Absolute Total Care and Wellcare

Q4 2024 Virtual Provider Town Hall

Meeting Overview

- Medicaid
- Medicare-Medicaid Plan (MMP)
- Ambetter
  - 2025 Product updates
  - Opioid Treatment Programs
  - Medicare Prescription Payment Program
- Wellcare Medicare Advantage
  - HMO
  - PPO, D-SNP
  - PDP
  - Medicare Prescription Payment Program (M3P)
  - Member Overpayment Reimbursement Requirement
- Annual Provider Training Requirement
- Secure Provider Portal Updates/ Availity
- Case Management

- Smart Start for Your Baby
- PaySpan
- Risk Adjustment
  - Continuity of Care (CoC)
  - Clinical Documentation Improvement (CDI)
- Quality Improvement
  - Partnership for Quality (P4Q)
  - CPT II Codes
  - Electronic Medical Record
  - Supplemental Data Feeds
- CAHPS® -Consumer Assessment of Healthcare Providers and Systems
- 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

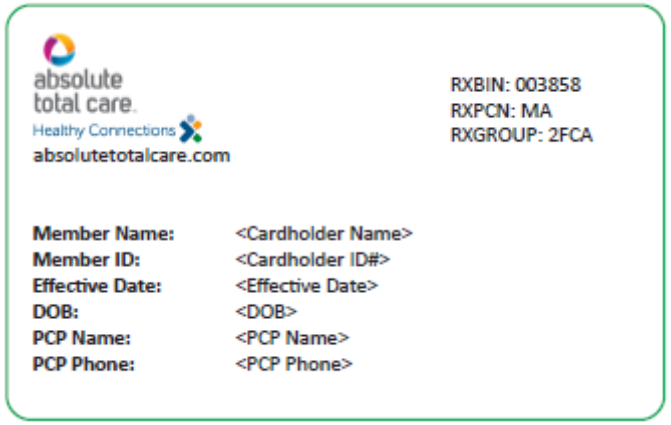
Products and Services

Absolute Total Care
Healthy Connections Medicaid

absolute total care™
Healthy Connections

Absolute Total Care
Healthy Connections Medicaid

2025 ID CARD


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>

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


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

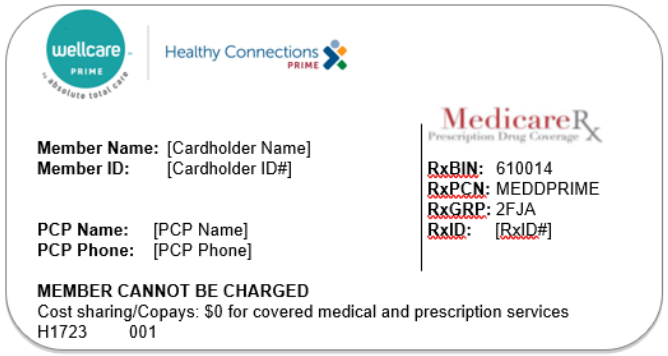
Back of member ID card

- 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

Wellcare Prime by Absolute Total Care

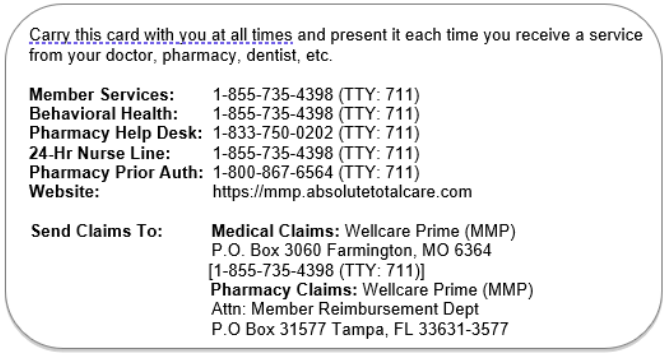
https://www.absolutetotalcare.com/providers/resources/member-rewards-allwell/Medicaid-Member-Rewards1.html

Wellcare Prime by Absolute Total Care 2025 ID Card



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



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

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:

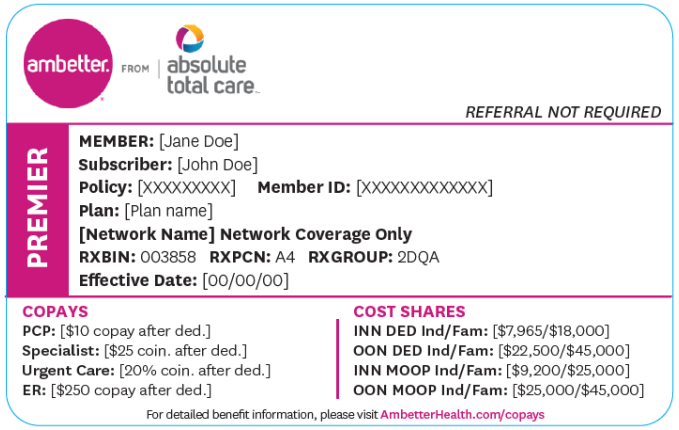
- Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services
- Ensure that a Member Acknowledgment Statement has been signed by both the provider and the Absolute Total Care member for non-covered services prior to rendering said service
- 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

My Health Pays Rewards Program

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

Ambetter Health Premier 2025 ID Cards



Front of member ID card

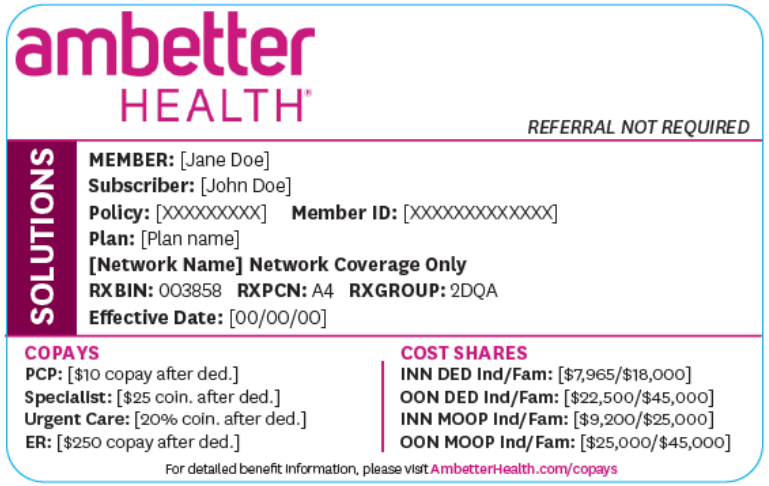
Back of member ID card

Effective January 1, 2025

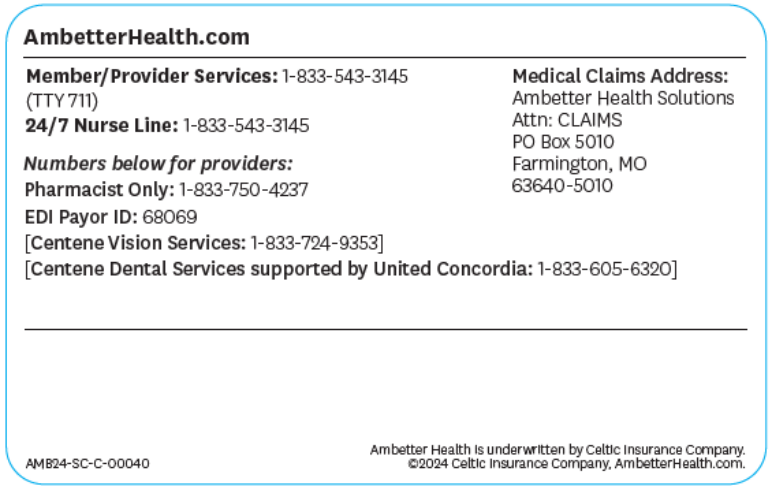
Bronze, Silver, Gold (core) network will be renamed PREMIER

