to obtain an authorization for referral to developmental evaluation services, and to enroll the member in Special Needs Care Management.

Absolute Total Care - Care Management Department
Telephone: 1-866-433-6041
Fax: 1-866-918-4451
NOTIFICATION OF PREGNANCY

Submit completed Notification of Pregnancy form for expectant mothers within five days of first prenatal visit to notify ATC of the pregnancy, the estimated date of confinement and delivery facility. The form will enroll members into our Start Smart for Your Baby® program. The earliest possible completion of the Notification of Pregnancy form allows ATC to best use our services to keep expectant mothers engaged with their pregnancy, as well as to achieve a healthy pregnancy outcome. The Notice of Pregnancy form can be found at absolutetotalcare.com under the provider manual and forms tab. Fax completed Notification of Pregnancy form to 1-866-681-5125.

Providers can complete the Prenatal Vitamin Program form if they would like expectant mothers to receive a free three months’ supply of prenatal vitamins. The Prenatal Vitamin Program form can be found at absolutetotalcare.com the provider manual and forms tab. Fax completed forms to 1-877-737-9135.

SECOND OPINION

Members, a member’s representative or healthcare professional with member’s consent may request and receive a second opinion from a qualified professional within ATC’s network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Services rendered by out-of-network providers may require PA. For an updated list of those services, visit the ATC website at absolutetotalcare.com and review the online PA tool.

ASSISTANT SURGEON

Reimbursement is provided to assistant surgeons when medically necessary. ATC utilizes guidelines for assistant surgeons as set forth by the American College of Surgeons.

Hospital medical staff by-laws that require an assistant surgeon to be present for a designated procedure is not grounds for reimbursement. Medical staff by-laws alone do not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests an assistant surgeon be present for the surgery. Coverage and subsequent reimbursement for an assistant surgeon’s service is based on the medical necessity of the procedure itself and the assistant surgeon’s presence at the time of the procedure.

CONTINUITY OF CARE

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

CARE MANAGEMENT SERVICES

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

ATC’s Care Manager supports the physician by tracking compliance with the care management plan, and facilitating communication between the member, the member’s managing physician and the Care Manager. The Care Manager also facilitates referrals and linkages to community providers, such as local health departments and school-based clinics. The managing physician maintains responsibility for the patient’s ongoing care needs. The ATC Care Manager will contact the managing physician if the member is not following the plan of care or requires additional services.

ATC will provide individual care management services for members who have high-risk, high-cost, complex or catastrophic conditions. The ATC Care Manager will work with all involved providers to coordinate care, provide referral assistance and other care coordination as required. The ATC Care Manager may also assist with a member’s transition to other care, as indicated, when ATC benefits end.

CARE MANAGEMENT PROCESS

ATC’s care management for high-risk, complex or catastrophic conditions contains the following key elements:

- Screen and identify members who potentially meet the criteria for high-risk care management;
- Assess the member’s risk factors to determine the need for care management;
- Obtain acceptance from the member to participate in care management;
- Notify the member’s PCP of the member’s enrollment in the ATC care management program;
- Develop and implement a treatment plan that accommodates the specific cultural and linguistic needs of the member;
- Establishment of treatment objectives and monitoring of outcomes;
- Refer and assist the member in ensuring timely access to providers;
- Coordinate medical, residential, social and other support services;
- Monitor care/services;
- Revise the treatment plan as necessary;
- Track plan outcomes; and
- Follow-up post discharge from care management.

LEAD CASE MANAGEMENT

ATC will provide case management services to all eligible children with blood lead levels (BLL) > 5 ug/dL. Services will include family education about lead poisoning, referral in obtaining lead abatement, coordination of testing of siblings of those children identified with high blood lead levels, scheduling of appointments and transportation when needed.

In addition, our MemberConnections program provides direct outreach to parents/guardians to educate them on blood lead poisoning.
CHRONIC AND COMPLEX CONDITIONS

ATC provides individual care management services for members who have chronic, complex, high-risk, high-cost or other catastrophic conditions. Members with special healthcare needs are included in the chronic and complex care management care coordination program. The ATC Care Manager will work with all involved providers to coordinate care and provide referral assistance and other support as required. ATC also uses disease management programs and associated practice guidelines and protocols for members with chronic conditions, including conditions such as asthma and diabetes.

Members who qualify for chronic or complex care management services have an ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities. These limitations are expected to last at least 12 months with a resulting functional limitation, reliance on compensatory mechanisms such as medications, special diet or assistive device, and require service use or need beyond that which is normally considered routine.

The ATC Care Manager will coordinate care needs, assist in identifying and obtaining supportive community resources, and arrange for long-term referral services as needed. The Care Manager may identify (and a member may request) a specialist with whom a member with a chronic condition has an ongoing relationship, who may serve as the PCP and coordinate services on the member’s behalf.

Members determined to need a course of treatment or regular care monitoring may have direct access to a specialist as appropriate for the member’s condition and identified needs, such as through a standing referral or an approved number of visits. A member’s PCP will develop a treatment plan with the member’s participation and in consultation with any specialists caring for the member. The ATC Medical Director oversees these processes in accordance with state standards.

ATC encourages all PCPs and physicians to notify ATC Care Management when a member is identified that meets the criteria for a chronic or complex condition.

Care Management Department
Telephone: 1-866-433-6041
Fax: 1-866-918-4451

DISEASE MANAGEMENT PROGRAMS

As a part of the ATC medical management quality improvement efforts, disease management programs are offered to members. Components of the programs available include, but are not limited to:

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

ASTHMA PROGRAM

The Asthma Disease Management Program targets ATC members with asthma who are over-using rescue medications, having repeated visits to the ER or being admitted to the hospital with a primary diagnosis of asthma. Care Managers will contact these members and provide additional education. The Care Manager will coordinate care with the member’s PCP. The goals of this program include increasing positive clinical outcomes for the member and controlling the asthma in order to improve the quality of life for the member.

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

EMERGENCY DEPARTMENT (ED) DIVERSION PROGRAM

The Medical Management Department has developed an Emergency Room (ER) Diversion Program that identifies members who misuse or utilize emergency room services inappropriately. The target population for this program is those individuals who use the ER for treatment of non-emergent medical conditions rather than their PCP or urgent care. The goals and objectives of the ER Diversion Program are:

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

DIABETES PROGRAM

This program targets ATC members who have been diagnosed and treated for diabetes mellitus. Members are then stratified based on the severity of their illness so that interventions can be targeted to the appropriate population. Through this program, ATC members can receive additional education, care management and support from the Medical Management team to enhance positive clinical outcomes.
PERINATAL/HIGH-RISK OBSTETRICAL

Pregnancy, labor and delivery account for a large proportion of care provided to ATC members. Those at high-risk for complications of pregnancy and poor neonatal outcomes are provided care coordination services through our Perinatal Program. The goals of the program are to screen all pregnant members, identify and coordinate care for pregnant members (who are at high-risk for complications of pregnancy) and assure that all members have access to appropriate care for diagnosis, monitoring and treatment of pregnancy. The ATC Perinatal Program nurse must authorize any high-risk ancillary service. Ancillary services include, but are not limited to, home pregnancy monitoring, home infusion therapy, education or testing and the provision of DME. To contact our OB Care Manager, call 1-866-433-6041 or fax 1-866-918-4451.

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

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

PREMATURE DELIVERY PREVENTION

ATC offers assistance with prevention of premature delivery. Use of Makena has shown a substantial reduction in the rate of recurrent pre-term delivery among women who were at a particularly high-risk for pre-term delivery. When a physician determines that a member is a candidate for Makena, the physician writes a prescription for Makena and completes the Universal Makena Form, which includes prenatal history. Because Makena requires prior authorization, the prescription and form are sent to the ATC Care Manager who will check for eligibility. The Care Manager will coordinate ordering and delivery of the prescribed medication directly to the physician’s office or the member’s home if Makena is to be administered in the home. An OB Care Manager will contact the member and perform an assessment regarding compliance. The Care Manager will remain in contact with the member and the prescribing physician during the entire treatment period. A copy of the Universal Makena Form may be found on our website at absolutetotalcare.com.

Other disease/case management programs will be developed based on SCDHHS or as determined through ATC’s analysis of the membership in conjunction with the QIC.

Providers are asked to contact an ATC Care Manager to refer a member identified in need of care coordination intervention:

Care Management Department
Telephone: 1-866-433-6041
Fax: 1-866-918-4451
Web address: absolutetotalcare.com
ATC Preventive and Clinical Practice Guidelines are based on the health needs and opportunities for improvement identified as part of the Quality Assessment and Performance Improvement (QAPI) Program. Whenever possible, ATC adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions. These guidelines have been reviewed by our QIC which includes representation from ATC network physicians. We encourage providers to use these guidelines as a basis for developing a personalized treatment plan for our members and to aid members in making decisions about their healthcare. ATC may measure compliance with these guidelines through monitoring of related HEDIS measures and/or through random ambulatory medical record audits.

ATC utilization management, member education, coverage of services and other areas, which the guidelines apply, are consistent with these guidelines. These guidelines are used for both preventive services as well as for the management of chronic diseases.

Preventive and Chronic Disease Guidelines include, but are not limited to:

**Preventive Guidelines**
- Adult Immunization Schedule 2016
- Adult Preventive Health Guidelines
  - Well-Male Examination
  - Well-Woman Examination
- Blood Lead Screening in Children
- Child Immunization Schedule 0-18 yrs.
- Child Immunization Catch-up Schedule
- Pediatric Well-Child Schedule:
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Prevention and Control of Influenza with Vaccines

**Quick Reference Guidelines Summaries**
- Summary of Recommended Key Clinical Activities for the Diagnosis and Management of Asthma
- Recommended Prenatal and Postpartum Health Care Guidelines
- Physician Guidelines for Routine Antepartum Care
- Guidelines for Preventive Health Maintenance of Sickle Cell Patients
- Reference Card on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7)
Full Clinical Practice Guidelines

- ADHD: Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents
- Guidelines for the Diagnosis and Management of Asthma (EPR-3)
  - Asthma Care Quick Reference: Diagnosing and Managing Asthma
- Practice Guidelines for the Treatment of Patients with Bipolar Disorder
- Diabetic Care: Summary of Revisions for the 2012 Practice Recommendations
- Treatment of Patients with Major Depressive Disorder
- Assessment and Treatment of Children and Adolescents with Depressive Disorders
- The Management of Sickle Cell Disease
  - ACC/AHA Update Guideline for the Management of Heart Failure

Guidelines are reviewed and updated at least every two years or upon significant change. Current preventive and clinical practice guidelines are available on the ATC provider website and may be mailed to practitioners as part of disease management or other quality program initiatives. The guidelines can be found at absolutetatatelcare.com under the Quality Improvement Program section or you may request a hard copy by calling Provider Services Department at 1-866-433-6041.

NEW TECHNOLOGY

ATC evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical and behavioral health care procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the ATC population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

When a request is made for coverage with a new technology, which has not been reviewed by the CPC, the ATC Medical Director will review all information and make a one-time determination within two business days of receipt of all information. This new technology request will then be reviewed at the next regular meeting of the CPC. If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management Department at 1-866-433-6041. The SCDHHS will be notified in writing 30 days following any material change to the Medical Management Program.

SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)

SBIRT is an evidenced-based, integrated and comprehensive approach to the identification, intervention and treatment of substance (drug and alcohol) usage, domestic violence, depression and tobacco use in pregnant women to include 12 months postpartum. This initiative is a collaboration between SCDHHS, ATC (and all SC Medicaid Managed Care plans) and State Agencies to include SC Department of Health and Environmental Control (DHEC) and Department of Alcohol and Other Drug Abuse Substances (DAODAS).
SCREENING is the process of identifying substance use, behavioral health issues and domestic violence in the members using the Universal Screening Tool. The HCPCS code for the screening is H0002 and may be billed once during a fiscal year (July-June). All positive screening should be billed using H0002 with an HD modifier. Physicians and their clinical/social work staff are allowed to perform the Screening, but may only be billed under the physician. Non-clinical staff is not permitted to perform the screening.

BRIEF INTERVENTION is a 5-10 minute session to raise awareness with the member of the risks associated with behaviors. Also, the Brief Intervention should motivate the member to engage in choices that support a healthy pregnancy. The HCPCS code for Brief Intervention is H0004 and may be billed twice per year (July 1st through –June 30th). All brief interventions that result in Referral to Treatment should be billed using H0004 with an HD modifier. Physicians and their clinical/social work staff are allowed to perform the Brief Intervention, but may only be billed under the physician.

REFERRAL to TREATMENT is identifying the risk and the member accepts a referral to an outside agency for assistance to change their behavior.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>H0002</td>
</tr>
<tr>
<td>Positive Screen</td>
<td>H0002 HD modifier</td>
</tr>
<tr>
<td>Brief Intervention</td>
<td>H0004</td>
</tr>
<tr>
<td>Brief Intervention resulting in a Referral</td>
<td>H0004 HD modifier</td>
</tr>
</tbody>
</table>

For more information and details on SBIRT visit absolutetotalcare.com.

**ROUTINE, URGENT AND EMERGENCY CARE SERVICES DEFINED**

Members are encouraged to contact their PCP prior to seeking care, although it is not required in an emergency.

The following are definitions for routine, urgent and emergency services.

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

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

**Emergency** - An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, impairment to bodily functions or dysfunction of any bodily organ or part.
<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine visits with PCP</td>
<td>Within four (4) weeks</td>
</tr>
<tr>
<td>Routine visits with Unique Specialist</td>
<td>Within twelve (12) weeks</td>
</tr>
<tr>
<td>Urgent, non-emergency visits</td>
<td>Within forty-eight (48) hours</td>
</tr>
<tr>
<td>Emergent or emergency visits</td>
<td>Immediately upon presentation at a service delivery site</td>
</tr>
<tr>
<td>Twenty-four (24) hour PCP coverage</td>
<td>24 hours a day, 7 days a week or triage system approved by ATC</td>
</tr>
<tr>
<td>Office wait time for scheduled routine appointments</td>
<td>Not to exceed forty-five (45) minutes</td>
</tr>
<tr>
<td>Walk-in appointments/Non-urgent</td>
<td>Should be seen if possible or scheduled for an appointment</td>
</tr>
<tr>
<td>Walk-in appointments/Urgent</td>
<td>Should be seen within forty-eight (48) hours</td>
</tr>
</tbody>
</table>

Emergency services area covers inpatient and outpatient services that are as follows: (1) furnished by a qualified individual provider, or entity, that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services; and (2) needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

*Emergency Care is not subject to prior authorization or pre-certification. Urgent care provided in an urgent care facility does not require prior authorization. A qualified provider, regardless of network participation, must provide emergency services. The PCP plays a major role in educating ATC members about appropriate and inappropriate use of hospital emergency rooms. The PCP is responsible to follow up on members who receive emergency care from other providers.

In emergency medical conditions the facility should use its best efforts to contact the PCP, or in the case of a pregnant woman, the member’s OB. The facility should document all attempts to contact the PCP or the obstetrician and determinations made on appropriate care. At no time should emergency services be withheld or delayed.

For billing information please refer to the General Billing Guidelines section.

The attending emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

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

The facility should verify member eligibility as soon as possible after the member presents to the ED.
ELIGIBILITY

The State of South Carolina has the sole responsibility for determining eligibility for Medicaid for all coverage groups except for Supplemental Security Income (SSI). The Social Security Administration (SSA) determines eligibility for SSI.

