3rd Quarter Provider Webinar
September 11th, 2019

Housekeeping

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

Disclaimer

- Arkansas Total Care has produced this material as an informational reference for providers furnishing services in our contract network and Arkansas Total Care employees, agents and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material.
- The presentation is a general summary that explains certain aspects of the program, but is not a legal document.
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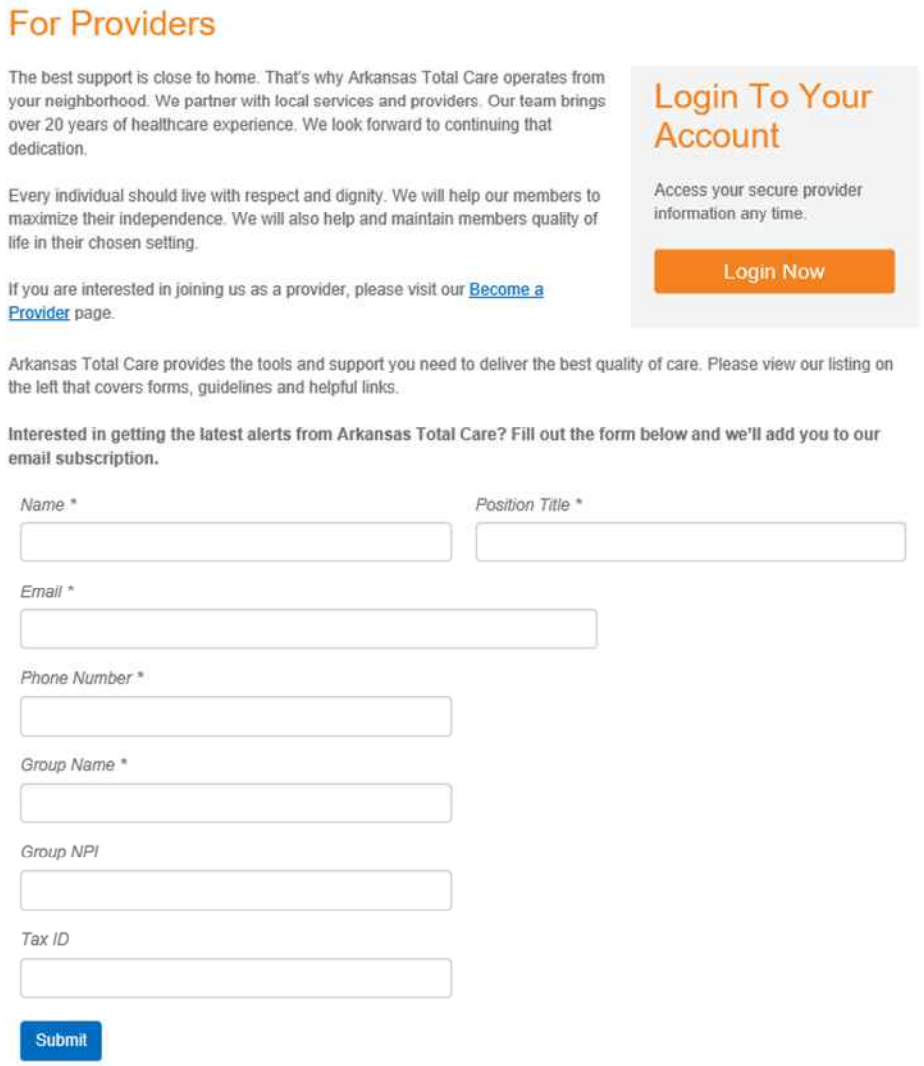
- Receive current updates:
  - Arkansas Total Care:
    - ✓ https://www.arkansastotalcare.com/providers.html



For Providers

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

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

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

Login To Your Account

Access your secure provider information any time.

Login Now

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

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

*Name **

*Position Title **

*Email **

*Phone Number **

*Group Name **

Group NPI

Tax ID

Submit

Agenda

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

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Where to Find Us

FOR MEMBERS | FOR PROVIDERS | CONTACT US

FOR PROVIDERS

- Login
- Become a Provider
- Pharmacy
- Provider Webinars
- Provider Resources
- Provider News
- Grievance and Appeals
- QI Program
- Provider Relations