Ambetter Health Solutions

2025 ID Card



Front of member ID card



Back of member ID card

Ambetter Health (ICHRA)
Network name: SOLUTIONS

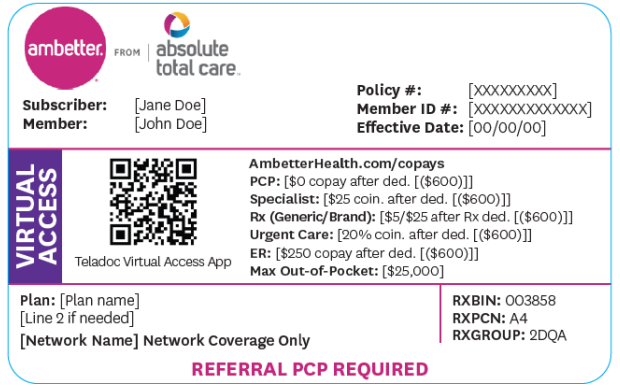
Ambetter Health Solutions plans are "off-exchange" options for individuals purchasing health insurance through defined contributions or health reimbursement arrangements, such as an individual coverage health reimbursement arrangement (ICHRA) or qualified small employer health reimbursement arrangement (QSHERA). Plans are available in the bronze, silver and gold levels.

Ambetter Health Solutions plans are available for 2025 coverage in Georgia, Indiana, Mississippi, Missouri, Ohio and South Carolina.

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.**


ambetter. FROM absolute total care.

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

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

VIRTUAL ACCESS

Teladoc Virtual Access App

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

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

RXBIN: 003858
RXPCN: A4
RXGROUP: 2DQA

REFERRAL PCP REQUIRED


Ambetter.AbsoluteTotalCare.com

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

Numbers below for providers:
Pharmacist Only: 1-833-750-4237
EDI Payor ID: 68069

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

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

Ambetter Virtual Access will not be available effective 1/1/2025

Opioid Treatment Programs Prior Authorization Update

Effective 12/15/2024

Ambetter from Absolute Total Care is committed to delivering cost effective care to our members. This effort requires us to ensure that our members receive only treatment that is medically necessary according to current standards of practice. As a condition of payment, Ambetter from Absolute Total Care requires prior authorization for many services.

Effective December 15, 2024, prior authorization will be required for these Opioid Treatment Programs (OTPs) codes:

G0137	G1028	G2067	G2068	G2069	G2070
G2073	G2074	G2076	G2077	G2215	G2216

Please verify member eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered. Please contact your Provider Engagement Account Manager or call Provider Services at 1-833-270-5443 with any questions you may have.

Wellcare Medicare Advantage

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.

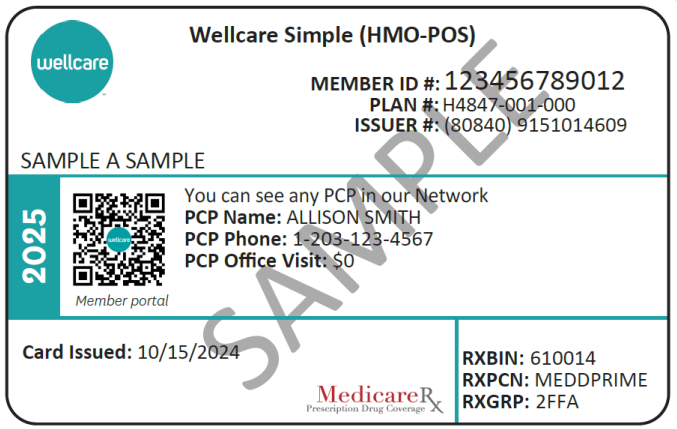
Additional benefits may include:

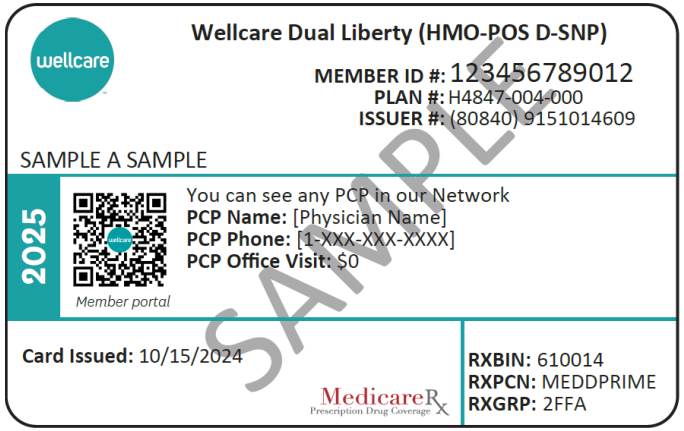
- **No or low monthly health plan premiums with predictable copays for in-network services**
- **Outpatient prescription drug coverage**
- **Routine dental, vision and hearing benefits**
- **Preventive care from participating Providers with no copayment**

Medicare – HMO / HMO DSNP

2025 ID CARDS

Front of member ID card





Back of member ID card

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

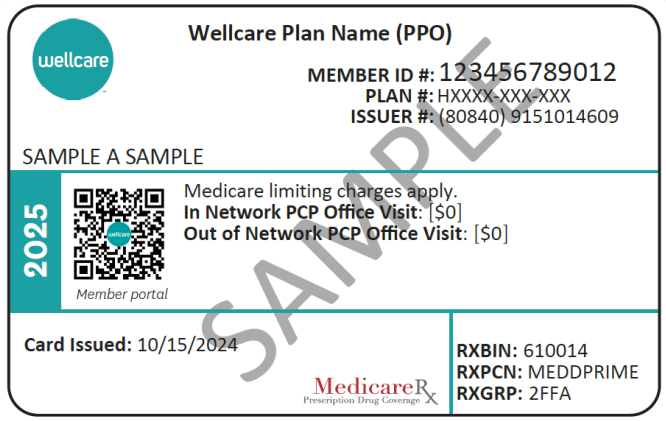
- Referrals not required from primary care physician for specialist or hospital visits. However, using providers in Wellcare's network may cost less than choosing one that is out-of-network. Medicare providers who do not contract with Wellcare are under no obligation to treat our members, except in emergency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

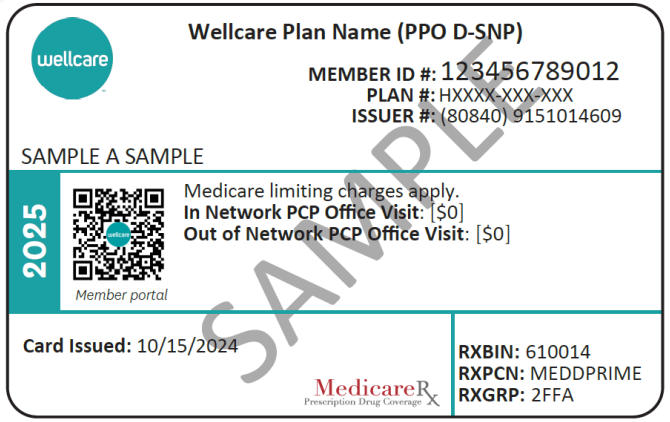
In addition, the Wellcare Medicare Advantage PPO plan:

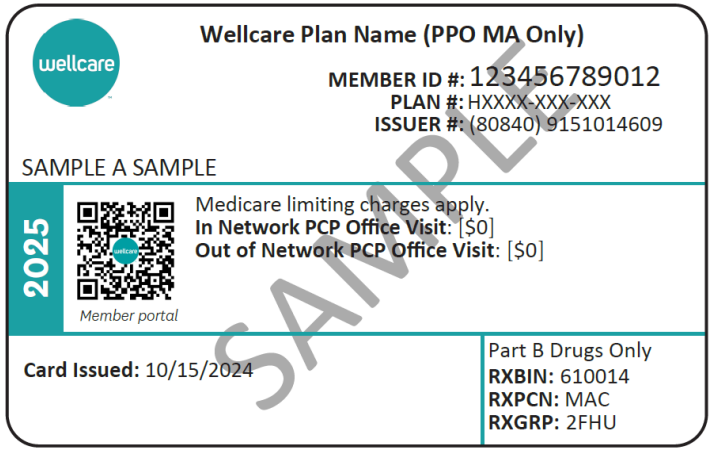
- Offers a simple copayment for doctor visits, hospital stays and many other healthcare services, making healthcare costs more predictable
- Gives members Medicare Parts A, B, and D coverage as well as vision, dental, and hearing benefits not covered by original Medicare
- Covers all original Medicare 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/PPO D-SNP/ PPO HMO MA Only

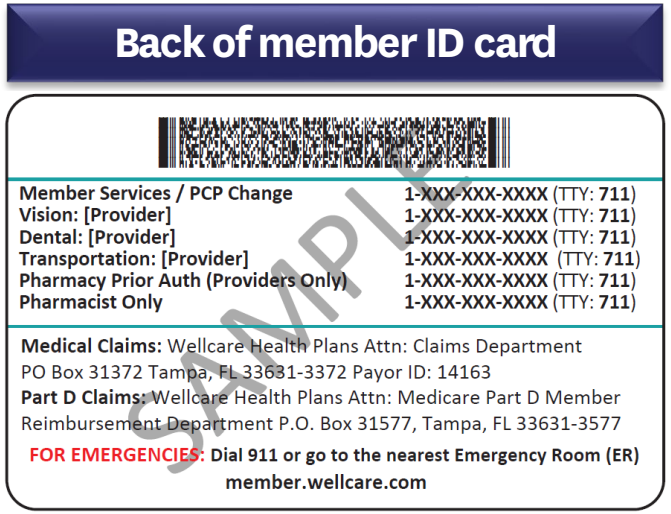
Front of member ID card







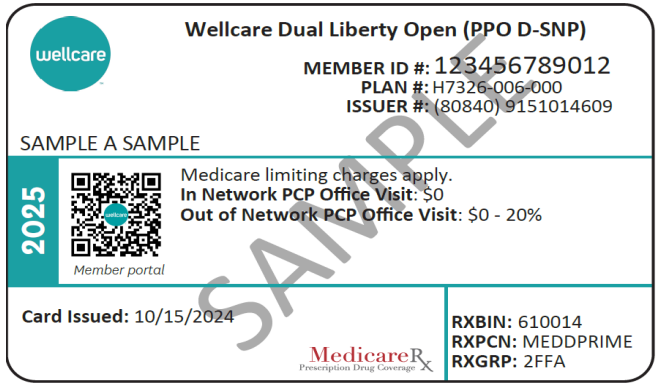
Back of member ID card

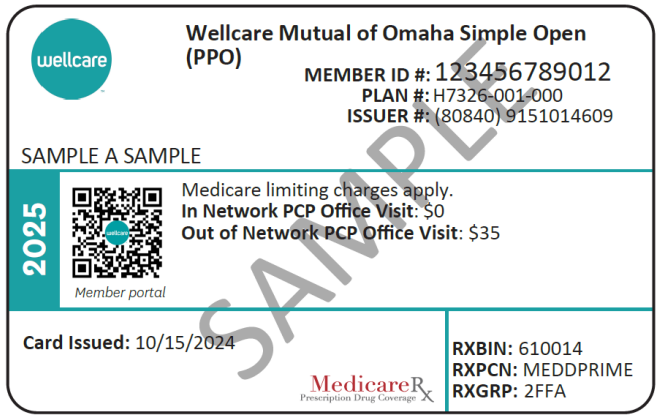


Medicare – PPO (HMO) and PPO HMO D-SNP

2025 ID CARDS

Front of member ID card





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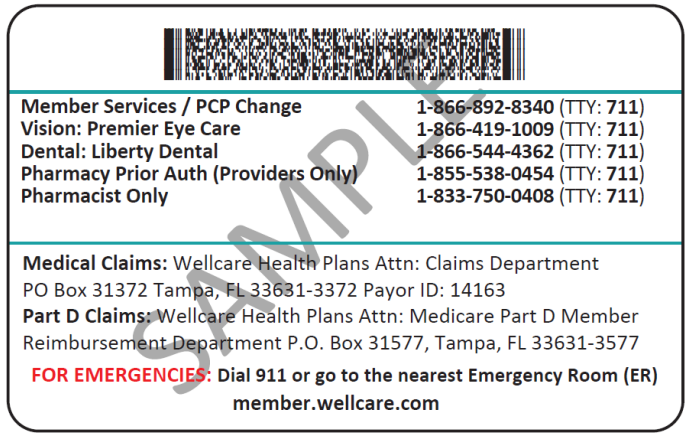
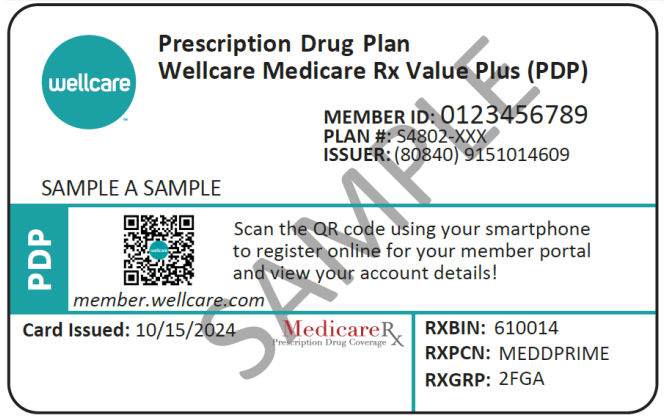
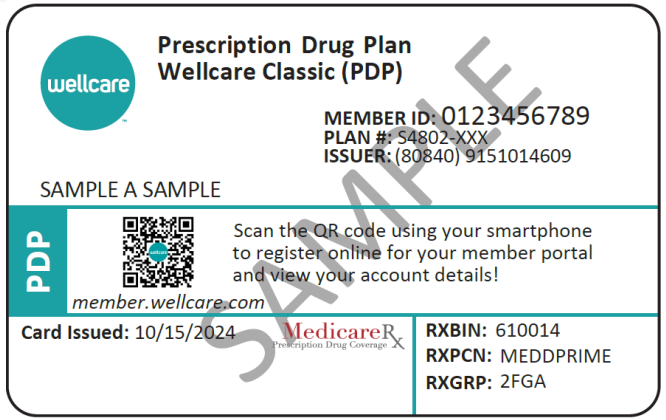


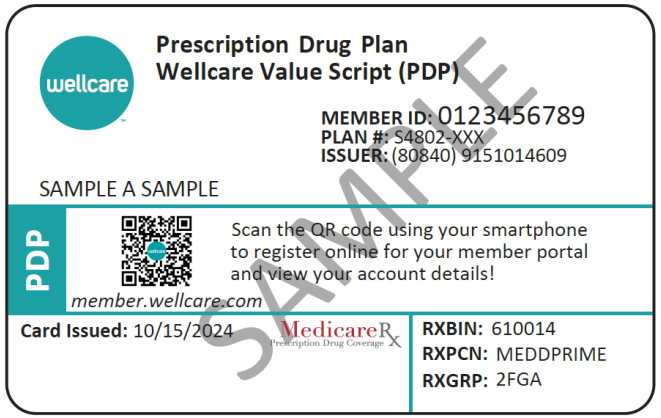
H7326

Medicare – Prescription Drug Plan (PDP)

Front of member ID card







Back of member ID card

Medicare Prescription Payment Program (M3P)

A New Program That Makes Rx Drugs More Affordable by Allowing Medicare Members to Spread Their Prescription Costs Over Time

Medicare Prescription Payment Plan (M3P) will be available to all eligible Medicare members*, beginning Jan. 1, 2025.