Those eligible persons who are assigned to ATC currently include individuals in the following categories:

- Temporary Assistance for Needy Families (TANF)
- Sixth Omnibus Budget Reconciliation Act (SOBRA) – Pregnant women and children, including presumptive eligibility
- Social Security Income (SSI) without Medicare

VERIFYING ELIGIBILITY

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

Call 1-866-912-3604 to reach the IVR System for quick eligibility verification or check online at www.scdhhs.gov (must have provider login).

Until the actual date of enrollment with ATC, ATC is not financially responsible for services the prospective member receives. In addition, ATC is not financially responsible for services members receive after their coverage has been terminated. ATC is responsible for those individuals who are ATC members at the time of a hospital inpatient admission and change health plans during that confinement.

NEWBORN ENROLLMENT

Newborns of ATC members will be enrolled in ATC for the first 90 calendar days from birth, unless otherwise specified by the mother prior to delivery. The newborn shall continue to be enrolled in ATC unless the mother changes to another health plan during the second or third month of the newborn’s life. If the mother changes to a new health plan, the newborn will be moved to the new plan with the mother unless the mother request the newborn stay on ATC’s plan.
Providers are encouraged to refer the mother to ATC to select a PCP for their newborn. A newborn enrollment packet will be mailed to all ATC expectant mothers. This packet includes information that the newborn will be auto-assigned to ATC and that the mother may select a PCP for her newborn prior to the birth by contacting Member Services. If the mother does not select a PCP after delivery, the mother’s PCP will automatically be assigned to the newborn, unless the PCP is not accepting new members or the provider has age restrictions.

To make a PCP selection for the newborn, members should be referred to:

**Member Services Department**
1-866-433-6041
TTY 711

All providers are also encouraged to direct the mother to her county caseworker to ensure the newborn is officially deemed eligible for the Medicaid program.

Eligibility for newborns – whose mothers are ATC members on the date of delivery – is effective on the date of birth.

Frequently, ATC receives a claim(s) for a newborn prior to the state sending the member’s eligibility information. It is imperative for providers to obtain a newborn’s Medicaid ID number prior to billing for services. Without a member Medicaid number on the claim, the claim will be denied.

The above describes ATC’s general approach and is subject to modification in accordance with SCDHHS policies.

**END STAGE RENAL DISEASE (ESRD)**

ATC follows the policies and procedures for ESRD as outlined in Section Two of the SCDHHS Physicians Provider Manual for program services. ATC will reimburse as the primary sponsor of ESRD services, during the initial 90 day waiting period required by Medicare for eligibility determination. When it has been determined that the member is ineligible for Medicare coverage, ATC will continue to reimburse ESRD services as the primary sponsor.

ATC will not reimburse as primary sponsor for any Medicare-covered services once a determination of Medicare eligibility is received from the Social Security Administration. This would include any services provided after the 90 day waiting period even if the Medicare determination is pending.

The ESRD facility, as the primary provider, is responsible for ensuring a Medicare application is made on behalf of the beneficiary.

We encourage you to complete and submit the CMS form 2728 within the first 30 days of the member’s receipt of dialysis treatments. If a member is denied Medicare coverage, a copy of the Medicare denial letter must be faxed immediately to ATC’s ESRD Program Coordinator at 1-866-912-3606.
ENROLLMENT/MARKETING GUIDELINES

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

Please contact ATC prior to beginning any communications or marketing initiatives.

NON-COMPLIANT MEMBERS

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

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

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

All requests to remove a member from a panel must be made in writing, contain detailed documentation and must be directed to:

Absolute Total Care  
Member Services Department  
Attention: Member Services Manager  
1441 Main Street, Ste. 900  
Columbia, SC 29201

Upon receipt of such request, the Member Services Manager may:

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

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

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

**COVERED SERVICES**

**Ambulance Transportation (Emergency and Non-Emergency)** – ATC will pay for all transportation services provided via ambulance (provider code 82) for **ALL** member ambulance transports for Advanced Life Support (ALS) or Basic Life Support (BLS) – either emergency or non-emergency transports billable by an Ambulance provider as medically necessary. These trips may be routine or non-routine transports to a Medicaid covered service. ATC will provide stretcher trips, as well as air ambulance or medivac transportation.

**After Hours Services (CPT 99050 and 99051)**

99050 - Service provided in the office at times other than regularly scheduled office hours or days when the office is normally closed (i.e. Sundays and Holidays) and may be billed in addition to other services.

99051 - Service provided in the office during regularly scheduled evening, weekend or holiday office hours and may be billed in addition to other services.

**THE ABOVE CODES MAY ONLY BE BILLED BY PCPs** (defined as Pediatricians or Family Practice, General Practice, Internal Medicine or OB/GYN Specialists).

**Audiological Services** – ATC will pay for audiological services including diagnostic, screening, preventive and/or corrective services provided to individuals with hearing disorders or for the purpose of determining the existence of a hearing disorder by or under the direction of an Audiologist. A physician or other Licensed Practitioner of the Healing Arts (LPHA), within the scope of his or her practice under state law, must refer individuals to receive these services. Audiological services involve testing and evaluation of hearing-impaired children ages 20 and younger who may or may not be improved with medication or surgical treatment. This includes services related to hearing aid use. Limits: covered for ages 20 years old and younger.

**Care Management** – This service is available to non-institutionalized individuals with mental retardation/developmental disability, emotionally disturbed children, certain pregnant women and other targeted groups with complex medical conditions. Members with medical conditions such as ESRD, HIV/AIDS, metastatic cancers, progressive degenerative disorders, other catastrophic illness and injuries and transplant recipients that require pre- and post-transplant care coordination are evaluated for case management. Case Management services are defined as those services necessary to coordinate an optimum lifestyle for the targeted population. The services include:

- Monitoring the patient’s needs
- Working collaboratively with the affected member’s PCP or other health care providers to coordinate medical needs
- Referral process to providers for medical, educational, legal and rehabilitative services, with documented follow-up

Care Management will assist in self-sufficiency of the member and act as a deterrent to institutional care by facilitating service delivery. The Care Manager will deliver no counseling services.
Chiropractic Services – Chiropractic services are available to all recipients. Chiropractic services are limited to manual manipulation of the spine to correct a subluxation. Chiropractic visits are counted separately from the ambulatory visit limit. ATC’s Chiropractic Network is Health Network Solutions (HNS). An HNS provider must render all chiropractic services. This service has a limit of six visits per year per year (July 1st through June 30th).

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

Durable Medical Equipment and Orthotics and Prosthetics – Durable medical equipment (DME) provides therapeutic benefits or enables a recipient to perform certain tasks that the member would be unable to undertake otherwise due to certain medical conditions and/or illnesses. Durable medical equipment can withstand repeated use and is primarily and customarily used for medical reasons and is appropriate and suitable for use in the home. Included are medical supply products, surgical supplies, traction equipment, walkers, canes, crutches, kidney machines, ventilators, oxygen and other items when ordered by a physician as medically necessary in the treatment of a specific medical condition. The attending physician has the responsibility of determining the type or model of equipment and length of time the equipment is needed through a written necessity statement. Approval for ATC coverage of products requiring prior authorization is patient-specific and is determined according to certain established criteria. Luxury and deluxe models are restricted if standard models would be appropriate. Repairs to medical equipment are covered if reasonable.

ATC follows SCDHHS DME rental guidelines. Prior authorization may be required for some durable medical equipment.

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

- Most parenteral infusion pumps are capped rental items except nutrition infusion pumps with or without alarm, stationary and portable parenteral nutrition infusion pumps, ambulatory infusion pumps and stationary parenteral infusion pumps. These items are not considered purchased after the tenth month of rental and can continue to be rented.

- Limited rental equipment has a limited rental period and cannot be rented over ten months. Some examples of limited rental equipment include powered air overlay mattresses, power pressure-reducing air mattresses and negative pressure wound therapy electrical pumps.

- Maintenance of rented equipment is not covered by ATC. Parts and supplies used in the maintenance of rented equipment are included in the rental payment of the equipment.

ATC also covers certain prosthetic and orthotic devices when ordered by a physician and determined to be medically necessary. ATC only covers hearing aids and hearing aid accessories for members age 20 and younger with a prior authorization. For a complete list of covered codes that may be rendered by physician offices, visit absolutetotalcare.com and use the online Prior Authorization tool.
Covered services by provider type are determined by SCDHHS fee schedules. You will receive a notification of non-benefit if the CPT or HCPCS code you are billing is not listed on the fee schedule for your provider type. Please contact ATC at 1-866-433-6041 if you have any questions.

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program** – This program provides free medical check-ups for all Medicaid eligible members through the month of their 21st birthday and treatment for medical problems. It is designed to be a preventive program.

**Family Planning Services** – This program provides counseling, diagnosis, treatment and birth control drugs and supplies to help prevent unplanned and unintended pregnancy.

All Family Planning Services should be provided on a voluntary and confidential basis to all members, including those that are less than 18 years of age.

Covered services prescribed and furnished by physicians, hospitals, clinics and pharmacies include:

- Examinations
- Assessments
- Diagnostic procedures
- Health Education and counseling services related to alternative birth control and prevention
- Traditional contraceptive drugs and supplies
- Preventive contraceptive methods

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

**Federally Qualified Health Center (FQHC)** – Healthcare services furnished by FQHCs are cost-based reimbursed through encounter codes at an all-inclusive rate that reflects the cost of services.

**Home Health Services** – These services cannot be restricted to a requirement that the individual be homebound. The use of a homebound requirement under the Medicaid Home Health benefit violates Federal regulatory requirements at 42 CFR Section 440.230(c) and Section 440.240(b). Home Health services cannot otherwise be restricted to services furnished in the home itself. A Medicaid Home Health beneficiary can receive home health services in the beneficiary’s place of residence, a doctor’s office, outpatient clinic, an adult day center, or in another type of outpatient facility, not including a hospital or skilled nursing facility. These services include skilled nursing, home health aide, physical, occupational and speech therapy services and physician ordered supplies. These services have a limitation of 50 visits per member per year (July 1st through June 30th). Prior authorization is required.

**Inpatient Hospital Services** – ATC will pay for medically necessary inpatient hospital care. Medicaid will pay for a semi-private room only, unless it is medically necessary to have a private room. The need for this care must be medically necessary and is reviewed by the Utilization Management Department throughout the admission for appropriate level of care. Prior authorization is required.
Inpatient Physician Visits – ATC will also pay for a physician to visit patients in the hospital. If the patient must be seen by more than one physician while in the hospital, ATC will pay for those visits.

Institutional Long-Term Care Facilities – ATC covers first 90 days of confinement in a long-term care facility only when the CLTC certification (Form 185) has been completed by SCDHHS prior to admission, a level of care determination is indicated on the form and the completed form is provided to ATC. Services include nursing facility and rehabilitative services at the skilled or intermediary level of care. After the first 90 days, the State Medicaid Program will reimburse institutional long-term care services as FFS. Prior authorization is required.

Laboratory and X-ray – ATC will pay for laboratory tests in a physician’s office that are on the STAT lab list below. Quest Laboratory, Laboratory Corporation of America (LabCorp) and in-network local and regional laboratories are our preferred clinical laboratories. ATC will also pay for X-ray services ordered by a physician that are medically necessary. CT, PET and MRI will require prior authorization through National Imaging Associates (NIA) and can be reached by calling 1-866-433-6041.

<table>
<thead>
<tr>
<th>ATC STAT LAB Listing Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36415</td>
<td>COLLECTION VENOUS BLD VENIPUNCTURE</td>
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<tr>
<td>36592</td>
<td>COLLECT BLOOD FROM PICC</td>
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<tr>
<td>81000</td>
<td>UA DIP STICK/TABLET REAGENT; NON-AUTO W/MICRO</td>
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<tr>
<td>81001</td>
<td>UA DIP STICK/TABLET REAGENT; AUTO W/MICRO</td>
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<tr>
<td>81002</td>
<td>UA DIP STICK/TABLET REAGENT; WO MICRO NON-AUTO</td>
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<tr>
<td>81003</td>
<td>UA DIP STICK/TABLET REAGENT; WO MICRO AUTO</td>
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<tr>
<td>81015</td>
<td>UA; MICRO ONLY</td>
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<tr>
<td>81025</td>
<td>URIN PG TEST BY VISUAL COLOR COMPAR METHD</td>
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<tr>
<td>82043</td>
<td>ALBUMIN; URIN MICROALBUMIN QUAN</td>
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<tr>
<td>82044</td>
<td>ALBUMIN; URIN MICROALBUMIN SEMIQUAN</td>
</tr>
<tr>
<td>82247</td>
<td>BILIRUBIN; TOT</td>
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<tr>
<td>82270</td>
<td>BLD OCCULT; FECES 1-3 SIMULTANEOUS DETERM</td>
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<td>82465</td>
<td>CHOL SERUM TOT</td>
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<td>82951</td>
<td>GLU; TOLERANCE TEST 3 SPECMN</td>
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<td>82952</td>
<td>GLU; TOLERANCE TEST EA ADD BEYOND 3 SPECMN</td>
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<tr>
<td>82962</td>
<td>GLU BLD MONITOR CLEARED-FDA-HOME USE</td>
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<tr>
<td>83036</td>
<td>HGB; GLYCATED</td>
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<tr>
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<td>HGB; PLASMA</td>
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<td>83880</td>
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<td>83986</td>
<td>PH BODY FLUID EX BLD</td>
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<tr>
<td>85009</td>
<td>BLD CNT; MNL DIFF WBC CNT BUFFY COAT</td>
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<tr>
<td>85013</td>
<td>BLD CT; SPUN MICROHEMATOCRIT</td>
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<tr>
<td>85014</td>
<td>BLOOD COUNT; HEMATOCRIT</td>
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<td>BLOOD COUNT; HEMOGLOBIN</td>
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<td>BLD CNT; CMPL AUTO&amp;AUTO DIFF WBC CNT</td>
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<td>BLOOD COUNT; COMPLETE AUTOMATIC</td>
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<td>85041</td>
<td>BLOOD COUNT; RBC AUTOMATED</td>
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<td>BLOOD COUNT; LEUKOCYTE AUTO</td>
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<td>85049</td>
<td>BLOOD COUNT; PLATELET AUTOMATED</td>
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<td>85610</td>
<td>PROTHROMBIN TIME</td>
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<td>86308</td>
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<td>86580</td>
<td>SKIN TEST; TUBERCULOSIS INTRADERMAL</td>
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<td>ANY OTHER SOURCE EXC URINE, BLD OR ST</td>
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<td>87210</td>
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<td>87420</td>
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<tr>
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<td>INFEC AGT-DNA/RNA; CHLAMYDIA TRACHOMATIS-AMPLI</td>
</tr>
<tr>
<td>87590</td>
<td>INFEC AGT-DNA/RNA; NEISSERIA GONORRHEA-DIR PROBE</td>
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<tr>
<td>87591</td>
<td>INFEC AGT-DNA/RNA; NEISSERIA GONORRHEA-AMPL PROB</td>
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<tr>
<td>87650</td>
<td>INFEC AGT-DNA/RNA; STREP GROUP A-DIRECT PROBE</td>
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<td>87804</td>
<td>INFLUENZA IMMUNOASSAY DETECTION WITH OPTIC</td>
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<tr>
<td>87807</td>
<td>INF AGT ANTIG DETCT IMMUNOASSY DIR OPTICL OBS; RSV</td>
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<td>87808</td>
<td>TRICHOMONAS VAGINALIS</td>
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<td>87880</td>
<td>INFEC AGT-IMMUNOASSAY W/DIR OBSERV; STREP GRP A</td>
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<td>Q0091</td>
<td>SCREEN PAP SMEAR OBTAIN PREP CONVEY TO LAB</td>
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<tr>
<td>Q0111</td>
<td>WET MOUNTS INCL PREP VAG/CERV/SKIN SPECMN</td>
</tr>
<tr>
<td>Q0112</td>
<td>ALL POTASSIUM HYDROXIDE PREP</td>
</tr>
</tbody>
</table>

Outpatient Hospital Services – ATC will pay for medically necessary outpatient hospital visits.

