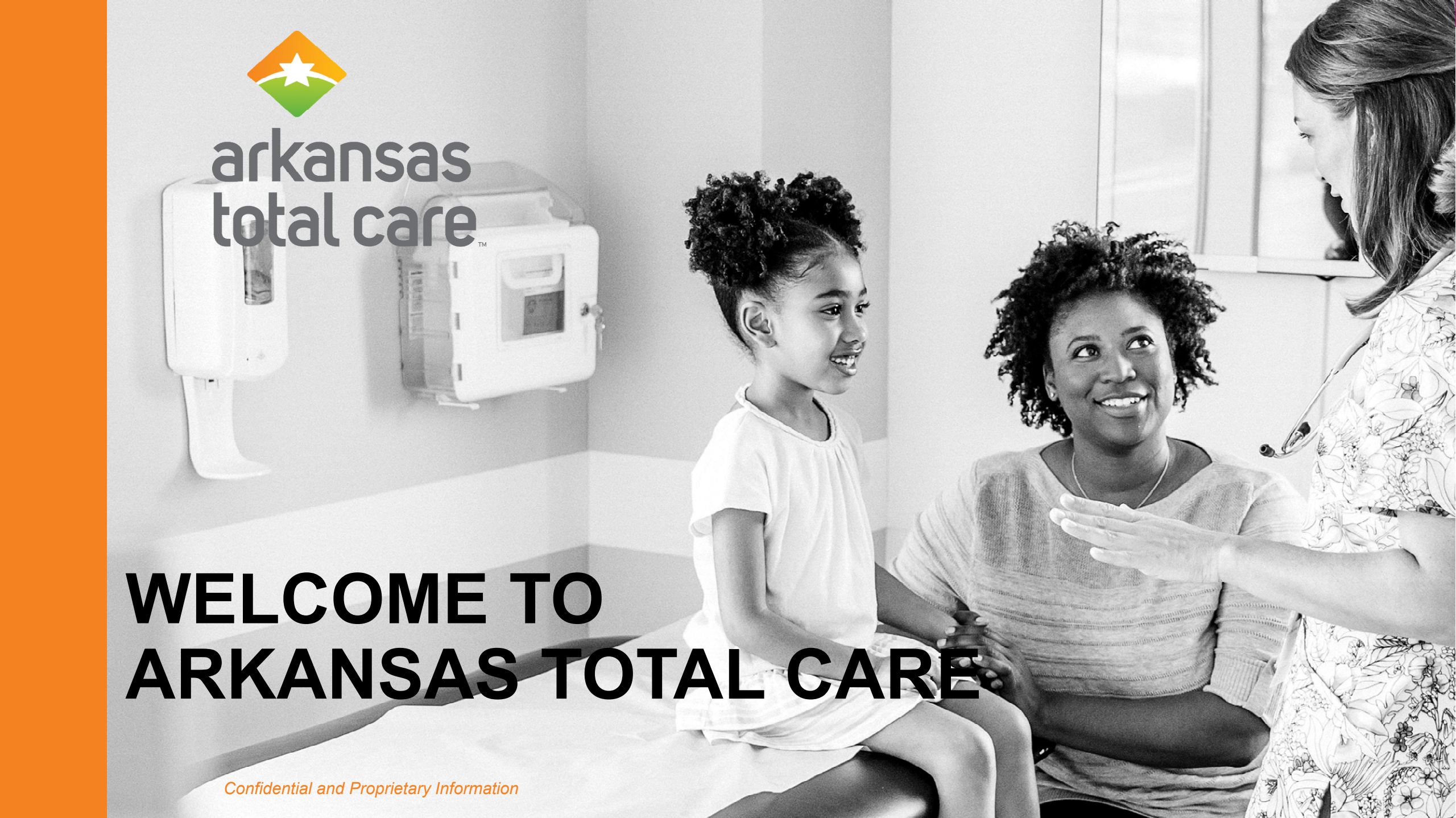

WELCOME TO ARKANSAS TOTAL CARE

AGENDA

- **OVERVIEW**
  - Who We Are

- **WHAT YOU NEED TO KNOW**
  - Key Contact Information
  - Provider Toolkit and Manual
  - Provider Relations
  - Public Website and Secure Portal
  - Verification of Eligibility, Benefits and Cost Shares
  - Specialty Referrals
  - Prior Authorization
  - Claims, Billing and Payments
  - Complaints, Grievances and Appeals
  - Specialty Companies and Vendors
- **Q & A**