- **Financial benefits to all Medicare members in 2025 include an elimination of the coverage gap and capping the maximum out-of-pocket (OOP) prescription costs at $2,000 annually — which beneficiaries can spread across the plan year.**
- **Participants will pay $0 at the pharmacy for covered Part D drugs and be billed monthly for any cost-sharing they incur while in the program.**
- **The program is voluntary, and eligible members can choose to opt-in to the program during the annual enrollment period and throughout the plan year. Members can conveniently opt-in via online, by phone, or mail.**

  Online: express-scripts.com/mppp

  Phone: 1-833-750-9969

  Mail: Express Scripts Medicare
  Prescription Payment Plan
  P.O. Box 2
  St. Louis, MO 63166

Excludes plans that solely charge $0 cost sharing for Part D covered drugs. See your plan's Evidence of Coverage for more details.

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
Cultural Competency	https://www.absolutetotalcare.com/providers/resources/provider-training.html

Additional Provider Training Opportunities Behavioral Health

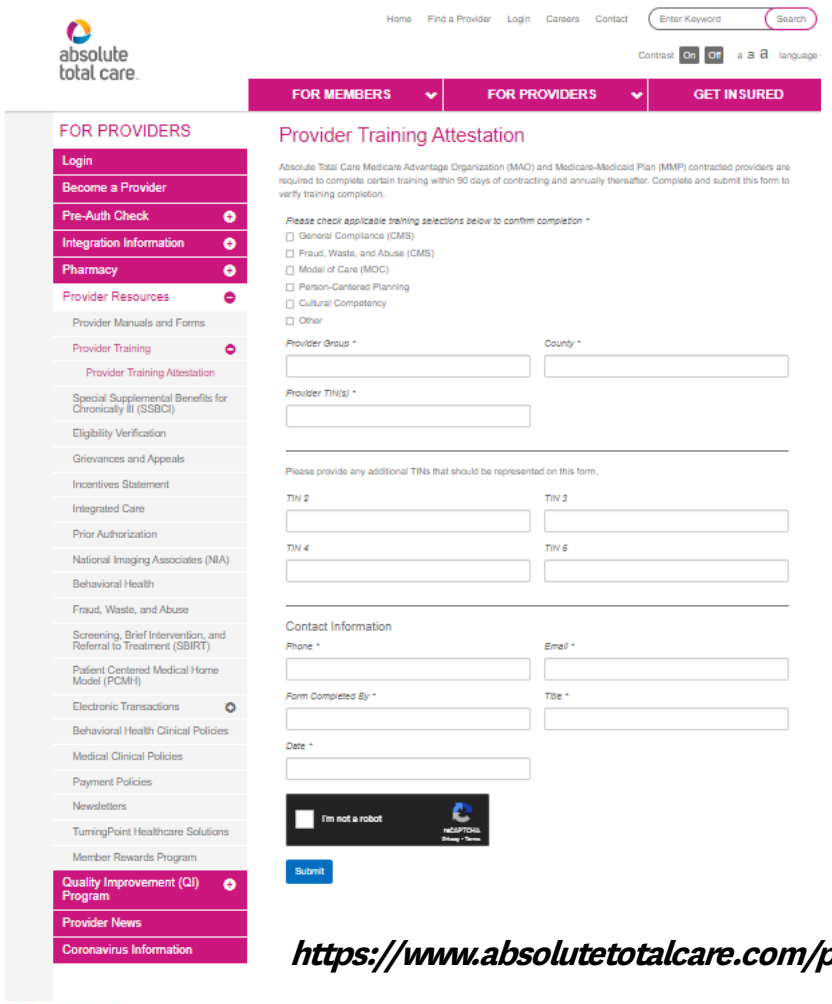
Absolute Total Care offers additional trainings for medical and behavioral health providers to recognize the intent of the Behavioral Health HEDIS measures and share strategies to impact quality care and outcomes for our members.

- **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

Secure Provider Portals

Updates

Availity Essentials: New Multi-Payer Portal

Centene Corporation has chosen Availity Essentials as its new, secure provider portal. Effective Sept. 24, 2024, providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources via Availity Essentials for Absolute Total Care Healthy Connections Medicaid, Ambetter from Absolute Total Care, Wellcare Prime by Absolute Total Care and Wellcare of South Carolina.

Here's how to get started:

If you are new to Availity Essentials, getting your Essentials account is the first step toward working with the Health Plan on Availity. Your provider organization's designated Availity administrator is the person responsible for registering your organization in Essentials and managing user accounts. This person should have legal authority to sign agreements for your organization. Visit Register and Get Started with Availity Essentials to enroll for training and access other helpful resources.

If you already work in Essentials, you can log in to your existing Essentials account to enjoy these benefits:

- Verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and more.
- Look for additional functionality in the Health Plan's payer space on Essentials and use the heart icon to add apps to My Favorites in the top navigation bar.
- Save provider information in Essentials and auto-populate it to save time and prevent errors.

We encourage you to use Availity Essentials for transactions. With an active Availity Essentials account, providers will have immediate access to new health plans and features as soon as they become available. Our current secure portal will still be available for other functions you may use today, and we will notify you when our current secure portal will be retired.

We're excited to welcome you to Availity Essentials, helping you transform the way you impact patient care. If you need additional assistance with your registration, please call Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Mon. through Fri., 8 am – 8 pm. EST. For general questions, please contact Provider Services or reach out to your Provider Engagement Administrator.

Question #2

Are you currently using Availity?

Yes

No

Case Management

Case Management Services

Case Management is a FREE service provided by Absolute Total Care to help our members get the care and services they need. Our goal is to support our members in managing their health and improving their quality of life.

How Do You Use Case Management Program Services? Our Case Management services include:

- **Referrals** to specialists and other services
- **Coordinating Care** between doctors and other providers
- **Developing Care Plans** and setting health goals
- **Learning About Other Services** that can make our member's lives easier

How to Become Eligible for Case Management? Members may become eligible through:

- Referrals or medical claims
- A review of medical information by a Care Manager
- After being hospitalized
- A Care Manager may reach out to members to discuss your healthcare needs
- Provider referral

For more information or to request Case Management services, please contact Absolute Total Care at 1-866-433-6041 or visit Absolutetotalcare.com.

Member Connections Referral Form

MemberConnections
Referral Form

Use this form to refer an Absolute Total Care member for a visit from an Absolute Total Care MemberConnections Representative.

