wellcare™

Absolute Total Care and Wellcare

2024 Virtual Provider Town Hall 2nd Quarter

8/27/2024

1-866-433-6041

ATC-08272024-AP-1

Meeting Overview

- Absolute Total Care Healthy Connections Medicaid
  - Removal of Co-pay
  - Redetermination
  - Single Preferred Drug List
- Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan)
- Balance Billing
- Ambetter from Absolute Total Care
- Wellcare Medicare Plans
- Annual Provider Training Requirements for Medicare
- Behavioral Health Provider Training
- Website Features and Secure Provider Portal Features
- Risk Adjustment
  - Clinical Documentation Improvement (CDI) 2024 Upcoming Webinars
- PaySpan®
- Quality Improvement
- CAHPS® -Consumer Assessment of Healthcare Providers and Systems
- Access to care, Appointment Availability & Wait times
- Questions

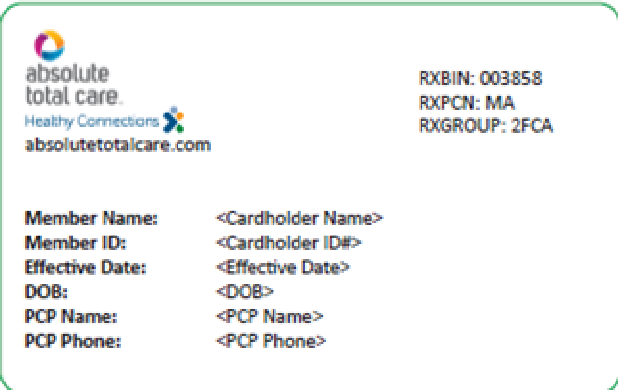
Question# 1

What area do you support in your organization/practice?

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

Products and Services

Absolute Total Care Healthy Connections Medicaid



absolute total care
Healthy Connections
absolutetotalcare.com

RXBIN: 003858
RXPCN: MA
RXGROUP: 2FCA

Member Name:	<Cardholder Name>
Member ID:	<Cardholder ID#>
Effective Date:	<Effective Date>
DOB:	<DOB>
PCP Name:	<PCP Name>
PCP Phone:	<PCP Phone>

If you have an emergency, call 911 or go to the nearest emergency room.

Member/Provider Services:	1-866-433-6041
24/7 Nurse Advice Line:	1-866-433-6041
Behavioral Health:	1-866-433-6041
Imaging, X-rays, Radiology:	1-866-433-6041
DME, Home Health, Infusion:	1-866-433-6041
Pharmacy Help Desk (Pharmacists Only):	1-833-750-4506

Billing Address: P.O. Box 3050, Farmington, MO 63640-3821

absolutetotalcare.com

Front of member ID card

- ATC and Healthy Connections Logo
- Member Name
- Member ID: ATC Unique member Medicaid ID number-required for all members & used when filing claims
- Effective date: indicates when member becomes eligible for benefits
- PCP Name
- PCP Phone number
- RxBIN/RxPCN: need for pharmacy benefits

Back of member ID card

- Member/provider service number: Toll-free number for questions and information such as Nurse Advice line, behavioral health, imaging, X-rays, DME, Home Health, information
- Pharmacy Help Desk: for pharmacist only
- ATC Billing address
- ATC website

****All copays for Healthy Connections Medicaid covered services will be removed for services received on or after July 1, 2024.*****

Absolute Total Care Healthy Connections Medicaid

https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards.html

My Health Pays® Rewards

Healthy Activities Eligible For Rewards

- **$15** – Annual flu vaccination. One per flu season. September to April. Ages 2 to 64.
- **$15** – Initial flu vaccination(s). Up to two flu vaccinations age 6 months to 24 months. 1st vaccine must occur between age 6 - 12 months and 2nd vaccine must occur between ages 12 and 24 months.
- **$20** – Child well-care visit with primary care provider for infant through 24 months old. These visits are recommended within the 1st, 2nd, 4th, 6th, 9th, 12th, 15th, 18th and 24th month time periods. Up to 9 visits / $180 maximum.
- **$10** – Annual well care visit with primary care provider. Ages 3 to 64. One per calendar year.
- **$20** – Diabetes care - HbA1c test. Age 18 to 64. One per calendar year.
- **$20** – Diabetes care - retinopathy screening (dilated eye exam). Age 18-64. One per calendar year.
- **$10** – Annual cervical cancer screening. Age 18 to 64. One per calendar year.
- **$20** – Annual breast cancer screening. Age 50 to 64. One per calendar year.
- **$10** – Annual chlamydia screening. One per calendar year.
- **$20** – Adolescent immunizations. Must be received within these age spans:
- HPV-1 – on or after the 9th birthday and before or on the 13th birthday
- HPV-2 – on or after the 9th birthday and before or on the 13th birthday
- TDAP – on or after the 10th birthday and before or on the 13th birthday
- Meningococcal – on or after the 11th birthday and before or on the 13th birthday

For Pregnant And New Moms

- **$50** – Prenatal Doctor Visit. Needs to be completed within first trimester or 42 days of enrollment.
- **$50** – Postpartum Doctor Visit*. Seven to 84 days after delivery.

https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards.html

Medicaid Annual Eligibility Review Process Continues

- *SCDHHS has reimplemented the standard annual review process effective* ***April 1, 2023,*** *and has begun reviewing 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, as members may no longer be eligible for Medicaid or may have changed managed care organizations (MCOs) during the review process.***

Medicaid Transition to Single Preferred Drug List

Background:

A preferred drug list (PDL) is a list of outpatient drugs health care payors utilize to encourage providers to prescribe certain drugs over others. A PDL allows the health care payor to support use of the most cost-effective medication within a drug class and negotiate higher supplemental rebates. In formulating PDLs, state Medicaid agencies negotiate with drug manufacturers for supplemental rebates on certain drugs in addition to the federal statutory rebates they receive from the Medicaid Drug Rebate Program.

*In support of the agency's goals of purchasing access to needed services in a manner that effectively aligns administrative resources, SCDHHS will transition from multiple MCO-operated PDLs to a single, state-directed PDL effective **July 1, 2024**. This transition to the federal statutory rebates they receive fee-for-service Medicaid program or one of the five Medicaid MCOs. This is a best practice among state Medicaid agencies with 29 of the 40 states who currently operate a managed care delivery system also operating single PDLs.*

*In conjunction with the transition to a single PDL, SCDHHS will continue a state-directed payment to independent pharmacies for all prescriptions dispensed to Medicaid members who are enrolled in a Managed Care Organization (MCO) plan effective **July 1, 2024**, for the duration of state fiscal year (SFY) 2025. All state directed payments must be approved yearly.*

All copays for Healthy Connections Medicaid covered services will be removed for services received on or after July 1, 2024.

Wellcare Prime by Absolute Total Care

MedicareRx
Prescription Drug Coverage

Member Name: [Cardholder Name]
Member ID: [Cardholder ID#]

PCP Name: [PCP Name]
PCP Phone: [PCP Phone]

RxBIN: 610014
RxPCN: MEDDPRIME
RxGRP: 2FJA
RxID: [RxID#]

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

Front of member ID card

- ATC and Healthy Connections Prime Logo
- Member Name
- Member ID: ATC Unique member ID PCP Name
- PCP Phone number
- RxBIN/RxPCN: need for pharmacy benefits
- Disclaimer: Member cannot be charged

Carry this card with you at all times and present it each time you receive a service from your doctor, pharmacy, dentist, etc.

Member Services: 1-855-735-4398 (TTY: 711)
Behavioral Health: 1-855-735-4398 (TTY: 711)
Pharmacy Help Desk: 1-833-750-0202 (TTY: 711)
24-Hr Nurse Line: 1-855-735-4398 (TTY: 711)
Pharmacy Prior Auth: 1-800-867-6564 (TTY: 711)
Website: https://mmp.absolutetotalcare.com

Send Claims To:
Medical Claims: Wellcare Prime (MMP)
P.O. Box 3060 Farmington, MO 6364
[1-855-735-4398 (TTY: 711)]
Pharmacy Claims: Wellcare Prime (MMP)
Attn: Member Reimbursement Dept
P.O Box 31577 Tampa, FL 33631-3577

Back of member ID card

- Member/provider service number: Toll-free number for questions and information
- such as Nurse Advice line, behavioral health
- Pharmacy Help Desk: for pharmacist only
- Pharmacy Prior Authorization
- ATC Billing address for medical and pharmacy
- ATC website

Medicare-Medicaid Plan Member Rewards

myhealthpays™

Help your patients earn My Health Pays™ rewards by completing healthy activities!

Absolute Total Care (Medicare-Medicaid Plan) is proud to be your partner in care. Your Absolute Total Care patients can earn My Health Pays™ rewards by completing healthy activities, such as routine checkups and screenings. When your patients stay focused on their ongoing and preventive care, you receive the benefit of improving the health of your patients, which results in greater quality scores.

Examples of Qualifying Healthy Activities

Annual flu vaccine

Diabetic screening

Colon cancer screening

Annual breast cancer screening

Follow up visit after inpatient hospitalization

Redeeming Rewards

Your patients can use their My Health Pays Visa® Prepaid Card to help pay for a variety of products and services*:

- Everday items at Walmart
- Rent
- Child Care
- Utilities
- Telecommunications
- Transportation
- Education

The reward dollars earned will be added to a My Health Pays Visa Prepaid Card. Your patients will receive their first card by mail after they earn their first reward.

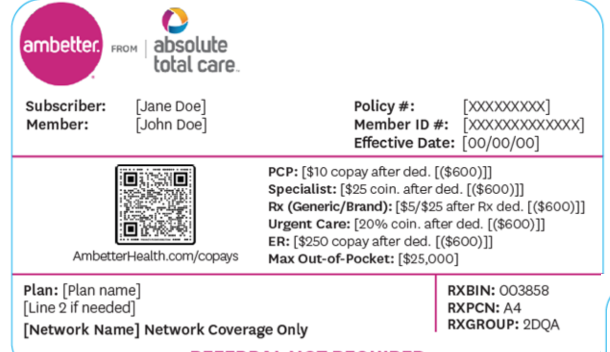
https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards1.html

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*
- ***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*

Ambetter from Absolute Total Care

- *Health Insurance Marketplace*
- *2024 benefit highlights:*
  - *$0 copay for telehealth services for medical care*
  - *Health Savings Accounts*
  - *Dental buy-up options*
  - *Routine vision buy-up options*
  - *Virtual plan option*
  - *Concierge services for disease management*
- *Balance billing protection via the "No Surprises Act"*



Ambetter.AbsoluteTotalCare.com

Member/Provider Services: 1-833-270-5443 (Relay 711)
24/7 Nurse Line: 1-833-270-5443

Medical Claims Address:
Absolute Total Care
ATTN Claims
PO Box 5010
Farmington, MO
63640-5010

Numbers below for providers:
Pharmacist Only: 1-833-750-4237
EDI Payor ID: 68069
[**Envolve Vision:** 1-833-724-9353]
[**Envolve Dental Powered by United Concordia:** 1-833-605-6320]

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.AbsoluteTotalCare.com.

