Absolute Total Care 2022 Virtual Provider Town Hall 4th Quarter

12/15/2022

Meeting Overview

- Absolute Total Care Healthy Connections Medicaid
- Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan)
- Wellcare by Allwell
- 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® -Consumer Assessment of Healthcare Providers and Systems
- Start Smart for Your Baby Q&A

Provider Relations Team

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Provider Relations Team

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Products and Services

Absolute Total Care Healthy Connections Medicaid

- Serving approximately 230,000 members statewide

- **2022 Benefit Highlights:**
  - Telehealth services for medical and behavioral health*
  - Copay waived for medically necessary COVID-19 testing
  - Boys and Girls Club
  - Boy Scouts and Girl Scouts
  - Step2Success

- **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)**

Wellcare Prime

- Serving approximately 4,500 dual-eligible members (age 65+)

- 2022 Benefit Highlights:
  - State-wide service area
  - Telehealth services for medical and behavioral health
  - Transportation: Unlimited one-way rides to plan-approved locations
  - Over-the-counter: $100 per calendar quarter
  - Hearing: One hearing aid per calendar year
  - 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

Wellcare by Allwell

- Wellcare No Premium Medicare (HMO)
- Wellcare Dual Access* (HMO D-SNP) and Wellcare Dual Liberty (HMO D-SNP)
- Serving approximately 3,000 members
  2022 benefit highlights:
  - State-wide service area
  - New plan names and look
  - Telehealth services for medical and behavioral health
  - D-SNP transportation
  - Over-the-counter
  - Dental, hearing, routine vision
  - Fitness

**Wellcare Dual Access and Dual Liberty –Medicaid benefits are paid fee for service (FFS) by SC Department of Health and Human Services SCDHHS*

Ambetter from Absolute Total Care

- Health Insurance Marketplace
- Serving approximately 33,000 members in 42 counties
- 2022 benefit highlights:
  - Service area expanded into 12 new counties
  - $0 copay for telehealth services for medical care
  - Health Savings Accounts
  - Dental
  - Routine vision
  - Virtual plan option
  - Concierge services for disease management
- Balance billing protection via the “No Surprises Act”

**service area excludes Anderson, Cherokee, Spartanburg and Union*

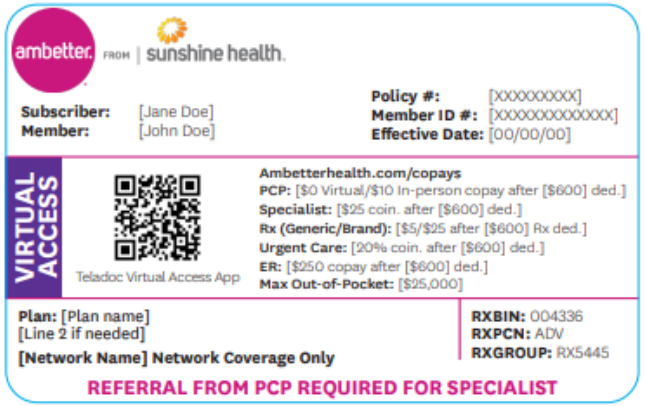
Ambetter Virtual Access

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.
  - Members cannot self-direct care outside of PCP care
  - Non-emergent, non-authorized, out-of-network is not covered
  - 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

VIRTUAL ACCESS

absolute total care™


ambetter. FROM | sunshine health.

Subscriber: [Jane Doe]
Member: [John Doe]

Policy #: [XXXXXXXXX]
Member ID #: [XXXXXXXXXXXX]
Effective Date: [00/00/00]

VIRTUAL ACCESS

Teladoc Virtual Access App

Ambetterhealth.com/copays
PCP: [$0 Virtual/$10 In-person copay after [$600] ded.]
Specialist: [$25 coin. after [$600] ded.]
Rx (Generic/Brand): [$5/$25 after [$600] Rx ded.]
Urgent Care: [20% coin. after [$600] ded.]
ER: [$250 copay after [$600] ded.]
Max Out-of-Pocket: [$25,000]

Plan: [Plan name]
[Line 2 if needed]
[Network Name] Network Coverage Only

RXBIN: 004336
RXPCN: ADV
RXGROUP: RX5445

REFERRAL FROM PCP REQUIRED FOR SPECIALIST


Ambetter.SunshineHealth.com

Member/Provider Services: 1-877-687-1169
(Relay Florida 1-800-955-8770)
24/7 Nurse Line: 1-877-687-1169

Numbers below for providers:
Pharmacy Help Desk: 1-888-304-9081
EDI Payor ID: 68069

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

Scan to receive 20% off Walgreens brand health and wellness items*

* Exclusions and restrictions apply. See Walgreens.com/SmartSavings for details.

AMB22-FL-C-00013

Ambetter from Sunshine Health is underwritten by Sunshine Health Plan, Inc.

No Surprises Act

The No Surprises Act is specific to the Ambetter (Marketplace) product. If you do not have an Ambetter agreement, please disregard.

- 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 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
- 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 https://msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing-healthy-connections-prime-members-0

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 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)

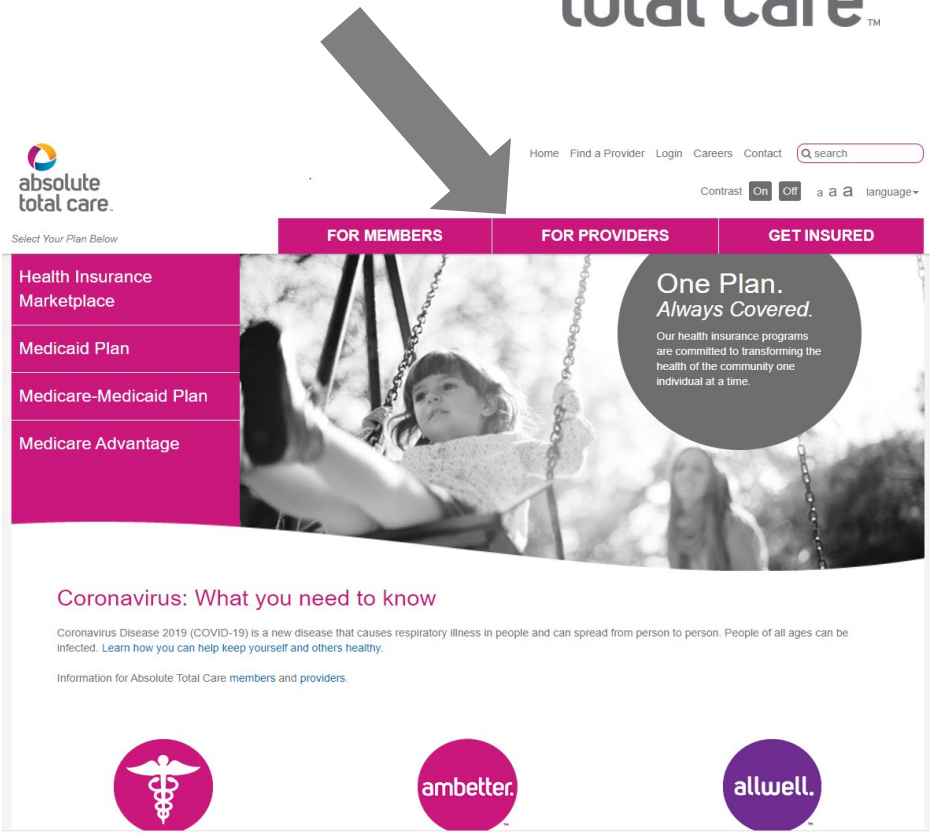
Websites and Secure Portals

Absolute Total Care Website

www.absolutetotalcare.com

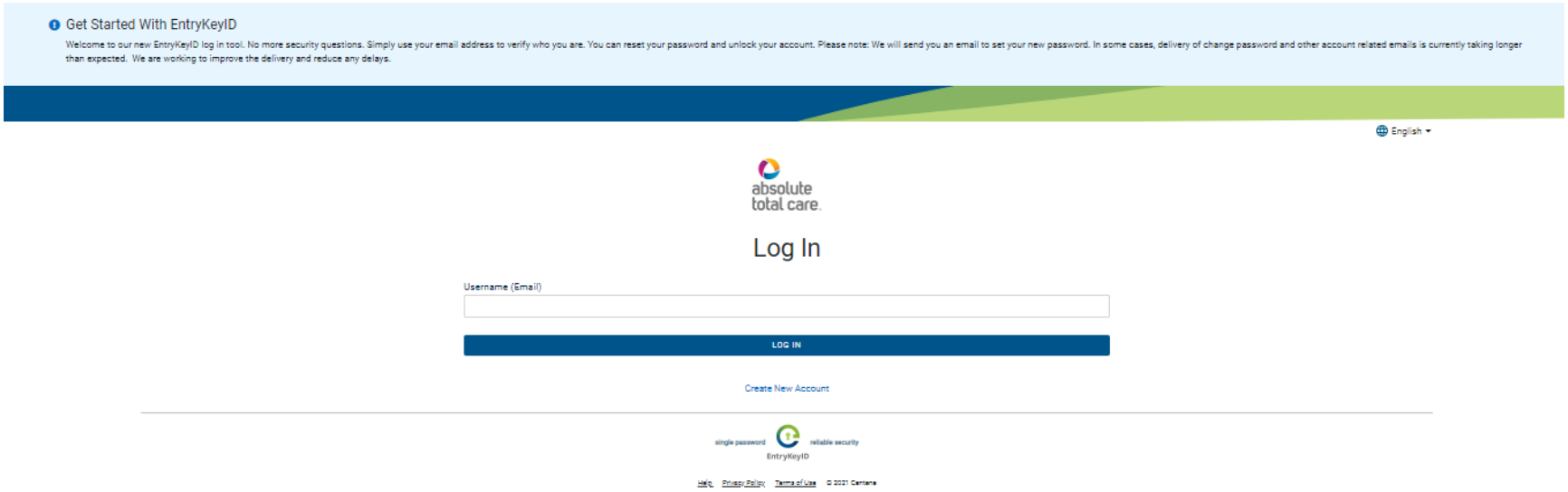
For Providers section:

- Pre-Auth Check Tool
- Clinical and Payment Policies
- Forms- Medical and Pharmacy Auths



