Absolute Total Care and Wellcare

2025 New Provider Orientation

absolute total care Healthy Connections

ambetter. FROM absolute total care

wellcare PRIME by absolute total care

Healthy Connections PRIME

Meeting Overview

01—

Products and Services
- Medicaid
- Medicare-Medicaid Plan (MMP)
- Am better

02—

Wellcare Medicare Advantage
- HMO, PPO, D-SNP, PDP
- Medicare Prescription Payment Program (M3P)
- Member Overpayment Reimbursement Requirement
- Annual Provider Training Requirement

03—

Secure Provider Portal Updates/Availity

04—

Authorized Vendors

05—

Case Management

06—

Interpreter and Oral Translation Services

07—

Start Smart for Your Baby

08—

Claims 411 - Did you Know?

09—

Electronic Funds Transfer

10—

Network Development & Participation

11—

Credentialing Rights

12—

Cultural Competency

13—

Quality Improvement
- Partnership for Quality
- CPTII Codes
- Electronic Medical Record
- Supplemental Data Feeds

14—

CAHPS – Consumer Assessment of Healthcare Providers & Systems

15—

Accessibility & Availability Standards

16—

Q&ASession

absolute total care™
Healthy Connections

Absolute Total Care
Healthy Connections Medicaid

Our health insurance programs are committed to transforming the health of the community one individual at a time.

absolute total care℠

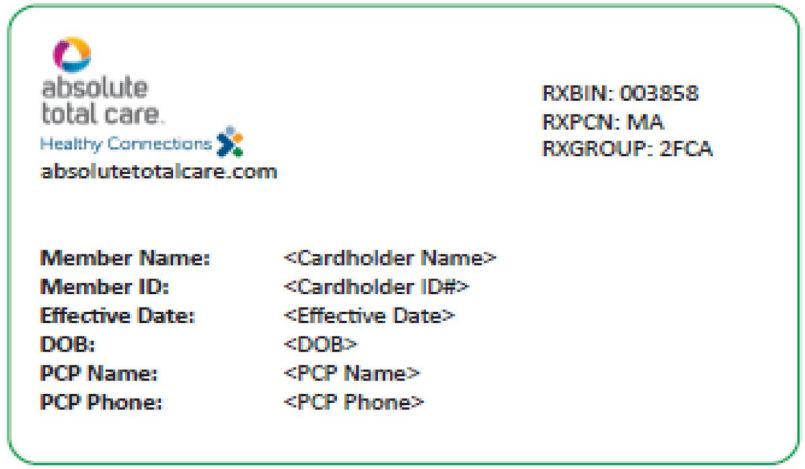
Healthy Connections

Products and Services

absolute total care

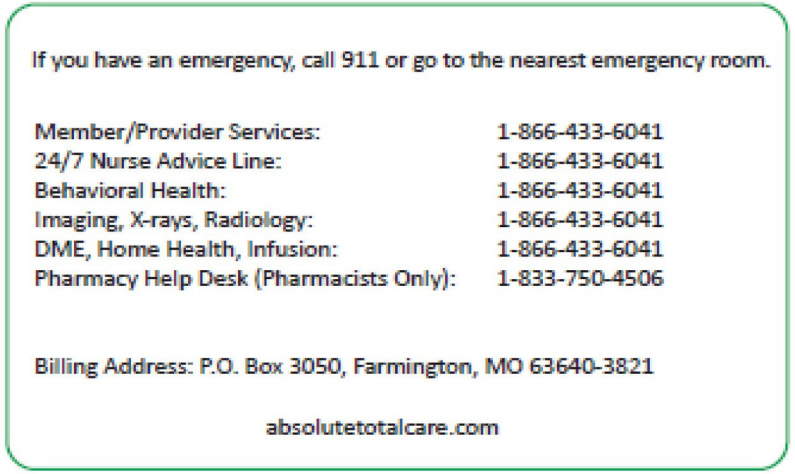
Absolute Total Care
Healthy Connections Medicaid

FRONT 2025-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
- PCPName
- PCP Phone number
- RxBIN/RxPCN: need for pharmacy benefits

BACK 2025-MEMBER ID CARD



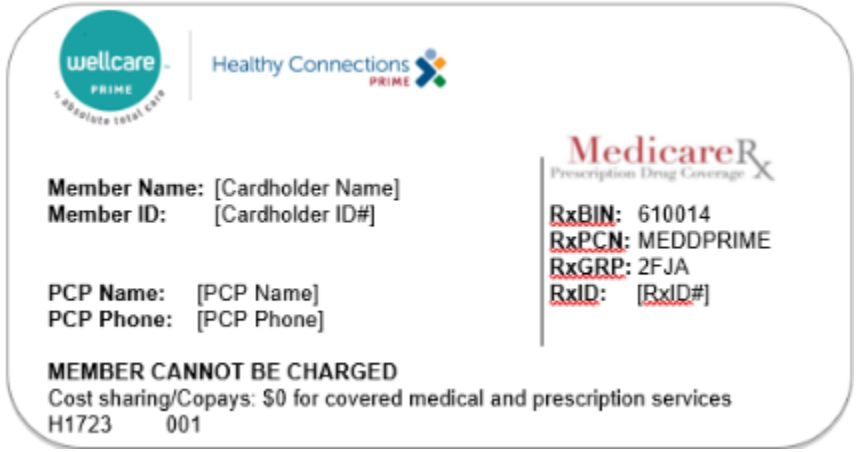
- Member/provider service number: Toll-free number for questions and information such as Nurse Advice line, behavioral health, imaging, X-rays, DME, Home Health, information
- Pharmacy Help Desk: for pharmacist only
- ATC Billing address
- ATC website

Wellcare Prime by Absolute Total Care

https://mmp.absolutetotalcare.com/

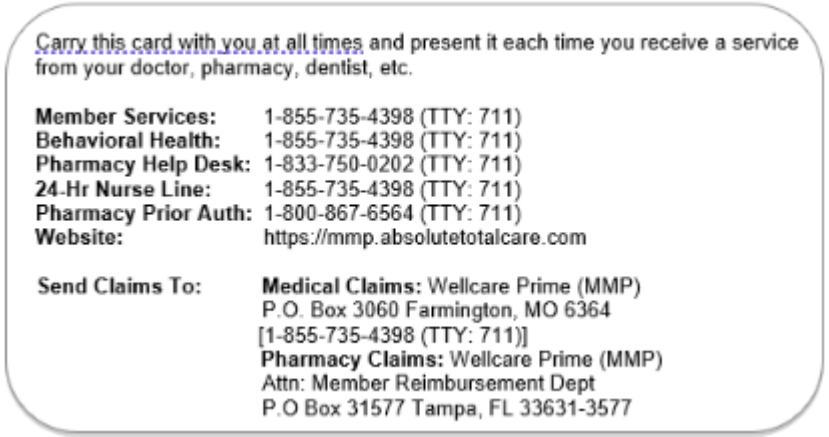
Wellcare Prime by Absolute Total Care

FRONT 2025-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

BACK 2025-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

https://mmp.absolutetotalcare.eom/.html

What is Balance Billing?

Understanding Balance Billing

1. Definition: Seeking payment from members for the difference between the billed charges and the contracted rate paid by the plan.
2. Payment Consideration: Payments less any copays, coinsurance or deductibles are considered payment in full.

Federal Law Prohibitions

1. 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.
2. 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 costsharing.

Compliance Steps

1. Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services.
2. 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.
3. If you have erroneously billed these members, recall the charges (including referrals to collection agencies) and refund the invalid payments.

Prohibition on Billing Qualified Medicare Beneficiaries Improper Billing Guidance for Providers (Jul 15 2024).pdf

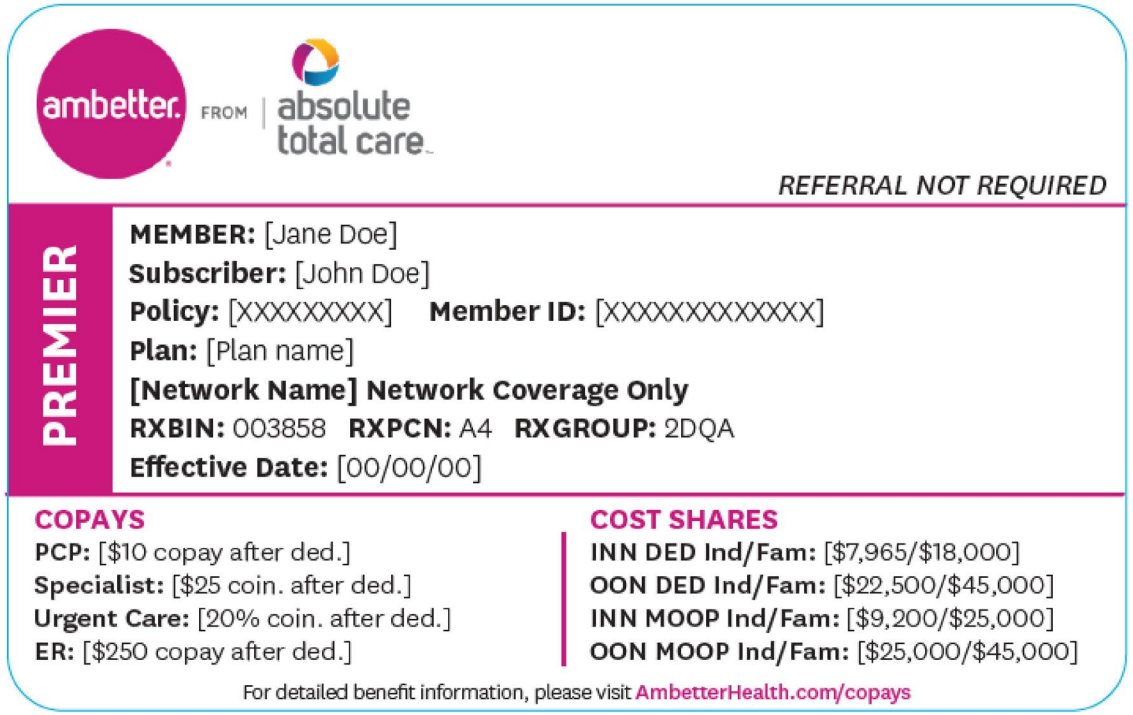
Am better from Absolute Total Care

My Health Pays Rewards Program


https://ambetter.absolutetotalcare.com/health-plans/my-health-pays
ambetter.
FROM
absolute total care