Date: _____

Member Name: _____

MMIS ID Number: _____

Member Address: _____

Member Phone Number: _____

Provider Fax Number and Contact Name: _____

Please check the reason for the referral:

☐ Non-compliance

☐ Missed appointments (minimum of three)

☐ High emergency room usage

☐ Other (please explain): _____

_____

Please give details as to the reason for the referral and your expectation of the MemberConnections visit: _____

_____

_____

_____

Provider Name: _____

Provider Phone Number: _____

1-866-433-6041
Fax: 1-866-912-3610

absolutetotalcare.com
ATC-12182019-AP-1


Start
Smart
FOR YOUR BABY®


absolute
total care™


Start
Smart
FOR YOUR BABY®

Start Smart for Your Baby

absolute total care™

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

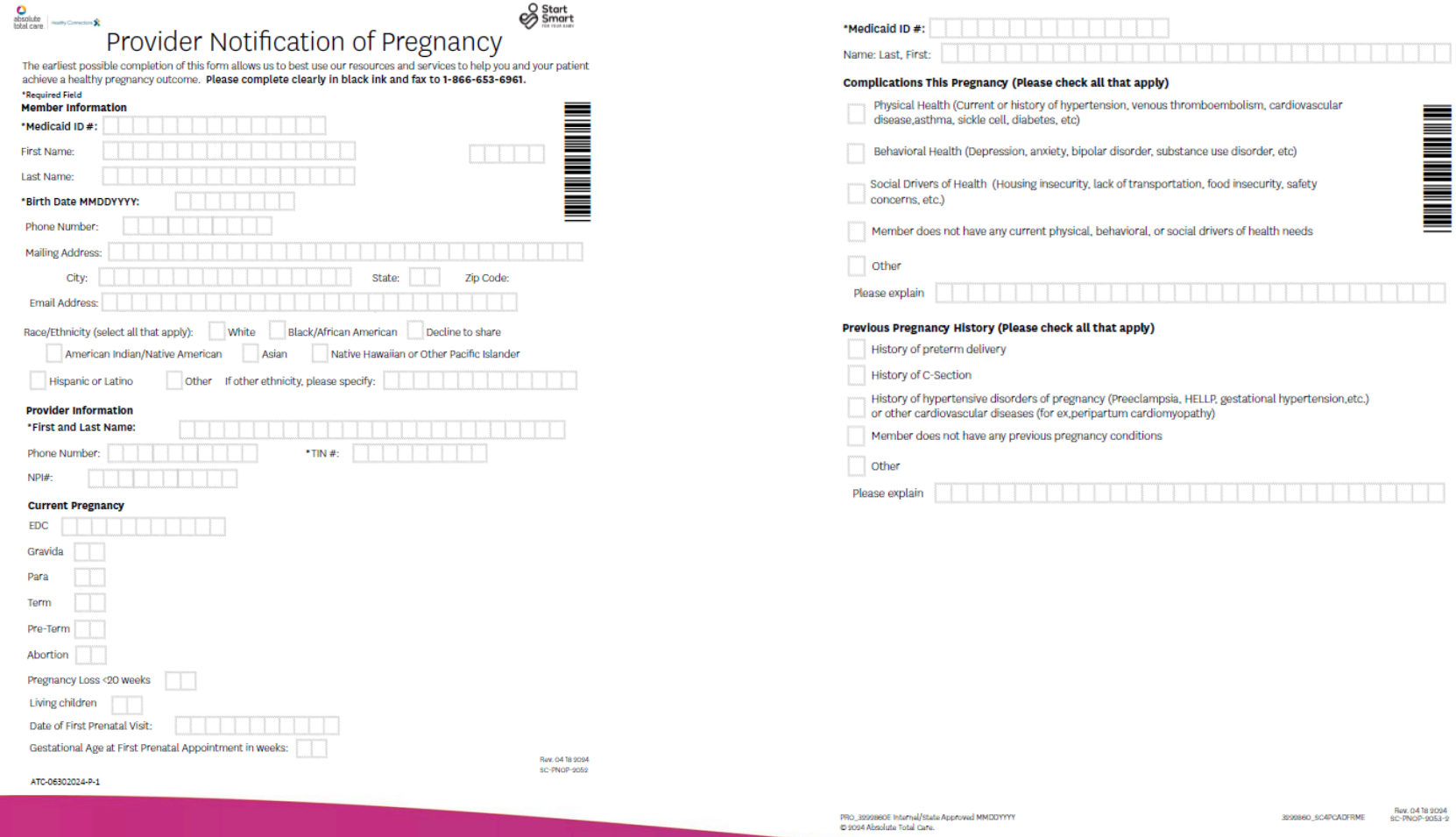
Start Smart for Your Baby

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



Provider Notification of Pregnancy

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.**

*Required Field

Member Information

*Medicaid ID #:

First Name:

Last Name:

*Birth Date MMDDYYYY:

Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share

American Indian/Native American Asian Native Hawaiian or Other Pacific Islander

Hispanic or Latino Other If other ethnicity, please specify:

Provider Information

*First and Last Name:

Phone Number: *TIN #:

NPI#:

Current Pregnancy

EDC

Gravida

Para

Term

Pre-Term

Abortion

Pregnancy Loss <20 weeks

Living children

Date of First Prenatal Visit:

Gestational Age at First Prenatal Appointment in weeks:

Rev. 04 18 2024
SC-PNOP-3052

ATC-06302024-P-1

*Medicaid ID #:

Name: Last, First:

Complications This Pregnancy (Please check all that apply)

Physical Health (Current or history of hypertension, venous thromboembolism, cardiovascular disease,asthma, sickle cell, diabetes, etc)

Behavioral Health (Depression, anxiety, bipolar disorder, substance use disorder, etc)

Social Drivers of Health (Housing insecurity, lack of transportation, food insecurity, safety concerns, etc.)

Member does not have any current physical, behavioral, or social drivers of health needs

Other

Please explain

Previous Pregnancy History (Please check all that apply)

History of preterm delivery

History of C-Section

History of hypertensive disorders of pregnancy (Preeclampsia, HELLP, gestational hypertension,etc.) or other cardiovascular diseases (for ex,peripartum cardiomyopathy)

Member does not have any previous pregnancy conditions

Other

Please explain

PRO_3999860E Internal/State Approved MMDDYYYY
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3999860_SC4PCADFRME

Rev. 04 18 2024
SC-PNOP-3053-2

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New form effective 7/1/2024

Start Smart for Your Baby.

Electronic Funds Transfer

PaySpan®

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.**
- **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.**

PaySpan®

- 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 (CoC) 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 Account Manager 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

Quality Improvement

Partnership for Quality(P4Q) Bonus Program

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 2024

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) Wellcare 2025

Program Measures	Amount Per
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$75
COA – Care for Older Adults – Functional Status*	$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
KED – Kidney Health Evaluation for Patients with Diabetes	$50
Medication Adherence – Blood Pressure Medications	$50
Medication Adherence – Diabetes Medications	$50
Medication Adherence – Statins	$50
OMW – Osteoporosis Management in Women Who Had Fracture	$50
SPC – Statin Therapy for Patients with CVD	$25
SUPD – Statin Use in Persons With Diabetes	$25
TRC – Medication Reconciliation Post Discharge	$25

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

Partnership For Quality (P4Q)
Absolute Total Care 2024

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 2024

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 ≤ 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

CPT II and HCPCS Billing

Important Information on CPT II and HCPCS Codes

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

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

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

CPTII Codes and HCPCS Billing PRO_91371E_Approved_01112022.pdf

What measures do these codes apply to?

- Controlling Blood Pressure
  - Blood pressure results
- 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

Electronic Medical Record (EMR) System

absolute total care™

Remote Access to EMR:

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

- **Reduce provider office staff activities regarding HEDIS Hybrid chart chase requests**
- **Decrease and avoid duplication of over utilization or retrieval efforts**
- **Lead to improved HEDIS performance reporting**

Contact Jane Brown via email at jane.f.brown@centene.com

Supplemental Data Feeds

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.