AMB23-SC-C-00048

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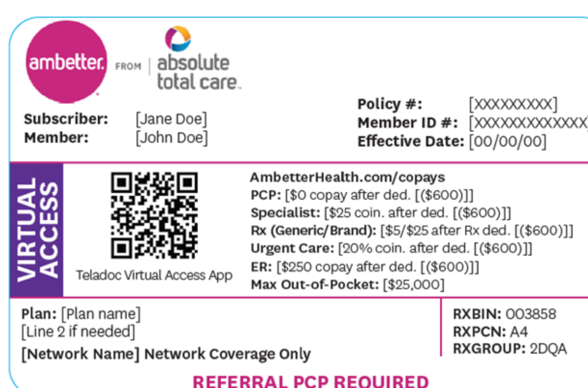
My Health Pays Rewards Program

https://ambetter.absolutetotalcare.com/health-plans/my-health-pays.html

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 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.*



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absolute
total care

Start
Smart
FOR YOUR BABY®

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*

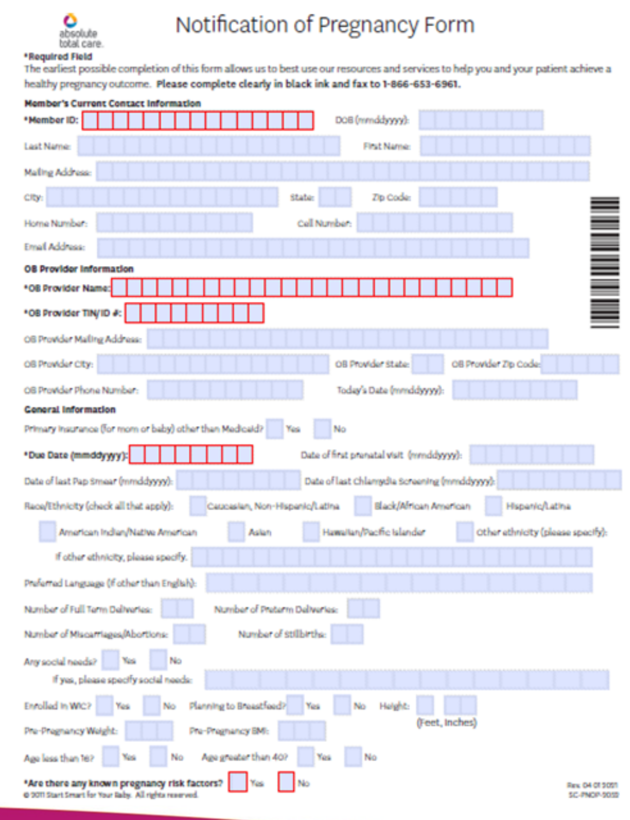
Start Smart for Your Baby

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



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 1-866-653-6961.**

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 18? Yes No Age greater than 40? Yes No
***Are there any known pregnancy risk factors?** Yes No

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Rev. 04 01 2011
SC-PNOP-2012

***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 17P? 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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Rev. 04 01 2011
SC-PNOP-2012-1

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.*

Additional benefits may include:

- *No or low monthly health plan premiums with predictable copays for in-network services*
- *Outpatient prescription drug coverage*
- *Routine dental, vision and hearing benefits*
- *Preventive care from participating Providers with no copayment*

Wellcare Medicare Advantage PPO

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.

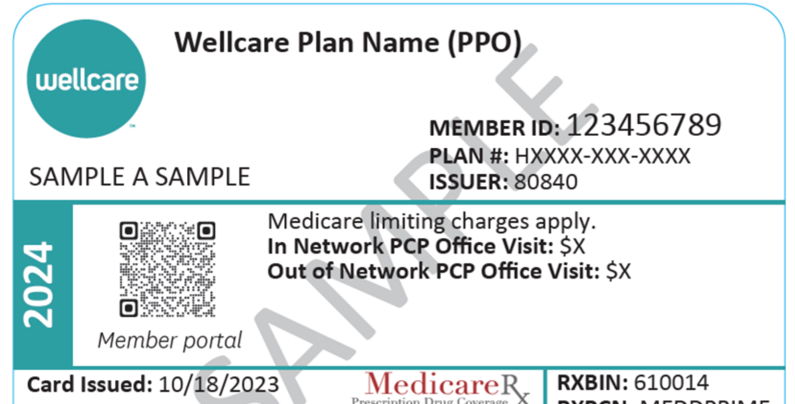
INCREASED FLEXIBILITY

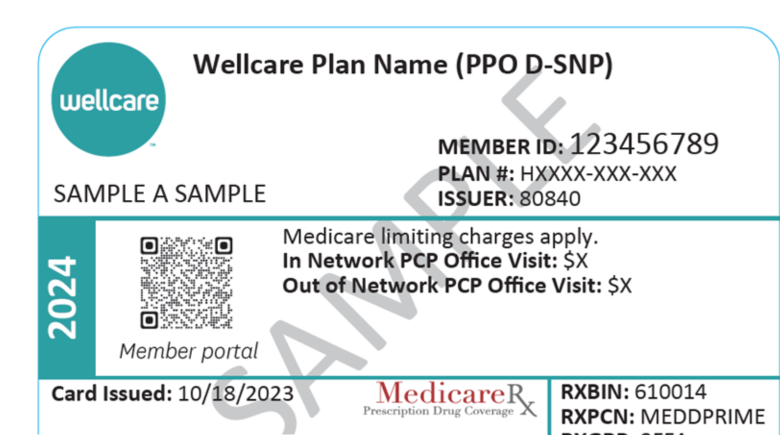
- *Referrals not required from primary care physician for specialist or hospital visits. However, using providers in Wellcare's network may cost less than choosing one that is out-of-network. Medicare providers who do not contract with Wellcare are under no obligation to treat our members, except in emergency situations.*

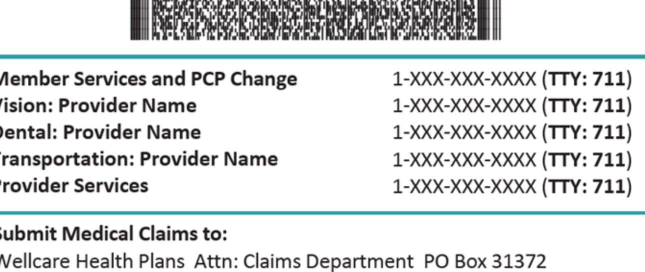
In addition, the Wellcare Medicare Advantage PPO plan:

- *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*

Medicare – PPO (HMO) and PPO HMO D-SNP 2024







PDP 2024

Wellcare Classic (PDP)

Prescription Drug Plan
Wellcare Classic (PDP)

MEMBER ID: 1234567890
PLAN #: S4802-094
ISSUER: 80840

SAMPLE A SAMPLE

PDP

Scan the QR code using your smartphone to register online for your member portal and view your account details!

member.wellcare.com

Card Issued: 10/18/2023

MedicareRx Prescription Drug Coverage

RXBIN: 610014
RXPCN: MEDDPRIME
RXGRP: 2FGA

SAMPLE

Value Script (PDP)

Prescription Drug Plan
Wellcare Value Script (PDP)

MEMBER ID: 1234567890
PLAN #: S4802-138
ISSUER: 80840

SAMPLE A SAMPLE

PDP

Scan the QR code using your smartphone to register online for your member portal and view your account details!

member.wellcare.com

Card Issued: 10/18/2023

MedicareRx Prescription Drug Coverage

RXBIN: 610014
RXPCN: MEDDPRIME
RXGRP: 2FGA

SAMPLE

Rx Value Plus (PDP)

Prescription Drug Plan
Wellcare Medicare Rx Value Plus (PDP)

MEMBER ID: 1234567890
PLAN #: S4802-214
ISSUER: 80840

SAMPLE A SAMPLE

PDP

Scan the QR code using your smartphone to register online for your member portal and view your account details!

member.wellcare.com

Card Issued: 10/18/2023

MedicareRx Prescription Drug Coverage

RXBIN: 610014
RXPCN: MEDDPRIME
RXGRP: 2FGA

SAMPLE

Member Services	1-888-550-5252 **(TTY: 711)**
Mail Order Pharmacy	1-833-750-0201 **(TTY: 711)**
Provider Services	1-855-538-0453 **(TTY: 711)**
Pharmacists Only	1-833-750-0408 **(TTY: 711)**

Submit Part D Claims To:
Attn: Member Reimbursement Department
P.O. Box 31577 Tampa, FL 33631-3577

FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room (ER)

member.wellcare.com

Back of ID card

Member Overpayment Reimbursement Requirement

Providers are required by 42 C.F.R. §422.270(b), to refund all amounts incorrectly collected from its Medicare patients. This includes reimbursements owed due to claims adjusted by the health plan when the member had previously paid the provider or provider office.

Reimbursement is expected to be completed within a reasonable timeline and can be in the form of a check payment, member account credit, and/or other forms as deemed appropriate by the member/provider. Non-Compliance with timely reimbursement to make member whole can lead to Civil Monetary Penalties (CMP) imposed by CMS.

Annual Provider Training Requirements

*We partner 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*

Annual Provider Training Requirements

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.html
Person-Centered Planning	https://www.absolutetotalcare.com/providers/resources/provider-training.html

Additional Provider Training Opportunities Behavioral Health

Absolute Total Care offers additional trainings for medical and behavioral health providers to recognize the intent of the Behavioral Health HEDIS measures and share strategies to impact quality care and outcomes for our members.

- *Initiation and Engagement, Follow-Up After Emergency Department or High Intensity Care for Substance Use Disorders: Optimizing the IET, FUA, and FUI HEDIS® Measures (Absolute Total Care)*
- *Follow-Up Care After a Hospital or Emergency Department Visit for Mental Illness: Optimizing the FUH and FUM HEDIS® Measures (Absolute Total Care)*
- *Strategies to Improve Cardiovascular, Diabetes, and Metabolic Monitoring: APM, SSD, SMC, and SMD HEDIS® Measures (Absolute Total Care)*
- *Antidepressant Medication Management and Antipsychotic Medication Adherence: Optimizing the AMM and SAA HEDIS® Measures (Absolute Total Care)*

Additional Provider Training Opportunities Behavioral Health

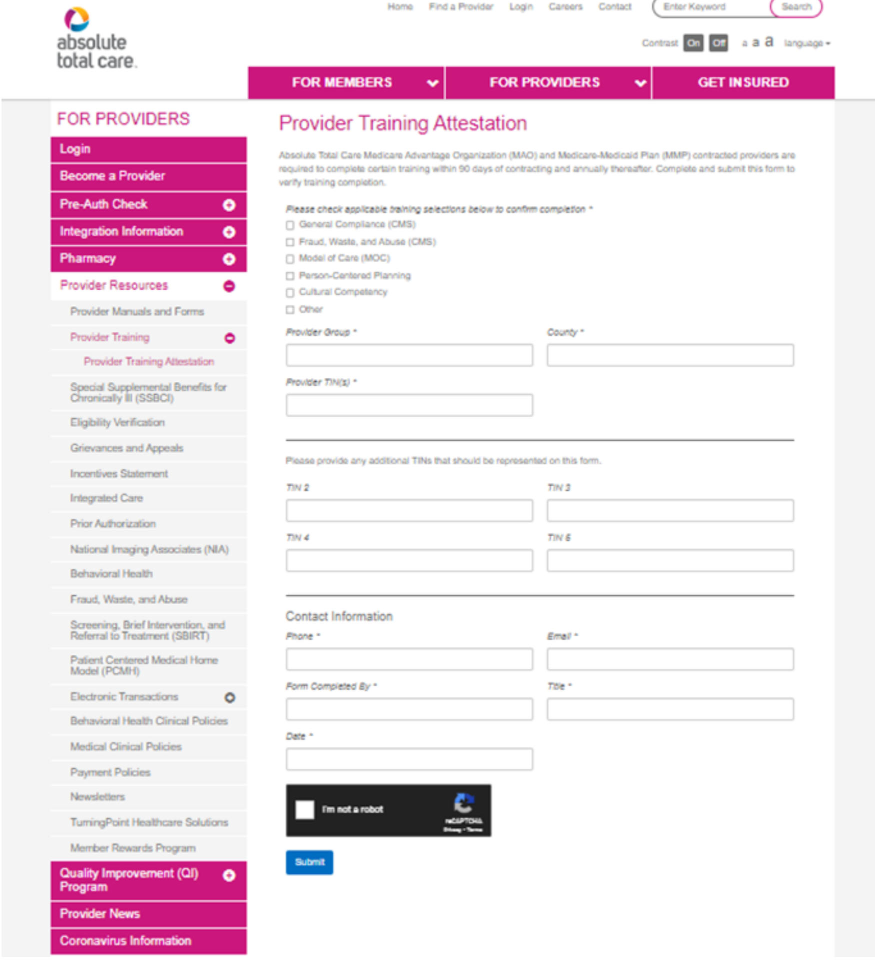
- *(Ambetter) Antidepressant Medication Management, Follow-Up After Hospitalization for Mental Illness, and Initiation and Engagement of Substance Use Disorder Treatment: Optimizing the AMM, FUH, and IET HEDIS® Measures (Absolute Total Care)*

- *Enhancing Member Experience with Behavioral Health Care Services: Experience of Care and Health Outcomes (ECHO) Survey (Absolute Total Care)*

- *Strategies to Minimize the Risk of Opioid Overuse and Misuse: Optimizing the Impact of the POD, COU, UOP, and HDO HEDIS® Measures (Absolute Total Care)*

- *Optimizing the Impact of the ADD and APP HEDIS® Measures: Follow-Up Care for Children Prescribed Medication for ADHD and the Use of Psychosocial Care for Children and Adolescents Prescribed Antipsychotics (Absolute Total Care)*

Provider Training Attestation



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

Websites and Secure Portals

Absolute Total Care Website

For Members For Providers Get Insured

Copay Removal for Healthy Connections Medicaid

All copays for Healthy Connections Medicaid covered services will be removed for services received on or after July 1, 2024.