Absolute Total Care Secure Provider Portal

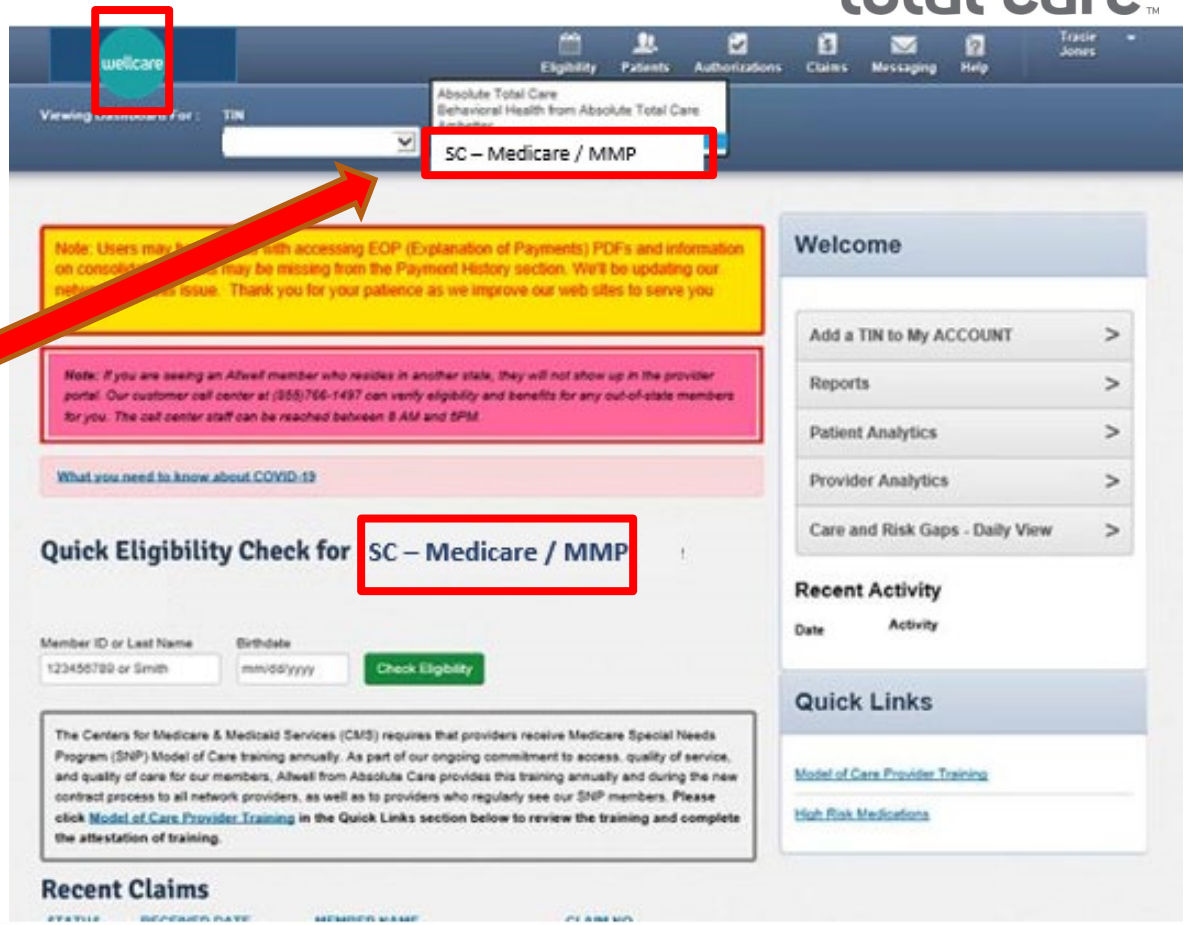
- Log in: https://www.absolutetotalcare.com/login.html



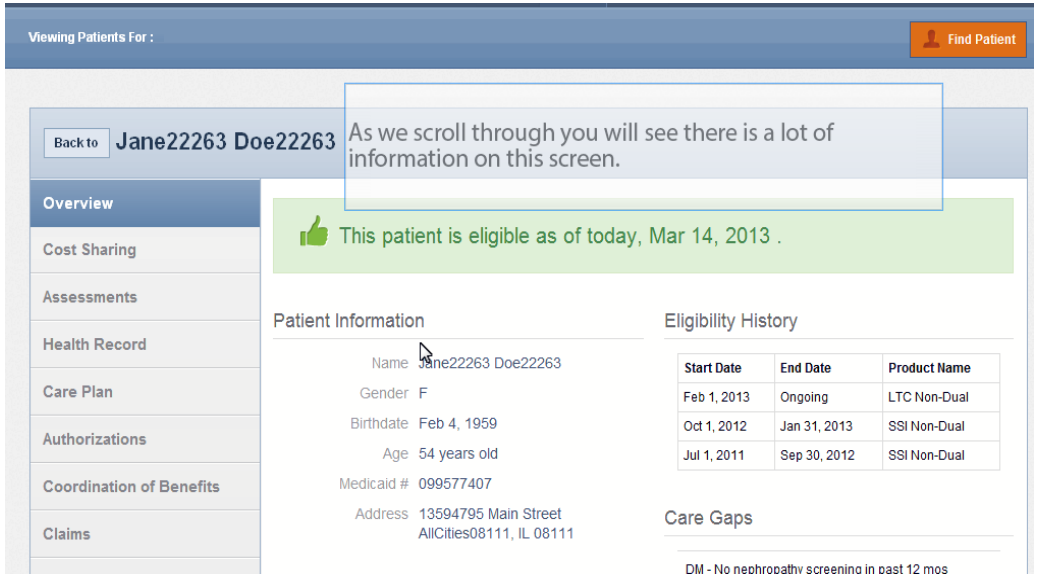
Absolute Total Care Secure Provider Portal

Updated logo and plan name in drop down

Medicare Advantage and MMP Members



Absolute Total Care Secure Provider Portal



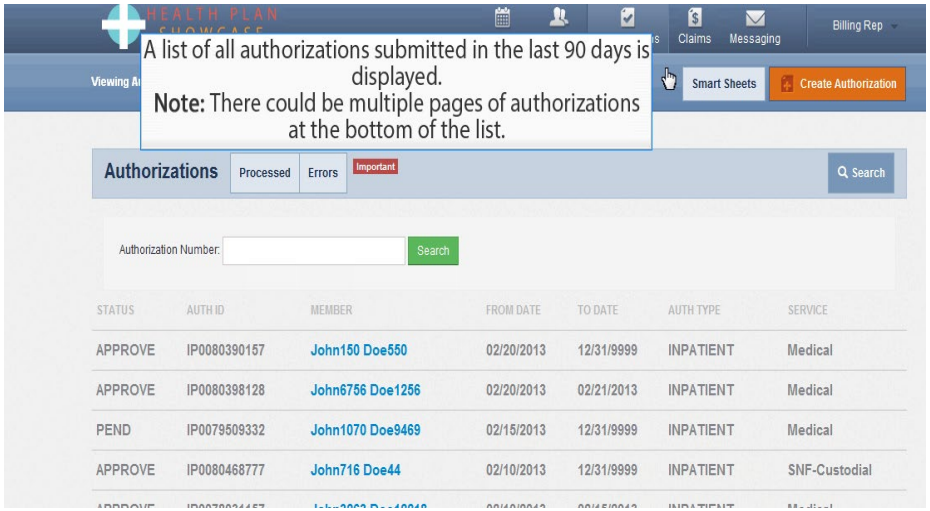
Member eligibility should be checked each month and each time prior to rendering services

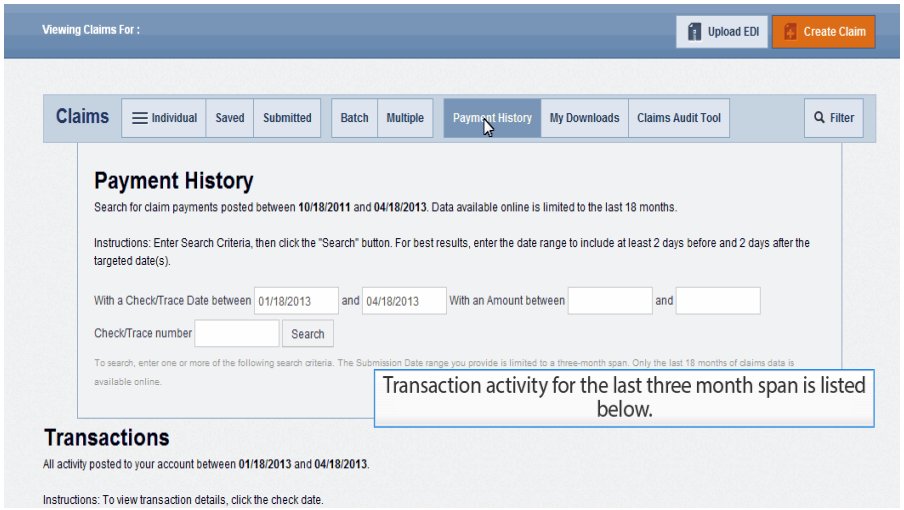
The Absolute Total Care Secure Provider Portal or the Interactive Voice Response (IVR) system are available 24 hours a day, seven days a week

- 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

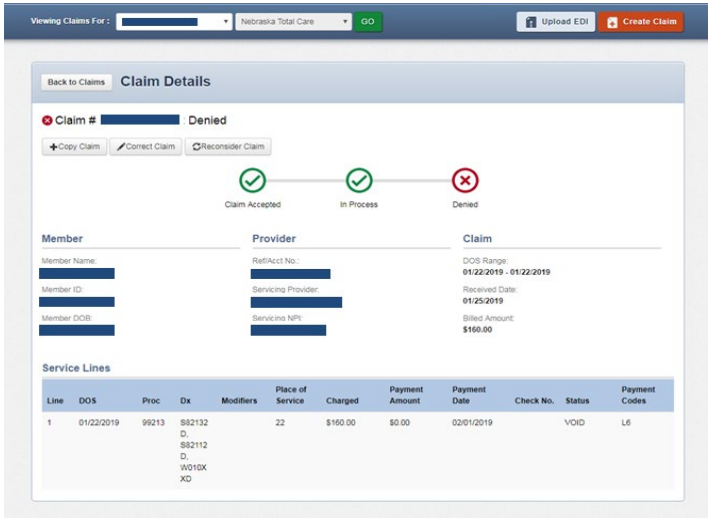
Authorizations and Claims

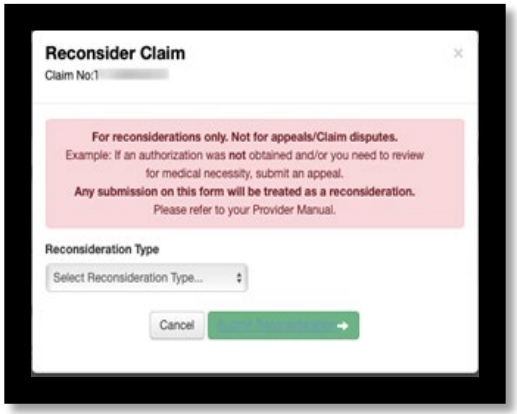


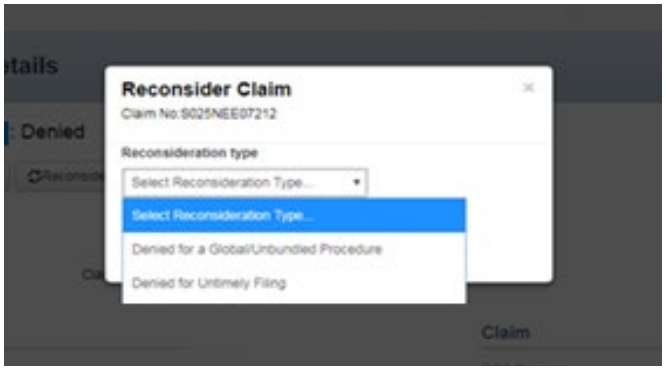


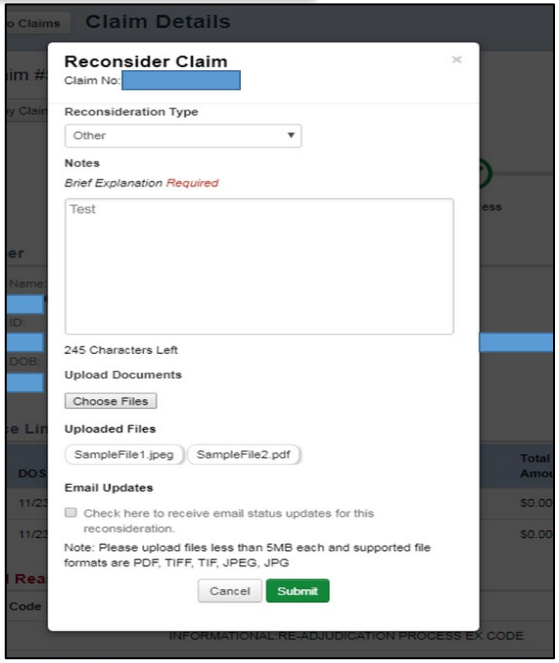
Absolute Total Care Secure Provider Portal