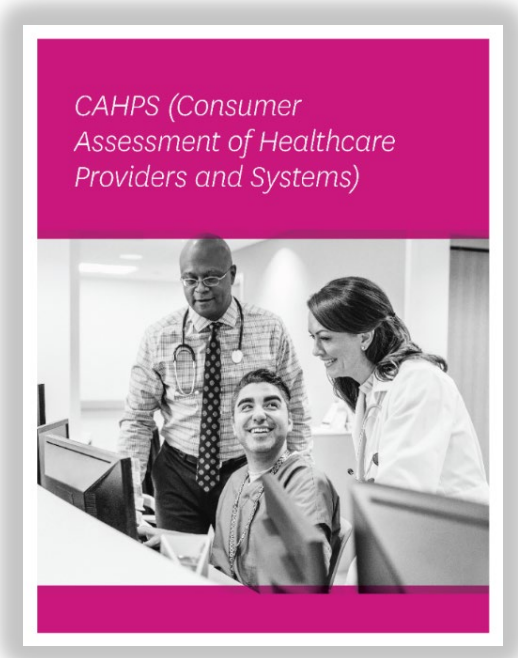
- **Close care gaps**
- **Improve our HEDIS scores**
- **Potential incentives**
- **Reduces request for medical records**

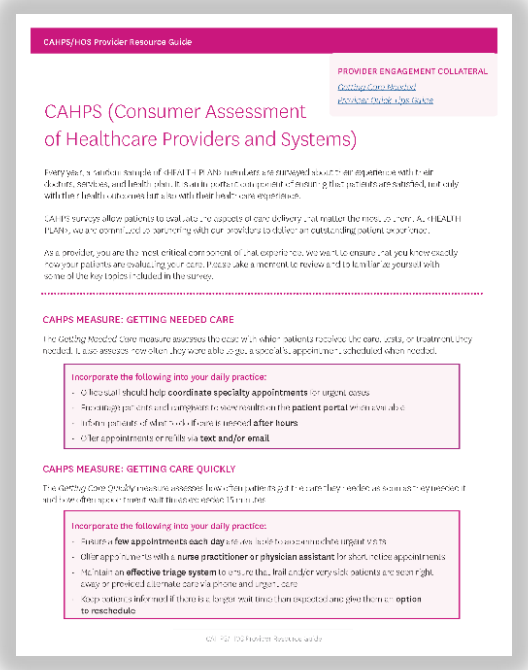
Contact Jane Brown via email at jane.f.brown@centene.com

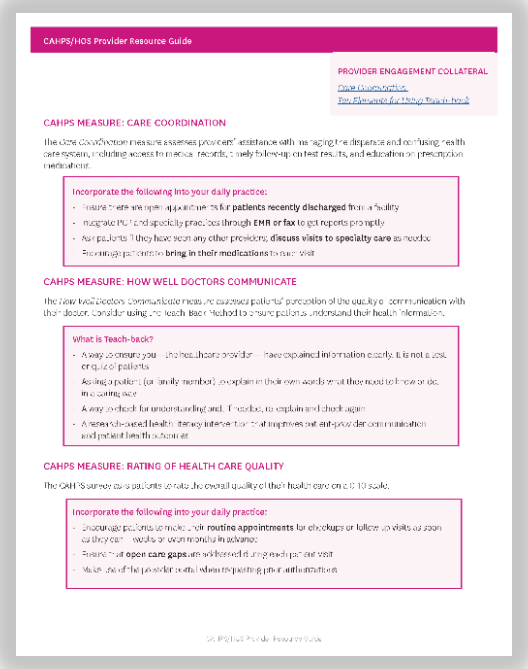
CAHPS®

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

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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.
- 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.

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
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

Q&A Session

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Scan the QR Code to learn more about our Provider Resources, such as manuals, forms and quick reference guides

Absolute Total Care is committed to giving our providers the tools & support you need.

absolutetotalcare.com

ATC-08262024-AP-1

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APPENDIX

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 aged 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."*

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."

HEALTH PLAN PARTNERS

Contracted Networks

HEARING	VISION	DENTAL
HCS	Premier	Liberty
Phone: 1-866-344-7756	Phone: 1-866-419-1009	Phone: 1-866-544-4362

TRANSPORTATION

Modivcare aka LogistiCare

Phone: 1-877-718-4201

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.

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

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

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

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

Wellcare Prime members can be billed for:

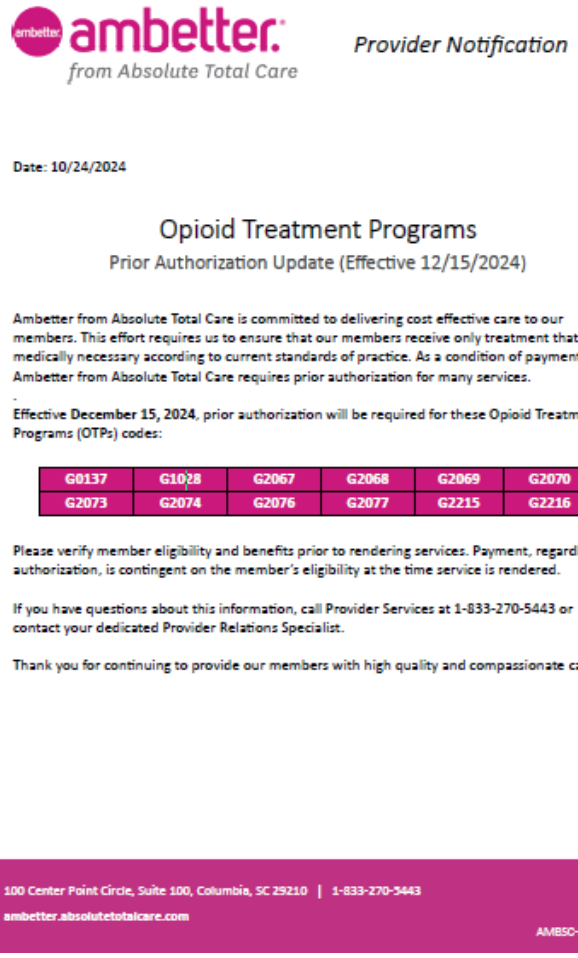
- Medicaid participation in cost of care amounts for long-term services and supports as determined by SCDHHS.
- Medicaid copay for Medicaid only covered Durable Medical Equipment (DME) items.

How Wellcare Prime resolves balance billing issues with the provider:

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

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

Ambetter from Absolute Total Care



ambetter. from Absolute Total Care

Provider Notification

Date: 10/24/2024

Opioid Treatment Programs

Prior Authorization Update (Effective 12/15/2024)

Ambetter from Absolute Total Care is committed to delivering cost effective care to our members. This effort requires us to ensure that our members receive only treatment that is medically necessary according to current standards of practice. As a condition of payment, Ambetter from Absolute Total Care requires prior authorization for many services.

Effective **December 15, 2024**, prior authorization will be required for these Opioid Treatment Programs (OTPs) codes:

G0137	G1028	G2067	G2068	G2069	G2070
G2073	G2074	G2076	G2077	G2215	G2216

Please verify member eligibility and benefits prior to rendering services. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

If you have questions about this information, call Provider Services at 1-833-270-5443 or contact your dedicated Provider Relations Specialist.

Thank you for continuing to provide our members with high quality and compassionate care.

100 Center Point Circle, Suite 100, Columbia, SC 29210 | 1-833-270-5443

ambetter.absolutetotalcare.com

AMBSC-24-O-10242024-P-1

https://www.absolutetotalcare.com/providers/provider-news.html

MMP Example EOP – Medicaid

Balance Billing

Run Date: 8/17/2022

PAY TO: [redacted]

