

# MEDICARE-MEDICAID PROVIDER MANUAL 2015

ABSOLUTE TOTAL CARE



Absolute Total Care (ATC) is a Coordinated and Integrated Care Organization (CICO) contracted with the Centers for Medicare and Medicaid Services (CMS) and South Carolina Healthy Connections Medicaid to coordinate medical services to Medicare-Medicaid (dual eligible) members in South Carolina.

ATC's main goals are as follow:

- Improve health outcomes;
- Coordinate necessary care to dual eligible members;
- Reduce avoidable emergency department visits and hospital readmissions;
- Increase access to home and community based services.

All of our programs, policies and procedures are designed with these objectives in mind. These objectives mirror and support the objectives of the CMS and South Carolina Healthy Connections Medicaid guidelines to provide covered healthcare services to low-income and elderly members. This manual will be updated and revised as needed based on CMS, South Carolina Healthy Connections Medicaid, and ATC guidelines.

ATC takes the privacy and confidentiality of our member's health information seriously. We have processes, policies, and procedures that comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and CMS regulations.

Our goal is to reinforce the relationship between our members and their Primary Care Provider (PCP). We want our members to benefit from their PCP having the opportunity to deliver high quality care using contracted clinicians, hospitals and specialists. The PCP is responsible for coordinating our member's health services, maintaining a complete medical record for each member under their care, and ensuring continuity of care. The PCP advises the member about their health status, medical treatment options, which include the benefits, consequences of treatment or non-treatment, and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.

If a PCP is unable to provide treatment to a member, including counseling and referral services, because of religious or moral reasons, they should contact our Provider Services number at 1-855-735-4398.

We appreciate your partnership in achieving our objectives.

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## How to reach us:

### Absolute Total Care

1441 Main Street, Suite 900

Columbia, SC 29201

Provider and Member Services: 1-855-735-4398

Administrative Offices: 1-803-933-3638

[www.absolutetotalcare.com](http://www.absolutetotalcare.com)

Hours of Operation: Monday- Friday, 8am-6pm

Claims Submission Address: PO Box 3060, Farmington, MO 63640

### Vendor Contacts:

| Vendor   | Contact Number | Service                             |
|--|----------------|-------------------------------------|
| Argus (Pharmacy)   | 1-855-735-4398 | Pharmacy Claims Administrator       |
| US Script PBM (Prescribers)  | 1-855-735-4398 | Pharmacy Benefit Manager            |
| Cenpatico Behavioral Health  | 1-855-735-4398 | Behavioral Health Services          |
| National Imaging Associates (NIA)<br><a href="http://www.radMD.com">http://www.radMD.com</a> | 1-855-735-4398 | Authorizations for CT, PET, MRI     |
| NurseWise  | 1-855-735-4398 | 24-Hour Nurse Triage Service        |
| Opticare Vision  | 1-855-735-4398 | Routine Vision Services             |
| PaySpan  | 1-877-331-7154 | 835 Vendor for EFT/ERA Transactions |

### Healthy Connections PRIME Contacts:

| Vendor  | Contact Number  | Service               |
|---|-----------------|-----------------------|
| Maximus<br><a href="https://www.scchoices.com/Member/MemberHome.aspx">https://www.scchoices.com/Member/MemberHome.aspx</a>        | 1-877-552-4642  | Enrollment Processor  |
| South Carolina Department of Health and Human Services (SCDHHS)<br><a href="http://www.scdhhs.gov/prime">www.scdhhs.gov/prime</a> | 1-800- 726-8774 | Program Administrator |

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# MARKETING GUIDELINES

ATC will follow CMS and South Carolina Healthy Connections Medicaid guidelines.

ATC and providers with whom they have a relationship (contractual or otherwise) that assist members with plan selection will ensure that provider assistance results in plan selection that is always in the best interest of the member. Providers that have entered into co-branding relationships with ATC must also follow these guidelines.

ATC will not conduct sales activities in healthcare settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.

ATC will not conduct sales presentations, distribute and accept enrollment applications, and solicit members in areas where patients primarily receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

ATC will only schedule appointments with members residing in long-term care facilities (including nursing homes, assisted living facilities, board and care homes, etc.) upon request by the member. ATC may use providers to make available or distribute plan marketing materials as long as the provider or the facilities distributes or makes available marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available or distribute plan marketing materials they should do so if ATC indicates the provider must accept future requests from other plans with which they participate. ATC may also provide materials for providers to display posters or other materials in common areas such as the provider's waiting room. Additionally, ATC may provide materials to long-term care facilities to provide materials in admission packets announcing all plan contractual relationships.

For more information on CMS Marketing guidelines visit <http://cms.gov>

# QUALITY IMPROVEMENT

ATC conducts an ongoing Quality Improvement (QI) Program. ATC's QI Program includes a Chronic Care Improvement Program and QI Projects. The QI Program is evaluated at least annually concerning its impact and effectiveness.

The goal of the QI Program is to achieve sustained improvement in aspects of clinical care and non-clinical services, through ongoing measurement and intervention; which, can be expected to have a beneficial effect on health outcomes and member satisfaction.

The QI Program:

- Incorporates information from Member Service, Claim Disputes & Appeals, Medical Management, Credentialing, Provider Services, Claims and Marketing.
- Designates a senior official responsible for QI administration.
- Has a committee that evaluates the effectiveness of the QI Program.
- Has an annual evaluation of its QI Program which:
  - Assesses both progress in implementing the QI strategy and the extent to which the strategy is in fact promoting the development of an effective QI Program.
  - Considers whether activities in ATC's Work Plan are being completed on a timely basis or whether commitment of additional resources is necessary.
  - Includes recommendations for needed changes in program strategy or administration. These recommendations are forwarded to and considered by the designated committee.
- Encourage ATC's providers to participate in CMS and South Carolina Healthy Connections Medicaid QI initiatives.

ATC corrects all significant systematic problems that come to its attention through internal surveillance, complaints, or other mechanisms. To accomplish this, ATC:

- Has a mechanism for assessing the severity of identified problems.
- Takes timely and specific action to correct identified problems, depending on the severity and impact of the identified problems.

The scope of the QI Program is comprehensive and addresses both the quality and safety of clinical care and the quality of service provided to ATC members as defined by CMS and South Carolina Healthy Connections Medicaid. ATC incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its QI activities, including preventive care, emergency care, primary care, specialty care, acute care, short term care, and ancillary services. ATC's Quality Assessment and Performance Improvement (QAPI) Program monitors the following:

- Acute and chronic care management
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health and clinical practice guidelines
- Continuity and coordination of care
- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment

- Member grievance system
- Member satisfaction
- Patient safety
- Provider and ATC's after-hours telephone accessibility
- Provider appointment availability and accessibility
- Provider network adequacy and capacity
- Provider satisfaction

## **MEDICARE QUALITY MEASURES (STARS)**

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CMS developed the Medicare Star Ratings in order to provide information to consumers about Medicare health plans and to reward top-performing health plans. CMS rates the quality of service and care provided by Medicare health plans based upon a five-star rating scale. This scale is comprised of: Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, and the Medicare Health Outcomes Survey (HOS).

### **How can providers help to improve Star Ratings?**

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Continue to talk to your patients and document interventions regarding topics such as: fall prevention; bladder control; and the importance of physical activity.
- Create office practices to identify non-compliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members.
- Review member listing of gaps in care. This listing is available on our secure portal.
- Identify opportunities for you or your office to have an impact.

### **Healthcare Effectiveness Data and Information Set (HEDIS)**

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. CMS uses HEDIS rates to evaluate the effectiveness of a managed care plan's ability to demonstrate an improvement in preventive health outreach to its members.

### **HEDIS Rate Calculations**

HEDIS rates are calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include annual mammogram, Body Mass Index Assessment, cholesterol management, colorectal cancer screenings, use of disease modifying anti-rheumatic drugs for members with rheumatoid arthritis, osteoporosis screening for female members having suffered a fracture, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-9 (ICD-10 effective October 1, 2015) and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review include: diabetic HbA1c and LDL lab results, eye exams and nephropathy, and controlling high-blood pressure.

