2nd Quarter Provider Webinar
June 2020

Housekeeping

- Please mute your phone.
- Please do not put this call on hold-we can hear your hold music.
- **Please hold all questions until the end of the presentation.**

Disclaimer

- Arkansas Total Care has produced this material as an informational reference for providers furnishing services in our contract network and Arkansas Total Care employees, agents and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material.
- The presentation is a general summary that explains certain aspects of the program, but is not a legal document.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the program is constantly changing, and it is the responsibility of each provider to remain abreast of the program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice.
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Agenda

- Introductions
- Provider Updates
- Waiver Services Updates
- Prior Authorization
- Claim Reminders/Updates
- Secure Provider Portal Reminders/Updates
- Envolve Vision
- Important Reminders and Tips
- Contact Information

Where to Find Us

FOR MEMBERS | FOR PROVIDERS | CONTACT US

FOR PROVIDERS

- Provider News
- QI Program
- Provider Relations
- Login
- Become a Provider
- Pharmacy
- Provider Webinars
- Provider Resources
- Grievance and Appeals
- Coronavirus Information for Providers
- Provider Financial Support & Resources

Provider Relations

Arkansas Total Care Provider Relations Associate Territories

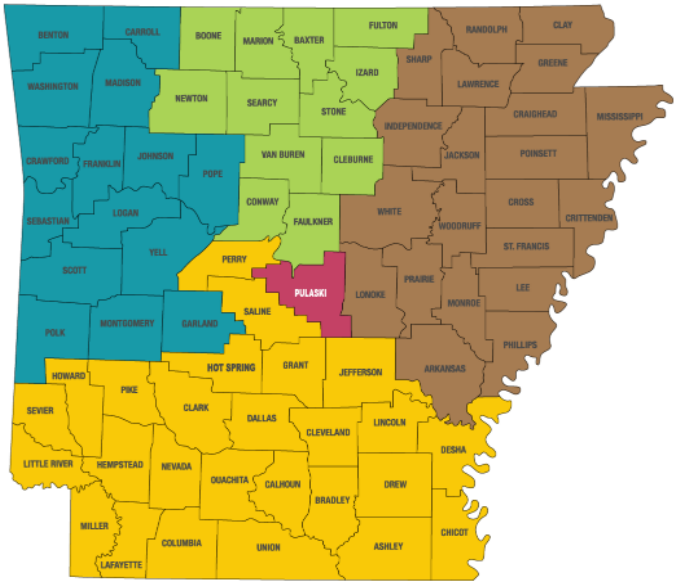

Christopher Ishmael


Kari Murphy


Meghan Hunt


Patrice Eackles


Valinda Perkins



4/20/2020

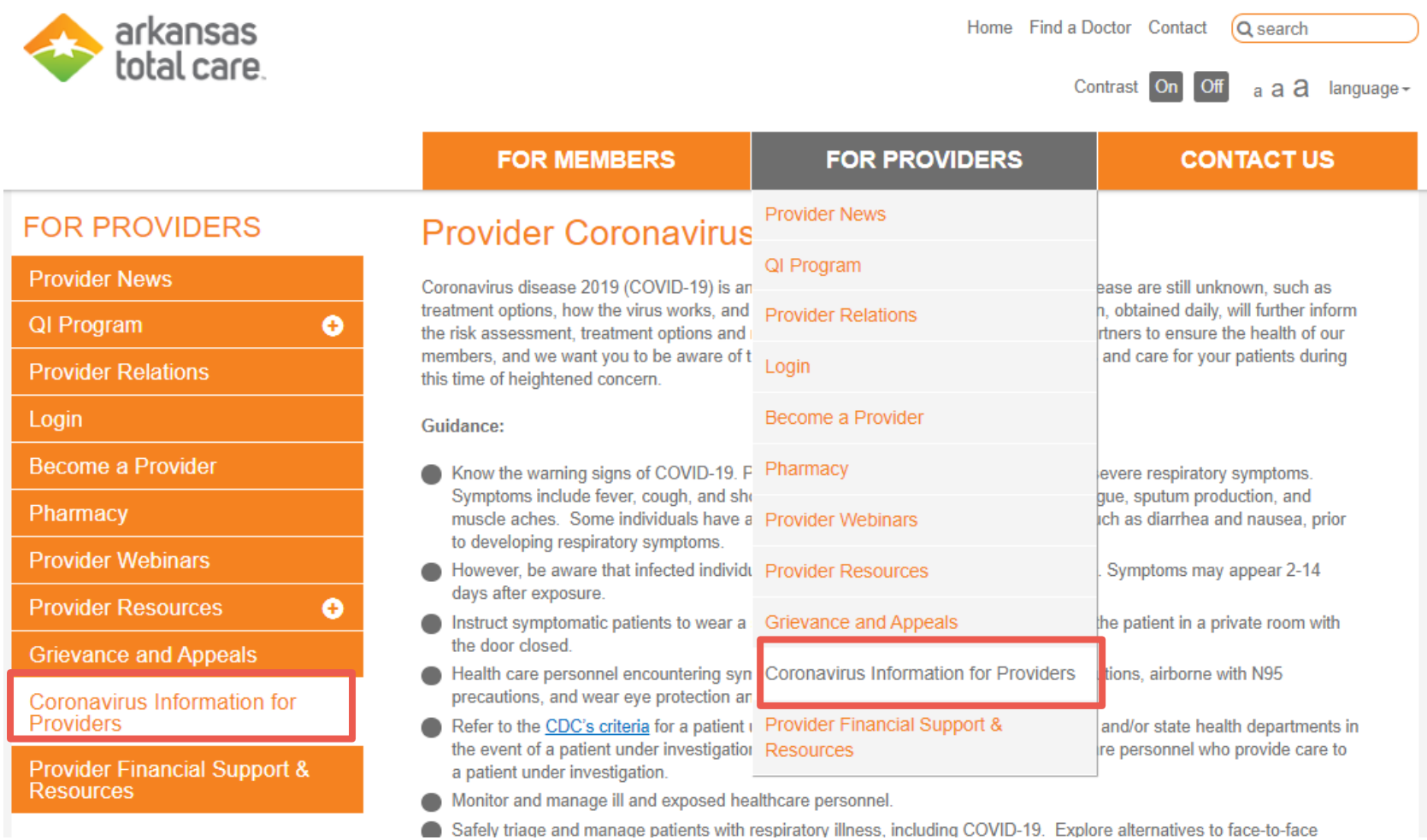
- *CHRISTOPHER ISHMAEL*
- *KARI MURPHY*
- *MEGHAN HUNT*
- *PATRICE EACKLES*
- *VALINDA PERKINS*

Provider Updates

LexisNexis Risk Solutions

- We are proud to introduce our contracted clinicians to VerifyHCP®, a quick and easy clinician directory verification portal developed by LexisNexis® Risk Solutions. To make attestation more efficient for you and your staff, VerifyHCP enables practices to validate or update pre-populated directory information in one place across all participating health plans.
- Updated practice information allows us to provide patients with current directory information so they can select in-network providers, choose health plans, and ultimately access care. Our goal is to make this process as easy as possible for clinicians and their practices and to receive 100% response to outreach requests. Clinicians who do not respond to verification requests may face delayed claim reimbursements and removal from directories.
- Several outreach methods will be used including email, fax, and phone, with email being the primary method. Clinicians and practices will be directed to register and log in to the Verify Health Care Portal to confirm their directory information on file is accurate. The Portal is a secure, free website for clinicians and their staff to use to confirm directory information, as required by CMS and various state laws.

COVID-19 Information & Updates



COVID-19 Information & Updates

- Supplement Support Services have been extended to June 30, 2020

- The following services may be utilized by all ARTC PASSE members, as follows:
  - **T2020 Modifier U1** – Telephonic service
    - Used to check on members to ensure their health, safety, medical and Behavioral Health needs are being met
    - Billed in 15 minute units and is limited to 6 units of service per week (1 ½ hours)
    - Rate for this service is $7.55 and no prior authorization requirement
  - **T2020 Modifier UB** – Face to Face Service
    - Used when the member needs to have a face to face interaction to check on health and safety or to deliver supplies (food, medicine, groceries etc.)
    - Billed in 15 minute units and is limited to 12 units of service per week (3 hours)
    - Rate for this service is $15.10 and no prior authorization requirement
  - **T2020 U1 - Location 02**
  - **T2020 UB - Location 12, 14 or 99**
    - Emergency adjustments for one-on-one or shared staffing
      - CES Waiver Emergency Request Form (PDF)

Waiver Services Updates

Waiver Rate Conversion

- Providers are transitioning to a new payment method which will occur in phases:
  - June 1st, July 1st, August 1st
  - Notification emails sent to providers explaining transition date and documentation needs
- A Conversion Tool and individual consultations are available as needed:
  - Providers are to follow instructions in the email received to request assistance or submit questions to Provides@ArkansasTotalcare.com.
- Codes, modifiers, and rates will be included with the email and are currently available under the Provider Resources Tab at www.akansastotalcare.com.

Changing the Rate Method Only – Documents Needed

- If you are only changing the rate method, please provide only the documents listed below:
  - Updated budget sheet reflecting the most current proposed hours
  - Provide a current Treatment Plan/Goals and Objectives:
    - ✓ Treatment Plan/Goals and Objectives are a separate document from the Person-Centered Service Plan (PCSP)
    - ✓ A template, if needed, is available on the Arkansas Total Care (ARTC) website under the Provider Resources tab

Changing the Current Level of Care – Documents Needed

- If you are making any changes to the current level of care currently provided, please provide the documents listed below:
  - Updated budget sheet reflecting the most current proposed hours
  - Current Treatment Plan/Goals and Objectives:
    - ✓ The Treatment Plan/Goals and Objectives are a separate document from the PCSP
    - ✓ A template, if needed, is available on the ARTC website under the Provider Resources tab
  - Documentation of the last 3-12 months of all Supportive Living Progress notes remitted by all Direct Support Professional (DSP) staff
  - Completed treatment plan (goals & objectives) for the upcoming plan year
  - Provide hours and days of natural supports that are in place
  - Any additional information that could be used in a determination

ARTC Performance Base Incentive

ARTC Performance Based Incentive

- Performance Based Incentive Payment Program offers incentive payments to active Medicaid primary care providers
- This is in addition to your current Arkansas Total Care reimbursement rates
- This incentive program was developed to support your efforts in engaging with our members, and to reward you for your ongoing care of our members:
  - Active Medicaid primary care providers will receive a $3.00 per-member-per-month (PMPM) Primary Care Case Management payment
  - When you meet the 40% PCP annual visit threshold you can receive up to $3.75 per-member-per-month (PMPM)
  - This year Arkansas Total Care will consider your PCP annual visit threshold met
  - This will be evaluated annually each subsequent year

ARTC Performance Based Incentive – con't

- Primary Care Case Management payments will be paid monthly
- PCP attribution will be evaluated the 15th of each month, and paid at the end of each month
- You may check your monthly attribution utilizing our provider portal at www.arkansastotalcare.com – (**Coming Soon**)
- Additional opportunities to earn per-member-per-month (PMPM) quarterly payments, are available:
  - Each measure will be evaluated independently, based on performance when specific Healthcare Effectiveness Data Information Set (HEDIS)/Non-HEDIS targets are met
- If you have additional questions, please contact our contracting team at (844) 631-6830 or email us at arkansascontracting@centene.com