Ambetter Health Premier

FRONT 2025-MEMBER ID CARD



BACK 2025-MEMBER ID CARD

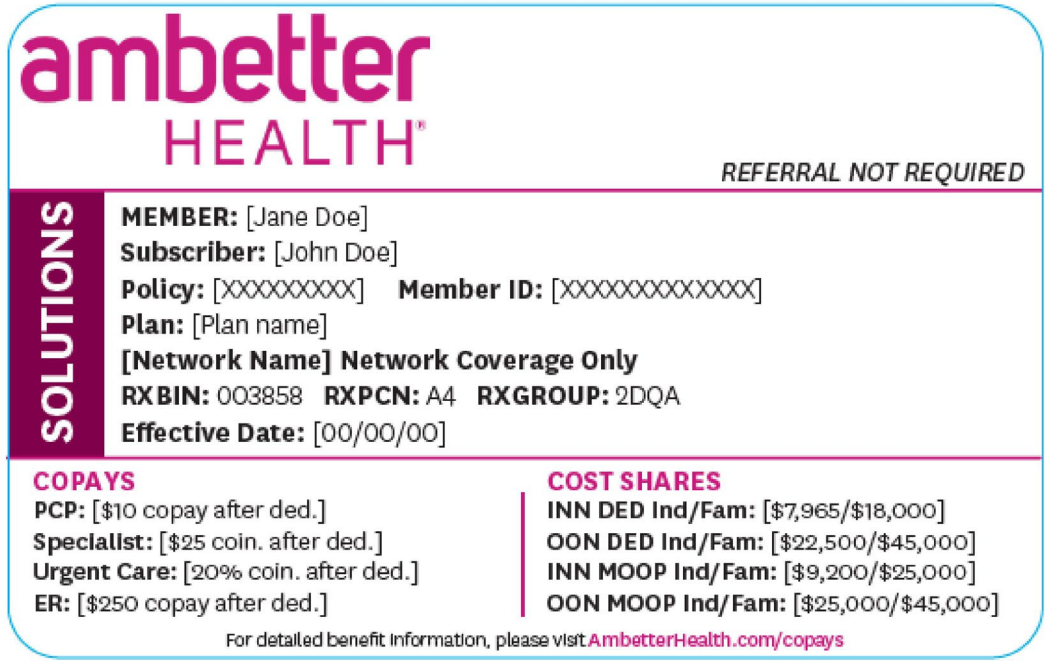
Effective January 1, 2025

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

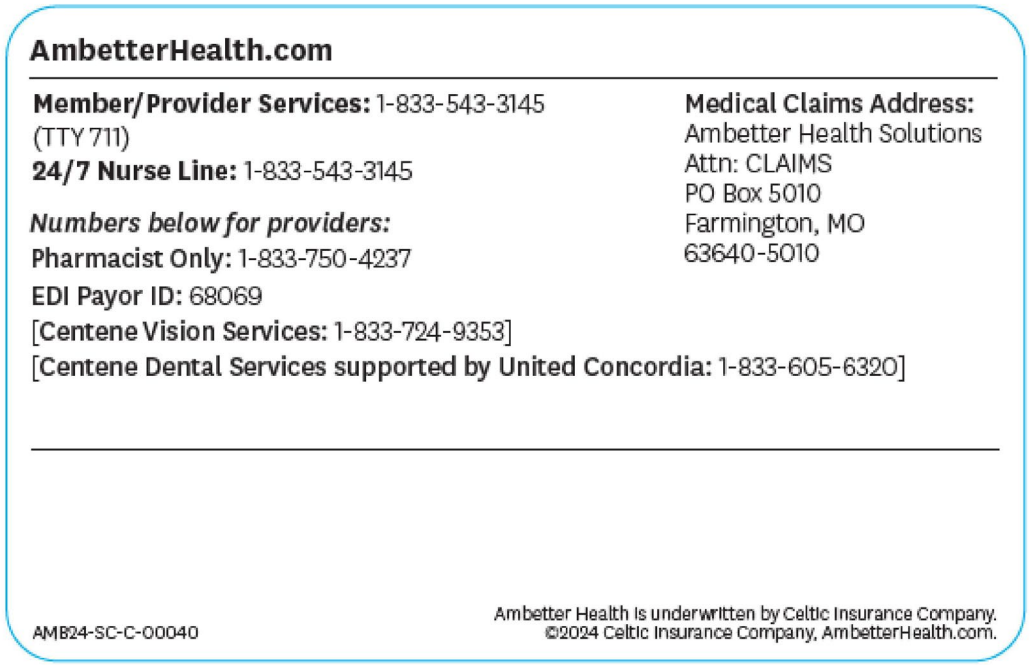
Ambetter Health Solutions

Ambetter Health (ICHRA) Network Name: SOLUTIONS

FRONT 2025-MEMBER ID CARD



BACK 2025-MEMBER ID CARD



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.

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, prio 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

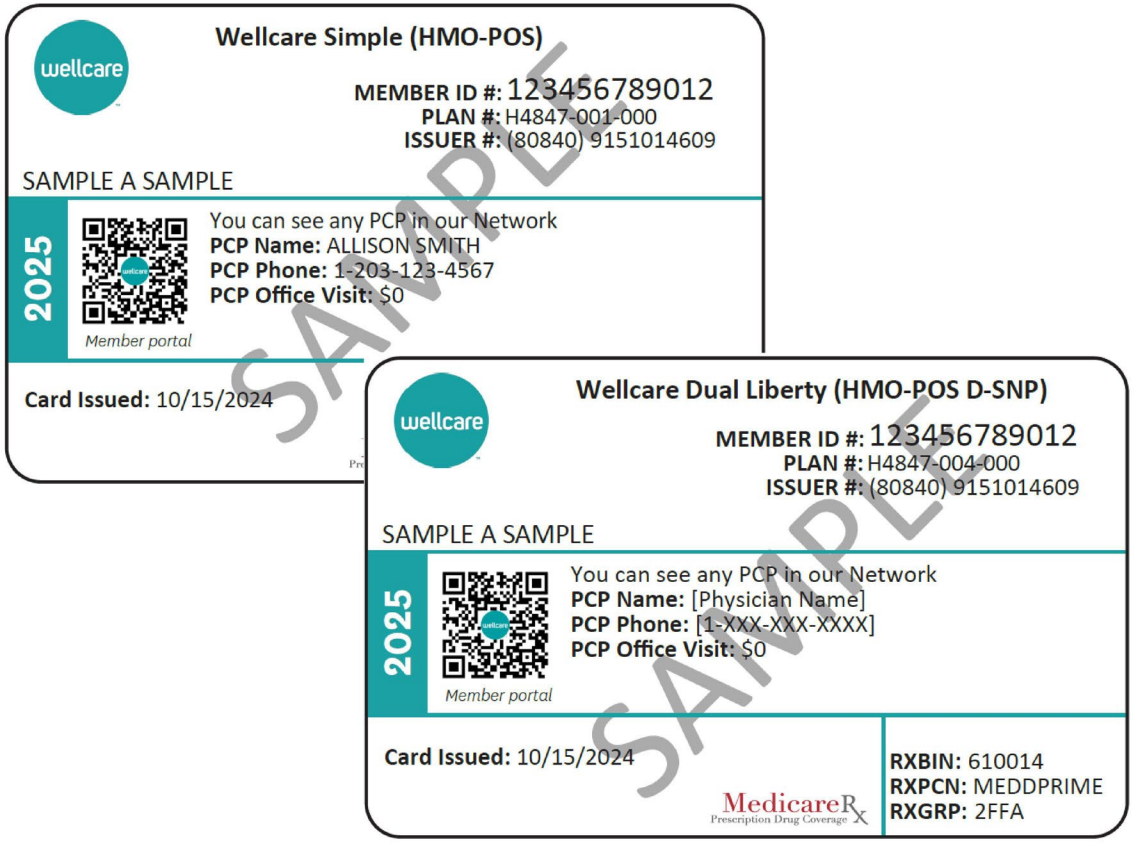
Wellcare Medicare Advantage HMO

- 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

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 innetwork. Some services require prior authorization by Wellcare, or its designee.

