

Absolute Total Care 2023 Virtual Provider Town Hall 1<sup>st</sup> Quarter

4/12/2023

1-866-433-6041 ATC-04062023-AP-1

absolutetotalcare.com

#### Meeting Overview

- Absolute Total Care Healthy Connections Medicaid
  - Redetermination
- Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan)
- Ambetter from Absolute Total Care
  - Ambetter Virtual Access
  - No Surprises Act
- Wellcare Medicare Plans
- Annual Provider Training Requirements for Medicare
- Balance Billing
- No-cost interpreter services and oral translation services
- Website Features and Secure Provider Portal Features
- Claims 411 Did You Know?
- Electronic Funds Transfer (EFT)
- Network Development and Participation
- Credentialing Rights
- Quality Improvement
- CAHPS<sup>® -</sup>Consumer Assessment of Healthcare Providers and Systems
- Start Smart for Your Baby Q&A



#### 4/12/2023

#### Provider Relations Team



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#### Provider Relations Team



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### Poll Question #1



#### What area do you support in your organization/practice?

- o Billing/Claims Payment/Revenue Cycle
- o Community Relations
- o Direct Patient Care
- o Medical Management
- o Network Development/Contracting
- o Pharmacy
- o Pre-cert/Authorizations
- o Quality Improvement





#### Products and Services



#### Absolute Total Care Healthy Connections Medicaid



- Serving approximately 240,000 members statewide
- 2023 Benefit Highlights:
  - o Telehealth services for medical and behavioral health\*
  - o Copay waived for medically necessary COVID-19 testing
  - o Sports physicals one per calendar year
- My Health Pays Rewards- Members can earn \$5 to \$50 by completing healthy behaviors
  - https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards.html

\*ongoing continuation is being evaluated based on Public Health Emergency (PHE)



## Medicaid Annual Eligibility Review Process



- SCDHHS will restart the standard annual review process April 1, 2023, and will review groups of members each month over the next 12 months.
- SCDHHS will try to renew individuals' Medicaid eligibility with information readily available.
  - If the SCDHHS can verify continued eligibility, the member will receive a "continuation of benefits" notice and will not receive an annual review form.
- If continued eligibility cannot be confirmed, SCDHHS will mail an annual review form to the member to be completed and returned.
  - SCDHHS will notify the member via mail and text message (if email and cell phone number is on file).
- Members will have approximately 60 days to return the completed annual review form.
- Failure to return a completed annual review form may result in a member's loss of Medicaid benefits.
- Providers should know their patients' Medicaid coverage may be impacted when we restart of the standard annual review process.
- Providers should verify Medicaid eligibility starting April 1, 2023, as members may no longer be eligible for Medicaid or may have changed managed care organizations (MCOs) during the review process.

### How Does the Annual Review Process Affect Your Patients



- Some patients who complete an annual review form will no longer meet Medicaid eligibility requirements and their Medicaid coverage will end on the date specified in the notification from SCDHHS.
- Providers should verify Medicaid eligibility starting April 1, 2023, as patients may no longer be eligible for Medicaid.
- These members will be forwarded to the Health Insurance Exchange where they may shop for and enroll in private medical insurance.
- These patients may also contact their current MCO for information on other coverage products they may qualify for on the Health Insurance Marketplace or check with their current employer to see if they offer health coverage.
- Providers should verify Medicaid eligibility starting April 1, 2023, as patients may no longer be eligible for Medicaid.

### How Does the Annual Review Process Affect Your Patients



- Some patients will submit an incomplete annual review form or may be required to submit additional information to verify eligibility.
- These patients will receive a follow-up letter from SCDHHS identifying the information needed to make an eligibility determination and the requirement to submit the information 15 days from the letter date.
- Patients whose Medicaid coverage ends due to the failure to submit an annual review form are encouraged to submit the completed form as soon as possible to allow SCDHHS to make an eligibility determination.
- If the annual review form is returned late and the patient is determined eligible, Medicaid coverage may be provided up to 90 days retroactively. Managed care enrollment is not retroactive. As a result, some patients will not be enrolled in an MCO for a period of time or may be enrolled in a different MCO.
- Providers should verify Medicaid eligibility starting April 1, 2023, as patients may no longer be eligible for Medicaid or may have changed managed care organizations (MCOs) during the review process.

#### What Should Your Patients Do?



- Contact SCDHHS now to update their mailing address, contact information and other household details. This can be accomplished by:
  - Updating their information online at <u>apply.scdhhs.gov</u> and selecting the "Update your address here" link in the center of the page; or
  - Calling Healthy Connections at (888) 549-0820 Monday through Friday from 8 a.m. to 6 p.m.; or
  - Visiting their local <u>Healthy Connections Local Eligibility Office</u> in person.
- Look for mail from Healthy Connections Medicaid starting April 1, 2023.
- Complete fully and clearly the annual review form and return all requested information by the date listed on the annual review form using one of the options below:
  - Online Use our document upload tool at <u>apply.scdhhs.gov</u>
  - Fax (888) 820-1204
  - Email <u>8888201204@fax.scdhhs.gov</u>
  - Mail SCDHHS Central Mail, PO Box 100101, Columbia, SC 29202
  - In-person Visit <u>scdhhs.gov</u> for a <u>list of local eligibility offices</u>
- Absolute Total Care members can call Absolute Total Care at (866) 433-6041 for questions and/or assistance with competing the annual review form.

#### How Providers Can Help Patients



- Encourage patients to update their mailing address and contact information with SCDHHS.
- Post the SCDHHS change of address flyer available on SCDHHS' website in a prominent place in the office. The flyer is available in <u>English</u> and <u>Spanish</u>.
- Help patients understand that the standard annual reviews process will restart April 1, 2023, and their Medicaid coverage may be impacted after this date.
- Remind patients that starting April 1, 2023, they may receive an annual review form or continuation of benefits notice in the mail from SCDHHS.
- Encourage patients to complete fully and clearly the annual review form and return all requested information by the date listed on the annual review form they receive.
- Visit, and encourage patients to, visit <u>www.scdhhs.gov/annualreviews</u> for the latest information and resources about Medicaid annual eligibility reviews.
- Encourage patients that have questions or need assistance completing the annual review from to contact their current MCO.
- Encourage patients that lose Medicaid coverage to contact their current MCO for information on other coverage products they may qualify for or check with their current employer to see if they offer health coverage.

# Absolute Total Care is Here to Help



- Absolute Total Care will be conducting telephonic, email and text outreach to members to encourage members to complete fully and clearly the annual review form and return all requested information by the date listed on the annual review form they receive.
- Absolute Total Care will have information posted on our public website and secure member/provider portals on the annual review process.
- Absolute Total Care has Retention Specialists available to answer questions and assist members completing the annual review form.
- Absolute Total Care is available to partner on member events to assist with the annual review process.
- Absolute Total Care has in-office material available on the annual review process and other healthcare options we offer.

#### Important Links and Contact Information

- SCDHHS <u>Medicaid Annual Reviews</u> Resources
- <u>apply.scdhhs.gov</u> contact information updates and document uploads
- SCDHHS <u>Provider Fact Sheet</u>
- SCDHHS <u>Member Fact Sheet English</u>
- SCDHHS <u>Member Fact Sheet Spanish</u>
- SCDHHS Change of Address Flyer English
- SCDHHS Change of Address Flyer Spanish
- Healthy Connections Local Eligibility Offices

Absolute Total Care 1-866-433-6041 absolutetotalcare.com South Carolina Medicaid 1-888-549-0820 apply.scdhhs.gov Health Insurance Marketplace 1-800-318-2596 healthcare.gov



#### 4/12/2023

#### Wellcare Prime by Absolute Total Care





- Serving approximately 3,800 dual-eligible members (age 65+)
- 2023 Benefit Highlights:
  - o State-wide service area
  - o Telehealth services for medical and behavioral health
  - o Transportation: Unlimited one-way rides to plan-approved locations
  - o Over-the-counter: \$100 per calendar quarter
  - o Hearing: One hearing aid per calendar year
  - o Fitness: Up to \$250 toward gym membership
- My Health Pays rewards-Members can earn \$20 by completing healthy behaviors
  - https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards1.html

### Ambetter from Absolute Total Care



- Health Insurance Marketplace
- Serving approximately 100,000 members statewide
- 2023 benefit highlights:
  - o \$0 copay for telehealth services for medical care
  - o Health Savings Accounts
  - o Dental
  - o Routine vision
  - o Virtual plan option
  - o Concierge services for disease management
- Balance billing protection via the "No Surprises Act"

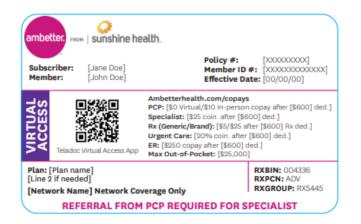
# Ambetter Virtual Access



Ambetter Virtual Access was designed for members who desire a Virtual Primary Care experience.

- Members enrolled in Ambetter Virtual Access-Teladoc require a referral from their PCP in order to see a specialist.
  - o Members cannot self-direct care outside of PCP care
  - o Non-emergent, non-authorized, out-of-network is not covered
  - o Emergent & Authorized Services OON are covered
- Members 18 and above are assigned to a Teladoc PCP.
  - Minors are assigned to traditional brick and mortar PCPs.
  - Members can "opt-out" and choose an in-network brick and mortar PCP.
  - A member who opts out will lose the \$0 PCP copay benefit and a copay will apply.
- Members assigned to Teladoc can see any Teladoc provider within their group

#### Ambetter Virtual Access



Member/Provider Services: 1-877-687-1169 (Relay Florida 1-800-955-8770) 24/7 Nurse Line: 1-877-687-1169	Medical Claims Address: Sunshine Health Attn: CLAIMS PO Box 5010
Numbers below for providers: Pharmacy Help Desk: 1-888-304-9081 EDI Payor ID: 68069	Farmington, MO 63640-5010 Scanto receive 20% off Waigewent brach health and
* Exclusions and restrictions apply. See Walgreens.com/SmartSavings fr	ar details.



