arkansas total care™

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

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.
- PASSEs were developed in Arkansas to provide more extensive care coordination to high-needs intellectually/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.

What You Need to Know

Key Contact Information

Arkansas Total Care

Phone

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

Web

- ArkansasTotalCare.com

Portal

- Provider.ArkansasTotalCare.com

Getting Acquainted

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 such as:

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

The Provider Manual

The Provider Manual s your comprehensive guide to doing business with Arkansas Total Care.

The Manual includes a wide array of important information relevant to providers, including:

- 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 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 **1-866-282-6280**, 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 Engagement Account Managers serves 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
- Secure Portal registration and training
- Provider education
- Financial analysis
- EHR utilization
- Demographic information updates
- Escalation assistance

Provider Relations

Provider Relations Support

The Provider Relations team assists with:

- Escalated concerns
- Policy and procedure clarification
- Training for new and existing providers
- Provider Outreach and Engagement activities

When contacting your **assigned Provider Engagement Account Manager**, please include:

- Call reference number assigned by Provider Services
- Provider name
- Tax ID (TIN)
- National Provider Identifier (NPI)
- Summary of the issue
- Applicable claim numbers (if any)

The ARTC Public Website

ArkansasTotalCare.com

The ARTC Public Website

What's on the public website?

- Provider and Billing Manual
- Quick reference guides
- Important forms (claim disputes, prior authorization, etc.)
- Pre-Auth Needed tool
- Policies
- Preferred Drug List
- And much more!

Clinical Policies

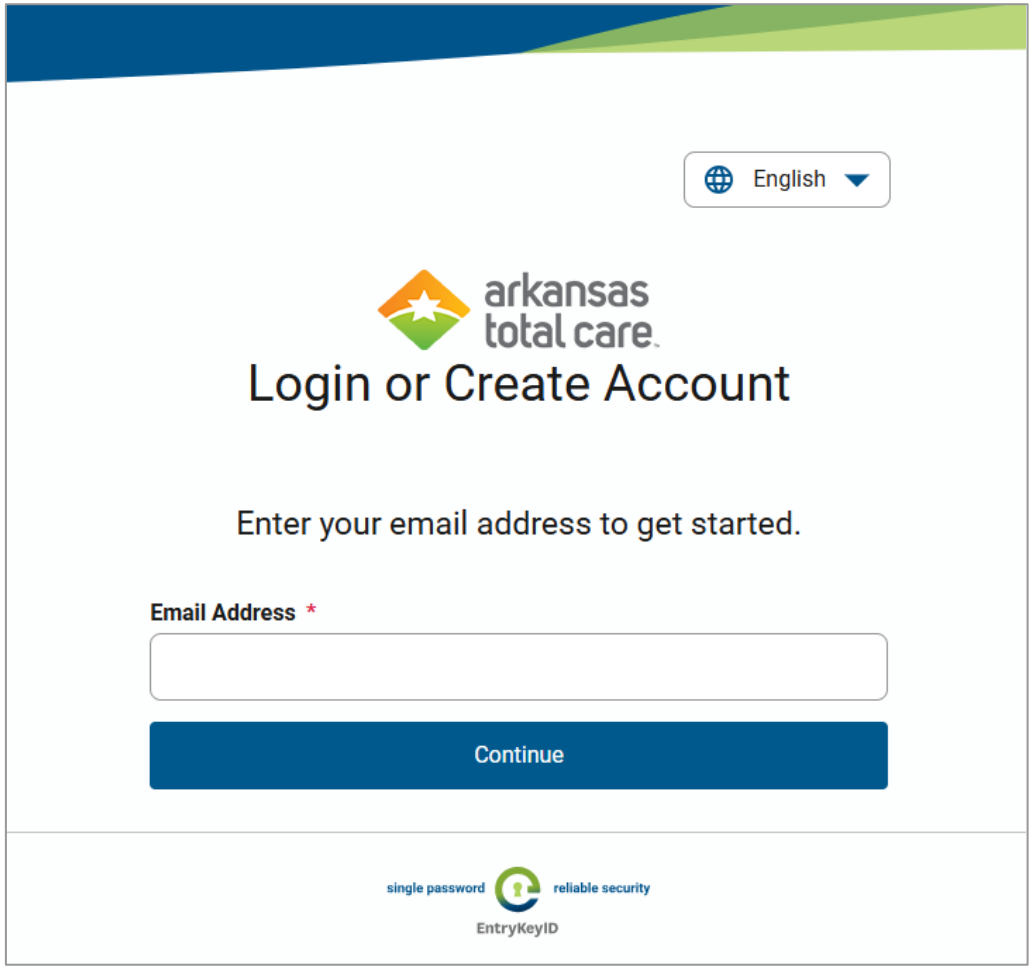
Arkansas Total Care routinely amends and/or implements clinical and payment policies.