### **Who conducts Medical Record Reviews (MRR) for HEDIS?**

ATC may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. Prompt cooperation with the MRR process is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with ATC that allows them to collect PHI on our behalf.

### **How can Providers improve their HEDIS scores?**

- *Understand the specifications* established for each HEDIS measure.
- *Submit claims and encounter data for each and every service rendered.* All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with ATC claims and encounter data is the most efficient way to report HEDIS.
- *Submit claims and encounter data correctly, accurately, and on time.* If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- *Ensure chart documentation reflects all services provided.* Keep accurate chart/medical record documentation of each member service and document conversation/services.
- *Submit claims and encounter data using CPT codes related to HEDIS measures* such as diabetes, eye exam, and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the QI department at 1-855-735-4398.

### **Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey**

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well the plan is meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability. CAHPS survey material that may reflect on the service of providers includes:

- Whether the member received an annual flu vaccine;
- Whether members perceive they are getting needed care including specialist and prescriptions;



- How quickly members were able to get appointments and care.

### **Medicare Health Outcomes Survey (HOS)**

The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather data to help target quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; and helping Medicare beneficiaries make informed health care choices. ATC must participate in the Medicare HOS. Medicare HOS questions that may reflect on the service of providers includes:

- Whether the member perceives their physical or mental health is maintained or improving;
- Whether the member has seen their physician and discussed starting, increasing, or maintaining their level of physical activity;
- If provider has discussed fall risks and bladder control with the member.

## **NETWORK PARTICIPATION**

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The enrollment, credentialing and re-credentialing processes exist to ensure that participating providers meet and remain compliant to the criteria established by ATC, as well as government regulations and standards of accrediting bodies. **Failure of an applicant to provide adequate information to meet all criteria may result in termination of the application process.**

**Notice:** In order to maintain a current provider profile, providers are required to notify ATC of any relevant changes to their credentialing information in a timely manner.

Providers must submit at a minimum the following information when applying for participation with ATC:

- Complete signed and dated ATC Standardized Credentialing Form or Council for Affordable Quality Health Care (CAQH) Provider Data Form, the application must include the following:
  - Signed attestation of the correctness and completeness of the application,
  - History of loss of license or clinical privileges
  - Disciplinary actions or felony convictions, lack of current illegal substance or alcohol abuse, mental and physical competence
  - Ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name
- Copy of current State Controlled Substance certificate (if applicable);
- Copy of current Drug Enforcement Administration (DEA) Registration Certificate for South Carolina and in the state where care is being provided
- Copy of W-9

- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted Medical License to practice in the state of South Carolina (applicable to Organizational Providers)
- Evidence of specialty/board certification, if applicable
- If practitioner is not Board Certified, proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Willingness to submit to a site visit evaluation (applicable to Primary Care Providers and OB/GYNs)
- Copy of Clinical Laboratory Improvement Amendments (CLIA) (if applicable)
- Ability to demonstrate enumeration by National Plan and Provider Enumeration System (NPES), depicting the provider's unique National Provider Identifier (NPI)
- Copy of current written protocol and name of supervising physician is required for all Nurse Practitioners
- Disclosure of Ownership and Financial Interest Statement, version 1514

ATC will review for the following information:

- Current, unrestricted state license to practice, if license is required to practice
- Education and training or board certification
- Reports of malpractice settlements via the National Practitioner Data Bank (NPDB)
- Current DEA Registration
- Hospital privileges in good standing at a participating ATC hospital
- Gaps of six (6) months or greater within the past five (5) years of work history
- Medicare/Medicaid-specific exclusions or determination if disbarment, suspension or other exclusion from participation in federal procurement activities via Office of Inspector General (OIG), System of Award Management (SAM), and SC Excluded Providers List (SC EPLS)
- Potential fraudulent activity by ensuring provider is not listed on the Social Security Administration's Death Master File
- Proof of professional liability coverage in an amount accepted by ATC
- Proof of collaborative agreement, protocols or other written authorization with a licensed physician

Providers must be credentialed and contracted prior to accepting or treating members. PCP's cannot accept member assignments until they are fully credentialed and have an executed contract.

All PCP and OB/GYN offices will be required to pass the Site Visit Evaluation with a score of 80% or higher. Locations that do not meet the standard will receive a letter from the Vice President (VP) of Contracting and Network Management within ten (10) days advising of the required corrections and a sixty (60) day timeframe to accomplish needed modifications. During that time, credentialing of the practitioners for those offices will be placed on hold until a passing score is achieved.

Once the application is completed, the ATC Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting. Recredentialing is performed at least every three (3) years.

# REPORTING

ATC is required to maintain a health information system that collects, analyzes and integrates all data necessary to aggregate, evaluate and report certain statistical data related to cost, utilization, quality and other data requested by CMS. As an ATC provider, you are required to submit all data necessary to fulfill these requirements in a timely manner. You are required to certify, in writing, that the data submission to ATC is complete, accurate, and truthful. This includes all data, including encounter data, medical records, or other information required by CMS.

**Physician/Provider Profiling** - As part of its incentive strategies, ATC will systematically profile the quality of care delivered by high-volume PCPs to improve provider compliance with clinical practice guidelines and clinical performance indicators. The profiling system is developed with ATC network physicians and providers to ensure the process has value to physicians, providers, members and ATC.

ATC's QI Committee will work with network providers to build useful, understandable and relevant analyses and reporting tools to improve care and compliance with clinical practice guidelines. This collaborative effort helps to establish the foundation for physician and provider acceptance of results leading to continuous QI activities that yield performance improvements.

Profiles will include a multidimensional assessment of a PCP's performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to the target population. Additional assessment, at ATC's discretion may include such elements as availability of extended office hours, member complaint rates, and compliance with medical record standards.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by ATC in publications such as newsletters, bulletins, press releases, and recognition in ATC Provider Directories.

Interventions will be implemented to address practitioners performance that is out of range (outliers) from their peers, and such interventions may include, but are not limited to, provider education, sharing of best practices or documentation tools, assistance with barrier analysis, development of corrective action plans, ongoing medical record reviews, and potential termination of network status when recommended improvements are not made. Providers identified as significantly outside the norm will be re-measured.

# MEMBER INFORMATION

## MEMBER ELIGIBILITY

The dual eligible demonstration will be available to individuals who meet the following criteria:

- Enrolled in Medicare Part A and B and are receiving full Medicaid benefits
- Age 65+
- Not in an institution (at time of enrollment)
- Not enrolled in a PACE program (Program of All-Inclusive Care for the Elderly)
- Non-Department of Disabilities Special Needs (Non- DDSPN) waiver
- Not a patient in Hospice

You should always verify member eligibility prior to delivering services. It is very important to ask the member for a copy of the health plan ID card and some other form of identification, such as a driver's license or photo ID.

ATC's card replaces the member's original red, white, and blue Medicare card and their Medicaid Fee for Service (FFS) ID card. See below sample ATC member ID card.

## Member Identification Card



Eligibility may be verified in three ways:

1. The Secure Portal found at [www.absolutetotalcare.com](http://www.absolutetotalcare.com)
  - If you are already a registered user of the Portal, you do not need a separate registration.
  - If you are not currently a registered user, registration is a quick process. There is a video on our registration page which will walk you through the process should you experience any difficulties.
2. 24/7 Interactive Voice Response System: 1-855-735-4398.
3. Provider Services at 1-855-735-4398.

## MEMBER BENEFITS

ATC will cover all current/traditional Medicare FFS benefits (including primary and acute care, Part D, and skilled nursing facility services) and current Medicaid FFS (including nursing facilities and behavioral health services and home and community based waiver services) subject to eligibility verification, medical necessity determination and prior authorization requirements. The table below represents the covered benefits offered. This table may not be all-inclusive. Should you have questions regarding benefits, you may call Provider Services at 1-855-735-4398.