#### 4/12/2023

#### No Surprises Act



The No Surprises Act is specific to the Ambetter (Marketplace) product.

Effective January 1, 2022 and applies to:

- Emergency care at out-of-network facilities
- Post stabilization care at out-of-network facilities
- Non-emergency services provided by out-of-network providers at in-network facilities, unless
  notice and consent is given
- Out-of-network air ambulance services
- No balance billing for out-of-network emergency services.
- No balance billing for non-emergency services rendered by nonparticipating providers at in-network hospitals and ambulatory surgical centers:
  - Emergency Medicine, Anesthesiology, Pathology, Radiology and Neonatology
  - Services provided by assistant surgeons, hospitalists, and intensivists
  - Items and services provided by a nonparticipating provider if there is no participating provider who can provide such item or service at the facility

#### Wellcare Medicare Advantage HMO



**Health Maintenance Organization (HMO)** –Traditional MA plan. All services must be provided within the Wellcare network unless an emergency or urgent need for care arises, or such service is not available in-network. Some services require prior authorization by Wellcare, or its designee.

**HMO with Point-of-Service Option (HMO-POS)** – The point-of-service (POS) benefit allows Members to access most Medicare-covered, Medically Necessary services from non-network providers, and they are entitled to use their POS option anywhere in the United States.

State	Services NOT covered by POS benefit
Arkansas, , Florida, Georgia, Illinois, Kentucky, Michigan, Mississippi, New Jersey, Ohio, South Carolina, Tennessee, and Texas	Services not covered by Medicare

### Wellcare Medicare Advantage PPO



With the Wellcare Medicare Advantage PPO plan, members enjoy the freedom to receive healthcare services from Medicare providers of their choice. As an eligible Medicare provider, Wellcare reimburses you at 100% of the Medicare allowable rate for all plan-covered, medically necessary services for our PPO members – whether you are contracted with us or not.

#### INCREASED FLEXIBILITY

• The Wellcare Medicare Advantage PPO plan offers members flexibility as they navigate their care journeys. PPO members don't need a referral from a primary care physician for specialist or hospital visits. However, using providers in Wellcare's network may cost less than choosing one that is out-of-network. Medicare providers who do not contract with Wellcare are under no obligation to treat our members, except in emergency situations.

In addition, the Wellcare Medicare Advantage PPO plan:

- Offers a simple copayment for doctor visits, hospital stays and many other healthcare services, making healthcare costs more predictable
- Gives members Medicare Parts A, B, and D coverage as well as vision, dental, and hearing benefits not covered by original Medicare
- Covers all original Medicare services and follows original Medicare's coverage rules
- Only covers medically necessary services rendered by providers who are eligible to participate in Medicare

#### Annual Provider Training Requirements



Absolute Total Care partners with each of our contracted providers to ensure that you have received the necessary training to deliver quality care to our members and your patients and to be compliant with Centers for Medicare & Medicaid Services (CMS) and state requirements. All Medicare Advantage Organization (MAO) and Medicare-Medicaid Plan (MMP) contracted providers are required to complete the following trainings within 90 days of contracting and annually thereafter:

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

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

#### Balance Billing



- What is balance billing?
  - Seeking payment from members for the difference between the billed charges and the contracted rate paid by the plan
    - Payments less any copays, coinsurance, or deductibles are considered payment in full
- Prohibited by federal law
  - Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances
    - Original Medicare and Medicare Advantage providers and suppliers not only those that accept Medicaid – must not charge individuals enrolled in the QMB program for Medicare cost-sharing

#### **Balance Billing**



- Steps to ensure compliance with QMB billing prohibitions:
  - Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services
  - Ensure that a Member Acknowledgement Statement has been signed by both the provider and the Absolute Total Care member for non-covered services prior to rendering said service
  - If you have erroneously billed these members, recall the charges (including referrals to collection agencies) and refund the invalid payments
  - Healthy Connections prime link <u>https://msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing-healthy-connections-prime-members-0</u>

### No Cost Interpreter Services and Oral Translation Service



Absolute Total Care 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, Absolute Total Care is committed to the following:

- Having 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 24/7 in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.
- In-person interpreter services are made available when Absolute Total Care is notified two business days in advance of the member's scheduled appointment.
- Providing TTY access for members who are hearing impaired through 711.
- Absolute Total Care medical/nurse advice line is available 24/7 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.

For an interpreter for a medical visit, contact Member Services at 1-866-433-6041 (TTY: 711).

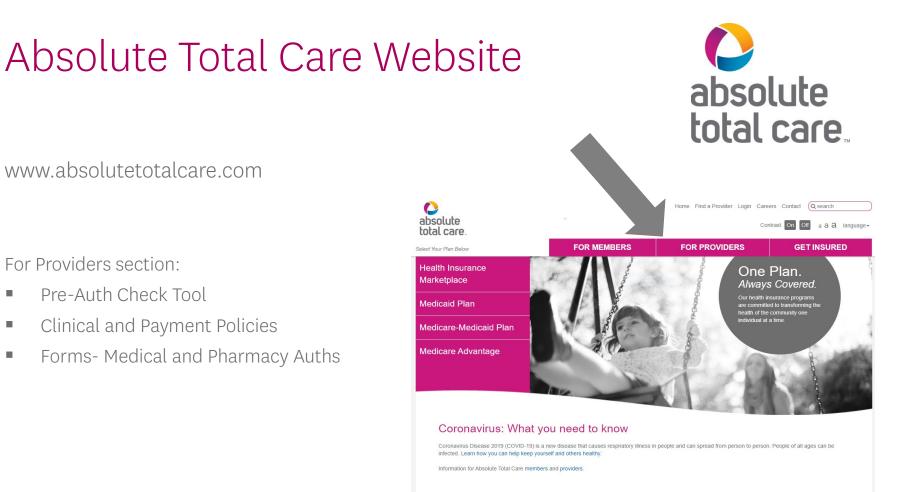
*For ASL interpreter requested please use the vendor portal:* <u>*www.lsaweb.com*</u>, call the vendor directly at 1-866-827-7028 *or email clientservices@lsaweb.com.* 

#### 4/12/2023



#### Websites and Secure Portals







## Pre-Auth Lookup Tool

Are Services being performed in the Emergency Department (other than observation), or Urgent Care Center, or Public Health or Public Welfare Agency, or Family Planning services billed with contraceptive management diagnosis?



🗌 Yes 🗹 No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	$\bigcirc$	۲
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	0	۲
Are services being rendered by a podiatrist?	$^{\circ}$	۲
Are anesthesia services being rendered for pain management?	0	۲

Enter the code of the service you would like to check:
99213
Check

No

**99213** - OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20-29 MIN No Pre-authorization is required for all providers.

If an authorization is needed, you can log in to your account to submit one online or fill out the appropriate fax form on the Provider Manuals and Forms page.

## Authorization Vendors



- Vision Services need to be verified by Envolve Vision.
- Musculoskeletal Services need to be verified by Turning Point
- Hospice requests should be submitted to SC DHHS Medicaid Fee for Service program.
- Oncology/supportive drugs for members age 18 and older need to be verified by New Century Health.
- Complex imaging, MRA, MRI, PET, CT scans need to be verified by NIA.
- Outpatient rehabilitative and habilitative physical medicine services PT, OT, and Speech need to be verified by NIA.

#### Absolute Total Care Secure Provider Portal

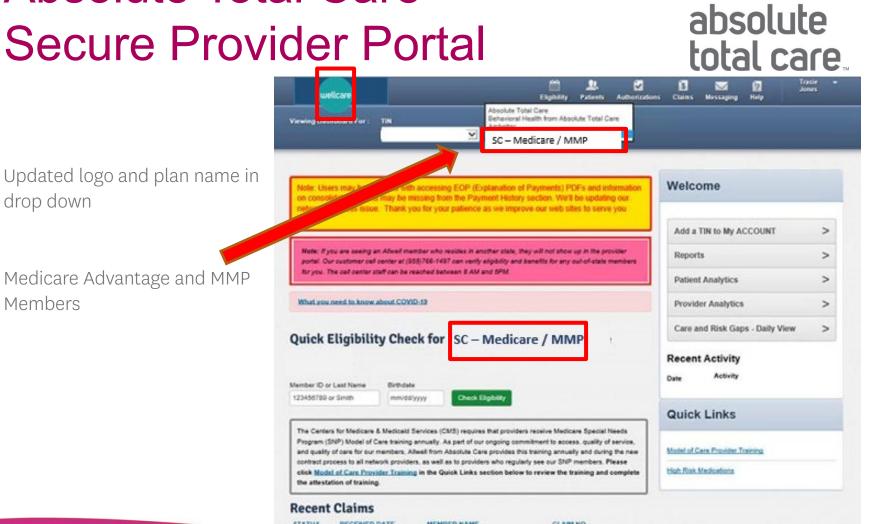


Log in: https://www.absolutetotalcare.com/login.html

Welcome to our n	With EntryKeyID new EntryKeyID log in tool. No more security questions. Simply use your email address to verify who you are. You can reset your password and unlock your account. Please note: We will send you an email to set your new password. In so lea are working to improve the delivery and reduce any delays.	ume cases, delivery of change password and other account related emails is currently taking longer
		🌐 English 👻
	absolute total care.	
	Log In	
	Username (Email)	
	LOG IN	
	Create New Account	
	single parameter Entry/KeyID	
	Help, EntropyEdity, Terma of Use © 2021 Centeres	