ARTC Performance Based Incentive (PCMH only)

Performance Based Incentive Payment (PBIP)					
Metric #	**Metric Name**	**Measured Service Description**	**Target**	**PMPM Amount**	**Payment Frequency**
HEDIS Measures					
1	**HbA1c**	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. (All payer source)	75%	$0.50	Quarterly
2	**Eye exam**	Percentage of diabetic beneficiaries 18-75 years of age who had an eye exam (retinal) performed.	73%	$0.50	Quarterly
Clinical					
3	**PCP Visits**	Percentage of a practice's beneficiaries who have been seen by any PCP within their practice one or more times during the measurement year.	40%	$0.75	Monthly (When 40% threshold is met)
Non-Clinical					
4	**Medication Management**	1. Define the practice's medication reconciliation process. For high priority beneficiaries, document updates to the active medication list in the EHR at least twice a year. Indicate if the medication list is updated on a timely basis from the last visit. 2. Practices are to document completion of the activity in the beneficiaries medical record, and ensure the proper evidence of such can be provided upon request.	100%	$1.50	Quarterly
5	**EMR Access**	Allow EMR access to obtain medical records.	100%	$1.50	Quarterly

Performance Based Incentive Payment (PBIP)					
Metric #	**Metric Name**	**Measured Service Description**	**Target**	**PMPM Amount**	**Payment Frequency**
Non-Clinical					
1	**Active Medicaid PCP**	Pays an active Medicaid provider a $3PMPM. When 40% PCP annual visit threshold is met PMPM increases $.75	N/A	$3.00	Monthly (Evaluated each year annually)

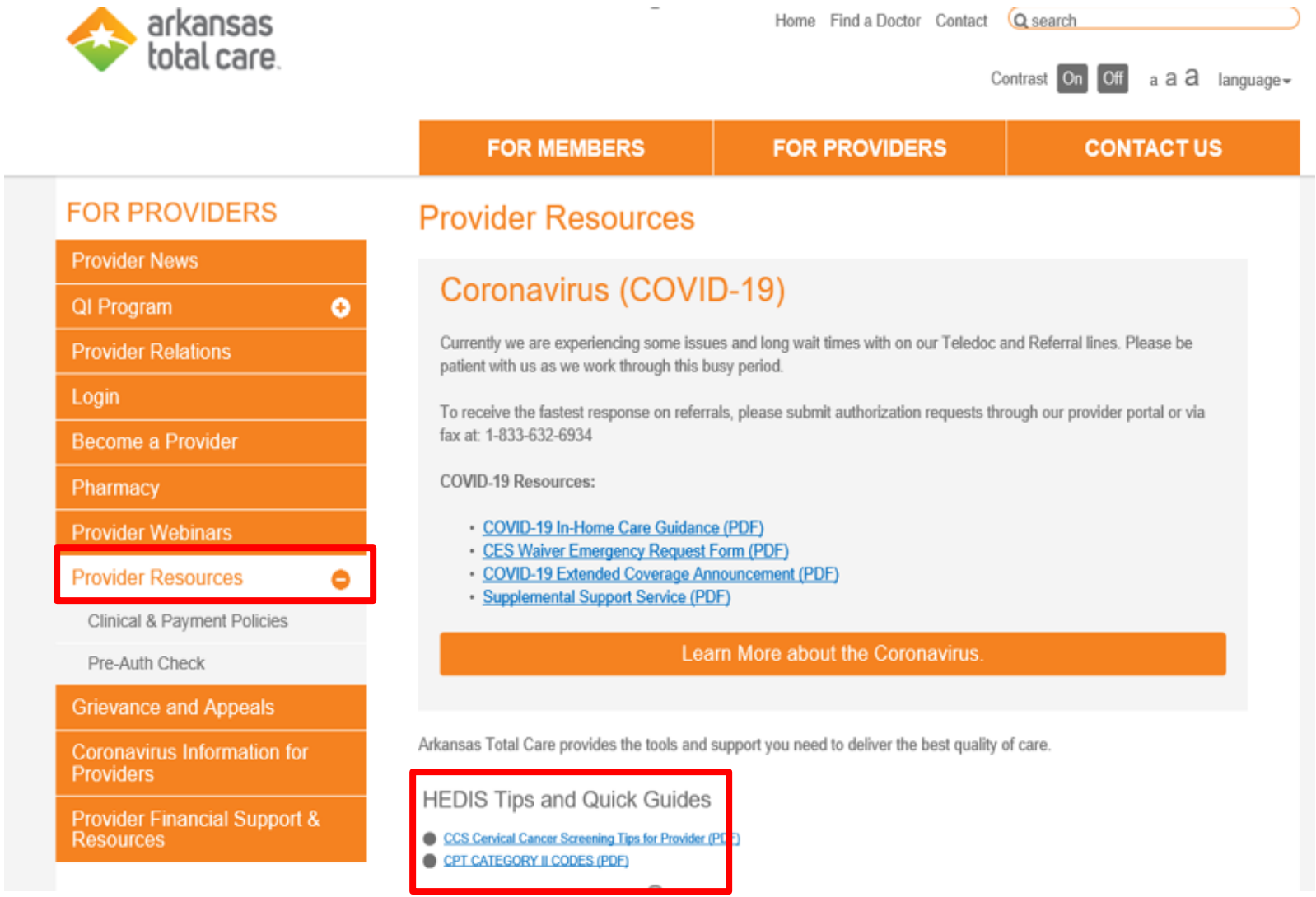
Healthcare Effectiveness Data and Information Set

HEDIS

- Healthcare
- Effectiveness
- Data and
- Information
- Set

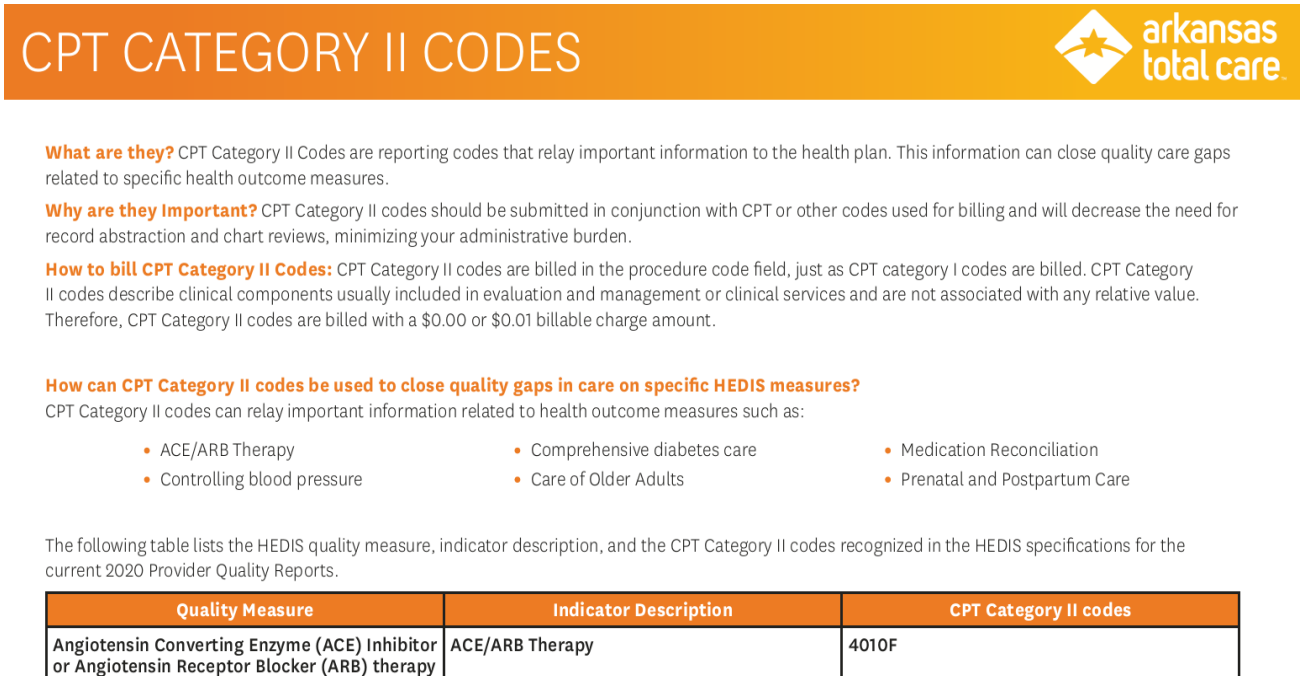
- A standard measurement tool created by the National Committee for Quality Assurance (NCQA)
- Measures quality performance and identifies areas in need of quality improvement
- Used by 90% of American health plans to measures performance on important dimensions of care and service
- HEDIS reporting is required for NCQA accreditation, CMS Medicare Advantage Programs, and used for Consumer Report health plan rankings
- Allows for measurement, standardized reporting and accurate, objective side-by-side comparison

HEDIS Tips and Quick Guides



HEDIS CPT Category II Codes Tip Sheet

- Utilizing CPT Category II codes and submitting in conjunction with CPT or other codes used for billing, will decrease the need for record abstraction and chart review.
- Visit the website at www.ArkansasTotalCare.com to view full copy of this tip sheet



CPT CATEGORY II CODES

What are they? CPT Category II Codes are reporting codes that relay important information to the health plan. This information can close quality care gaps related to specific health outcome measures.

Why are they Important? CPT Category II codes should be submitted in conjunction with CPT or other codes used for billing and will decrease the need for record abstraction and chart reviews, minimizing your administrative burden.

How to bill CPT Category II Codes: CPT Category II codes are billed in the procedure code field, just as CPT category I codes are billed. CPT Category II codes describe clinical components usually included in evaluation and management or clinical services and are not associated with any relative value. Therefore, CPT Category II codes are billed with a $0.00 or $0.01 billable charge amount.

How can CPT Category II codes be used to close quality gaps in care on specific HEDIS measures?
CPT Category II codes can relay important information related to health outcome measures such as:

- ACE/ARB Therapy
- Controlling blood pressure
- Comprehensive diabetes care
- Care of Older Adults
- Medication Reconciliation
- Prenatal and Postpartum Care

The following table lists the HEDIS quality measure, indicator description, and the CPT Category II codes recognized in the HEDIS specifications for the current 2020 Provider Quality Reports.