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

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

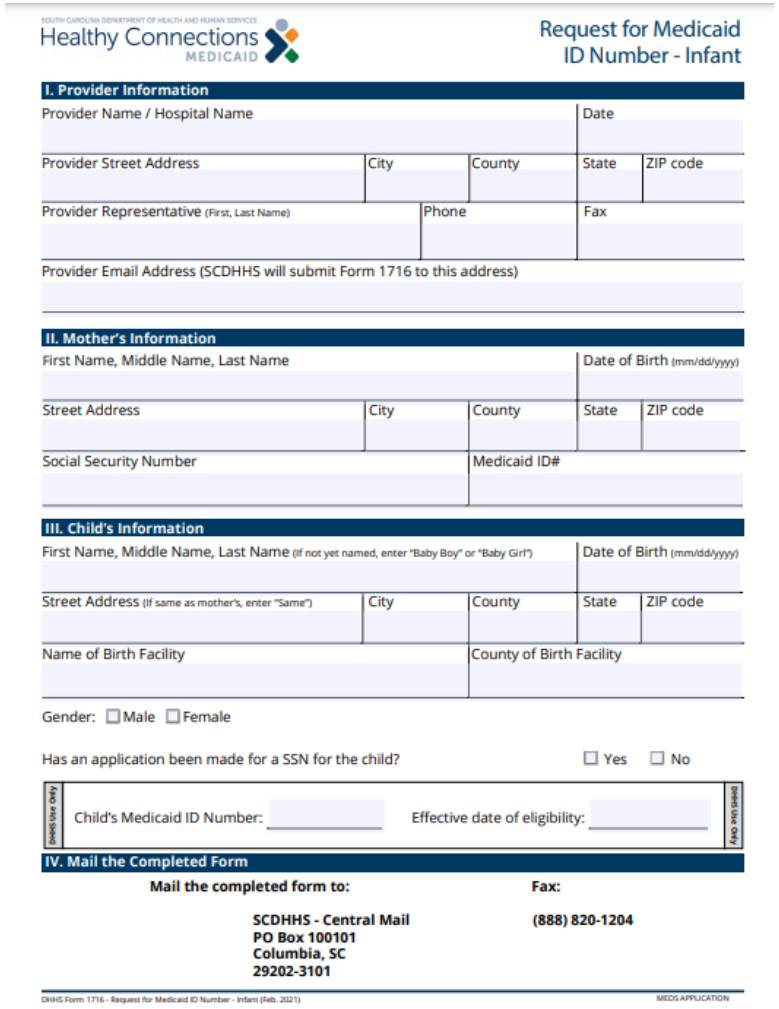
Payee ID: [redacted]
IRS#: [redacted]

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

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur/ Penalty	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
0100	7/20/2022	99214		1.00	$310.00 $66.87	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$145.00 $116.00	$0.00	$0.00	MX PM Aa	$0.00 $0.00
			Sub-total		$310.00 $66.87	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$145.00 $116.00	$0.00	$0.00		$0.00 $0.00
			Total		$310.00 $66.87	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$145.00 $116.00	$0.00	$0.00		$0.00 $0.00

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

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

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

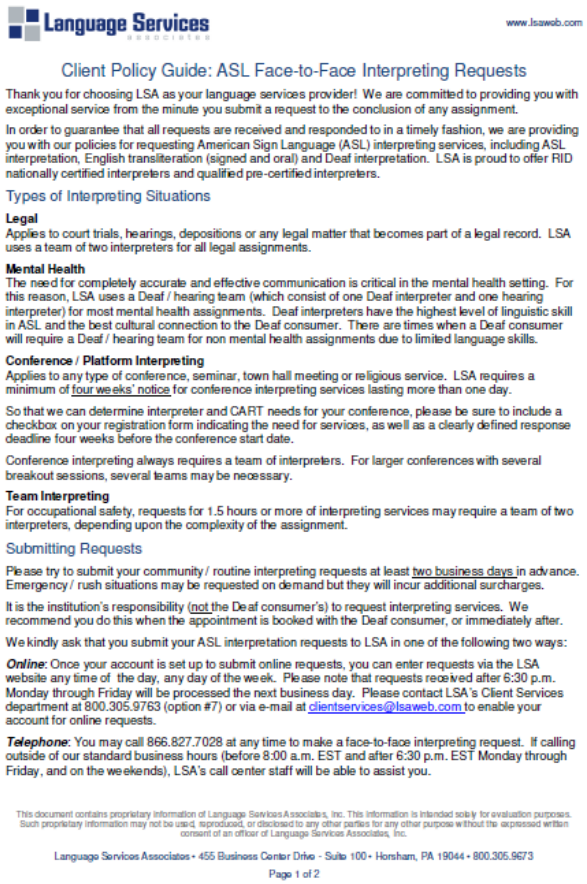
Fax:

(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



Language Services Associates www.lsawob.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

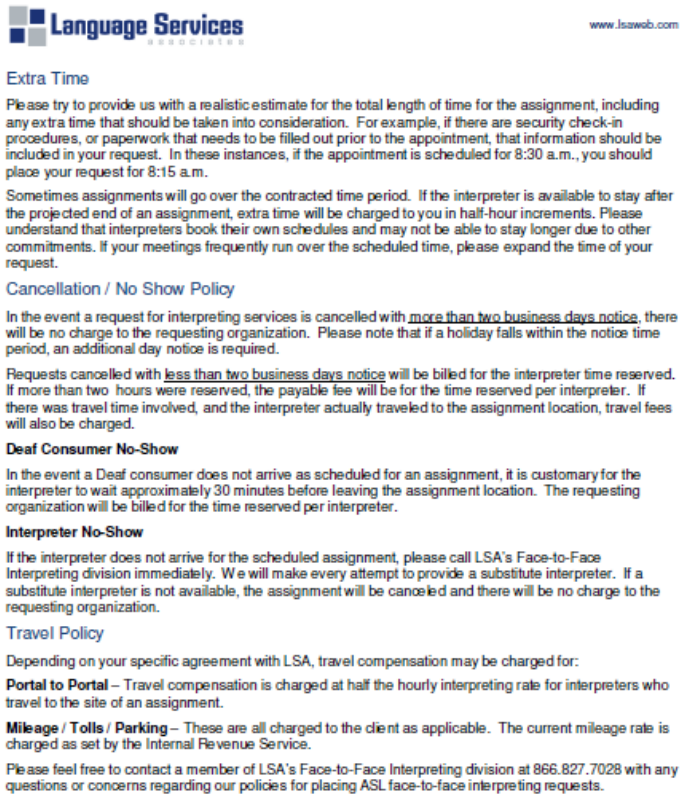
Please try to submit your community / routine interpreting requests at least two business days in advance. Emergency / rush situations may be requested on demand but they will incur additional surcharges.

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.



Language Services Associates www.lsawob.com

Extra Time

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

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

Cancellation / No Show Policy

In the event a request for interpreting services is cancelled with 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.

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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

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MEDICAID		
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	**365 days**	**365 days**
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 **(NEW)**	**180 days**	**180 days**
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		

Effective 7/1/24

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:

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

Claims submission - Wellcare

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

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

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

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

Medicare Prescription Payment Program (M3P)

Effective January 1, 2025

Medicare Prescription Payment Program

A New Program That Makes Rx Drugs More Affordable by Allowing Medicare Members to Spread Their Prescription Costs Over Time

Passed into law August 2022 by President Biden, H.R. 5376 — Inflation Reduction Act (IRA) includes policies on Medicare drug pricing. The IRA significantly reforms the Medicare Part D benefit design, including a new program, Medicare Prescription Payment Plan (M3P), which will be available to all eligible Medicare members[1], beginning **Jan. 1, 2025**.

Program Overview for Eligible Participating Medicare Members[1]

- Financial benefits to all Medicare members[1] in 2025 include an elimination of the coverage gap and capping the **maximum out-of-pocket (OOP) prescription costs at $2,000 annually** — which beneficiaries can spread across the plan year.
- M3P participants will pay **$0 at the pharmacy** for covered Part D drugs and be billed monthly for any cost-sharing they incur while in the program. Importantly, this will help them manage prescription costs by enabling them to spread their monthly payments over time.
- Payment *might change* every month as additional prescriptions are filled.
- The program is **voluntary**, and **eligible** members can choose to opt-in to the program during the **annual enrollment period** and **throughout the plan year**. Members can conveniently opt-in via online, by phone, or mail.
  - Online: express-scripts.com/mppp.
  - Phone: **1-833-750-9969**
  - Mail: Express Scripts Medicare
    Prescription Payment Plan
    P.O. Box 2
    St. Louis, MO 63166
- **Existing members** will receive additional information in their **Annual Notice of Change**.
- **New members** will receive additional information within 10 days of confirmed enrollment.