# Absolute Total Care Secure Provider Portal



4/12/2023

#### Absolute Total Care Secure Provider Portal

wing Patients For :							<b>1</b> Find Pa
Back to Jane 22263 D	00000060	As we	scroll through you w	/ill see	there is	a lot of	
Janezzzoj L	0622203	inform	nation on this screen.				
Overview	,						
Cost Sharing		This pat	ient is eligible as of toda	ay, Ma	r 14, 2013	3.	
Assessments							
	Patient In	nformatio	n	E	ligibility His	story	
Health Record	_	Name	Jane22263 Doe22263		Start Date	End Date	Product Name
Care Plan		Gender	F		Feb 1, 2013	Ongoing	LTC Non-Dual
Authorizations		Birthdate	Feb 4, 1959		Oct 1, 2012	Jan 31, 2013	SSI Non-Dual
Authorizations		Age	54 years old		Jul 1, 2011	Sep 30, 2012	SSI Non-Dual
Coordination of Benefits	1	/ledicaid #	099577407				
Claims	_	Address	13594795 Main Street AllCities08111, IL 08111	С	are Gaps		
	-					ropathy screening in	



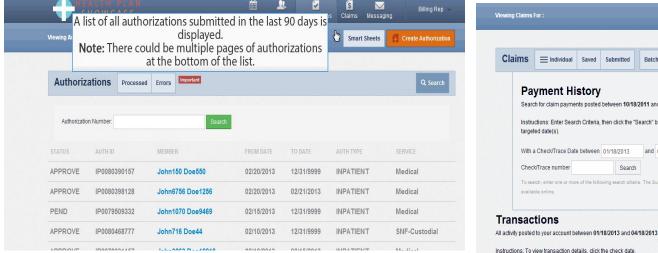
Member eligibility should be checked each month and each time prior to rendering services

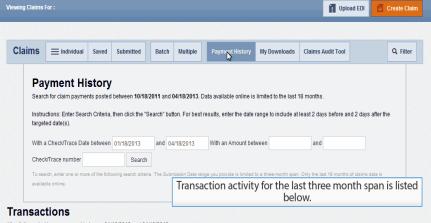
The Absolute Total Care Secure Provider Portal or the Interactive Voice Response (IVR) system are available 24 hours a day, seven days a week

- Absolute Total Care 1-866-433-6041 (Medicaid)
- Wellcare by Allwell 1-855-766-1497 (Medicare)
- Ambetter by Absolute Total Care 1-833-270-5443 (Marketplace)
- Wellcare Prime by Absolute Total Care 1-855-735-4398 (Medicare-Medicaid Plan)
- Wellcare Medicare 1-866-270-5223 (Medicare)

# Absolute Total Care Secure **Provider Portal**

#### Authorizations and Claims





absolute

total care.

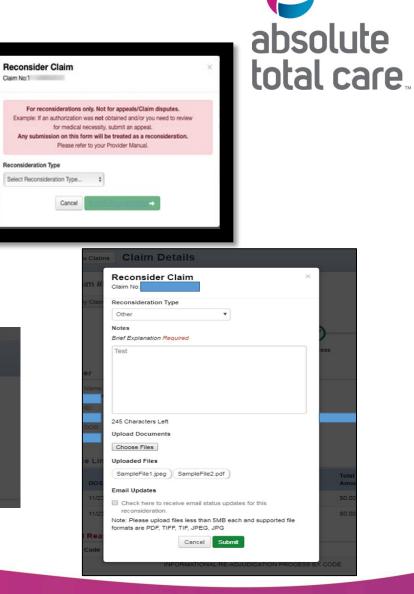
Instructions: To view transaction details, click the check date



#### Absolute Total Care Secure Provider Portal Provider Reconsideration

-		-	_		-						
Back	to Claims C	laim D	etails								
🕴 Cla	aim #		Deni	ed							
+00	py Claim	Correct Clain	CRec	onsider Claim							
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Membe	DOB:			Ser	vicina NPI:			Billed Amo \$160.00	unt		
								2100.00			
Servi	ce Lines										
Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Payment Amount	Payment Date	Check No.	Status	Payment Codes
1	01/22/2019	99213	\$82132 D, \$82112 D, W010X		22	\$160.00	\$0.00	02/01/2019		VOID	L6

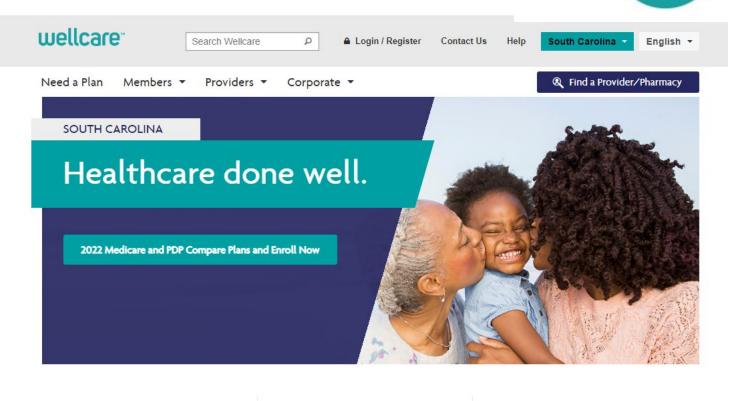
Reconsider Claim		
Reconsideration type		
Select Reconsideration Type	•	
Select Reconsideration Typ	1	
Denied for a Global/Unbund	led Procedure	
Denied for Untimely Filing		





#### Wellcare Website

wellcare



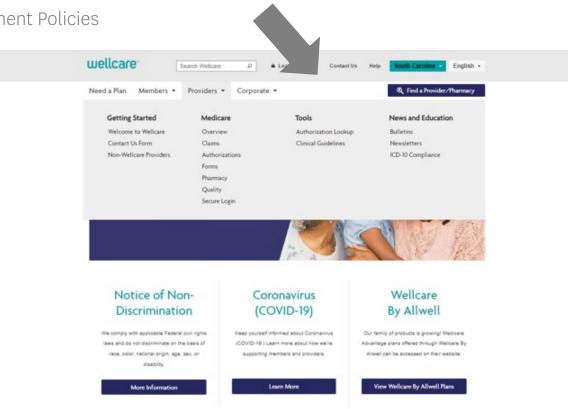
Notice of Non-Discrimination Coronavirus (COVID-19) Wellcare By Allwell

4/12/2023

### Wellcare Website

- For Providers section
- Pre-Auth Check Tool
- Forms
- Clinical and Payment Policies





## Pre-Auth Lookup Tool

#### **Authorization Lookup**

Please select your line of business and enter a CPT to look up authorization for services.

Select Line of Business Ø

South Carolina Medicare and PPO Plans

Enter CPT Code 📀

99213

<u>Reset</u>

Lookup

Results as of : 3/8/2023 11:58:25 AM CPT Code :

99213

**Description**:

OFFICE OR OTH OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST

11 Office :

No Authorization Required



## Authorization Vendors



- <u>eviCore</u> is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: Lab Management and Sleep Diagnostics.
- <u>NIA (National Imaging Associates)</u> is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: Advanced Radiology, Advanced Cardiology, Pain Management, Physical, Occupational and Speech Therapy.
- <u>HealthHelp</u> is our in-network vendor for the following programs, and provider resources can be accessed through the corresponding program links: Radiation Therapy and Medical Oncology.
- <u>CareCentrix</u> is our in-network vendor for the following programs and provider resources can be accessed through the corresponding program links: Skilled Nursing Facility, Long Term Acute Care and Inpatient Rehab.
- <u>TurningPoint</u> is our in-network Surgical Quality & Safety Management Program vendor for the following programs Orthopedic Surgery and Spinal Surgery.

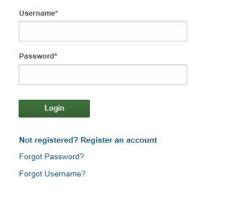


Log in: <a href="https://provider.wellcare.com/">https://provider.wellcare.com/</a>

Wellcare " Provider Portal



#### **Provider Login**



#### Thank you for using our Provider Portal.

Do you know about our **live agent chat feature?** Live-agent chat is the easiest and fastest way to get real-time support for an array of topics, including:

- Member Eligibility
- Claims adjustments
- Authorizations
- Escalations

You can even print your chat history to reference later!

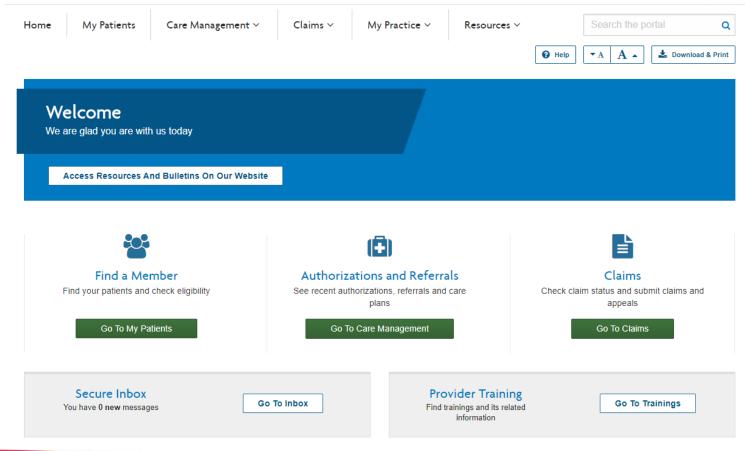
We encourage you to take advantage of this easy-to-use feature.

If you are having difficulties registering please click the "Chat with an Agent" button to receive assistance.

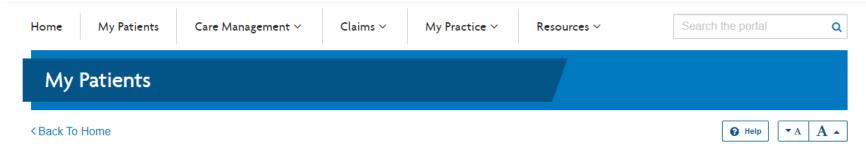
\*NOTE: The secure provider portal is for participating Wellcare providers only.