- These policies are available online at ArkansasTotalCare.com.
- To view our latest policy updates, visit our Clinical Coverage/Medical Policy Updates page.

Secure Provider Portal

Registration is free and easy at Provider.ArkansasTotalCare.com

- 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

Verification of Eligibility, Benefits, and Cost Share

Providers must verify member eligibility:

- Prior to rendering services
- Services are rendered

Panel status:

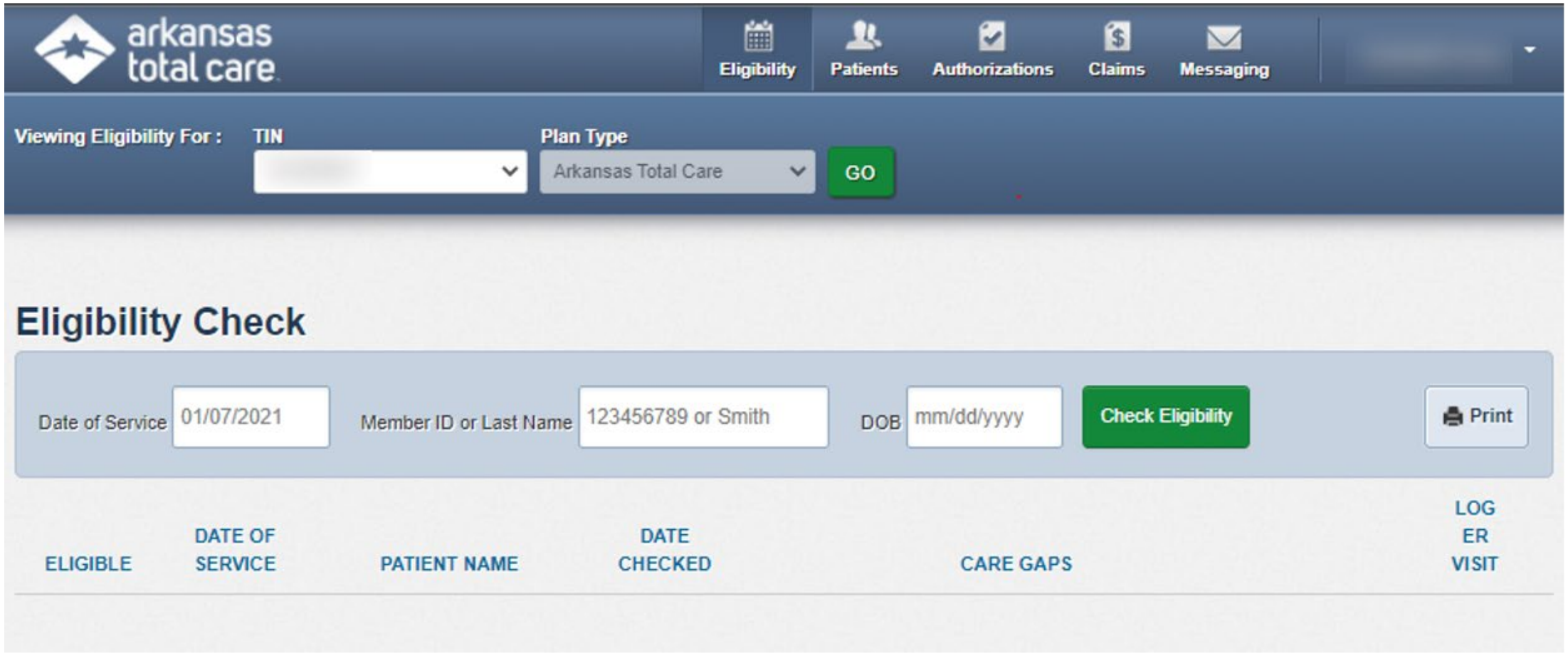
- PCPs should confirm that a member is assigned to their patient panel. This can be done via our Secure Provider Portal.
- PCPs can still administer services if the member is not on their panel and they wish to have the member assigned to them for future care.

Verification of Eligibility and Benefits

Eligibility and benefits can be verified in three ways:

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

Verification of Eligibility on The Portal



Specialty Referrals

When our members need to visit a specialist, know that:

- We educate them to seek care or consultation with their 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 specialists.
- 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.