[1]Excludes plans that solely charge $0 cost sharing for Part D covered drugs. See your plan's Evidence of Coverage for more details.

Questions or Concerns?
As always, we encourage you to use the resources on Medicare.gov/prescription-payment-plan *or* to contact your **Provider Services team.**

M3P_Rx_Y0020_WCM_P

Internal Approved MMDDYYYY

Medicare Quick Reference Guide

Effective January 1, 2025

South Carolina Medicare Quick Reference Guide

January 2025
wellcare.com/South-Carolina/Providers/Medicare

CONVENIENT SELF-SERVICE

Wellcare understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks. **The Provider Portal is the fastest way to get help with those routine tasks.** Keep this Guide accessible to make pre-visit planning and post-visit tasks quick and easy.

	Portal	Chat	(IVR) Interactive Voice Response
Authorization Requirements/Status	Fastest Result	Available	Available
Authorizations Request	Fastest Result	Available	N/A
Benefit/Copayment Information	Fastest Result	Available	Available
Claims/Reconsiderations/ Appeals Status	Fastest Result	Available	Available
Eligibility Verification	Fastest Result	Available	Available
Submit Appeals/Claims/ Claims Disputes/Corrections	Fastest Result	Available	N/A

HELPFUL LINKS

Portal Registration | Joining our Network | Resources (Manual and Guides)
Portal Training | Forms (AOR, Auth, Claims and more)

PROVIDER SERVICES PHONE (IVR): 1-855-538-0454 (TTY: 711)

OTHER PHONE NUMBERS

CARE AND DISEASE MANAGEMENT REFERRALS
Phone: **1-866-635-7045** (TTY: **711**) | Fax: **1-866-287-3286**
Hours: M–F, 8 a.m.–7 p.m. Eastern Standard Time

RISK MANAGEMENT FRAUD, WASTE & ABUSE HOTLINE
1-866-685-8664

COMMUNITY CONNECTIONS HELP LINE
1-866-775-2192

BEHAVIORAL HEALTH CRISIS
24 hours a day, members should call Member Services.

NURSE ADVICE LINE
1-800-581-9952 (24 hours)

HEALTH PLAN PARTNERS

Contracted Networks

HEARING
HCS
Phone: **1-866-344-7756**

VISION
Premier
Phone: **1-866-419-1009**

DENTAL
Liberty
Phone: **1-866-544-4362**

TRANSPORTATION
ModivCare
Phone: **1-877-718-4201**

NOTE: Please refer to the member ID card to determine appropriate authorization and claims submission process.
This guide is not intended to be an all-inclusive list of covered services under the Health Plan.

3223172_SCSPCARGDEE
Internal Approved 08210024

CLAIM SUBMISSION INFORMATION

SUBMISSION INQUIRIES
EDI team: **EDIBA@centene.com** or call Provider Services.

PREFERRED EDI CLEARINGHOUSE
Availity: **1-800-282-4548**.
Web portal for direct data entry (DDE) claims:
availity.com/Essentials-Portal-Registration.

PAYER IDs: 14163 (CH – Chargeable)
59354 (RF – Reporting only)

Visit our **Claims** page to locate detailed claims information, addresses, claim forms and guidelines.

Timely Filing guidelines: 180 days from date of service.

EFT
Register: **payspanhealth.com** or call **1-877-331-7154**.
Email: **providersupport@payspanhealth.com**

MAIL PAPER CLAIMS TO:
Wellcare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

PHARMACY SERVICES

PHARMACY SERVICES Phone: **1-855-538-0454**

Rx BIN	Rx PCN	Rx GRP
610014	MEDDPRIME	2FFA
610014	MAC	2FHU (MA only)

MAIL ORDER
Express Scripts® Phone: **1-833-750-0201** (TTY: **711**)
24 hours a day, 7 days a week

SPECIALTY PHARMACY
AcariaHealth™
Phone: **1-866-458-9246** (TTY: **1-855-516-5636**)
Monday–Thursday, 8 a.m. to 7 p.m., Friday, 8 a.m. to 6 p.m. ET.
Fax: **1-866-458-9245**

AcariaHealth™ Pharmacy #26, Inc.
8715 Henderson Rd.
Tampa, FL 33634

MEDICAL ONCOLOGY SERVICES
New Century Health Phone: **1-888-999-7713**

MEDICATION APPEALS Fax: **1-866-388-1766**
Submit a **Medication Appeal Request form** with supporting documentation by fax or mail within 60 days from the date of the denial notice.

Wellcare
Attn: Pharmacy Appeals Department
P.O. Box 31383
Tampa, FL 33631-3383

COVERAGE DETERMINATION REQUESTS
Fax: **1-866-388-1767**
Electronic Prior Authorization (ePA):
account.covermymeds.com

Access the **Pharmacy page** for Pharmacy related information and forms, including:
- Coverage Determination Request Form and exceptions
- Other Request forms such as Injectible Infusion
- Formulary
- Express Scripts Mail Order Service
- Home Infusion/Enteral Services
- and more

PRIOR AUTHORIZATION (PA)

A **Pre-Auth Needed tool** is available to determine if prior authorization is required. Detailed Prior Authorization list and important PA information can be found in the **Prior Authorization Guide**. Most current information can be found within the Pre-Auth tool.

For fastest results, submit requests **online** using the associated **PA forms**.

Medical Fax: 1-833-562-7172
Behavioral Health Fax: Outpatient **1-855-710-0160** | Inpatient **1-855-710-0159**
Pharmacy Medical Requests Fax: 1-888-871-0564

Urgent Authorization Requests and Admission Notifications: Call 1-855-538-0454 and follow the prompts.
Notification is required for inpatient Hospital admissions **by the next business day** (except normal maternity delivery admissions). Phone authorizations must be followed by a fax submission of clinical information.

Wellcare does not accept handwritten, faxed or replicated claim forms. Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

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.

Absolute Total Care Provider Engagement Territory Assignment

Adria Felder, Provider Engagement Account Manager
(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 Account Manager
(803) 904-6430, Kisthomas@centene.com
Dialysis Centers and Ambulatory Surgery Centers

Margaretta Jones, Provider Engagement Account Manager
Margaretta.jones@centene.com
Durable Medical Equipment and Home Health (statewide)

ATCNetworkRelations@centene.com

Absolute Total Care Provider Engagement Territory Assignment

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

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

Camille Gray, Provider Engagement Account Manager
(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 Account Manager
(803) 553-7324, Latoya.Jones3@Centene.com
Counties: Cherokee, Greenville, Lancaster, Laurens, Spartanburg, Union, York and Border-NC

Absolute Total Care Provider Engagement Territory Assignment

Neshelle Miller, Provider Engagement Account Manager
(803) 972-1460, Neshelle.Miller@centene.com
Behavioral Health (statewide)

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

Regina Meade, Provider Engagement Account Manager
***803-351-9065,* Regina.Meade@centene.com**
Counties: Abbeville, Anderson, Greenwood, McCormick, Oconee, Pickens and Non-facility Labs

Tiffany Rachells, Provider Engagement Account Manager
(205) 568-3603, Tiffany.Rachells@wellcare.com
Occupational Therapy, Physical Therapy, and Speech Therapy, (statewide)

Absolute Total Care Provider Engagement Territory Assignment

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

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

Tonya Carpenter, Senior Provider Engagement Account Manager
(864) 492-5669, Tonya.S.Carpenter@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

Absolute Total Care Provider Engagement Management Team

Jennifer Helms, Vice President of Operations
Jennifer.B.Helms@centene.com

SaBrina Macon, Director of Provider Relations
SaBrina.C.Macon@centene.com

Kristen Graham, Manager of Provider Relations
Kristen.Graham@centene.com

ATCNetworkRelations@centene.com

Quality Improvement and Case Management Team

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

Adjournment