#### Home Screen



#### Eligibility and Member Information



#### Check Member Eligibility

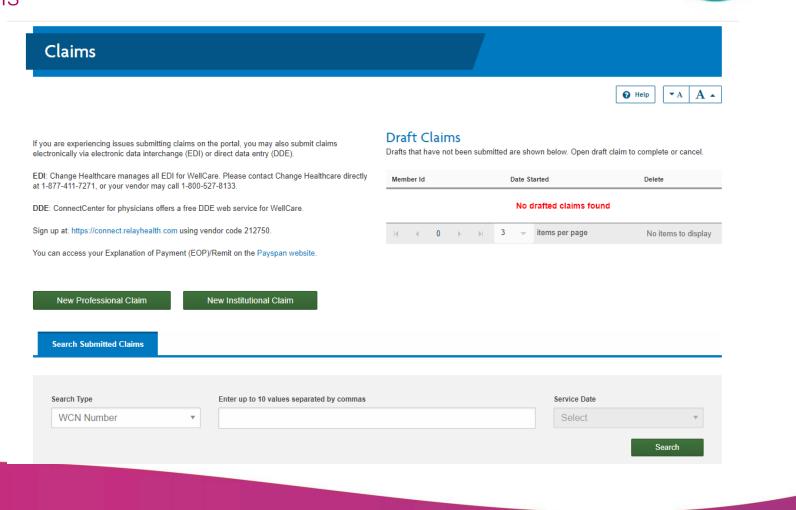
This section allows you to search for members and check eligibility.

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

Member ID	Check patient eligibility on this date
	11/04/2022
Medicaid ID Medicare ID	
	Search
	Search



### Wellcare Secure Portal Claims



wellcare

#### Authorizations



Care Management

Help • A A •

Search for status of previously submitted authorizations and referrals. Newly submitted authorizations may take up to 48 hours to be available for view of status in the portal.

Medical Authorizations	Referrals	Drug Authorizations			
				_	
Search by					
Authorization ID	Ŧ				Create Referral
Authorization ID					Create Authorization
					Submit Institutional Claim
					Submit Professional Claim
					SureScripts
					Wellcare.com
Search					



### Claims 411 – Did You Know?



### Claims 411 – Did You Know?



- Most common claim rejections:
  - o Member Not Valid at Date of Service (DOS)
  - o Invalid Member
  - o Invalid Member DOB
- Most common claim denials:
  - o Services Not on the Fee Schedule are Not Separately Reimbursable
  - o This Service is Not Covered
  - o Duplicate Claim Service
  - o CMS Medicaid NCCI Unbundling
  - o No Authorization on File that Matches Service(s) Billed
- Pre-authorization
  - o All inpatient services require an authorization
    - Professional services being performed per inpatient stay require a separate authorization and must be obtained to avoid claims denying for no authorization on file

### Claims 411 – Did You Know?

#### Clinical Policies



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

#### Payment Policies

Healthcare claims payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding. They are used to help identify whether healthcare services are correctly coded for reimbursement. Each payment rule is sourced by a generally accepted coding principle.

All policies found in the Absolute Total Care Payment/Clinical Policy Manual apply with respect to Absolute Total Care members. Policies in the Absolute Total Care Payment/Clinical Policy Manual may have either an Absolute Total Care or a "Centene" heading.

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

## Claims Submission



Claims must be filed electronically or sent directly to our claims processing center. Claims mailed to the physical office address will be returned and will not be able to be processed.

For claims processing efficiency, Absolute Total Care encourages providers to submit claims electronically.



## Claims Submission

Submit following one of the procedures below, according to line of business:



Line of Business	Electronic Claim Submission	Paper Claim Submission
	Secure Provider Portal:	Absolute Total Care
	www.AbsoluteTotalCare.com/Login	P.O. Box 3050
	or	Farmington, MO 63640-3821
Medicaid	EDI Payer Numbers:	
	68069 - Emdeon/WebMD/Envoy/PayerPath	Behavioral Health:
	42772 - Relay Health/McKesson	P.O. Box 7001
	68068 - Behavioral Health	Farmington, MO 63640-3811
		Ambetter from Absolute Total Care
Marketplace	Secure Provider Portal:	P.O. Box 5010
-	www.AbsoluteTotalCare.com/Login	Farmington, MO 63640-5010
ММР	or	
	EDI Payer Numbers:	Wellcare Prime by Absolute Total Care
	68069 - Emdeon/WebMD/Envoy/PayerPath	P.O. Box 3060
		Farmington, MO 63640-3822

## Claims Submission - Wellcare



- Claims are not accepted at local office
- Submit following one of the procedures below, according to line of business:

Line of Business	Electronic Claim Submission			Paper Claim Submission	
Medicare Advantage	Register online using the simplified, enhanced provider registration process at <u>PaySpan.com</u> or call <b>1-877-331-7154</b> Or Change Healthcare EDI Clearinghouse <b>1-877-411-7271</b> .			Wellcare Attn: Claims Department P.O. Box 31372 Tampa, FL 33631-3372	
	CHANGE HEA PAYER IDS (C	ITHCARE CLEAR PIDS) Fee-for-Service	Encounter		
	Claim Type Professional	(CH - Chargeable) Submissions 1844	(RF - Reporting only) Submissions 3211		
	Institutional	8551	4949		
	Change Heat use the follo Encounters · Fee-for-Ser Type Code expecting a · Encounters Code BHTO NOT expect	Ithcare and recovering accordin file type: vice (FFS) is define BHT06 as CH, which adjudication. s (ENC) is defined in 6 as RP, which mea- ting adjudication. FFS	Iling system is no quires a 5-digit Pa g to Fee-for-Serv d In the Transaction h means Chargeable, n the Transaction Type ns Reportable only, Encounter	ayer ID, please	
	Ctalm Type Professional or	(CH - Chargeable) Submissions	(RF - Reporting only) Submissions 59354		
	Institutional	100	w w w d w 1		

## Transition to Wellcare

#### CLAIMS SUBMISSIONS DATE OF SERVICE GUIDANCE

Date of Service	Health Plan	Health Plan Name	Transaction Type	Pa	per Claim Submissions
	Wellcare No Premium		EDI	Payer ID 68069	
Before	Wellcare by Allwell Medicare	(HMO) Wellcare Dual Liberty (HMO D-SNP) Wellcare Dual Access (HMO D-SNP)	Fee-For- Service &	Portal	https://www.absolutetotalcar e.com/login.html
01/01/2023			Encounter	Paper	Absolute Total Care P.O. Box 3060 Farmington, MO 63640
		Wellcare No Premium (HMO) Wellcare Assist		EDI	Payer ID 14163
After			(HMO) Wellcare Assist Fee-For- (HMO) Service	Portal	https://provider.wellcare.com /Provider/Login
01/01/2023	Wellcare	Wellcare Dual Liberty		Paper	Wellcare Attn: Claims Department P.O. Box 31372 Tampa, FL 33631-3372
	Wellcare	Wellcare No Premium		EDI	Payer ID 59354
After 01/01/2023		(HMO) Wellcare Assist (HMO) Wellcare Dual Liberty (HMO D-SNP)	Encounter	Portal	https://provider.wellcare.com /Provider/Login
				Paper	Wellcare Attn: Claims Department P.O. Box 31372 Tampa, FL 33631-3372

wellcare

### Claim Adjustments, Reconsiderations, and Disputes



*Claim Adjustments: Requests to change the initial claim* 

*Reconsiderations: Submitted when a provider disagrees with how a clean or adjusted claim was processed* 

*Disputes: Submitted when a provider has received an unsatisfactory response to a previous reconsideration request* 

### Provider Timeframes Claim Adjustments, Reconsiderations, and Disputes



MEDICAID				
Submission Timeframes	Par	Non-Par		
Claim Initial/Resubmission	365	365		
Claim Adjustment	365	365		
Claim Dispute	60	60		
Decision Timeframes Par Non-Par				
Dispute Decision	30	30		
Mailing Address				
P.O. Box 3050				
Farmington, MO 63640-3821				

MARKETPLACE			
Submission Timeframes	Par	Non-Par	
Claim Initial/Resubmission	120	120	
Claim Adjustment	60	60	
Claim Reconsideration	60	60	
Claim Dispute	60	60	
Decision Timeframes	Par	Non-Par	
Appeal Decision	30	30	
Dispute Decision	30	30	
Mailing Address			
P.O. Box 5010			
Farmington, MO 63640-5010			

## Provider Timeframes Claim Adjustments, Reconsiderations, and Disputes



	MMP	
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	365	365
Claim Adjustment	365*	365*
Claim Reconsideration	365*	365*
Claim Appeal	60	60**
Claim Dispute	60	60
Decision Timeframes	Par	Non-Par
Appeal Decision	30	60
Dispute Decision	30	30

Mailing Address

P.O. Box 3060 Farmington, MO 63640-3822

\*from date of service \*\*Waiver of Liability required \*\*\*from date of last processed claim

### Wellcare Provider Timeframes Claim Adjustments & Disputes



	PAR	NON-PAR
Claim initial/resubmission	180*	180*
Claim Payment Dispute	90*	90*
Claim Payment Policy Dispute	30***	30***
Appeal (Medical)	90	60**

\*from date of service

\*\*Waiver of Liability required

\*\*\*from date of last processed claim

## Electronic Funds Transfer



Absolute Total Care and PaySpan are in partnership to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment.

#### PaySpan Benefits:

- Elimination of paper checks
- Convenient payments and retrieval of remittance information.
- Electronic Remittance Advice (ERAs) presented online.
- HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System.
- Reduce accounting expenses: Electronic remittance advices can be imported directly into practice management or patient accounting systems

### Electronic Funds Transfer



PaySpan Benefits [CON'T]

- Improve cash flow: Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts: You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advices quickly: You can associate electronic payments with ERAs quickly and easily.
- Manage multiple payers: Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts, as desired.