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

Podiatry Services – Children may receive podiatry care from an in-network PCP or a podiatrist. Limits: covered for member’s ages 20 years old and younger. Diabetic members who are age 22 or older will be allowed to receive their annual foot exams from a podiatrist.

Rehabilitative Therapy Services for Members with Special Needs (non-hospital based) – These services are available to members age 20 and younger with special needs (e.g. sensory impairments, mental retardation, physical disabilities, developmental disabilities and delays, etc.) and to members of any age who are enrolled in the Mental Retardation/Related Disabilities Waiver and the Head and Spinal Cord Injury Waiver. For services to be covered, the member must have an Individualized Family Service Plan (IFSP), an Individualized Education Plan (IEP) or a valid treatment plan; and be referred by either the South Carolina Department of Disabilities and Special Needs, the South Carolina Department of Health and Environmental Control (SCDHEC), the South Carolina School for the Deaf and the Blind or a local Education Agency (School District). Frequency limits: combined total of 105 hours (420 units) per year (July 1st through June 30th). Prior authorization is required.

Rural Health Clinic Services (RHC) – Healthcare services furnished by Rural Health Clinics are cost-based reimbursed through encounter codes at an all-inclusive rate that reflects the cost of the services (up to the current year's Medicaid CAP).

Therapy - Therapy can be provided in the following situations as ordered by a physician:

- In a long-term care facility (payment is included in the Medicaid payment to the long-term care facility, inpatient only)
- As a Home Health Service
- As an inpatient in a hospital, which has a certified therapy department, and therapy may be continued at the hospital as an outpatient if ordered by the doctor
• Therapy may be continued at the hospital as an outpatient if ordered by a doctor and the member is age 20 and younger

• By an independent therapist for members age 20 and younger

• When prior approved by a sponsoring agency, such as the Department of Education, DHEC, etc.

Covered Therapy Services for Members over Age 20 – If members are over 20 years old and NOT on a FFS waiver, reimbursement is allowed for physical, occupational and speech therapies performed under the following guidelines. The member’s record must substantiate at least ONE of the following requirements for therapy:

• The attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay and therapy continues on an outpatient basis until that plan of treatment is concluded

• The attending physician prescribes therapy as a direct result of outpatient surgery

• The attending physician prescribes therapy to avoid an inpatient hospital admission

Vision Care – Adult vision is not covered by ATC. Members who are age 20 and younger are covered for one vision test during any 12 month period, eyewear repairs as needed and/or one eyewear replacement within a 12 consecutive month period.

If you have any questions about these services or additional benefits, please contact:

Absolute Total Care
Provider Services
1-866-433-6041

MENTAL HEALTH, ALCOHOL AND OTHER DRUG ABUSE

Developmental Evaluation and Testing Services
ATC is responsible for reviewing, authorizing and reimbursing for certain Developmental Evaluation Services (DES). These are medically necessary, comprehensive, neurodevelopmental and psychological developmental, evaluation and treatment services for members between the ages of 0 to 21 years. These members have or are suspected of having a developmental delay, behavioral or learning disability, or other disabling condition. Developmental Evaluation Services are provided only at the Developmental Evaluation Centers located: (1) Within the Department of Pediatrics at the Greenville Hospital, Greenville; (2) The University School of Medicine, USC, Columbia; or, (3) The Medical University of South Carolina, Charleston.

Mental/Behavioral Health Initial Evaluation and Management
Medical doctors and private psychiatrists may bill 90801 and 90802 in office services to ATC. A maximum of one psychiatric assessment every six months is allowed for adult and child members.

Mental/Behavioral Health Services
All inpatient and outpatient behavioral health services including South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) and Rehabilitative Behavioral Health Services (RBHS), are authorized and provided by ATC via Cenpatico Behavioral Health. Call 1-866-534-5976 for information on how to obtain prior authorization for these services.
Psychiatric Services
Psychiatric services to include assessment, treatment plan development and modification, and therapy services are covered services for all members.

SERVICES NOT COVERED BY ATC
Some services are not covered by ATC. These services include:

- Abortions (elective) except in the case of rape, incest or when medically necessary to save the mother’s life (must have supporting SCDHHS Abortion Statement Form signed by physician and medical documentation)
- Acne treatment for members who are 19 years of age and older
- Acupuncture & biofeedback services
- Care for the treatment of obesity unless medically necessary
- Care provided by any provider, when the insured has other primary coverage at the time of the episode of care
- Care or supplies that are not medically necessary
- Comfort items in the hospital (for example, TV or phone)
- CLTC Waiver Home and Community Based Services (covered by Medicaid Fee-for-Service)
- Cosmetic surgery/procedures
- Court ordered testing
- Dental services (covered by Medicaid Fee-for-Service/DentaQuest)
- Experimental care, such as drugs and supplies, not covered by Medicaid
- Experimental or investigational procedures, technologies or supplies
- Hospice care covered by Medicaid Fee-for-Service
- Infertility services
- Transplants, except corneal, covered by Medicaid Fee-for-Service
- Paternity testing
- Reversal of sterilization services
- Routine adult vision services and hardware
- Services to find cause of death
- Sex therapy or marriage therapy
• Shots to travel outside of the country

• Sterilization of a person who is age 21 years or younger, mentally incompetent or institutionalized

OUT-OF-NETWORK SERVICES AND PROVIDERS

ATC realizes that there may be times when a member needs care from a provider who is not in the ATC network. ATC will approve medical services to an out-of-network provider if these services: (1) are not available by an in-network provider; (2) can't be provided in-network in a timely manner; and (3) are medically necessary, as determined by the member's physician and ATC. (Prior authorization may be required based on service).

VALUE ADDED BENEFITS FOR ATC MEMBERS

ATC has developed a package of Value Added Services for its members that includes benefits in addition to the SCDHHS Covered Services. The Value Added Services were designed to improve members' well-being, encourage responsible and prudent use of healthcare benefits and enhance the cost effectiveness of the South Carolina Medicaid Program.

NURSEWISE®

Our members have many questions about their health, PCP and access to emergency care. ATC offers a nurse line service to encourage members to talk with their PCP and to promote education and preventive care.

NurseWise is our 24-hour nurse line for members. Our registered nurses provide basic health education, nurse triage and answer questions about urgent or emergency access. The nurses often answers questions about pregnancy and newborn care. In addition, members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use NurseWise to request information about providers and services available in your community after ATC’s hours and on holidays. PCPs can utilize NurseWise to verify eligibility any time of the day. The NurseWise staff is conversant in both English and Spanish and can offer the Language Line for additional translation services. Each nurse documents their calls in a web-based data system using Barton Schmitt, M.D. triage protocols for pediatrics and McKesson proprietary products to perform triage services for adults. These protocols are widely used in nurse call centers and have been reviewed and approved by physicians from around the country.

We provide this service to support your practice and offer access to a Registered Nurse (RN) for our members every day. If you have any additional questions, please call Provider Services or NurseWise at 1-866-433-6041.

START SMART FOR YOUR BABY®

Start Smart for Your Baby (Start Smart) is ATC’s special program for women who are pregnant. This program provides educational materials that tackle the most critical issues affecting the child’s development during pregnancy. Start Smart offers a preventive approach that encourages prenatal education for the expectant mother in an effort to achieve the best possible outcome. Start Smart encourages pregnant women to keep their prenatal care appointments, educates members and their families about pregnancy, identifies members who may be at high risk for developing complications,
and provides support in dealing with medical, socioeconomic and environmental issues that may contribute to complications or inhibit a member’s ability to receive optimal healthcare.

Identifying pregnant members as early as possible, providing them with adequate prenatal care and guidance, as well as addressing complications as effectively as possible should result in improved outcomes for both the mother and the newborn baby.

**CENTACCOUNT® REWARDS PROGRAM**

ATC will provide expanded services to gain and retain members through the use of the CentAccount Program to reward the healthy behaviors of our members.

This program will operate in a fashion similar to a health reimbursement account (HRA). When a member performs any of the designated activities, ATC will deposit a set amount of dollars into their rewards account. The ATC member will be able to utilize the money in their HRA account for variety of health related items, including but not limited to:

- Over-the-counter medications
- Baby care items
- Personal care items
- Products for smoking cessation

ATC will target and reward the following healthy behaviors, including but not limited to:

- Annual well-visits with PCP
- Routine prenatal and postpartum visits
- Completion of health risk screening
- EPSDT well-visits for members through the month of their 21st birthday

**NON-EMERGENCY TRANSPORTATION SERVICES**

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

South Carolina Medicaid Transportation program provides non-emergency transportation for members through LogistiCare. If a member needs to schedule a ride for non-emergency reasons, the member should call the call the LogistiCare reservation line for the region that the member’s county is located in. Regions and phone numbers can be found https://memberinfo.logisticare.com/scmember and in the ATC Member Handbook. They will schedule the ride for the member. The member may also call the Member Services Department at 1-866-433-6041 if they are having difficulty scheduling a ride for a medical appointment. Member Services will assist the member in contacting the transportation broker to arrange transportation.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
<th>Limits</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion – Elective</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abortion – Medically Necessary</td>
<td>Covered</td>
<td>Prior authorization, completed SCDHHS Abortion Statement and medical records are required. Submit Abortion Statement and medical records with claim.</td>
<td></td>
</tr>
<tr>
<td>Acne</td>
<td>Covered</td>
<td>Ages 18 and younger. Limits apply.</td>
<td></td>
</tr>
<tr>
<td>Acupuncture &amp; Biofeedback Service</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance – Emergency and Non-Emergency</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiology Services</td>
<td>Covered</td>
<td>Ages 20 and younger.</td>
<td></td>
</tr>
<tr>
<td>Bariatric Surgery – Surgery for Morbid Obesity</td>
<td>Covered</td>
<td>Only if medically necessary.</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health including screenings (inpatient)</td>
<td>Covered</td>
<td>Prior authorization required through ATC’s Behavioral Health Vendor – Cenpatico.</td>
<td>$25.00</td>
</tr>
<tr>
<td>Behavioral Health &amp; Alcohol, Drug and Substance Abuse (outpatient)</td>
<td>Covered</td>
<td>1 evaluation every 6 months using CPT 99801 and 99802.</td>
<td>$3.40</td>
</tr>
<tr>
<td>Biopharmaceuticals (specialty injectables)</td>
<td>Covered</td>
<td>Prior authorization required.</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Covered</td>
<td>1 per day/6 per year.</td>
<td></td>
</tr>
<tr>
<td>Circumcision</td>
<td>Covered</td>
<td>Covered during the initial newborn stay and up to 180 days after delivery in the office setting. Otherwise prior authorization required.</td>
<td></td>
</tr>
<tr>
<td>Clinic Visits</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatology Services</td>
<td>Covered</td>
<td>Cosmetic is not covered.</td>
<td></td>
</tr>
<tr>
<td>Dental Services</td>
<td>Covered</td>
<td>Covered by SCDHHS/DentaQuest.</td>
<td></td>
</tr>
<tr>
<td>Developmental Evaluation Services</td>
<td>Covered</td>
<td>Covered for members between the ages of 0 and 21.</td>
<td></td>
</tr>
<tr>
<td>Diabetic Shoes</td>
<td>Covered</td>
<td>1 pair per year (3 inserts per year).</td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Coverage</td>
<td>Limits</td>
<td>Copay</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Covered</td>
<td>Prior authorization may be required.</td>
<td></td>
</tr>
<tr>
<td>Diabetic Education</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Covered</td>
<td>Prior authorization may be required for some equipment.</td>
<td></td>
</tr>
<tr>
<td>Emergency Care (in-network and out-of-network)</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Transportation</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enteral/Parenteral Nutrition Therapy</td>
<td>Covered</td>
<td>If provided via tube and sole source of nutrition.</td>
<td></td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Covered</td>
<td>Self-referrals; in- and out-of network providers covered by ATC.</td>
<td></td>
</tr>
<tr>
<td>Fluoride Rinse/Varnish</td>
<td>Covered</td>
<td>As a part of EPSDT only.</td>
<td></td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>Covered</td>
<td>Prior authorization required.</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered</td>
<td>50 visits per year (July 1st – June 30th).</td>
<td></td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Covered</td>
<td>Prior approval may be required for certain medications.</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered by SCDHHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>Covered</td>
<td>Prior authorization and completed Consent for Sterilization form (SCDHHS Form 1723) required. Submit completed SCDHHS Form 1723 with claim.</td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infusion Centers</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Medical/Surgical &amp; Maternity Services</td>
<td>Covered</td>
<td>Prior authorization required. $25.00</td>
<td>$25.00</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Services</td>
<td>Covered</td>
<td>Prior authorization required.</td>
<td>$25.00</td>
</tr>
<tr>
<td>Insulin Pumps</td>
<td>Covered</td>
<td>Prior authorization required. Not covered for Type II diabetics</td>
<td></td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care Facility</td>
<td>Covered</td>
<td>Prior authorization required. Form 185 (CLTC) must be completed by SCDHHS prior to LTC facility admission. ATC covers first 90 days only.</td>
<td></td>
</tr>
<tr>
<td>Medical Transportation</td>
<td>Covered by SCDHHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Coverage</td>
<td>Limits</td>
<td>Copay</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Non-participating Providers</td>
<td>Covered</td>
<td>Must be medically necessary and service not available in network.</td>
<td>Varies</td>
</tr>
<tr>
<td>OB Ultrasounds</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits (PCP/Specialists) (Well &amp; Sick Visits)</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>Covered</td>
<td>Prior Authorization may be required, see website.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery; Ambulatory Surgical Centers</td>
<td>Covered</td>
<td>Prior authorization may be required.</td>
<td>$3.40</td>
</tr>
<tr>
<td>Pain Management Services</td>
<td>Covered</td>
<td>Ages 21 and younger may have services performed by PCP/Podiatrist. Ages 22 and older must be diabetic to receive.</td>
<td></td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power Wheelchairs</td>
<td>Covered</td>
<td>Every 7 years; limited accessories covered. Prior authorization required.</td>
<td></td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Covered</td>
<td>4 prescriptions per month; 3 additional if medically necessary; unlimited for age 20 and younger.</td>
<td>$3.40 begins at age 19 and over. $0 copay for select medications on the PDL for asthma, COPD and diabetes.</td>
</tr>
<tr>
<td>Preventive and Rehabilitative Services for Primary Care Enhancements (adults &amp; children)</td>
<td>Covered</td>
<td>Combined total of 105 hours (420 units) per year (July 1st – June 30th).</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reversal of Sterilization</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation Products</td>
<td>Covered</td>
<td>Quantity per PDL.</td>
<td></td>
</tr>
<tr>
<td>Sterilization</td>
<td>Covered</td>
<td>Consent for Sterilization form (SCDHHS Form 1723) required; submit completed form with claim. Prior authorization is not required.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative Therapies for Children Non-Hospital Based</td>
<td>Covered</td>
<td>Children ages 20 and younger get 105 hours or 420 units per year (July 1st – June 30th)</td>
<td></td>
</tr>
</tbody>
</table>
### Benefits Coverage Limits Copay

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
<th>Limits</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
<td>Covered</td>
<td>Corneal transplants are covered. Pre- and post-transplant services are covered for other transplants when coordinated by ATC and covered by Medicaid Fee-for-Service.</td>
<td></td>
</tr>
<tr>
<td>Vaccines/Immunizations (adult)</td>
<td>Covered</td>
<td>Only if medically necessary.</td>
<td></td>
</tr>
<tr>
<td>Vaccines/Immunizations (children)</td>
<td>Covered</td>
<td>Ages 21 and younger.</td>
<td></td>
</tr>
<tr>
<td>Vision – Routine Screening (children)</td>
<td>Covered</td>
<td>Ages 20 and younger. 1 pair of glasses every 12 months. 1 replacement set every 12 months.</td>
<td></td>
</tr>
<tr>
<td>X-Ray/Radiology Services</td>
<td>Covered</td>
<td>Prior authorization may be required for some services.</td>
<td></td>
</tr>
</tbody>
</table>

**ATC Member Exempt from Copayments:**
- From birth to the date of their 19th birthday
- Living in long-term care facilities
- During pregnancy

**SOUTH CAROLINA EPSDT SERVICES AND STANDARDS**

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, is a program of comprehensive preventive health services available to ATC recipients through the month of their 21st birthday. The program is designed to maintain health by providing early intervention to discover and treat health problems. EPSDT is a preventive program that combines diagnostic screening and medically necessary follow-up care for dental, vision and hearing examinations for eligible members.