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OVERVIEW

WHO WE ARE

- Arkansas Total Care is a Provider-Led Arkansas Shared Savings Entity (PASSE), a partnership between an insurance payer, a provider group, and a specialty services provider. We serve participants in the Arkansas Medicaid program as a Managed Care Organization.
- PASSE's were developed in Arkansas to provide more extensive care coordination to high-needs Intellectual/Developmentally Disabled (IDD) persons and persons with Behavioral Health (BH) needs. Arkansas Total Care empowers our members to achieve their health goals through care coordination, goal setting and connecting members to community resources.

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OUR PURPOSE

Helping Arkansas Live Better

CORPORATE PHILOSOPHY

Transforming the health of the community one person at a time

OUR MISSION

Better health outcomes at lower costs

OUR BRAND PILLARS

Focus on individuals + Active Local Involvement + Whole Health

OUR BELIEFS

- We believe in treating the whole person, not just the physical body.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- We believe local partnerships enables meaningful, accessible healthcare.
- We believe healthier individuals create more vibrant families and communities.

WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Arkansas Total Care

PHONE

1-866-282-6280

TTY/TDD

1-866-282-6280

WEB

www.arkansastotalcare.com

PORTAL

provider.arkansastotalcare.com

GETTING AQUAINTED

AFTER YOU HAVE COMPLETED THE CREDENTIALING PROCESS, YOU WILL RECEIVE A PROVIDER TOOLKIT. OUR TOOLKIT CONTAINS USEFUL INFORMATION FOR GETTING STARTED AS AN ARKANSAS TOTAL CARE PROVIDER.

While we'll cover some of that information in this presentation, your toolkit has additional information including:

- Credentialing Approval Letter
- Secure Portal Setup
- Electronic Funds Transfer Setup (Payspan)
- Prior Authorization Guide
- Quick Reference Guide

THE PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH Arkansas Total Care.

The Manual includes a wide array of important information relevant to providers including, but not limited to:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives
- And much more!

The Provider Manual can be found in the Provider section of the **Arkansas Total Care** website at **www.arkansastotalcare.com.**

PROVIDER SERVICES

- The **Arkansas Total Care** Provider Services department is available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
    - Member Eligibility/Benefits
    - Claim Status
    - Prior Authorization Request
    - Network Verification
    - Appeal Status
    - Check Stop Pay or Check Reissues
    - Negative Balance Report Request
    - Provider Demographic Change Request
- By calling **Arkansas Total Care** Provider Services at **866-282-6280,** providers will be able to access real time assistance for all their service needs