### Electronic Funds Transfer



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



## NETWORK DEVELOPMENT AND PARTICIPATION

## Network Development and Participation



- Network Participation
  - The enrollment, credentialing and recredentialing processes exist to ensure that participating providers meet and remain compliant to the criteria established by Absolute Total Care, as well as government regulations and standards of accrediting bodies
- Network Development
  - o To request a <u>new</u> agreement, send an email to ATC\_Contracting@centene.com
  - For contract updates and questions (i.e., change of ownership, TIN changes, amendments, etc.), send an email to ATC\_Contracting@centene.com
- To add a new practitioner, providers must submit a Provider Data (Add) Form and Current W-9 to SouthCarolinaPDM@centene.com to begin the credentialing process
  - This process takes approximately 60 days to complete (follow ups prior to receiving the Welcome Letter can be done so by emailing SouthCarolinaPDM@centene.com)
  - o Recredentialing is performed at least every 36 months
  - Provider updating existing participating providers and locations may do so by emailing the Provider Data Form (Update) to SouthCarolinaPDM@centene.com

## 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. 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.



### Quality Improvement



## Key Quality Improvement Activities

Path to Successful Member Care

- Member Visits
- Flu Vaccinations

Path to Successful Provider Satisfaction

- HEDIS Hybrid
- Data Requests
- Claims Coding for Gap Closure

Path to Successful Annual Surveys

– CAHPS



## Fluvention®

An annual program designed to prevent influenza by promoting flu vaccinations among our members.

Campaign timing: September through March

Campaign details: includes a variety of outreach communications, such as text messages, emails, automated phone calls, and public service announcements





## CPT II and HCPCS Billing



#### Important Information on CPT II and HCPCS Codes

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

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

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

CPTII Codes and HCPCS Billing PRO\_91371E\_Approved\_01112022.pdf

# What measures do these codes apply to?

- Controlling Blood Pressure
  - Blood pressure results
- Hba1c levels
- Diabetic Retinal Eye Exams
- Care of Older Adults
  - Pain Assessment
  - Medication List and Review
  - Functional Status Assessment
- Medication Reconciliation Post Discharge
  - Medication List and Review after hospital discharge



## Electronic Medical Record (EMR) System

Remote Access to EMR:

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

- Reduce provider office staff activities regarding HEDIS Hybrid chart chase requests
- Decrease and avoid duplication of over utilization or retrieval efforts
- > Lead to improved HEDIS performance reporting
- Contact Jane Brown via email at jane.f.brown@centene.com





## Supplemental Data Feeds



Monthly Supplemental Data Feed

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

- ➢ Close care gaps
- ➢ Improve our HEDIS scores
- Potential incentives
- ➢ Reduces request for medical records
- Contact Jane Brown via email at jane.f.brown@centene.com





## CAHPS<sup>®</sup> Consumer Assessment of Healthcare Providers and Systems



### Importance of CAHPS®



- CAHPS is a program of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.
- CAHPS is a tool used to evaluate *member perception and overall satisfaction* in order to improve *the member experience*. CAHPS allows health plans to receive anonymous feedback from its members.
- CAHPS is the interaction and conversations with the front desk, any staff, and especially their providers.
- CAHPS survey aims to capture accurate and complete information regarding real experiences with individuals' healthcare.
- CAHPS scores account for CMS Medicare STAR Ratings, NCQA Health Insurance Plan Ratings, CMS Marketplace Quality Rating System (QRS) and SCDHHS Medicaid Quality Withhold Program.

### CAHPS<sup>®</sup> Provider Resource Guide



CAHPS (Consumer Assessment of Healthcare Providers and Systems)



CAHPS (Consumer Assessment of Healthcare Providers and Systems)

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PROVIDER ENGAGEMENT COLLATERAL

CATIPS surveys allow patients to evaluate the associated care definery that matter the messure through ALTHEADTH PLANS, we are committed to partnering with our providers to define an outstanding patient experience.

As a produkt, you are the next edited consorted of that experience, we want to ensure that you have exactly now your patients are coalasting your core. Have sales a memoritie review and to familiarite yoursed with some of the fox to be? Included in the survey.

#### CAHPS MEASURE: GETTING NEEDED CARE

The Getting Meeded Care measure assesses the case with which patients received the care, tests, or treatment they needed, it also assess new often they were able to get a specially, appendixen is checkuled when received.

#### Incorporate the following into your daily practice:

O leaved should help coordinate specialty appointments for urgent costs.
 Proceedings particular decision of the speciality appointments for urgent costs.
 Inform process of older to do if one is respecial after tours.
 Other appointments or relify as text and/or enail.

#### CAHPS MEASURE: GETTING CARE OUICKLY

The Getting Core Qualify measure reasons have often patients gift the care they reacted as some at they reason it and to work the state that the state effect (Siminutes

#### Incorporate the following into your daily practice:

 - Institution from appointments and days statistics in the two concentration input varial collising approximation with a surrary ampatition are applicable and initiated to share, taking appointments - Miching an effective triage systemic or structules, fail and/or varys/side satisfies are seen right, apply or prevised attriate and varial previses and against and - apply prevised attriate and varial previses and against and - apply prevised attriate and varial previses.
 - apply practice attriates and warrary and and against and - apply prevised attriates and apply and and apply and and apply apply and apply apply and apply apply

CAL PS7 196 Proviner Resource and a

#### HOS Provider Resource Guide

#### PROVIDER ENGAGEMENT COLLATERAL Dark Connectation. Two Elements for Unity Transis break

\_\_\_\_\_

#### CAHPS MEASURE: CARE COORDINATION

The Cost CostNettor messure assesses providers' assistance with managing the departs and confusing realth care system, including assess to matcial records, they follow up on test results, and education of precatacion methodens:

#### Incorporate the following into your daily practice:

Ensure there are open appointments for patients recently discharged from a facility

- niceptae PG1 and specially practices through EMR or fax to get reports promptly
- As classified if they have seen any other provident; discuss visits to speciality care as needed. Encourses each other to bring in their medications to our wish

#### CAHPS MEASURE: HOW WELL DOCTORS COMMUNICATE

the New Well-Sectors Communicate measure assesses patients' perception of the quality of communication with their doctor. Consider using the Teach Back Helhod to prove patients understand their health information.

#### What is Teach-back?

 A way to create you — the healthcare provider — have explained information excitly. It is not a test or quick of patients
 Kaving a nation ( or family member) - occuriant in their over vanity what they read to know or do.

 A were scheck for understanding and Theories is excluded a characterized and a coning way.

 A research-cased health iteracy intervention that improves patient-pow der communication and restant health outcomet.

#### CAHPS MEASURE: RATING OF HEALTH CARE QUALITY

The GkHPS survey as is patients to rate the everall quality of their health care on a 0.10 scale

#### Incorporate the following into your daily practice:

Encourage protons to make their outline appointments for electarps or follow up white as soon as they are involved to an accompany in advance. Reversing a open care gaps any works even if using much part and year. We also due of the provider sorthal advance in participant and the matching.

Sk IPS/100Pcvde Resource/Uls

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

## Provider Focus Quick Tips



#### **Getting Needed Care**



• For urgent specialty appointments, office staff should help coordinate with the appropriate specialty office.

• If a patient portal is available, encourage patients and caregivers to view results there.

#### **Getting Care Quickly**

• Maintain an effective triage system to ensure that frail and/or very sick patients are seen right away or provided alternate care via phone and urgent care.



• For patients who want to be seen on short notice but cannot access their doctor, offer appointments with a nurse practitioner or physician assistant.

• Ensure a few appointments each day are available to accommodate urgent visits.

• Address the 15-minute wait time frame by ensuring patients are receiving staff attention.

• Keep patients informed if there is a wait and give them the opportunity to reschedule.

#### **Care Coordination**

• Ensure there are open appointments for patients recently discharged from a facility.

• Integrate PCP and specialty practices through EMR or fax to get reports on time.

• Ask patients if they've seen any other providers. If you are aware specialty care has occurred, please mention it and discuss as needed.

• Encourage patients to bring in their medications to each visit.

#### **Rating of Health Care**



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





• Does your organization/practice offer patient portal access to schedule appointments?







• Does your organization/practice encourage patients to schedule routine checkups/follow ups at check-out?





# **RISK ADJUSTMENT**



# Risk Adjustment



## Continuity of Care Incentive Program

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

## Clinical Documentation Improvement Program

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

Please reach out to your Provider Representative for more information regarding these programs.



# START SMART FOR YOUR BABY



# Start Smart for Your Baby



- Program goals
  - o Early identification of pregnant members and their risk factors
  - o Reducing the risk of pregnancy complications
  - o Better birth outcomes
- Strategy
  - o Submission of Notification of Pregnancy (NOP) Form
  - o High-risk members are prioritized for Care Management Program
  - OB Nurse Care Managers collaborate with members and providers to improve maternal and infant health

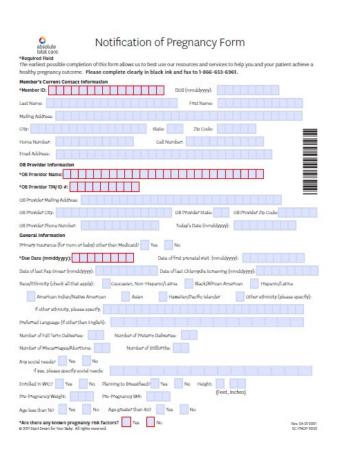
# Start Smart for Your Baby



- OB incentive reimbursements:
  - o Office staff NOP incentive:
    - Provider office staff can be reimbursed up to \$25 for each NOP Form, up to a total of \$500 for the year
      - \$25 check per form submitted during first and second month
      - \$20 check per form submitted during third and fourth month
      - \$15 check per form submitted during fifth and sixth month
      - If an NOP Form has already been received from another source, subsequent NOP Forms would not be eligible for incentive reimbursement
      - Provider office staff must submit a copy of the NOP Form along with the Pregnancy Incentive Reimbursement Form to receive the incentive

# Start Smart for Your Baby

Notification of Pregnancy (NOP) Form sample



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absolute
total care.