Quality Measure	Indicator Description	CPT Category II codes
Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy	ACE/ARB Therapy	4010F

HEDIS Team

Quality Fax: (800) 716-2380

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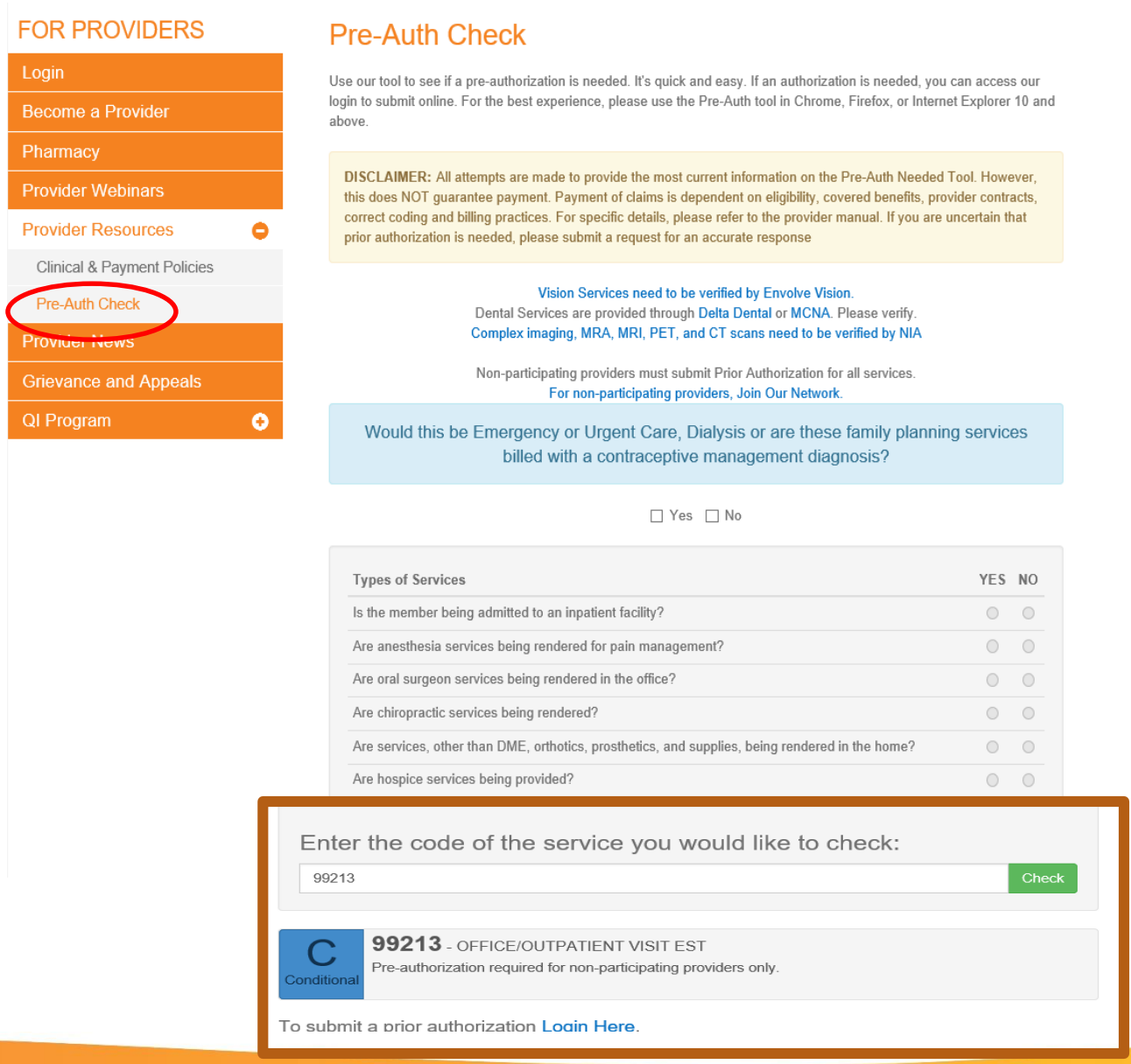
Prior Authorization

Prior Authorizations

- All services should be checked using our Pre-Auth Check Tool on the website to quickly determine if a service requires prior authorization
- Please visit www.arkansastotalcare.com under For Provider, Provider Resources tab, Pre-Auth Check
- To Submit: after you determine if a service requires an authorization, submit on of the following ways
  - Secure Web Portal: https://provider.arkansastotalcare.com
  - Phone: 1-866-282-6280 (TDD/TTY: 711)
    - ✓ After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advise line. Notification of authorization will be returned by phone, fax or web.
  - Fax: 1-833-249-2342

Pre-Auth Check Tool

- **It is the responsibility of each provider to confirm if a service requires a prior authorization.**
- Pre-Auth Check Tool – Utilize to determine if a service needs a Prior Authorization
- You will need to answer a few questions with the radio buttons before the box to enter your code will appear
- Once your code is entered, you will see a green N for no auth required, a red Y for auth required, or a blue C for conditional.



Behavioral Health Policies

- Most Behavioral Health (BH) codes require a Prior Authorization
- There are standard date spans authorized for different levels of care:
  - Intensive Outpatient (IOP) – services are typically authorized for 2-3 weeks at a time
  - Community-Based Services (CBS) – are typically authorized for 3 months at a time
- Prior Authorization requirements for all codes can be verified on our Pre-Auth Check Tool located at www.ArkansasTotalCare.com under Provider Resources

Behavioral Health Codes

- Codes described in the Initial Benefits Package either do not require Prior Authorizations or only require Authorization beyond the standard intensity (outlined below):

Code	Procedure	Benefits Allowed without Prior-Auth
90832, 90834, 90837, 90846, 90847, 90849, 90853, H2027	BHOP	No Prior Auth Required Unit = 1 Visit
90792	Psychiatric diagnostic evaluation with medical services (MH/SA)	1 unit/6 months; 2/rolling year Unit = 1 Visit
90791	Psychiatric diagnostic evaluation	1 unit/6 months; 2/rolling year Unit = 1 visit
90887	Interpretation or explanation of results of psychiatric, other medical examinations	1 unit/6 months; 2/rolling year Unit = 1 visit
H0001	Alcohol and/or drug assessment	1 unit/6 months; 2/rolling year Unit = 1 visit
90885	Treatment Plan	2 units/6 months; 4 units/year Unit = 30 minutes
H2011	Crisis intervention service, per 15 minutes	72 units/year Unit = 15 minutes
H0034	Medication training and support	No Prior Auth Required Unit = 1 Visit
99212, 99213, 99214	Office evaluation and management	No Prior Auth Required Unit = 1 Visit
96136, 96137, 97151, 97152, 97153, 97155, 97154, 97158, 97156	ABA Therapy	No Prior Auth Required Unit = 15 or 30 minutes

Physical Therapy, Occupational Therapy and Speech Therapy Authorization Guidelines

- No Prior Authorization required for PT/OT/ST services whether rehabilitative or habilitative services
  - Most members should receive no more than 90 minutes of services (PT/OT/ST) by discipline per week
  - Providers who appear to be outliers in performance against this standard are subject for review
  - Therapy benefits are covered based on medical necessity which should be documented in internal records
- ABA therapy is available to all members according to medical necessity and requires no prior authorization

- Arkansas Total Care launched an innovative Surgical Quality and Safety Management Program with TurningPoint Healthcare Solutions, LLC, which became effective 1/1/2020
- TurningPoint is responsible for processing prior authorizations requests for medical necessity and appropriate length of stay for Musculoskeletal Surgical procedures
- Physicians began submitting requests to TurningPoint for prior authorization on 12/1/19 for dates of service on or after 1/1/2020

MUSCULOSKELETAL

Orthopedic Surgical Procedures

Including all associated partial, total, and revision surgeries

- ✓ Knee Arthroplasty
- ✓ Unicompartmental/Bicompartmental Knee Replacement
- ✓ Hip Arthroplasty
- ✓ Shoulder Arthroplasty
- ✓ Elbow Arthroplasty
- ✓ Ankle Arthroplasty
- ✓ Wrist Arthroplasty
- ✓ Acromioplasty and Rotator Cuff Repair
- ✓ Anterior Cruciate Ligament Repair
- ✓ Knee Arthroscopy
- ✓ Hip Resurfacing
- ✓ Meniscal Repair
- ✓ Hip Arthroscopy
- ✓ Femoroacetabular Arthroscopy
- ✓ Ankle Fusion
- ✓ Shoulder Fusion
- ✓ Wrist Fusion
- ✓ Osteochondral Defect Repair

Spinal Surgical Procedures

Including all associated partial, total, and revision surgeries

- ✓ Spinal Fusion Surgeries
  - ✓ Cervical
  - ✓ Lumbar
  - ✓ Thoracic
  - ✓ Sacral
  - ✓ Scoliosis
- ✓ Disc Replacement
- ✓ Laminectomy/Discectomy
- ✓ Kyphoplasty/Vertebroplasty
- ✓ Sacroiliac Joint Fusion
- ✓ Implantable Pain Pumps
- ✓ Spinal Cord Neurostimulator
- ✓ Spinal Decompression

Clinical Categories:

- **Orthopedics**
- **Spine**

Clinical Coding:

- **Clinical coding is available by request by calling TurningPoint at 855-275-4500 or through your Provider Relations Specialist. Please note the coding is subject to regular updates/changes as CPT/HCPCS coding is added or deleted.**

Clinical policies and processes are easily accessible to providers via several access points

Authorization Submission:

- **Web:** https://myturningpoint-healthcare.com
- **Fax:** 501-588-0994
- **Phone:** 501-263-8850 | 866-619-7054

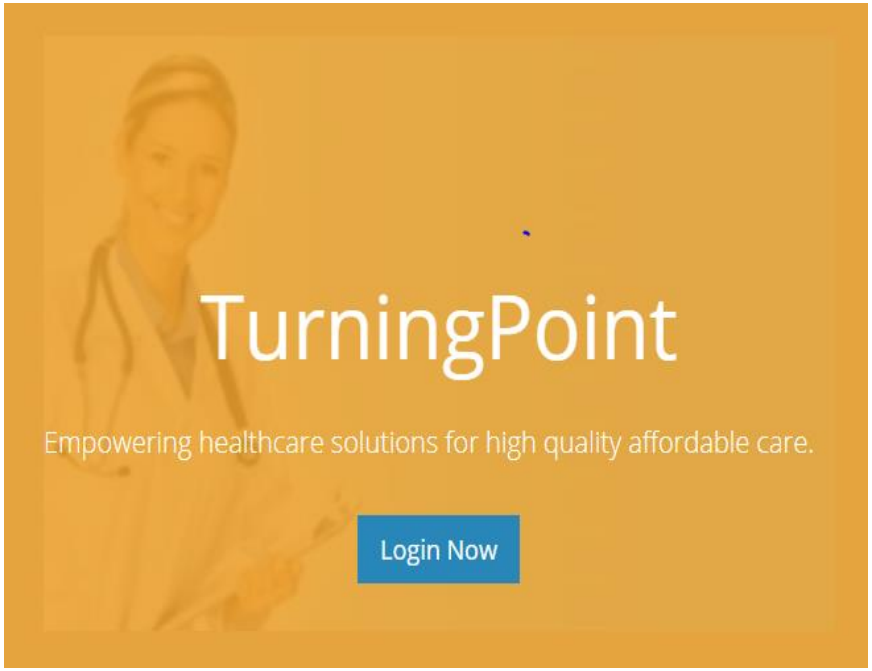
Provider Resources:

- Program PowerPoint presentation
- Frequently Asked Questions (FAQ) document
- TurningPoint Provider Manual
- Instructional Webinars
- TurningPoint medical professionals on-call 24 hours a day, 7 days a week

TurningPoint Provider Portal Access

- **Portal users must be registered before submitting requests**
- **All providers will receive a notification of staff registered for portal access**
- **Portal demonstrations can be set-up for your practice upon request**