The Interoperability and Patient Access Rule

You are now able to view your health information from a third-party app on a mobile device or PC! Check out the Interoperability Page to learn more.

Find A Provider

Finding a doctor is quick and easy. Search for primary care providers, hospitals, pharmacies, and more!

Health Insurance Marketplace

With quality healthcare solutions, Ambetter from Absolute Total Care helps residents of South Carolina live better.

All Together Now

In South Carolina, WellCare and Absolute Total Care are joining to better serve you.

www.absolutetotalcare.com

For Providers section:

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

Pre-Auth Lookup Tool

Medicaid Pre-Auth

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the Medicaid Provider Manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Prior authorization for medications will NOT be accepted through the web portal.

For Pharmacy prior authorization requests, please visit our pharmacy page.

- Vision Services need to be verified by Envolve Vision.
- 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.
- Dental services for members under 21 need to be verified by SCDHHS through the EPSDT program.
- Complex imaging, MRA, MRI, PET, CT scans, Interventional Pain Management and Musculoskeletal Services need to be verified by NIA.
- Outpatient rehabilitative and habilitative physical medicine services PT, OT, and Speech need to be verified by NIA. *Note - excludes services in the home setting.

For non-participating providers, Join Our Network.
Prior authorization is required for all non-emergent services provided by non-contracted providers.

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?	○	○
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○
Are services being rendered by a podiatrist?	○	○
Are anesthesia services being rendered for pain management?	○	○

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.

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?	○	◉
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	◉
Are services being rendered by a podiatrist?	○	◉
Are anesthesia services being rendered for pain management?	○	◉

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

99213 | CHECK FOR PRE-AUTH

N
No

99213 - OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 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.

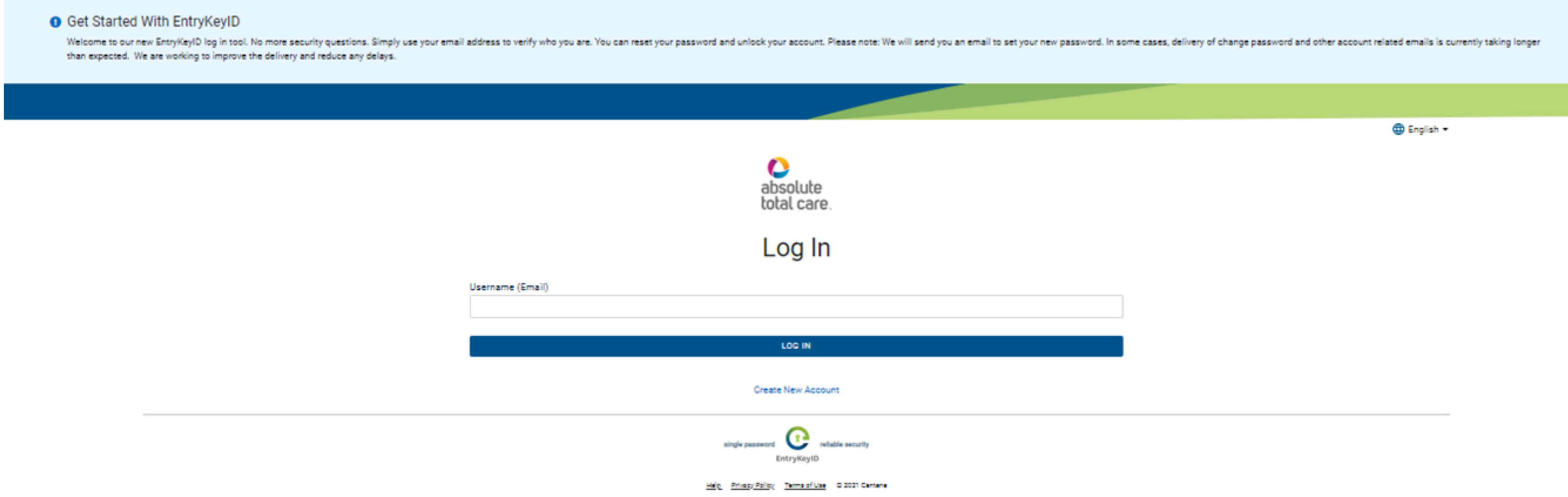
Authorization Vendors

- *Vision Services need to be verified by* ***Envolve Vision****.*
- *Musculoskeletal Services need to be verified by* ***National Imaging Associates (NIA)******
- *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****.*
- ***Dental Services*** *for members under 21 need to be verified by* ***SCDHHS*** *through the EPSDT program.*
- *Complex imaging, MRA, MRI, PET, CT scans need to be verified by* ***National Imaging Associates (NIA)****.*
- *Outpatient rehabilitative and habilitative physical medicine services PT, OT, and Speech need to be verified by* ***National Imaging Associates NIA****.*

Effective 1/20/2023, National Imaging Associates, Inc. is now a subsidiary of Evolent Health. Evolent Health and its affiliates and subsidiaries collectively referred to as "Evolent."

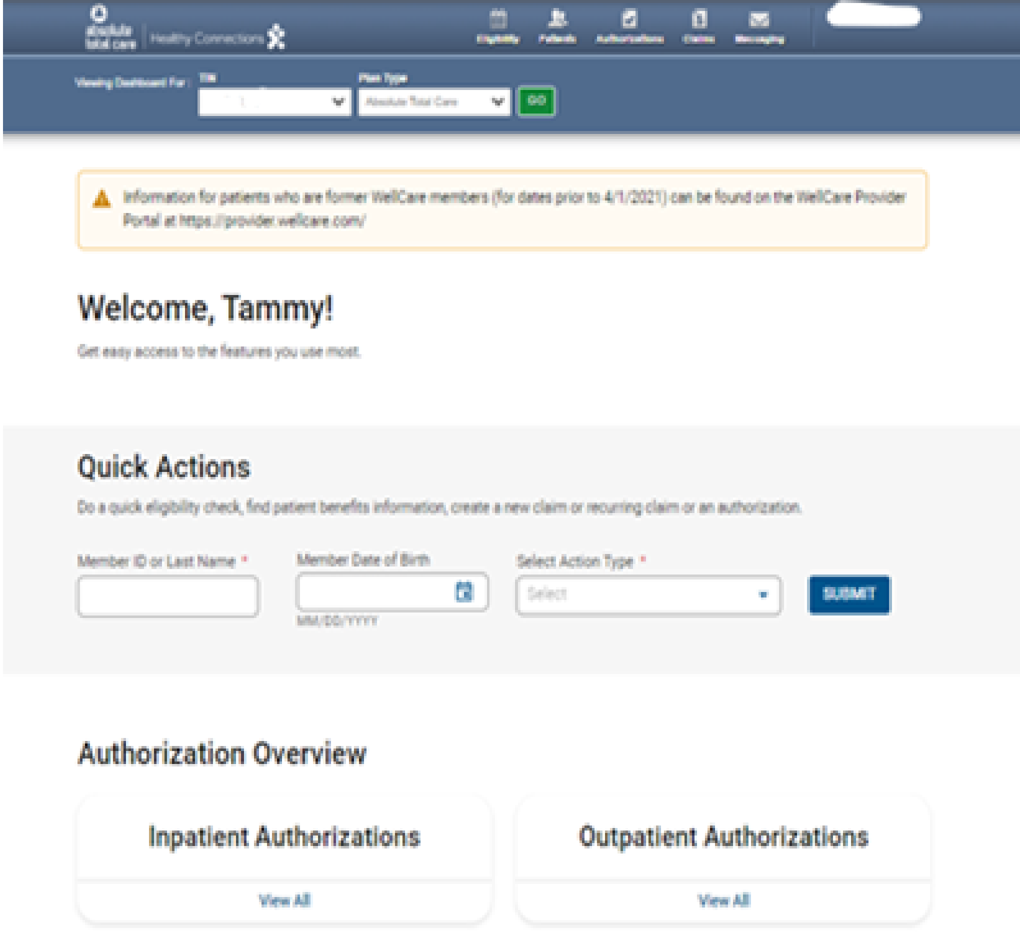
Absolute Total Care Secure Provider Portal

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



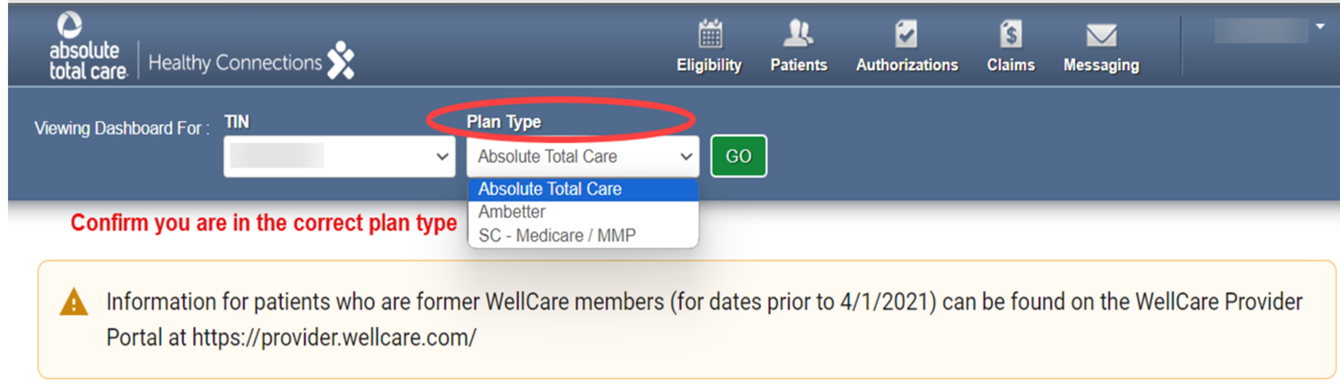
Absolute Total Care Secure
Provider Portal

absolute
total care


Healthy Connections
Information for patients who are former WellCare members (for dates prior to 4/1/2021) can be found on the WellCare Provider Portal at https://provider.wellcare.com/
Welcome, Tammy!
Get easy access to the features you use most.
Quick Actions
Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.
Member ID or Last Name *
Member Date of Birth
MM/DD/YYYY
Select Action Type *
Select
SUBMIT
Authorization Overview
Inpatient Authorizations
View All
Outpatient Authorizations
View All