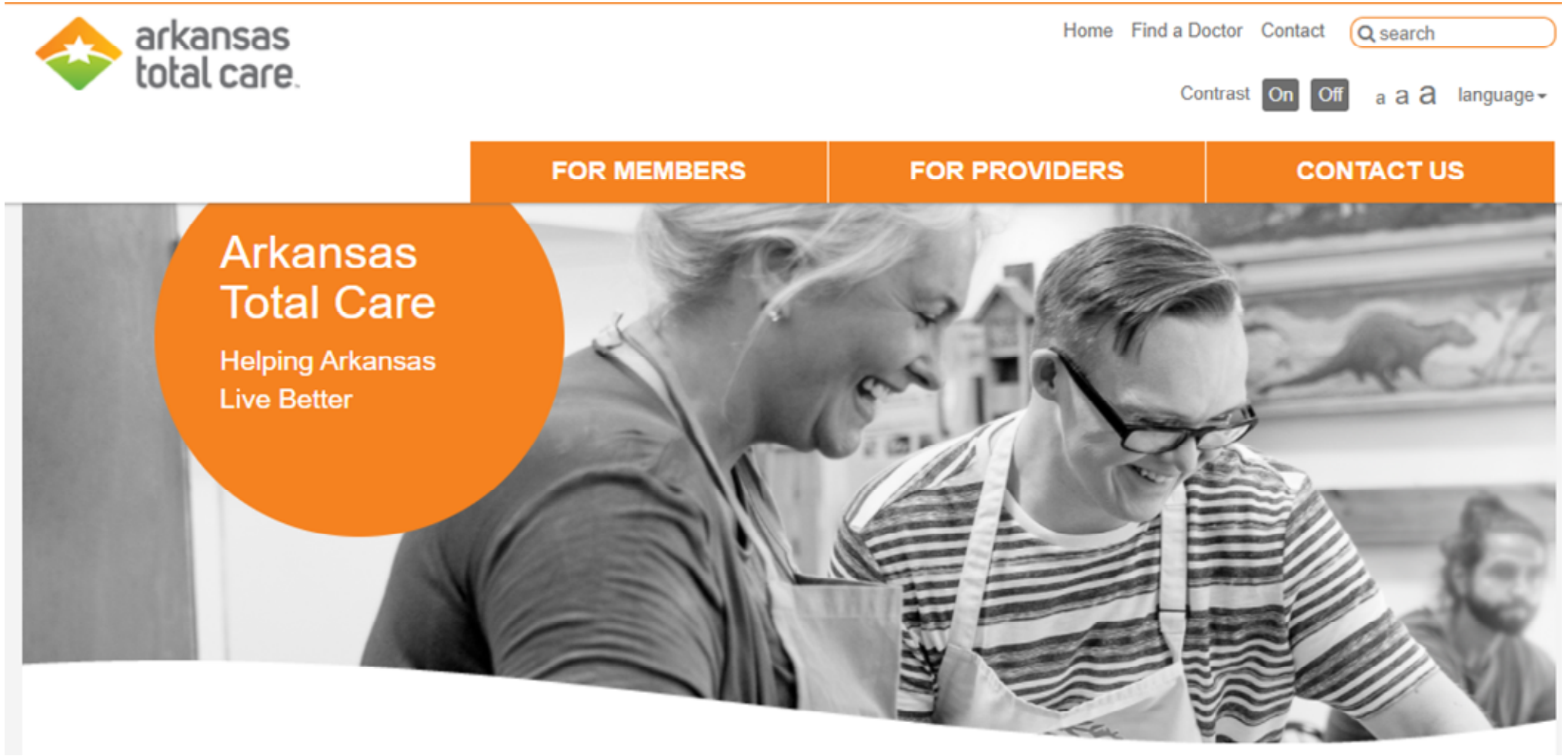
PROVIDER RELATIONS

- As an **Arkansas Total Care** provider, you will have a dedicated Provider Relations Specialist available to assist you
- Our Provider Relations Specialists serve as the primary liaisons between our health plan and provider network
- Your Provider Relations Specialist is here to help with things like:

- ✓ Inquiries related to administrative policies, procedures, and operational issues
- ✓ Performance pattern monitoring
- ✓ Membership/provider roster questions
- ✓ Secure Portal registration and Pay Span
- ✓ Provider education
- ✓ HEDIS/Care gap reviews
- ✓ Financial analysis
- ✓ EHR Utilization
- ✓ Demographic information updates
- ✓ Initiate credentialing of a new practitioner