NOTE: To become a registered user of TurningPoint's Web Portal, please contact their Provider Relations Team:
Phone: 866-422-0800
Email: *providersupport@turningpoint-healthcare.com*



Key Contact Information

Steve Morgan
Director, Provider Relations & Contracting
Ph: 321-888-3620
smorgan@tpshealth.com

Stacy Wolf
VP, Operations and Provider Relations
Ph: 805-896-7648
swolf@tpshealth.com

Robyn Schena
Provider Relations Representative
Ph: 407-278-2065
rschena@tpshealth.com

Provider Relations Support:
Ph: 1-866-422-0800
Email: Providersupport@turningpoint-healthcare.com

Hours of availability: Monday – Friday
8:00 AM – 5:00 PM

ARTC Appeals

- Retro authorization requests related to Medical and/or Waiver Services that requires authorizations may be submitted in the following ways:
  - Fax: 1-866-811-3255
  - Mail to:
    Arkansas Total Care
    Attn: Appeals
    P.O. Box 25010
    Little Rock, AR 72202

- Everything that is required when requesting an initial authorization is required when requesting a retro authorization with an addition to justification:
  - Justification as to why authorization was not obtained prior to rendering services
  - Requesting and Servicing Provider/Facility NPI
  - Contact Name/Number
  - Date(s)/ Date Span the provider/facility is requesting to have retro review.
  - DX Code(s)
  - CPT/HCPC code(s) and total number of visits/units
  - Inpatient/Outpatient Service Type (reference bottom of Authorization Request Form)

- You can find the Inpatient and Outpatient Authorization Forms on the website at www.ArkansasTotalCare.com

ARTC Pharmacy Appeals

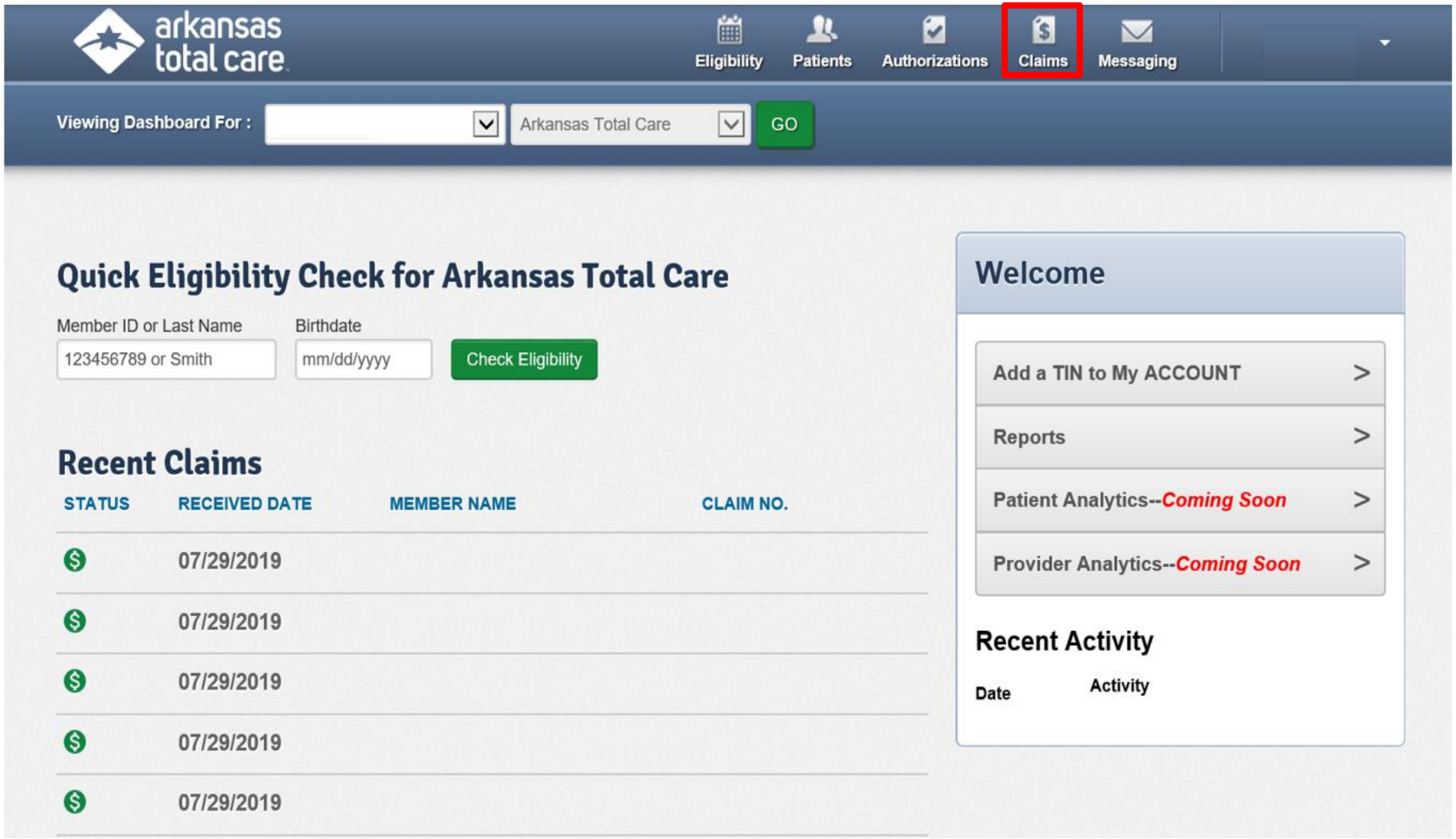
- Pharmacy appeals (if physician is providing additional supporting documentation as a reconsideration) is to be sent to Envolve Pharmacy
  - Mail to:

    Envolve People Care
    12515-8 Research Blvd., Suite 400
    Austin, TX 78759
    Fax 1-866-714-7991

- For assistance, please contact Provider Services at 866-282-6280

Claim Reminders/Updates

Secure Provider Portal Claim Submission – Preferred Method



Electronic Clearinghouse Claim Submission

- If a provider uses EDI software but is not setup with a clearinghouse, they must bill ARTC via paper claims or through our website until the provider has established a relationship with a clearinghouse listed on our website
- ARTC EDI Payor ID 68069

- EDI Help desk: 1-800-225-2573, ext. 6075525 or EDIBA@CENTENE.COM
- Acceptance of COB
- 24/7 Submission
- 24/7 Status

For a complete listing of approved EDI clearinghouse partners, please refer to www.ArkansasTotalCare.com

Paper Claim Submission Reminder

- Please remember to include your AR Medicaid Provider ID on your claims submission
- To submit Medical claims:

  Mail paper claims to:

  Arkansas Total Care

  Attn: Claims

  PO Box 8020

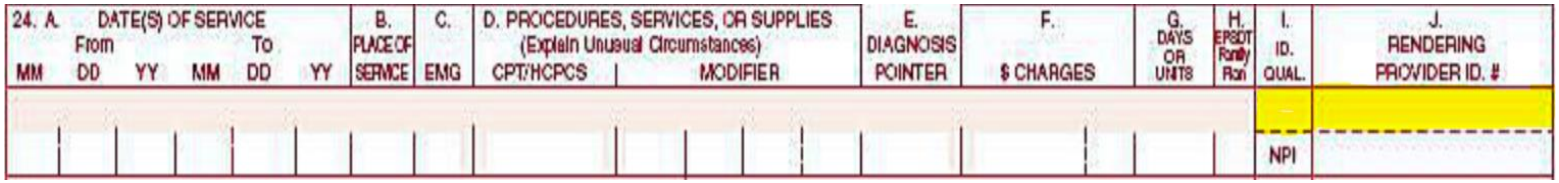
  Farmington, MO 63640-8020

NPI Requirement

- In accordance with the National Provider Identification (NPI) Final Rule, Arkansas Total Care requires **all** practitioners to have an NPI, and for all practitioners billed as the rendering provider on electronic and paper claims transactions to include their NPI on the claim transaction when billing
- Per the NPI Final Rule definition of healthcare, Behavioral Assistance, Therapeutic Behavioral Services and Applied Behavioral Analysis all fall under the scope of healthcare, and providers rendering these services must have an NPI
- ARTC sent a letter and email communication detailing this billing change to those providers affected by this change

Taxonomy Code

- Claims must be submitted with the rendering provider's taxonomy code:
  - CMS 1500 form:
    - ✓ If the rendering NPI and billing NPI are different, the taxonomy code is entered in the **shaded** portion of Box 24J and the Taxonomy qualifier "ZZ" in the **shaded** portion of Box 24I



    - ✓ If the rendering NPI and billing NPI are the same, the applicable taxonomy code utilizing the "ZZ" Qualifier is filed in Box 33b
  - CMS 1450 form (UB) – Box 81 CC, Taxonomy code with B3 Qualifier
  - **The claim will reject if the taxonomy code is not present**
- The following website can be utilized to verify a taxonomy code:
  - www.findacode.com/tools/taxonomy-codes.html

Facility Billing Information

Inpatient Services	Revenue Code	Supplemental Payment
Acute Inpatient Psychiatric	0114	Yes
RTC attached to Acute Hospital	0124	No
Residential Treatment Unit only	0129	No

***Revenue code 1001 is not allowed**

Timely Filing Guidelines

Initial Claims	Reconsideration or Claim Dispute/Appeals	Coordination of Benefits
Calendar Days	Calendar Days	Calendar Days
Par 365 days	Par 180 days	Par 365 days

- Effective 9/1/19 - Non Par providers must have a prior authorization before providing services to a member.
- Please include Provider Medicaid ID on all claims submissions. Provider Medicaid ID is required for Atypical providers but is also preferred for all providers.
- Initial Claims: Days are calculated from the Date of Service to the date received by the health plan. For observation and inpatient stays, the date is calculated from the date of discharge

Corrected Claim, Reconsideration and Claim Dispute

All Requests for corrected claims, reconsiderations or claim disputes must be received within **180 days** of the original Plan notification (ie. EOP). Original Plan determination will be upheld for requests received outside of the **180 day** timeframe, unless justification is provided to the Plan to consider

Corrected Claims

- Submit via Secure Web Portal
- Submit via an EDI Clearinghouse

- Submit via paper claim:
  - **Arkansas Total Care**
  - **Attn: Corrected Claims**
  - **PO BOX 8020**
  - **Farmington, MO 63640-8020**
  - **(Include original EOP)**

Reconsideration

- Written communication (i.e. letter) outlining disagreement of claim determination
- Indicate "Reconsideration of (original claim number)
- Include Medical Records when applicable.
- Submit reconsider to:
  - **Arkansas Total Care**
  - **Attn: Reconsideration**
  - **PO BOX 8020**
  - **Farmington, MO 63640-8020**