### Services Offered Under Healthy Connections Prime

|  |  |   |   |
|--|--|---|---|
| Inpatient Hospital Services                                  | Ambulance Services   | Family Planning Services                                  | <u>New Benefit</u>  |
| Inpatient Psychiatric Facility Services                      | Transportation Services <sup>1</sup>                                     | Home and Community Based Waiver Services                  | Palliative Care:  |
| Skilled Nursing Facility Services                            | Durable Medical Equipment  | Targeted Case Management (TCM)                            | An interdisciplinary practice aimed at improving the quality of life of beneficiaries and their families with advanced illness or life-threatening injury. This benefit provides interventions early in the course of illness to assist with symptom management or advance care planning. It uses of an interdisciplinary team approach to address the comprehensive needs of residents and families. |
| Cardiac and Pulmonary Rehab Services                         | Diabetic supplies and Services and Diabetic Therapeutic Shoes or Inserts | Outpatient Mental Health Services                         |   |
| Emergency Care   | End-Stage Renal Disease services <sup>2</sup>                            | Telemedicine  |   |
| Urgently Needed Care   | Nursing Home Transition Services   | Preventive Services & Other Defined Supplemental Services |   |
| Partial Hospitalization                                      | Over-the-Counter Items   | Medicare-covered Zero Cost-Sharing Preventive Services    |   |
| Home Health Benefits   | Meal Benefits <sup>3</sup>   | Annual Physical Exam                                      |   |
| Primary Care Physician Services                              | Behavioral Health Services   | Supplemental Education/Health Management Programs         |   |
| Chiropractic Services  | Institution for Mental Disease Services                                  | Supplemental Education/Wellness Programs                  |   |
| Occupational Therapy   | Federally Qualified Health Centers                                       | Kidney Disease Education Services                         |   |
| Physician Specialist Services excluding Psychiatric Services | Outpatient Diagnostic Procedures and Tests and Lab Services              | Diabetes Self-Management Training                         |   |
| Mental Health Specialty Services                             | Outpatient Hospital Services   | Medicare Part B Rx Drugs and Home Infusion Drugs          |   |
| Podiatry   | Ambulatory Surgical Center Services                                      | Eye Exams   |   |
| Other Health Care Professional Services                      | Outpatient Substance Abuse Services                                      | Eye Wear  |   |
| Psychiatric Services   | Outpatient Blood Services  | Hearing Exams   |   |
| Physical Therapy and Speech-Language Pathology Services      | Infusion Centers   |   |   |

In addition to the table above, ATC also offers the following value added benefits:

- Hearing: Free hearing test per year and up to \$750 for a hearing aid every year
- Over-the-Counter Supplies: Certain over-the-counter and personal wellness items shipped free to the member's home from our mail order pharmacy
- Health Club Membership: Up to \$250 reimbursement per year for a health club membership fee

## **MEMBER ORIENTATION**

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Once the enrollment application is processed, each new member will receive a letter from South Carolina Healthy Connections Medicaid stating the effective date of coverage and a packet of information about our program.

The following documents are provided to the new members:

- ID card
- Welcome Letter
- A comprehensive integrated formulary
- Information about how to access or receive the pharmacy/provider directory
- Summary of Benefits (SB)
- Member Handbook (Evidence of Coverage - EOC)

Members are encouraged to select a health plan contracted PCP. For all members in case management, a case management team will work with the member's PCP or facility personnel to address the needs of the member, coordinate needed healthcare and services and ensure the member accesses their preferred health service benefits.

Members receive various pieces of information through mailings and face-to-face contact. Many of these materials are printed in English and Spanish. These materials include but are not limited to:

- NurseWise Information (our 24/7 Nurse Advice Line)
- Emergency Room Information

Providers interested in receiving these materials may contact the Provider Services Department at 1-855-735-4398.

## **ENROLLMENT PROCESS**

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All enrollment and disenrollment related transactions, including enrollments from one CICO to a different CICO, will be processed by Maximus. Eligibility and enrollment is determined by the State or its enrollment broker/vendor based on CMS and South Carolina Healthy Connections Medicaid qualifying criteria.

## **VOLUNTARY DISENROLLMENT**

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A member may terminate their participation with ATC. Disenrollment from CICOs and enrollment from one CICO to a different CICO shall be allowed on a month-to-month basis any time during the year; however, coverage will continue through the end of the month.

**Note: It is very important to verify member's eligibility prior to rendering services.**

## **MEMBER RIGHTS AND RESPONSIBILITIES**

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Members are informed of their rights and responsibilities through the Member Handbook. ATC providers are also expected to respect and honor member's rights and to post the Members Rights and Responsibilities in their offices.

ATC members have certain right and protections designed to:

- Protect you when you get health care
- Make sure you get the health care services that the law says you can get
- Protect you against unethical practices
- Protect your privacy
- Be treated with dignity and respect at all times
- Be protected from discrimination. Every company or agency that works with Medicare must obey the law, and can't treat you differently because of your race, color, national origin, disability, age, religion, or sex
- Have your personal and health information kept private
- Get information in a way you understand from Medicare, health care providers, and, under certain circumstances, contractors
- Get understandable information about Medicare to help you make health care decisions, including:
  - What's covered
  - What Medicare pays
  - How much you have to pay
  - What to do if you want to file a complaint or appeal
- Have your questions about Medicare answered
- Have access to doctors, specialists, and hospitals
- Learn about your treatment choices in clear language that you can understand, and participate in treatment decisions
- Get health care services in a language you understand and in a culturally-sensitive way
- Get emergency care when and where you need it
- Get a decision about health care payment, coverage of services, or prescription drug coverage
  - When a claim is filed, you get a notice from Medicare, South Carolina Healthy Connections Medicaid or ATC letting you know what it will and won't cover.
  - If you disagree with the decision of your claim, you have the right to file an appeal.
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.
  - If you disagree with a decision about your claims or services, you have the right to appeal.
- File complaints (sometimes called "grievances"), including complaints about the quality of your care



## **MEMBER PRESCRIPTION DRUG PLAN RIGHTS**

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A member has the following rights related to the Prescription Drug coverage.

- To request a coverage determination or appeal to resolve differences with the plan.
- To file a complaint (called a “grievance”) with the plan.
- To have the privacy of health and prescription drug information protected.
  - Medications
  - Other Needs that form the basis of Our Integrated, Holistic Care Plan

Member engagement is critical to our Model – please help us:

- Explain benefits, provide health education, including how to access care (ex. appropriate Emergency Room utilization)
- Participate in community events and establish partnerships with local community agencies, churches, and high volume provider offices to promote healthy living and preventive care
- Identify and engage high-risk consumers
- Facilitate communication across medical, behavioral health, and long-term service and support specialties

Our approach with our Model of Care has been to:

- Focus on early identification
- Facilitate communication and coordination of services across medical and behavioral health specialties
- Identify and engage high-risk consumers
- Identify barriers to adherence with current treatment plans and goals
- Coordinate with consumer, their support system, and physicians to customize a plan of care
- Design a Care Coordination Team that has access to local community resources and supports such as shelter/housing, clothing, and utilities assistance

ATC strives to work with the provider community to ensure members’ individual needs are met leveraging our care coordination approach. To reach our Medical Management Team for additional information on our MOC, please contact: 1-855-735-4398.

## **MEMBER APPEALS**

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An appeal is a request for review of an adverse action. An appeal may be requested by a member, member representative or their physician. Appeals can be initiated verbally, but before being acted on, ATC must receive written documentation that includes the reason for the appeal and the evidence that explains why the member needs the service. If a member representative or doctor is acting on behalf of the member, written consent is required.

Appeal information can be mailed or faxed. See contact information below.

If the service is again denied, the denial decision will have the written instructions regarding additional appeals rights such as requesting a State Fair Hearing and how the member may exercise their additional appeal rights.