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

Standards for proving EPSDT services are described and are included in the SCDHHS MCO Policies and Procedures Manual.

**PCPs are required to perform EPSDT medical check-ups in their entirety and at the required intervals.** All components of exams must be documented and included in the medical record of each EPSDT eligible member. Initial well-child exams are to be completed within 90 days of the initial effective date of membership and within 24 hours of birth for all newborns.
The components of these visits are as follows:

- **Comprehensive health and developmental history** – Including assessment of both physical and mental health development;

- **Comprehensive unclothed physical exam**;

- **Appropriate immunizations** – According to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines;

- **Blood Lead Screening** - for children from the ages of nine months through 72 months. A Lead Screening Questionnaire should be completed at the time of each routine office visit for children in this age group. All children are considered at risk and must be screened for lead poisoning. The Centers for Medicaid & Medicare Services (CMS) requires that all children receive a screening blood lead test at 12 and 24 months of age. Children between the ages of 36 and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children, A blood lead test result equal to or greater than 5ug/dl obtained by capillary specimen must be confirmed using a venous blood sample;

- **Anemia Screening and Laboratory Tests** – as indicated, as well as is appropriate for age and risk factors-- (including a hemocrit or hemoglobin test performed between six and nine months of age and at least once during adolescence for menstruating females); Blood Pressure - Blood pressure should be measured on children ages three and over at each screening;

- **Anticipatory Guidance/Health Education** – Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms for the child’s development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention;

- **Vision Screening** – Vision should be assessed at each screening. In infants, the history and subjective findings of the ability to regard and reach for objects, the ability to demonstrate an appropriate social smile and to have age appropriate interaction with the examiner is sufficient. At ages four (4) and older, objective measurement using the age appropriate Snellen chart, Goodlite Test or Titmus Test should be done and recorded. If needed, a referral should be made to an ophthalmologist or optometrist;

- **Dental Screening** – A general assessment of the dental condition (teeth and/or gums) is obtained on all children, including fluoride treatments. Children with their first tooth eruption and age two and older should be referred to a dentist;

- **Topical Fluoride Varnish** – The best practices of the American Academy of Pediatrics recommend that children up to three years old who are at high risk for dental caries should receive fluoride varnish application in their primary care physician’s office during their EPSDT visit two times per year (once every six months) and in their dental home two times per year.
(once every six months). The American Dental Association has established a new Current Dental Terminology (CDT) procedure code, D1206, for the application of topical fluoride varnish. The primary care physician will bill this procedure to ATC on the CMS-1500 claim form.

- **Hearing Screening** – A hearing test is required appropriate to the child’s age and educational level. For the child under age four (4), hearing is determined by whatever method is normally used by a provider, including, but not limited to, a hearing kit. For the child over age four, an audiometer, if available, is recommended. If needed, an appropriate referral should be made to a specialist. It is recommended that high-risk neonates be evaluated with objective measures, such as brain stem evoked response testing, prior to discharge from the hospital nursery;

- **Other Necessary Healthcare** – States must provide other necessary healthcare, diagnosis services, treatment and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services;

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

<table>
<thead>
<tr>
<th>Infancy</th>
<th>Early Childhood</th>
<th>Late Childhood &amp; Adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>12 months</td>
<td>Ages 5 years and up through the month of the child’s 21st birthday – every year</td>
</tr>
<tr>
<td>3-5 days</td>
<td>15 months</td>
<td></td>
</tr>
<tr>
<td>One month</td>
<td>18 months</td>
<td></td>
</tr>
<tr>
<td>Two months</td>
<td>24 months</td>
<td></td>
</tr>
<tr>
<td>Four months</td>
<td>30 months</td>
<td></td>
</tr>
<tr>
<td>Six months</td>
<td>3 years</td>
<td></td>
</tr>
<tr>
<td>Nine months</td>
<td>4 years</td>
<td></td>
</tr>
</tbody>
</table>

Neonatal exam (identified from hospital claim and not billable as an EPSDT screening)

Preventive health is a major principal on which managed care organizations are based, measured and held accountable. ATC supports its contracted PCPs to encourage their ATC members to participate in the State of South Carolina preventive care program, EPSDT. ATC will send reminders of the need for a well-child examination to all EPSDT eligible members. A copy of ATC’s EPSDT Program Description can be found at absolutetotalcare.com in the Provider Manuals and Forms section.

**IMMUNIZATIONS**

Children must be immunized during medical check-ups according to the current Advisory Committee for Immunization Practices (ACIP) Schedule.

ATC encourages all members who are age 18 or younger to be immunized by their PCP unless medically contraindicated or against parental religious beliefs. Providers shall report all immunizations to the State Immunization Information System (SIIS) administered by SCDHEC.
Since immunizations are a required component of EPSDT screening services, an assessment of the child’s immunization status should be made at each screening and immunizations administered as appropriate. If the child is due for an immunization, it must be administered at the time of the screening. However, if illness precludes immunization, the reason for delay should be documented in the child’s record. An appointment should be given to return for administration of immunization at a later date.

PCPs should participate with the Vaccines for Children Program (VFC). If a provider does not routinely administer immunizations as part of their practice, they should refer the child to the county health department, but must maintain a current record of the child’s immunization status.

For PCPs, providing immunizations to our members is one of the most important services rendered. The VFC program provides PCP practices with the pediatric vaccines needed to administer this service.

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

BLOOD LEAD SCREENING

ATC EPSDT guidelines include Blood Lead Level Screenings for children from the ages of nine months through 72 months. A Lead Screening Questionnaire should be completed at the time of each routine office visit for children in this age group.

All Medicaid children are considered at increased risk for having elevated blood lead levels (BLL). A blood lead test must be used when screening Medicaid-eligible children. An elevated BLL is considered anything >5 ug/dL. A blood lead test result equal to or greater than 5 ug/dL obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample. According to CMS policy, all Medicaid children require a screening blood lead test at 12 and 24 months of age. Children between the ages of 36 and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning.

DOMESTIC VIOLENCE

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

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

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

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

It is important that providers ensure ATC 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 his/her 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**

Providers must bill with their NPI number in box 24J. ATC will return or reject claims, when billing information does not match the information that is currently in our files. **Claims missing the requirements in bold will be returned** and a notice will be 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 ATC in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider’s Tax Identification Number and/or address 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; and
- 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.

Providers must submit all claims and encounters within 365 days from the date of service, unless ATC or its vendors created the error. The filing limit may be extended for newborn claims. Claims where ATC is the secondary payer and where the eligibility has been retroactively received by ATC have up to a maximum of 365 days.

ATC 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 (2016, as amended) 42 CFR 438.3(g) (2016, as amended) and 42 CFR 447.26 (2016, as amended).

All adjustments and corrections must be received and resolved within 365 days from the date of service to be considered for payment.
ELECTRONIC CLAIMS SUBMISSION

Network providers are encouraged to participate in ATC’s Electronic Claims/Encounter Filing Program. The plan has the capability to receive electronic professional, institution or encounter transaction. In addition, it has the ability to generate an electronic remittance advice known as an Explanation of Payment (EOP). Providers can submit electronically using a clearinghouse or ATC’s secured web portal. For more information on electronic filing, contact:

Absolute Total Care
C/o Centene EDI Department
1-800-225-2573, extension 25525
or by email at: EDIBA@centene.com

EDI PAYER NUMBERS:
68069 Emdeon/WebMD/Envoy/Payerpath
42772 Relay Health/McKesson

Visit our website at absolutetotalare.com for a complete list of Payer ID numbers.

As of July 1, 2012, all providers are required to follow HIPAA 5010 format for claim submissions and all Current Procedural Technology (CPT) and National Correct Coding Initiative (NCCI) guidelines. ATC timely filing is within 365 days from the date of service.

Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

NATIONAL PROVIDER IDENTIFIER (NPI)

ATC requires all claims to be submitted with a provider’s National Provider Identifier (NPI). ATC will require this on all electronic and paper claim submissions. Providers must send a copy of the confirmation letter from the Enumerator to ATC to ensure that the NPI is loaded correctly into our claims payment database. Providers may register for an NPI at https://nppes.cms.hhs.gov/NPPES/. Providers may download forms at https://nppes.cms.hhs.gov/NPPES/.

CLAIMS SUBMISSION

ATC’s preferred method of claim submission is through Electronic Data Interchange (EDI). If you must submit a paper claim, please send to the address below and follow the imaging requirements listed below.

All claims sent to the wrong address will cause a delay in processing. Please ensure your claims are sent to the below addresses for proper and timely processing.
## CLAIMS SUBMISSION ADDRESSES

<table>
<thead>
<tr>
<th><strong>Electronic Claims:</strong></th>
<th><strong>Medical Appeals:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute Total Care</td>
<td>Absolute Total Care</td>
</tr>
<tr>
<td>EDI Payer ID: 68069-Emdeon/WebMD/Envoy/Payerpath</td>
<td>ATTN: Grievance and Appeals</td>
</tr>
<tr>
<td>EDI Payer ID: 4272 – Relay Health/McKesson</td>
<td>1441 Main Street, Suite 900</td>
</tr>
<tr>
<td><strong>Filing Limit:</strong> 365 days from Date of Service</td>
<td>Columbia, SC 29201</td>
</tr>
</tbody>
</table>

**Paper Claims:**

<table>
<thead>
<tr>
<th>Absolute Total Care</th>
<th>Absolute Total Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 3050</td>
<td>ATTN: Refunds</td>
</tr>
<tr>
<td>Farmington, MO 63640-3821</td>
<td>P.O. Box 602939</td>
</tr>
<tr>
<td><strong>Filing Limit:</strong> 365 days from Date of Service</td>
<td>Charlotte, NC 28260-2939</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Claim Adjustments/Corrections/Adjustments to:</strong></th>
<th><strong>Absolute Total Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute Total Care</td>
<td>ATTN: Corrected Claims</td>
</tr>
<tr>
<td>ATTN: Corrected Claims</td>
<td>P.O. Box 3000</td>
</tr>
<tr>
<td>P.O. Box 3000</td>
<td>Farmington, MO 63640-3800</td>
</tr>
<tr>
<td><strong>Resubmission Filing Limit:</strong> All adjustments and corrections must be resolved within 365 days from Date of Service</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cenpatico</th>
<th><strong>NIA Authorized services will be submitted to ATC claim address:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 7001</td>
<td>EDI Payer ID: 68069-Emdeon/WebMD/Envoy/Payerpath</td>
</tr>
<tr>
<td>Farmington, MO 63640-3811</td>
<td>EDI Payer ID: 4272 – Relay Health/McKesson</td>
</tr>
<tr>
<td><strong>Filing Limit:</strong> 365 days from Date of Service</td>
<td>Filing Limit: 365 days from Date of Service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Envolve Pharmacy Solutions PBM</th>
<th><strong>OptiCare Vision</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>5 River Park Place East, Suite 210</td>
<td><strong>Electronic Claims:</strong></td>
</tr>
<tr>
<td>Fresno, CA 93720</td>
<td>EDI Payer ID: 56190</td>
</tr>
<tr>
<td><strong>Filing Limit:</strong> Please refer to your agreement with Envolve Pharmacy Solutions</td>
<td><strong>Paper Claims:</strong></td>
</tr>
<tr>
<td>Paper Claims:</td>
<td>OptiCare Vision</td>
</tr>
<tr>
<td>OptiCare Vision</td>
<td><strong>EDI Payer ID:</strong> 56190</td>
</tr>
<tr>
<td>P.O. Box 7548</td>
<td><strong>P.O. Box 3050</strong></td>
</tr>
<tr>
<td>Rocky Mountain, NC 27804</td>
<td>Farmington, MO 63640-3821</td>
</tr>
<tr>
<td><strong>Filing Limits:</strong> Please refer to your agreement with OptiCare Vision</td>
<td><strong>Filing Limit:</strong> 365 days from Date of Service</td>
</tr>
</tbody>
</table>

If you are experiencing problems with electronic claims submission, please email our EDI Team for assistance at ediba@centene.com. ATC partners with Payformance to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). To learn more and register, please call 1-877-331-7154 x1 or email providersupport@payspanhealth.com.
IMAGING REQUIREMENTS

ATC 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 PO 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

CLEAN CLAIM DEFINITION

ATC uses SCDHHS’s definition of a clean claim. A clean claim means a claim received by ATC for adjudication in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment or alteration by the provider of the services in order to be processed and paid by ATC.

FEE SCHEDULE AND CODE UPDATES

Updates to billing-related codes or fee schedules (e.g. CPT, HCPCS, ICD, DRG, and revenue codes) shall become effective on the date (“Code Change Effective Date” or “Fee Change Effective Date”) that is the later of: (1) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency’s acceptance of such code/fee updates; or (2) the effective date of such code/fee updates, as determined by such governmental agency. **Claims processed prior to the Code/Fee Change Effective Date will not be reprocessed to reflect any code updates.**

WHAT IS AN ENCOUNTER VERSUS A CLAIM?

You are required to submit an encounter or claim for each service that you render to an ATC member.
If you are the PCP for an ATC member and receive a monthly capitation amount for services, you must file a “proxy claim” (also referred to as an “encounter”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the “proxy claim” or “encounter” is paid at zero dollar amounts. It is mandatory that your office submit encounter data. ATC utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by the State of South Carolina and by CMS.

A **claim** is a request for reimbursement either electronically or by paper for any medical service. A **claim** must be filed on the proper form, such as CMS 1500 or UB 04. A **claim** will be paid or denied with an explanation for the denial. For each claim processed, an Explanation of Payment (EOP) will be mailed to the provider who submitted the original claim.