  - **Medical records may be necessary**

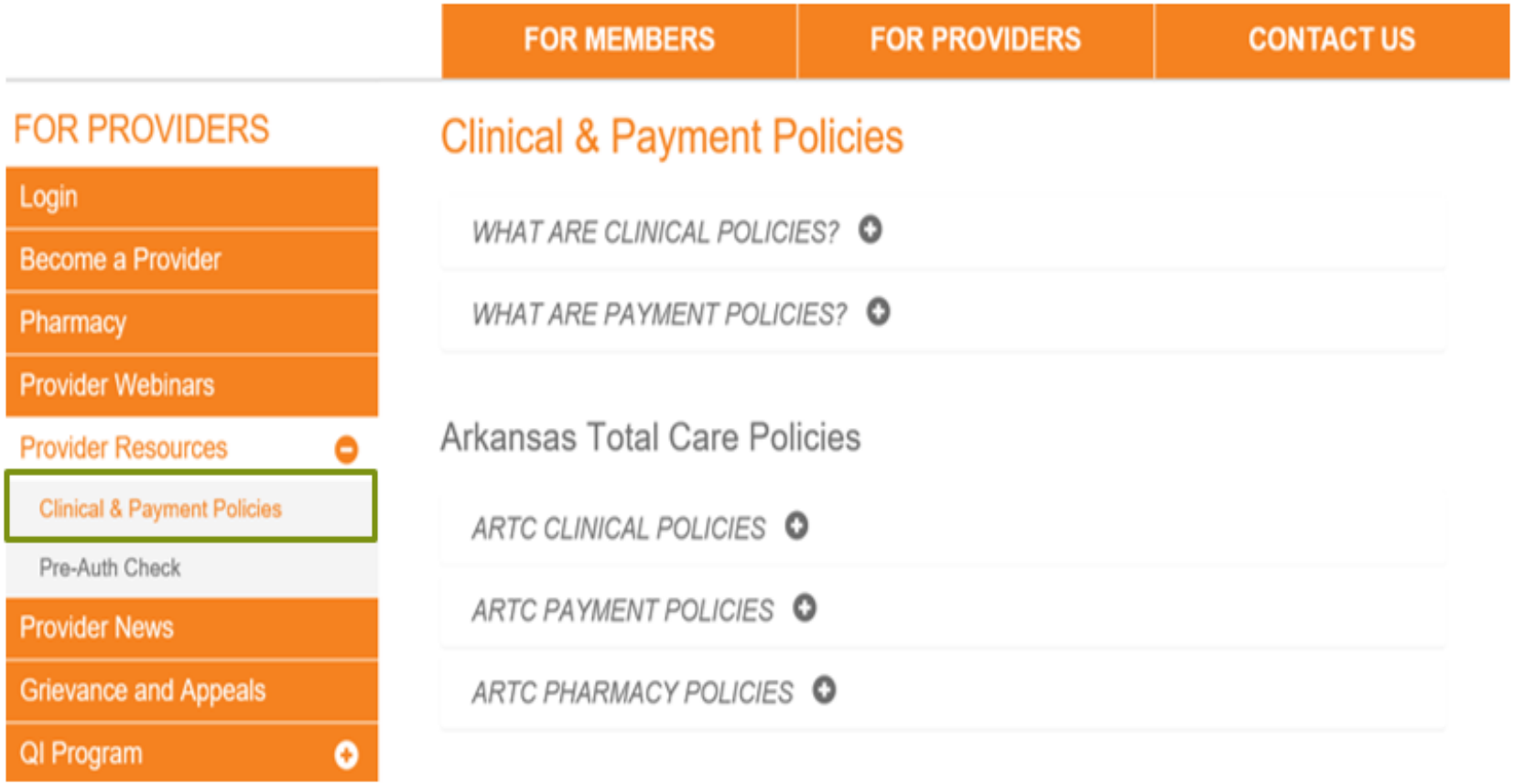
Claim Dispute

- ONLY used when disputing determination of Reconsideration request
- Must complete Claim Dispute form located on **ArkansasTotalCare.com**
- Include original request for reconsideration letter and the Plan response
- Include Medical Records when applicable.
- Send Claim Dispute form and supporting documentation to:
  - **Arkansas Total Care**
  - **Attn: Claim Dispute**
  - **PO BOX 8020**
  - **Farmington, MO 63640-8020**

  - **Medical records may be necessary**

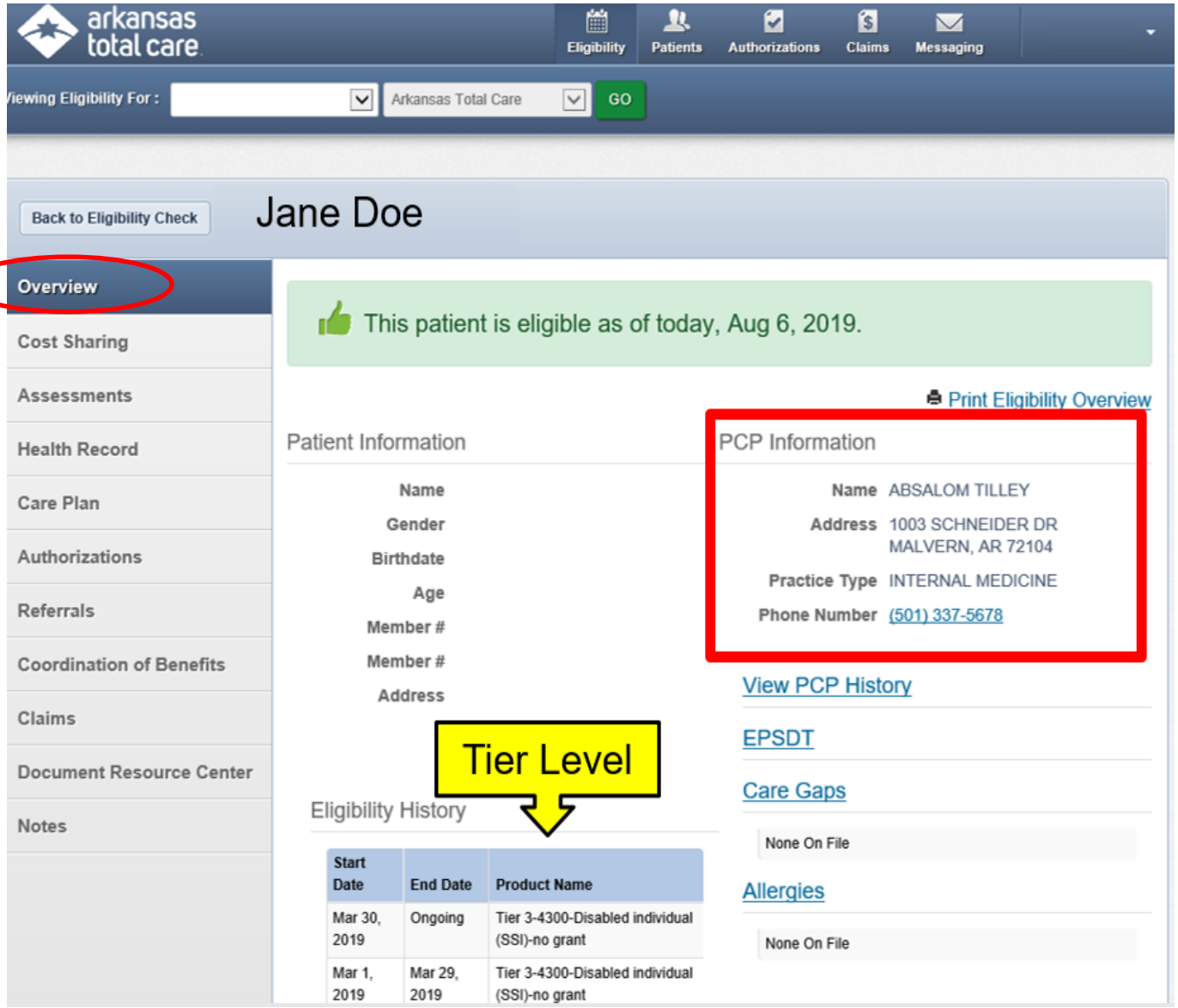
Clinical and Payment Policies

Check the Clinical and Payment Policies for updates. Sign up for the newsletter so you don't miss out on changes!