Provider Reconsideration

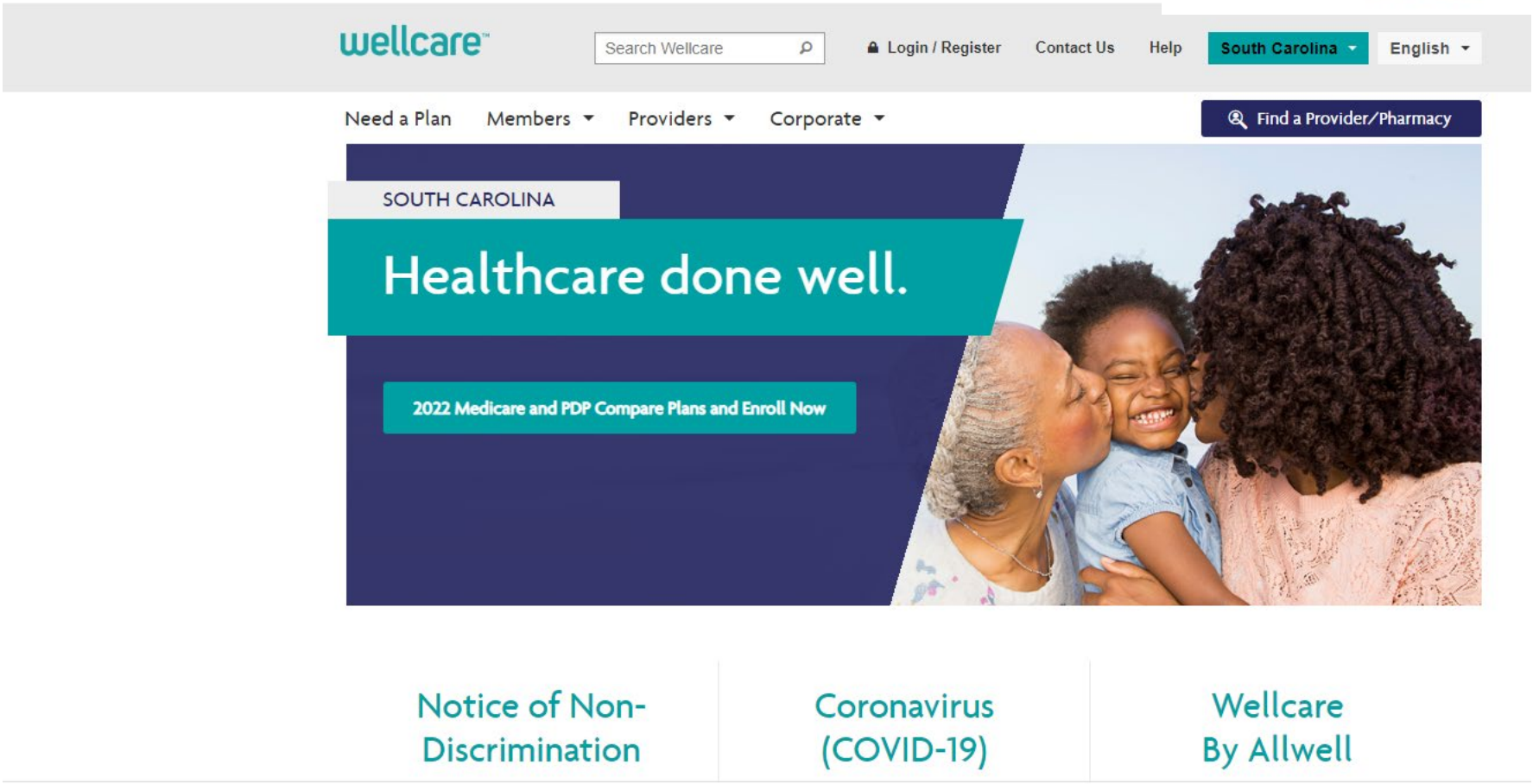






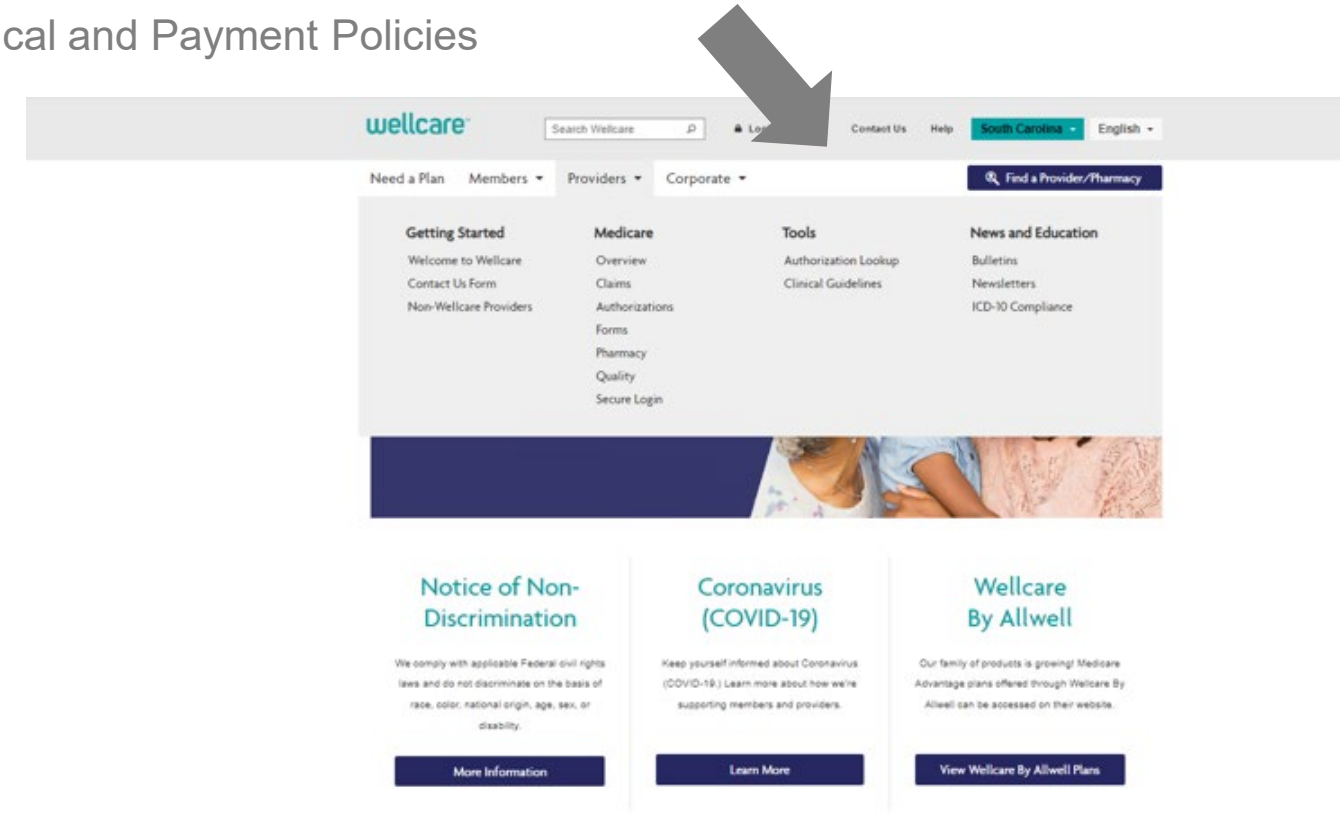


Wellcare Website



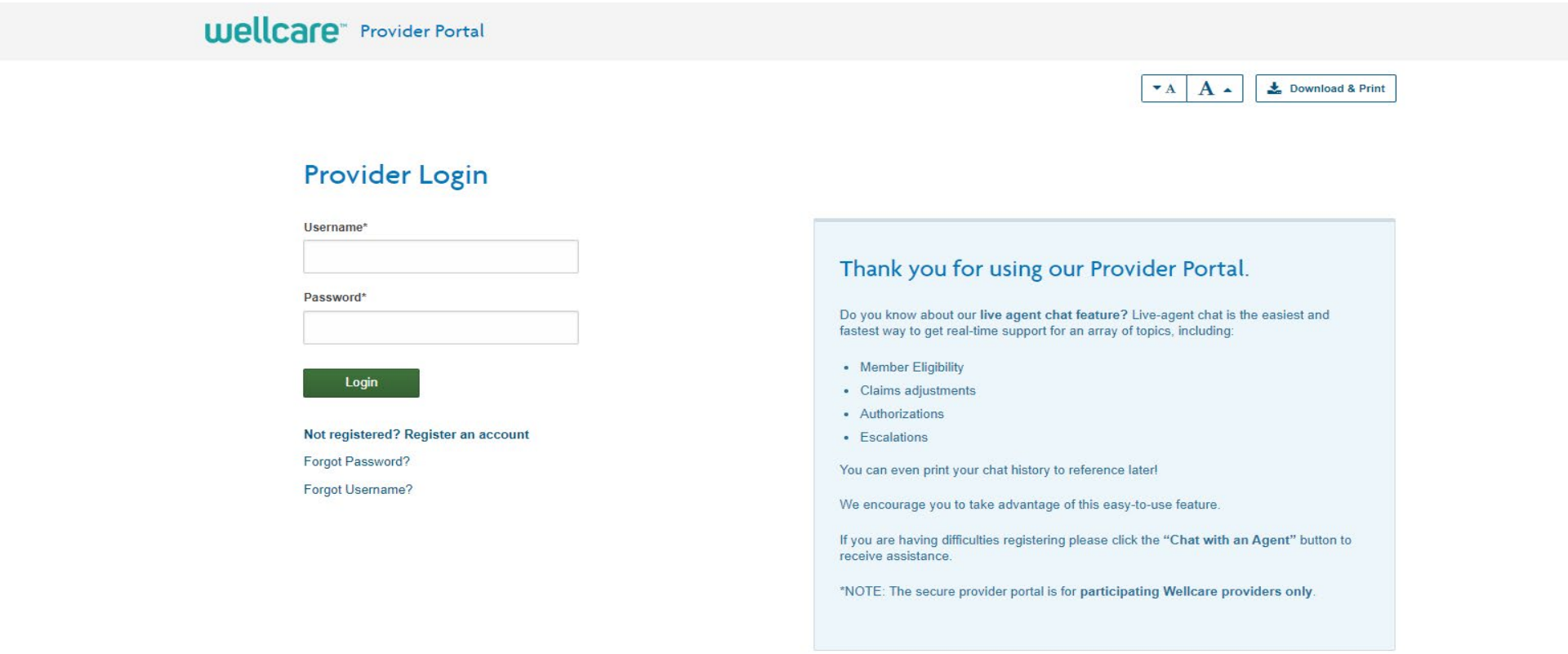
Wellcare Website

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



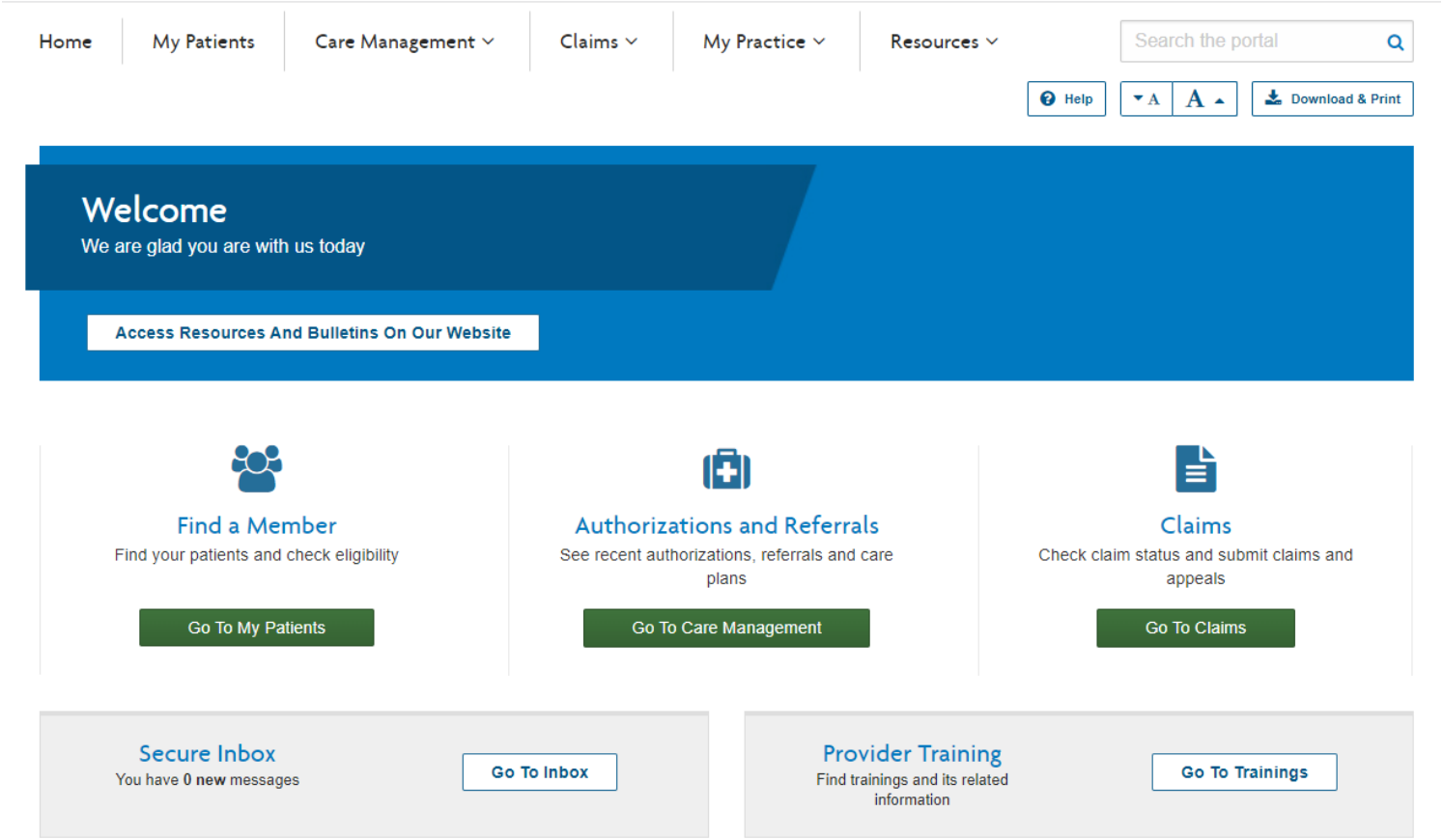
Wellcare Secure Portal

Log in: https://provider.wellcare.com/



