arkansas total care™

Q2 2026
Provider Webinar

Disclaimer

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- The presentation is a general summary that explains certain aspects of the program and 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

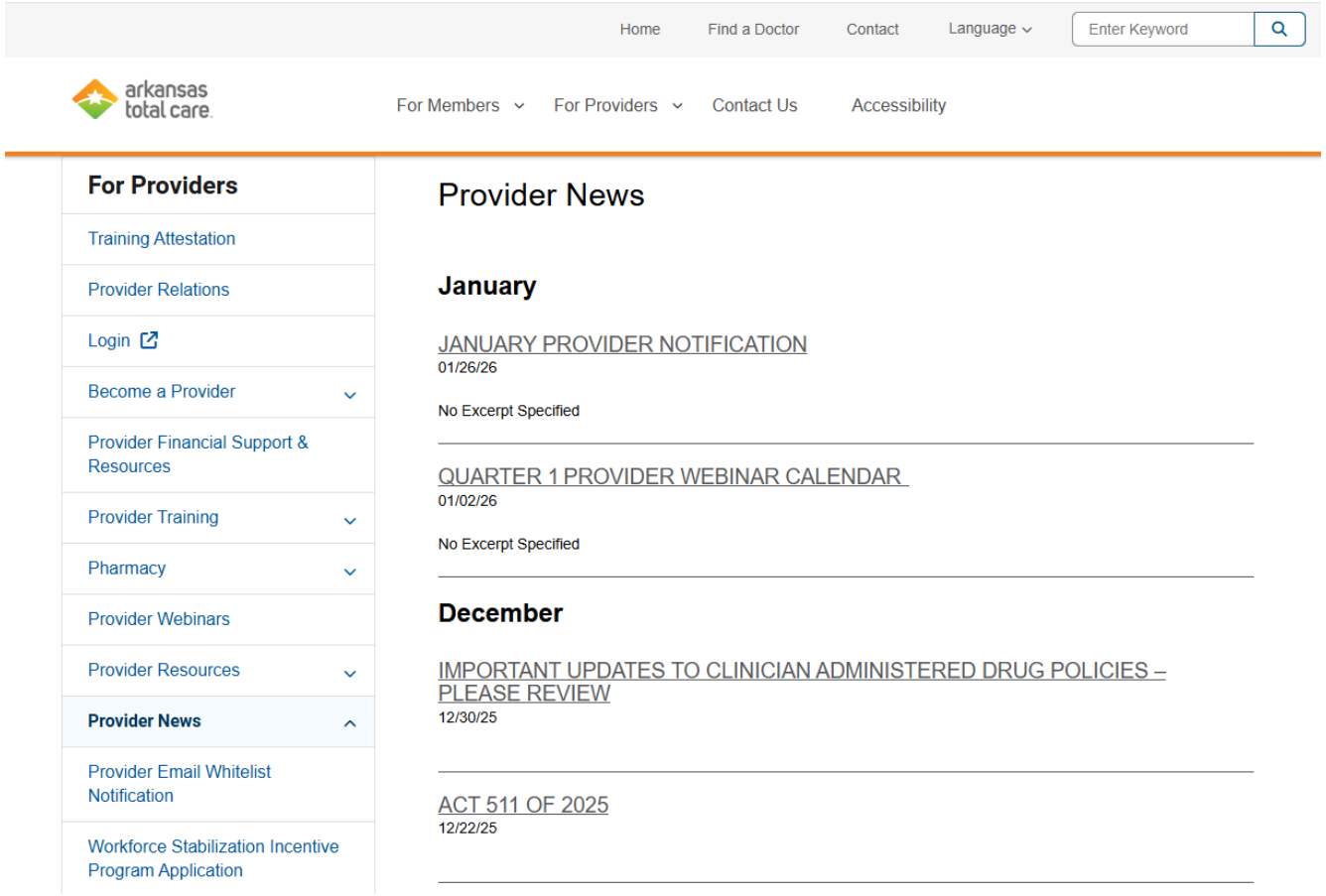
Arkansas Total Care Updates

- Provider News
- Clinical & Payment Policies
- Appointment Availability & Wait Times
- Claim Reconsiderations & Disputes
- Health Plan Updates
- New Supportive Living Criteria Policy
- Arkansas Medicaid ID Requirement
- Roster Notification
- Cultural Competency Trainings
- Provider Training
- Fraud, Waste, & Abuse
- Provider Demographic Accuracy
- Prior Authorizations
- Availity Essentials
- Secure Provider Portal
- Key Contacts