Medicare - HMO / HMO D-SNP

FRONT 2025-MEMBER ID CARD



BACK 2025-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.

MEDICARE ADVANTAGE PPO PLAN

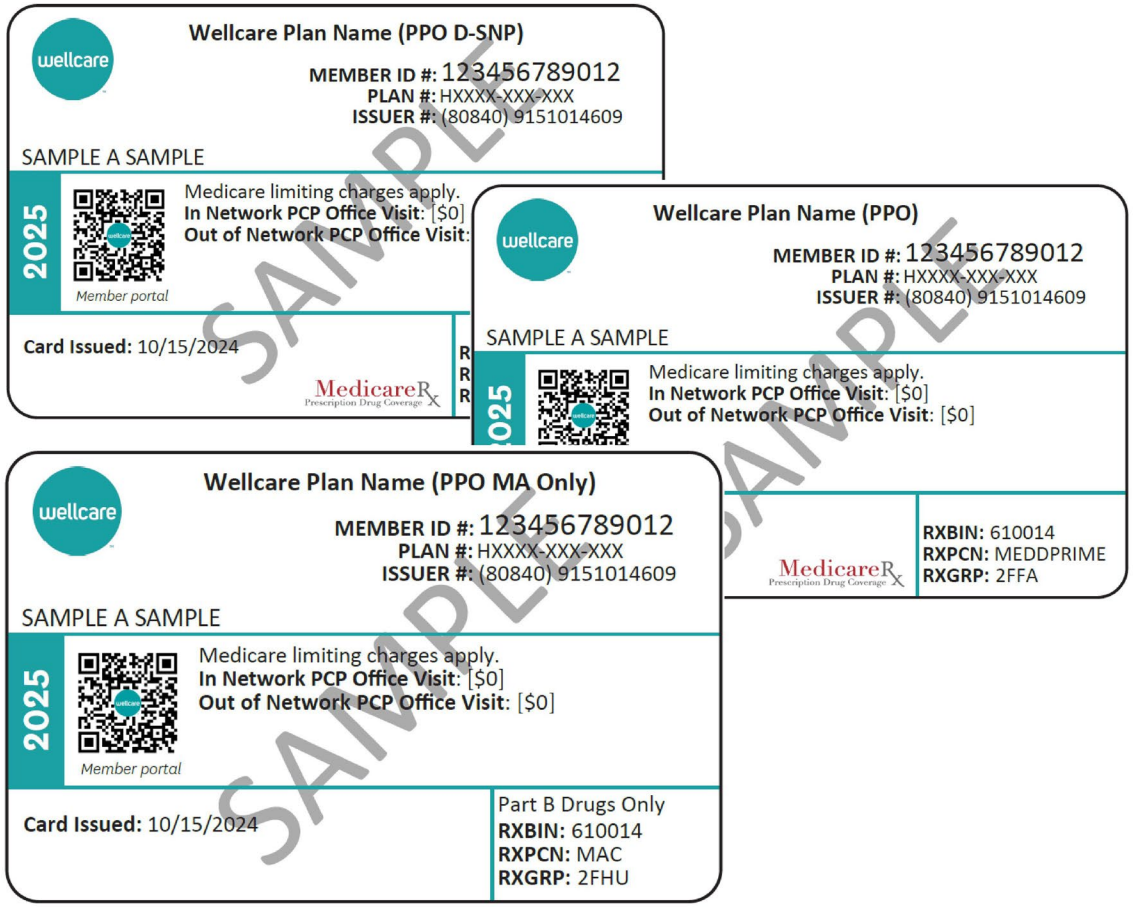
- Offers a simple copayment for doctor visits, hospital stays and many other healthcare services, making healthcare costs more predictable
- Gives members Medicare Parts A, B, and D coverage as well as vision, dental, and hearing benefits not covered by original Medicare
- Covers all original Medicare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

INCREASED FLEXIBILITY

- Referrals not required from primary care physician for specialist or hospital visits.
- 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.

