



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

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- 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
- Engolve Vision
- Important Reminders and Tips
- Contact Information

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



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Contrast ☒ On ☐ Off a a language ▾

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Grievance and Appeals

Coronavirus Information for Providers

Provider Financial Support & Resources

Provider Coronavirus

Coronavirus disease 2019 (COVID-19) is an... treatment options, how the virus works, and the risk assessment, treatment options and members, and we want you to be aware of this time of heightened concern.

Guidance:

- Know the warning signs of COVID-19. Symptoms include fever, cough, and shortness of breath. Some individuals have muscle aches. Some individuals have a sore throat. Some individuals have diarrhea. Some individuals have nausea. Some individuals have vomiting. Some individuals have loss of taste or smell. Some individuals have fatigue. Some individuals have confusion. Some individuals have difficulty breathing. Some individuals have chest pain. Some individuals have new or worsening asthma. Some individuals have new or worsening heart failure. Some individuals have new or worsening diabetes. Some individuals have new or worsening high blood pressure. Some individuals have new or worsening kidney disease. Some individuals have new or worsening liver disease. Some individuals have new or worsening thyroid disease. Some individuals have new or worsening autoimmune disease. Some individuals have new or worsening cancer. Some individuals have new or worsening HIV. Some individuals have new or worsening hepatitis. Some individuals have new or worsening tuberculosis. Some individuals have new or worsening syphilis. Some individuals have new or worsening gonorrhea. Some individuals have new or worsening chlamydia. Some individuals have new or worsening herpes. Some individuals have new or worsening HPV. Some individuals have new or worsening Zika. Some individuals have new or worsening Dengue. Some individuals have new or worsening Chikungunya. Some individuals have new or worsening Ebola. Some individuals have new or worsening Marburg. Some individuals have new or worsening SARS-CoV-2. Symptoms may appear 2-14 days after exposure.
- However, be aware that infected individuals may not develop symptoms for several days after exposure.
- Instruct symptomatic patients to wear a mask and keep the door closed.
- Health care personnel encountering symptomatic patients should wear appropriate precautions, and wear eye protection and gloves.
- Refer to the [CDC's criteria](#) for a patient under investigation or a patient under investigation.
- Monitor and manage ill and exposed healthcare personnel.
- Safely triage and manage patients with respiratory illness, including COVID-19. Explore alternatives to face-to-face

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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 measure 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



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Coronavirus (COVID-19)

Currently we are experiencing some issues and long wait times with on our Teledoc and Referral lines. Please be patient with us as we work through this busy period.

To receive the fastest response on referrals, please submit authorization requests through our provider portal or via fax at: 1-833-632-6934

COVID-19 Resources:

- [COVID-19 In-Home Care Guidance \(PDF\)](#)
- [CES Waiver Emergency Request Form \(PDF\)](#)
- [COVID-19 Extended Coverage Announcement \(PDF\)](#)
- [Supplemental Support Service \(PDF\)](#)

[Learn More about the Coronavirus.](#)

Arkansas Total Care provides the tools and support you need to deliver the best quality of care.

HEDIS Tips and Quick Guides

- [CCS Cervical Cancer Screening Tips for Provider \(PDF\)](#)
- [CPT CATEGORY II CODES \(PDF\)](#)

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



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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.

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Pre-Auth Check

Use our tool to see if a pre-authorization is needed. It's quick and easy. If an authorization is needed, you can access our login to submit online. For the best experience, please use the Pre-Auth tool in Chrome, Firefox, or Internet Explorer 10 and above.

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

Vision Services need to be verified by Envolve Vision.
Dental Services are provided through Delta Dental or MCNA. Please verify.
Complex imaging, MRA, MRI, PET, and CT scans need to be verified by NIA

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, [Join Our Network](#).

Would this be Emergency or Urgent Care, Dialysis or are these family planning services billed with a contraceptive management diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>
Are oral surgeon services being rendered in the office?	<input type="radio"/>	<input type="radio"/>
Are chiropractic services being rendered?	<input type="radio"/>	<input type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>
Are hospice services being provided?	<input type="radio"/>	<input type="radio"/>

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

99213

Check



99213 - OFFICE/OUTPATIENT VISIT EST
Pre-authorization required for non-participating providers only.

To submit a prior authorization [Login Here](#).