Provider News

Did you know we publish provider news articles on our website? With information on webinars, resources for educating patients and staff, and health plan policy changes and updates, our Provider News page is a great way to stay informed about how we can partner with you to help Arkansas live better.

Visit our Provider News page at ArkansasTotalCare.com.



Clinical & Payment Policies

Clinical & Payment Policies

Arkansas Total Care clinical, payment, and pharmacy policies are available online. To view them:

- Visit ArkansasTotalCare.com.
- Select Provider Resources from the For Providers menu tab.
- Select Clinical & Payment Policies.
- Use the Ctrl+F (Command+F on Mac) function on your keyboard to search by keyword, policy number, or effective date.

If you have questions, please call 1-866-282-6280 (TTY: 711).

Appointment Availability & Wait Times

Appointment Availability & Wait Times

Arkansas Total Care follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Arkansas Total Care monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care, and to reduce inappropriate emergency room utilization.

Appointment access audits:

- Arkansas Total Care may conduct appointment accessibility surveys telephonically and/or on-site or ad hoc for complaint/grievance investigation to determine appointment availability based on requirements outlined in the Provider Manual and state contract for each line of business.
- Arkansas Total Care may survey its top five specialties to ensure that specialty access standards are being met. The state may determine which specialties are to be audited, and the health plan shall comply with those requirements.
- Arkansas Total Care may assess and randomly audit PCPs and providers in each geographic region to ensure that certain services are available.

Appointment Availability & Wait Times

Service Type	Time Frame
Emergency care (medical, behavioral health, substance abuse)	Available 24 hours a day, seven days a week
Behavioral health service, developmental disability service, mobile crisis service, mobile crisis response	Available 24 hours a day, seven days a week
Urgent care (medical, behavioral health, substance abuse)	Available within 24 hours
Primary care (routine, non-urgent symptoms)	Available within 21 calendar days
Behavioral health and substance abuse care (routine, non-urgent, non-emergency)	Available within 21 calendar days
Prenatal care	Available within 14 calendar days
Primary care access to after-hours care	Office phone number must be answered 24/7 by an answering service or provide instructions on how to reach a physician
Preventive visit/wellness visit	Available within 30 calendar days
Specialty care (non-urgent)	Available within 60 calendar days
HCBS (identified as necessary to protect the health and safety of the member)	Available within 90 calendar days of completion of the PCSP

Claim Reconsiderations & Disputes

Requests for Reconsideration

Claim reconsiderations occur when a provider disagrees with the original claim outcome (payment amount, denial reason, etc.).

Reconsiderations may be submitted using one of the following ways:

- Using the Request for Reconsideration form available on our website (preferred method)
- Calling the Provider Services department
- Online through the Provider Portal
- Sending a written letter that includes a detailed description of the reason for the request
  - To ensure timely processing, the letter must include sufficient identifying information, which includes, at a minimum, member name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in Box 22 of the CMS 1500 form or Field 64 of the UB-04 form.

Reconsideration requests must be submitted within 180 days of the date of the original explanation of payment or denial for contracted providers.

Claim Disputes

A claim dispute occurs when a provider disagrees with the outcome of the request for reconsideration.

- A claim dispute/claim appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute form is submitted and a reconsideration request is not located in our system, the dispute will be considered a reconsideration.
- A claim dispute/appeal must be submitted on the claim dispute form located under the Provider Resources page. The form must be completed in its entirety.
- A claim dispute/appeal will be resolved within 30 calendar days. The provider who filed the dispute/appeal will receive a written letter detailing the decision to overturn or uphold the original decision.