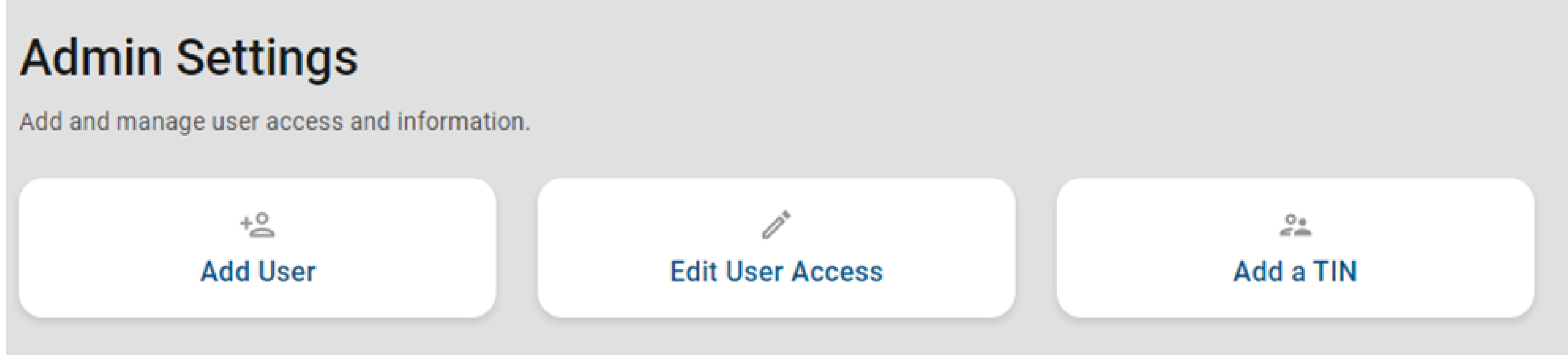
Tips and Tricks for Provider Portal

- *Confirm that you are in the correct plan type*



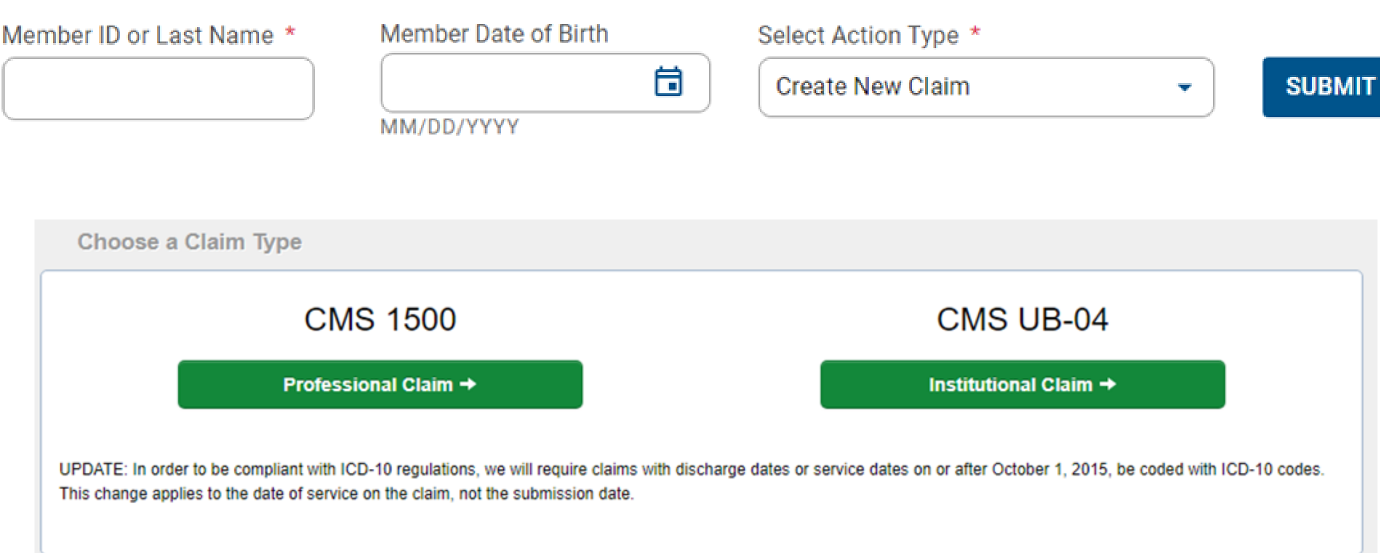
- *Instruction manual PDF is located at the bottom of page for any additional questions*

Admin Settings



To address accessibility issues with drop-down lists, admin functions are easily visible and clickable to the user.

Quick Actions- Claims



By providing the member information first, the system can direct the user directly to the claim type selection page, avoiding several unnecessary clicks and screen loads.

Quick Actions- Eligibility

Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name *

Member Date of Birth

MM/DD/YYYY

Select Action Type *

View Eligibility & Patient Informati...

SUBMIT

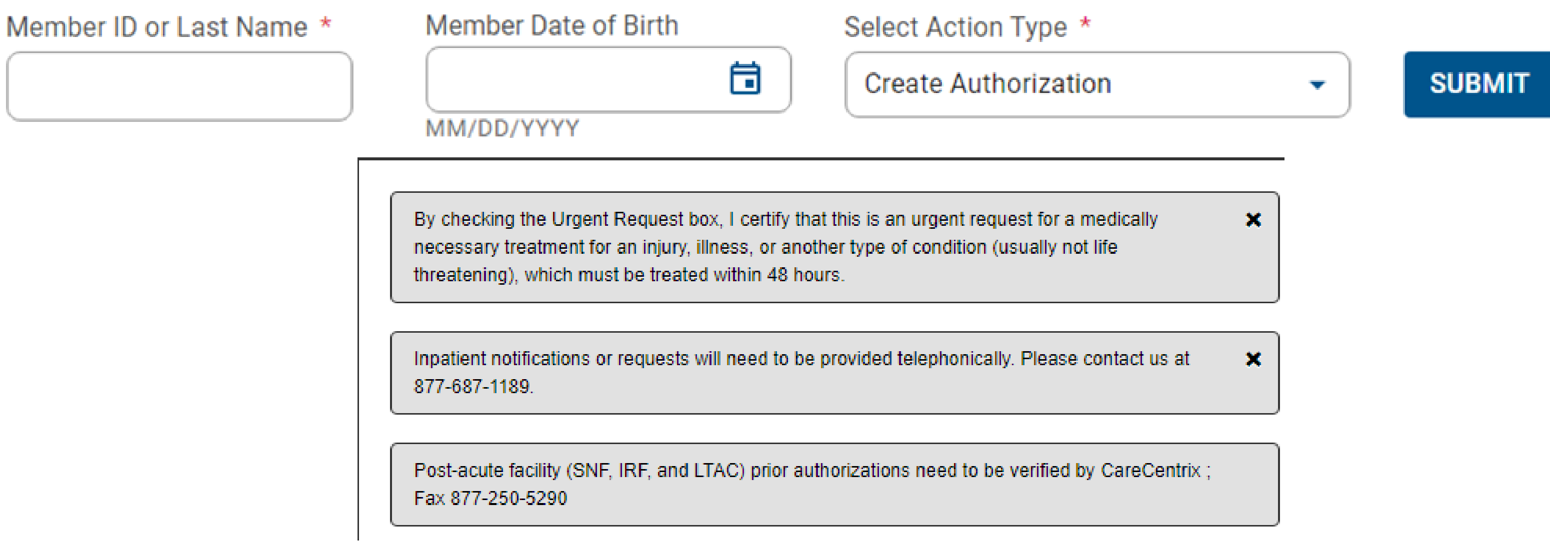
Overview

This patient is not eligible as of today, Jun 5, 2024 The premium paid through date is Jan 25, 2023. and the claims paid through date is Jan 25, 2023.

Print Eligibility Overview

By providing the member information first, the system can direct the user directly to the Eligibility page, avoiding several unnecessary clicks and screen loads.

Quick Actions- Authorizations



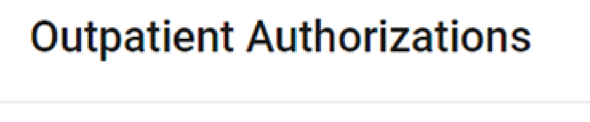
By providing the member information first, the system can direct the user directly to the authorization creation page, avoiding several unnecessary clicks and screen loads.

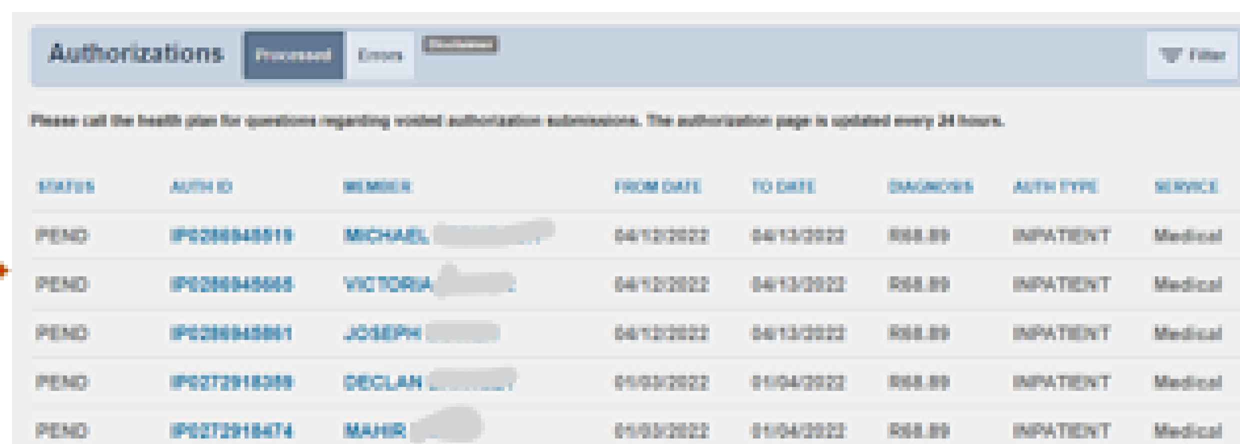
Authorizations

Authorization Overview

Inpatient Authorizations

View All





From the Home Screen, the user is directed to the authorization page with pre-defined filters already applied.

Reports and Analytics

absolute total care™

Useful Links

Reports

This repository contains reports that are uploaded and maintained by the health plan.

Provider Analytics

Used by PCP groups to get direct access to reports/dashboards that assist in providing better outcomes and lower costs.

Patient Analytics

This is a PHM tool that supports providers in the delivery of timely, efficient, and evidence-based care to our members.

Care & Risk Gaps

Providers are directed to Interpreta, where they can view data for high-risk/high impact members in the selected population.

ITC Provider Dispute Form

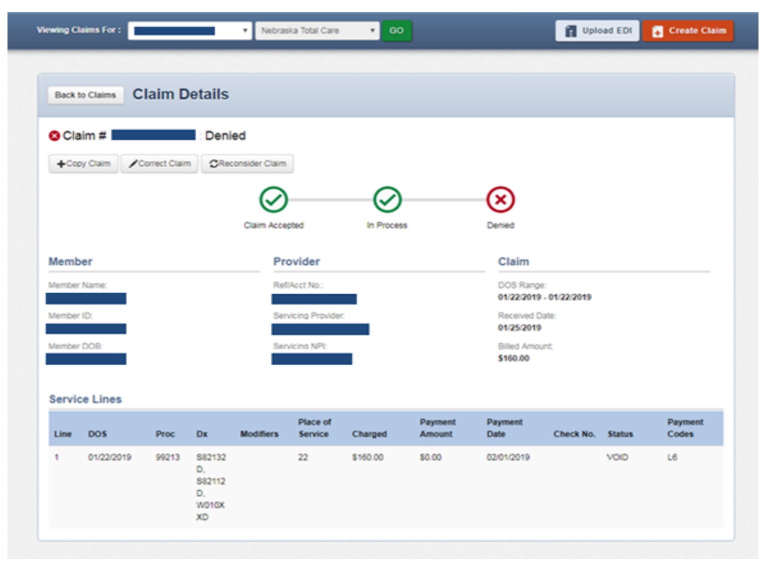
Use if claim is processed and a PRA has been issued or you received a letter subsequent to the reconsideration.