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 authorization 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
- ✓ Unicompartamental/Bicompartamental 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**

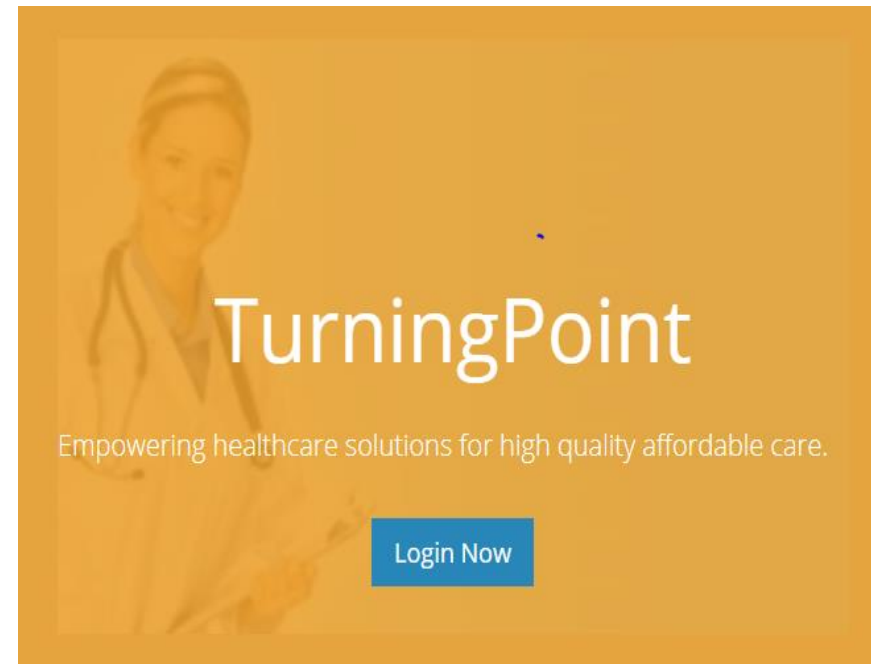
TurningPoint Provider Portal Access

- **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](mailto: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


 arkansas
total care

 Eligibility

 Patients

 Authorizations

 Claims

 Messaging

Viewing Dashboard For :

Quick Eligibility Check for Arkansas Total Care

Member ID or Last Name

Birthdate

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
\$	07/29/2019		
\$	07/29/2019		
\$	07/29/2019		
\$	07/29/2019		
\$	07/29/2019		

Welcome

Add a TIN to My ACCOUNT >

Reports >

Patient Analytics--**Coming Soon** >

Provider Analytics--**Coming Soon** >

Recent Activity

Date	Activity
------	----------

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

- [illegible]

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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!


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Clinical & Payment Policies


WHAT ARE CLINICAL POLICIES? 

WHAT ARE PAYMENT POLICIES? 

Arkansas Total Care Policies


ARTC CLINICAL POLICIES 

ARTC PAYMENT POLICIES 

ARTC PHARMACY POLICIES 

Secure Provider Portal Reminders/Updates

PCP Assignment and Tier Level



EligibilityPatientsAuthorizationsClaimsMessaging

Viewing Eligibility For : Arkansas Total Care

Back to Eligibility Check

Jane Doe

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations


Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

 This patient is eligible as of today, Aug 6, 2019.

Print Eligibility Overview

Patient Information

Name

Gender

Birthdate

Age

Member #

Member #

Address

PCP Information

Name

Address

Practice Type

Phone Number

View PCP History

EPSDT

Care Gaps

Allergies

Tier Level


Eligibility History


Start Date	End Date	Product Name
Mar 30, 2019	Ongoing	Tier 3-4300-Disabled individual (SSI)-no grant
Mar 1, 2019	Mar 29, 2019	Tier 3-4300-Disabled individual (SSI)-no grant


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


 arkansas
total care

 Eligibility

 Patients

 **Authorizations**

 Claims

 Messaging


Viewing Authorizations For : Arkansas Total Care

Authorizations






Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

	STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	OP			08/30/2019	02/28/2020	F91.9	OUTPATIENT	Community Based Services
APPROVE	OP			08/30/2019	02/28/2020	F91.9	OUTPATIENT	Community Based Services
APPROVE	IP			08/03/2019	12/31/9999	F32.2	INPATIENT	Psychiatric Admission

Member's Prior Authorizations Display



arkansas
total care

 Eligibility
  Patients
  Authorizations
  Claims
  Messaging

Viewing Authorizations For :

JANE DOE

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Auth Status: APPROVE
Auth Nbr: OP000123
Service: Community Based Services
Provider of Service(s): AMY HARDEE
[Diagnosis Code\(s\):](#) F91.9