Secure Provider Portal Reminders/Updates

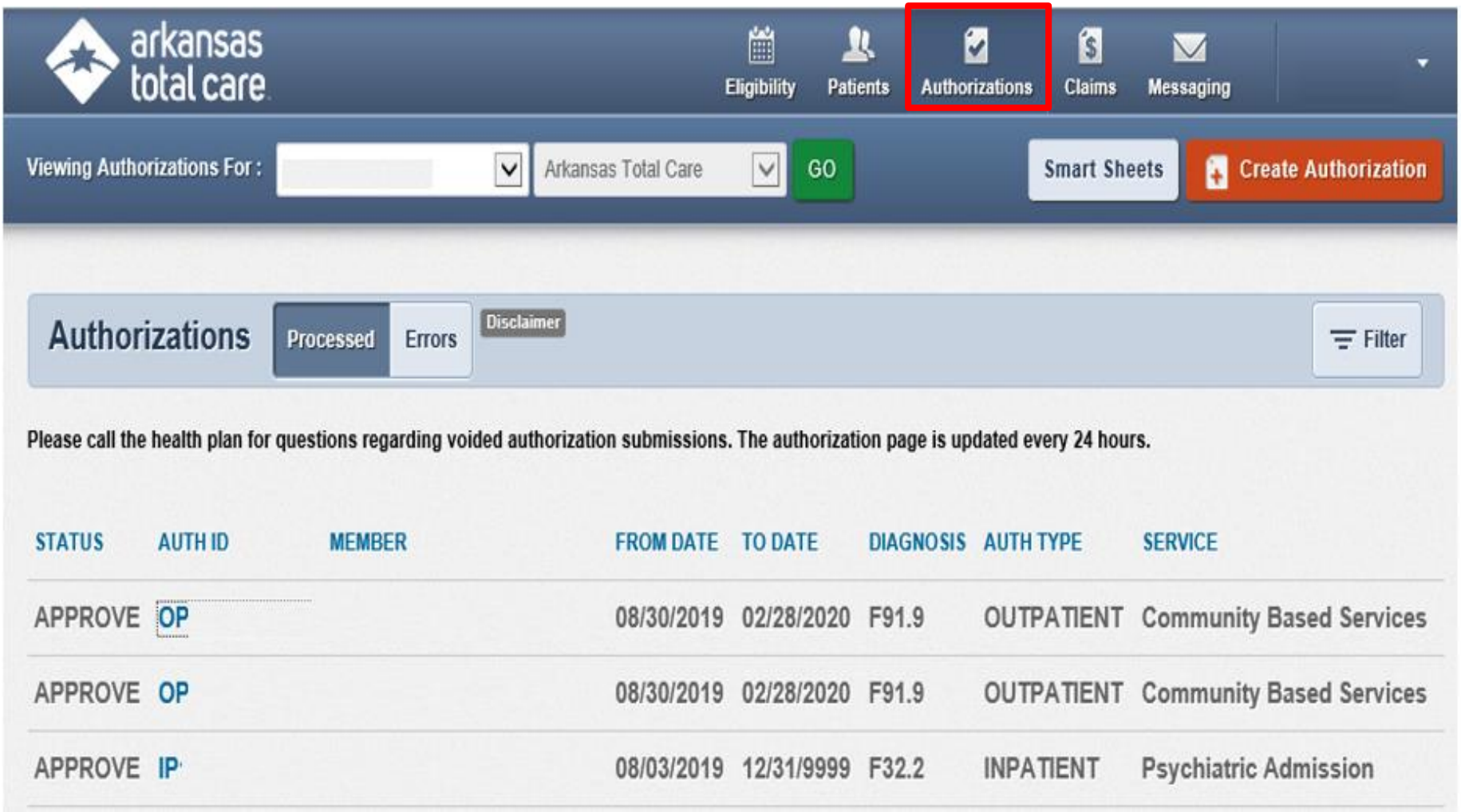
PCP Assignment and Tier Level



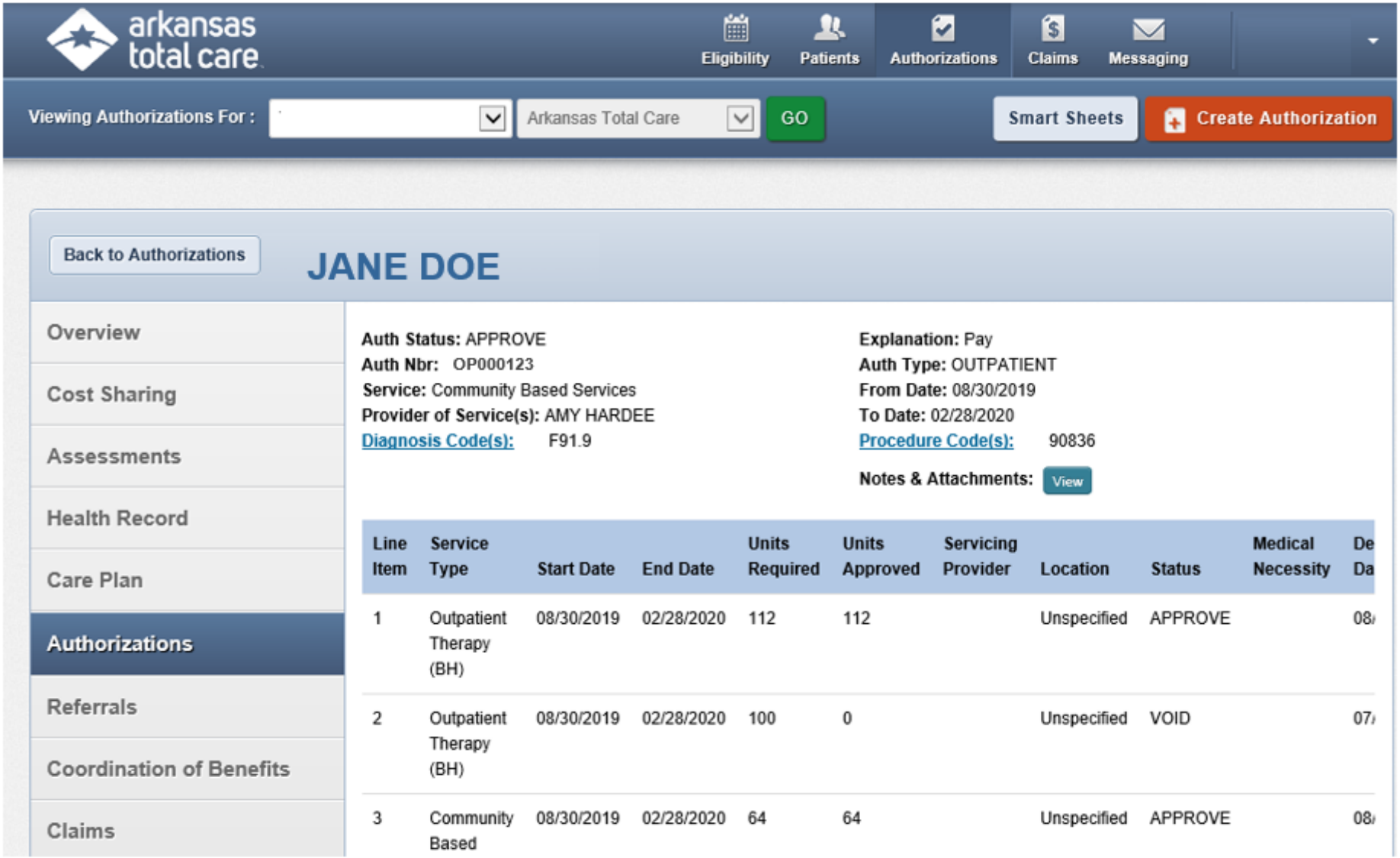
Tier Level Assignment

- Ways to obtain the Tier levels:
  - Secure Provider Portal – Under the Eligibility tab
  - Contact Member Services at 1-866-282-6280
  - Contact Optum at 1-844-809-9538
- Disagreement with Tier level determination should be submitted in writing as a request for a hearing
- Include a copy of your assessment results from Optum with your hearing request and mail to:
  - Arkansas Department of Human Services
    Office of Appeals & Hearings
    P.O. Box 1437, Slot N401
    Little Rock, AR 72203
    Department of Medical Services

Prior Authorization Display



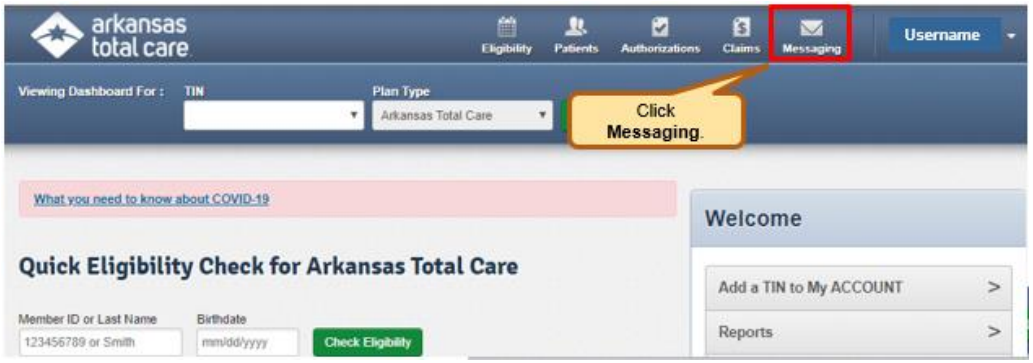
Member's Prior Authorizations Display



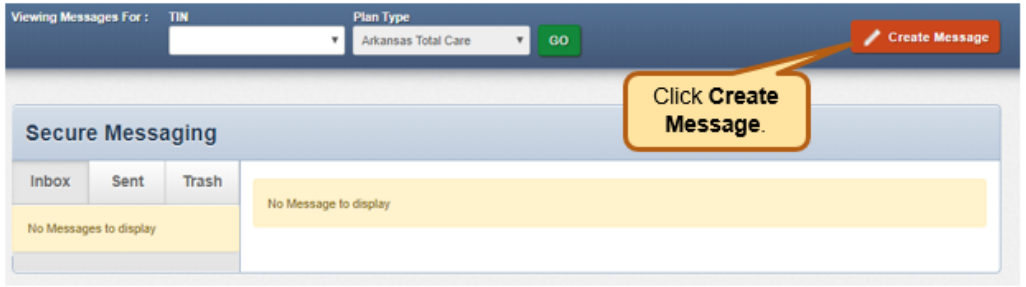
Secure Messaging

- Secure Messages submitted through the Secure Provider Portal are fully encrypted
  - You can include member and/or provider specific data without the fear of committing a HIPAA violation.

Step 1



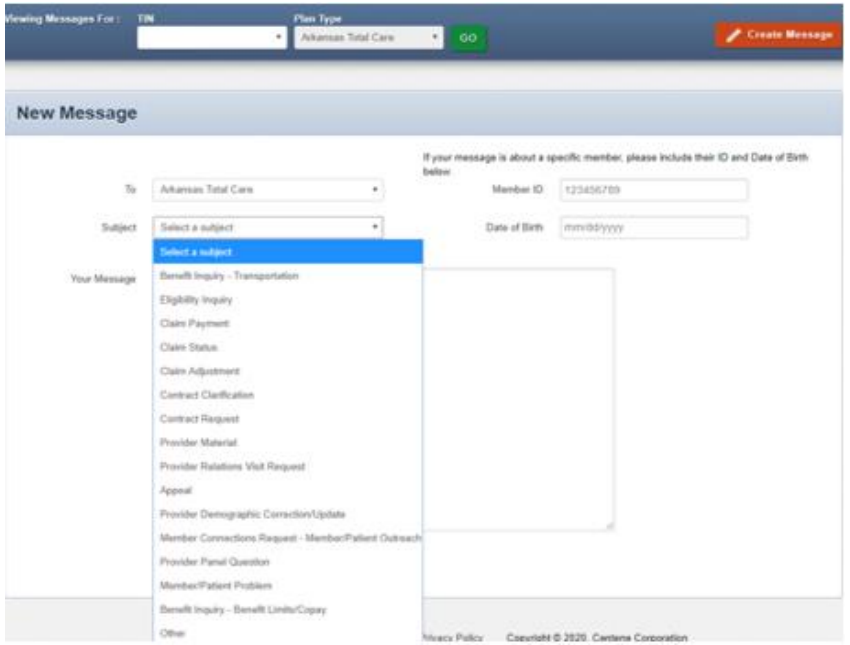
Step 2



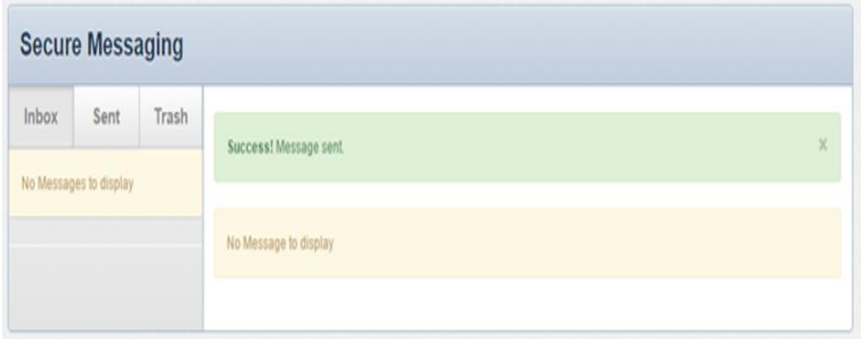
Secure Messaging

- In the New Message screen, you are able to select a Subject from the drop-down menu.
- In the Your Message field you can free text type the message to the Health Plan staff
- Click Send when complete
- You will receive a response to your message within 1-2 business days.