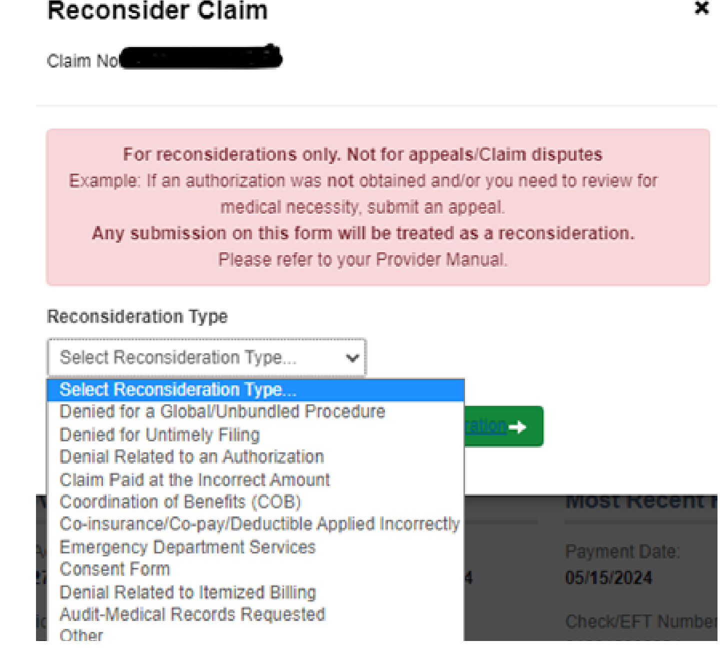
Clinical Payment Policies

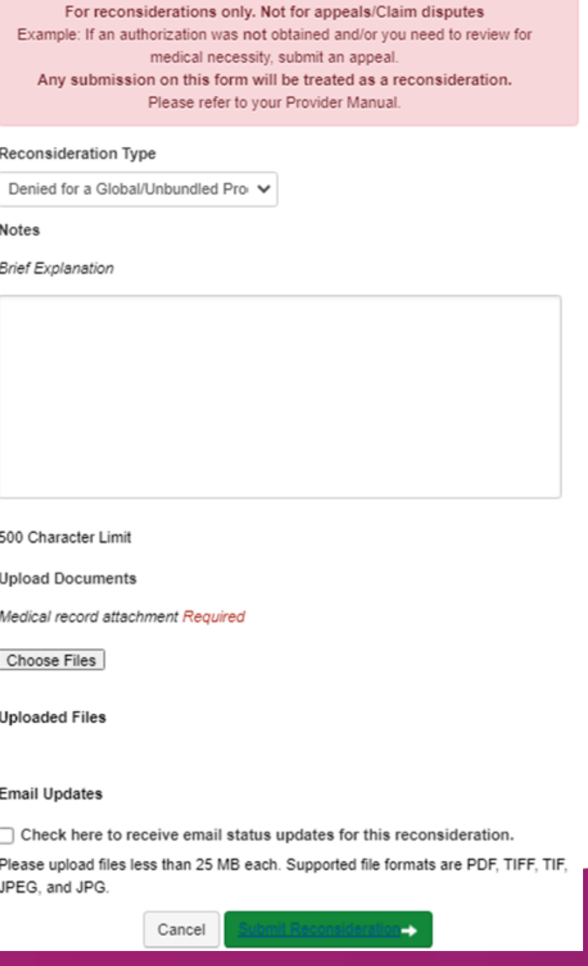
Guidelines used to assist in administering provider benefits

Each link in the new Useful Links section has detailed information about the link's purpose.

Absolute Total Care Secure Provider Portal Provider Reconsideration

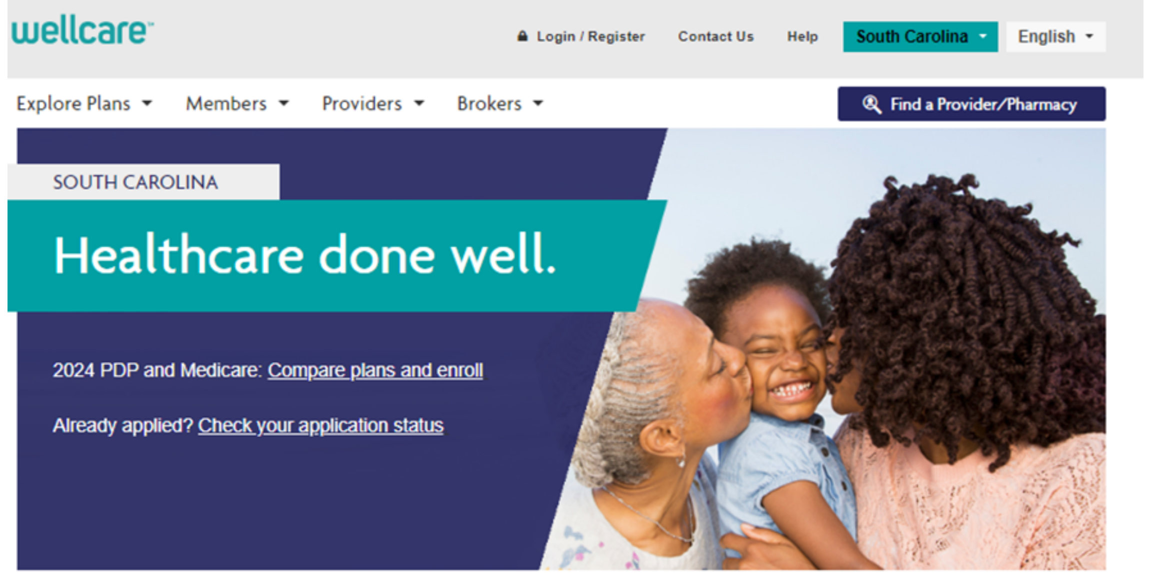






Wellcare Website and Secure Portal

Wellcare Website



Medicare-Medicaid Benefit Renewal

If you have Medicaid coverage, don't risk losing your Medicare Advantage Dual Special Needs Plan (D-SNP) and Medicaid benefits.

Learn More

Coronavirus (COVID-19)

Keep yourself informed about Coronavirus (COVID-19.) Learn more about how we're supporting members and providers.

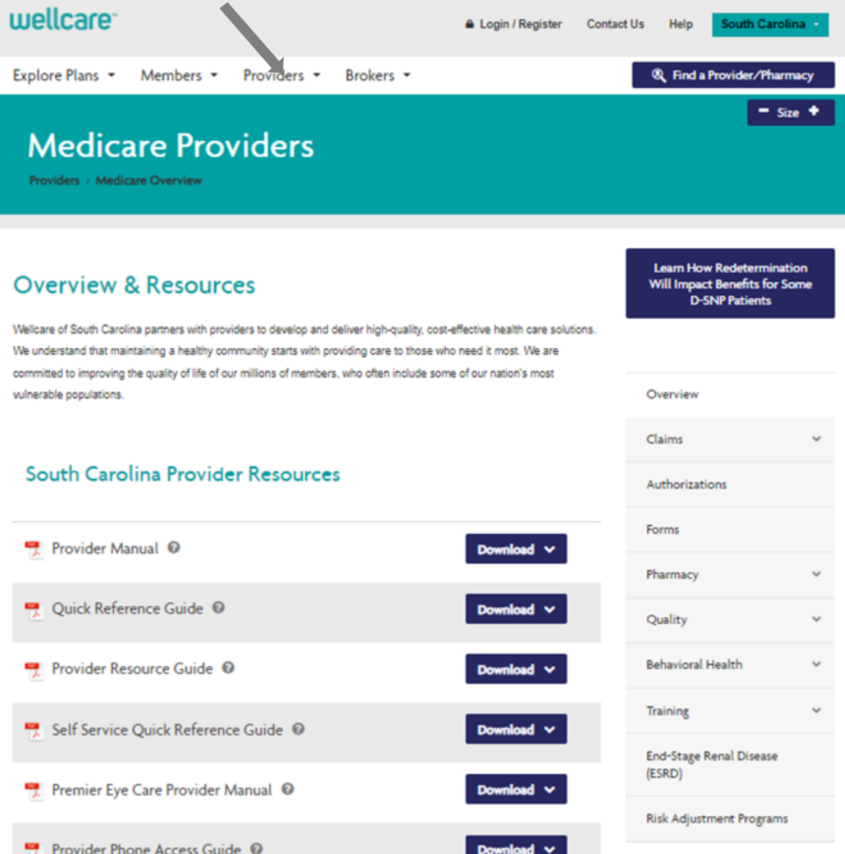
Learn More

Notice of Non-Discrimination

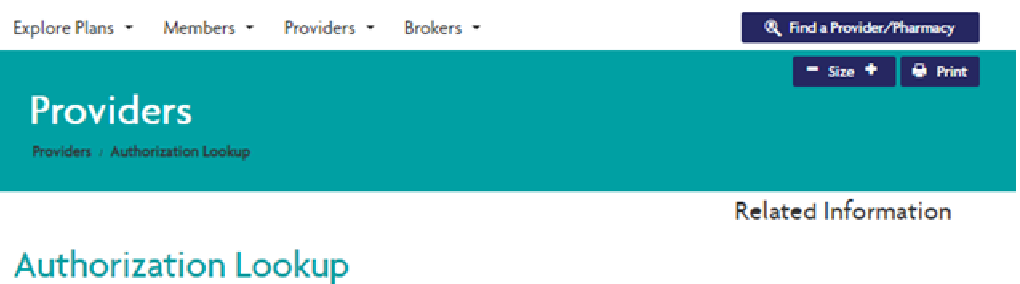
We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, sex, or disability.

More Information

Wellcare Website



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

South Carolina Medicare and PPO Plans

Enter CPT Code

99213

Reset

Lookup

Results as of : 6/14/2024 13:19:14 PM

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

22 Outpatient Hospital :

No Authorization Required

Authorization Vendors and Partners

- ***eviCore*** *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.*
- ***NIA (National Imaging Associates)*** *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 and Musculoskeletal (MSK) Management program.*
- ***CareCentrix*** *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.*
- ***New Century Health*** *is our in-network vendor for Oncology Pathways Solutions: Medical and Radiation Oncology, as well as Cardiology Management Program as of October 1, 2023.*

Effective 1/20/2023, National Imaging Associates, Inc. is now a subsidiary of Evolent Health. Evolent Health and its affiliates and subsidiaries collectively referred to as "Evolent."

Wellcare Secure Provider Portal

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

wellcare Provider Portal

A A Download & Print

Provider Login

Username*

Password*

Login

Not registered? Register an account

Forgot Password?

Forgot Username?