**PROCEDURES FOR FILING A CLAIM/ENCOUNTER DATA**

ATC encourages all providers to file claims/encounters electronically. See “Electronic Claims Submission” for more information on how to initiate electronic claims/encounters. Please remember the following when filing your claim/encounter:

- All documentation **must** be legible.
- PCPs and all participating providers must submit claims or encounter data for every member visit, even though they may receive a monthly capitation payment.
- Providers must ensure that all data and documents submitted to ATC, to the best of your knowledge, information and belief, are accurate, complete and truthful.
- All claims and encounter data must be submitted on either form CMS 1500, UB 04, or by electronic media in an approved format.
- Review and retain a copy of the error report that is received for claims that have been submitted electronically, then correct any errors and resubmit with your next batch of claims.
- Providers must submit all claims and encounters within 365 days of the date of service.
- All adjustments and corrections to processed claims must be received and resolved within 365 days from the date of service.
- Coordination of Benefits claim must be submitted with the appropriate primary payer’s Explanation of Payment information. Contact your clearinghouse or our EDI Department at ediba@centene.com or by calling 1-800-225-2573 x25525.
- Any provider for covered services must never bill ATC members unless the criterion listed under “Billing the Member” is met.
- In a Workers’ Compensation case for which ATC is not financially responsible, the provider should directly bill the employer’s Workers’ Compensation carrier for payment.

**COMMON BILLING ERRORS**

In order to avoid rejected claims or encounters always remember to:

- Submit all J-codes with the appropriate National Drug Control (NDC) number and format
- Bill the primary diagnosis in the first field following NCCI guidelines
- Use SPECIFIC and current ICD, CPT or HCPCS codes; avoid the use of non-specific or “catch-all” codes (i.e. 99070); out-of-date codes will be denied
• Submit all claims/encounters with the proper provider number
• Submit all claims/encounters with the member’s complete Medicaid number
• Verify other insurance information entered on claim

CODE AUDITING AND EDITING

ATC utilizes National Correct Coding Initiative Guidelines (NCCI) software for automated claims coding verification and to ensure that ATC is processing claims in compliance with general industry standards. We have partnered with Health Care Insight (HCI) to ensure all claims are processed and paid according to the NCCI guidelines.

NCCI code auditing software takes into consideration the conventions set forth in the healthcare insurance industry, such as CMS policies, current health insurance and specialty society guidelines, and the American Medical Association’s CPT Assistant Newsletter.

Using a comprehensive set of rules, the code auditing software provides consistent and objective claims review by:

• Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology as outlined by the American Medical Association’s (AMA) current CPT manual;

• Evaluating the CPT and HCPCS codes submitted by detecting, correcting and documenting coding inaccuracies including, but not limited to, unbundling, up coding, fragmentation, duplicate coding, invalid codes and mutually exclusive procedures;

• Incorporating Historical Claims Auditing (HCA) functionality which links multiple claims found in a member’s claims history to current claims to ensure consistent review across all dates of service.

The following provides conditions where code-auditing software will make a change on submitted codes:

**Age/Gender** – submitting codes inappropriate for the member’s age or gender because of the nature of the procedure.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99382</td>
<td>Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new member; early childhood (age 1 through 4 years)</td>
<td>All (1-4yrs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review (over 4yrs)</td>
</tr>
</tbody>
</table>

**Explanation:**

• Procedure code 99382 is appropriate for a member who is 1-4 years of age
• Procedure code 99382 is recommended for review for a member whose age exceeds four (4) years

**Duplicate services** – submitting the same procedure more than once on the same date for services that cannot or are normally not performed more than once on the same date.

**Example: excluding a duplicate CPT**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey study, anteroposterior &amp; lateral</td>
<td>Allow</td>
</tr>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey study, anteroposterior &amp; lateral</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**Explanation**

• Procedure code 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum and the coccyx

• It is clinically unlikely that this procedure would be performed twice on the same date of service

**Example: recommended replacement**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>22114</td>
<td>Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar</td>
<td>Allow</td>
</tr>
<tr>
<td>22114</td>
<td>Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar</td>
<td>Disallow and Replace</td>
</tr>
<tr>
<td>22116</td>
<td>Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (list separately in addition to code for primary procedure)</td>
<td>Add and Allow</td>
</tr>
</tbody>
</table>

**Explanation:**

• Procedure code 22114 is used to report a single vertebral segment excision

• When submitted twice on a single date of service, the second submission of procedure code 22114 is not recommended for separate reporting and procedure code 22116 is recommended as an alternate code to be added to the claim to indicate the excision of additional vertebral segments

**Evaluation and Management Services** – submission of an evaluation and management (E/M) service either within a global surgery period or on the same date of service of another E/M service.
Global Surgery
Procedures that are assigned a ninety (90) day global surgery period are designated as major surgical procedures. Procedures that are assigned a ten (10) day or zero (0) day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Effective for service dates in 2003, evaluation and management services, submitted with minor surgical procedures (0-day), are not recommended for separate reporting or reimbursement because these services are part of the global service.

Example: evaluation and management service submitted with minor surgical procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>11000</td>
<td>Debridement of extensive eczematous or infected skin; up to 10% of body surface</td>
<td>Allow</td>
</tr>
</tbody>
</table>
| 99213  | Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two (2) of these three (3) key components:  
1. an expanded problem focused history; 
2. an expanded problem focused examination; 
3. medical decision making of low complexity.  
Counseling and coordination of care with other providers or agencies are provided consistent with nature of problem(s) and the member’s and/or family’s needs; problem(s) are low/moderate severity; physicians spend 15 minutes face-to-face with member and/or family | Disallow |

Explanation:
- Procedure code 11000 (0-day global surgery period) is identified as a minor procedure.
- Procedure code 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

Example: global surgery period

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>Allow</td>
</tr>
</tbody>
</table>
Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two (2) of these three (3) key components:
1. an expanded problem focused history;
2. an expanded problem focused examination;
3. medical decision making of low complexity.
Counseling and coordination of care with other providers or agencies are provided consistent with nature of problem(s) and the member's and/or family's needs; problem(s) are low/moderate severity; physicians spend 15 minutes face-to-face with member and/or family.

Explanation:

- Procedure code 27447 has a global surgery period of ninety (90) days.
- Procedure code 99213 is submitted with a date of service that is within the ninety (90) day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

Same Date of Service

One (1) evaluation and management service is recommended for reporting on a single date of service.

Example: same date of service

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two (2) of these three (3) key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of problem(s) and the member's and/or family's needs; problem(s) are low/moderate severity; physicians spend 15 minutes face-to-face with member and/or family.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established member, which requires at least two (2) of these three (3) key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of problem(s) and member's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 minutes face-to-face with member and/or family.</td>
<td>Allow</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99242</td>
<td>Office consultation for a new or established member, which requires these three (3) key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or agencies is provided consistent with nature of problem(s) and member's/family's needs. Presenting problem(s) are low severity. Physicians spend 30 minutes face-to-face with member/family.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

Explanation:

- Procedure code 99215 is used to report an evaluation and management service provided to an established member during a visit.
- Procedure code 99242 is used to report an office consultation for a new or established member.
Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions, provided during an evaluation and management service, typically include the components of an office consultation.

**NOTE:**

**Modifiers** - Modifiers are added to the main service or procedure code to indicate that the service has been altered in some way by a specific circumstance.

**Modifier - 24** – used to report an unrelated evaluation and management service by the same physician during a post-operative period.

**Modifier - 25** – used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

When Modifiers - 24 and - 25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information may be required. Send medical records and a copy of the Explanation of Benefits (EOB) to the corrected/disputed claim address for review by HCI.

**Modifier - 79** – used to report an unrelated procedure or service by the same physician during the post-operative period.

When Modifier - 79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is allowed.

**Modifier - 26 (professional component)**

If modifier - 26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.

When the place of service is an inpatient setting, modifier - 26 is recommended to be appended to validate procedure codes submitted without modifier – 26.

When the place of service is an outpatient setting, procedure codes submitted with modifier - 26 are recommended for separate reporting.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>78278</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Disallow and Replace</td>
</tr>
<tr>
<td>78278-26</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Add and Allow</td>
</tr>
</tbody>
</table>
Explanation:
- Procedure code 78278 is valid with modifier - 26
- Modifier - 26 will be added to procedure code 78278 when submitted without modifier - 26

**Modifier - 50 (bilateral procedures)** – To report a bilateral procedure, bill the first procedure with no modifier, and the second procedure with a 50 modifier. Report on two lines instead of one. A bilateral procedure billed with only one line will result in underpayment. Codes with bilateral descriptions may not be billed with a 50 modifier.

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>69436</td>
<td>Tympanostomy (requiring insertion of ventilating tube), general anesthesia</td>
<td>Allow</td>
</tr>
<tr>
<td>69436</td>
<td>Tympanostomy (requiring insertion of ventilating tube), general anesthesia</td>
<td>Disallow and Replace</td>
</tr>
<tr>
<td>69436-50</td>
<td>Tympanostomy (requiring insertion of ventilating tube), general anesthesia</td>
<td>Add and Allow</td>
</tr>
</tbody>
</table>

Explanation:
- Procedure code 69436 was performed bilaterally and submitted twice without modifier - 50
- The second submission of procedure code 69436 is not recommended for separate reporting, but modifier - 50 is recommended to be added to this procedure code to indicate a bilateral performance of the procedure

**Modifier - 51 (multiple procedures)** – Modifier - 51 edit identifies a secondary procedure code when more than one (1) surgical procedure is performed.

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>51820</td>
<td>Cystourethroplasty with unilateral or bilateral ureteroneocystostomy</td>
<td>Allow</td>
</tr>
<tr>
<td>51840-51</td>
<td>Anterior vesicourethropexy, or urethropexy (e.g., Marshall-Marchetti-Krantz, Burch); simple</td>
<td>Allow</td>
</tr>
<tr>
<td>51920-51</td>
<td>Closure of vesicouterine fistula;</td>
<td>Allow</td>
</tr>
<tr>
<td>58140-51</td>
<td>Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure code); abdominal approach</td>
<td>Allow</td>
</tr>
</tbody>
</table>

Explanation:
- Procedure code 51820 is determined to be the primary procedure performed because it is the most clinically intensive procedure for this clinical scenario
- Procedure codes 51840, 58140, and 51920 are determined to be secondary procedure codes and modifier - 51 is recommended to be appended to each
**Modifier - 80, - 81, and - 82** – The Assistant Surgeon edit identifies procedures not requiring an assistant-at-surgery; many surgical procedures require aid in prepping and draping the member, monitoring visualization, keeping the wound clear of blood, holding and positioning the member, assisting with wound closure, and/or casting (if required); this assistance does not require the expertise of a surgeon; a qualified nurse, orthopedic technician or resident physician can provide the necessary assistance.

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>42820-81</td>
<td>Tonsillectomy and adenoidectomy; under age 12</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance of this procedure

**Modifier - LT and - RT (left, right)** – when submitted with a procedure code, identify procedures that are performed on the left and right side of the body; when a valid bilateral procedure is submitted more than one (1) time and either - LT or - RT is appended to of the codes, the modifier - 50 will be added to the remaining procedure code to indicate bilateral performance of the procedure

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>28400-LT</td>
<td>Closed treatment of calcaneal fracture; without manipulation</td>
<td>Allow</td>
</tr>
<tr>
<td>28400</td>
<td>Closed treatment of calcaneal fracture; without manipulation</td>
<td>Disallow and Replace</td>
</tr>
<tr>
<td>28400-50</td>
<td>Closed treatment of calcaneal fracture; without manipulation</td>
<td>Add and Allow</td>
</tr>
</tbody>
</table>

**Explanation:**
- The first submission of procedure code 28400 is submitted with modifier - LT, indicating performance of the procedure on the left side of the body
- The second submission of procedure code 28400 does not include a modifier indicating which side of the body the procedure was performed; As a result of this omission, modifier -50 is added to procedure code 28400 to indicate bilateral performance of the procedure

**Place of Service** – services billed with an incorrect place of service for the procedure billed.

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>96410</td>
<td>Chemotherapy administration, intravenous; infusion technique, up to one (1) hour</td>
<td>Disallow for POS=Inpatient</td>
</tr>
</tbody>
</table>
Explanation:
• Procedure code 96410 is not routinely administered by a physician in an inpatient setting and is not recommended for separate reporting
• Provision of this service in an office or outpatient facility place of service is recommended for separate reporting

Global Edit - procedure(s) submitted that are performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>47562</td>
<td>Laparoscopy, surgical; cholecystectomy</td>
<td>Allow</td>
</tr>
<tr>
<td>49000</td>
<td>Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

Explanation:
• Procedure code 49000 is routinely performed for most abdominal procedures and is considered clinically integral to performing the primary surgical procedure 47562

Unbundling – submission of a comprehensive code along with incidental procedure codes that are an inherent part of performing the global procedure code. The unbundled procedure code(s) will be rebundled to the comprehensive procedure code.

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>20102</td>
<td>Exploration of penetrating wound (separate procedure); abdomen/flank/back</td>
<td>Disallow</td>
</tr>
<tr>
<td>44120</td>
<td>Enterectomy, resection of small intestine; single resection and anastomosis</td>
<td>Allow</td>
</tr>
</tbody>
</table>

Explanation:
• Procedure code 20102 is an exploratory procedure for a penetrating wound that when performed with procedure code 44120 represents unbundling because exploration is considered to be a component of the more comprehensive procedure code 44120
• Unbundled procedure codes are re-bundled and paid as a single procedure

Fragmentation – billing all incidental codes or itemizing the components of procedures separately when a more comprehensive code is available.

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>82465</td>
<td>Cholesterol, serum, total</td>
<td>Replaced</td>
</tr>
<tr>
<td>83718</td>
<td>Lipoprotein, direct measurement, high density cholesterol</td>
<td>Replaced</td>
</tr>
<tr>
<td>84478</td>
<td>Triglycerides</td>
<td>Replaced</td>
</tr>
</tbody>
</table>
Explanation:

- Procedure code 82465, 83718 and 84478 are part of a more comprehensive code – 80061; the definition of procedure code 80061 includes procedures codes 82465, 83718 and 84478
- Fragmented procedure codes are replaced and paid as the single comprehensive procedure

The code auditing software is updated regularly to incorporate the most recent medical practices, coding practices, annual changes to the AMA’s CPT-4 Manual and other industry standards.

ATC uses only standard diagnosis and procedure codes to comply with the Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets Standards.

CODE EDITING ASSISTANT

A web-based code auditing reference tool designed to “mirror” how ATC's code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers. This allows ATC to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted
- Proactively determine the appropriate code/code combination representing the service for accurate billing purposes
- Retrospectively access the clinical edit clarifications on a denied claim for billed services after an EOP has been received

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location and modifier (if applicable) or other code(s) entered. However, this is not a guarantee of payment for the claim combination submitted.

BILLING CODES

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT, HCPCS or ASA, and ICD codes. Submit institutional claims with valid Revenue Codes and CPT or HCPCS (when applicable), ICD codes and DRG codes (when applicable).

For dates of service on or before September 30, 2015, ATC recognizes the medical terminology as defined in the Current Procedural Terminology (CPT), Fourth Edition, published by the American Medical Association; and the diagnosis codes as defined in the International Classification of Diseases, Ninth Edition (ICD-9), and provided by the U.S. National Center for Health Statistics.
For dates of service on or after **October 1, 2015**, ATC recognizes the medical terminology as defined in the Current Procedural Terminology (CPT), Fourth Edition, published by the American Medical Association; and the diagnosis codes as defined in the International Classification of Diseases, Tenth Edition (ICD-10), and provided by the U.S. National Center for Health Statistics.