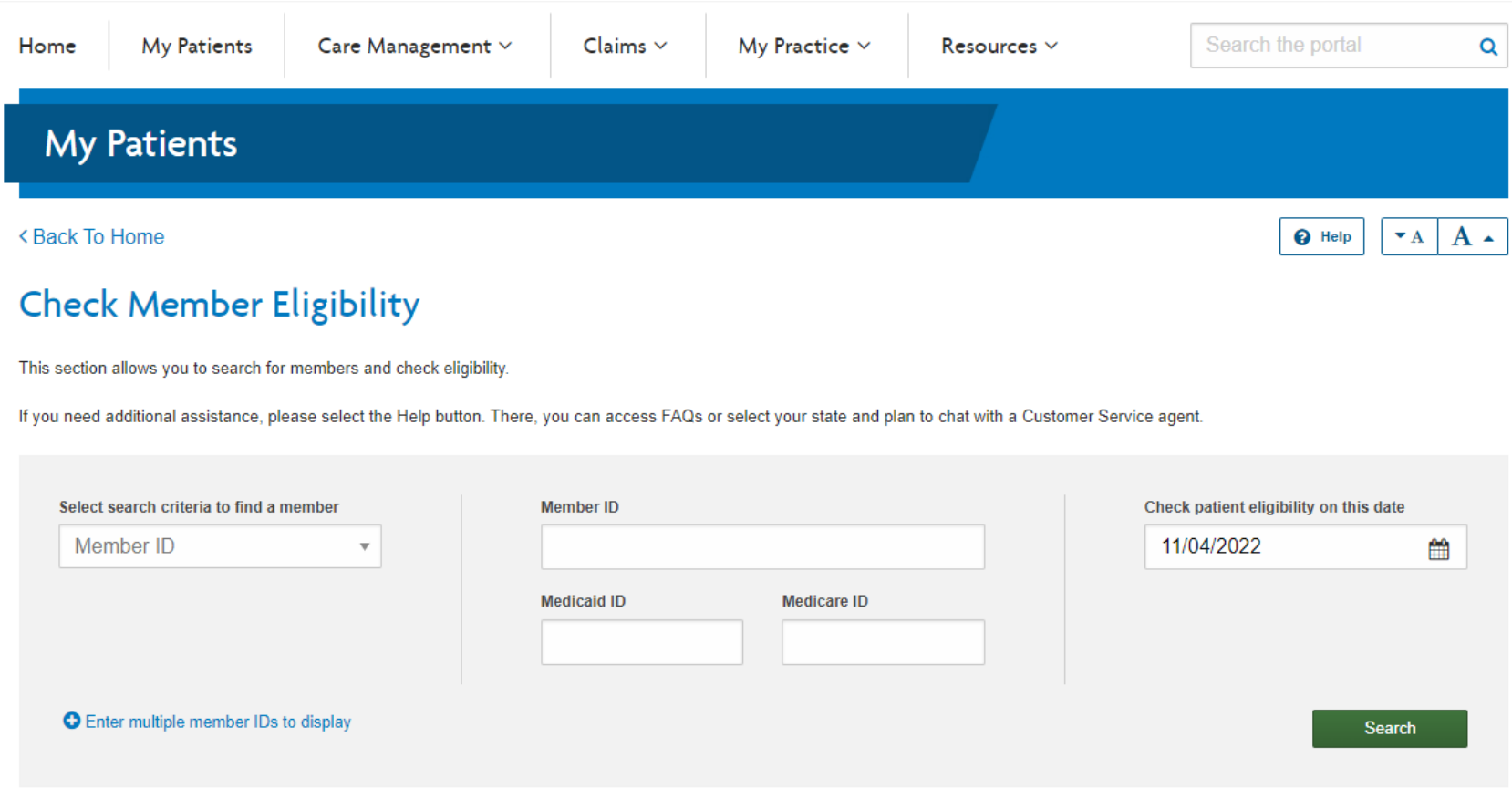
Wellcare Secure Portal

Home Screen



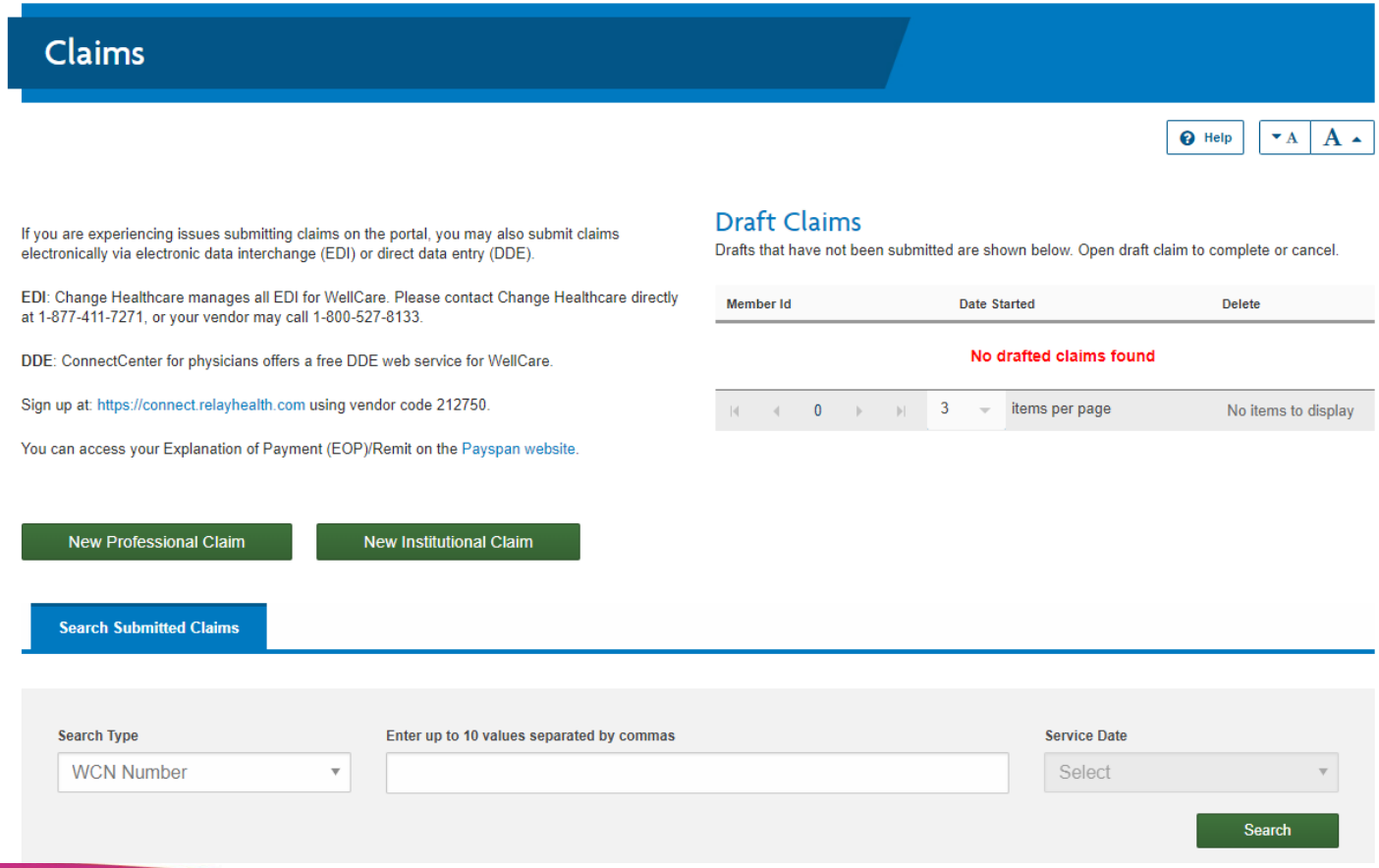
Wellcare Secure Portal

Eligibility and Member Information



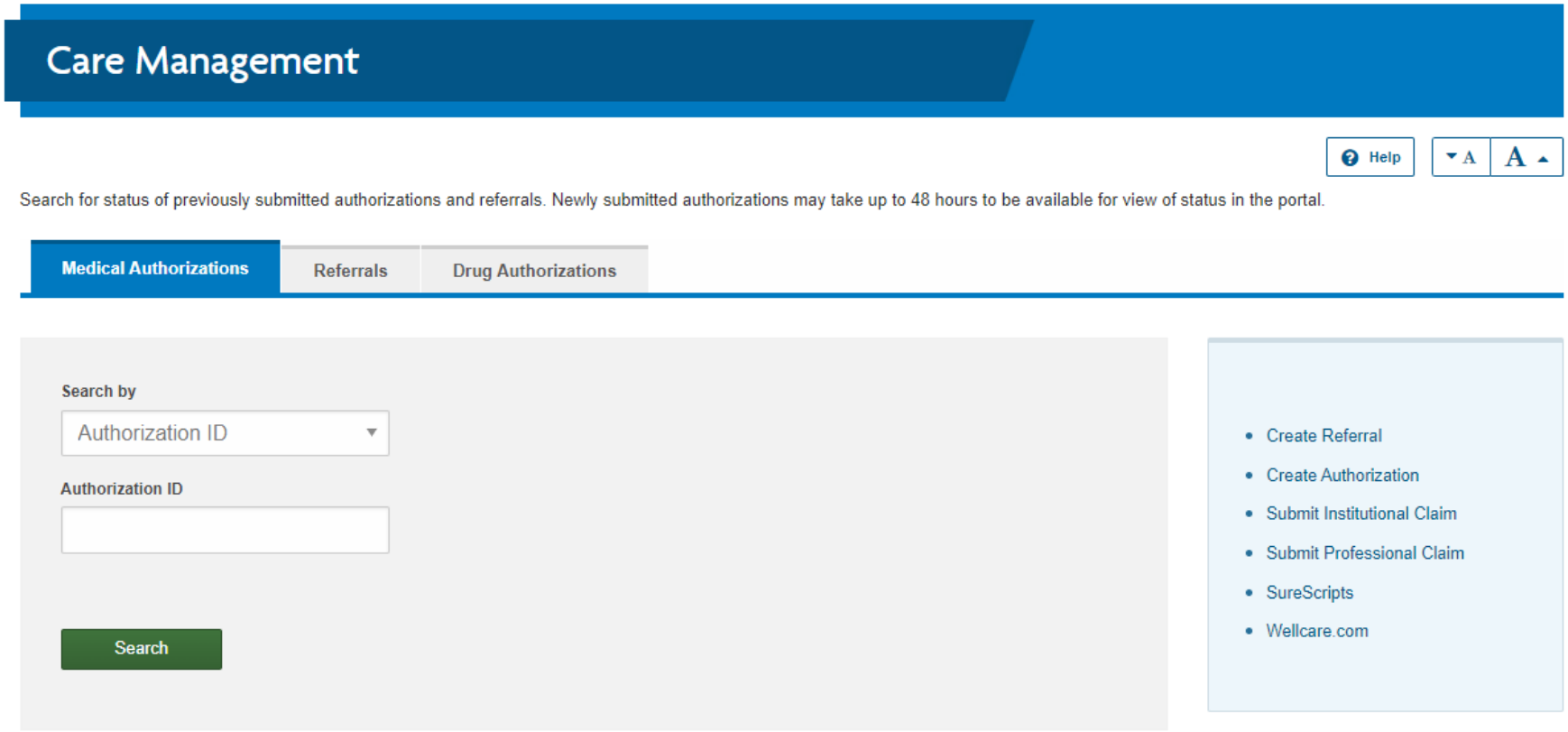
Wellcare Secure Portal

Claims



Wellcare Secure Portal

Authorizations



Claims 411 – Did You Know?