THE ARTC PUBLIC WEBSITE

www.arkansastotalcare.com



THE ARTC PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

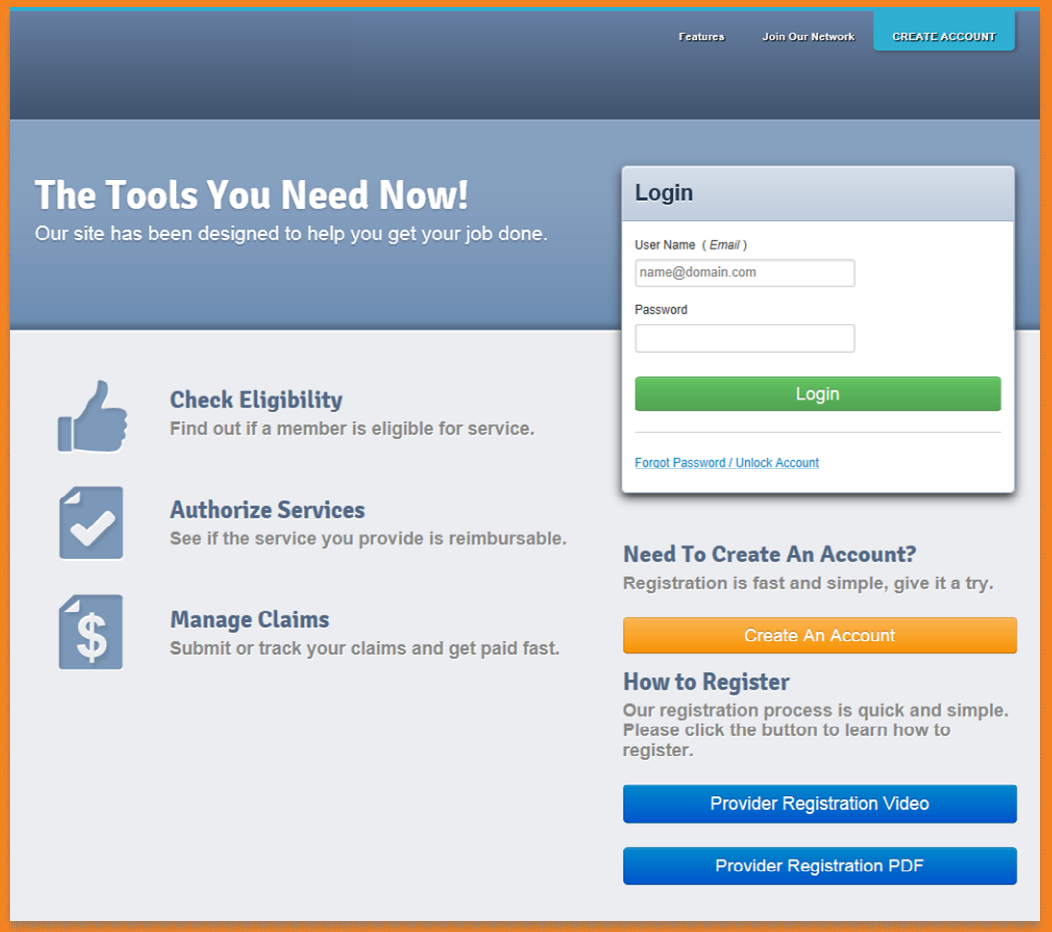
- The Provider and Billing Manual
- Quick Reference Guides
- Important Forms (Claim Dispute Form, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing
- And much more!

SECURE PROVIDER PORTAL

Registration is free and easy!

A registration video and PDF are available to assist you.

Contact your Provider Relations Specialist if you have questions.



SECURE PROVIDER PORTAL

What's on the Secure Provider Portal?

- Member Eligibility
- Health Records & Care Gaps
- Authorizations
- Claims Submissions & Claim Status
- Corrected Claims & Adjustments
- Payment History
- Monthly PCP Cost Reports
- Provider Analytics Reports (Coming Soon!)

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

MEMBER ID CARD

**** Possession of an ID Card is not a guarantee of eligibility and benefits***

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

PROVIDERS MUST VERIFY MEMBER ELIGIBILITY

- Every time a member schedules an appointment
- When the member arrives for the appointment