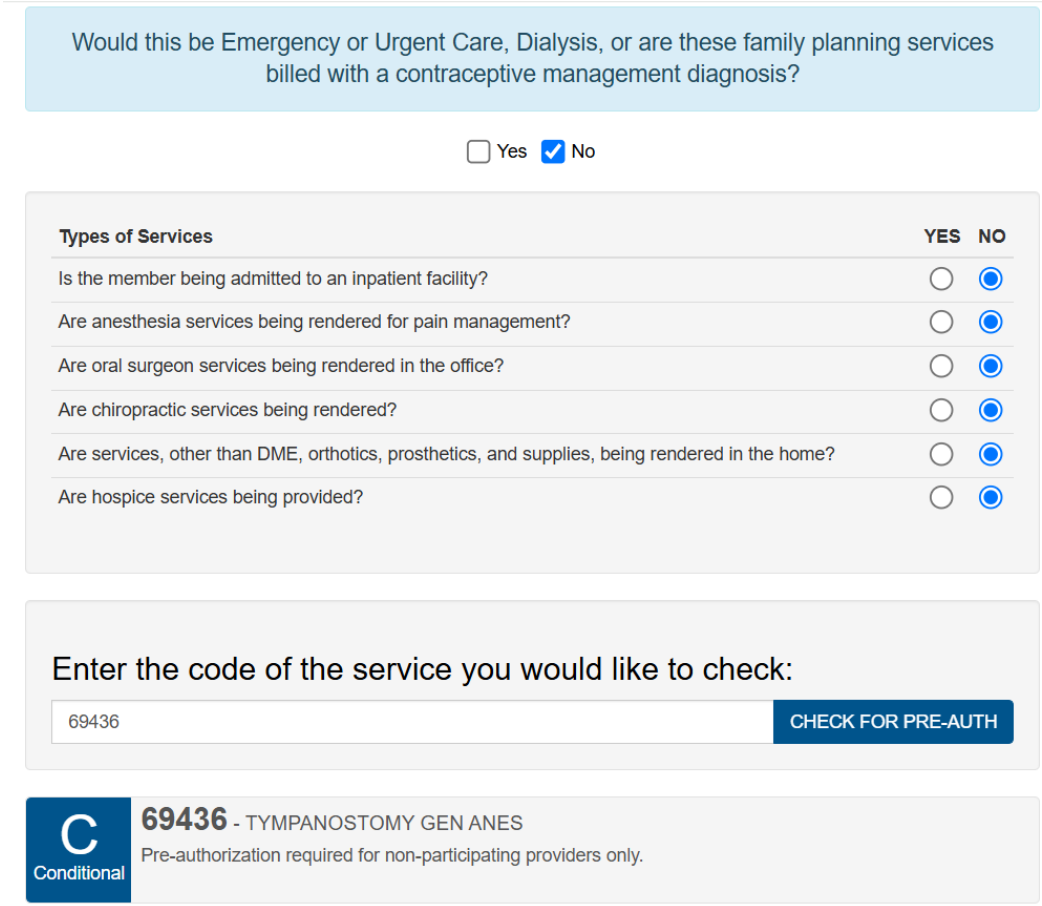
Phone: 1-866-282-6280

Fax: 1-833-249-2342

Availity Client Services:
Availity.com, 1-800-AVAILITY (282-4548)

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.

Is Prior Authorization Needed?



- Use the **Pre-Auth Check tool** to quickly determine if a service or procedure requires prior authorization.
- Available at **ArkansasTotalCare.com**

Prior Authorization Requirements

Procedures/services that need prior authorization:*

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (CT, MRI, PET)
- Infertility
- Pain management
- Obstetrical ultrasound
  - Two allowed in nine-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.

**This list is not all-inclusive. Use the Pre-Auth Check tool to verify whether a specific service or procedure requires prior authorization.*

Prior Authorization Requirements

Ancillary services that need prior authorization:*

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (DME)*
- Home healthcare 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 Check tool to verify if a specific service or procedure requires prior authorization.*

Prior Authorization Timeframes

Service Type	Time Frame
Scheduled admissions	Prior authorization required at least five business days before the scheduled admission date for residential admissions *unless* the member is stepping down directly from a higher level of care
Elective outpatient services	Prior authorization required at least five business days before service date
Emergent inpatient admissions	Notification required within 24 hours, or by the next business day following a weekend or holiday
Continued Inpatient Stay	Notification required within 24 hours of the last approved day
Maternity Admissions	Notification required within 24 hours, or by the next business day following a weekend or holiday
Clinical trials services	Prior authorization required at least 30 days before receiving services

Utilization Determination Timeframes

Type	Timeframe*
Prospective/Urgent	One business day
Prospective/Non-Urgent	Two business days
Concurrent/Urgent	One business day

*Turnaround time 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.

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 the date of primary payment when Arkansas Total Care is secondary.