Explanation: Pay
Auth Type: OUTPATIENT
From Date: 08/30/2019
To Date: 02/28/2020
[Procedure Code\(s\):](#) 90836

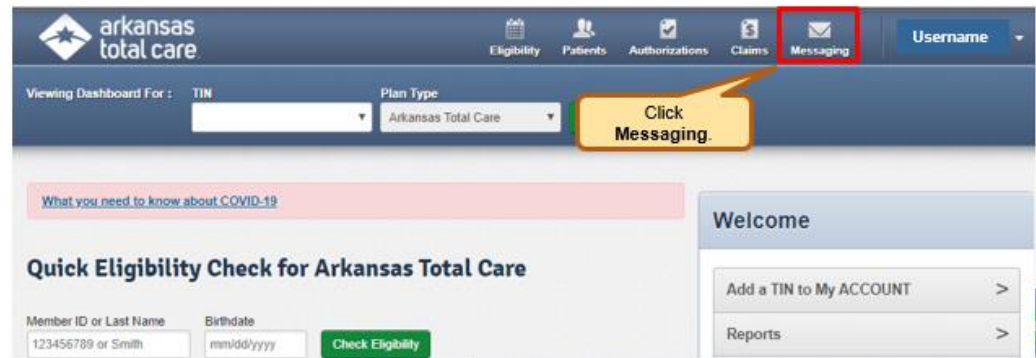
Notes & Attachments:

Line Item	Service Type	Start Date	End Date	Units Required	Units Approved	Servicing Provider	Location	Status	Medical Necessity	De
1	Outpatient Therapy (BH)	08/30/2019	02/28/2020	112	112		Unspecified	APPROVE		08/
2	Outpatient Therapy (BH)	08/30/2019	02/28/2020	100	0		Unspecified	VOID		07/
3	Community Based	08/30/2019	02/28/2020	64	64		Unspecified	APPROVE		08/

Secure Messaging

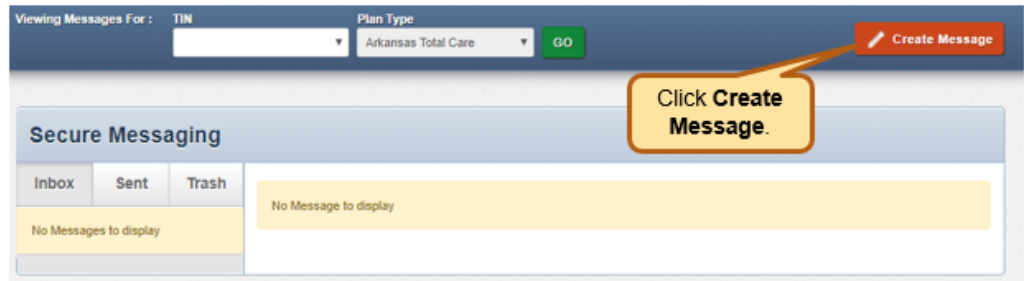
- Secure Messages submitted through the Secure Provider Portal are fully encrypted
 - You can include member and/or provider specific data without the fear of committing a HIPAA violation.

Step 1



The screenshot shows the Arkansas Total Care dashboard. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, and Messaging. The 'Messaging' link is highlighted with a red box. A callout bubble points to the 'Messaging' link with the text 'Click Messaging.' Below the navigation bar, there is a 'Viewing Dashboard For:' section with a TIN dropdown and a 'Plan Type' dropdown set to 'Arkansas Total Care'. A 'Quick Eligibility Check for Arkansas Total Care' section is visible, with fields for 'Member ID or Last Name' (123456789 or Smith) and 'Birthdate' (mm/dd/yyyy), and a 'Check Eligibility' button. A 'Welcome' sidebar on the right contains links for 'Add a TIN to My ACCOUNT' and 'Reports'.