**PROVIDER DISPUTE SYSTEM**

In and out-of-network providers may dispute the denial of payment of a claim (included non-payment) and the denial or reduction of a covered service, including emergency care. Contracted in-network providers may also dispute ATC's policies, procedures, or any aspect of ATC's administrative functions except ATC's decision not to contract, or to terminate a contract, with a provider; service denials due to payment adjustments for National Correct Coding Initiative (NCCI); grievances and appeals related to the provider acting as an Authorized Representative of a member; or services that are not covered under ATC's contract with SCDHHS.

The provider may file a dispute in person, by telephone, email or in writing to ATC. However to be classified a provider dispute these concerns must be submitted in writing.

To submit a provider dispute please download and complete the Provider Dispute Form from the Provider Resource section on the ATC website at absolutetotalcare.com. The provider can consolidate disputes of multiple claims that involve the same or similar payment, regardless of the number of individual patients or payment claims.

The completed Provider Dispute Form must be submitted to ATC within thirty (30) calendar days from the receipt of notice of an adverse action. Any disputes received outside of this timeframe will not be reviewed.

ATC will fully investigate the provider dispute and render a decision within 30 calendar days of the receipt of the provider dispute. If additional information is required to render a decision on the dispute, ATC may extend the timeframe by 15 calendar days based on mutual agreement of the provider with ATC.

If you wish to file a dispute please contact ATC:

**Absolute Total Care**  
**Attn: Provider Disputes**  
**1441 Main Street, Suite 900**  
**Columbia, SC 29201**  
**Phone: 866-433-6041**  
**Fax: 1-866-912-3605**  
**Email: atcnetworkrelations@centene.com**

**CLAIM PAYMENT**

ATC will pay ninety (90%) percent of clean claims within 30 days of receipt and ninety-nine (99%) percent of clean claims within (90 days of receipt. It is the provider's responsibility to cross check their submitted claims audit report to processed claims EOPs from ATC. Also, this is available at absolutetotalcare.com, but requires registration to access the Provider Secured Portal.

**CLAIM ADJUSTMENTS/CORRECTIONS**

If a provider has a question or is not satisfied with the information they have received related to a claim, they should contact:
Provider Relations Department: 1-866-433-6041

- Follow your clearinghouse guidelines when submitting corrected claims or you may submit a corrected claim using our secured website at absolutetotalcare.com.

- When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as “CORRECTED CLAIM” and [include the original claim number].” Failure to mark the claim as a resubmission and include the claim number or EOP may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline.

- Providers may discuss questions with ATC Provider Services Representatives regarding amount reimbursed or denial of a particular service; providers may also submit in writing, with all necessary documentation, including the EOP for consideration of additional reimbursement.

- Any response to approved adjustments will be provided by way of check with accompanying explanation of payment.

All adjustments and corrections to processed claims must be received and resolved within 365 days from the date of service.

ATC shall process and finalize all Adjusted/Corrected Claim Requests for reconsideration to a paid or denied status normally within 30 business days of receipt of the Adjusted/Corrected Claim Request. Adjusted/corrected claims are those in which a provider files a request for informal claims payment adjustment or a claim complaint with ATC.

BILLING FORMS

Providers submit claims using standardized claim forms whether filing on paper or electronically.

Submit claims for professional services and durable medical equipment on a CMS 1500. The following areas of information on CMS 1500 claim forms are common submission requirements of a clean claim accepted for processing:

- Full member name
- Member’s date of birth
- Valid member identification number
- Appropriate NDC number for all J-codes
- Appropriate Clinical Laboratory Improvement Amendments (CLIA) number for all laboratory services
- Complete service level information:
  - Date of service
  - Diagnosis
  - Place of service
  - Authorization number when appropriate
Procedural coding (appropriate and current CPT and ICD codes)

Charge information and units

- Servicing provider’s name, address and Medicaid Number
- Provider’s NPI
- Provider’s federal tax identification number
- All mandatory fields must be complete and accurate

Submit claims for hospital based inpatient and outpatient services as well as swing bed services on a UB 04.

THIRD PARTY LIABILITY

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and workers’ compensation) or program that is, or may be, liable to pay all or part of the healthcare expenses of the member.

Except for BabyNet and Children’s Rehabilitative Services, Medicaid is always the payer of last resort. ATC providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to ATC members. **The provider has 365 days from the date of service to submit first time claims. Denied claims for additional information may be submitted with the additional information needed within 365 days from the date of service for reimbursement consideration.**

If third party liability coverage is determined after services are rendered, ATC will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

PAY AND CHASE OB CLAIMS

ATC will reimburse claims for Maternity Services and will follow the Pay and Chase guideline. When a member has primary health insurance, ATC will reimburse Maternity Services only as the primary carrier. However, ATC has the right to pursue the Primary Insurance carrier to coordinate benefits. The Pay and Chase process will allow you to be paid upfront and decrease maternity denials surrounding other health insurance payments.

BILLING THE MEMBER

ATC reimburses only services that are covered medically necessary services through Medicaid. Carved out services outlined earlier in this manual should be billed to the State Medicaid FFS Program. **Providers may not bill ATC members for covered services.** A provider may only bill an ATC member if the provider obtains written consent from the member as outlined in the Member Acknowledgment Statement section below.

MEMBER ACKNOWLEDGEMENT STATEMENT

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if the provider has counseled the member of their out-of-pocket responsibilities and obtained a signed member
acknowledgement statement to bill for non-covered or non-medically necessary services prior to the service(s) being rendered.

A member acknowledgement statement must include all of the following:

- The cost of each service.
- The member’s acknowledgement of responsibility for payment statement:
  
  “I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered by my Medicaid plan, ATC, as being reasonable and medically necessary for my care. I understand that ATC through its contract with the SCDHHS determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive, if these services or items are determined not to be reasonable and medically necessary for my care.”
- The member’s signature.

Providers must keep signed member acknowledgement statements.

**BALANCE BILLING PROHIBITION**

Members cannot be balance billed by any provider for authorized services, including in-network services and authorized out-of-network services. This includes services that are covered and services not covered unless a Member Acknowledgement Statement has been signed by both the provider and the ATC member for non-covered services prior to rendering said services. Please reference the Member Acknowledgement Statement section for requirements. Providers may not bill members for such services if the Member Acknowledgement Statement is not obtained prior to rendering said services.

Balance billing is prohibited under the terms of your provider agreement with ATC and in the ATC Provider Manual,

- Members cannot be billed for the difference between the provider’s usual and customary charge and the provider’s contracted rate.
- Members cannot be billed for the difference between the amount billed by the provider and the amount paid by ATC.
- ATC members cannot be billed, nor can any deposits be collected from ATC members, for any amounts other than allowable co-payment, which cannot exceed the co-payment amount allowed by SCDHHS.
- If a member does not keep a scheduled appointment, you are not permitted to bill the member or ATC for the missed appointment.

**HOSPITAL CLAIMS**

ATC will process and reimburse for inpatient hospitals claims that qualify for additional outlier reimbursement under SCDHHS guidelines as follows. This policy only affects inpatient hospitals claims that meet the following two criteria: (1) claims that qualify for outlier reimbursement based on the billed amount, and (2) claims with billed charges in excess of $200,000.
It is ATC’s policy to request both an itemized bill and the patient’s medical records for any inpatient claim that meets both criteria as detailed above. Upon receipt these requested records will be reviewed for the appropriateness of all charges in accordance with the generally-accepted charging practices and NCCI guidelines.

Eligible outlier claims will have their total claim reimbursement divided into two parts – the applicable DRG case rate and the potential calculated outlier portion. The DRG case rate will be calculated and released for payment immediately to the provider, but the outlier portion of the total reimbursement will be held until the requested documentation is received and reviewed in accordance with this policy. Once charges are reviewed and validated, the outlier portion of the reimbursement will be released and the total claims payment will have been adjudicated.

Forensic Review Process
1. DRG+Outlier are paid and one line which doesn’t impact payment is denied
2. A letter will be sent to you requesting both an itemized bill and the patient’s medical records
3. The records are sent to the Claims Department who will forward the claim and medical records to forensic review vendor, The Assist Group
4. The Assist Group reviews the claim and records and informs the Claims Department of the results of the review highlighting exceptions
5. The claim is adjusted based on the exceptions. You will be sent a second letter informing you of the status of the exceptions.

EMERGENCY DEPARTMENT CLAIMS

ATC global period for ED claims is 24 hours. Authorization is not required for ED services.

REQUIREMENTS FOR NETWORK PARTICIPATION

The enrollment, credentialing and recredentialing processes exist to ensure that participating providers meet and remain compliant to the criteria established by ATC, 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.

Notice: In order to maintain a current provider profile, providers are required to notify ATC of any relevant changes to their credentialing information in a timely manner.

Practitioners must submit at a minimum the following information when applying for participation with ATC:

- Complete signed and dated ATC Standardized Credentialing Form of CAQH (Council for Affordable Quality Health Care) Provider Data Form, the application must include the following:
  - Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy fact sheet that includes expiration dates, amounts of coverage and provider’s name
• Copy of current Federal Drug Enforcement Administration (DEA Certificate
• Copy of current State Controlled Substance Certificate for SC
• W-9
• Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate (if applicable)
• Copy of current unrestricted state license to practice in South Carolina
• Evidence of specialty/board certification (if applicable)
• Proof of highest level of education (certificate or letter certifying formal post-graduate training) if practitioner is not board certified,
• Copy of CLIA certificate (if applicable)
• Ability to demonstrate enumeration by NPPES (National Plan and Provider Enumeration System), depicting the provider’s unique National Provider Identifier (NPI)
• Nurse Practitioners: current written protocol and name of preceptor (supervising) physician
• Current (dated within one year of application) SCDHHS Form 1514 Disclosure of Ownership and Control Interest Statement

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

• Complete Credentialing Application
• Copy of current general liability insurance policy fact sheet that includes expiration dates and amounts of coverage
• Other applicable current State/Federal/Licensures (i.e. CLIA, DEA, SC Controlled Substance Certificate, Pharmacy, or Department of Health)
• Copy of current accreditation/certification by a nationally recognized accrediting body or site evaluation results by a government agency if not accredited
• Attestation of current professional liability coverage in the minimum amounts of $1,000,000 per occurrence and $3,000,000 aggregate
• Copy of current CMS Certification, if applicable
• W-9
• Ability to demonstrate enumeration by NPPES (National Plan and Provider Enumeration System), depicting the provider’s unique National Provider Identifier (NPI)
• Current (dated within one year of application) SCDHHS Form 1514 Disclosure of Ownership and Control Interest Statement
ATC will review for the following information:

- Current, unrestricted state license to practice, if license is required to practice
- Education and training and/or board certification
- Reports of malpractice settlements via the National Practitioner Data Bank (NPDB)
- Current Drug Enforcement Administration Registration
- Hospital privileges in good standing at a participating ATC hospital
- Justification of gaps of six months or greater within the past five years of work history
- Medicare/Medicaid-specific exclusions and/or determination if disbarment, suspension or other exclusion from participation in federal procurement activities via Office of Inspector General (OIG), System of Award Management (SAM), and SC 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 and/or general liability coverage in an amount accepted by ATC
- Proof of collaborative agreement, protocols or other written authorization with a licensed physician (if applicable)

Note: All providers must be enrolled in the South Carolina Healthy Connections Medicaid Program. 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 ATC Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting. Recredentialing is performed at least every 36 months.

**NURSE PRACTITIONERS AS PCP**

Medicaid MCOs may utilize Nurse Practitioners (NPs) to provide health care services under the following conditions:

1. To ensure NPs are able to perform the healthcare services allowed within the parameters of the SC Nurse Practice Act (State statute Section 40-33) ATC must:
   - Validate NP status
   - Confirm the NPs ability to provide the allowed services as evidenced by written protocols
   - Verify there is a process in place to accommodate medically necessary hospital admissions

2. Supervising physicians (preceptors) for practices staffed only by NPs must also be enrolled in the MCO’s network and must have an active license.

MCOs must:
- Authenticate the formal relationship between the NP and supervising physician (i.e. preceptor).
• Contract with any off-site supervising physician who is not already enrolled in the plan’s network.

Note: If the supervising physician will not enroll, the NP-only practice cannot be enrolled into or, if already enrolled, cannot remain in the MCO’s network.

3. Members shall not be automatically assigned to a NP; however, members may choose a NP to provide the health care services allowed with their scope of services. NPs submitted on provider files to the enrollment broker must be coded to allow member choice only.

CREDENTIALING COMMITTEE

The Credentialing Committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination and direction of the credentialing procedures, including provider participation, denial and termination.

Committee meetings are held monthly and more often as deemed necessary.

CERTIFICATION AND LICENSING REQUIREMENTS

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

Ambulance Transportation
• Licensed by SCDHEC.

Ambulatory Surgical Centers
• Surveyed and licensed by SCDHEC and certified by CMS.

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

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

Dispensing Physician
• Licensed by the Board of Medical Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

End Stage Renal Disease Clinics
• Surveyed and licensed by SCDHEC and certified by CMS.
**Federally Qualified Health Clinics (FQHC)**
- Must have a Notice of Grant Award under 319, 330 or 340 of the Public Health Services Act and be certified by CMS.
- Providers billing laboratory procedures must have a CLIA certificate.

**Home Health**
- Surveyed and licensed by SCDHEC and certified by CMS.

**Inpatient/Outpatient Hospitals**
- Surveyed and licensed by SCDHEC and certified by CMS

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

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

**Long-Term Care Facilities/Nursing Homes**
- Surveyed and licensed under State law and certified as meeting the Medicaid and Medicare requirements of participation by SCDHEC.

**Mail Order Pharmacy**
- Licensed by the appropriate state board.
- A special non-resident South Carolina Permit Number is required of all out-of-state providers. The Board of Pharmacy, under the South Carolina Department of Labor, Licensing and Regulations, issues such permits.

**Mammography Services**
- The US Department of Health and Human Services, Public Health Services and Food and Drug Administration (FDA) must certify facilities providing screening and diagnostic mammography services.

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

**Mobile Ultrasound**
- No license or certification required.

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

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

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

Physiology Labs
• Providers must be enrolled with Medicare.

Podiatrists
• Licensed by the Board of Podiatry Examiners, under the South Carolina Department of Labor, Licensing and Regulations.
• Providers billing laboratory procedures must have a CLIA Certificate.
• Laboratories can only provide services that are consistent with their type of CLIA certification.

Portable X-ray
• Surveyed by SCDHEC and certified by CMS.

Rural Health Clinics (RHC)
• Surveyed and licensed by DHEC and certified by CMS.
• Providers billing laboratory procedures must have a CLIA Certificate.
• Laboratories can only provide services that are consistent with their type of CLIA certificate.

Stationary X-ray
• SCDHEC registration.

RECREREDENTIALING

ATC conducts the recredentialing process for providers at least every three years from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner’s licensure, sanctions, certification, competence or health status, which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners (including PCPs and specialists), ancillary providers and/or facilities previously credentialed to practice within the ATC network.

Additionally, between credentialing cycles, a provider may be requested to supply current proof of any credentials such as state licensure, malpractice insurance, DEA registration, a copy of certificate of cultural competency training, etc. that have expiration dates prior to the next review process.