Step 3



Step 4

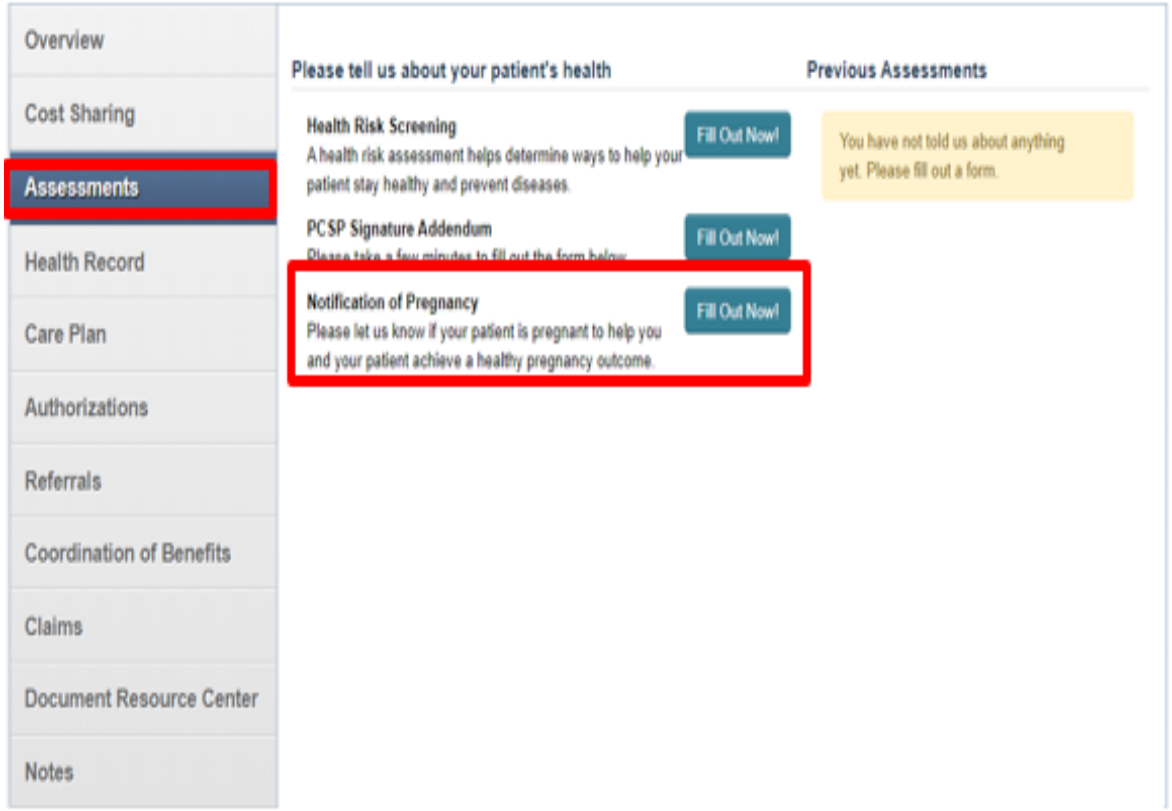


Notification of Pregnancy (NOP)

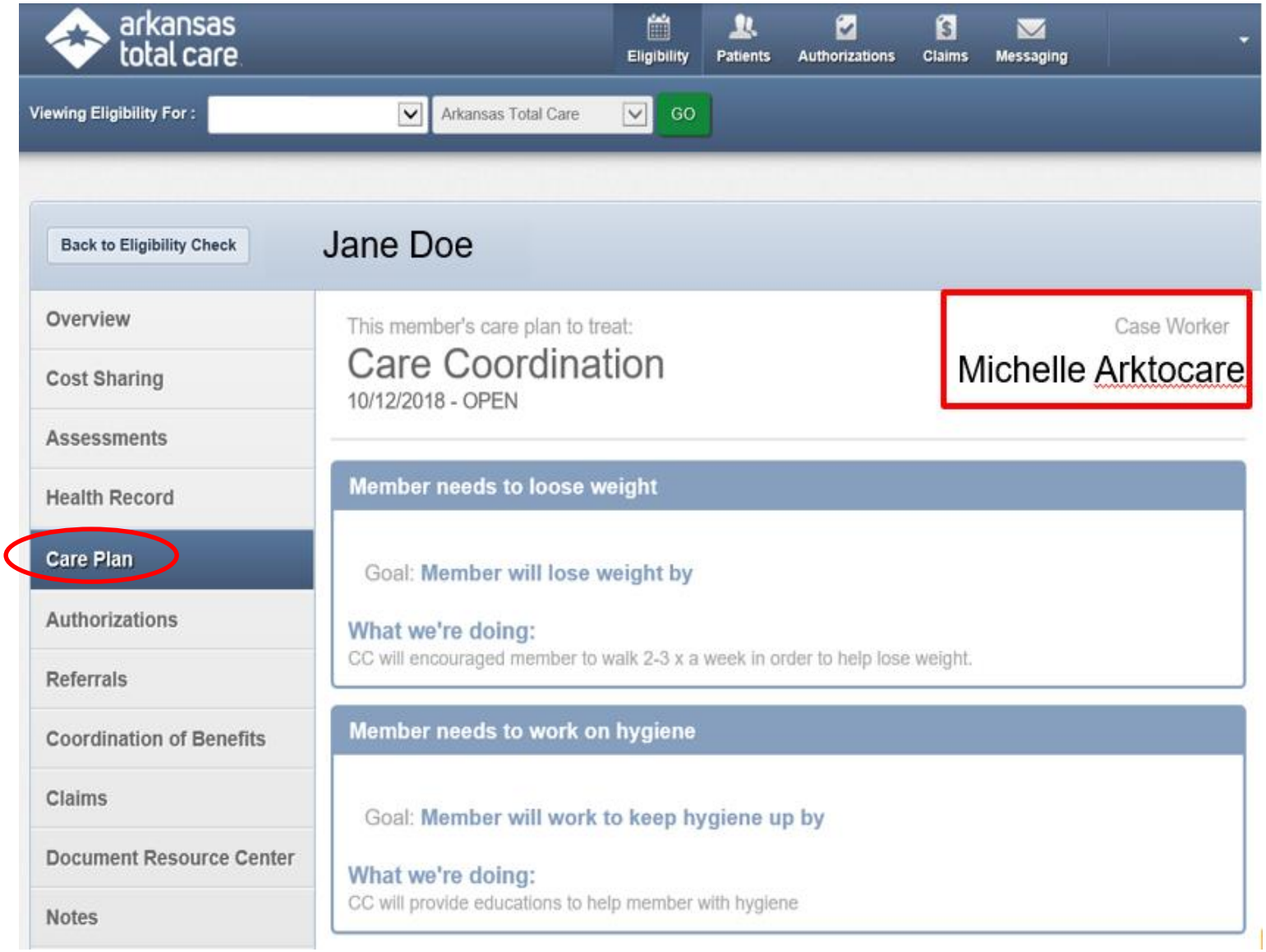
- ARTC NOP forms help identify members with:
  - History of preterm delivery
  - Psychosocial issues
  - Other conditions that may complicate their pregnancy
- Allow the Start Smart for Your Baby® program resources and services to begin with assistance of Care Managers
- Start Smart for Your Baby® services include:
  - Educating patients in normal and high risk pregnancies
  - Identify undetected problems that may put them at risk
  - Help assure compliance with antepartum and postpartum visits
- Care Managers are available to assist the provider and member should the member need:
  - Home Health services
  - Assistance monitoring blood pressure or blood sugar
  - Compliance with OB visits
  - Other assistance as needed

Notification of Pregnancy (NOP)

- Completion and Submission to ARTC by Provider:
  - Complete and submit NOP forms to the plan following initial OB visit
  - Anyone in the provider's office may complete the NOP form
  - Log onto Secure Provider Portal to access, complete, and submit form
  - Send by mail or call provider services for assistance



NEW Care Coordinator Assignment



Envolve Vision

Eye Health Manager Provider Portal

- Eye Health Manager features:
  - Verify member benefits and eligibility
  - File claims
  - Review claims status
  - Use audit tools
  - Download, research, and reprint EOB's
- To access *Eye Health Manager*:
  - Go to https://visionbenefits.envolvehealth.com/logon
  - Log in with your user name and password
  - Contact Envolve Network Management if you have misplaced your username/password or if you would like to have access to the Eye Health Manager

Claim Submission

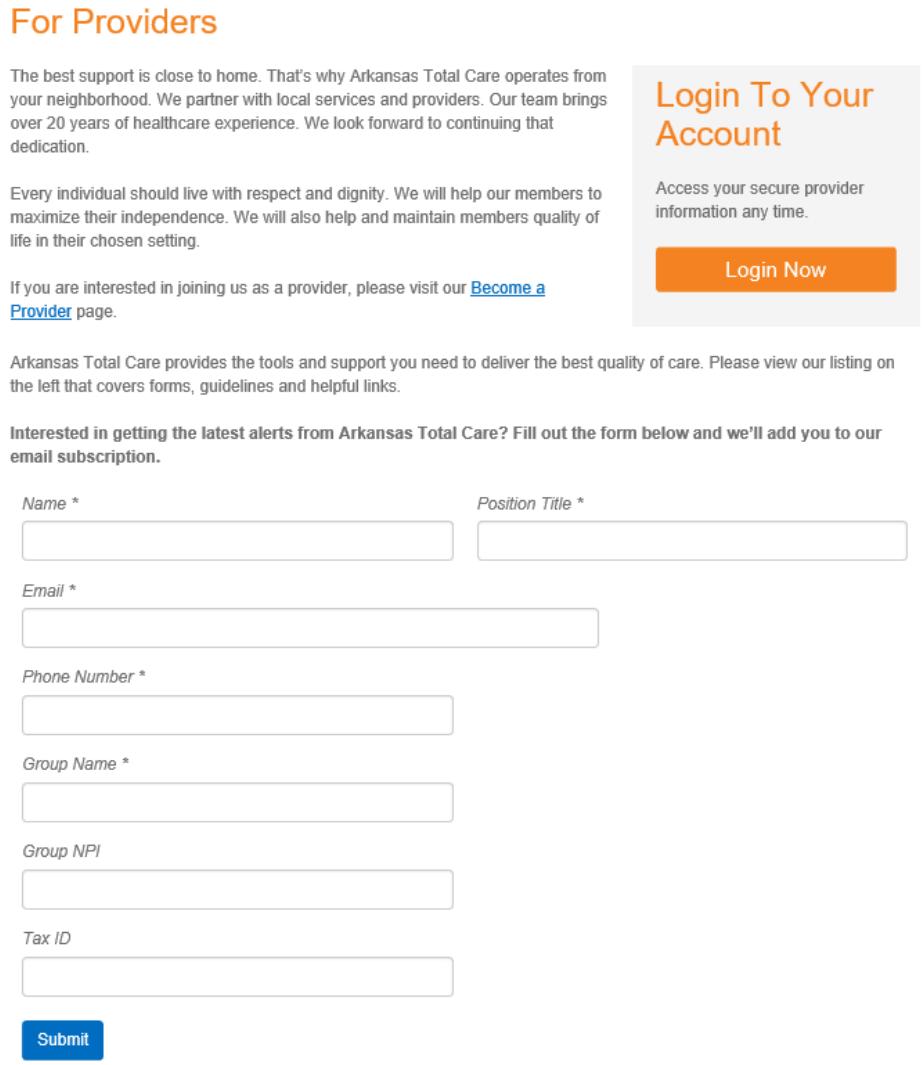
- All claims must be submitted within 365 days of the date of service
- No reimbursement will be made for claims received beyond this date
- Claims received after the 365-day filing period will be considered a Provider liability and Members may not be billed for services

- The following options to submit claims to Envolve Vision:
  - Eye Health Manager at https://visionbenefits.envolvehealth.com/logon
  - Electronic Claim Submission:
    - ✓ Change Healthcare Payer ID#: 56190
  - Paper Claim Submission:
    - ✓ Envolve Vision, Inc.
      P.O. Box 7548
      Rocky Mount, NC 27804

Important Tips and Reminders

Join Our Email List Today

- Receive current updates:
  - Arkansas Total Care:
    - ✓ https://www.arkansastotalcare.com/providers.html



For Providers

The best support is close to home. That's why Arkansas Total Care operates from your neighborhood. We partner with local services and providers. Our team brings over 20 years of healthcare experience. We look forward to continuing that dedication.