Step 2

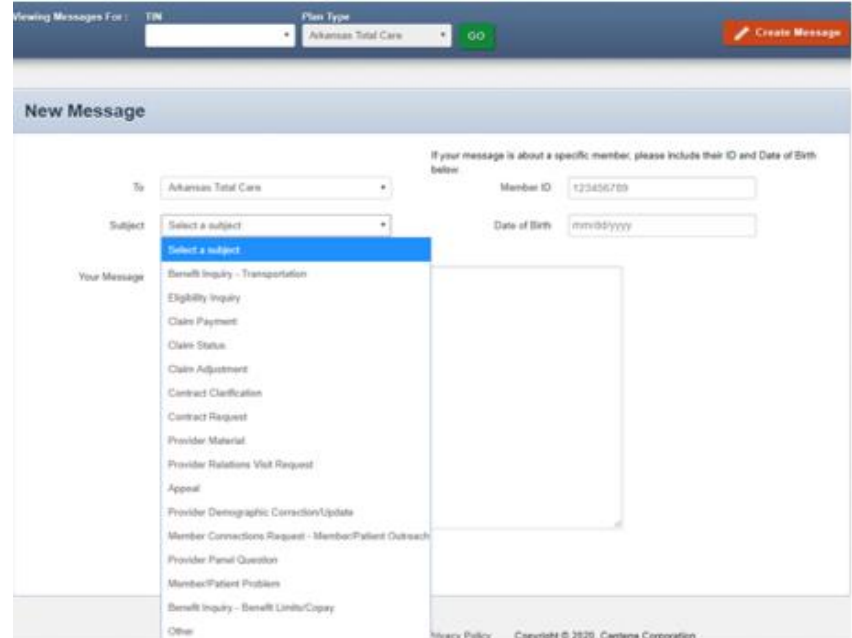


The screenshot shows the 'Secure Messaging' interface. The top navigation bar includes a 'Viewing Messages For:' section with a TIN dropdown and a 'Plan Type' dropdown set to 'Arkansas Total Care', followed by a 'GO' button. A 'Create Message' button is highlighted in the top right. A callout bubble points to the 'Create Message' button with the text 'Click Create Message.' Below the navigation bar, there is a 'Secure Messaging' section with tabs for 'Inbox', 'Sent', and 'Trash'. The 'Inbox' tab is selected, and a message box displays 'No Message to display'.

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



Viewing Messages For: **TIN** **Arkansas Total Care** **GO** **Create Message**

New Message

If your message is about a specific member, please include their ID and Date of Birth below

To: **Arkansas Total Care**

Subject: **Select a subject**

Member ID: **123456789**

Date of Birth: **mm/dd/yyyy**

Your Message

Benefit Inquiry - Transportation
 Eligibility Inquiry
 Claim Payment
 Claim Status
 Claim Adjustment
 Contract Clarification
 Contract Request
 Provider Material
 Provider Relations Visit Request
 Appeal
 Provider Demographic Correction/Update
 Member Connections Request - Member/Patient Outreach
 Provider Panel Question
 Member/Patient Problems
 Benefit Inquiry - Benefit Limits/Copy
 Other

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Step 4



Secure Messaging

Inbox Sent Trash

Success! Message sent.