**Part C – Medical**

- *Standard appeal*– pre-service, decision within 14 calendar days; post-service, within 30 calendar days
- *Expedited appeal*– 72 hours

**Part D – Drug**

- *Standard appeal*–decision within 7 calendar days
- *Expedited appeal*– 72 hours

**Send Member Medicare Service (Part C) appeals to:**

Absolute Total Care  
Medicare Grievance & Appeals  
7700 Forsyth Blvd  
Clayton, MO 63105

Phone: 1-855-735-4398

Fax: 1-844 273 2671

**Send Member Medicaid Service appeals to:**

Absolute Total Care  
Medicaid Grievance & Appeals  
1441 Main Street, Suite 900  
Columbia, SC 29201

Phone: 1-866-433-6041

Fax: 1-866-918-4457

**Send Member Part D (Medication appeals) to:**

Absolute Total Care  
Medicare Grievance & Appeals  
7700 Forsyth Blvd  
Clayton, MO 63105

Phone: 1-855-735-4398

Fax: 1-844-273-2673

## **MEMBER COMPLAINTS**

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A complaint is a grievance or dispute, other than one that constitutes an organization determination (prior authorization determination), where the member is expressing dissatisfaction with the manner in which a health plan or delegated entity provides health care services.

A complaint may be requested by a member or the member's authorized representative within 60 days of the issue with the health plan or the provider.

A complaint is either called in, mailed or faxed. See below contact information. We will review the complaint and work with the member to identify a mutually beneficial outcome.

**Standard complaint** – Most complaints are answered in 5 business days. If we need more information and the delay is in the member's best interest, or if you ask for more time, we can take up to 14 more calendar days to answer a complaint.

**Fast complaint** – within 24 hours

**Telephonic Grievances:**

Call 1-855-735-4398 from 8 a.m. to 8 p.m., seven days a week. TTY users call 711.

**Written Grievances:**

Absolute Total Care  
1441 Main Street, Suite 900  
Columbia, SC 29201

Fax: 1-866-918-4457

# PROVIDER RESPONSIBILITIES

## PROVIDER RESPONSIBILITIES

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Providers must comply with each of the items listed below.

1. To help or advocate for members to make decisions within their scope of practice about their relevant or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered
  - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
2. To treat members with fairness, dignity, and respect
3. To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy or hospitalization, the expectation for frequent or high cost care
4. To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to State and Federal laws and regulations regarding confidentiality
5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service
6. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
7. To allow members to request restriction on the use and disclosure of their personal health information
8. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
9. To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process
10. To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
11. To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
12. To respect members' advance directives and include these documents in the their medical record
13. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions
14. To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately
15. To follow all state and federal laws and regulations related to patient care and rights
16. To participate in ATC data collection initiatives, such as HEDIS and other contractual or regulatory programs
17. To review clinical practice guidelines distributed by ATC

18. To comply with the ATC Medical Management program as outlined herein
19. To disclose overpayments or improper payments to ATC
20. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
21. To obtain and report to ATC information regarding other insurance coverage the member has or may have
22. To give ATC timely, written notice if provider is leaving/closing a practice
23. To contact ATC to verify member eligibility and benefits, if appropriate
24. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
25. To provide members with information regarding office location, hours of operation, accessibility, and translation services
26. To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
27. To provide hours of operation to ATC members which are no less than those offered to other Medicare patients

## **APPOINTMENT AVAILABILITY**

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The following standards are established regarding appointment availability:

- **A full-time practice** is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.
- **Routine appointments and physicals** should be available within 30 days of the request.
- **Primary care urgent appointments (non-life threatening)** should be available within one week of the request.
- **Urgent care** should be available within 24 hours.
- **Urgent Specialty care** should be available within 24 hours of referral.
- **Referrals to Specialist** should be made within 4 weeks of the request.
- **Emergency care** should be received immediately and 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 care—appointment for sick visit** should be available within 72 hours of the request.
- **Prenatal care** patients should be seen within the following timeframes:
  1. Three (3) weeks of a positive pregnancy test (home or laboratory)
  2. Three (3) weeks of identification of high-risk
  3. Seven (7) days of request in first and second trimester
  4. Three (3) days of first request in third trimester
- **Behavioral healthcare** must be provided immediately for emergency services, within 24 hours of the request for urgent care, and within ten (10) days of the request for routine care.

## TELEPHONE ARRANGEMENTS

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Providers are required to develop and use telephone protocol for all of the following situations:

- Answering member telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally deficient.
- Response time for telephone call-back waiting times:
  - after hours telephone care for non-emergent, symptomatic issues within 30 to 45 minutes;
  - same day for non-symptomatic concerns;
  - crisis situations within 15 minutes;
- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other method, and transferred to the patient's medical record.

*Note: If after hours urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care or emergency center to notify the facility.*

ATC will monitor appointment and after-hours availability on an on-going basis through its QI Program.

# CULTURAL COMPETENCY

ATC views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community, within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender or ethnic groups and accommodating the patient's culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices that are important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

ATC is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate 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.

As part of ATC's Cultural Competency Program, providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them;
- Medical care is provided with consideration of the member's primary language, race or ethnicity as it relates to the member's health or illness;
- Office staff routinely interacting with members has been given the opportunity to participate in, and have participated in, cultural competency training;
- Office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each member. Staff will also explain race categories to a member in order assist the member in accurately identifying their race or ethnicity;
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on health care;
- Office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area; and
- An appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act (ADA) including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

## **AMERICANS WITH DISABILITIES ACT (DISABILITY AWARENESS)**

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ATC strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504 which requires that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and
- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services

The term "disability" means, with respect to an individual -

- (a) A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- (b) A record of such an impairment; or
- (c) Being regarded as having such impairment

If an individual meets any one of these three tests, he or she is considered to be an individual with a disability for purposes of coverage under the ADA.

### General Requirements

§ 35.130 General prohibitions against discrimination include:

- (a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
- (b)

- (1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability:
  - (i) Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;
  - (ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
  - (iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;
  - (iv) Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;
  - (v) Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;
  - (vi) Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;
  - (vii) Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.
- (2) A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.
- (3) A public entity may not, directly or through contractual or other arrangements, use criteria or methods of administration:



- (i) That has the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;
  - (ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
  - (iii) That perpetuates the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.
- (4) A public entity may not, in determining the site or location of a facility, make selections:
  - (i) That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
  - (ii) That has the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- (5) A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.
- (6) A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- (7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- (8) A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
- (c) Nothing in this part prohibits a public entity from providing benefits or services, to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
- (d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
- (e)
  - (1) Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.
  - (2) Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
- (f) A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.
- (g) A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

## **LONG TERM SERVICES AND SUPPORTS (LTSS)**

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Long Term Services and Supports (LTSS) are a means to provide medical and non-medical services to seniors and people with disabilities in need of sustained assistance. These services aid individuals with activities of daily living. Activities of daily living include eating, grooming, and dressing, toileting, bathing and transferring. These services are covered benefits when authorized under the Medicare-Medicaid product. More information regarding these services is included in the Medical Management section of this Manual.

# PRIOR AUTHORIZATION

ATC's Medical Management Department is available seven days a week from 8a.m. to 8.p.m. however, NurseWise, our 24/7 Nurse Advise line provides 24/7 coverage.

The preferred method for submitting authorizations is through the Secure Web Portal at [www.absolutetotalcare.com](http://www.absolutetotalcare.com). The provider must be a registered user on the Secure Web Portal. (If a provider is already registered for the Secure Web Portal for one of our other products, no further registration is required. If the provider is not already a registered user on the Secure Web Portal and needs assistance or training on submitting prior authorizations, the provider should contact his or her dedicated Provider Relations Specialist.

Other methods of submitting the prior authorization requests are as follows:

- Call the Medical Management Department at 1-855-735-4398. Our 24/7 Nurse Advice line can assist with authorizations after normal business hours.
- Fax prior authorization requests utilizing the Prior Authorization fax forms posted on our website. Our fax number is 1-844-503-8866. Please note: faxes will not be monitored after hours and will be responded on the next business day. Please contact our 24/7 Nurse Advice Line at 1-855-735-4398 for after hour urgent admissions or inpatient notifications or requests.