A provider’s agreement may be terminated if at any time it is determined by ATC’s Board of Directors or the Credentialing Committee that credentialing requirements are no longer being met.
PRACTITIONER CREDENTIALING RIGHTS

All practitioners requesting participation with ATC have the right to review information obtained by ATC to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, malpractice insurance carriers and the State of South Carolina State Board of Medical Examiners and South Carolina State Board of Nursing for Nurse Practitioners. This does not allow a practitioner to review references, personal recommendations or other information that is peer review protected.

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

Practitioners also have the right to request status of their credentialing/recredentialing application by contacting ATC's Provider Relations department.

PRACTITIONER APPEAL RIGHTS

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

QUALITY IMPROVEMENT PROGRAM

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

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

**PROGRAM STRUCTURE**

The ATC Board of Directors (BOD) oversees development, implementation and evaluation of the QAPI Program and has the ultimate authority and accountability for oversight of the quality of care and services provided to members.

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

ATC recognizes the integral role of practitioner involvement in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. ATC encourages PCP, Behavioral Health, Pediatrics, OB/GYN, Specialist and Allied Health Practitioner representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, Peer Review Committee and select ad-hoc committees.

**QUALITY IMPROVEMENT PROGRAM GOALS**

ATC’s primary quality improvement goal is to ensure that ATC’s members have access to the highest quality of health care services that is also responsive to their health needs and able to improve their health outcomes.

**QUALITY IMPROVEMENT PROGRAM SCOPE**

The scope of the QAPI Program is comprehensive and addresses both the quality and safety of clinical care and the quality of service provided to ATC’s members as defined by the South Carolina Medicaid Program. ATC 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. ATC’s QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care services
- Clinical quality initiatives
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Member and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member grievance and appeal system
- Member satisfaction
- Patient safety
- Medical record documentation
- Pharmacy services
- Provider and ATC’s after-hours telephone accessibility
- Provider appointment availability and accessibility
- Provider network adequacy and capacity
- Provider satisfaction
- Quality of care review
- Selection and retention of providers (credentialing and recredentialing)
- Utilization Management, including under and over utilization

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

INTERACTION WITH FUNCTIONAL AREAS

The QI Department maintains strong working relationships with key functional areas within the health plan such as Provider Network Services, Member Services and Connections, Utilization Management, Regulatory Compliance and the Grievance and Appeals Coordinator(s). Quality is integrated throughout ATC and represents the strong commitment to quality of care and services for members.

- **Provider Network Services** such as Provider Relations and Contracting and the QI Department work together to verify that clinical materials distributed to providers are understandable and useful, and that providers understand the members’ rights and responsibilities and treat enrolled members accordingly. These departments also coordinate efforts for appropriate access and availability through ongoing monitoring.

- **Members Services, MemberConnections** and the QI staff collaborate in relation to Member Satisfaction survey activities, to include Performance Improvement Projects (PIP). The QI and Member Services/Connections departments work collaboratively to maintain performance data related to EPSDT outreach activities and any other QI activities related to member services functions, including call center functions, are tracked, trended and used as a tool to identify opportunities for performance improvement, as appropriate.

- **Utilization Management** provides utilization management, case management and disease-focused services to enrolled members. Utilization Management staff identifies and refers quality
concerns to the QI department for investigation, and recommends benefit enhancements and participates in QI activities and projects.

- **Regulatory Compliance** and the QI Department work together to ensure that ATC’s initiatives comply with State contract and accreditation requirements for NCQA.

- **Grievance and Appeals Coordinator(s)** and the Provider Relations Department work closely with the QI department to ensure that: any grievance related to a quality of care issue is promptly investigated; grievances and second-level reviews of grievances and administrative reviews are handled timely; data collection and reporting is in compliance with relevant contractual and regulatory requirements; and reporting to appropriate quality committees occurs.

**PERFORMANCE IMPROVEMENT PROCESS**

ATC’s QI Committee reviews and adopts an annual QAPI Program Description and QI Work Plan based on managed care Medicaid appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. As part of this approach, the Plan President or designee, and the Medical Director, in conjunction with the QI Department, determine the scope and frequency of QI initiatives (clinical and non-clinical PIPs, focus studies, etc.). Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service. Other initiatives will be selected to test an innovative strategy. Each initiative topic will reflect distinctive regional emphasis on populations and cultures. Once a QI topic is selected, the QI Department, in conjunction with specific functional areas as appropriate, will present the proposed QI initiative to the QIC for approval. The QIC will select those initiatives that have the greatest potential for improving health outcomes or the quality of service delivered to the Plan’s members and network providers.

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

The development and selection of clinical PIPs are the responsibility of QIC due to its clinical representation. The QIC continues to monitor progress of clinical PIPs. The ATC QAPI Program allows for continuous performance of quality improvement activities through analysis, evaluation and improvement in the delivery of healthcare provided to all members, and has established mechanisms to track issues over time.

Annually, ATC develops a QI Work Plan for the upcoming year. The QI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QI activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QI Committee as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QI Work Plan.
The QI Work Plan is used by the QI Department to manage projects. Also, it is used by the QI committees, QI sub-committees and ATC Board of Directors to monitor progress. The Work Plan is modified and enhanced throughout the year.

At any time, ATC providers may request information on ATC’s quality program including a description of the QAPI Program and a report on the Plan’s progress in meeting the QAPI Program goals by contacting ATC’s QI Department.

**FEEDBACK ON PHYSICIAN SPECIFIC PERFORMANCE**

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

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency and in-office waiting time
- Preventive care, including well-child exams, immunizations, lead screening, cervical cancer screening, breast cancer screening and screening for detection of chronic diseases such as diabetes and kidney disease
- Prenatal care
- Member complaint and grievance data
- Utilization management data including referrals/1000 and bed days/1000 reports
- Sentinel events and/or adverse outcomes
- Compliance with clinical practice guidelines

**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 simply cost differences. HEDIS reporting is a required part of the SCDHHS contract. Through HEDIS, ATC is accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse membership.

HEDIS consists of 20+ Effectiveness of Care type measures as well as Access to Care and Use of Services measures for which the health plan contractually reports rates to the State of South Carolina based on claims and/or medical record review data.

As both the State and Federal 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 as well. State purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in Preventive Health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as ‘pay for performance’ and ‘quality bonus funds.’ These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.
How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual Chlamydia screening, annual Pap test, treatment of pharyngitis, treatment of URI, appropriate treatment of asthma, cholesterol management, antidepressant medication management, 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 member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the necessity of medical record review. Measures typically requiring medical record review include: comprehensive diabetes care, control of high-blood pressure, immunizations, prenatal care and well-child care.

Who will be conducting the Medical Record Reviews (MRR) for HEDIS?

ATC will contract with a national medical record review vendor to conduct the HEDIS medical record reviews on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from an MRR representative if any of your patients are selected into HEDIS samples for ATC. Your prompt cooperation with the MRR representative is greatly needed and appreciated.

ATC is pleased to be able to contract with a medical record review vendor that is able to offer several medical record correspondence options including confidential fax, traditional mail or onsite copying by qualified staff. These various options allow you as the provider to choose the most convenient method for your practice.

As a reminder, 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/patient. The Medical Record Review vendor will sign a HIPAA compliant Business Associate Agreement with ATC, which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS.
- If services are not billed or not billed accurately they are not included in the calculation.
- Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Chart documentation must reflect the services provided.

If you have any questions, comments or concerns related to the annual HEDIS project or the medical record reviews, please contact ATC’s QI Department.
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEY

CAHPS is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The adult CAHPS survey provides information on the experiences of Medicaid members with the MCO services and gives a general indication of how well the MCO meets members’ expectations. Global rating questions reflecting overall satisfaction include rating of members’ personal doctor and rating of specialist seen most often. Composite scores summarize responses in key areas such as getting care quickly, getting needed care, how well doctors communicate and shared decision-making. The child CAHPS survey looks at the same global and composite areas but provides information on parents’ experience with ATC services. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

PROVIDER SATISFACTION SURVEY

ATC conducts an annual provider satisfaction survey, which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management and provider services. An external vendor conducts the survey. The vendor randomly selects participants, meeting specific requirements outlined by ATC, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives. Other surveys may be used for provider feedback as well.

FEEDBACK OF AGGREGATE RESULTS

Aggregate results of studies and guideline compliance audits are presented to the QI Committee. Participating physician members of the QIC provide input into action plans and serve as a liaison with physicians in the community. Aggregate results are also published in the provider newsletter or a special provider mailing may be distributed.

At least quarterly, a provider relations specialist meets with PCPs and bi-annually with high volume specialists to review policies, guidelines, indicators, medical record standards and provide feedback of audit/study results. These sessions are also an opportunity for providers to suggest revisions to existing materials and recommend priorities for further initiatives. When a guideline, indicator or standard is developed in response to a documented quality of care deficiency, ATC disseminates the materials through an in-service training program to upgrade providers' knowledge and skills. The ATC Medical Director and Pharmacist conduct special training and meetings to assist physicians and other providers with quality and service improvement efforts.

FRAUD, WASTE AND ABUSE (FWA)

ATC is committed to preventing, detecting, identifying and reporting suspected cases of fraud, waste and abuse, and has a Fraud, Waste and Abuse (FWA) Program that complies with all state and federal laws. ATC, in conjunction with its management company, Centene Corporation, successfully operates a Payment Integrity Department (PI) and a Special Investigations Unit (SIU). ATC routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review
the Billing and Claims chapter of this manual. The 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
- Any other remedies available to rectify

Some of the most common errors seen are:

- Unbundling of codes
- Up-coding services
- Add-on codes without primary CPT
- Diagnosis and/or procedure code not consistent with the patient’s age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- 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 hotline at 1-866-685-8664. ATC takes all reports of potential fraud, waste and abuse very seriously and will investigate all reported issues.

**COMPLIANCE AUTHORITY AND RESPONSIBILITY**

The ATC Vice President of Compliance & Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program.

ATC is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

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

These are the primary agencies to which incidents or practices of abuse and/or fraud are to be reported:

**ATC Fraud, Waste & Abuse reporting contact information:**

Mail: Absolute Total Care
Compliance Department
ATC's staff is available to answer any questions or concerns you have regarding fraud, waste and abuse. Please contact ATC's Provider Services Department at 1-866-433-6041 (TTY: 711) with any questions.

**MEMBER SERVICES**

ATC is committed to providing its members with information about the health benefits that are available to them through the ATC program. ATC encourages members to take responsibility for their healthcare by providing basic information to assist with making decisions about their healthcare choices.

ATC has developed targeted programs to address the needs of its members. Members may attend classes and receive specific disease management bulletins and treatment updates, appointment reminder cards and informational mailings.

As a provider for ATC, please remember that it is your obligation to identify any member who requires translation, interpretation, or sign language services. ATC will pay for these services whenever you need them to effectively communicate with an ATC member. ATC members are not to be held liable for these services. To arrange for any of the above services, please call the ATC Provider Services Department at 1-866-433-6041.

**MEMBERCONNECTIONS® PROGRAM**

ATC recognizes the special needs of the population it serves. In response to these special needs, the MemberConnections program has been developed to address the challenges in member outreach, member education, and in members’ understanding of the managed care health system.

MemberConnections is an educational and outreach program that brings our members a special personal-touch service. The program is designed to promote preventive health practices and connect members to quality healthcare and community social services. By assigning MemberConnections representatives to individual members, MemberConnections creates a special link between members and ATC providers.

MemberConnections representatives will:

- Coordinate health and literacy focused community events for members
- Educate members about the Managed Care Plan system in each area
• Provide information to appropriate ATC staff regarding member and community needs
• Assist in the development and distribution of educational materials via telephone contact, mailings or home visits
• Promote self-empowerment through the provision of community resources, information and education
• Develop a community presence by attending community meetings
• Introduce members to ATC managed care and assist them in understanding their available options for preventive healthcare in the ATC network and how to access services appropriately
• Conduct home visits and monthly member orientation sessions for basic member education about ATC and services available through the ATC network
• Participate in community activities centered on health education
• Counsel members on accessing appropriate levels of care and non-compliance issues
• Assist members in making appointments
• Advise members of their rights and responsibilities

MemberConnections serves as a link between the member, PCP and ATC. This is encouraged through face-to-face activities such as new ATC mom visits and member orientation sessions.

Watch for activities that MemberConnections may be hosting in the ATC provider mailings. Participating ATC providers can contact the Member Services Department at 1-866-433-6041 to request that a home visit be completed when an ATC member is found to be non-compliant, (for example, missing medical appointments) with recommended medical treatment or has other identified issues or high-risk factors (for example, frequent emergency room visits for routine medical care) that negatively impact the member’s health status. ATC members who require additional coaching to learn how to access the system appropriately can be referred by the ATC PCP to have a visit from the MemberConnections representative.

MEMBER MATERIALS

Members will receive various pieces of information from ATC through mailings and through face-to-face contact. The Member Handbook is printed in English. These materials include:

• Quarterly Newsletters
• Targeted Disease Management Brochures
• Provider Directory
• NurseWise Information
• Emergency Room Information
• Member Handbook which includes:
Providers interested in receiving any of these materials may visit absolutetotalcare.com or contact:

**Member Services Department**
Telephone: 1-866-433-6041
Fax: 1-866-912-3610
TTY: 711
absolutetotalcare.com

**PROVIDER BILL OF RIGHTS**

ATC Providers shall be assured of the following rights:

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

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

ATC members have the following rights and responsibilities:

- To choose a PCP and to change to another PCP.
- To voice grievances or file appeals about ATC decisions that affect their privacy, benefits or the care provided.
- To request and receive a copy of their medical record.
- To make recommendations regarding ATC’s member rights and responsibilities policy.
- To request that their medical record be amended or corrected.
- To file for a State Fair Hearing with SCDHHS.
- To make an advance directive, such as a living will.
- To receive information about ATC’s benefits, services, practitioners, providers, member rights and responsibilities.
- To be treated with respect and with due consideration for his or her dignity and the right to privacy and non-discrimination as required by law.
- To participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive assistance from both SCDHHS and ATC in understanding the requirements and benefits of the health plan.
- To have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To receive information on the Grievance, Appeal and State Fair Hearing procedures.
- To expect their medical records and care be kept confidential as required by law.
- To receive ATC’s policy on referrals for specialty care and other benefits not provided by the
member’s PCP.

- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).

- To exercise these rights without adversely affecting the way ATC, its providers or SCDHHS treat the members.

- To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law.

- To receive timely access to care, including referrals to specialists when medically necessary without barriers.

- To receive materials – including enrollment notices, information materials, instructional materials, available treatment options and alternatives, etc. – in a manner and format that may be easily understood.

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

- To receive oral interpretation services free of charge for all non-English languages.

- To be notified that oral interpretation is available and how to access those services.

- To receive information about the basic features of managed care; which populations may or may not enroll in the program and ATC’s responsibilities for coordination of care in a timely manner in order to make an informed choice.

- To receive information on the following:
  
  o Benefits covered
  
  o Procedures for obtaining benefits, including any authorization requirements
  
  o Cost sharing requirements
  
  o Service area
o Names, locations, and telephone numbers of non-English language speaking ATC providers, including at a minimum, PCPs, specialists and hospitals

o Any restrictions on member’s freedom of choice among network providers

o Providers not accepting new patients

o Benefits not offered by ATC, but available to members and how to obtain those benefits, including how transportation is provided

• To receive a complete description of disenrollment rights at least annually.

• To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.

• To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  o Emergency medical condition, emergency services and post-stabilization services
  o Emergency services do not require prior authorization
  o Process and procedures for obtaining emergency services
  o Locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract
  o The right to use any hospital or other setting for emergency care
  o Post-stabilization care services rules in accordance with Federal guidelines

**MEMBER RESPONSIBILITIES**

ATC members have the following responsibilities:

• To choose a person to act on their behalf.