Health Plan Updates

New Supportive Living Criteria Policy

The Supportive Living Criteria policy supports the utilization management review process for the CES-Waiver benefits and management of service coverage and limitations as described in the current CES-Waiver and Arkansas Total Care Provider Waiver Services Manual.

It is the provider's responsibility to ensure that all information submitted is an accurate and current representation of the member's needs. Instances in which information is not current or accurate could lead to investigation of potential fraud, waste, or abuse.

Arkansas Medicaid ID Requirement

Arkansas Medicaid ID Requirement

Effective **October 15, 2025**, providers that meet the below criteria will be required to submit their Arkansas Medicaid ID to Arkansas Total Care on each claim submission.

1. All atypical providers and practitioners that bill for the following provider types:
   67, 70, 71, 72, 73,74, 75, 82, 84, 86, 87, 95, 96, 97
2. All providers that bill under a single NPI number with multiple associated Medicaid IDs.

All claims meeting the above criteria will be denied, when the Arkansas Medicaid ID is not billed.

Arkansas Medicaid ID Requirement

Professional EDI claims billing provider NPI, taxonomy, and Medicaid ID:

2010BB: Billing Provider Secondary Identification			
2010BB: Billing Provider Secondary Identification	REF	For healthcare providers, submit the Medicaid Provider ID in REF02, the NPI in Loop 2010AA, and taxonomy in Loop 2000A. For atypical providers, submit the Medicaid ID only in REF02.	
		REF01	Value = G2 (Provider Commercial Number)
		REF02	Length = 9 Value = Billing Provider Secondary Identification (Medicaid Provider ID)

Arkansas Medicaid ID Requirement

Professional EDI Claims Rendering Provider Medicaid ID:

2310B: Rendering Provider Secondary Identification			
2310B: Rendering Provider Secondary Identification	REF	For healthcare-rendering providers, submit the Medicaid Provider ID in REF02 and submit the NPI and Taxonomy in Loop 2310B.	
		REF01	Value = G2 (Provider Commercial Number)
		REF02	Length = 9 Value = Rendering Provider Secondary Identification (Medicaid Provider ID)

Roster Notification

Roster Notification

The PASSE program has been working with other carriers to streamline its enrollment processes to create a uniform roster template. This will allow providers to fill out a single roster that every carrier can accept for adding, terminating, or updating provider information. Rosters will continue being submitted to ArkCredentialing@centene.com

Practitioners who require credentialing must still include the following:

- Attestation
- Disclosure of Ownership
- CAQH ID
  - MD/DOs are required to submit our MD/DO specific application
  - If you do not have a CAQH ID, you are required to submit our application

Required fields left blank will be returned to the provider for completion. Features of the new roster include:

- Separate tabs for
  - Full Roster
  - Adds
  - Terms
  - Updates
  - Guidance
  - Field Options
- Columns on the Full Roster tab that identify which products are covered by the practitioner's contract
- Instructions on how to use each tab
- An outline of data elements on each tab, marked as "required" or "optional"C

Cultural Competency Trainings

Cultural Competency Trainings

- Arkansas Total Care now provides self-led trainings for providers to complete at their leisure.
- This course allows providers to receive information on how to service the member's healthcare needs in a culturally competent manner.
- Submit the attestation form on our website to confirm course completion.

Fraud, Waste, & Abuse

Fraud, Waste, & Abuse

- Arkansas Total Care takes the detection, investigation, and prosecution of fraud, waste, and abuse (FWA) very seriously and has a FWA program that complies with the federal and state laws.
- Arkansas Total Care routinely conducts audits to ensure compliance with billing regulations.
- The Centene Special Investigation Unit (SIU) performs retrospective audits, which may result in taking actions against providers who commit FWA.