## Medical Necessity:

Medically Necessary services are generally accepted medical practices provided in light of conditions present at the time of treatment. These services are:

- Essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a member;
- Are provided at an appropriate facility and at the appropriate level of care for the treatment of member's medical condition; and
- Are provided in accordance with generally accepted standards of medical practice.

The following criteria used to determine medical necessity includes but is not limited to:

|                                 |   |
|---------------------------------|---|
| Medical Services                | InterQual <sup>®</sup> Adult Guidelines   |
| Behavioral Health Services      | InterQual <sup>®</sup> Adult Guidelines   |
| High Tech Imaging               | Internally developed criteria by National Imaging Associates (NIA). Criteria developed by representatives in the disciplines of radiology, internal medicine, nursing and cardiology. |
| Substance Use Disorder Services | Based upon the American Society for Addiction Medicine (ASAM) Patient Placement Criteria. The criteria are available at <a href="http://www.asam.org">www.asam.org</a>                |

There must be no other effective and more conservative or substantially less costly treatment, service and setting available. In keeping with CMS and South Carolina Healthy Connections Medicaid policies and procedures, ATC shall not cover experimental, investigational or cosmetic procedures.

Information necessary for authorization may include but is not limited to:

- Member's name and ID number;
- Physician's name and telephone number;
- Hospital name, if the request is for an inpatient admission or outpatient services;
- Reason for admission – primary and secondary diagnoses, surgical procedures, surgery date;
- Relevant clinical information – past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed;
- Admission date or proposed surgery date, if the request is for an inpatient admission;
- Requested length of stay, if the request is for an inpatient admission;
- Discharge plans, if the request is for an inpatient admission;

If more information is required, the RN or LPN will notify the caller of the specific information needed to complete the authorization process.

ATC affirms that Utilization Management decision making is based only on appropriateness of care and service and the existence of coverage. ATC does not specifically reward practitioners or other individuals for issuing denials of coverage or care.

Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

## **MODEL OF CARE**

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The MOC defines the management, procedures and operational systems that provide access, coordination and structure needed to provide services and care to our members.

### **Purpose**

To improve quality, reduce costs, and improve the member experience:

- Ensure members have full access to the services they are entitled
- Improve the coordination between the federal government and state requirements
- Develop innovative care coordination and integration models
- Eliminate financial misalignments that lead to poor quality and cost shifting

MOC Elements include:

- Description of the Special Needs Provider (SNP) Population
- Care Coordination
- SNP Network
- Quality Measurements and Performance Improvement

MOC Process:

- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.

- The HRA collects information about the member's medical, psychosocial, cognitive, and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate case management program for follow up.

## **INDIVIDUALIZED CARE PLAN**

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An Individualized Care Plan (ICP) is developed with input from all parties involved in the member's care. The ICP includes:

- Goals and Objectives
- Specific services and benefits to be provided
- Measureable Outcomes

Members receive monitoring, service referrals, and condition specific education. Case Managers and PCPs work closely together with the member and their family to prepare, implement and evaluate the ICP. ATC disseminates evidence-based clinical guidelines and conducts studies to:

- Measure member outcomes
- Monitor quality of care
- Evaluate the effectiveness of the MOC

## **INTERDISCIPLINARY CARE TEAM (ICT)**

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The Case Managers will coordinate the member's care with the Interdisciplinary Care Team (ICT). The ICT includes the health plan, member and caregiver, external practitioners, and vendors involved in the plan for the member's care which all are dependent on who the member chooses to attend.

- Inpatient Care: Case Managers will coordinate with facilities to assist members with the appropriate level of care and develop an appropriate discharge plan. ATC will then notify the PCP of the transition of care and anticipated discharge date to ensure members receive the appropriate follow-up care.
- Transition of Care: Managing transition of care for discharged members may include but is not limited to face to face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan.
- Provider ICT Responsibilities: Provider responsibilities include accepting ICT meeting invitations on members when possible, maintain copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record, and collaborating with our Case Managers, ICT, and members or caregivers.
- ICT Training: All internal and external ICT members will be trained annually on the current MOC.

## **How to identify Long Term Services and Supports (LTSS)**

LTSS are covered services in the Medicare-Medicaid product. Services include eating, grooming, dressing, toileting, bathing, transferring, meal planning and preparation, managing finances, shopping for food or other essential items, performing essential household chores, communicating by phone or by other media, as well as participating in the community. Members may qualify for these services through an eligibility assessment conducted by South Carolina Healthy Connections Medicaid or its designee. Additionally, upon enrollment with ATC, members will complete a HRA. This HRA will be provided to the member's PCP. Should you identify members who are not currently receiving LTSS services and may benefit from these services, please contact ATC Case Management at 1-855-735-4398.

## **How to identify Behavioral Health Needs**

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Common behavioral health needs include but are not limited to depression, anxiety, and alcohol and/or drug abuse. PCPs will be provided the member's HRA to assist with identifying behavioral health needs. Should you identify members who are not currently receiving behavioral health services and may benefit from these services, please contact ATC case management at 1-855-735-4398.

The Table below reflects services that require prior authorization. This is not an all-inclusive list. For a complete list of prior authorization requirements, please visit our website at [www.absolutetotalcare.com](http://www.absolutetotalcare.com).

| Service  | Description   |
|--|---|
| <b>All out of network practitioners and providers rendering service to dually eligible members are required to obtain a prior authorization before rendering services.</b> |   |
| Ambulance  | <ul style="list-style-type: none"> <li>• Fixed-wing aircraft</li> <li>• Non-emergent</li> </ul>   |
| Behavioral Health Services includes Substance Use Disorder   | <ul style="list-style-type: none"> <li>• Inpatient Psychiatric</li> <li>• Partial hospitalization</li> <li>• Intensive Outpatient Therapy</li> <li>• Psychological Testing</li> <li>• Neuropsychological Testing</li> <li>• Electroconvulsive Therapy (ECT)</li> <li>• Substance Use Disorder Treatment/Rehabilitation</li> </ul>   |
| Cosmetic Procedures  | Includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. (Medicare Definition)   |
| Durable Medical Equipment (DME)  | Includes <u>but not limited to</u> : <ul style="list-style-type: none"> <li>• Custom Wheelchairs</li> <li>• Power Wheelchairs</li> <li>• Hearing aids</li> <li>• BIPAP</li> <li>• CPAP</li> <li>• Hospital Bed/Mattress</li> <li>• Lift Devices including Hoyer</li> <li>• Infusion Pumps</li> <li>• Oxygen</li> <li>• TENS Units</li> <li>• Ventilators</li> <li>• Wound Vacuum (Negative Pressure) Devices</li> <li>• Bone growth stimulator</li> <li>• Vagus nerve stimulator</li> </ul> <b>To determine if other DME codes require prior authorization, please refer to:</b><br><a href="http://www.absolutetotalcare.com/for-providers/pre-auth-needed/">http://www.absolutetotalcare.com/for-providers/pre-auth-needed/</a> |
| Experimental/Investigational Services/Clinical Trial   | Any item or service potentially considered investigational, experimental or as part of a clinical trial must be authorized in advance.  |
| Genetic Counseling and Testing   | Genetic testing is a type of medical test that identifies changes in chromosomes, genes, or proteins. Prior Authorization required.   |
| Home Health Services   | <ul style="list-style-type: none"> <li>• Home IV Infusion</li> <li>• Occupational Therapy</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> <li>• Skilled Nursing Visits</li> <li>• Social Work Visits</li> <li>• Home Health Aide</li> </ul>  |
| Hospice  | Home or Inpatient   |
| Infertility  | Includes the following: <ul style="list-style-type: none"> <li>• Drug Therapy</li> <li>• Testing</li> <li>• Treatment</li> </ul>  |
| Inpatient Admission: Elective or Scheduled   | <ul style="list-style-type: none"> <li>• Acute Inpatient Hospital</li> <li>• Inpatient Rehabilitation Hospital</li> <li>• Long Term Acute Care Hospital (LTAC)</li> <li>• Skilled Nursing Facility (SNF)</li> </ul>   |