• To inform ATC of the loss or theft of their ID card.

• To present their ID card when using healthcare services.

• To be familiar with ATC procedures to the best of their ability.

• To call or contact ATC to obtain information and have questions clarified.

• To provide information (to the extent possible) that ATC and its practitioners and providers need in order to provide care.

• To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with their practitioners/providers.
• To inform their provider on reasons they cannot follow the prescribed treatment of care recommended.

• To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

• To keep their medical appointments and follow-up appointments.

• To access preventive care services.

• To follow the policies and procedures of the SCDHHS Medicaid Plan.

• To be honest with providers and treat them with respect and kindness.

• To get regular medical care from their PCP before seeing a specialist.

• To follow the steps of the appeal process.

• To notify SCDHHS, ATC and your providers of any changes that may affect their membership, healthcare needs or access to benefits. Some examples may include:
  
  o If they have a baby
  
  o If their address changes
  
  o If their telephone number changes
  
  o If they or one of your children are covered by another health plan
  
  o If they have a special medical concern
  
  o If their family size changes

• To keep all scheduled appointments, be on time for those appointments and cancel (24) hours in advance if they cannot keep an appointment.

 MEMBER GRIEVANCES

A grievance is an expression of dissatisfaction about any matter other than an “action” such as:

Examples:
  
  • Wait time to see a doctor
  
  • Rudeness of a provider or office staff
  
  • Unclean facilities

Grievances may be filed either orally or in writing with ATC within 30 days of the occurrence. A member or a member’s authorized representative can file a grievance with ATC. An authorized representative is a person or provider a member gives the right to act on their behalf.

A member can give permission for a person or a provider to act on their behalf in writing or by completing the Appointment of Authorized Representative Form found on the website at absolutetotalcare.com.
If needed ATC will assist members in filing a grievance. This includes providing assistance with accessing interpreter services and hearing impaired services, if needed, at no cost to the member. ATC cannot and will not treat members differently because they have filed a grievance and their benefits will not be affected.

To file a grievance members can do one of the following:

- Call Member Services at 1-866-433-6041.
- Mail, email or fax a completed Grievance Form or written letter telling us why they are not satisfied. Obtain a Grievance Form from the ATC website at absolutetotalcare.com or by calling Member Services. Information should include:
  - Member's first and last name
  - Member’s ATC Member ID card number
  - Member’s address and telephone number
  - The reason for the grievance

  **Mail:** Absolute Total Care
  Grievance and Appeals Coordinator
  1441 Main Street Suite 900
  Columbia, SC 29201
  **Fax:** 1-866-918-4457
  **Email:** SC_Appeals_And_Grievs@centene.com
- Members can present their evidence in person at the address above

ATC will send a letter to the member confirming the receipt of the grievance within **five calendar days.** We will try to make a decision right away. If not, we will send a written decision within **90 calendar days** from receipt of the grievance. ATC may extend the timeframe to resolve the grievance up to **14 calendar days** if the member or the member’s authorized representative requests additional time or ATC can demonstrate that there is a need for additional information that is in the member’s best interest. ATC will send written notification to the member of the reason for the additional time to resolve the issue.

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

**MEDICAL APPEALS**

An appeal is the request for review of an “action” or a request to change a previous decision made by ATC. NCQA refers to all requests to reverse a decision as appeals.

An “action” is the denial or limited authorization of a **requested service**, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner, as defined by the State of South Carolina; the failure of ATC to act within authorization time frame requirements; or the denial of a member, who is resident of a rural area where there is only one MCO, request to exercise his or her right to obtain services outside the ATC network. NCQA refers to all requests to reverse a decision as appeals.
An appeal may be filed within **90 calendar days** from the receipt of the Notice of Action letter. The Notice of Action letter will explain the action ATC has taken, explain the appeals process and includes a copy of the Appeal Form. Information on the appeals process and a copy of the Appeal Form can also be found on our website at absolutetotalcare.com. A member or a member’s authorized representative file an appeal with ATC. An authorized representative is a person or provider a member gives the right to act on their behalf. A member can give permission for a person or a provider to act on their behalf in writing or by completing the Appointment of Authorized Representative Form found on the website at absolutetotalcare.com. Requests for an appeal that are received without the member consent cannot be processed.

If needed ATC will assist members in filing an appeal. This includes providing assistance with accessing interpreter services and hearing impaired services, if needed, at no cost to the member. ATC cannot and will not treat members differently because they have filed an appeal and their benefits will not be affected. The review may be requested in writing or orally, however oral requests for appeals within the standard time frame must be confirmed in writing within **30 calendar days** of the date of the request, unless the member or the member’s authorized representative request expedited resolution.

**To file an appeal do one of the following:**

- **Call Member Services at 1-866-433-6041.** For a standard appeal a written request confirming the appeal must be sent to ATC within **30 calendar days**. An expedited appeal does not require written confirmation.
- **Mail, email or fax a completed Appeal Form or written letter about the appeal.** Obtain an Appeal Form from the ATC website at absolutetotalcare.com or by calling Member Services. A copy of the Appeal Form is also included with the Notice of Action letter. Information should include:
  - Member’s first and last name
  - Member’s ATC Member ID card number
  - Member’s address and telephone number
  - The reason for the appeal

  **Mail:** Absolute Total Care
  Grievance and Appeals Coordinator
  1441 Main Street Suite 900
  Columbia, SC 29201
  **Fax:** 1-866-918-4457
  **Email:** SC_Appeals_And_Grievs@centene.com

- **Members can present their evidence in person at the address above.** For a standard appeals a written request confirming the appeal must also be sent to ATC within **30 calendar days**. An expedited appeal does not require written confirmation.

ATC will send a letter letting the member know that we received the appeal. Members also have the right to present evidence regarding their appeal in person, in writing or by phone. Members also have the right to review any evidence and documents regarding their appeal in person at the ATC office address listed above. **There are two kinds of appeals:**

**Standard Appeal** – ATC will provide a written decision within **30 calendar days** from the date the request was received.

**Expedited Appeal** – If a decision on an appeal is required immediately due to the member’s health needs, which cannot wait with the standard resolution time, an expedited appeal may be requested.
ATC’s decision on the expedited resolution will be provided within **72 hours** of the receipt of the request. **An expedited appeal does not require written confirmation.**

If the request for an expedited appeal is denied ATC will make efforts to contact the member and provider promptly by phone. In addition, the member and provider will be sent a written notice within **72 hours** from date of receipt of the expedited appeal. ATC will follow the standard appeal timeframe and provide a written decision within **30 calendar days** from the original appeal request.

**Extension of an Appeal** - ATC may extend the timeframe to resolve a standard or an expedited appeal up to **14 calendar days** if the member or the member’s authorized representative request an extension, or ATC can demonstrate that there is a need for additional information that is in the member’s best interest. The member will be notified in writing of the reason for the additional time to resolve the issue for an extension not requested by the member.

The appeal will be reviewed, and a final decision will be made, by a medical director who was not involved in the prior decision.

ATC will not take punitive action against a provider who requests an expedited resolution or supports a member’s appeal request.

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

**Member Rights to a State Fair Hearing**
If the member is not satisfied with the final appeal decision, the member or the member’s authorized representative may file an appeal directly to SCDHHS Division of Appeals and Hearings. The request for a State Fair Hearing must be made within **30 calendar days** from the date the member receives the Notice of Resolution letter or ATC receives a failure of delivery notification. An authorized representative is a person or a provider a member gives the authority to act on their behalf. The member can give permission for a person or a provider to act on their behalf in writing by completing the Appointment of Authorized Representative Form found on the website at absolutetotalcare.com.

Request for a State Fair Hearing must be in writing and sent to:
South Carolina Department of Health and Human Services
Division of Appeals and Hearings (Suite 901)
P.O. Box 8206
Columbia, SC 29202-8206
1-803-898-2600

**CONTINUATION OF BENEFITS**

ATC members may continue receiving services or items until a decision is made about his or her appeal or State Fair Hearing process if the member was receiving ongoing services that were suspended, reduced or terminated. To ensure continuation of currently authorized services or the member’s authorized representative must file a medical appeal within **ten calendar days** following ATC’s mailing of the Notice of Action or the intended effective date of the Action. The member can give permission for a person or a provider to act on their behalf in writing by completing the Appointment of Authorized Representative Form found on the website at absolutetotalcare.com.
Members may be required to pay the costs of the services if the final appeal or State Fair Hearing decision is adverse to the member.

ATC will continue the member’s benefits if the following conditions are met:

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

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

- The member or the member’s authorized representative withdraws the appeal request
- Ten calendar days pass after ATC mails the Notice of Action letter providing the resolution of the appeal, unless the member, within the 10-day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached
- A State Fair Hearing officer issues a decision adverse to the member
- The time period or service limits of a previously authorized service has been met

ASSISTANCE AND CONTACTING ABSOLUTE TOTAL CARE

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

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

The Managed Care Organization contract allows for a provider or another person, acting on behalf of the member with the member’s written consent, to file a grievance, an appeal or request a State Fair Hearing. A member can give written consent for a provider or another person to act on their behalf by completing the Appointment of Authorized Representative Form found on the website at absolutetotalcare.com. A copy of the completed Authorized Representative Form will need to be attached when an authorized provider or person files a grievance, an appeal or request a State Fair Hearing on behalf of a member. Requests that are received without the member consent cannot be processed.

SPECIAL SERVICES TO ASSIST WITH MEMBERS

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

There are several services that are also available to the members to assist with their everyday needs. Please see the description below.
INTERPRETER/TRANSLATION SERVICES

ATC is committed to ensuring that staff and subcontractors are educated about, remain aware of and are sensitive to the linguistic needs and cultural differences of its members. In order to meet this need, ATC is committed to the following:

- Having individuals available who are trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical or treatment information with members as needed.

- Providing Language Line services that will be available 24 hours a day, seven days a week in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.

- In-person interpreter services are made available when ATC is notified in advance of the member’s scheduled appointment in order to allow for a more positive encounter between the member and provider; telephonic services are available for those encounters involving urgent/emergent situations, as well as non-urgent/emergent appointments as requested.

- Providing TTY access for members who are hearing impaired through 711.

- ATC medical advice line, NurseWise, provider 24-hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line.

- Providing or making available Member Services and Health Education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee.

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

COVERED PHARMACY SERVICES

Prescription drug benefits are managed though ATC and are administered by ATC’s prescription benefit manager, Envolve Pharmacy Solutions. ATC uses a Preferred Drug List (PDL). This is a list of prescription drugs approved by ATC for use by our members. All generic drugs and certain brand name drugs listed in the PDL are covered. Some drugs, even though they are listed on the PDL, may have special limitations such as quantity limits and age restrictions. Others may require the member to try and fail other preferred medications first. Non-PDL drugs may be requested through the Prior Authorization process. Some drugs are excluded from the pharmacy benefits such as those for weight loss, infertility and cosmetic purposes. The PDL is available to providers on the ATC website at absolutetotalcare.com. There is a limit of four prescriptions per month for adults ages 21 and older (no limit for members age 20 and younger). If a member meets the four prescription limit up to three additional prescriptions are available if a provider believes there is a need for additional medications and if the
prescription meets certain specified criteria. Please see the PDL for details on what prescriptions qualify. There is a Limit 31-day supply limit per prescription filled, new or refilled.

PHARMACY POLICY

ATC’s pharmacy benefit provides access to a broad range of approved medications using a PDL. The PDL does not:

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

The PDL is administered by the P&T Committee, composed of the Medical Director, Pharmacy Director and community based PCP and specialists. The primary function of the committee is to assist with the maintenance of the ATC PDL and to establish programs and procedures for promoting positive patient outcomes in the Medicaid population. The Drug Utilization Review (DUR) program of South Carolina must approve inclusion and exclusion of drugs on the ATC PDL.

Generic substitution is mandatory when a generic equivalent is available. All branded products that have three or more A-rated generic equivalents will be reimbursed at the maximum allowable cost (MAC). The mandatory generic substitution provision is waived for drugs that have a narrow therapeutic index.

PRIOR AUTHORIZATION

The PDL attempts to provide appropriate and cost effective drug therapy to all participants covered by the ATC pharmacy program. If a patient requires medication that does not appear on the PDL, the physician can make a request for a non-preferred medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. The P&T Committee or the Clinical Policy Committee established the prior authorization criteria. In order for a member to receive coverage for a medication requiring prior authorization, the physician or pharmacist must submit a “Prior Authorization Request Form.” To ensure timely processing of requests, all relevant clinical information and previous drug history must be included and the form mailed, faxed or telephoned to:

**Envolve Pharmacy Solutions**
5 River Park Place East, Suite 210
Fresno, California 93720

Prior Authorization Phone: 1-866-399-0928
Prior Authorization Fax: 1-866-399-0929
www.envolverx.com

OVER-THE-COUNTER MEDICATIONS

Many over-the-counter (OTC) medications are available to our members on the PDL. OTC medications must be written on a valid prescription, by a licensed prescriber, in order to be filled by the pharmacy.

INJECTABLES AND ORAL ANTI-CANCER DRUGS

Some injectable drugs and oral cancer drugs that can be self-administered by the patient or family member are listed in the PDL and are covered under the pharmacy benefit. The majority of self-
administered injectable drugs, and several oral anti-cancer drugs, will require prior authorization from ATC prior to dispensing. Please refer to the Biopharmaceutical Pharmacy Program Document found on the ATC website at absolutetotalcare.com for instructions on how to get a prior authorization from the ATC Pharmacy Department or call 1-866-433-6041.

FIVE DAY SUPPLY POLICY

State law requires that a pharmacy dispense a five day supply of medication to any member awaiting a prior authorization or medical necessity determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy for medications not included in the PDL. All participating pharmacies are authorized to provide a five day supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the five day supply of medication whether or not the prior authorization or medical necessity request is ultimately approved or denied. This five day supply should be allowed without the need for a phone call; but if there is a problem, the pharmacy must call Envolve Pharmacy Solutions at 1-800-364-6331 for a prescription override to submit the five day supply of medication for payment.

CONTINUITY OF CARE/TRANSITION OF CARE

The Continuity of Care (COC) process promotes the appropriate, safe and effective transition of medications for new members on a prescription drug not on ATC’s PDL to a prescription drug on the PDL. ATC will review the previous 90 days of claim history to determine if a member is on a non-formulary drug. The member will be allowed to fill the prescription for an additional 30 calendar days without requiring a prior authorization or disruption. Members being treated for major depression, schizophrenia, bipolar disorder, major anxiety disorder and attention-deficit/hyperactivity disorder are allowed to receive their prescriptions for an additional 60 calendar days.

EXCLUSIONS

All prescriptions are limited to a 31-day supply per fill. The following drug categories are not part of the ATC PDL and are not covered regardless of circumstance:

- Weight control products (except lipase inhibitors)
- Investigational pharmaceuticals or products
- Immunizing agents (except for influenza, pneumococcal and hepatitis-B vaccines)
- Pharmaceuticals identified by CMS as less than effective and identical, related or similar drugs (DESI drugs)
- Injectable pharmaceuticals (except those listed in the PDL)
- Fertility products
- Infusion supplies
- Nutritional supplements
- Pharmaceuticals used for cosmetic purposes or hair growth
- Erectile dysfunction products prescribed to treat impotence