Fraud, Waste, & Abuse

These actions may include but are not limited to:

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

Some of the most common FWA submissions seen are:

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

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664

Provider Demographic Accuracy

Provider Demographic Accuracy

- Verify your demographic data through credentialing, rosters, provider date change forms, and/or third-party vendor requests, such as LexisNexis.
- Maintaining correct clinic information ensures our members are able to locate the providers they need through the Arkansas Total Care provider directory.
- Changes can be submitted through the Provider Portal or by submitting a provider data change form to ArkCredentialing@centene.com.
- Changes can include, but are not limited to:
  - Adding or removing a location
  - Updating your phone number
  - Removing inactive practitioners
- We are required to report directory accuracy to the state.

Prior Authorizations

Prior Authorizations

Prior Authorizations can be requested in the following ways:

Provider Portal: This is the preferred and fastest method.

- Provider.ArkansasTotalCare.com

Phone:

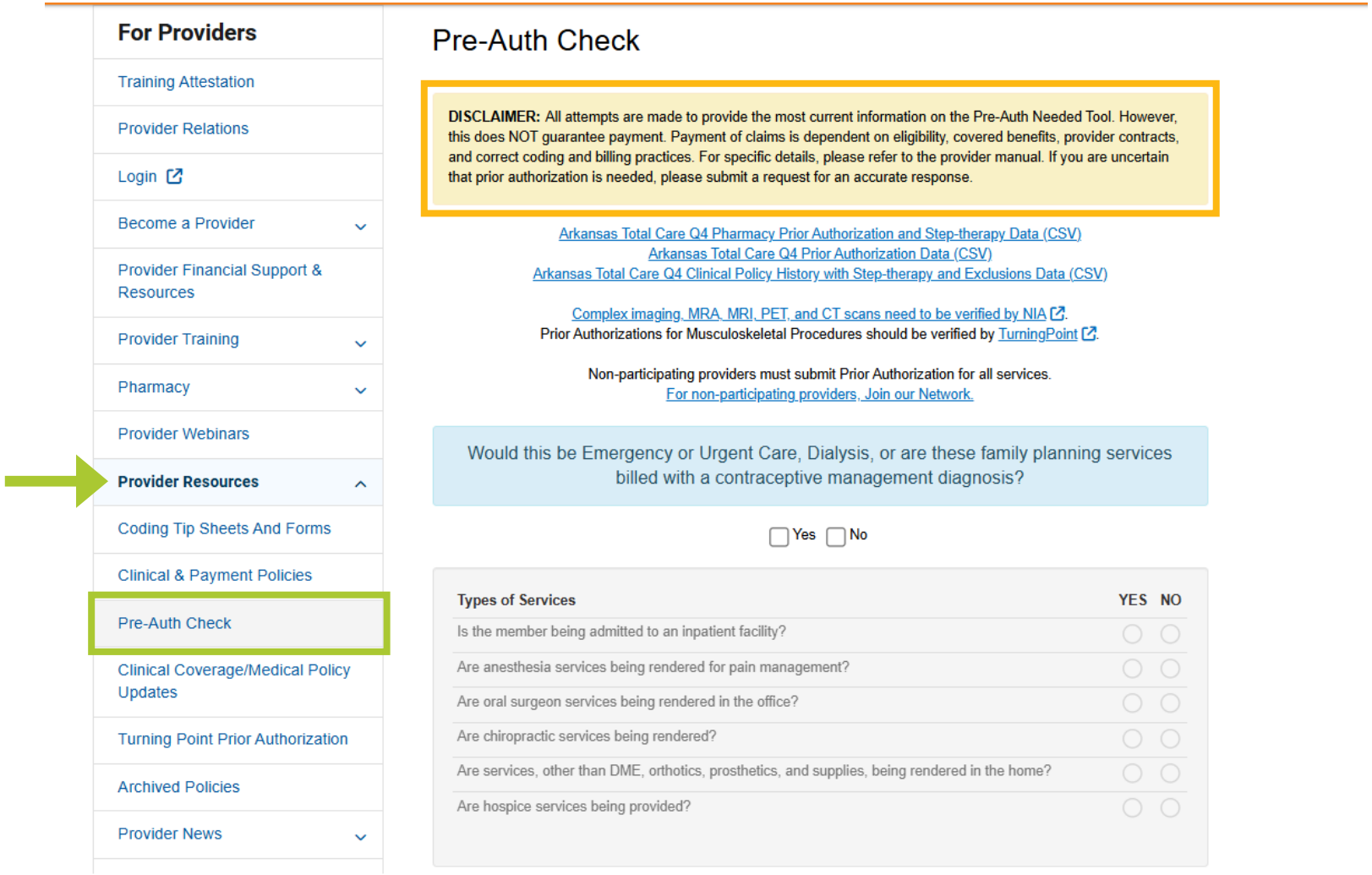
- 1-866-282-6280 (TTY: 711)