Medicare - PPO / PPO D-SNP / PPO HMO MA Only

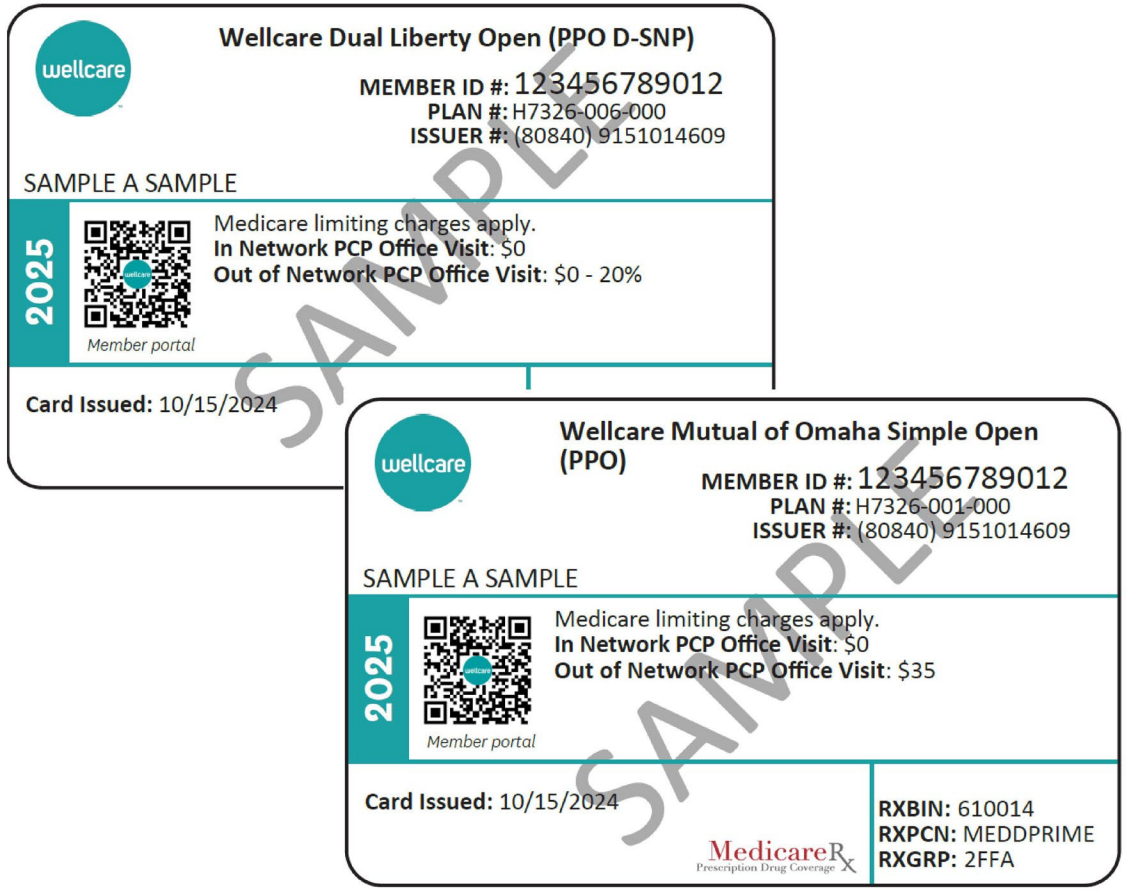
FRONT 2025-MEMBER ID CARD



BACK 2025-MEMBER ID CARD

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

FRONT 2025-MEMBER ID CARD

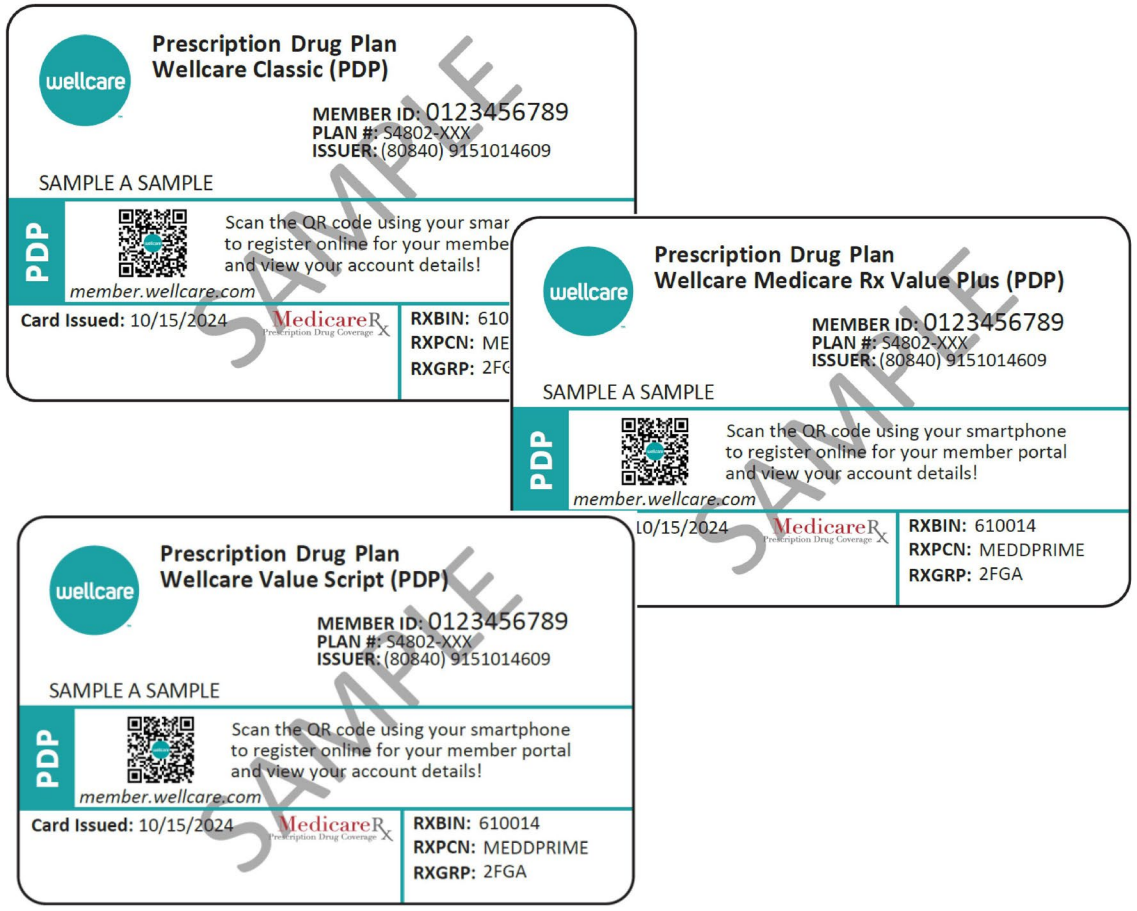


BACK 2025-MEMBER ID CARD

H7326

Medicare - Prescription Drug Plan (PDP)

FRONT 2025-MEMBER ID CARD



BACK 2025-MEMBER ID CARD

Medicare Prescription Payment Plan (M3P)

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

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.

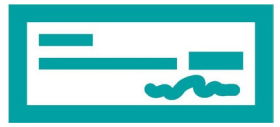
Phone:	1-833-750-9969
Online:	express-scripts.com/mppp
Mail:	Express Scripts Medicare Prescription Payment Plan P.O. Box 2 St Louis MO 63166

- 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

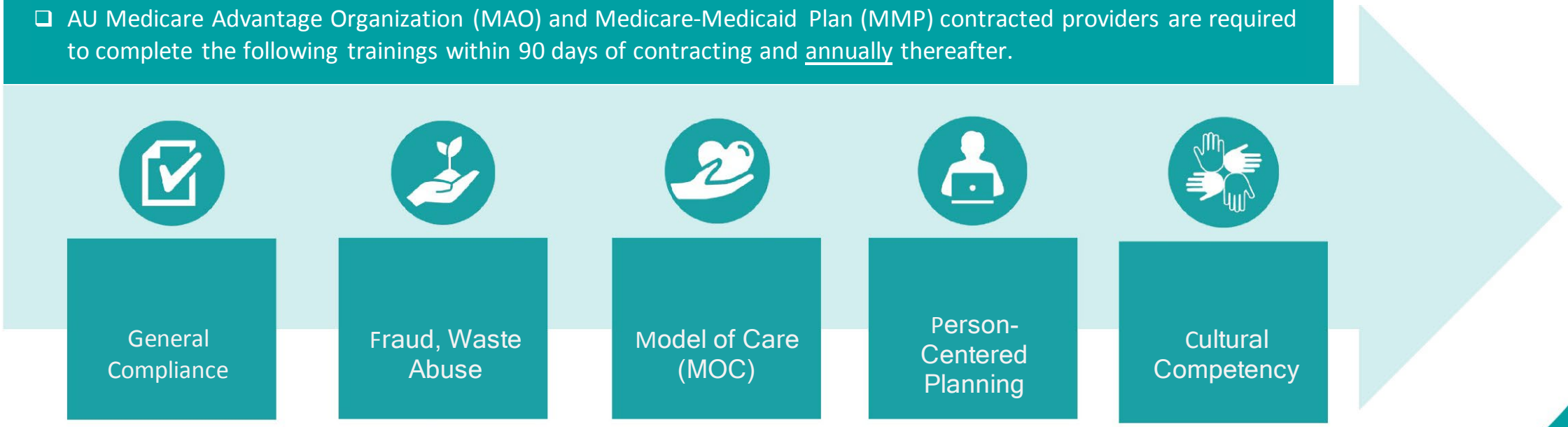
Providers are required by 42 C.F.R. §422.270(b), to refund all amounts incorrectly collected from its Medicare patients. This includes reimbursements owed due to claims adjusted by the health plan when the member had previously paid the provider or provider office.



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. NonCompliance 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.
- AU 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.



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-M_LN4649244-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

Behavioral Health Provider Training Opportunities

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 FUA 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)

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.

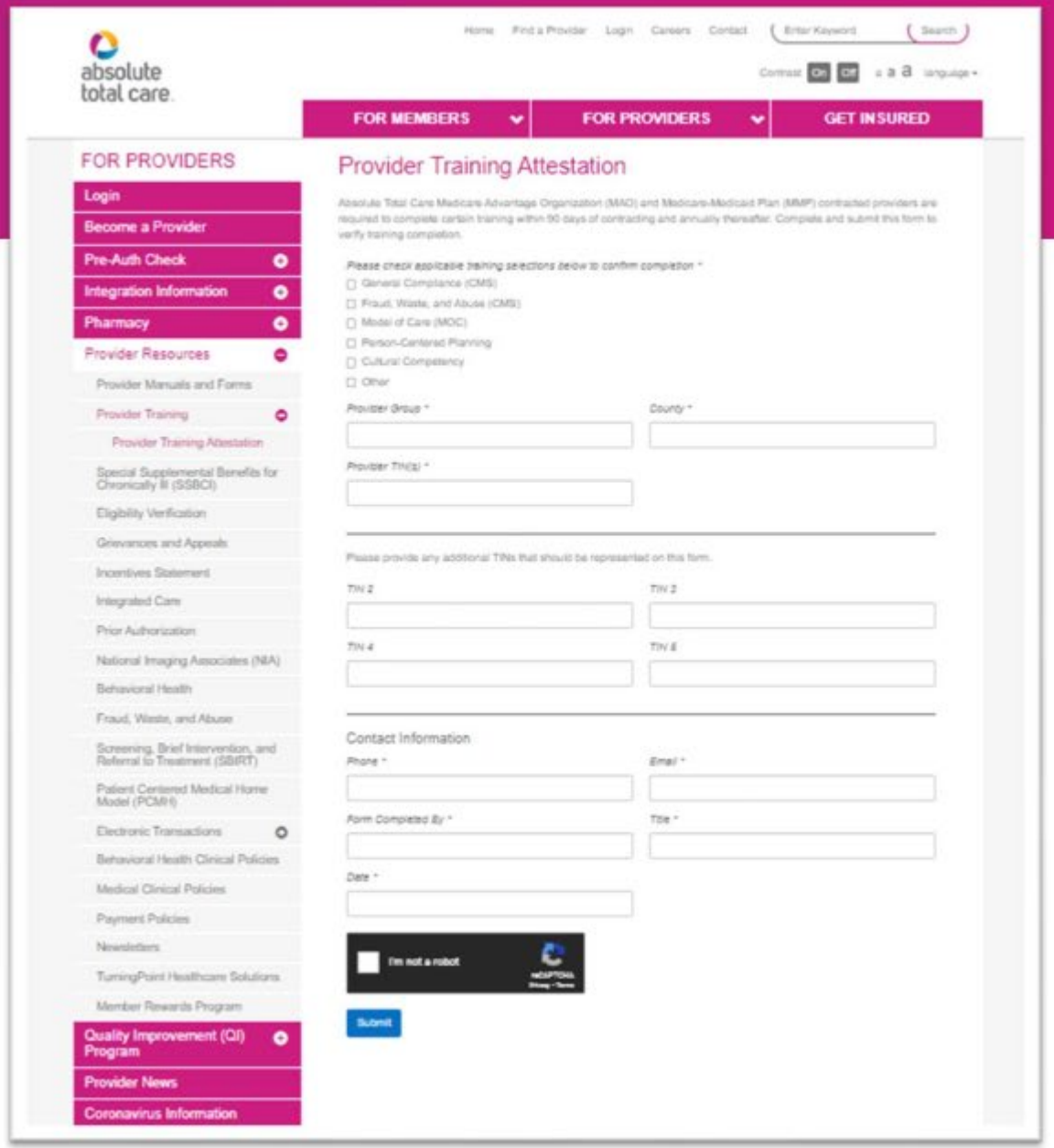
Behavioral Health Provider Training Opportunities

- 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)
- 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)

Absolute Total Care provides additional training sessions for medical and behavioral health providers to understand the purpose of Behavioral Health HEDIS measures.

Provider Training Attestation

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



Secure Provider Portals

Updates

absolute total care

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 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 a.m. - 8 p.m.. EST. For general questions, please contact Provider Services or reach out to your Provider Engagement Administrator.

Authorized Vendors

absolute total care

Authorized Vendors

- Vision Services need to be verified by Envolve Vision.
- Musculoskeletal Services need to be verified by Evolent.
- 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 Evolent.
- Outpatient rehabilitative and habilitative physical medicine services PT, OT, and Speech need to be verified by Evolent.