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

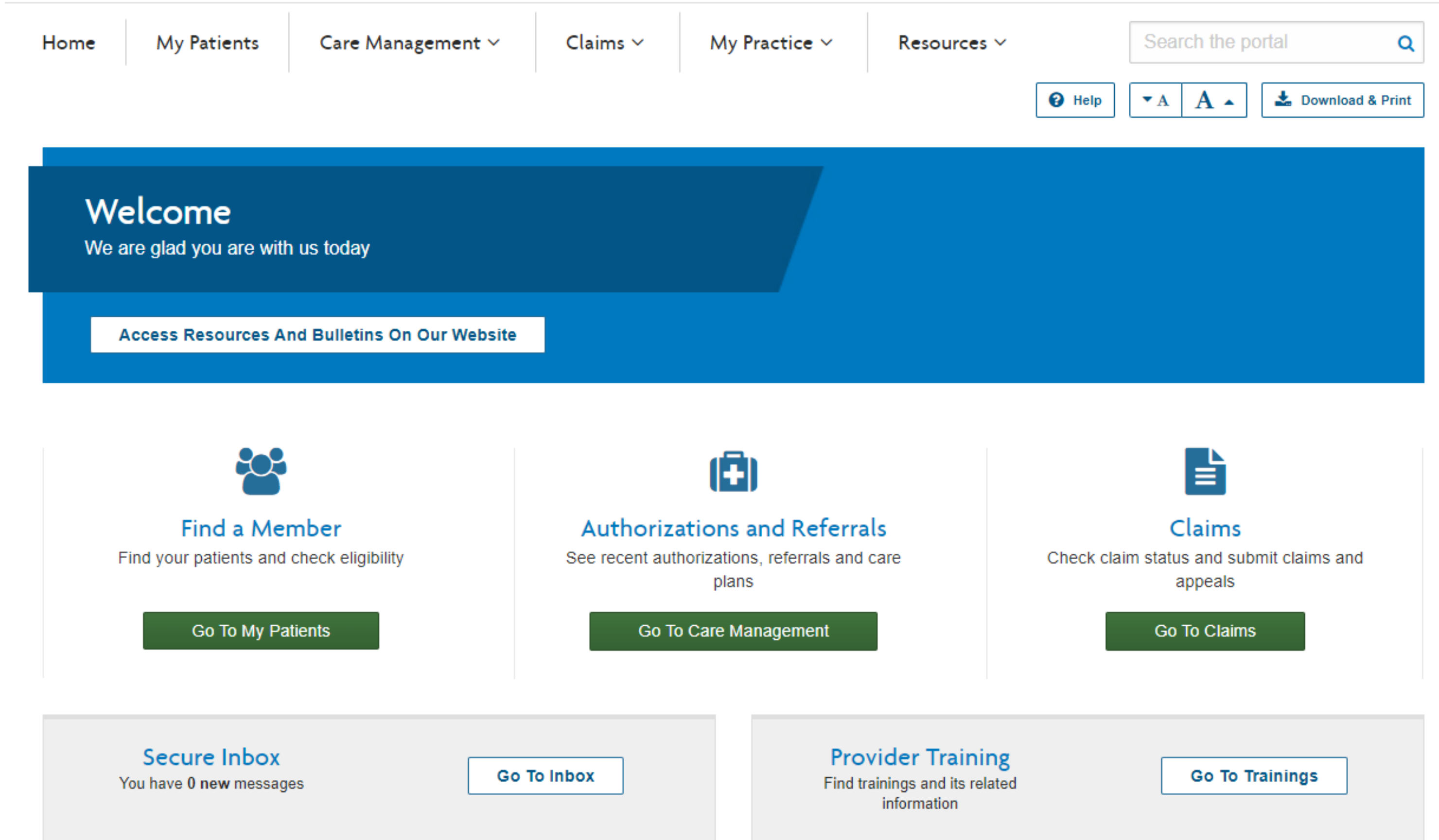
You can even print your chat history to reference later!

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**.

Wellcare Secure Provider Portal



Wellcare Secure Portal
Eligibility & Member Information

Home | My Patients | Care Management | Claims | My Practice | Resources | Search the portal

My Patients

< Back To Home

Help

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.

Select search criteria to find a member: Member ID

Member ID

Medicaid ID

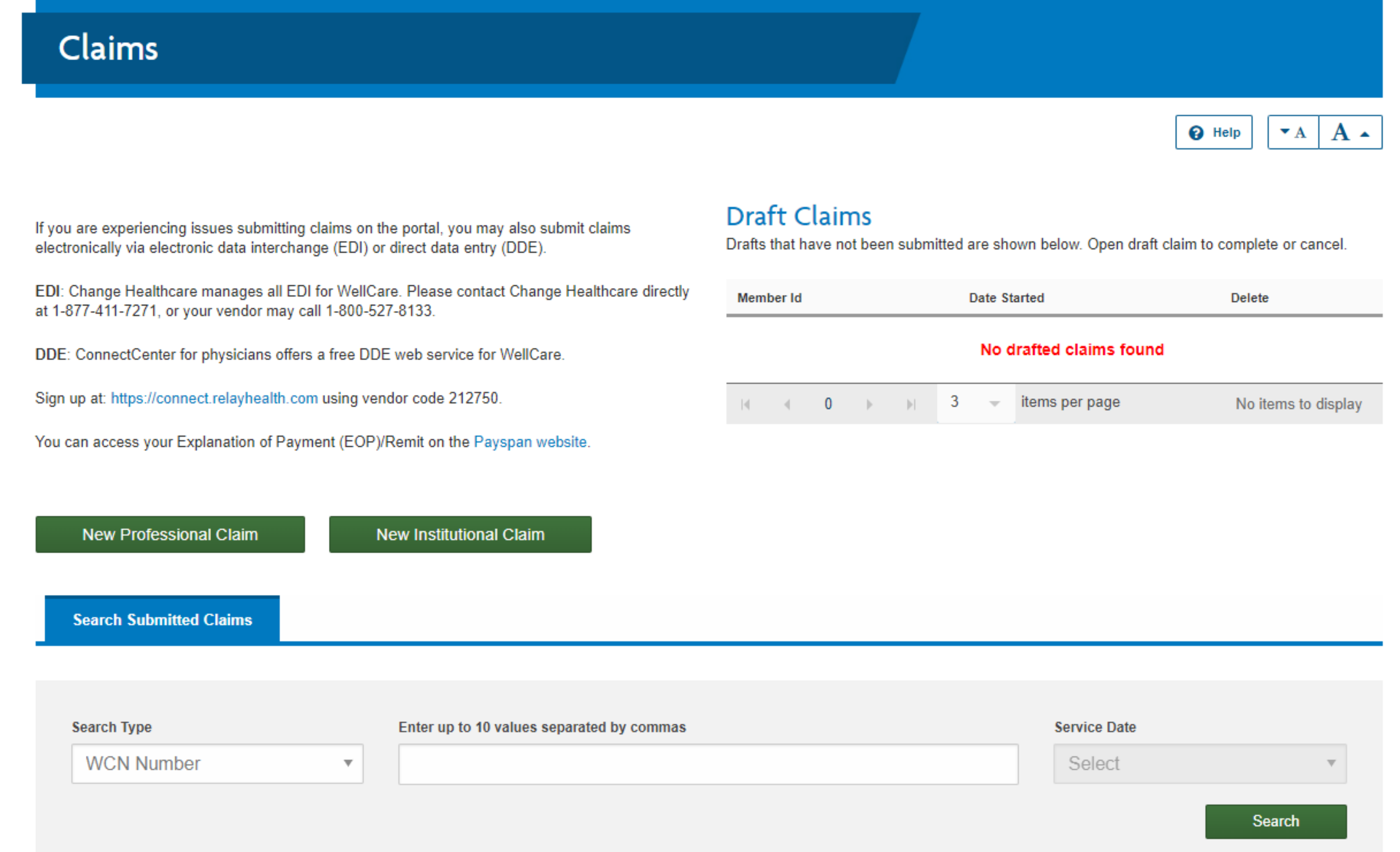
Medicare ID

Check patient eligibility on this date: 11/04/2022

Enter multiple member IDs to display

Search

Wellcare Secure Provider Portal Claims



Wellcare Secure Portal Additional Features

Self-Service Secure Web Portal Offering and Benefit

Service	Web Portal
Appeal Requests/Status (Rx)	☑ Fastest Results
Appeals & Disputes	☑ Fastest Results
Authorization Requests	☑ Fastest Results
Authorization Requirements	☑ Fastest Results
Authorization Status	☑ Fastest Results
Benefits & Eligibility	☑ Fastest Results
Claim Status	☑ Fastest Results
Claim Submission (and Corrections)	☑ Fastest Results
Co-payment Information	☑ Fastest Results
Coverage Determination Requests/Status (Rx)	☑ Fastest Results
Form Requests	☑ Fastest Results
Provider Resources	☑ Fastest Results

Note: For contract-related questions and/or web portal training, providers should continue to contact their Provider Relations representative.

Wellcare Secure Portal

Chat

Faster than email and easier than phone calls, Chat is a convenient way to ask simple questions and receive real-time support. Providers now have the ability to use our Chat application instead of calling and speaking with agents. Here are some ways our Chat support can help you and your staff:

- Web support assistance
- Real-time claim adjustments

Explore the benefits you will experience by using live Chat!

Convenience – Live Chat offers the convenience of getting help and answers without needing to have a phone call.

Increase Efficiency – If you ever have to wait for a Chat agent to respond, it's easy to carry on with your other tasks and responsibilities.

Documentation of Interaction – Chat logs provide transparency and proof of contact. When customers engage with customer support via phone, they don't typically receive a recording of the verbal conversation. Live Chat software gives you the option of printing a transcription of the conversation afterward.

Question #2

Does your practice use Absolute Total Care and/or Wellcare provider portal?

Question #3

How are you utilizing ATC/Wellcare provider portal?

- ☐ *Benefits/Eligibility*
- ☐ *Prior Authorization*
- ☐ *Claim submission/status*
- ☐ *Appeals/Reconsideration*
- ☐ *Education/training*

Question #4

What other sources do you use instead of Absolute Total Care/Wellcare provider portal to obtain information?

- ☐ *Availity*
- ☐ *SCDHHS*
- ☐ *Other*

Electronic Funds Transfer

PaySpan® provides 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/Virtual Credit Card Payment.*
- *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.*

PaySpan®

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.*

- *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.*

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 Engagement Administrator for more information regarding these programs.

Risk Adjustment Training for Providers (Medicare)

On-Demand CDI Webinar now available!

The Clinical Documentation Improvement (CDI) TEAM invites you to attend a pre-recorded webinar that will cover risk adjustment, coding, documentation and best practices to promote quality documentation, accurate coding and regulatory compliance.

Registration Link:
https://centene.az1.qualtrics.com/jfe/form/SV_eu66FH2kJ6hUeOO

Link to Prerecorded Webinar:

https://centene.qumucloud.com/view/fYzA4SnMBWU600pfrBXHvd

Clinical Documentation Improvement (CDI)

Upcoming Webinars

Annual Wellness Visit

- June 26 @ 6pm (EST) https://centene.zoom.us/meeting/register/tJArdemorj0pG9IQwHaW5ZdUiPHMn6XXuioH
- July 2 @ 11am (EST) | https://centene.zoom.us/meeting/register/tJItduutqTkiG9GLS4cv6G8qJemeQFh6Jd9V
- July 25 @ 6pm (EST) | https://centene.zoom.us/meeting/register/tJIufuiqrT0uE9ZRTrbwXeflBxPKIH6e7Q99

Learn more about: Risk Adjustment Documentation and Coding

Each webinar includes an overview of Risk Adjustment (RA) and Hierarchical Condition Categories (HCCs). To register, please click on the link next to the webinar you would like to attend.

Clinical Documentation Improvement (CDI)

Upcoming Webinars

Common HCC Coding Errors in Risk Adjustment

- July 8 @ 12noon (EST) | https://centene.zoom.us/meeting/register/tJErcO6orjgrGdLliwZzn6VG7Il5vX1UPxM0
- July 30 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJUtce-uqjouGNJ1FmTiaJKRHleJcREeZDcN

Risk Adjustment and Quality-HEDIS Documentation Best Practices

- July 10 @ 5pm (EST) | https://centene.zoom.us/meeting/register/tJIvcO-uqTMsHNwlfkgnQZt5lTmPo1tS91Zr
- July 18 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJIocOGhrj0rGdOB_DytZPIqHCrIY0Os85uW
- July 22 @ 1pm (EST) | https://centene.zoom.us/meeting/register/tJcrcu2upzwiHNQ-iJ9l40UbYXeB-vEXqCb7

How to Improve Risk Adjustment Coding Accuracy

- July 16 @ 3pm (EST) | https://centene.zoom.us/meeting/register/tJ0rfuGgrjIsHdHe86SF3TGMJSjpQM6jS_Rs
- July 31 @ 12noon (EST) | https://centene.zoom.us/meeting/register/tJIvdumgqz4sHtLLPboh8Y_xd4BiW_ENy4du

Learn more about: Risk Adjustment Documentation and Coding

Each webinar includes an overview of Risk Adjustment (RA) and Hierarchical Condition Categories (HCCs). To register, please click on the link next to the webinar you would like to attend.