Fax: IP and OP forms are available on the Provider Resources page.

- 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 Provider Portal.

Pre-Auth Check Tool



Prior Authorizations

Effective April 1, 2026, Arkansas Total Care may:

- Remove Prior Authorization requirements based on criticality of review and clinical need
- Create a more uniform set of Prior Authorization requirements across its market, including adding and changing some requirements, to simplify processes, reduce confusion, and support future efforts to expand real-time responses to requests

Availity Essentials

Availity Essentials

Arkansas Total Care has a new platform for the Secure Provider Portal called Availity.

Benefits of Availity:

- Validate eligibility and benefits
- Submit claims
- Check claim status
- Submit authorizations
- Access Arkansas Total Care payer resources

If you are already working in Essentials, you can log in to your existing Essentials account External Link to enjoy these benefits for Arkansas Total Care's members.

If you are new to Availity Essentials, getting your Essentials account and delegating an Availity administrator for your provider organization is the first step toward working with Arkansas Total Care on Availity.

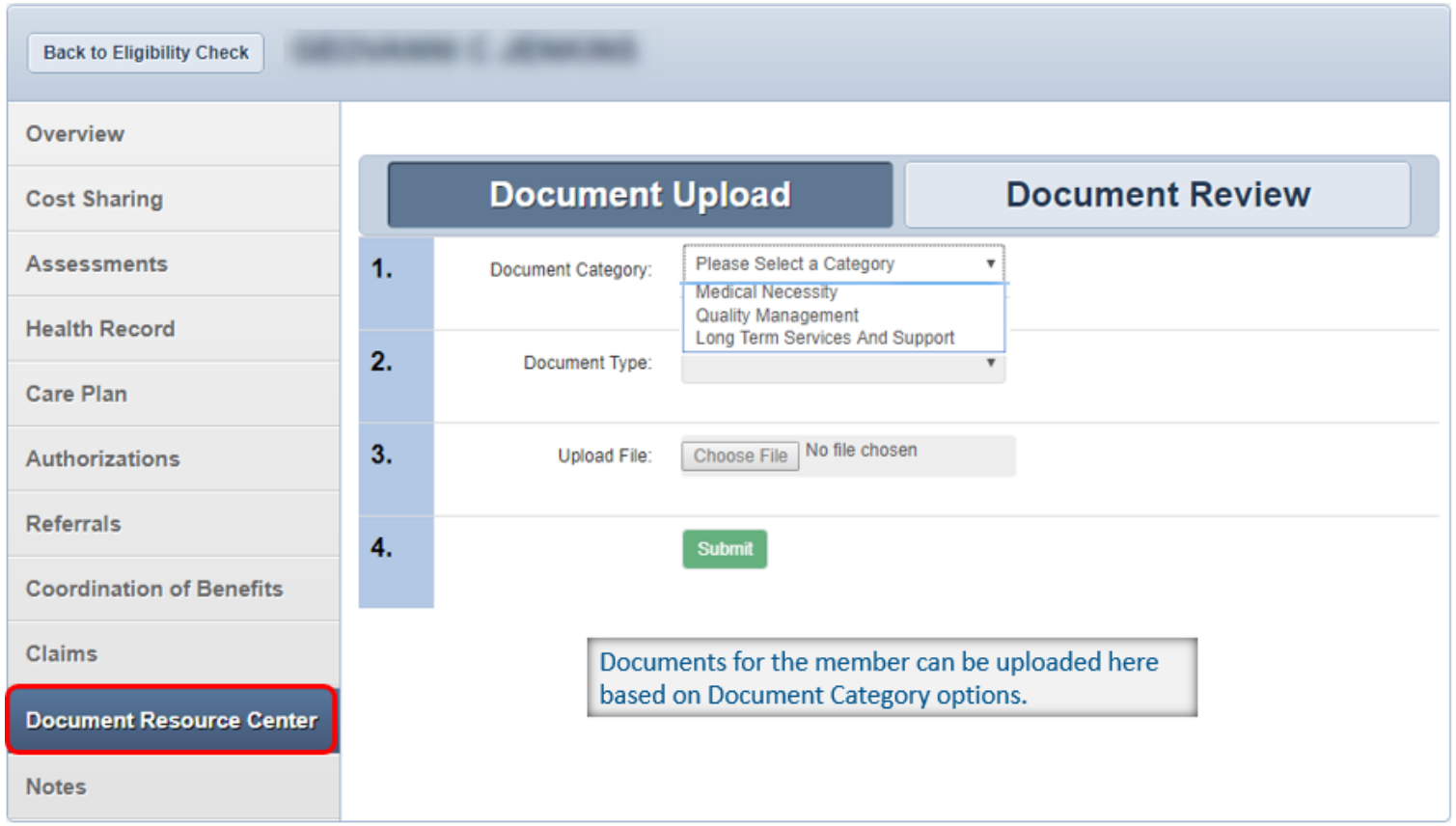
For additional assistance with your registration, please call Availity Client Services at 1-800-AVAILITY (1-800-282-4548). Assistance is available Monday through Friday from 7 a.m. to 7 p.m. CT.