Authorization Vendors and Partners

CareCentrix provides in-network access to Skilled Nursing Facilities, Long Term Acute Care and Inpatient Rehab.

eviCore is our in-network vendor for Lab Management and Sleep Diagnostics programs; clinical criteria are accessible through the program links.

Evolent is our in-network vendor for Advanced Radiology, Advanced Cardiology, Pain Management, Physical, Occupational & Speech Therapy, and Musculoskeletal Management programs. Clinical criteria are accessible through the program links.

New Century Health is our in-network vendor for Oncology Pathways Solutions: Medical and Radiation Oncology, as well as Cardiology Management Program.

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
Motive are aka LoglstiCare
Phone:1-877-718-4201

Case Management

absolute total care

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?

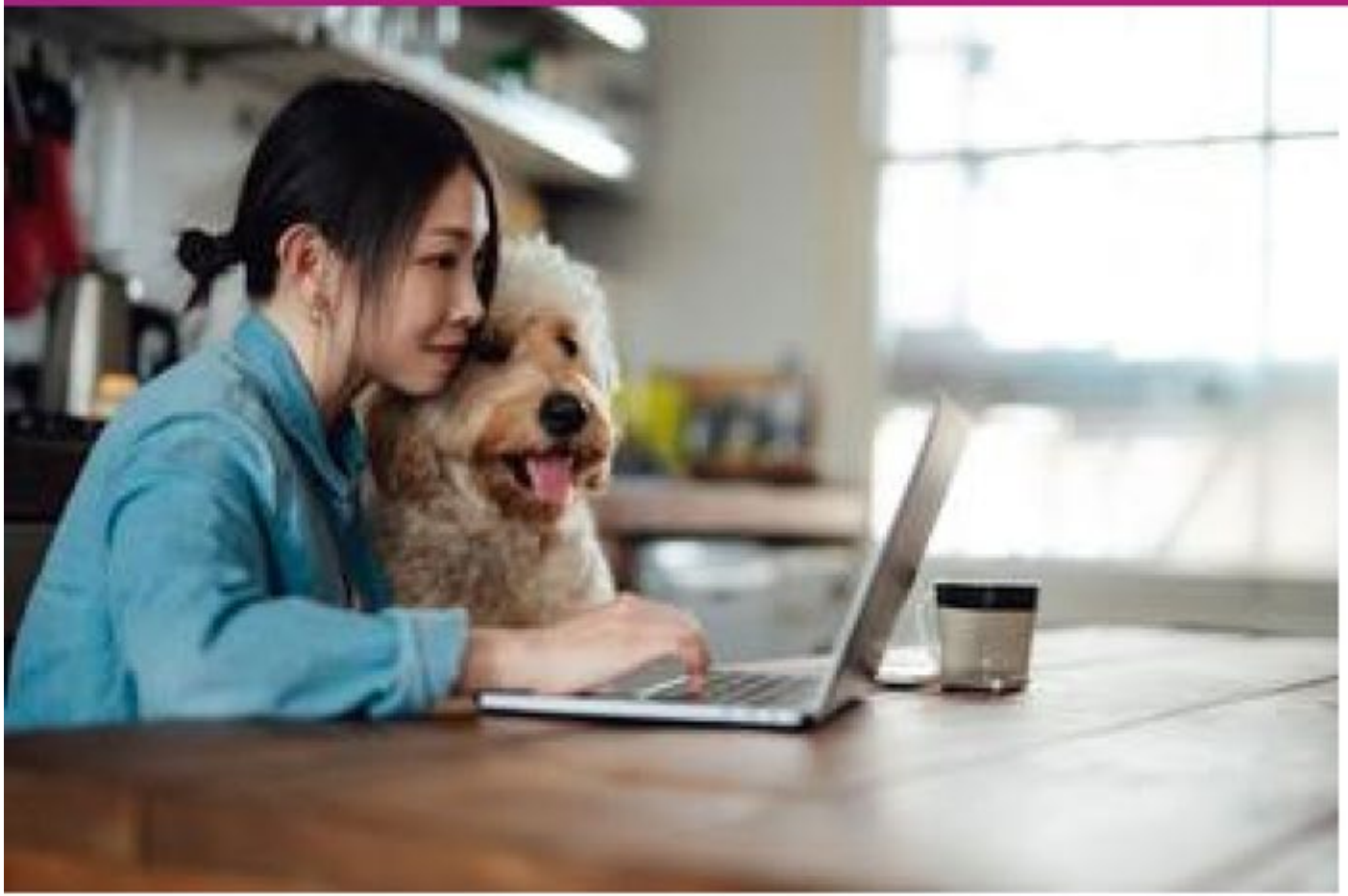
- ❑ Referrals to specialists and other services
- ❑ Coordinating care between doctors and other providers
- ❑ Developing care plans and setting health goals
- ❑ Learning about other services that can make our member's lives easier

How to become eligible for Case Management?

- ❑ 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 Cast 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: _____

Interpreter and Oral Translation Services

absolute total care

No Cost Interpreter Services and Oral Translation Service

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

- Having trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with members as needed.
- Providing Language Line services that will be available 24/7 in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.
- In-person interpreter services are made available when Absolute Total Care is notified in advance of the member's scheduled appointment
  - Providing TTY access for members who are hearing impaired through 711.
- Absolute Total Care medical/nurse advice line is available 24/7 for interpretation of Spanish or the coordination of non- English/Spanish needs via the Language Line.
- Providing or making available Member Services and health education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee.

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

ASL Interpretation Services

Language Services Associates

www.lsaweb.com

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

Thank you for choosing LSA as your language services provider! We are com mined to providing you with exceptional service ircm the minute you submit a request to the conclusion of ary assignment.

In order to guarantee that all requests ore received and responded to in a timely fashion, we are providing you with our policies! ar re questing American Sign Language (ASL) interpreting services, inducing ASL interpretation, English transite ration (signed and oral) and Deaf interpretation. LSA is proud to offer RID rationally certified interpreters and qualified pro-cert tied interpreters.

Types of Interpreting Situations

Legal
ADD es to coin trials, head res. depositions or any legal matter that becomes part of a legal record. LSA uses a team of two interpreters tor all legal assignments.

Mental Health
The need lor 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 aye times when a Deaf consumer will require a Deaf / hearing team for non menial health assignments due to limited language skills.

Conference / Platform Interpreting
Apples to any type of conference, seminar, town hall meeting or re c cus 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 yew conference, please be sure to metate a checkbox on your registration form indicating the need for services, as well as a clearly defined response dead re four weeks before the conference start date.

Conference interpreting always requires a team of irterpreters. For larger conferences with several breakout sessions, several teams maybe 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 assignmert.

Submitting Requests

Pease try to submit your community / routine interpreting requests at least twe cosiness days in alance. Emergency / rush situations may be requested on demand but they will incur additional sweharges.

It is the institution's responsibility inotthe Deal consumer's) to request interpreting services. We recommend you do this when 1he appointment s booted with the Deaf consumer, or im mediately after.

We kindly ask that you subm it your ASL interpretation requests to LSA in one of the folia wing two ways:

Online: Once yew account is sei up tn submit online requests, you can enter requests via the LSA website any time of the day, any day of the week. Please note than requests received after 6:30 p.m. Monday through Friday will be processed the next business day. Please contad LSA's Cient Services department at 800.305.9763 (option #7) or via e-mai at clientservices@lsaweb.com to enable your account for online requests.

absolute total care

Language Services Associates

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 1hat 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 inform alien should be included in your request. In these instances, if the appointment is sched. ed for 8:30 a.m., you should place your request for 8:15 am.

Sometimes assignmentswill go over the contracted time period- If the interpreter is mailable to slay alter the projected end of an assignment, extra time will be charged to you in half-increments. Please understand that interpreters bock their own schedules and may not be able to stay longer due to ether 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 w ilh more than two bus reas 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 not oe is required.

Requests cancelled with less than two bus ress days notice will be billed for the interpreter time reserved. If more than two hows 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.

Deal Consumer No-Show

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

Interpreter No-Show

If the interpretee 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 yuur specific agreement with LSA, Havel compensation may be charged for:

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

Mileage / Tolls / Parking - These are al charged to the client as applicable. The current mieage rate is charged as sei by the Internal Revenue Service.