Clinical Documentation Improvement (CDI)

absolute total care

Upcoming Webinars

Coding for Vascular Conditions

- Aug 6 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJIkcOCorzwqGdPP32uG8xNiyROmkNJ1O-ai
- Aug 8 @ 3pm (EST) | https://centene.zoom.us/meeting/register/tJcofu-uqDotGN2gEfZb-schgd8n4i89SGtr
- Aug 12 @ 12noon (EST) | https://centene.zoom.us/meeting/register/tJcrd-upqzkqGtfa6DwJ-PbVH6UyU1KTu2zZ
- Aug 16 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJwlf--sqD8sGtEbe7EI_ct6sHJ8WKzYhyHP
- Aug 20 @ 3pm (EST) | https://centene.zoom.us/meeting/register/tJcuc-GgrzwrH9e1WNplh1kyEFDOdE0i0Rpd
- Aug 21 @ 12noon (EST) | https://centene.zoom.us/meeting/register/tJAqcO6qrD8oG9ZaZZgkgT1a6qR0kuOtGMPx
- Aug 26 @ 4pm (EST) | https://centene.zoom.us/meeting/register/tJUudOygqjItHddNr0XgIXKGg-ML0OlMBaxI
- Oct 24 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJIrce2upjwpHd3qJLAPXwUS0p2kEwKLW_bp

Annual Wellness Visit

- Aug 14 @ 6pm (EST) | https://centene.zoom.us/meeting/register/tJUlcu2tqDIrH9ZQMlEuzlnY7DZY41pW06oF
- Sept 4 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJwtcemrqz0vGtCkodwRh6nkSwDq5JBTUPJB
- Oct 3 @ 11am (EST) | https://centene.zoom.us/meeting/register/tJwrc-yrrDooHNEcyVMC1A85JCbc46ZaYSYi

Learn more about: Risk Adjustment Documentation and Coding

Each webinar includes an overview of Risk Adjustment (RA) and Hierarchical Condition Categories (HCCs). To register, please click on the link next to the webinar you would like to attend.

Clinical Documentation Improvement (CDI)

Upcoming Webinars

Risk Adjustment and Quality-HEDIS Documentation Best Practices

- *Aug 29 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJAsd--vpj8oGdbvH5lX3y3vB6oZGy7zXwKA*
- *Sept 30 @ 4pm (EST) | https://centene.zoom.us/meeting/register/tJcsce-rrz0iHtywyr6NFKpKbPKgsHnHYkX6*
- *Oct 16 @ 12noon (EST) | https://centene.zoom.us/meeting/register/tJMsc-ipqzIrG9x7VMjdNR0YRVq-7vhznZIO*

Navigating Neoplasm Coding

- *Oct 1 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJMrc-CgqT4iHNHkLLQLCTAT7cQSnUYeWKVw*
- *Oct 17 @ 3pm (EST) | https://centene.zoom.us/meeting/register/tJUlf-CsrjMrG9HSH3ncYtxgr27MxVEZn_gD*
- *Oct 22 @ 12noon (EST) | https://centene.zoom.us/meeting/register/tJMof--oqT4rH9dbnixkgBK0y5_aiXmu-8YG*

Acute Conditions: The Impact on Risk Adjustment

- *Oct 7 @ 12noon (EST) | https://centene.zoom.us/meeting/register/tJMod-mrrzIrHNQ_0fhHBNveMNlQPjcodp2U*
- *Oct 9 @ 5pm (EST) | https://centene.zoom.us/meeting/register/tJYtc--qpzsvEtF4_K_0YwpCgT3tYFASmmeh*

Learn more about: Risk Adjustment Documentation and Coding

Each webinar includes an overview of Risk Adjustment (RA) and Hierarchical Condition Categories (HCCs). To register, please click on the link next to the webinar you would like to attend.

Clinical Documentation Improvement (CDI)

Upcoming Webinars

ICD-10 Updates

- Nov 5 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJ0lcOmgpzMuHtGIHnOy8dnWpI04yDxcldBC
- Nov 6 @ 12noon (EST) | https://centene.zoom.us/meeting/register/tJYtce-upjspG9fPRs9dCbAtnP2QOlS7BB5a
- Nov 7 @ 3pm (EST) | https://centene.zoom.us/meeting/register/tJ0qcu6upjsvGNNTGGN-6D88dC_2N7TOhpeM
- Nov 12 @ 4pm (EST) | https://centene.zoom.us/meeting/register/tJwlfu-sqD4rHtPzbOMvKvTpBvuAeqgGtZax
- Nov 13 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJEsd-ioqT4vE9Cnhj7pEw3A8Q6xUeiIeGDm
- Nov 14 @ 12noon (EST) | https://centene.zoom.us/meeting/register/tJErduCqqj4iGdbpf1NJ3p-HVoswcRaHiXIE
- Nov 19 @ 3pm (EST) | https://centene.zoom.us/meeting/register/tJAsdO2sqTMtGdXK7WamIEfdav9j6v_lTbGR
- Nov 20 @ 5pm (EST) | https://centene.zoom.us/meeting/register/tJMocOuurz0uGdSZb2nxRQYGG5NICR-TZAe8
- Nov 21 @ 9am (EST) | https://centene.zoom.us/meeting/register/tJAsdOChpjwvGtAOjVZEWWEEv58Cg7LxcycG

Learn more about: Risk Adjustment Documentation and Coding

Each webinar includes an overview of Risk Adjustment (RA) and Hierarchical Condition Categories (HCCs). To register, please click on the link next to the webinar you would like to attend.

Quality Improvement

Partnership for Quality(P4Q) Bonus Program

NEW in South Carolina

The 2024 Partnership for Quality Program has been extended to all South Carolina Product lines : Absolute Total Care, Ambetter and Wellcare.

Absolute Total Care understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because Absolute Total Care recognizes these important partnerships, we are pleased to offer the 2024 Partnership for Quality (P4Q) Bonus Program, which rewards PCPs for improving quality and closing gaps in care.

The measurement period is Jan. 1 to Dec. 31, 2024. Absolute Total Care must receive all claims/encounters by January 31, 2025.

Partnership For Quality (P4Q) Wellcare

Program Measures	Amount Per
BCS – Breast Cancer Screening	$75
CBP – Controlling High Blood Pressure	$25
COA – Care for Older Adults – Pain Assessment*	$25
COA – Care for Older Adults – Review*	$25
COL – Colorectal Cancer Screen	$50
EED – Diabetes – Dilated Eye Exam	$25
FMC – F/U ED Multiple High Risk Chronic Conditions	$50
GSD – Diabetes HbA1c <= 9	$75
Medication Adherence – Blood Pressure Medications	$50
Medication Adherence – Diabetes Medications	$75
Medication Adherence – Statins	$75
OMW – Osteoporosis Management in Women Who Had Fracture	$50
SPC – Statin Therapy for Patients with CVD	$50
SUPD – Statin Use in Persons With Diabetes	$75
TRC – Medication Reconciliation Post Discharge	$50
TRC – Patient Engagement after Inpatient Discharge	$50

**Special Needs Plan (SNP) members only.*

Partnership For Quality (P4Q) Absolute Total Care

Program Measures	Amount Per
ADD - ADHD Maintenance Phase Visit	$50
AMM - Antidepressant Management - Continuation Phase	$50
AMR - Asthma Medication Ratio 5 - 64 yrs	$50
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$50
EED - Diabetes – Dilated Eye Exam	$50
GSD - Diabetes HbA1c < 8	$50
BPD - Diabetes BP < 140/90	$50
CHL - Chlamydia Screening in Women	$50
CIS - Childhood Immunization Status Combo 10	$50
IMA - Immunizations for Adolescents Combo 2	$50
KED - Kidney Health for Patients With Diabetes	$50
PPC - Postpartum Visit	$50
PPC - Prenatal Visit (Timeliness)	$50
PRS-E - Prenatal Immunizations	$50
SPC - Statin Therapy for Patients with CVD	$50
SPC - Statin Adherence for Patients with CVD	$50
SPD - Statin Therapy for Patients With Diabetes	$50
SPD - Statin Adherence for Patients with Diabetes	$50

Partnership For Quality (P4Q) Ambetter

Program Measures	Amount Per
AMM - Antidepressant Management - Continuation Phase	$50
AMR - Asthma Medication Ratio 5 - 64 yrs	$50
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$50
EED - Diabetes – Dilated Eye Exam	$50
GSD - Diabetes HbA1c $\leq$ 9	$50
CHL - Chlamydia Screening in Women	$50
CIS - Childhood Immunization Status Combo 10	$50
COL – Colorectal Cancer Screen	$50
IMA - Immunizations for Adolescents Combo 2	$50
KED - Kidney Health for Patients With Diabetes	$50
PDC - Proportion of Days Covered - Diabetes	$50
PDC - Proportion of Days Covered - Statins	$50
PPC - Postpartum Visit	$50
PPC - Prenatal Visit (Timeliness)	$50

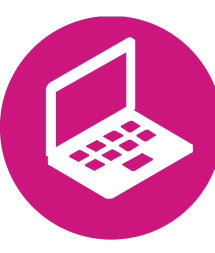
What measures do these codes apply to?

- *Controlling Blood Pressure*
    - *Blood pressure results*
- *A1C 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*

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®
Consumer Assessment of Healthcare Providers and Systems

CAHPS® Provider Resource Guide

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.*

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.*

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.*
- *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.*

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.*

Question # 5

Does your organization/practice have patient notices posted in the waiting areas that give expected waiting time expectations for different appointment types (well, sick, labs, etc.) so patients have a realistic expectation of the wait time?

Question #6

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

Accessibility and Availability standards

Accessibility and Availability

***Accessibility** is defined as the extent to which a member can obtain available services as needed. Such services refer to both telephone access and ease of scheduling an appointment, if applicable.*

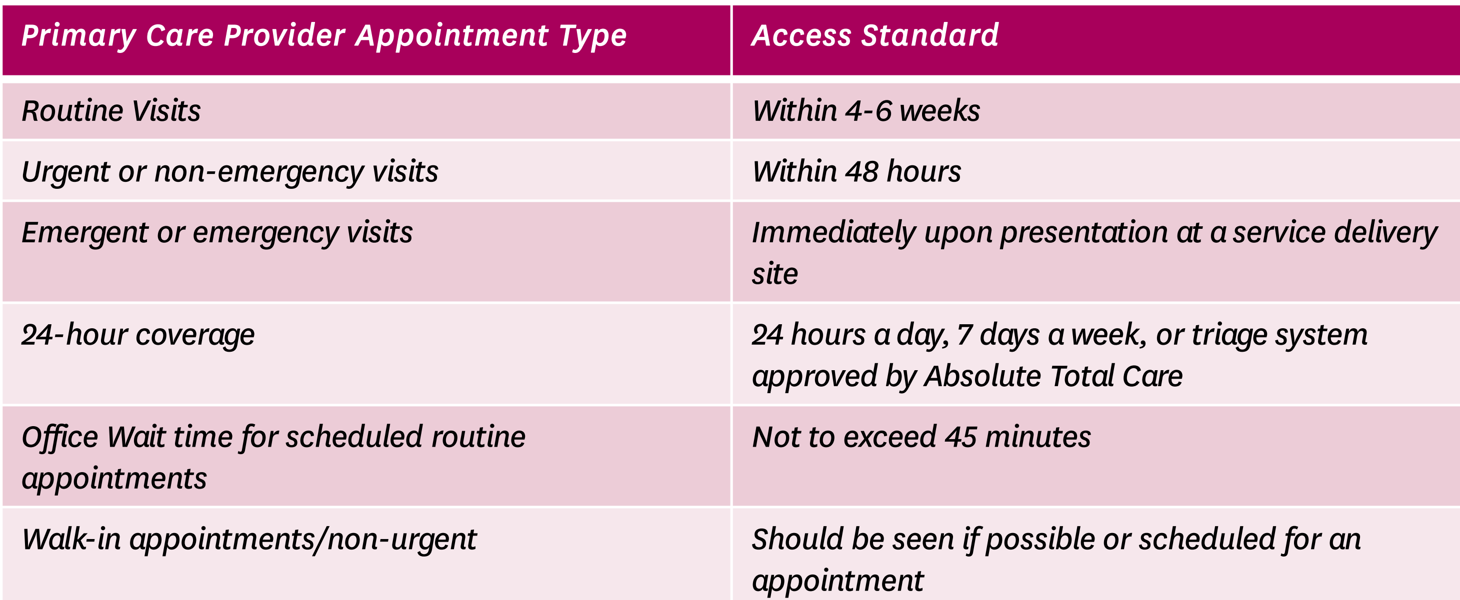
***Availability** is defined as the extent to which Absolute Total Care contracts with the appropriate type and number of practitioners and providers necessary to meet the needs of its members within defined geographical areas*

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Member's needs. Absolute Total Care and Wellcare will monitor Providers against the standards for each line of business to help Members obtain needed health services within acceptable appointment times, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions.