Secure Provider Portal

Features

- A member eligibility overview page that reflects all critical data in a single view
- Ability to submit and track the status of claim reconsiderations online
- Expanded free text fields for reconsideration comments and explanations
- Ability to attach required documentation when filing a reconsideration
- Ability to upload records for care gap information.
- Option to receive push notifications regarding reconsideration status changes
- Void/recoup option on claims already adjudicated by the health plan

Patient Overview: Document Resource Center



Key Contacts

Department	Phone/Website	Fax/Email
HHAeXchange Support	1-855-400-4429	HHA Client Support Portal
EDI Claims Assistance	1-800-225-2573 ext. 6075525	EDIBA@centene.com
TurningPoint	501-263-8850/1-866-619-7054	501-588-0994
Evolent Advanced Imaging (MRI,CT, PET)	1-866-500-7685 RadMD.com	N/A

Provider Services Call Center

First line of communication:

Arkansas Total Care Provider Services Call Center

- 1-866-282-6280 (TTY: 711)

Representatives are available
Monday through Friday, 8 a.m.–5 p.m. CT.

Provider Service Representatives can assist with:

- Eligibility
- Authorizations
- Claims
- Negative balance reports
- Payment inquiries
- Appeals
- Check re-issues
- Provider Portal password resets

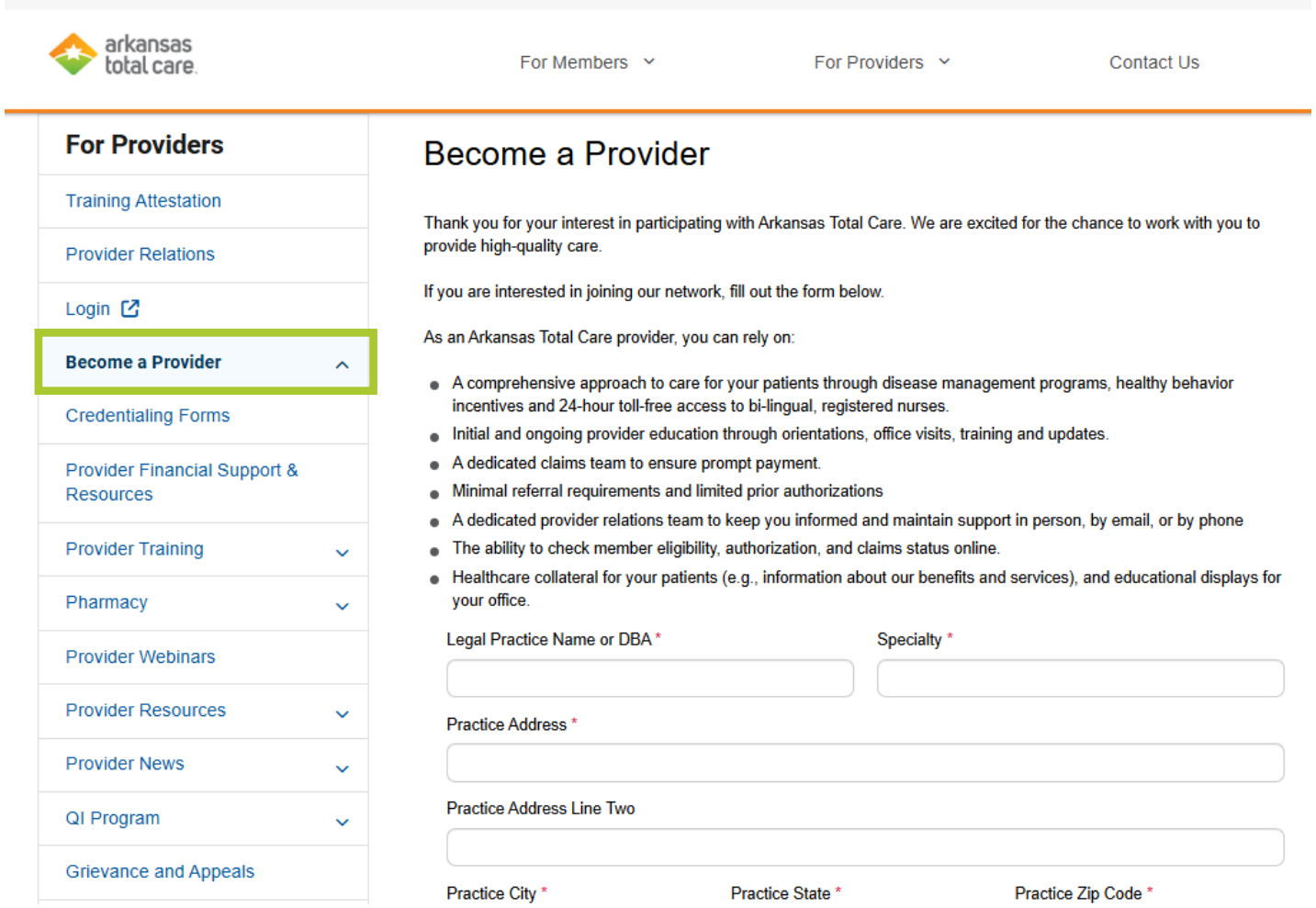
Second line of communication:

Email:

- Providers@ArkansasTotalCare.com
  - Any related call reference number assigned by Provider Services
  - Provider's Name, Tax ID (TIN), and NPI
  - Summary of issue
  - Claim numbers (if applicable)

Provider Contracting

To join our network, visit our website and select **Become a Provider** from the For Providers tab. You must be a current participating Arkansas Medicaid provider.



Contracting and Credentialing

Contracting

- ArkansasContracting@centene.com

  Regular contracting inquiries and contract requests are answered between 8 a.m. and 4:30 p.m.

Credentialing

- ArkCredentialing@centene.com

Stay Connected

- Join our email list to get the latest health plan news
- Questions? Email us!
  - Providers@ArkansasTotalCare.com
  - Include "**Provider Webinar**" in the subject line.