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


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

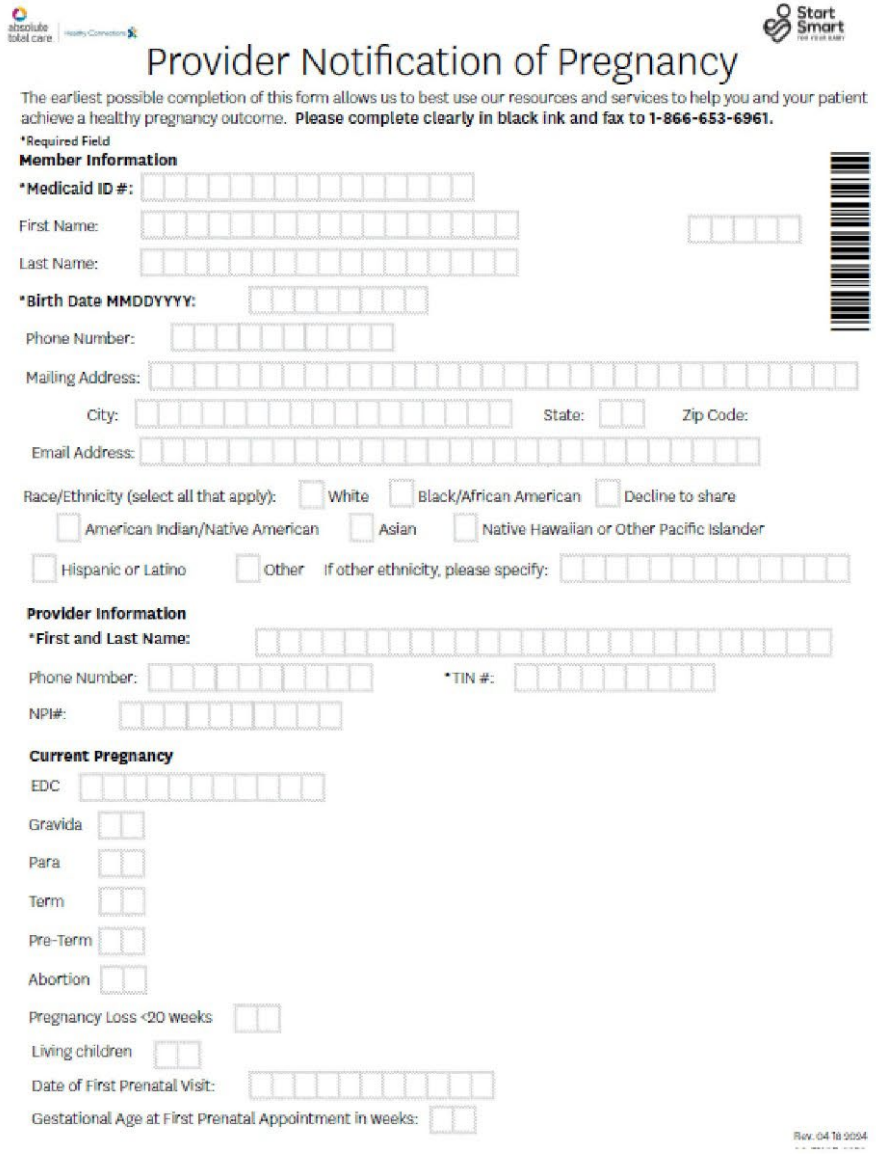
- Office staff NOP incentive:
    - Provider office staff can be reimbursed up to $25 for each NOP Form, up to a total of $500 for the year

- $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®

Start Smart for Your Baby

Notification of Pregnancy (NOP) Form Sample



absolute total care | Healthy Connections

Start Smart

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 to 2024

*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

Claims 411 - Did You Know?

absolute total care

Claims Adjustments, Reconsiderationsand 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.

Claims Adjustments, Reconsiderationsand Disputes

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 3050 Farmington, MO 63640-3821		

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	30
Dispute Decision	30	30

* From date of service

** Waiver of Liability required

*** From date of last processed claim

Claims Submission

Line of Business	Electronic Claim Submission	Paper Claim Submission
Medicaid	Secure Provider Portal: www.AbsoluteTotalCare.com/Login or EDI Payer Numbers: 68069 - Enncleon/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 submitted at the local office will not be accepted.
- Follow the applicable procedure based on your line of business

Wellcare Provider Timeframes, Claim Adjustmentsand Disputes

Type	Par	Non-Par
Initial Claim/Resu bmission	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

Wellcare Claim Submission

- Claims submitted at the local office will not be accepted.
  - Follow the appropriate procedure for your line of business to submit your claim.

<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 <u>PaySpan.com</u> 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, wich means Chargeable, expecting adjudication.
Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, wich means Reportable only, NOT expecting adjudication.
<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 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>

Electronic Funds Transfer

absolute total care

Pays pan®

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.
- ❑ 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.
- ❑ Providers can register using PaySpan's enhanced provider registration process at http://www.pavspanhealth.com/.
- ❑ 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 access additional resources by clicking Need More Help on the PaySpan® homepage or link directly to https://www.payspanhealth.com/nps/Support/Index.
- ❑ 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.

Network Development and Participation

absolute total care

Network Development and Participation

Network Participation

- The enrollment, credentialing and recredentialing processes exist to ensure that participating providers meet and remain compliant to the criteria established by Absolute Total Care.
- These processes also ensure that providers remain compliant with government regulations and standards of accrediting bodies

Network Development

- To request a new agreement, send an email to ATC Contracting@centene.com
- For contract updates and questions (i.e., change of ownership, TIN changes, amendments, etc.), send an email to ATC Contracting@centene.com

Network Development and Participation

To initiate the credentialing process for a new practitioner at ATC, providers are required to submit a Provider Data (Add) Form along with a Current W-9 to SouthCarolinaPDM@centene.com.

- The process takes about 60 days to complete. For follow-ups before receiving the Welcome Letter, email SouthCarolinaPDM@centene.com.
- Recredentialing occurs every 36 months.
- To update existing participating providers and locations, email the Provider Data Form (Update) to SouthCarolinaPDM@centene.com.

To enroll a new practitioner with Wellcare, providers need to submit a completed Provider Profile Sheet along with a Current W-9 to atcnetworkrelations@centene.com.

- The process takes roughly 60 days to complete.
- Recredentialing occurs every 36 months.
- Providers can update existing participating providers and locations by emailing their assigned representatives or at atcnetworkrelations@centene.com.

Credentialing Rights

absolute total care

Credentialing Rights

Practitioners seeking participation with ATC are entitled to review the information ATC collects to assess their credentialing and recredentialing applications, including details from external primary sources. However, they cannot access references, personal recommendations, or peer-review protected information.

If a practitioner believes any information used in the credentialing or recredentialing process to be incorrect, or if any information gathered during the primary source verification process differs from what the practitioner submitted, they have the right to correct any erroneous information provided by another party.

To obtain such information, you must send a written request to the ATC Credentialing Department. Once the information is received, the practitioner has 14 days to submit a written explanation highlighting any errors or discrepancies to ATC. Subsequently, ATC s Credentialing Committee will incorporate this information into the credentialing or recredentialing process.

Cultural Competency

absolute total care

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, s communication without cost to the member.
- Care is provided with consideration of the members' race/ethnicity ar or illness.
- Office staff that routinely meets members have access to and particip
- Office staff responsible for data collection make reasonable attempts Staff also must explain race/ethnicity categories to a member so that and/or their children.
- Treatment plans are developed, and clinical guidelines are followed v\ native language, social class, religion, mental or physical abilities, her characteristics that may result in a different perspective or decision-n
- Office sites have posted and printed materials in English, Spanish and SCDHHS.

❖ Visit absolutetotalcare.com to learn about our Cultural C

Quality Improvement

absolute total care

Partnership for Quality (P4Q) Bonus Program

The 2025 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) Medicaid

2025 Partnership for Quality

absolute total care
Healthy Connections

Absolute Total Caro understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because Absolute Total Cane recognizes these important partnerships, we are pleased to offer the 2025 Partnership for Quality (P4Q) Bonus Program, which rewards PCPs for improving quality and closing gaps in care.

HOW IT WORKS

Providers have the opportunity to earn a bonus by successfully addressing the measures outlined in the table below. Schedule and conduct appointments to close care gaps, review medications, and strategize a plan for maintaining your patient's well-being.

Program Measures	Amount Per
ADD - ADHD Maintenance Phase Visit	$50
AMR - Asthma Medication Ratio 5 - 64yrs	$50
BCS - Breast Cancer screening	$50
CBP - Controlling High Blood Pressure	$50
EED - Diabetes - Dilated Eye Exam	$50
GSD - Diabetes HbAlc < 8	$50
BPD - Diabetes BP < 140/90	$50
CHL - Chlamydia Screening in Women	$50
CIS - Childhood immunization Status Combo 10	$50
COL - Colorectal Cancer screening	$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
PESE - 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

absolute total care

Partnership for Quality (P4Q)
Wellcare 2025

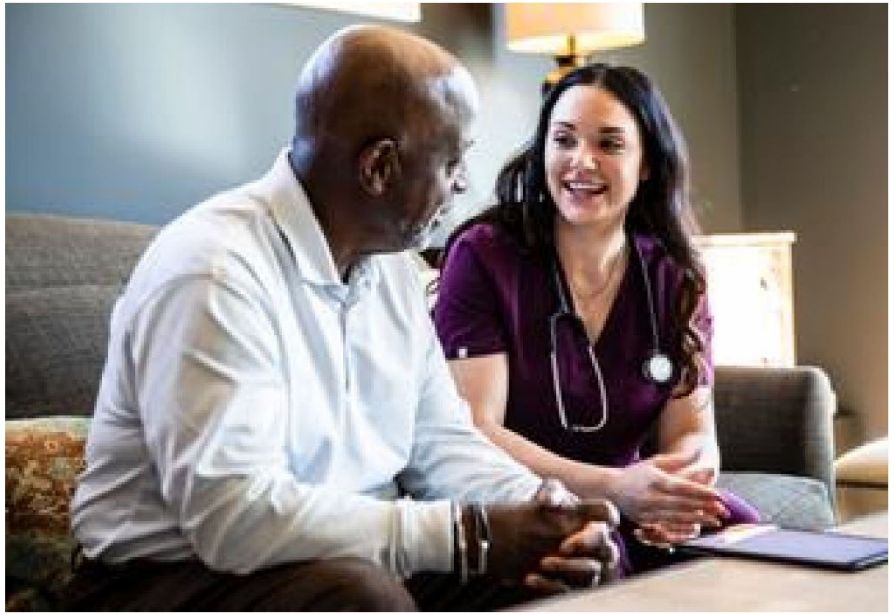
Wellcare ¡s pleased to announce the launch of the 2025 Partnership for Quaky (P4Q) Bonus program, primary care providers have the opportunity to earn a bonus by addressing preventive care and closing care gaps.