PANEL STATUS

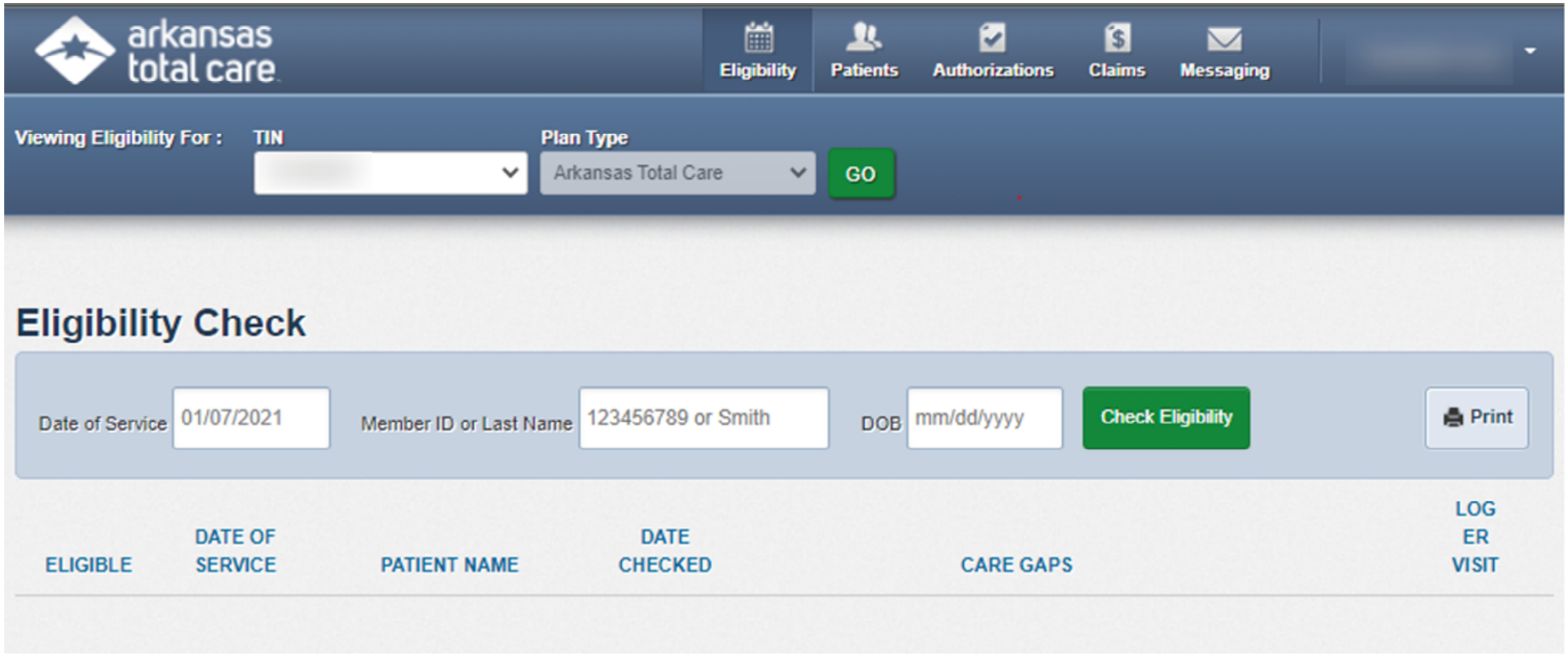
- Primary Care Physicians (PCPs) should confirm that a member is assigned to their patient panel
- This can be done via our Secure Provider Portal
- PCPs can still administer services if the member is not on their panel and they wish to have member assigned to them for future care

VERIFICATION OF ELIGIBILITY AND BENEFITS

ELIGIBILITY AND BENEFITS CAN BE VERIFIED IN 3 WAYS:

- ✓ **The Arkansas Total Care Secure Portal: Provider.arkansastotalcare.com**
- ✓ **24/7 Interactive Voice Response System**
  - Enter the Member ID Number and the month of service to check eligibility
- ✓ **Contact Provider Services: 1-866-282-6280**

VERIFICATION OF ELIGIBILITY ON THE PORTAL



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SPECIALTY REFERRALS

WHEN OUR MEMBERS NEED TO VISIT A SPECIALIST, KNOW THAT:

- We educate them to seek care or consultation with their Primary Care Provider (PCP) first
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers
- *PAPER REFERRALS ARE NOT REQUIRED FOR MEMBERS TO SEEK CARE WITH IN-NETWORK SPECIALISTS*

HOW TO SECURE PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION? It can be requested in THE FOLLOWING ways:

✓ Secure Web Portal

Provider.arkansastotalcare.com

This is the preferred and fastest method.

✓ Phone

1-866-282-6280

✓ Fax

1-833-249-2342

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned via phone, fax or web.