Claims 411 – Did You Know?

- Most common claim rejections:
  - Member Not Valid at Date of Service (DOS)
  - Invalid Member
  - Invalid Member DOS
- Most common claim denials:
  - Services Not on the Fee Schedule are Not Separately Reimbursable
  - This Service is Not Covered
  - Duplicate Claim Service
  - CMS Medicaid NCCI Unbundling
  - No Authorization on File that Matches Service(s) Billed
- Pre-authorization
  - 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
Medicaid	**Secure Provider Portal** **www.Absolutetotalcare.com/login** or **EDI Payer Numbers:** 68069 - Emdeon/WebMD/Envoy/Payerpath 42772 - Relay Health/McKesson 68068 – Behavioral Health	**Absolute Total Care** **P.O Box 3050** **Farmington, MO 63640-3821** **Behavioral Health:** **Absolute Total Care** **P.O. Box 7001** **Farmington, MO 63640-3811**
Marketplace	**Secure Provider Portal** **www.Absolutetotalcare.com/login** or **EDI Payer Number** 68069	**Ambetter from Absolute Total Care** **P.O. Box 5010** **Farmington, MO 63640-5010**
MMP		**Wellcare Prime by Absolute Total Care** **P.O. Box 3060** **Farmington, MO 63640-3822**
Medicare Advantage		**Wellcare By Allwell** **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:

<table>
<tr><th>Line of Business</th><th>Electronic Claim Submission</th><th>Paper Claim Submission</th></tr>
<tr><td>Medicare Advantage</td><td>Register online using the simplified, enhanced provider registration process at PaySpan.com or call 1-877-331-7154
Or
Change Healthcare EDI Clearinghouse
1-877-411-7271.

CHANGE HEALTHCARE CLEARINGHOUSE PAYER IDS (CPIDS)
<table><tr><th>Claim Type</th><th>Fee-for-Service (CH - Chargeable) Submissions</th><th>Encounter (RF - Reporting only) Submissions</th></tr><tr><td>Professional</td><td>1844</td><td>3211</td></tr><tr><td>Institutional</td><td>8551</td><td>4949</td></tr></table>
If your clearinghouse or billing system is not connected to Change Healthcare and requires a 5-digit Payer ID, please use the following according to Fee-for-Service or Encounters file type:
• Fee-for-Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication.
• Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication.
<table><tr><th>Claim Type</th><th>FFS (CH - Chargeable) Submissions</th><th>Encounter (RF - Reporting only) Submissions</th></tr><tr><td>Professional or Institutional</td><td>14163</td><td>59354</td></tr></table></td><td>Wellcare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372</td></tr>
</table>

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

absolute total care™

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		MAPD/D-SNP	
Submission Timeframes	**Par**	**Non-Par**	**Par**	**Non-Par**
Claim Initial/Resubmission	365	365	365	365
Claim Adjustment	365*	365*	90***	365*
Claim Reconsideration	365*	365*	90***	365*
Claim Appeal	60	60**	60	60**
Claim Dispute	60	60	60	60
Decision Timeframes	**Par**	**Non-Par**	**Par**	**Non-Par**
Appeal Decision	30	60	30	30
Dispute Decision	30	30	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 http://www.payspanhealth.com/
- Providers can access additional resources by clicking Need More Help on the PaySpan homepage or link directly to https://www.payspanhealth.com/nps/Support/Index.
- PaySpan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 1-877-331-7154 or on the web at 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
  - To request a new 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)
  - 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

absolute total care™

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®

absolute total care™

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

absolute total care™

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

absolute total care™

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®
Consumer Assessment of Healthcare Providers and Systems

12/15/2022

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® Provider Resource Guide

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

Provider Focus Quick Tips

absolute total care™

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.

START SMART FOR YOUR BABY

Start Smart for Your Baby

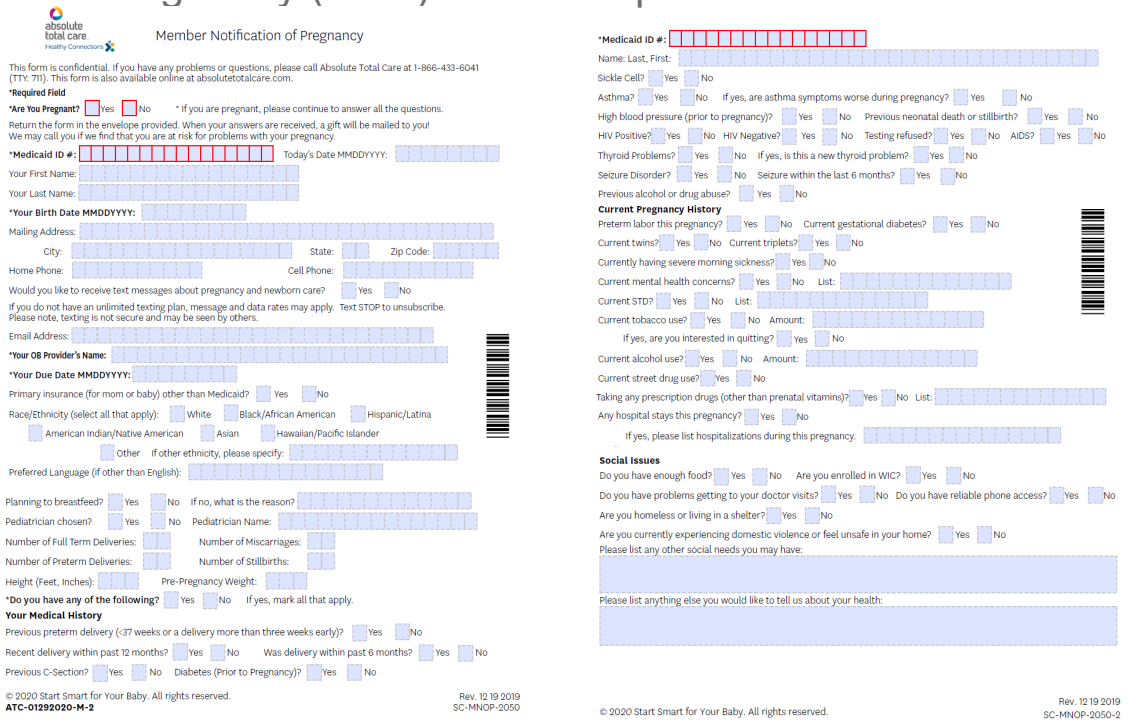
- Program goals
  - Early identification of pregnant members and their risk factors
  - Reducing the risk of pregnancy complications
  - Better birth outcomes
- Strategy
  - Submission of Notification of Pregnancy (NOP) Form
  - High-risk members are prioritized for Care Management Program
  - OB Nurse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

Start Smart for Your Baby

- OB incentive reimbursements:
  - 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



absolute total care Healthy Connections

Member Notification of Pregnancy

This form is confidential. If you have any problems or questions, please call Absolute Total Care at 1-866-433-6041 (TTY: 711). This form is also available online at absolutetotalcare.com.

***Required Field**

***Are You Pregnant?** Yes No * If you are pregnant, please continue to answer all the questions.

Return the form in the envelope provided. When your answers are received, a gift will be mailed to you!
We may call you if we find that you are at risk for problems with your pregnancy.

***Medicaid ID #:** Today's Date MMDDYYYY:

Your First Name:

Your Last Name:

***Your Birth Date MMDDYYYY:**

Mailing Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Would you like to receive text messages about pregnancy and newborn care? Yes No

If you do not have an unlimited texting plan, message and data rates may apply. Text STOP to unsubscribe.
Please note, texting is not secure and may be seen by others.

Email Address:

***Your OB Provider's Name:**

***Your Due Date MMDDYYYY:**

Primary insurance (for mom or baby) other than Medicaid? Yes No

Race/Ethnicity (select all that apply): White Black/African American Hispanic/Latina
American Indian/Native American Asian Hawaiian/Pacific Islander
Other If other ethnicity, please specify:

Preferred Language (if other than English):

Planning to breastfeed? Yes No If no, what is the reason?

Pediatrician chosen? Yes No Pediatrician Name:

Number of Full Term Deliveries: Number of Miscarriages:

Number of Preterm Deliveries: Number of Stillbirths:

Height (Feet, Inches): Pre-Pregnancy Weight:

***Do you have any of the following?** Yes No If yes, mark all that apply.

Your Medical History

Previous preterm delivery (<37 weeks or a delivery more than three weeks early)? Yes No

Recent delivery within past 12 months? Yes No Was delivery within past 6 months? Yes No

Previous C-Section? Yes No Diabetes (Prior to Pregnancy)? Yes No

ATC-01292020-M-2

Rev. 12 19 2019
SC-MNOP-2050

***Medicaid ID #:**

Name: Last, First:

Sickle Cell? Yes No

Asthma? Yes No If yes, are asthma symptoms worse during pregnancy? Yes No

High blood pressure (prior to pregnancy)? Yes No Previous neonatal death or stillbirth? Yes No

HIV Positive? Yes No HIV Negative? Yes No Testing refused? Yes No AIDS? Yes No

Thyroid Problems? Yes No If yes, is this a new thyroid problem? Yes No

Seizure Disorder? Yes No Seizure within the last 6 months? Yes No

Previous alcohol or drug abuse? Yes No

Current Pregnancy History

Preterm labor this pregnancy? Yes No Current gestational diabetes? Yes No

Current twins? Yes No Current triplets? Yes No

Currently having severe morning sickness? Yes No

Current mental health concerns? Yes No List:

Current STD? Yes No List:

Current tobacco use? Yes No Amount:

If yes, are you interested in quitting? Yes No

Current alcohol use? Yes No Amount:

Current street drug use? Yes No

Taking any prescription drugs (other than prenatal vitamins)? Yes No List:

Any hospital stays this pregnancy? Yes No

If yes, please list hospitalizations during this pregnancy.