Program Measures	Amount Per
BCS - Breast Cancer Screening	$53
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
EMC - F/u ED Multiple High Risk chronic conditions	$50
GED - Diabetes HbAic <= 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
DMW - Osteoporosis Management in Women Who Had Fracture	$50
SPC - Statin Therapy for patients with CVD	$25
SUPD - Statin use in Persons with Diabetes	$25
IRC - Medication Reconciliation Post Discharge	$25

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

Partnership for Quality (P4Q) Ambetter

2025 Partnership for Quality



Ambetter from Absolute Total care understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because Ambetter from Absolute Total caro recognizes these important partnerships, we are pleased to offer the 2025 Partnership for Quality (M Q) Bonus Program, which rewards PCPsfor improving quality and closinggap* in care.

HOW IT WORKS

providers have the opportunity to earn a bonus by successfully addressing the measures outlined in the table below. Schedule and conduct appointments to close care gap* review med ¡cation* and strategize a plan for maintaining your patient's well-being.

Program Measures	Amount Per
AMR - Asthma Medication Ratio 5 - 64 yrs	$50
BCS - Breast cancer screening	$50
CEP - Controlling H igh Blood Pressure	$50
EED - Diabetes - Dilated Eye EXam	$50
GSD - Diabetes HbAic< 9	$50
CHLL - chlamydia Screening in Women	$50
OS - childhood immunization Status Com bo 10	$50
COL - Colorectal Cancer screening	$50
IMA - immunizations for Adolescents combo 2	$50
KED - Kidney Health for Patients With Diabetes	$50
PDC - Proportion of Day* Covered - Diabetes	$50
PDC - Proportion of Days covered - statins	$50
PPC- Postpartum visit	$50
PPC - Prenatal Visit (Timeliness)	$50

CPT II and HCPCS Billing

- We request that our providers use accurate CPT category II codes and HCPCS codes to enhance efficiency in closing patient care gaps and collecting data for performance measurement.
- By verifying that you have performed quality procedures and closed care gaps, you ensure that you are delivering the highest quality care to our members

- Absolute Total Care allows the billing of these important codes without a denial of “nonpayable 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 Records (EMR) System

Remote access to EMR allows designated health plan representatives access to your medical records directly through remote access.

- Streamline provider office staff activities regarding HEDIS Hybrid chart chase requests
- Decrease and avoid duplication of over utilization or retrieval efforts
- Contribute to enhanced HEDIS performance metrics

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
- Potential incentives
- Improve HEDIS scores
- Reduces medical record requests

CAHPS®
Consumer Assessment of Healthcare Providers and Systems

absolute total care

CAHPS® Provider Resource Guide

CAHPS (Consumer Assessment of Healthcare Providers and Systems)

CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL

CAHPS (Consumer Assessment of Healthcare Providers and Systems)

CAHPS MEASURE: GETTING NEEDED CARE

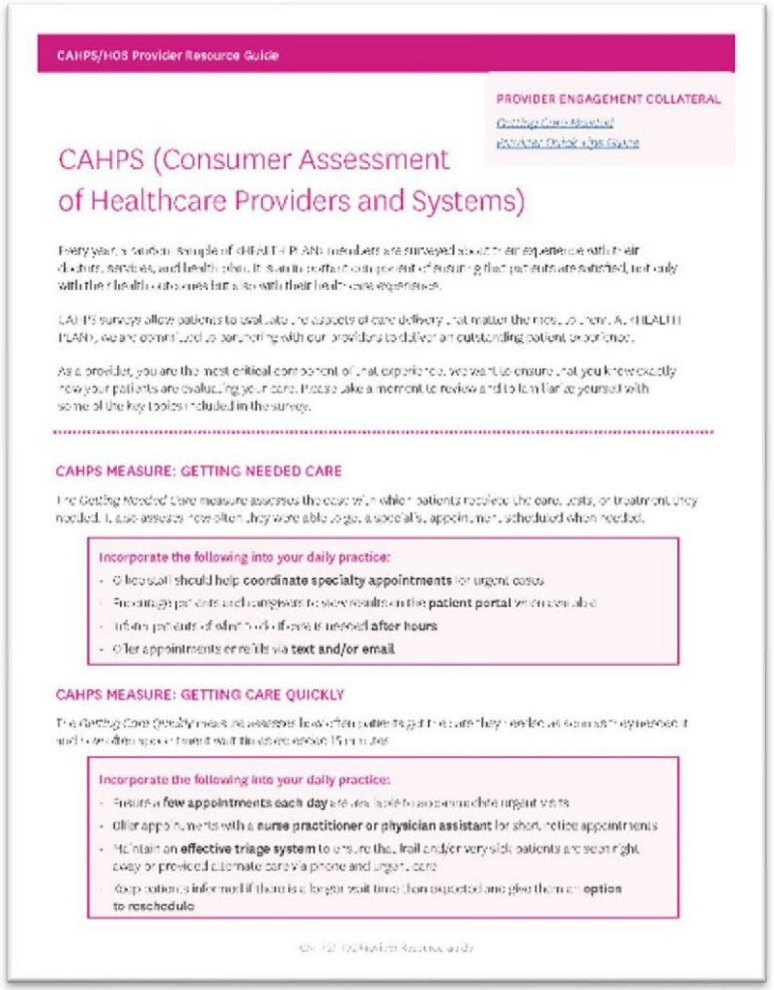
Incorporate the following into your daily practice:

- Clinical staff should help **coordinate specialty appointments** for urgent cases
- Encourage patients and caregivers to view results in the **patient portal** when available
- Inform patients of alternative if care is needed **after hours**
- Offer appointments or refills via **text and/or email**

CAHPS MEASURE: GETTING CARE QUICKLY

Incorporate the following into your daily practice:

- Reserve **a few appointments each day** are available to accommodate urgent visits
- Offer appointments with a **nurse practitioner or physician assistant** for short notice appointments
- Maintain an **effective triage system** to ensure the frail and/or very sick patients are seen right away or provided alternate care via phone and urgent care
- Ask patients if they have a longer wait time than expected and give them an **option to reschedule**



CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL

CAHPS MEASURE: CARE COORDINATION

Incorporate the following into your daily practice:

- Ensure there are open appointments for **patients recently discharged** from a facility
- Integrate PCP and specialty practices through **EMR or fax** to get reports promptly
- Ask patients if they have seen any other providers; **discuss visits to specialty care** as needed
- Encourage patients to **bring in their medications** to each visit

CAHPS MEASURE: HOW WELL DOCTORS COMMUNICATE

What is Teach-back?

- A way to ensure you (the healthcare provider) have explained information clearly. It is not a test of the patient's
- Asking a patient (or family member) to explain in their own words what they need to know or do, in a caring way
- A way to check for understanding and, if needed, to explain and check again
- A research-based health literacy intervention that improves out-of-provider communication and patient health outcomes

CAHPS MEASURE: RATING OF HEALTH CARE QUALITY

Incorporate the following into your daily practice:

- Encourage patients to make their **routine appointments** for checkups or follow up visits as soon as they can – weeks or even months in advance
- Prevent **open care gaps** with addressed during each patient visit
- Make use of the provider portal when requesting prior authorizations

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

Provider Focus Quick Tips

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.

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 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.

Accessibility and Availability Standards

absolute total care

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

- AH 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 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 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
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 non-life-threatening emergency visits	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 emergency) visits	Within 1 week of the request
Urgent specialty care	Should be available within 24 hours of referral
Referrals to specialist	Should be available 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
Behavioral health urgent care	48 hours
Non-urgent appoint 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

Primary Care and Specialist Appointment Type	Access Standard
PCP-Urgent	Within 24 hours
PCP-Non-urgent	Within 1 week of the request
PCP-Regular and routine	Within 30 calendar days
All specialists (including high volume and high impact) - Urgent	Within 24 hours
All specialists (including high volume and high impact) - Urgent	Within 30 calendar days
Behavioral health provider - Urgent care	48 hours
Behavioral health provider - Initial routine care	Within 10 business days
Behavioral health provider - Non-life-threatening emergency	6 hours
Behavioral health provider - Initial routine care follow-up	Within 10 business days

Access Standards - Ambetter

Appointment Type	Access Standard
PCP's - Routine visit	30 calendar days
PCP's - Adult sick visit	48 hours
PCP's - Pediatric sick visit	24 hours
Behavioral health non-life-threatening emergency	6 hours or direct memberto 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	Answering service 24 hours a day, 7 days a week or instructions on how to reach a physician
Emergency	24 hours a day, 7 days a week

Q and A Session

absolute total care

absolute total care

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

wellcare™

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.