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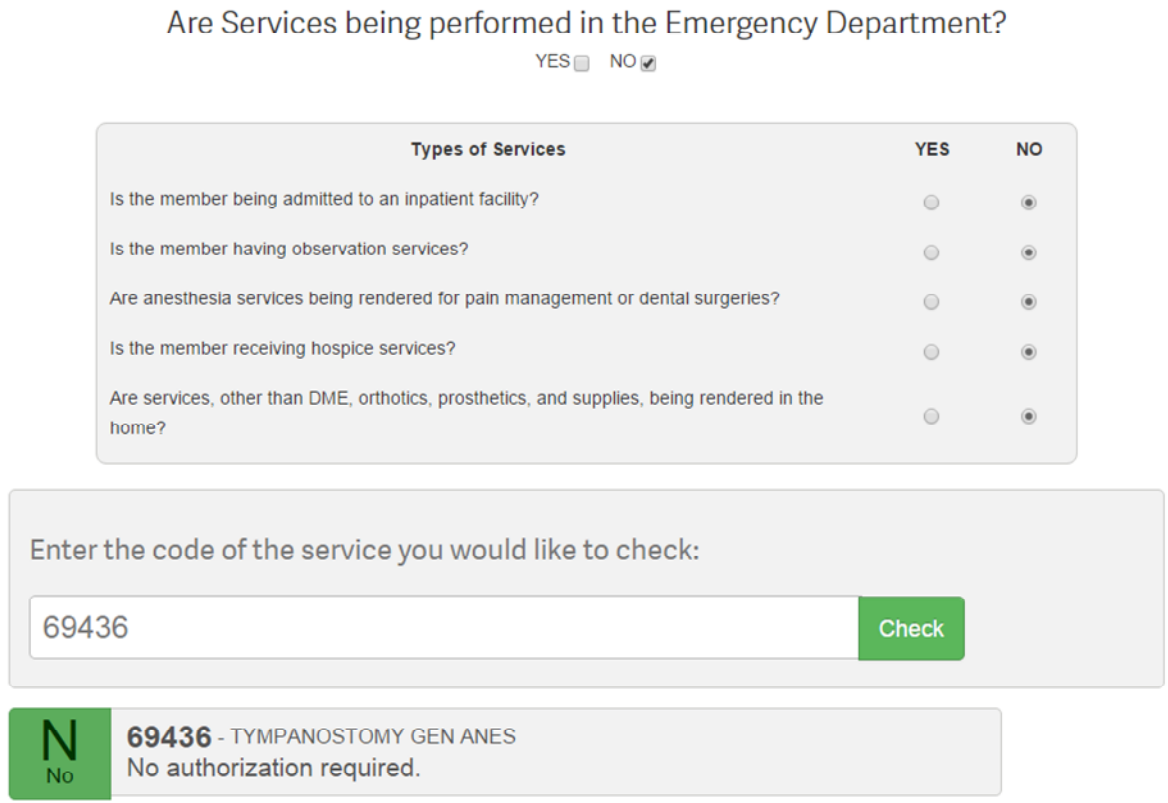
IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.

- Available on the provider section of the Arkansas Total Care website at **www.arkansastotalcare.com**



PRIOR AUTHORIZATION REQUIREMENTS

PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility
- Obstetrical ultrasound
  - Two allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists.
  - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PRIOR AUTHORIZATION REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING*:

- All elective/scheduled admission notifications requested at least 5 business days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral health/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Observation stays exceeding 23 hours require Inpatient Authorization
- Urgent/Emergent Admissions
- Within 1 business day following the date of admission
- Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization*

PRIOR AUTHORIZATION REQUIREMENTS

ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (DME)
- Home health care services including, home infusion, skilled nursing, and therapy:
  - Home health services
  - Private duty nursing
  - Adult medical day care
  - Hospice
  - Furnished medical supplies & DME

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PRIOR AUTHORIZATION TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five (5) business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within 24 hours or by the next day
Organ transplant initial evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.
Clinical trails services	Prior Authorization required at least 30 days prior to receiving clinical trial services.