Social Issues

Do you have enough food? Yes No Are you enrolled in WIC? Yes No

Do you have problems getting to your doctor visits? Yes No Do you have reliable phone access? Yes No

Are you homeless or living in a shelter? Yes No

Are you currently experiencing domestic violence or feel unsafe in your home? Yes No

Please list any other social needs you may have:

Please list anything else you would like to tell us about your health:

Rev. 12 19 2019
SC-MNOP-2050-2

Questions

APPENDIX

- 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

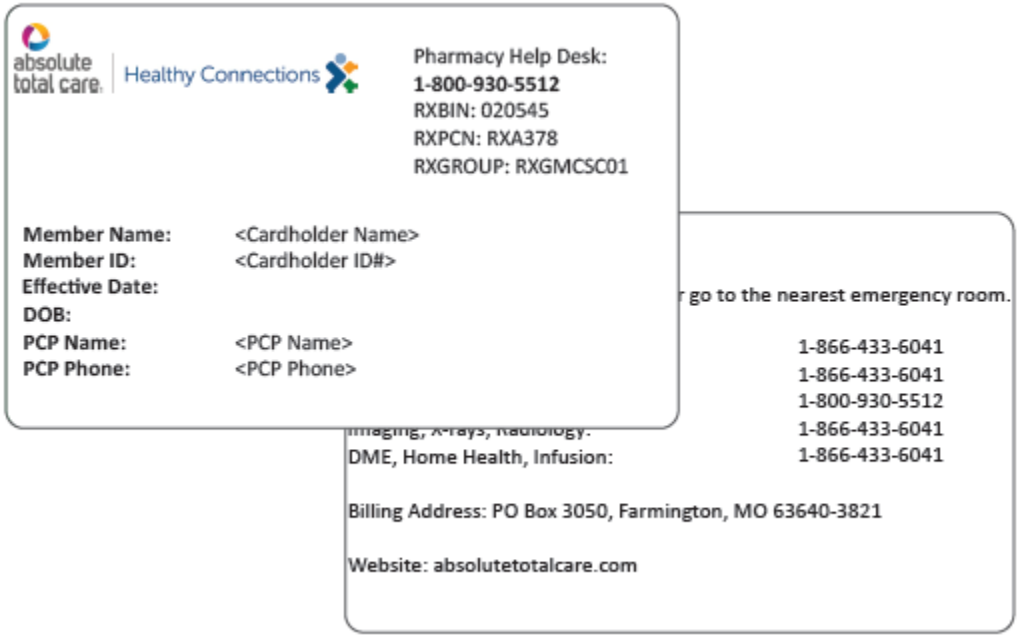
https://ambetter.absolutetotalcare.com/provider-resources/manuals-and-forms.html

Wellcare Provider Resources

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

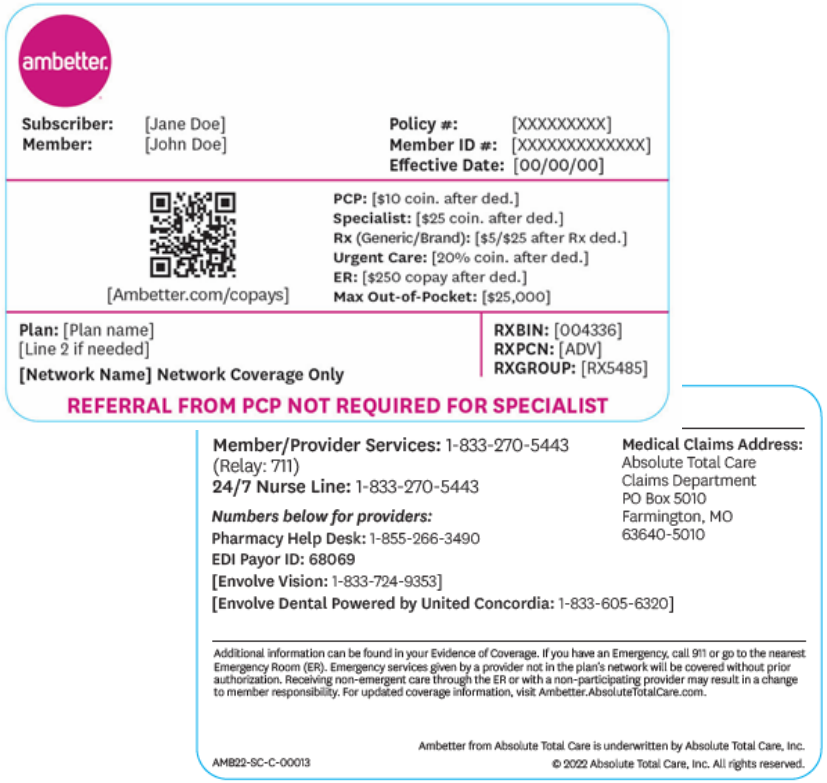
https://www.wellcare.com/Global-Content/Trainings/AcctRegandAffil

Medicaid Member ID Card

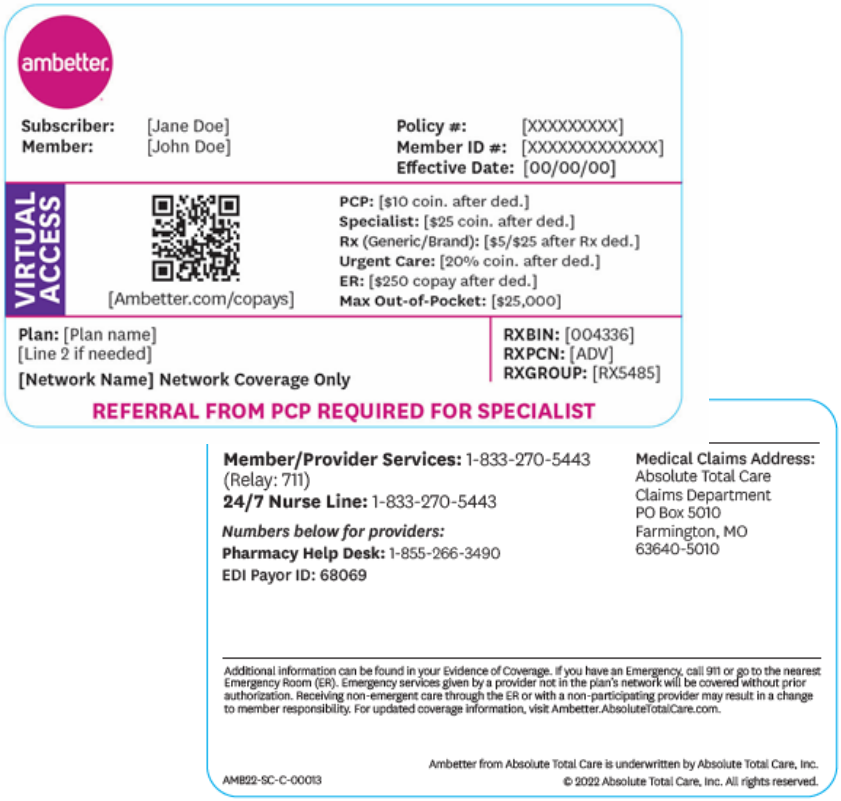


Ambetter from Absolute Total Care Member ID Card (2023)

Core ID Cards

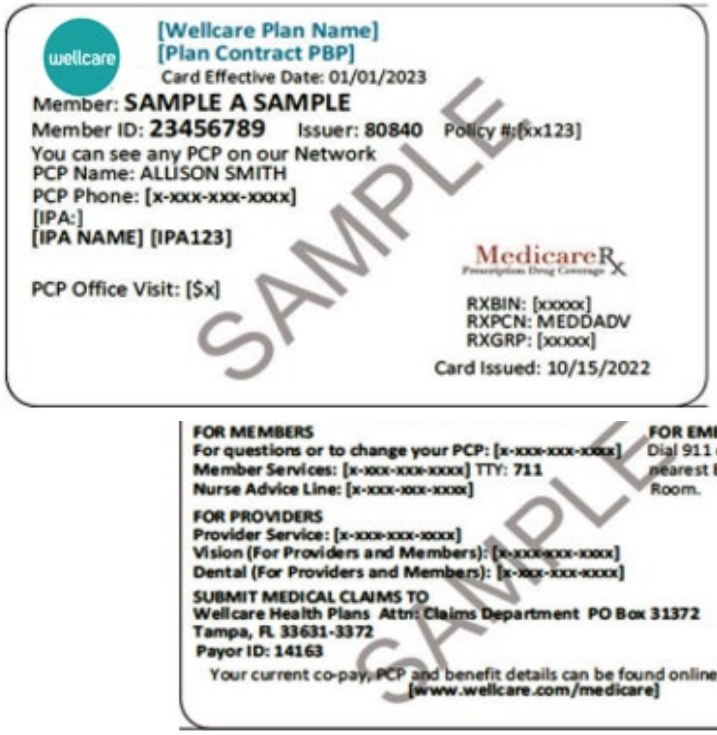


Virtual ID Cards



Medicare-Wellcare Member ID Card (2023)

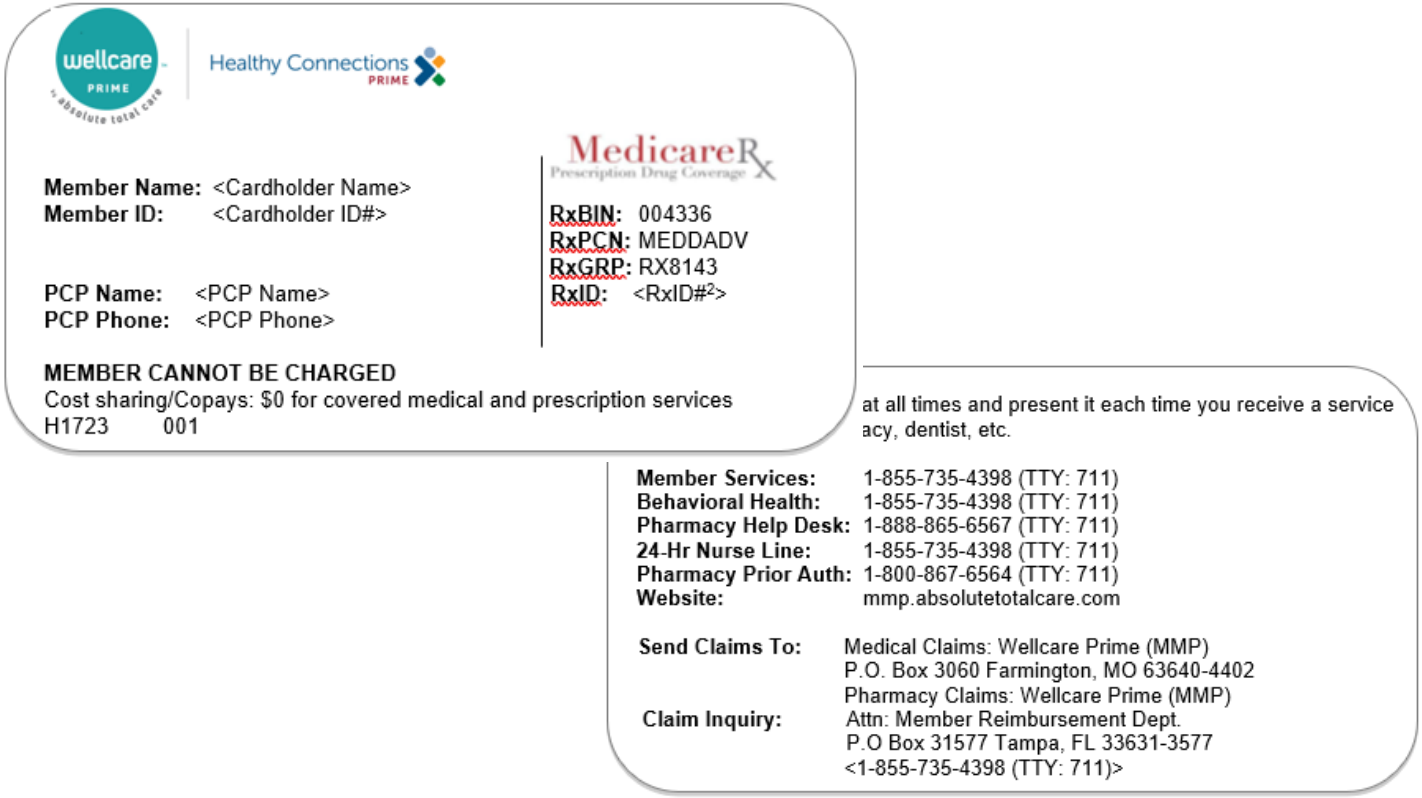
HMO and HMO DSNP



PPO

Wellcare Classic Prescription Drug Plan Member ID Card (2023)