Claims may be submitted in four ways:

1. **The Secure Provider Portal**
   Provider.ArkansasTotalCare.com
2. **Electronic Clearinghouse**
   Payor ID 68069
3. **Mail**
   Arkansas Total Care
   Attn: Claims
   P.O. Box 8020
   Farmington, MO 63640-8020
4. **Availity Essentials**

EVV/HHA Exchange

EVV uses electronic means to verify provider visits for personal or home healthcare services. Information collected during such visits includes:

- The date of service
- The start and end times for service provided
- The type of healthcare service performed
- The location of the service provided
- Details about the service provider

EVV offers a modern way for providers to record their visits by location, time, and tasks. Visits can be logged using an app on the caregiver's cell phone, or over the member's landline phone.

Arkansas Total Care works with HHAeXchange to process EVV submissions. To avoid claim denials, any visits for the services above must be submitted through an EVV system. You can submit these visits via HHAeXchange or a chosen third-party EVV system that aggregates with HHAeXchange.

Claim Reconsiderations and Disputes

Claim Reconsiderations

- For reconsideration requests, use the **Reconsider Claim** button on the Claim Details screen within the Provider Portal.
- To submit a written request about a disagreement in the manner in which a claim was processed, use the Claim Dispute form available on our website.
- Requests must be submitted within 180 days of the Explanation of Payment.
- Paper requests should be mailed to:
  P.O. Box 8020
  Farmington, MO 63640-5010

Claim Disputes

- Must be submitted within 180 days of the Explanation of Payment using the Claim Dispute form available on our website
- Mail completed Claim Dispute form to:
  P.O Box 8020
  Farmington, MO 63640-5000

Complaints, Grievances, and Appeals

Provider Complaint/Grievance and Appeal Process

Claim complaints must follow the Dispute process first, then the Complaint Process. Medical necessity and authorization denial complaints are handled in the Appeal process. Please note that claim payments are not appealable. These must be handled via the Claim Dispute and Complaint process.

Claim Disputes may be mailed to:

Arkansas Total Care
Attn: Appeals Department
PO Box 25010
Little Rock, AR 72221

Learn more at ArkansasTotalCare.com, or refer to your Provider Manual.

Other Helpful Information About Claims

Make sure to include the taxonomy code when a NPI is billed!

- 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.

Other Helpful Information

- Every claim submitted to Arkansas Total Care undergoes established verification procedures.
- Member ID and date of birth combinations must match an enrolled Arkansas Total Care member.
- Refer to this manual for complete details on taxonomy requirements.
- Confirm that all diagnosis, procedure, modifier, location (place of service), revenue, type of admission, and source of admission codes are valid for:
  - The applicable date of service
  - The billing provider type and/or provider specialty
  - The member's age and/or sex for the date of service billed
- Every diagnosis code is documented to the greatest number of digits available.

Other Helpful Information

Atypical provider

- Atypical providers are not always assigned an NPI number; however, if an atypical provider has been assigned an NPI, they need to follow the same requirements as a medical provider. An atypical provider that provides non-medical services is not required to have an NPI number (e.g. carpenters, transportation, etc.).
- Existing atypical providers need only send the provider tax ID in the ref segment of the billing provider loop.

Note: If an NPI is billed on any part of the claim, it will not follow the atypical provider logic.

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.

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 PaySpanhealth.com and click Register.
- You may need your NPI, TIN, and/or EIN.

Psychiatric Residential Treatment Active Treatment and Incident Reporting

Active Treatment:

Active treatment is defined as a minimum of 40 treatment hours per week, not including classroom time, five of which are conducted by a licensed mental health professional (LMHP), with a minimum of one being in an individual setting rather than a group setting.

Included in the five hours per week by a LMHP, there should be a minimum of two family therapy sessions per month, as well as a weekly visit with a psychiatrist.

Incident Reporting:

All incidents should be reported to Arkansas Total Care in accordance with the standards outlined in the Provider Manual. The DHS QA Incident Report form is available at ArkansasTotalCare.com. List your facility in the HCBS Provider field at the bottom of the form.

Send completed forms via secure email to: **Incident@ArkansasTotalCare.com.**

Psychiatric Residential Treatment Discharge Planning

Discharge planning should start at admission. A final discharge plan should include:

- Member education that is specific to the diagnosis and includes information on recognizing signs and symptoms
- Integrated care, including follow-up appointments with scheduled dates/times and a release to send treatment records to all providers that members will follow up with for medication management
- Self-care with reminders and cues to use skills developed in treatment
- Supports, roles and responsibilities, school transition, and any needed follow-up with the school to which the member will return
- Information on how to return to care if needed, including phone numbers and instructions

The discharge plan will be sent to either the Care Coordination or Utilization Management department within one business day of discharge so that Arkansas Total Care can ensure the member/their family are following up with the discharge instructions.

A training module is available on our website at ArkansasTotalCare.com.

Key Contacts

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