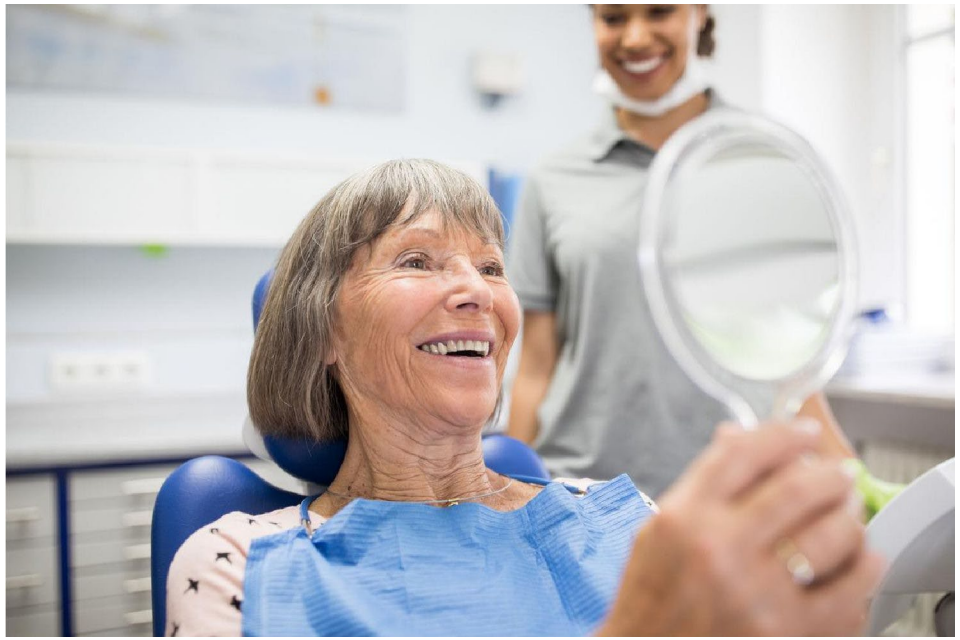
wellcare.com/medicare

absolute total care

wellcare™

Appendix

absolute total care



Centers far Medicare & MoUcasd Services
Atlanta Regional Office
61 Forsyth St., SW; Surte 4T2l>
Atlanta, CA 3080»

May 19, 2016

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

BALANCE BILUNG 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 MedicareMedicaid 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 termina bon 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 noncovered items or services. If such notice is not given and the agreement is not in place, providers may not bill members for such items or services.
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 Welfare 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 Welkare Prime/Heatthy Connections Prime Provider Services Agreement. **Please be advised that it is unlawful for providers to "balance MT 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.

Welkare 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 Welkare Prime resolves balance billing issues with the provider:

- Welkare Pnme informs the provider that the member has been inappropriately balance billed and educates the provider on balance biling.
- 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. Welkare 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 **absolutetoukare.com**. You can also refer to CMS' Balance Billing Prohibition Notice at this link (**https://msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing-heatthy-connections-prime-members-0**) on the Healthy Connections Prime website. If you have any questions, please contact Member Services at 1-855-73S4398

ambetter from Absolute Total Care

Provider Notification

ambetter. FROM absolute total care

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 accord inf to current standards of practice. As a condition of payment, Ambetter from Absolute Total Care requires prior authorisation for many services.

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

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

Pease verify member el g b ty and benefit: prior to rendering services Payment, regardless of authorisation, is contingent on the member's eligibility at the time service is rendered

If you have question: about this information, call Provider Services at 1*5 53-2 70-544 3 or contact your dedicated Proveer Relation: Specialist.

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

MMP Example EOP - Medicaid Balance Billing

EXPLANATION OF PAYMENT
Wellcane Prime by Absolute Total Care
Medicare-Medicaid Plan
100 Center Point Circle, Suite 100
Columbia, SC 29210
1-856-73M398

Payment Date:	8/17/2022
Payment #:	
Payment Amt:	50.00

PAY TO:
XXXXX
XXXXX
XXXXX

Payee ID: XXXXX
IRS#: XXXXX

Insured Name: XXXXX | **Mbr No:** XXXXX | **MRN:** XXXXX | **Claim/Ctrl No:** XXXXX
Patient Name: XXXXX | **SvcFrov No:** XXXXX | **Carrier:** MM | **PatCtrl No:** XXXXX
Servicing Provider: XXXXX | **NPI:** XXXXX | **Group:** SCTCC - BERKELEY

Please note: This bill has crossed over from Medicare to Medicaid. Paymet is now complete.

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur/ Penalty	Discount/ Interest	Med Allowi Med Paid	Third Party Payer	Denied	EXPL Codes	Payment[1] 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	$115.00 $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: PC P IS NOT EFFECTIVE AT THE TIME OF SERVICE

SC DHHS 1716 Form For Newborns

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

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 Street Address	Phone		Fax	
Provider Emil 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 (is same as mother's, enter "Same")	City	County	State	ZIP code
Name of Birth Facility		Country of Birth Facility		

Gender: ☐ Male ☐ Female

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

DHHS Use Only	Child'sMedicaid ID Number: _____ Effective date of eligibility: _____	DHHS Use Only

IV. Mail the Completed Form

Mail the completed form to:

SCDHHS - Central Mail
PO Box 100101
Columbia, SC

Fax:

(88 8} 820-1204

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 significant y 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.

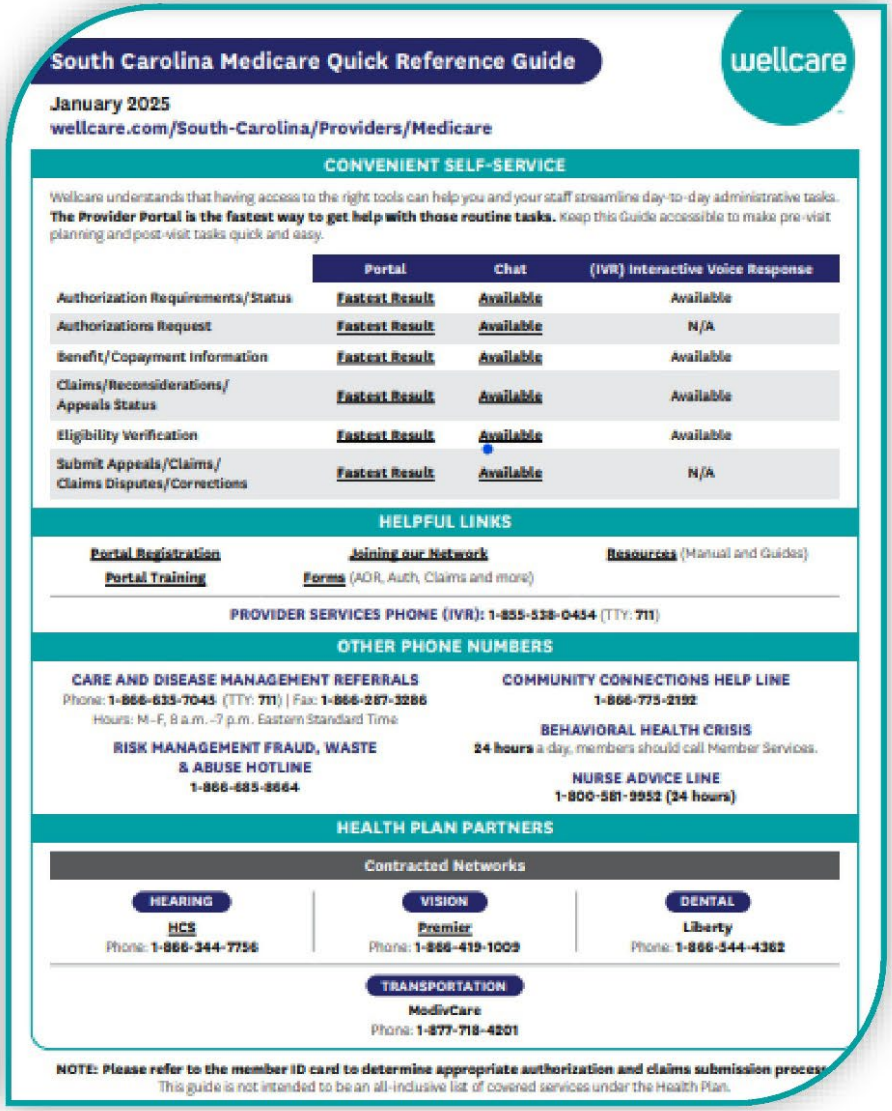
Program Overview for Eligible Participating Medicare Members

- Financial benefits to all Medicare members - in 2025 include an elimination of the coverage gap and capping the maxim uni 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 he them manage prescription costs by enabling them to spread their monthly payments overtime.
- 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 Chang
- New members will receive additional information within 10 days of confirmed enrollment.

[1]Excludes plans that solely charge SO 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 Service team**.

Medicare Quick Reference Guide



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: 1-866-267-3286
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.

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	MEDIMPACT	2FFA
610014	MAC	2FHJ (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.

Absolute Total Care Provider Engagement Territory Assignment

Identify your region and discover your designated Provider Engagement Manager through the link below:

https://www.absolutetotalcare.com/providers/find-my-provider-engagement-administrator.html

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

Absolute Total Care

Quality Improvement and Case Management Team

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


absolute
total care™
Thank You.