*Member ID: DOB (mmddyyyy):
Last Name: Fifst Name:
History
Previous Preterm delivery (<37 weeks)? Yes No If yes, was the delivery spontaneous? Yes No
Currently on 1707 Yes No
Recent delivery (within past 12 months)? Yes No Recent delivery (within past 6 months)? Yes No
Recent delivery (within past 12 months)? Yes No Recent delivery (within past 6 months)? Yes No Provious C-Section? Yes No Previous servere preactanges/a? Yes No Dabetes (prior to pregnancy)? Yes No Sidde Call? Yes No Authma? Yes No Fyes, are asthma symptoms worke during pregnancy? Yes No
Diabatas (prior to pregnancy)? Yes No. Siddle Call? Yes No.
Asthma? Yes No Fyes, are asthma symptoms worse during pregnancy? Yes No
High Blood Pressure (prior to pregnancy)? Yes No. If yes, is high blood pressure well controlled? Yes No.
Previous meanetal death or stillborn? Ves No
If yes, was neonatal death associated with an underlying maternal health condition?
HV Positive? Yes No HIV Negetive? Yes No HIV Test Refused? Yes No AIDS? Yes No
Setture disorder? Yes No if yes, has there been a setture within the last 6 months? Yes No
Current Prognancy
Preterm labor this pregnancy? Yes No Current placenta previe? Yes No
Vaginal bleading after 14 weeks? Yes No
Shortened Cenvix 40.3 weeks this pregnancy? Yes No If yes, Length cm.
Current gestational diabetes? Yes No Current preaclempsie? Yes No Current oligohydramnios? Yes No
Current Twins? Yes No Current Triplets? Yes No Discordant growth? Yes No
Current fetal growth restriction? Yes No Current congenital anomalies? Yes No
BMI < 90 or poor weight gein during this pregnancy? Yes No UTI/Pyelo Bacteriuria this pregnancy? Yes No
Current severe hypertemesis? Yes No
Current mental health concerns? Yes No
If yes, please specify mental health concerns.
Current STD? Yes No If yes, please list STD's.
Current tabacco use? Yes No If yes, please specify amount used.
Current alcohol use? Yes No If yes, please specify amount used.
Current street drug use? Yes No If yes, please specify amount used.
Are there any other significant risk factors? Yes No
F yes, Please list other risk factors:
Rev. 04 01 2021
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# Questions





- ATC/Wellcare Resources
- Member ID Cards Images
- CMS Notification of Balance Billing Regulations
- ATC Provider Annual Training Requirements
- Cultural Competence and Linguistics Mandatory Training Guidelines





# ATC Provider Resources

https://www.absolutetotalcare.com/providers/resources/forms-resources.html

https://ambetter.absolutetotalcare.com/provider-resources/manuals-and-forms.html





# Wellcare Provider Resources

https://www.wellcare.com/South-Carolina/Providers/Medicare/Training/New-Provider-Portal-Overview-Training

https://www.wellcare.com/Global-Content/Trainings/AcctRegandAffil

## ATC Provider Network Territory Assignment

Sarah Wilkinson, Provider Network Specialist II (843) 344-0009, <u>Sarah.Wilkinson@centene.com</u>

• Counties: Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Marion, Marlboro and Williamsburg

Porsha Lewis, Provider Network Specialist II (803) 873-8691, <u>Porsha.Lewis@centene.com</u>

• Counties: Aiken, Calhoun, Chester, Edgefield, Fairfield, Kershaw, Lee, Lexington, Orangeburg, Richland, Saluda, Sumter, Border GA counties and Tenet Health

LaToya Jones, Provider Network Specialist II (803) 553-7324, Latoya.Jones3@Centene.com

• Counties: Abbeville, Anderson, Cherokee, Greenville, Greenwood, Lancaster, Laurens, McCormick, Newberry, Oconee, Pickens, Spartanburg, Union, York and Border-NC

S. Brandi Crosby, Provider Network Specialist II (843) 518-3918, <u>shunta.crosby@centene.com</u>

• Counties: Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Border GA-Savannah and MUSC



## ATC Provider Network Territory Assignment



Janet Kimbrough, Network Performance Advisor 803-873-4454, <u>Janet.H.Kimbrough@centene.com</u>

• Provider Groups: Abbeville Medical Center, Bon Secours St Francis, CenterWell Senior Primary Care, Preferred Care of Aiken, Prisma Health- Upstate, Spartanburg Regional Health/Regional HealthPlus

Tracey Snowden, Network Performance Advisor

(803)606-5328, Tracey.D.Snowden@centene.com

• Provider Groups: AnMed Health, Atrium Health, Newberry Hospital, Self Regional, SC Oncology Associates

Kristen Graham, Manager- Provider Relations 803-457-2128, <u>Kristen.Graham@centene.com</u>

• Provider Groups: HCA Healthcare, Lexington Medical Center, McLeod Health, Palmetto Primary Care Physician, Prisma Health Midlands, Roper St. Francis Healthcare, SC Pediatric Alliance, The Regional Medical Center, United Physicians Inc

## ATC Provider Network Territory Assignment

Adria Felder, Provider Network Specialist I (803)315-8405, <u>Adria.Felder@CENTENE.COM</u>

Ambulatory/EMS, Health Network Solutions, Chiropractors, Long Term Acute Care, Rehabilitation Facility and Skilled Nursing Facilities

Anna Truesdale, Provider Network Specialist II Cell: (803) 427-3260, Anna.Truesdale@CENTENE.COM *Federally Qualified Health Center (Statewide)* 

Camille Gray, Provider Network Specialist II 803-213-1661, Camille.L.Gray@centene.com *Speech Therapy, Occupational Therapy and Physical Therapy (statewide)* 

Kisha Thomas, Provider Network Specialist I (803) 904-6430, <u>Kisthomas@centene.com</u> *Dialysis Centers and Ambulatory Surgery Centers* 

Neshelle Miller, Provider Network Specialist I (803) 972-1460, Neshelle.Miller@centene.com Durable Medical Equipment and Home Health (statewide)

Wendy McCrea, BH Provider Network Specialist II 803-260-7093, <u>Wendy.McCrea@CENTENE.COM</u> Behavioral Health to include school districts, Department of Alcohol and Other Drug Abuse Services, SC Department of Mental Health



## Medicaid Member ID Card



absolute total care. Healthy	Connections 💸	Pharmacy Help Desk: <b>1-800-930-5512</b> RXBIN: 020545 RXPCN: RXA378 RXGROUP: RXGMCSC01	
Member Name: Member ID: Effective Date:	<cardholder na<br=""><cardholder id<="" th=""><th></th><th>r go to the nearest emergency room.</th></cardholder></cardholder>		r go to the nearest emergency room.
DOB: PCP Name:	<pcp name=""></pcp>		
PCP Name: PCP Phone:	<pcp name=""></pcp>		1-866-433-6041
PCP Phone:	<pcp phone=""></pcp>		1-866-433-6041
			1-800-930-5512
	IIII	арттр, л-тауз, паціотору.	1-866-433-6041
	DN	1E, Home Health, Infusion:	1-866-433-6041
	Bill	ing Address: PO Box 3050, Farmir	ngton, MO 63640-3821
	We	ebsite: absolutetotalcare.com	

# Ambetter from Absolute Total Care Member ID Card (2023)





## Core ID Cards

Subscriber: Member:	[Jane Doe] [John Doe]	Policy #: [XXXXX Member ID #: [XXXXX Effective Date: [00/00,	OXXXXXXXX]
[Am	Detter.com/copays]	PCP: [\$10 coin. after ded.] Specialist: [\$25 coin. after ded.] Rx (Generic/Brand): [\$5/\$25 after   Urgent Care: [20% coin. after de ER: [\$250 copay after ded.] Max Out-of-Pocket: [\$25,000]	
	i] ] Network Coverage	Only RXBIN: [0 RXPCN: [/ RXGROUP DT REQUIRED FOR SPECIAI	ADV] : [RX5485]
	(Relay: 711) 24/7 Nurse Numbers belo Pharmacy Hel EDI Payor ID: [Envolve Visio	ovider Services: 1-833-270-5443 Line: 1-833-270-5443 ow for providers: lp Desk: 1-855-266-3490 68069 on: 1-833-724-9353] tal Powered by United Concordia: 1-	Medical Claims Address: Absolute Total Care Claims Department PO Box 5010 Farmington, MO 63640-5010 833-605-6320]
	Emergency Room ( authorization. Rece	ion can be found in your Evidence of Coverage. If you ER). Emergency services given by a provider not in the twing non-emergent care through the ER or with a non ability. For updated coverage information, visit Ambet	plan's network will be covered without prior -participating provider may result in a change
		Amhattar fram Albahita Tatal (	Care is underwritten by Absolute Total Care, Inc