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



wellcare PRIME by absolute total care | Healthy Connections PRIME

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

MedicareRx Prescription Drug Coverage

RxBIN: 004336
RxPCN: MEDDADV
RxGRP: RX8143
RxID: <RxID#[2]>

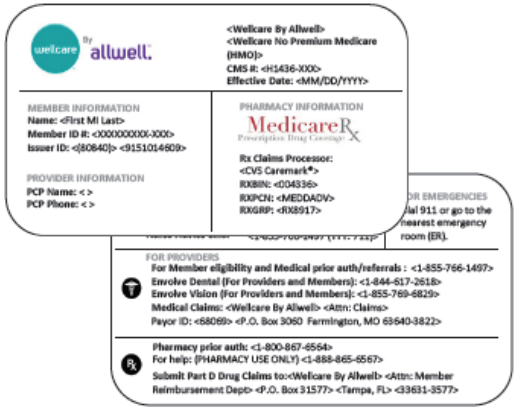
MEMBER CANNOT BE CHARGED
Cost sharing/Copays: $0 for covered medical and prescription services
H1723 001

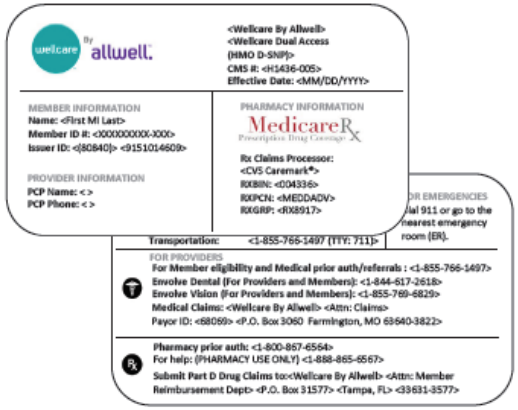
at all times and present it each time you receive a service
acy, dentist, etc.

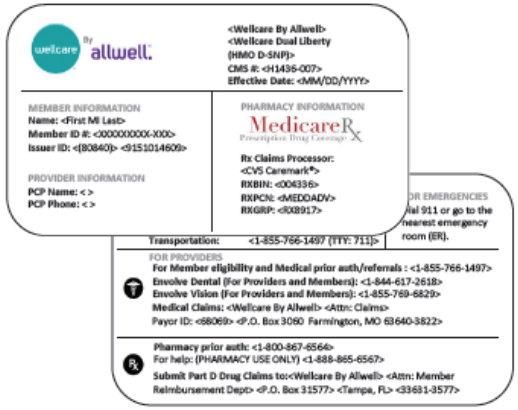
Member Services: 1-855-735-4398 (TTY: 711)
Behavioral Health: 1-855-735-4398 (TTY: 711)
Pharmacy Help Desk: 1-888-865-6567 (TTY: 711)
24-Hr Nurse Line: 1-855-735-4398 (TTY: 711)
Pharmacy Prior Auth: 1-800-867-6564 (TTY: 711)
Website: mmp.absolutetotalcare.com

Send Claims To: Medical Claims: Wellcare Prime (MMP)
P.O. Box 3060 Farmington, MO 63640-4402
Pharmacy Claims: Wellcare Prime (MMP)
Claim Inquiry: Attn: Member Reimbursement Dept.
P.O Box 31577 Tampa, FL 33631-3577
<1-855-735-4398 (TTY: 711)>

Medicare – Wellcare by Allwell Member ID Card







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 **unlawful for providers to "balance bill" any patient who is a member of Healthy Connections Prime** 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 for non-payment. Providers who inappropriately balance bill Healthy Connections Prime members are subject to sanctions and/or termination of their MMP provider agreement.

WHAT CAN BE BILLED TO MEMBERS?

1. 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 non-covered 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.
2. 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 (http://www.scdhhs.gov/prime) to learn more details about the program or email PrimeProviders@scdhhs.gov 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-prime-members-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

Run Date: 8/9/2022

wellcare PRIME by absolute total care | Healthy Connections PRIME

PAY TO: [redacted]

EXPLANATION OF PAYMENT
Wellcare Prime by Absolute Total Care
Medicare-Medicaid Plan
100 Center Point Circle, Suite 100
Columbia, SC 29210
1-855-735-4398

Payment Date:	8/9/2022
Payment #:	0900158619
Payment Amt:	$116.00

Payee ID: UDEF
IRS#: [redacted]

Insured Name: [redacted] Mbr No: [redacted] MRN: [redacted] Claim/Ctrl No: [redacted]
Patient Name: [redacted] SvcProv No: PatCtrl No: [redacted]
Servicing Provider: [redacted] NPI: [redacted] Group: MMP SC ATC
Please note: Medicare crossover claim forwarded to Medicaid for secondary payment. Please do not bill the patient.

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	WrapPaymt	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 $145.00	0.00	$0.00 $0.00	$29.00 $0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	10 21	$116.00 $0.00
			Sub-total		$310.00 $145.00	$0.00	$0.00 $0.00	$29.00 $0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00		$116.00 $0.00
			Total		$310.00 $145.00	$0.00	$0.00 $0.00	$29.00 $0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00		$116.00 $0.00

Explanation Code	Description
10	PAY - PAID PER CONTRACTUAL AGREEMENT
21	PAID-COINSURANCE APPLIED

MMP Example EOP- Medicaid

Balance Billing

Run Date: 8/17/2022

EXPLANATION OF PAYMENT
Wellcare Prime by Absolute Total Care
Medicare-Medicaid Plan
100 Center Point Circle, Suite 100
Columbia, SC 29210
1-855-735-4398

Payment Date:	8/17/2022
Payment #:	
Payment Amt:	$0.00

PAY TO: [redacted]

Payee ID: [redacted]
IRS#: [redacted]

Insured Name: [redacted] Mbr No: [redacted] MRN: [redacted] Claim/Ctrl No: [redacted]
Patient Name: [redacted] SvcProv No: Carrier: MM PatCtrl No: [redacted]
Servicing Provider: [redacted] NPI: [redacted] Group: SCTCC - BERKELEY
Please note: This bill has crossed over from Medicare to Medicaid. Payment is now complete.

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 http://go.cms.gov/mln, 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 Planning**	https://www.absolutetotalcare.com/providers/resources/provider-training.html

*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

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

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:

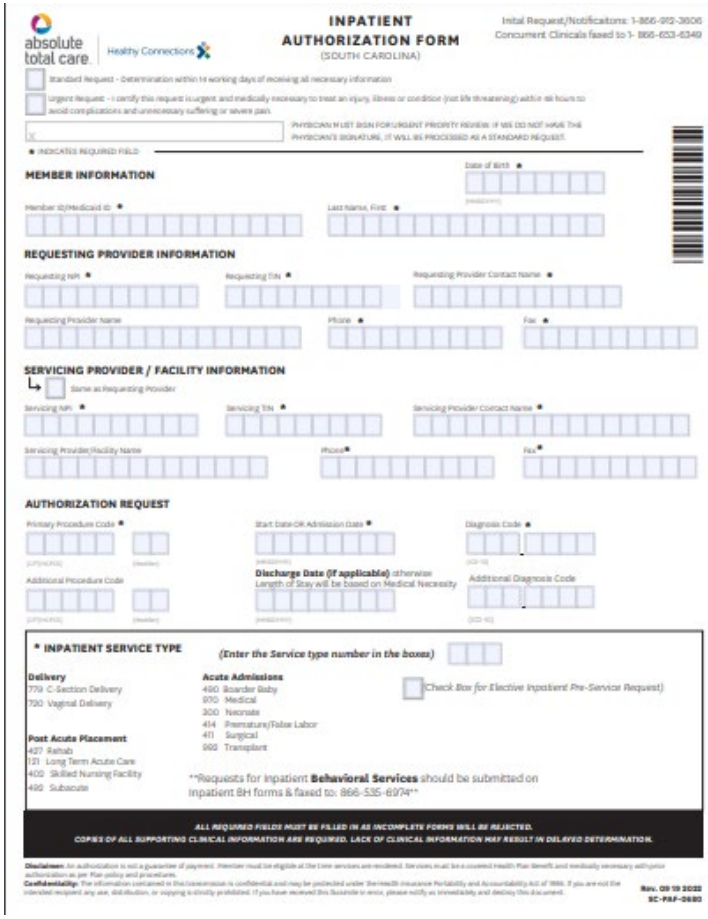
- What is cultural competency
- Sources of diversity
- Steps for becoming culturally competent
- Communicating across cultures
- Tips for successful cross-cultural communications

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



absolute total care Healthy Connections

INPATIENT AUTHORIZATION FORM
(SOUTH CAROLINA)

Inital Request/Notifications: 1-866-912-3606
Concurrent Clinicals faxed to 1- 866-653-6349

Standard Request - Determination within 14 working days of receiving all necessary information

Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

X _____ PHYSICIAN MUST SIGN FOR URGENT PRIORITY REVIEW. IF WE DO NOT HAVE THE PHYSICIAN'S SIGNATURE, IT WILL BE PROCESSED AS A STANDARD REQUEST.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID/Medicaid ID * | Last Name, First * | Date of Birth *

REQUESTING PROVIDER INFORMATION

Requesting NPI * | Requesting TIN * | Requesting Provider Contact Name *
Requesting Provider Name | Phone * | Fax *

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider
Servicing NPI * | Servicing TIN * | Servicing Provider Contact Name *
Servicing Provider/Facility Name | Phone* | Fax*

AUTHORIZATION REQUEST

Primary Procedure Code * | Start Date OR Admission Date * | Diagnosis Code *
Additional Procedure Code | **Discharge Date (if applicable)** otherwise Length of Stay will be based on Medical Necessity | Additional Diagnosis Code

*** INPATIENT SERVICE TYPE** *(Enter the Service type number in the boxes)*

Delivery
779 C-Section Delivery
780 Vaginal Delivery

Post Acute Placement
401 Rehab
101 Long Term Acute Care
402 Skilled Nursing Facility
466 Subacute

Acute Admissions
480 Boarder Baby
970 Medical
300 Neonate
414 Premature/False Labor
411 Surgical
992 Transplant

Check Box for Elective Inpatient Pre-Service Request)

Requests for inpatient **Behavioral Services should be submitted on inpatient BH forms & faxed to: 866-535-6974**

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.
Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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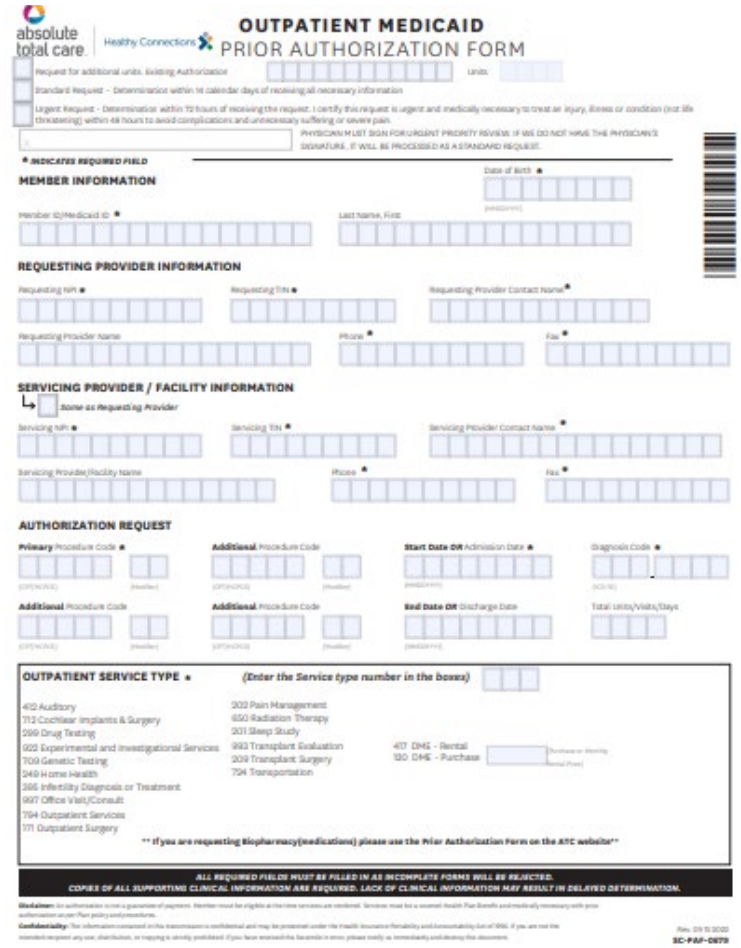
SC-PAF-0680