Every individual should live with respect and dignity. We will help our members to maximize their independence. We will also help and maintain members quality of life in their chosen setting.

If you are interested in joining us as a provider, please visit our Become a Provider page.

Login To Your Account

Access your secure provider information any time.

Login Now

Arkansas Total Care provides the tools and support you need to deliver the best quality of care. Please view our listing on the left that covers forms, guidelines and helpful links.

Interested in getting the latest alerts from Arkansas Total Care? Fill out the form below and we'll add you to our email subscription.

*Name **

*Position Title **

*Email **

*Phone Number **

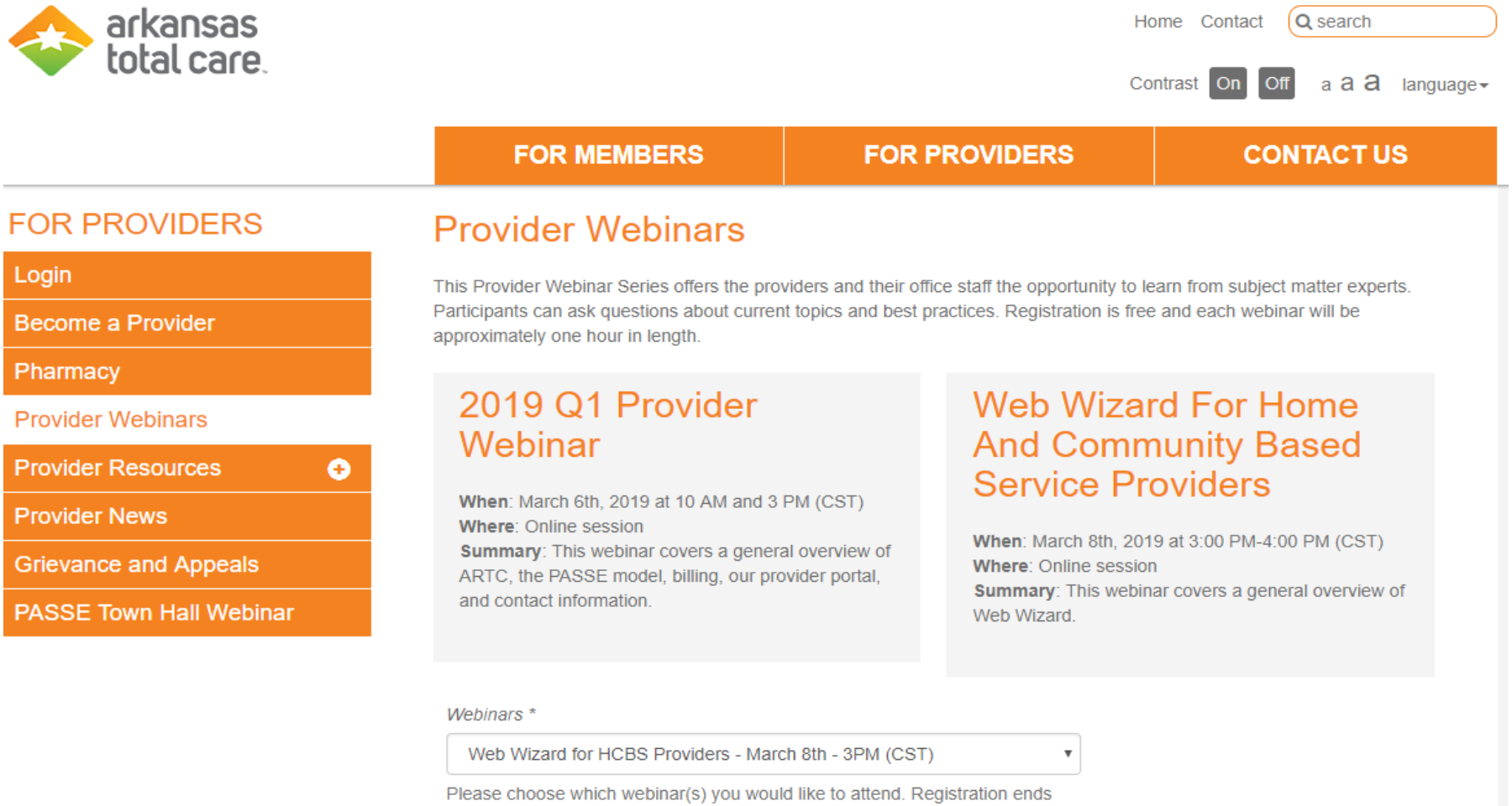
*Group Name **

Group NPI

Tax ID

Submit

Provider Webinars



Daily Care Gap Information - Now Available

- Daily Care Gap information for all ARTC members can be obtained through Arkansas Total Care's Payer Space on the Availity Portal
- Through the Availity Portal you will be able to:
  - Close gaps
  - Receive real-time analytics
  - HEDIS care gap information is updated daily by Interpreta
    - Using data from pharmacy, membership and claims

- The information provided by Interpreta includes:
  - Date a member should be scheduled to see a provider when a gap has not yet been closed
  - Percentages of total care gaps that have been closed
  - Total care gaps that need to be closed
  - Total care gaps that are past deadline for closure

- Use your existing Avality login. If you do not yet have an Availity login, or need assistance or training, visit Availity's website at www.Availity.com

Contact Information

Arkansas Total Care

Provider Services

Phone: 1-866-282-6280

Website: arkansastotalcare.com

Email inquiries to:

Providers@ArkansasTotalCare.com

Provider Services

Provider Services Call Center:

First line of communication - **1-866-282-6280**

- Answer questions regarding
  - Eligibility
  - Authorizations
  - Claims
  - Payment inquiries
- Available Monday through Friday, 8am to 5pm CST

Provider Inquiries

- After speaking with a Provider Service Representative you will receive the following:
  - All inquiries are assigned a reference number, which will be used to track the status of your inquiry
- If you need to contact your assigned Provider Relations Representative, you should have the following when calling or submitting an email inquiry:
  - Reference number assigned by the Provider Services Center
  - Provider's Name
  - Tax ID
  - National Provider Identifier (NPI)
  - Summary of the issue
  - Claim numbers (if applicable)

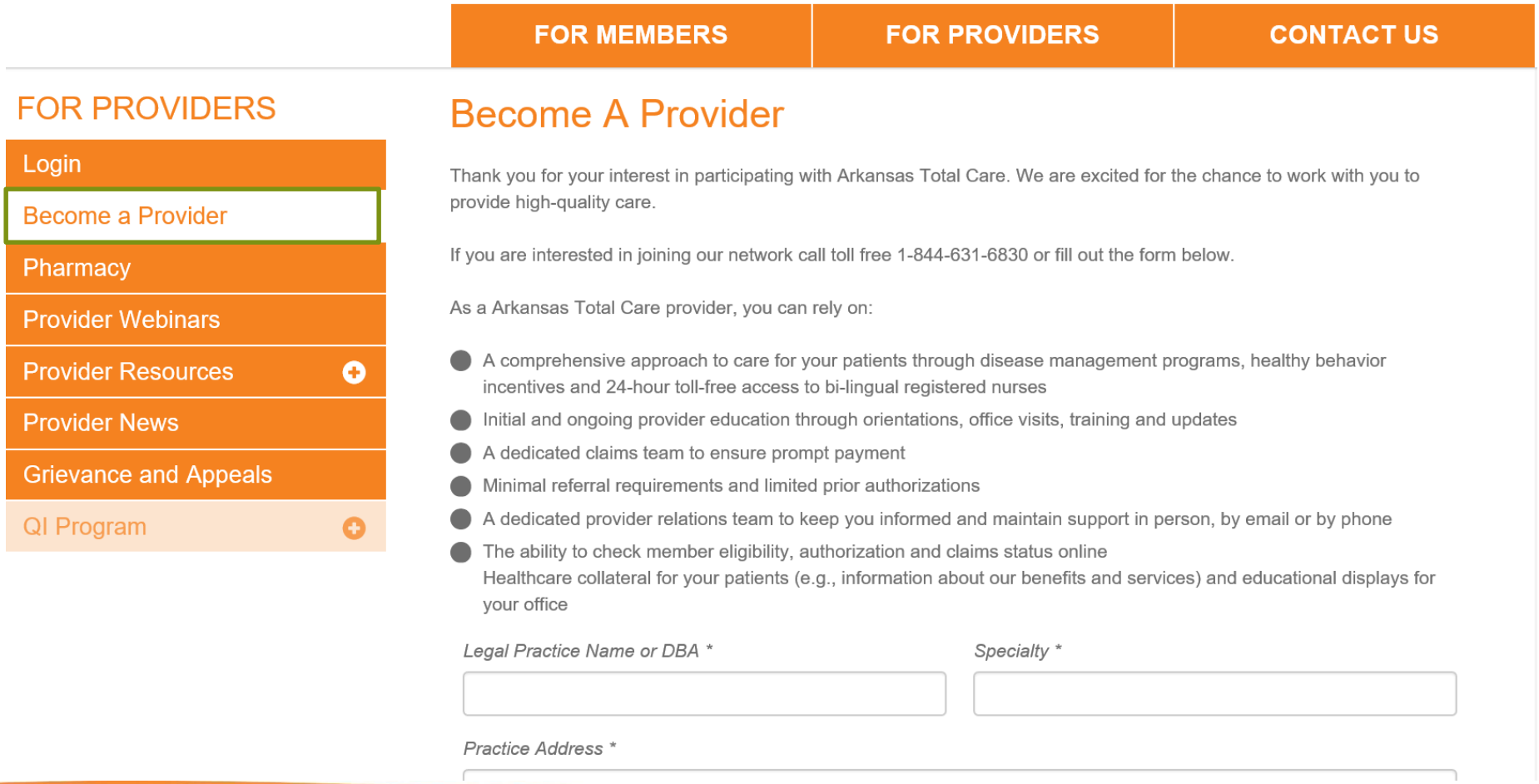
Contracting Department

Phone Number: 1-844-631-6830
Hours of Operation: 8am-4:30pm

Provider Contracting Email Address:
ArkansasContracting@centene.com
Regular contracting inquiries and contract requests

Provider Contracting

To join our network select ‘Become A Provider’ from the ‘For Providers’ tab on our website. You must currently be a participating Arkansas Medicaid provider.



Credentialing

- All ARTC providers must be credentialed
- Credentialing forms can be found on our website at https://www.arkansastotalcare.com/providers/resources.html :
  - Credentialing Atypical Provider Application (PDF)
  - Allied and Advance Practice Nurse Credentialing Application (PDF)
  - Medical Doctor or Doctor of Osteopathy Credentialing Application (PDF)

Phone Number: 844-263-2437

Secure Fax: 844-357-7890

Email: ARKCredentialing@Centene.com

Please use the Q & A feature to enter your questions.

Thank you for joining us!