| Service   | Description  |
|---|--|
| Orthotics/Prosthetics   | <p><b>To determine if Orthotic/Prosthetic codes require prior authorization, please refer to:</b><br/> <a href="http://www.absolutetotalcare.com/for-providers/pre-auth-needed/">http://www.absolutetotalcare.com/for-providers/pre-auth-needed/</a></p>   |
| Observation Stay  | Prior Authorization required   |
| Outpatient therapy performed at free standing facility or outpatient hospital | <ul style="list-style-type: none"> <li>• Occupational Therapy (OT)</li> <li>• Physical Therapy (PT)</li> <li>• Speech-Language Therapy (ST)</li> </ul>   |
| Pain Management   | <ul style="list-style-type: none"> <li>• Facet Injections</li> <li>• Trigger Point Injections</li> <li>• Epidural Injections</li> <li>• Median Branch Block</li> <li>• Radio Frequency Ablation</li> <li>• Authorization required, unless being performed as part of a surgery</li> </ul>  |
| Medicare Part B Drugs   | Please see Medicare Part B Prior Authorization List  |
| Radiology: Visit <a href="http://www.radmd.com">www.radmd.com</a>             | <ul style="list-style-type: none"> <li>• MRI</li> <li>• PET</li> <li>• CT</li> </ul>   |
| Sleep Studies   | <ul style="list-style-type: none"> <li>• Diagnostic and Treatment (including surgery)</li> </ul>   |
| Surgeries, regardless of place of service                                     | <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Bariatric Surgery</li> <li>• Blepharoplasty</li> <li>• Breast Augmentation (except following mastectomy)</li> <li>• Breast Reduction</li> <li>• Cochlear Implant</li> <li>• Diagnostic Left Heart Catheter</li> <li>• Excision of Lesion</li> <li>• Facial Osteotomy</li> <li>• Hysterectomy</li> <li>• Joint replacements</li> <li>• Mastectomy for Gynecomastia</li> <li>• Oral Surgery – Temporomandibular Joint Surgery</li> <li>• Otoplasty</li> <li>• Reconstructive and Plastic Surgery</li> <li>• Rhinoplasty</li> <li>• Sacral Nerve Neuromodulation</li> <li>• Scar Revision</li> <li>• Septoplasty</li> <li>• Spinal surgeries including fusion, stabilization, discectomy</li> <li>• Uvulopalatopharyngoplasty/Uvulopharyngoplasty</li> <li>• Veins (ablation, ligation, stripping, sclerotherapy)</li> </ul> |
| Transplants   | All transplant evaluations and procedures, including but not limited to evaluation, transplant consult visits, HLA typing, donor search, and transplant procedure.   |



# PHARMACY

The covered pharmacy services for ATC members vary based on the plan benefits. Information regarding the member's pharmacy coverage can be best found via our secure Provider Portal. Additional resources available on the website include the ATC Preferred Drug List (PDL), the Argus (Pharmacy Benefit Manager) Provider Manual and Medication Request/Exception Request forms.

The ATC PDL is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The PDL provides instruction on the following:

- Which drugs are covered, including restrictions and limitations;
- The Pharmacy Management Program requirements and procedures;
- An explanation of limits and quotas;
- How prescribing providers can make an exception request; and
- How ATC conducts generic substitution, therapeutic interchange and step-therapy.

The ATC PDL does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the professional judgment of the physician or pharmacist; and
- Relieve the physician or pharmacist of any obligation to the member.

The ATC PDL will be approved initially by the ATC Pharmacy and Therapeutics Committee (P&T), led by the Pharmacist and Medical Director, with support from community based primary care providers and specialists. Once established, the PDL will be maintained by the P&T Committee, using quarterly meetings, to ensure that ATC members receive the most appropriate medications. The ATC PDL contains those medications that the P&T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the PDL Change Request policy can be used as a method to address the request. The ATC P&T Committee will review the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the PDL are available on our website, [www.absolutetotalcare.com](http://www.absolutetotalcare.com). Providers may also call Provider Services for a hard copy of the PDL.

The majority of prescriptions will be covered based on the Medicare formulary. In addition, ATC will assist with the following:

- Transitions of prescription drugs
- Out Of Network Coverage
- Quality Assurance
- Utilization Management (Prior Authorization Requirements)
- Exceptions and Appeals
- Locate a pharmacy near you
- Information about any formulary changes
- Specialty Pharmacy

## TRANSITION POLICY

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Under certain circumstances ATC can offer a temporary supply of a drug if the drug is not on the formulary or is restricted in some way. To be eligible for a temporary supply, members must meet the requirements below:

1. The drug the member has been taking is no longer on the ATC formulary or — the drug is now restricted in some way
2. The member must be in one of the situations described below:

- **Are new to the plan and do not live in a long-term care facility:**

We will cover a temporary supply of the drug during the first **180 days** of membership in the plan. This temporary supply will be for up to a 30-day supply for Part D drugs and a 90-day supply for Non-Part D drugs. If the prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of the number of days allowed.

*Prescriptions must be filled at a network pharmacy.*

- **Are new to the plan and live in a long-term care facility:**

We will cover a temporary supply of the drug during the first **180 days** of membership in the plan. The total supply will be for up to a 91- to 98-day supply for Part D drugs and a 90-day supply for non-Part D drugs. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of the number of days allowed. *(Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)*

- **A member has been in the plan for more than 90 days and live in a long-term care facility and need a supply right away:**

We will cover one 31-day supply, or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply. Throughout the plan year, a member may have a change in treatment setting because of the type of level of care that is required. Such transitions may include, but are not limited to:

1. Members who are discharged from a hospital or skilled-nursing facility to a home setting.
2. Members who are admitted to a hospital or skilled-nursing facility from a home setting.
3. Members who transfer from one skilled-nursing facility to another and are served by a different pharmacy.
4. Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit.
5. Members who give up Hospice Status and go back to standard Medicare Part A and B coverage.
6. Members discharged from chronic psychiatric hospitals with highly individualized drug regimes.

For these changes in treatment settings, ATC will cover as much as a 31-day temporary supply of a Part D-covered drug when you fill your prescription at a pharmacy. If a member has changed treatment settings multiple times within the same month, an exception or prior authorization can be requested for approval for continued coverage of the drug. We will review these requests for continuation of therapy on a case-by-case basis when the member is on a stabilized drug regimen that, if changed, is known to have risks.

## PRIOR AUTHORIZATION REQUIREMENTS

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ATC has a team of providers and pharmacists to create tools to help provide quality coverage to ATC members. The tools include, but are not limited to: prior authorization criteria, clinical edits and quantity limits. Some examples include:

- **Age Limits:** Some drugs require a prior authorization if the member's age does not meet the manufacturer, Food and Drug Administration (FDA), or clinical recommendations.
- **Quantity Limits:** For certain drugs, ATC limits the amount of the drug we will cover per prescription or for a defined period of time.
- **Prior Authorization:** ATC requires prior authorization for certain drugs. (Prior Authorization may be required for drugs that are on the formulary or drugs that are not on the formulary and were approved for coverage through our exceptions process.) This means that approval will be required before prescription can be filled. If approval is not obtained, ATC may not cover the drug.
- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the generic version, unless the brand name drug was requested. If the brand name drug is approved, the member may be responsible for higher co-pay or the difference in cost between the brand and generic medications.

Prior Authorization may be requested by calling us at 1-855-735-4398 or completing the prior authorization fax form found on our website at [www.absolutetotalcare.com](http://www.absolutetotalcare.com).

# BILLING GUIDELINES

## GENERAL BILLING GUIDELINES

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Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with ATC for payment of covered services.

It is important that providers ensure ATC has accurate billing information on file. Please confirm with your Provider Relations Department that the following information is current in our files:

- **Provider Name** (as noted on his/her current W-9 form)
- **Provider National Provider Identifier (NPI)**
- Physical location address (as noted on current W-9 form)
- Billing name and address (if different)
- **Tax Identification Number (TIN)**

Providers must bill with their NPI number in box 24J. ATC will return or reject claims when billing information does not match the information that is currently in our files. **Claims missing the above requirements in bold will be returned, with a** notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be entered into the system.