- *All Providers must adhere to standards of timeliness for appointments and in-office waiting times.*
- *These standards take into consideration the immediacy of the Member's needs.*
- *Absolute Total Care and Wellcare will monitor Providers against the standards for each line of business to help Members obtain needed health services within acceptable appointment times, in-office waiting times, and after-hours standards.*
- *Providers not in compliance with these standards will be required to implement corrective actions.*

Access Standards Medicaid

PRIMARY CARE



Primary Care Provider Appointment Type	Access Standard
Routine Visits	Within 4-6 weeks
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24-hour coverage	24 hours a day, 7 days a week, or triage system approved by Absolute Total Care
Office Wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment

SPECIALTY CARE

Specialty Care Provider Appointment Type	Access Standard
Routine Visits	Within 4-12 weeks for unique specialists
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site

Access Standards Medicaid

BEHAVIORAL HEALTHCARE

Behavioral Healthcare Specialist Appointment Type	*Access Standard*
Initial visit for routine care	*Within 10 business days*
Follow-up routine care	*Within calendar days of initial care*
Care for a non-life-threatening emergency	*Within 6 hours or referred to the emergency room or behavioral health crisis unit*
Urgent or non-emergency visits	*Within 48 hours*

Access Standards Medicare-Medicaid Plan

Primary Care and Specialist Appointment Type	Access Standard
Routine appointment and physicals	Within 4 weeks
Primary care urgent (non-life threatening) visits	Within 1 week of the request
Urgent specialty care	Should be available within 24 hours of referral
Referrals to specialists	Should be made within 4 weeks of the request
Emergency Care	Should be received immediately and be available 24 hours a day
Persistent symptoms	Must be treated no later than the end of the following working day after initial contact with the PCP
Non-urgent appointment for sick visit	Should be available within 72 hours of the request

Behavioral Healthcare Specialist Appointment Type	Access Standard
Initial visit for routine care	Within 10 days
Urgent or non-emergency visits	Within 24 hours
Emergency	Immediately

Access Standards Medicare

Appointment Type	*Access Standard*
PCP-Urgent	≤ 24 hours
PCP- Non-urgent	≤ 1 week
PCP-Regular and Routine	≤ 30 calendar days
All Specialists (including High Volume and High Impact) –Urgent	≤ 24 hours
All Specialists (including High Volume and High Impact) –Regular Routine	≤ 30 calendar days
Behavioral Health Provider-Urgent Care	≤ 48 hours
Behavioral Health Provider - Initial Routine Care	≤ 10 business days
Behavioral Health Provider- Non-Life-Threatening Emergency	≤ 6 hours
Behavioral Health Provider - Initial Routine Care follow up	≤ 10 business days

Access Standards Ambetter

Appointment Type	Access Standard
PCPs-Routine visits	30 calendar days
PCPs-Adult Sick Visit	48 hours
PCPs-Pediatric Sick Visit	24 hours
Behavioral Health-Non-life-Threatening Emergency	6 hours, or direct member to crisis center or emergency room (ER)
Specialist	Within 30 calendar days
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	48 hours
After Hours Care	Office number answered 24 hours/seven days a week by answering service or instructions on how to reach a physician
Emergency	24 hours a day, seven days a week

APPENDIX

ATC Provider Engagement Territory Assignment

Janet Kimbrough, Provider Engagement Administrator III
803-873-4454, Janet.H.Kimbrough@centene.com
Provider Groups: Abbeville Medical Center, Bon Secours St Francis, CenterWell Senior Primary Care, Preferred Care of Aiken, Spartanburg Regional Health/Regional HealthPlus

Tracey Snowden, Provider Engagement Administrator III
(803)606-5328 , Tracey.D.Snowden@centene.com
Provider Groups: AnMed Health, Atrium Health, Newberry Hospital, Self Regional, SC Oncology Associates

Tonya Ruff, Provider Engagement Administrator III
(864) 492-5669, Tonya.C.Ruff@centene.com
Provider Groups: HCA Healthcare, Lexington Medical Center, McLeod Health, Palmetto Primary Care Physician, Prisma Health Midlands, Prisma Health- Upstate, Roper St. Francis Healthcare, SC Pediatric Alliance

ATC Provider Network Territory Assignment

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

Brandi Crosby, Provider Engagement Administrator II
(843) 518-3918, shunta.crosby@centene.com
Counties: Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Border GA-Savannah and MUSC

Camille Gray, Provider Engagement Administrator II
(803) 213-1661, Camille.L.Gray@centene.com
Counties: Aiken, Allendale, Bamberg, Barnwell, Calhoun, Edgefield, Lexington, Newberry, Saluda, Orangeburg and Border GA Counties (Augusta)

LaToya Jones, Provider Engagement Administrator II
(803) 553-7324, Latoya.Jones3@Centene.com
Counties: Cherokee, Greenville, Lancaster, Laurens, Spartanburg, Union, York and Border-NC

ATC Provider Engagement Territory Assignment

Porsha Lewis, Provider Engagement Administrator II
(803) 873-8691, Porsha.Lewis@centene.com
Counties: Chester, Fairfield, Kershaw, Lee, Richland, Sumter and Tenet Health

Regina Meade, Provider Engagement Administrator II
Regina.Meade@centene.com
Counties: Abbeville, Anderson, Greenwood, McCormick, Oconee, Pickens and Non-facility Labs

Sarah Wilkinson, Provider Engagement Administrator II
(843) 344-0009, Sarah.Wilkinson@centene.com
Counties: Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Marion, Marlboro and Williamsburg

ATC Provider Engagement Territory Assignment

Adria Felder, Provider Engagement Administrator I
(803)315-8405, Adria.Felder@CENTENE.COM
Ambulatory/EMS, Health Network Solutions, Chiropractors, Long Term Acute Care, Rehabilitation Facility and Skilled Nursing Facilities

Kisha Thomas, Provider Engagement Administrator I
(803) 904-6430, Kisthomas@centene.com
Dialysis Centers and Ambulatory Surgery Centers

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

Name	Title	Email
Sharon Mancuso	*Vice President, Quality Improvement*	*Sharon.Mancuso@centene.com*
Janet Bergen	*Manager, Case Management*	*Jbergen@centene.com*
Betty Smith	*Lead Program Coordinator*	*BetSmith@centene.com*
Aimee L. Kincaid	*Senior Manager, Quality Improvement*	*Aimee.Kincaid@centene.com*
Jane F. Brown	*Project Manager, Quality Improvement*	*Jane.F.Brown@wellcare.com*
Kellie M. Williamson	*Manager, Quality Improvement*	*Kellie.M.Williamson@centene.com*

Cultural Competency Overview

Cultural competency within Absolute Total Care's network is defined as, "A set of interpersonal skills that allow individuals to increase their understanding, appreciation; acceptance and respect for cultural differences; similarities within, among and between groups; and the sensitivity to know how these differences influence relationships with members."

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

Cultural Competency Overview

Network providers must ensure that:

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

Absolute Total Care is committed to helping providers develop a culturally competent practice. For information on Absolute Total Care's Cultural Competency Plan, please visit our website at absolutetotalcare.com. You can also request a hard copy by calling Provider Services at 1-866-433-6041.

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:

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>
MEMBER CANNOT BE CHARGED
Cost sharing/Copays: $0 for covered medical and prescription services
H1723 001

Carry this card with you at all times and present it each time you receive a service from your doctor, pharmacy, 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)
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) Attn: Member Reimbursement Dept. P.O Box 31577 Tampa, FL 33631-3577
Claim Inquiry: <1-855-735-4398 (TTY: 711)>

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- Medicaid

Balance Billing

Run Date: 8/17/2022

Page 1 of 4

PAY TO:

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

Payee ID:
IRS#:

Insured Name: Mbr No: MRN: Claim/Ctrl No:
Patient Name: SvcProv No: Carrier: MM PatCtrl No:
Servicing Provider: NPI: 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

SC DHHS 1716 Form for Newborns

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: ______

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

https://www.scdhhs.gov/sites/default/files/documents/FM%201716%20ME_1.pdf

ASL Interpretation 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 transliteration (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 team (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 limited language skills.

Conference / Platform Interpreting
Applies to any type of conference, seminar, town hall meeting or religious service. LSA requires a minimum of four weeks' notice 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 via the LSA website any time of the day, any day of the week. Please note that requests received after 6:30 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 clientservices@lsaweb.com 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 weekends), LSA's call center staff will be able to assist you.

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www.lsaweb.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 more than two business days notice, 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.

Please request a copy of this policy from your Provider Engagement Administrator if needed

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 and 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

Claims Submission

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>Medicaid</td><td>Secure Provider Portal:
www.AbsoluteTotalCare.com/Login
or
EDI Payer Numbers:
68069 - Emdeon/WebMD/Envoy/PayerPath
42772 - Relay Health/McKesson
68068 - Behavioral Health</td><td>Absolute Total Care
P.O. Box 3050
Farmington, MO 63640-3821

Behavioral Health:
P.O. Box 7001
Farmington, MO 63640-3811</td></tr>
<tr><td>Marketplace</td><td rowspan="2">Secure Provider Portal:
www.AbsoluteTotalCare.com/Login
or
EDI Payer Numbers:
68069 - Emdeon/WebMD/Envoy/PayerPath</td><td>Ambetter from Absolute Total Care
P.O. Box 5010
Farmington, MO 63640-5010</td></tr>
<tr><td>MMP</td><td>Wellcare Prime by Absolute Total Care
P.O. Box 3060
Farmington, MO 63640-3822</td></tr>
</table>

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 PaySpan.com or call **1-877-331-7154** Or Change Healthcare EDI Clearinghouse 1-877-411-7271. **CHANGE HEALTHCARE CLEARINGHOUSE PAYER IDS (CPIDS)** Claim Type / Fee-for-Service (CH - Chargeable) Submissions / Encounter (RF - Reporting only) Submissions Professional: 1844 / 3211 Institutional: 8551 / 4949 **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. Claim Type / FFS (CH - Chargeable) Submissions / Encounter (RF - Reporting only) Submissions Professional or Institutional: 14163 / 59354	**Wellcare** **Attn: Claims Department** **P.O. Box 31372** **Tampa, FL 33631-3372**

Wellcare

CLAIMS SUBMISSIONS DATE OF SERVICE GUIDANCE

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

NETWORK DEVELOPMENT AND PARTICIPATION

Network Development and Participation

- *Network Development*
  - *To request a <u>new Medicare</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 contact their Provider Engagement Administrator*
  - *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 contacting your Provider Engagement Administrator*

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.

For more information, please contact your assigned Provider Engagement Administrator.

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*

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

Adjournment