UTILIZATION DETERMINATION TIMEFRAMES

Type	Timeframe*
Prospective/Urgent	1 Business Day
Prospective/Non-Urgent	Two (2) business days
Concurrent/Urgent	1 Business Day

*Turnaround time (Timeframe) is based on receipt of all necessary information.

CORRECT CODING FOR PRIOR AUTHORIZATION

PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.

- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.
    - It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission or the claim will deny.

- Arkansas Total Care will update authorizations but will **not** retro-authorize services.
    - The claim will deny for lack of authorization.
    - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

CLAIMS

WHAT IS A CLEAN CLAIM?

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

ARE THERE ANY EXCEPTIONS?

- A claim for which fraud is suspected
- A claim for which a third party resource should be responsible

HOW TO SUBMIT A CLAIM

THE TIMELY FILING DEADLINE FOR INITIAL CLAIMS IS 365 DAYS FROM THE DATE OF SERVICE OR DATE OF PRIMARY PAYMENT WHEN ARKANSAS TOTAL CARE IS SECONDARY.

CLAIMS MAY BE SUBMITTED IN 3 WAYS:

1. **The Secure Provider Portal**
   - Provider.arkansastotalcare.com

2. **Electronic Clearinghouse**
   - Payor ID 68069

3. **Mail**
   Arkansas Total Care
   Attn: Claims
   PO Box 8020
   Farmington, MO 63640-8020

CLAIM RECONSIDERATIONS AND DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, Providers can use the **Reconsider Claim** button on the Claim Details screen within the portal
- A written request from a provider about a disagreement in the manner in which a claim was processed. The Claim Dispute form should be utilized.
- Must be submitted within 180 days of the Explanation of Payment.
- Mail claim reconsiderations to:

  P.O. Box 8020

  Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at arkansastotalcare.com
- Mail completed Claim Dispute form to:

  P.O Box 8020

  Farmington, MO 63640-5000

OTHER HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

- Claims **must** be submitted with the rendering provider's taxonomy code
- The claim will deny if the taxonomy code is not present
- This is necessary in order to accurately adjudicate the claim

AND DON'T FORGET THE CLIA NUMBER!

- If the claim contains CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of a paper claim form or in the appropriate loop for EDI claims
- Claims will be rejected if the CLIA number is not on the claim

CLAIMS PAYMENTS: ELECTRONIC FUNDS TRANSFER

PAYSPAN: A FASTER, EASIER WAY TO GET PAID

- Arkansas Total Care offers PaySpan Health, a free solution that helps providers transition into electronic payments and automatic reconciliation
- If you currently utilize PaySpan, you will need to register specifically for Arkansas Total Care
- **Set up your PaySpan account:**
  - Visit www.payspanhealth.com and click Register
  - You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

COMPLAINTS, GRIEVANCES AND APPEALS

APPEALS

- Claims: The Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing a State Fair Hearing
- Authorization Appeal (Medical Necessity): An appeal request must be exhausted prior to filing a State Fair Hearing

AUTHORIZATION APPEAL (MEDICAL NECESSITY)

- Must be filed within 60 calendar days from the Notice of Action
- Arkansas Total Care shall acknowledge receipt within 5 business days of receiving Standard appeals
    - An oral expedited appeal request must be follow with a written, signed appeal within ten (10) calendar days of the oral filing.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health of the member or the member's ability to regain maximum function.

COMPLAINTS, GRIEVANCES AND APPEALS

MEMBER REPRESENTATIVES

- Members may designate a provider to act as their representative for filing appeals related to medical necessity
    - ARTC requires that this designation by the member be made in writing and provided to ARTC
- No punitive action will be taken against a provider by Arkansas Total Care for acting as a member's representative

NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual, located on our website at www.arkansastotalcare.com

OUR SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	866-282-6280 www.radmd.com
Vision Services	Envolve Vision Benefits	1-800-334-3937 www.envolvevision.com
Pharmacy Services	Envolve Pharmacy Solutions	866-282-6280 (Phone) 1-866-399-0929 (Fax)
Orthopedic and Spinal Surgical Services	TurningPoint	1-866-619-7054 (Phone) 501-263-8850 (Phone) 501-588-0994 (Fax) https://myturningpoint-healthcare.com

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QUESTIONS?