We recommend that providers notify ATC in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's TIN or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member's contract on the date of service
- Referral and prior authorization processes were followed

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

## TIMELY FILING

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Providers must submit all claims and encounters within 120 days from the date of service, unless ATC or its vendors created the error.

ATC must comply with state and federal requirements mandating provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR 434.6(a)12 (2011, as amended) and 42 CFR 447.26 (2011, as amended).

**All requests for reconsideration or adjustments to processed claims must be received within 120 calendar days from the date of service.**

**Failure to obtain authorization**

Providers may NOT bill members for services when the provider fails to obtain an authorization and the claim is denied.

**No Balance Billing**

Providers may not seek payment from members for the difference between the billed charges and the contracted rate paid.

## **IMAGING REQUIREMENTS FOR PAPER CLAIMS**

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ATC uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

**Do's**

- **Do** use the correct PO Box number
- **Do** submit all claims in a 9" x 12", or larger envelope
- **Do** type all fields completely and correctly
- **Do** use black or blue ink only
- **Do** submit on a proper and current form . . . CMS 1500 or UB 04

**Don'ts**

- **Don't** submit handwritten claim forms
- **Don't** use red ink on claim forms
- **Don't** circle any data on claim forms
- **Don't** add extraneous information to any claim form field
- **Don't** use highlighter on any claim form field
- **Don't** submit photocopied claim forms (Black and White)
- **Don't** submit carbon copied claim forms
- **Don't** submit claim forms via fax

## **CLAIMS FILING INSTRUCTIONS**

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Network providers are encouraged to participate in ATC's Electronic Claims/Encounter Filing Program. The plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

Submit electronic claims using the following EDI numbers:

EDI PAYER NUMBER: 68069

For EDI assistance contact:

Absolute Total Care  
C/o Centene EDI Department  
1-800-225-2573, extension 25525  
or by e-mail at:  
[EDIBA@centene.com](mailto:EDIBA@centene.com)

You are required to follow HIPAA 5010 format for claim submissions. ATC's timely filing is within 365 days from the date of service.

Monitor your error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. You are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Submit Paper claims to: Absolute Total Care

Medicare Claims  
PO Box 3060

Farmington, MO 63640

## **COORDINATION OF BENEFITS FOR MEDICARE AND MEDICAID**

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Claims for ATC members will be automatically "crossed-over". You will receive one remit (EOP/ERA) and payment (check/ERA) for the Medicare claim adjudication. The Medicare EOP will show EX 30 (alpha) to indicate the claim will be "crossed over" to process for the Medicaid benefits. Once "crossed-over" you will receive one remit (EOP/ERA) and payment for the Medicaid claim adjudication. Members will receive one EOB showing both Medicare and Medicaid payments.

## **BALANCE BILLING**

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Balance billing, also sometimes referred to as "extra billing" is the practice of healthcare providers billing its patients for the difference between the health insurance's reimbursement rate and the provider's billed amount.

Members enrolled in the Medicare-Medicaid product are protected from the practice of balance billing due to CMS' **prohibiting balance billing** to all of its Qualified Medicare Beneficiaries.

All Medicare physicians, providers, and suppliers who offer services and supplies to members must be aware that they may **not bill members** for Medicare cost-sharing programs.

This article was revised on August 28, 2012, to clarify the section of the Social Security Act that prohibits Medicare providers from balance billing members for Medicare cost-sharing programs including those enrolled in the Medicare-Medicaid product.

Balance billing a member for a covered service is not permitted under any circumstances. This includes deductible, coinsurance, and copayments, known as "balance billing." Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing members for Medicare cost-sharing.

Members have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. You are subject to sanctions if you inappropriately bill a *member*.

## **RISK ADJUSTMENT AND CORRECT CODING**

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Risk adjustment is a critical and a requirement defined in CFR42 (Section 42 of the Code of Federal Regulations) and the Medicare Modernization Act, that will help ensure the long-term success of the program. Accurate calculation of risk adjustment requires accuracy, documentation completeness, and specificity in diagnostic coding. Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-9 CM, CPT, DSM-IV, and HCPCs code sets. Services rendered after October 1, 2015 are required, per CMS, to be billed using ICD-10 and DSM-V coding guidelines. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity, when applicable and defensible through chart audits and medical assessments;
- Code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care, treatment, or management;
- Ensure that medical record documentation is clear, concise, consistent, complete and legible and meets CMS signature guidelines (each encounter must stand alone);
- Submit claims and encounter information according to the requirements specified in your contract or this provider manual
- Alert us of any erroneous data submitted and follow our policies to correct errors as set forth in your contract or this provider manual
- Provide ongoing training to your staff regarding appropriate use of ICD coding for reporting diagnoses.

## **HOME AND COMMUNITY BASED SERVICES (HCBS)**

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ATC is responsible for payment to the HCBS providers within 7 days of submitted services. South Carolina Healthy Connections Medicaid will continue to authorize these services using the Phoenix and Call Care systems. All disputes concerning services authorized and payments for services are handled by SCDHHS. Please contact SCDHHS for assistance.

Contact ATC for any questions related to the status of your payment.

# COMPLIANCE

ATC's Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program.

ATC is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

ATC's provider network must cooperate fully in making personnel or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations, at ATC's or the subcontractor's own expense.

## **FIRST TIER AND DOWNSTREAM PROVIDERS**

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Through written agreement, we may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 438.230 to First-Tier, downstream, and delegated entities. These functions and responsibilities include but are not limited to contract administration and management, claims submission, claims payment, credentialing and re-credentialing, network management, and provider training. We oversee and are accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities' performance is inadequate. We will ensure written agreements which specify these responsibilities by us and the delegated entity are clear and concise. Agreements will be kept on file for reference.

## **FRAUD, WASTE AND ABUSE (FWA)**

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ATC takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a fraud, waste and abuse (FWA) program that complies with the federal and state laws. ATC, in conjunction with its parent company, Centene, operates a fraud, waste and abuse unit. ATC routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. The Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud. These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity;
- More stringent utilization review;
- Recoupment of previously paid monies;
- Termination of provider agreement or other contractual arrangement;
- Civil and/or criminal prosecution; and
- Any other remedies available to rectify

Some of the most common fraud, waste and abuse practices include:

- Unbundling of codes;
- Up-coding services;
- Add-on codes billed without primary CPT;
- Diagnosis and/or procedure code not consistent with the member's age/gender;
- Use of exclusion codes;
- Excessive use of units;
- Misuse of benefits; and
- Claims for services not rendered.



If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential fraud, waste and abuse hotline at 1-866-685-8664. ATC takes all reports of potential fraud, waste and abuse very seriously and investigates all reported issues.

OIG/GSA Exclusion –As a provider in our network, the plans expectation is that you will check the exclusion list as outlined below for all your staff, volunteers, temporary employees, consultants, Board of Directors, and any contractors that would meet the requirements as outlined in The Act §1862(e)(1)(B), 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 1001.1901

### **Providers' implementation of fraud, waste and abuse safeguards to identify excluded providers and entities**

Medicare payment may not be made for items or services furnished or prescribed by an excluded provider or entity. Plans shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee or FDR excluded by the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) or the General Services Administration (GSA). ATC will review the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties List (EPLS) prior to hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or First Tier, Downstream or Related entities (FDR), and monthly thereafter.

If anyone is identified, providers are required to notify ATC immediately so that if needed ATC can take appropriate action. Providers may contact the ATC Compliance officer at 1-855-735-4398.