## Virtual ID Cards

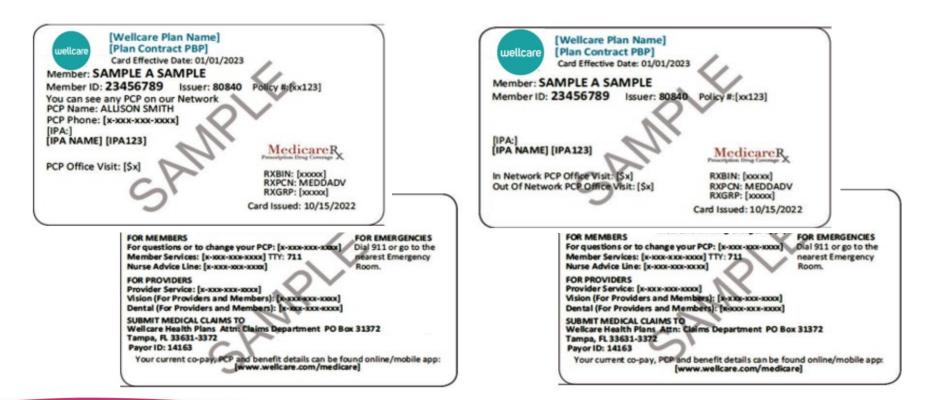


# Medicare-Wellcare Member ID Card (2023)

HMO and HMO DSNP



PPO



# Wellcare Prime by Absolute Total Care (MMP) Member ID Card (2023)



Session and a sess	MedicareR Prescription Drug Coverage
Member Name: <cardholder name=""></cardholder>	Prescription Drug Coverage
Member ID: <cardholder id#=""></cardholder>	RxBIN: 004336
	RxPCN: MEDDADV
	RxGRP: RX8143
PCP Name: <pcp name=""></pcp>	RxID: <rxid#<sup>2&gt;</rxid#<sup>
PCP Phone: <pcp phone=""></pcp>	
Cost sharing/Copays: \$0 for covered media	· · · / ·· · · · · · · · · · · · · · ·
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MEMBER CANNOT BE CHARGED Cost sharing/Copays: \$0 for covered medic H1723 001	acy, dentist, etc.           Member Services:         1-855-735-4398 (TTY: 711)           Behavioral Health:         1-855-735-4398 (TTY: 711)           Pharmacy Help Desk:         1-888-865-6567 (TTY: 711)           24-Hr Nurse Line:         1-855-735-4398 (TTY: 711)           Pharmacy Prior Auth:         1-800-867-6564 (TTY: 711)           Website:         mmp.absolutetotalcare.com           Send Claims To:         Medical Claims: Wellcare Prime (MMP)



Centers for Medicare & Medicaid Services Atlanta Regional Office 61 Forsyth St., SW; Suite 4T20 Atlanta, GA 30303



May 19, 2016

## TO: Providers SUBJECT: Prohibition on Balance Billing of Healthy Connections Prime Members

### BALANCE BILLING IS PROHIBITED

Balance billing is the practice in which providers bill dually eligible beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare cost-sharing. This population is exempt from paying any cost-sharing for deductibles, coinsurance and co-payments related to Medicare services and prescription drugs. Healthy Connections Prime Members are considered QMBs. Please be advised that it is <u>unlawful for providers to "balance bill" any patient who is a member of Healthy</u> <u>Connections Prime</u> for any covered services. Balance billing for Healthy Connections Prime members is billing the patients for the difference between what the Medicare-Medicaid plan (MMP) pays and the retail price you charge for your services. The provider must accept payment in full from the Medicare-Medicaid plan (MMP) and should not deny any services to members are subject to sanctions and/or termination of their MMP provider agreement.

#### WHAT CAN BE BILLED TO MEMBERS?

- For non-covered items and services, providers must give members advance notice that such items
  or services will be non-covered and have a written agreement with the members for these noncovered items or services. If such notice is not given and the agreement is not in place, providers
  may not bill members for such items or services.
- For certain Medicaid-only items and services (such as durable medical equipment and home health agency care), members can be billed the allowable Medicaid co-pays.

### ABOUT HEALTHY CONNECTIONS PRIME

Healthy Connections Prime is a new option for South Carolina seniors 65 and older with Medicare and Healthy Connections Medicaid. It is part of a national initiative designed to integrate all the services of Medicare, Medicare Part D and Medicaid into a single set of benefits fully managed by an MMP. Visit the Provider page on the Healthy Connections Prime website (<u>http://www.scdhhs.gov/prime</u>) to learn more details about the program or email <u>PrimeProviders@scdhhs.gov</u> with any questions.



1-855-735-4398 mmp.absolutetotalcare.com

### Prohibition on Billing Medicare-Medicaid Plan (MMP) Enrollees for Medicare Cost-Sharing

This communication serves as a reminder that for Wellcare Prime by Absolute Total Care Healthy Connections Prime members, providers **may not bill and/or collect** any Medicare cost-sharing amounts, including deductibles, coinsurance, and copayments that may be represented on the Explanation of Payment (EOP), as they are not the member's responsibility.

This practice, known as "balance billing", is prohibited by Federal Law and as stipulated under your Wellcare Prime/Healthy Connections Prime Provider Services Agreement. Please be advised that it is unlawful for providers to "balance bill" any patient who is a member of Healthy Connections Prime for any covered services.

If your patient presented the following Member ID Card, you provided services to Wellcare Prime (Healthy Connections Prime) MMP member:



#### Wellcare Prime members can be billed for:

- Medicaid participation in cost of care amounts for long-term services and supports as determined by SCDHHS.
- Medicaid copay for Medicaid only covered Durable Medical Equipment (DME) items.

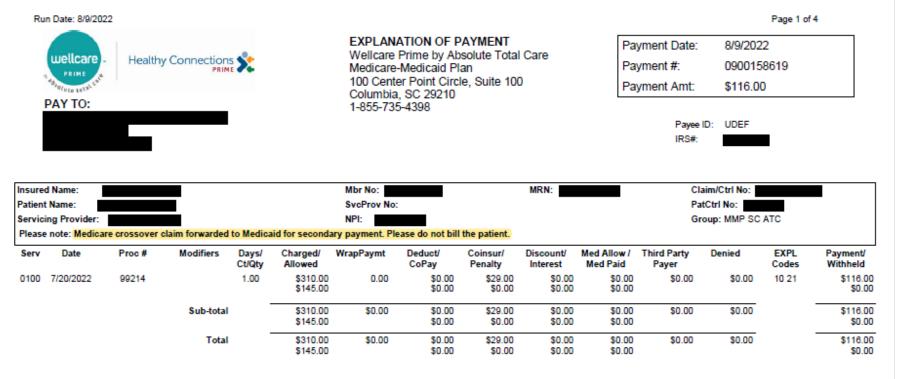
#### How Wellcare Prime resolves balance billing issues with the provider:

- Wellcare Prime informs the provider that the member has been inappropriately balance billed and educates the provider on balance billing.
- If Wellcare Prime reimbursed the member for an inappropriately balance billed amount, the plan will notify the provider and request reimbursement be made to the plan.
- If after outreach and education efforts to the provider, Wellcare Prime identifies ongoing
  inappropriate balance billing activities, Wellcare Prime may take disciplinary action up to and
  including termination of the Provider Agreement.

For more information regarding balance billing please refer to the Wellcare Prime Provider Manual at absolutetotalcare.com. You can also refer to CMS' Balance Billing Prohibition Notice at this link (https://msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing-healthy-connections-primemembers-0) on the Healthy Connections Prime website. If you have any questions, please contact Member Services at 1-855-735-4398.



# MMP Example EOP- Medicare Balance Billing



Explanation Code	Description

10 PAY - PAID PER CONTRACTUAL AGREEMENT

21 PAID-COINSURANCE APPLIED



# MMP Example EOP- Medicaid Balance Billing





Insured	d Name:					Mbr No:			MRN:		CI	aim/Ctrl No:		
Patient	Name:					SvcProv No:			Carrier: N	IM	Pa	atCtrl No:		
Servici	ing Provider:					NPI:					G	roup: SCTCC	- BERKELEY	
Please	e note: This b	ill has crossed	over from Med	licare to N	ledicaid. Payme	ent is now com	plete.							
Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur/ Penalty	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
0100	7/20/2022	99214		1.00	\$310.00 \$66.87	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$145.00 \$116.00	\$0.00	\$0.00	MX PM Aa	\$0.00 \$0.00
			Sub-total		\$310.00 \$66.87	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$145.00 \$116.00	\$0.00	\$0.00		\$0.00 \$0.00
			Total		\$310.00 \$66.87	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$145.00 \$116.00	\$0.00	\$0.00		\$0.00 \$0.00

Explanation Code	Description
Aa	INFORMATIONAL: CLAIM PROCESSED THROUGH COORDINATION OF BENEFITS
MX	PAY: MAXIMUM ALLOWABLE HAS BEEN PAID BY PRIME INS
PM	PAY: PCP IS NOT EFFECTIVE AT THE TIME OF SERVICE

### **Annual Provider Training Requirements**

Absolute Total Care partners with all of our contracted providers to ensure that you have received the necessary training to deliver quality care to our members and your patients and to be compliant with Centers for Medicare & Medicaid Services (CMS) and state requirements. All Medicare Advantage Organization (MAO) and Medicare-Medicaid Plan (MMP) contracted providers are required to complete the following trainings within 90 days of contracting and **annually** thereafter:

- General Compliance (Compliance)
- Fraud, Waste, and Abuse
- Model of Care (MOC)\*
- Person-Centered Planning\*\*

General Compliance and Fraud, Waste, and Abuse trainings are posted on the CMS Medicare Learning Network (MLN) website at <a href="http://go.cms.gov/mln">http://go.cms.gov/mln</a>, and links to the specific trainings can be found in the table below. The MOC training\* and Person-Centered Planning training\*\* can be found on the Absolute Total Care website as indicated in the table below. Once practitioners have taken the required trainings, we ask that you attest to their completion by filling out an Attestation Form or submitting CMS certificates of completion. While the training itself must be completed by every participating practitioner, attestation can be completed one time for all practitioners within a given provider group.

### Required Training Resources

Required Training	Training Location
General Compliance	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-
	MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf
Fraud, Waste, and Abuse	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-
	MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244-Print-Friendly.pdf
Model of Care (MOC)*	https://www.absolutetotalcare.com/providers/resources/provider-training/model-of-
	care-provider-training.html
Person-Centered	https://www.absolutetotalcare.com/providers/resources/provider-training.html
Planning**	

\*MOC training is required for providers who directly or indirectly facilitate and/or provide Medicare Part C or D benefits for any Allwell from Absolute Total Care HMO SNP Member. Please refer to the Quick Reference Guide for additional information on MOC training.