No Messages to display

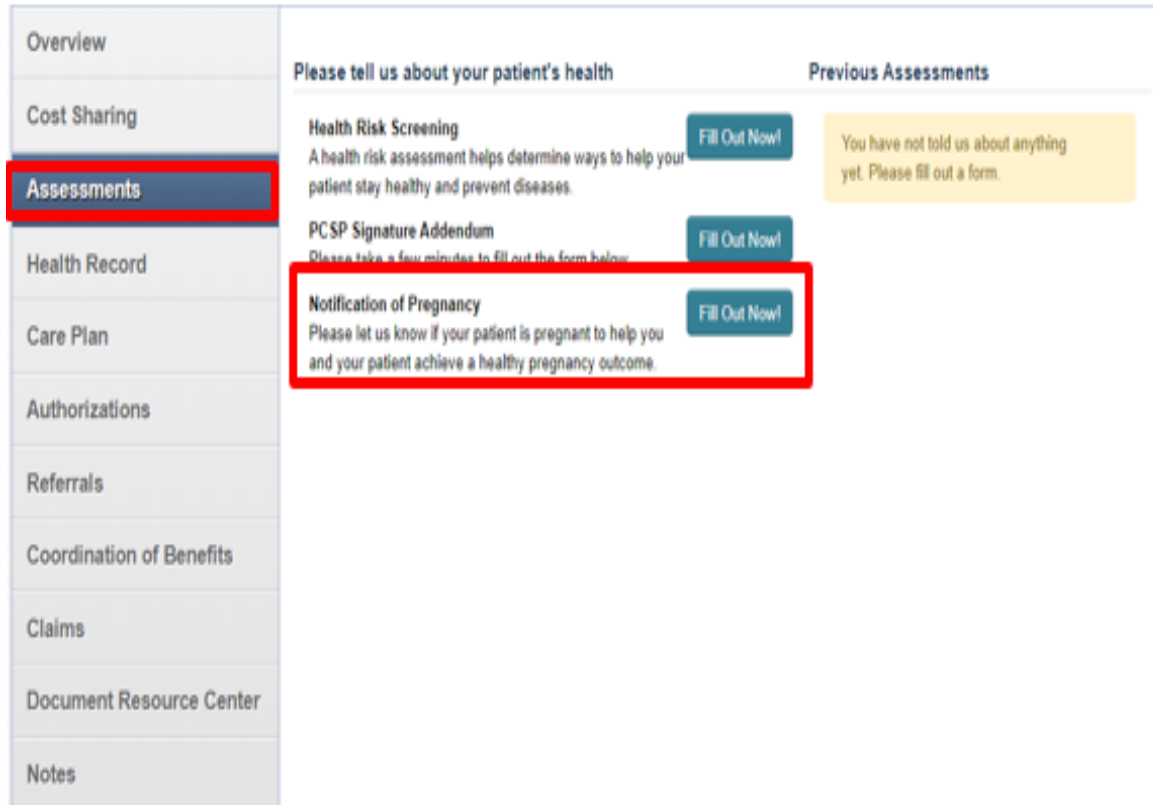
No Message to display

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



Overview	Please tell us about your patient's health	Previous Assessments
Cost Sharing	Health Risk Screening A health risk assessment helps determine ways to help your patient stay healthy and prevent diseases. Fill Out Now!	You have not told us about anything yet. Please fill out a form.
Assessments	PCSP Signature Addendum Please take a few minutes to fill out the form below. Fill Out Now!	
Health Record	Notification of Pregnancy Please let us know if your patient is pregnant to help you and your patient achieve a healthy pregnancy outcome. Fill Out Now!	
Care Plan		
Authorizations		
Referrals		
Coordination of Benefits		
Claims		
Document Resource Center		
Notes		

NEW Care Coordinator Assignment

 arkansas
total care

EligibilityPatientsAuthorizationsClaimsMessaging

Viewing Eligibility For : Arkansas Total Care

Jane Doe

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

This member's care plan to treat:

Care Coordination

10/12/2018 - OPEN

Case Worker

Michelle Arktocare

Member needs to loose weight

Goal: Member will lose weight by

What we're doing:

CC will encouraged member to walk 2-3 x a week in order to help lose weight.

Member needs to work on hygiene

Goal: Member will work to keep hygiene up by

What we're doing:

CC will provide educations to help member with hygiene

Engolve 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.

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

Login To Your Account

Access your secure provider information any time.

Login Now

Provider Webinars

FOR MEMBERS

FOR PROVIDERS

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Provider Webinars

This Provider Webinar Series offers the providers and their office staff the opportunity to learn from subject matter experts. Participants can ask questions about current topics and best practices. Registration is free and each webinar will be approximately one hour in length.

2019 Q1 Provider Webinar

When: March 6th, 2019 at 10 AM and 3 PM (CST)**Where:** Online session**Summary:** This webinar covers a general overview of ARTC, the PASSE model, billing, our provider portal, and contact information.

Web Wizard For Home And Community Based Service Providers

When: March 8th, 2019 at 3:00 PM-4:00 PM (CST)**Where:** Online session**Summary:** This webinar covers a general overview of Web Wizard.*Webinars **

Please choose which webinar(s) you would like to attend. Registration ends one hour before the scheduled class time.

*First Name ***Last Name **

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 Availity 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.

[FOR MEMBERS](#)[FOR PROVIDERS](#)[CONTACT US](#)

FOR PROVIDERS

[Login](#)[Become a Provider](#)[Pharmacy](#)[Provider Webinars](#)[Provider Resources](#)[Provider News](#)[Grievance and Appeals](#)[QI Program](#)

Become A Provider

Thank you for your interest in participating with Arkansas Total Care. We are excited for the chance to work with you to provide high-quality care.

If you are interested in joining our network call toll free 1-844-631-6830 or fill out the form below.

As a Arkansas Total Care provider, you can rely on:

- A comprehensive approach to care for your patients through disease management programs, healthy behavior incentives and 24-hour toll-free access to bi-lingual registered nurses
 - Initial and ongoing provider education through orientations, office visits, training and updates
 - A dedicated claims team to ensure prompt payment
 - Minimal referral requirements and limited prior authorizations
 - A dedicated provider relations team to keep you informed and maintain support in person, by email or by phone
 - The ability to check member eligibility, authorization and claims status online
- Healthcare collateral for your patients (e.g., information about our benefits and services) and educational displays for your office

Legal Practice Name or DBA *

Specialty *

Practice Address *

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!**