### **FWA Program Compliance Authority and Responsibility**

The ATC Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. ATC is committed to identifying, investigating, sanctioning and prosecuting suspected fraud, waste and abuse. The ATC provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

### **False Claims Act**

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government. The Act prohibits:

1. knowingly presenting, or causing to be presented a false claim for payment or approval
2. knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim
3. conspiring to commit any violation of the False Claims Act
4. falsely certifying the type or amount of property to be used by the Government
5. certifying receipt of property on a document without completely knowing that the information is true
6. knowingly buying Government property from an unauthorized officer of the Government
7. knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government

For more information regarding the False Claims act, please visit [www.cms.hhs.gov](http://www.cms.hhs.gov)

## **SOUTH CAROLINA OMNIBUS ADULT PROTECTION ACT**

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The Omnibus Adult Protection Act is the statute in South Carolina that provides for the protection of vulnerable adults from abuse, neglect and exploitation. The Act is found in Title 43, Chapter 35 of the South Carolina Code of Laws. Persons age eighteen or older who meet the definition of a vulnerable adult under the statute are protected from abuse, neglect or exploitation. Vulnerable adults can live in private homes, in the community or in facilities.

If suspected abuse, neglect or exploitation of a vulnerable adult occurs in a facility, reports of your suspicions should be made to the State Long Term Care Ombudsman at 1-800-868-9095. Reports of incidents in facilities operated by or contracted for operation by the South Carolina Department of Mental Health or South Carolina Department of Disabilities and Special Needs must be reported to SLED at 1-866-200-6066.

If suspected activity occurs in a private home or in the community, report your suspicions to your local county Department of Social Services or to the State Department of Social Services at 1-803-898-7601. Reports can be made to local law enforcement for any location.

## **MEDICARE REGULATORY REQUIREMENTS**

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As a Medicare contracted provider, you are required to follow Medicare regulations and CMS requirements. Some of these requirements are found in your provider agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- You may not discriminate against Medicare members in any way based on health status.
- You must ensure that members have adequate access to covered health services.
- You may not impose cost sharing on members for influenza vaccination or pneumococcal vaccination.
- You must allow members to directly access screening mammography and influenza vaccinations.
- You must provide female members with direct access to women's health specialists for routine and preventative healthcare.
- You must comply with the plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- ATC will provide you with at least 60 days written notice of termination if electing to terminate our agreement without cause, or as described in your participation agreement if greater than 60 days. You agree to notify the health plan according to the terms outlined in your provider agreement.
- You will ensure that your hours of operations are convenient to the member and do not discriminate against the member for any reason. You will insure necessary services are available to members 24 hours per day, 7 days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Medicare members without CMS approval of the materials or forms.
- Services must be provided to members in a culturally competent manner, including members with limited reading skills, limited English proficiency, hearing or vision impairments and diverse cultural and ethnic backgrounds.
- You will work with plan procedures to inform our members of healthcare needs that require follow up and provide necessary training in self-care.

- You will document in a prominent part of the member's medical record, whether the member has executed an advance directive.
- You must provide services in a manner consistent with professionally recognized standards of care.
- You must cooperate with ATC to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make an informed choice about their Medicare coverage.
- You must cooperate with the health plan in notifying members of provider contract terminations
- You must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- You must comply with any plan medical policies, QI programs and medical management procedures.
- You will cooperate with the ATC in disclosing quality and performance indicators to CMS.
- You must cooperate with the ATC's procedures for handling grievance appeals, and expedited appeals.
- You must fully disclose to all members before providing a service, if you feel the service may not be covered by the plan. The member must sign an agreement of this understanding. If they do not, the claim may be denied and the provider will be liable of the cost of the service.

# CENPATICO BEHAVIORAL HEALTH

## **BEHAVIORAL HEALTH PROVIDERS**

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### **Coordination of Behavioral Health Services**

ATC partners with our Behavioral Health affiliate, Cenpatico, to deliver Mental Health and Substance Use Disorder services to our members. For information regarding Behavioral Health Services, locating providers, or for assistance in coordinating services for the member, please contact ATC's Integrated Medical Management department at 1-855-735-4398.

### **Behavioral Health Services Accessibility**

To ensure members have access to care, providers are required to comply with the following appointment standards:

- Emergent Care – immediately (24 hours per day, 7 days per week)
- Urgent Care - within 24 hours
- Non-urgent care – within 2 weeks
- Post Discharge Follow Up - within 5 days
- Office Wait Times - not to exceed 1 hour

### **Continuity of Care Coordination**

When members are newly enrolled and have been previously receiving Behavioral Health Services, Cenpatico will make best efforts to maximize the transition of members' care through providing for the transfer of pending prior authorization information for at least 180 days; and work with the member's provider to honor those existing prior authorizations.

### **Coordination and Communication between Behavioral Health Providers and PCP**

ATC encourages PCPs to consult with their members' Behavioral Health (Mental Health and/or Substance Use Disorder) provider(s). In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required. We encourage all service Providers to coordinate care with a member's entire treatment team, including but not limited to PCPs and the Behavioral Health Provider. Additionally, ATC and Cenpatico will offer trainings to PCPs and Behavioral Health Providers focused on the concepts of integrated care, cross training in medical, behavioral and substance use disorders, and screening tools.

Network Providers should communicate and coordinate with the member's PCP and with any other Behavioral Health Providers whenever there is a Behavioral Health problem or treatment plan that can affect the member's medical condition or the treatment being rendered to the member. Examples of some of the items to be communicated include:

- Prescription medication.
- Results of health risk screenings.
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect Medical or Behavioral Health treatment.
- The member is receiving treatment for a Behavioral Health diagnosis that can be misdiagnosed as a physical disorder (such as Panic Disorder being confused with Mitral Valve Prolapse).
- The member's progress toward meeting the goals established in their treatment plan.

A form to be used in communicating with the PCP and other Behavioral Health Providers is located on our websites at [www.absolutetotalcare.com](http://www.absolutetotalcare.com) and [www.cenpatico.com](http://www.cenpatico.com). Network Providers can identify the name and contact information for a member's PCP by performing an eligibility inquiry on the ATC Provider Secured Portal or by contacting their Provider Services helpline at 1-855-735-4398. Network Providers should screen for the existence of Co-Occurring Behavioral Health and Substance Use Disorders and make appropriate referrals. Network Providers should refer members with known or suspected untreated physical health problems or disorders to their PCP for examination and treatment. Cenpatico will also offer provider training on screening tools that can be used to identify possible Behavioral Health and Substance Use Disorders. Resources and training will include referral processes for Providers to assist members in accessing support through Cenpatico.

Cenpatico requires that Network Providers report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the Network Provider's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner.

**The following information should be included in the report to the PCP:**

- A copy or summary of the intake assessment.
- Written notification of member's noncompliance with treatment plan (if applicable).
- Member's completion of treatment.
- The results of an initial Psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order.
- The results of functional assessments.

**Prior Authorization Requirements:**

All Non-Participating providers require authorization for all services, including traditional outpatient therapy services. The following services require prior authorization from Cenpatico for Participating providers:

|   |   |
|---|---|
| <p>Behavioral Health Services includes Substance Use Disorder (Department of Alcohol and Other Drug Abuse Services – DAODAS) Services</p> | <ul style="list-style-type: none"> <li>• Inpatient Psychiatric</li> <li>• Detoxification</li> <li>• Residential Treatment Programs (SUD Only)</li> <li>• Partial Hospitalization Program (PHP)</li> <li>• Intensive Outpatient Therapy (IOP)</li> <li>• Psychological Testing</li> <li>• Neuropsychological Testing</li> <li>• Electroconvulsive Therapy (ECT)</li> <li>• Alcohol and/or Drug Treatments</li> <li>• Day Treatment</li> <li>• Vivitrol Injections</li> </ul> |
| <p>Community Support Services: Behavioral Health</p>  | <ul style="list-style-type: none"> <li>• Peer Support Service</li> <li>• Behavior Modification</li> <li>• Family Support</li> <li>• Case Management</li> <li>• Psychosocial Rehabilitation</li> </ul>   |

Participating Network Providers are not required to obtain authorization for specific outpatient therapy services. For a comprehensive listing of covered Behavioral Health and Substance Use Disorder billing codes, including authorization requirements, please refer to the Covered Services and Authorization Guidelines section of the Cenpatico Provider Manual.