\*\*Person-Centered Planning training is required for providers who directly or indirectly provide services for our Absolute Total Care MMP members.

ATC-06072021-AP-2 Approved 06072021 SC1PROLTR75289E 0000





# Cultural Competence and Linguistics Appropriate Services (CCLAS) Program

https://www.absolutetotalcare.com/content/dam/centene/absolute-total-care/test/ATC-CCLAS\_ProgramDescriptionFinal.pdf



# absolute total care.

### Cultural Competency Quick Reference Guide

### What is cultural competency?

- A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups, and the sensitivity to know how these differences influence relationships with members
- It is a set of complimentary behaviors, attitudes, and policies that help professionals work
  effectively with people of different cultures

### Purpose of cultural competency

- Learn about, understand and provide excellent customer service to all members across all segments of the population
- Promote sensitivity to the needs of patients who are members of various racial, religious, age, gender, or ethnic groups
- Accommodate the patient's culturally-based attitudes, beliefs, and needs

### You will learn:

- What is cultural competency
- Sources of diversity
- Steps for becoming culturally competent
- Communicating across cultures
- Tips for successful cross-cultural communications

### Resources

Resources for Cultural Competency training can be found on Wellcare Prime by Absolute Total Care's website on the Provider Manuals and Forms page

(https://www.absolutetotalcare.com/providers/resources/forms-resources.html).

- Medicare-Medicaid Plan (MMP) Provider Manual
- Cultural Competency PDF

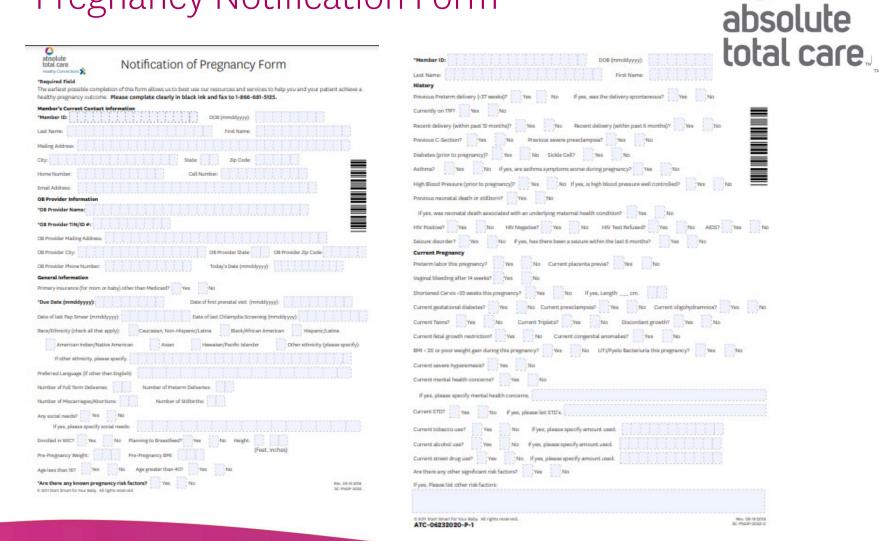
# Authorization Forms



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# Pregnancy Notification Form



# SC DHHS 1716 Form for Newborns

DHHS Form 1716 - Request for Medicaid ID Number - Infant (Feb. 2021)

Healthy Connectio			R		or Medicaid hber - Infant
I. Provider Information					
Provider Name / Hospital Na	me			Date	
Provider Street Address		City	County	State	ZIP code
Provider Representative (First,	Last Name)	Pł	none	Fax	
Provider Email Address (SCDI	HHS will submit Fo	rm 1716 to t	this address)		
II. Mother's Information					
First Name, Middle Name, La	st Name			Date of	Birth (mm/dd/yyyy)
Street Address		LCity.	Country	State	ZIP code
Street Address		City	County	State	ZiP code
Social Security Number			Medicaid ID	#	
Social Security Number		1	Medicaid ID	#	
Social Security Number		1	Medicaid ID	#	
-			Medicaid ID	#	
III. Child's Information	st Name (if not yet na	med, enter "Baby			Birth (mm/dd/yyyy)
III. Child's Information First Name, Middle Name, La		med, enter "Baby	(Boy" or "Baby Girl")	Date of	
III. Child's Information First Name, Middle Name, La		med, enter "Baby			Birth (mm/dd/yyyy) ZIP code
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III. Child's Information First Name, Middle Name, La Street Address (If same as mother			/Boy" or "Baby Girl")	Date of State	
III. Child's Information First Name, Middle Name, La Street Address (If same as mother Name of Birth Facility			/Boy" or "Baby Girl")	Date of State	
III. Child's Information First Name, Middle Name, La Street Address (If same as mother Name of Birth Facility			/Boy" or "Baby Girl")	Date of State	
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MEDS APPLICATION



# **ASL Interpretation Services**

## Please request a copy of this policy from your PR Rep if needed

### Language Services

www.lsaweb.com

#### Client Policy Guide: ASL Face-to-Face Interpreting Requests

Thank you for choosing LSA as your language services provider! We are committed to providing you with exceptional service from the minute you submit a request to the conclusion of any assignment.

In order to guarantee that all requests are received and responded to in a timely fashion, we are providing you with our policies for requesting American Sign Language (ASL) interpreting services, including ASL interpretation, English transiteration (signed and oral) and Deaf interpretation. LSA is proud to offer RID nationally certified interpreters and qualified pre-certified interpreters.

Types of Interpreting Situations

#### Legal

Applies to court trials, hearings, depositions or any legal matter that becomes part of a legal record. LSA uses a team of two interpreters for all legal assignments.

#### Mental Health

The need for completely accurate and effective communication is critical in the mental health setting. For this reason, LSA uses a Deaf / hearing learn (which consist of one Deaf interpreter and one hearing interpreter) for most mental health assignments. Deaf interpreters have the highest level of linguistic skill in ASL and the best cultural connection to the Deaf consumer. There are times when a Deaf consumer will require a Deaf / hearing team for non mental health assignments due to linited language skills.

#### Conference / Platform Interpreting

Applies to any type of conference, seminar, town hall meeting or religious service. LSA requires a minimum of <u>four weeks' notice</u> for conference interpreting services lasting more than one day.

So that we can determine interpreter and CART needs for your conference, please be sure to include a checkbox on your registration form indicating the need for services, as well as a clearly defined response deadline four weeks before the conference start date.

Conference interpreting always requires a team of interpreters. For larger conferences with several breakout sessions, several teams may be necessary.

#### Team Interpreting

For occupational safety, requests for 1.5 hours or more of interpreting services may require a team of two interpreters, depending upon the complexity of the assignment.

#### Submitting Requests

Please try to submit your community / routine interpreting requests at least two business days in advance. Emergency / rush situations may be requested on demand but they will incur additional surcharges.

It is the institution's responsibility (not the Deaf consumer's) to request interpreting services. We recommend you do this when the appointment is booked with the Deaf consumer, or immediately after.

We kindly ask that you submit your ASL interpretation requests to LSA in one of the following two ways:

Online: Once your account is set up to submit online requests, you can enter requests with the LSA website any time of the day, any day of the week. Please note that requests received after 5:30 p.m. Monday through Friday will be processed the next business day. Please contact LSA's Client Services department at 800.305.9763 (option #7) or via e-mail at <u>clientservices@lsaweb.com</u> to enable your account for online requests.

Telephone: You may call 866.827.7028 at any time to make a face-to-face interpreting request. If calling outside of our standard business hours (before 8:00 a.m. EST and after 6:30 p.m. EST Monday through Friday, and on the weekendb, LSA's call center staff will be able to assist you.

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Language Services Associates + 455 Business Center Drive - Suite 100 + Horsham, PA 19044 + 800.305.9673

Page 1 of 2



www.lsawob.com



#### Extra Time

Please try to provide us with a realistic estimate for the total length of time for the assignment, including any extra time that should be taken into consideration. For example, if there are security check-in procedures, or paperwork that needs to be filled out prior to the appointment, that information should be included in your request. In these instances, if the appointment is scheduled for 8:30 a.m., you should place your request for 8:15 a.m.

Sometimes assignments will go over the contracted time period. If the interpreter is available to stay after the projected end of an assignment, extra time will be charged to you in half-hour increments. Please understand that interpreters book their own schedules and may not be able to stay longer due to other commitments. If your meetings frequently run over the scheduled time, please expand the time of your request.

#### Cancellation / No Show Policy

In the event a request for interpreting services is cancelled with <u>more than two business days notice</u>, there will be no charge to the requesting organization. Please note that if a holiday falls within the notice time period, an additional day notice is required.

Requests cancelled with less than two business days notice will be billed for the interpreter time reserved. If more than two hours were reserved, the payable fee will be for the time reserved per interpreter. If there was travel time involved, and the interpreter actually traveled to the assignment location, travel fees will also be charged.

#### Deaf Consumer No-Show

In the event a Deaf consumer does not arrive as scheduled for an assignment, it is customary for the interpreter to wait approximately 30 minutes before leaving the assignment location. The requesting organization will be billed for the time reserved per interpreter.

#### Interpreter No-Show

If the interpreter does not arrive for the scheduled assignment, please call LSA's Face-to-Face Interpreting division immediately. We will make every attempt to provide a substitute interpreter. If a substitute interpreter is not available, the assignment will be canceled and there will be no charge to the requesting organization.

#### Travel Policy

Depending on your specific agreement with LSA, travel compensation may be charged for:

Portal to Portal - Travel compensation is charged at half the hourly interpreting rate for interpreters who travel to the site of an assignment.

Mileage / Tolls / Parking – These are all charged to the client as applicable. The current mileage rate is charged as set by the Internal Revenue Service.

Please feel free to contact a member of LSA's Face-to-Face Interpreting division at 866.827.7028 with any questions or concerns regarding our policies for placing ASL face-to-face interpreting requests.



# Adjournment