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OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Request for additional units: Existing Authorization | Units:

Standard Request - Determination within 14 calendar days of receiving all necessary information

Urgent Request - Determination within 72 hours of receiving the request. I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

X _____ PHYSICIAN MUST SIGN FOR URGENT PRIORITY REVIEW. IF WE DO NOT HAVE THE PHYSICIAN'S SIGNATURE, IT WILL BE PROCESSED AS A STANDARD REQUEST.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID/Medicaid ID * | Last Name, First | Date of Birth *

REQUESTING PROVIDER INFORMATION

Requesting NPI * | Requesting TIN * | Requesting Provider Contact Name *
Requesting Provider Name | Phone * | Fax *

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider
Servicing NPI * | Servicing TIN * | Servicing Provider Contact Name *
Servicing Provider/Facility Name | Phone * | Fax *

AUTHORIZATION REQUEST

Primary Procedure Code * | **Additional** Procedure Code | **Start Date OR** Admission Date * | Diagnosis Code *
Additional Procedure Code | **Additional** Procedure Code | **End Date OR** Discharge Date | Total Units/Visits/Days

OUTPATIENT SERVICE TYPE * *(Enter the Service type number in the boxes)*

412 Auditory
713 Cochlear Implants & Surgery
599 Drug Testing
922 Experimental and Investigational Services
709 Genetic Testing
249 Home Health
266 Infertility Diagnosis or Treatment
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
903 Pain Management
650 Radiation Therapy
301 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
794 Transportation
417 DME - Rental
120 DME - Purchase

** If you are requesting Biopharmacy(medications) please use the Prior Authorization Form on the ATC website**

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.
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Pregnancy Notification Form

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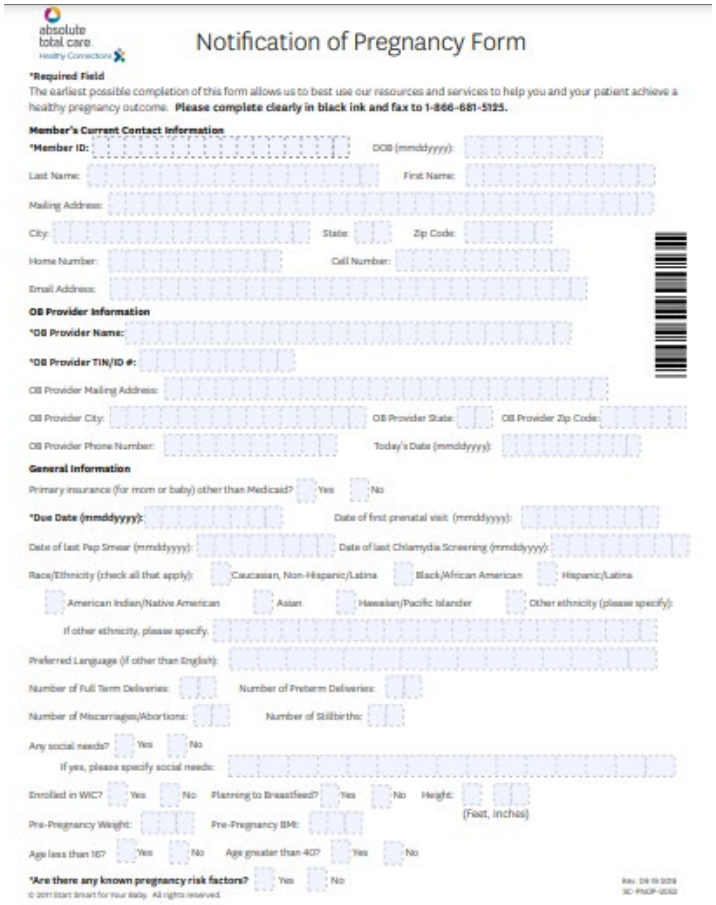

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Healthy Connections

Notification of Pregnancy Form

*Required Field

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 1-866-681-5125.**

Member's Current Contact Information

*Member ID: DOB (mmddyyyy):

Last Name: First Name:

Mailing Address:

City: State: Zip Code:

Home Number: Cell Number:

Email Address:

OB Provider Information

*OB Provider Name:

*OB Provider TIN/ID #:

OB Provider Mailing Address:

OB Provider City: OB Provider State: OB Provider Zip Code:

OB Provider Phone Number: Today's Date (mmddyyyy):

General Information

Primary insurance (for mom or baby) other than Medicaid? Yes No

*Due Date (mmddyyyy): Date of first prenatal visit (mmddyyyy):

Date of last Pap Smear (mmddyyyy): Date of last Chlamydia Screening (mmddyyyy):

Race/Ethnicity (check all that apply): Caucasian, Non-Hispanic/Latina Black/African American Hispanic/Latina

American Indian/Native American Asian Hawaiian/Pacific Islander Other ethnicity (please specify):

If other ethnicity, please specify.

Preferred Language (if other than English):

Number of Full Term Deliveries: Number of Preterm Deliveries:

Number of Miscarriages/Abortions: Number of Stillbirths:

Any social needs? Yes No

If yes, please specify social needs:

Enrolled in WIC? Yes No Planning to Breastfeed? Yes No Height: (Feet, Inches)

Pre-Pregnancy Weight: Pre-Pregnancy BMI:

Age less than 16? Yes No Age greater than 40? Yes No

*Are there any known pregnancy risk factors? Yes No

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SC-PNOP-2052

*Member ID: DOB (mmddyyyy):

Last Name: First Name:

History

Previous Preterm delivery (<37 weeks)? Yes No If yes, was the delivery spontaneous? Yes No

Currently on TIP? Yes No

Recent delivery (within past 12 months)? Yes No Recent delivery (within past 6 months)? Yes No

Previous C-Section? Yes No Previous severe preeclampsia? Yes No

Diabetes (prior to pregnancy)? Yes No Sickle Cell? Yes No

Asthma? Yes No If yes, 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 neonatal death or stillborn? Yes No

If yes, was neonatal death associated with an underlying maternal health condition? Yes No

HIV Positive? Yes No HIV Negative? Yes No HIV Test Refused? Yes No AIDS? Yes No

Seizure disorder? Yes No If yes, has there been a seizure within the last 6 months? Yes No

Current Pregnancy

Preterm labor this pregnancy? Yes No Current placenta previa? Yes No

Vaginal bleeding after 14 weeks? Yes No

Shortened Cervix <23 weeks this pregnancy? Yes No If yes, Length ___ cm.

Current gestational diabetes? Yes No Current preeclampsia? 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 < 20 or poor weight gain during this pregnancy? Yes No UTI/Pyelo Bacteriuria this pregnancy? Yes No

Current severe hyperemesis? 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 tobacco 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

If yes, Please list other risk factors:

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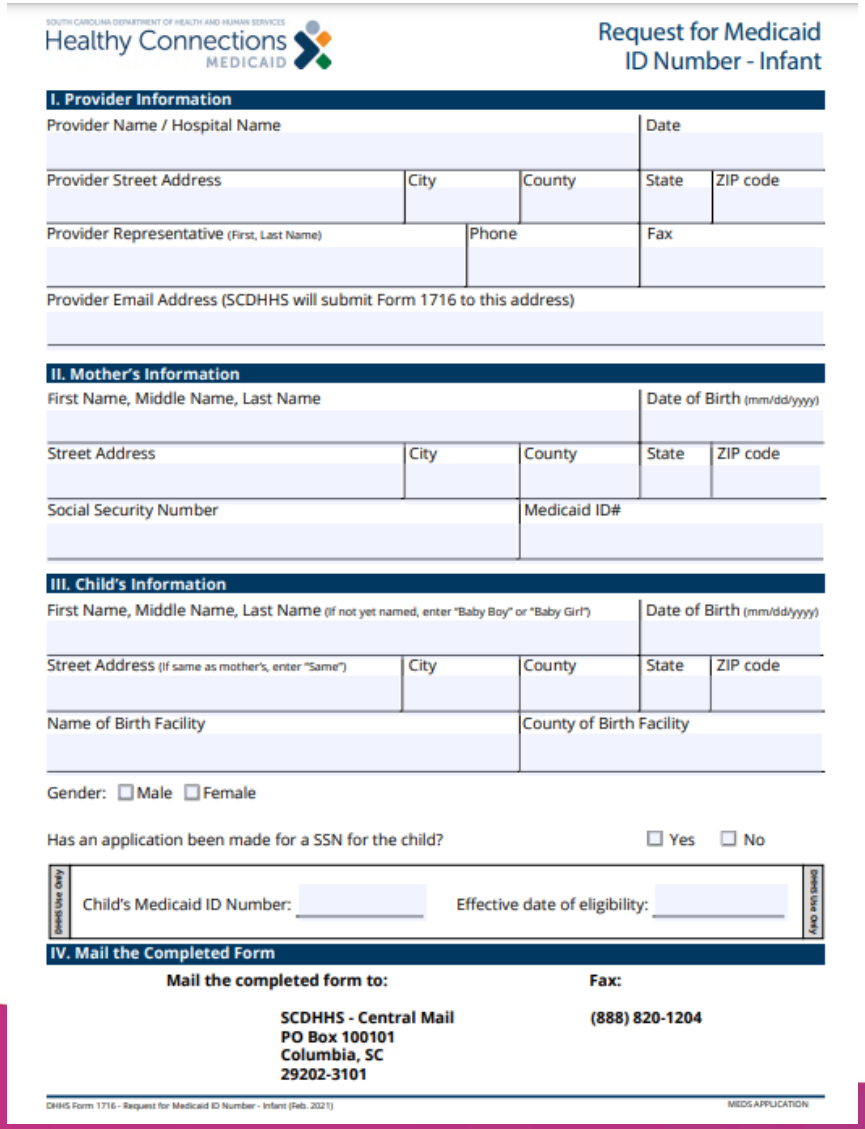
SC-PNOP-2052-2

SC DHHS 1716 Form for Newborns



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Request for Medicaid ID Number - Infant

I. Provider Information

Provider Name / Hospital Name | Date

Provider Street Address | City | County | State | ZIP code

Provider Representative (First, Last Name) | Phone | Fax

Provider Email Address (SCDHHS will submit Form 1716 to this address)

II. Mother's Information

First Name, Middle Name, Last Name | Date of Birth (mm/dd/yyyy)

Street Address | City | County | State | ZIP code

Social Security Number | Medicaid ID#

III. Child's Information

First Name, Middle Name, Last Name (If not yet named, enter "Baby Boy" or "Baby Girl") | Date of Birth (mm/dd/yyyy)

Street Address (If same as mother's, enter "Same") | City | County | State | ZIP code

Name of Birth Facility | County of Birth Facility

Gender: ☐ Male ☐ Female

Has an application been made for a SSN for the child? ☐ Yes ☐ No

DHHS Use Only — Child's Medicaid ID Number: _____ Effective date of eligibility: _____ — DHHS use ONLY

IV. Mail the Completed Form

Mail the completed form to:

SCDHHS - Central Mail
PO Box 100101
Columbia, SC
29202-3101

Fax:

(888) 820-1204

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

Adjournment