Provider Relations

Arkansas Health & Wellness Provider Relations Associate Territories


Christopher Ishmael


Kari Murphy


Meghan Hunt


Patrice Eackles


Tanya Brooks

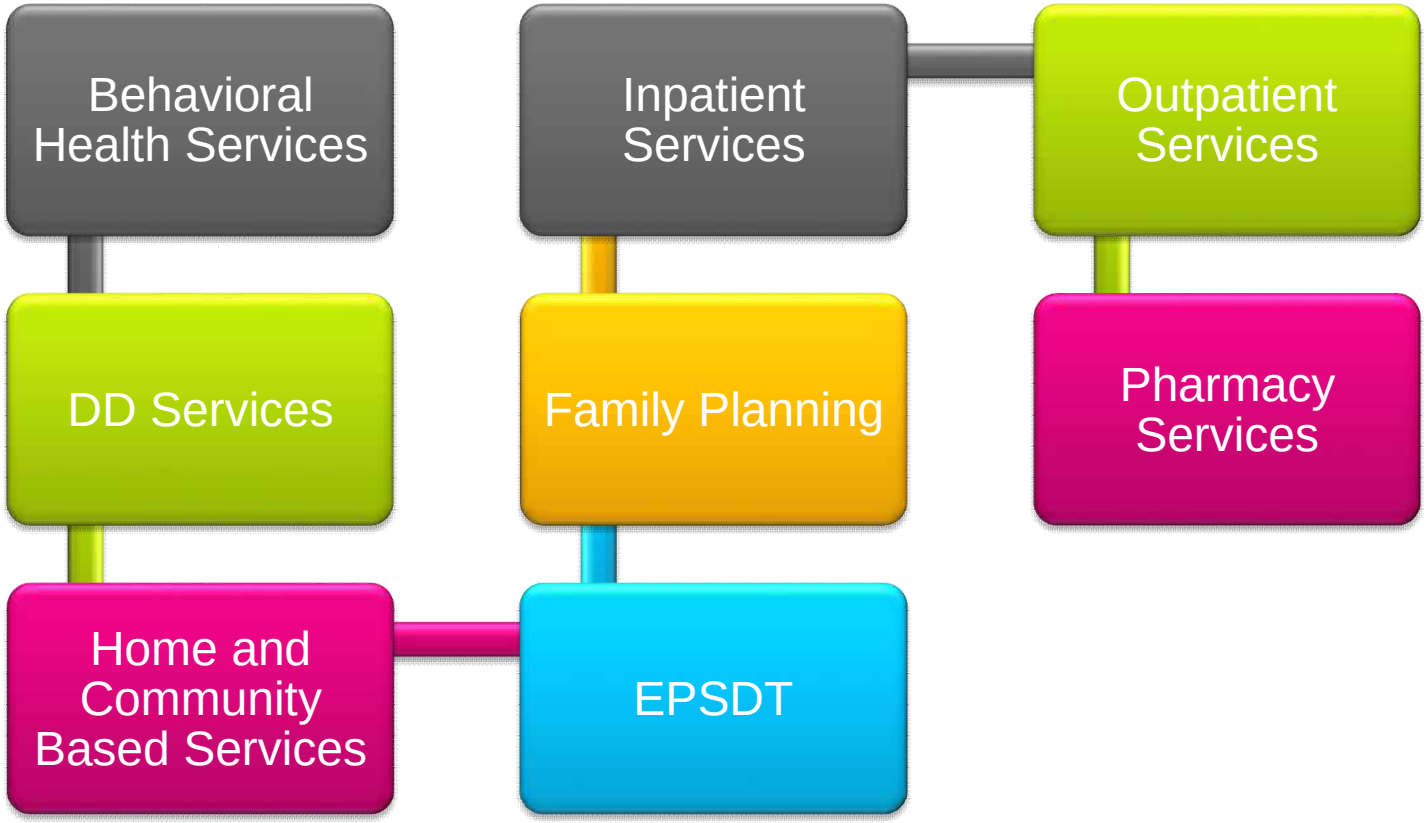

Valinda Perkins

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

PASSE Covered Services

Covered Services

- The PASSE is required to ensure that a member has access to all services covered under the Medicaid state plan, as well as under Section 1915(i) and CES waiver services



Covered CES and HCBS Waiver Services

1915 (c) CES Waiver Services	1915 (i) HCBS Services
Supportive Living	Adult Rehabilitation Day Services
Respite	Behavior Assistance
Supported Employment	Peer Supports
Adaptive Equipment	Family Support Partners
Environmental Modification	Supportive Life Skills Development
Specialized Medical Supplies	Child and Youth Support Services
Supplemental Support Device	Supportive Employment
Consultation Services	Partial Hospitalization
Crisis Intervention Services	Mobile Crisis Intervention
Community Transition Services	Therapeutic Communities
	Therapeutic Host Homes
	Residential Community Reintegration
	Planned and Emergency

Excluded Services

- The PASSE is not responsible for the services below:
  - Nonemergency Medical Transportation (NET)
  - Dental benefits in a capitated program
  - School-based services provided by school employees
  - Skilled nursing facility services
  - Assisted living facility services
  - Human development center services
  - Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program of the Arkansas Independent Choices program

Provider Updates

Provider Responsibilities

- Provider must comply with the following items:
  - Be enrolled as a qualified Arkansas Medicaid provider
  - Comply with all credentialing and re-credentialing requirements
  - Work with the member's Care Coordinator to facilitate care
  - Follow all state and federal laws and regulations related to patient care and rights
  - Participate in ARTC data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of provider performance data
  - Disclose overpayments or improper payments to ARTC
  - Inform members of their rights and responsibilities
  - Attend Provider Educations events hosted by ARTC
- This is not an all inclusive listing. A complete listing of responsibilities can be found in the ARTC Provider Manual.

Credentialing

- Providers have been notified by letter if a credentialing application is needed before 12/31/19
  - **Providers can/should begin submitting applications now so you aren't overwhelmed with them all at once.**
- 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)

Credentialing– FAQ 1

If a provider is currently credentialed through Arkansas Medicaid, will the provider be required to credential under Arkansas Total Care?

Yes

The provider will need to be credentialed under Arkansas Total Care.

Credentialing – FAQ 2

If a provider is currently credentialed under Arkansas Health and Wellness (Ambetter and Allwell), will the provider be required to credential under ARTC?

No

If the provider is credentialed for Ambetter or Allwell, the credentialing would cover all lines of business.

Prior Authorization

Prior Authorizations

All new requests for services (for new or existing members) should be checked using our **Pre-Auth Check Tool** on the website to quickly determine if a service requires prior authorization.

Please visit ArkansasTotalCare.com

under For Provider, Provider Resources tab, Pre-Auth Check

Submit Prior Authorization

After you determine if a service requires authorization, submit via one of the following ways:

SECURE WEB PORTAL

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 advice line. Notification of authorization will be returned phone, fax, or web.

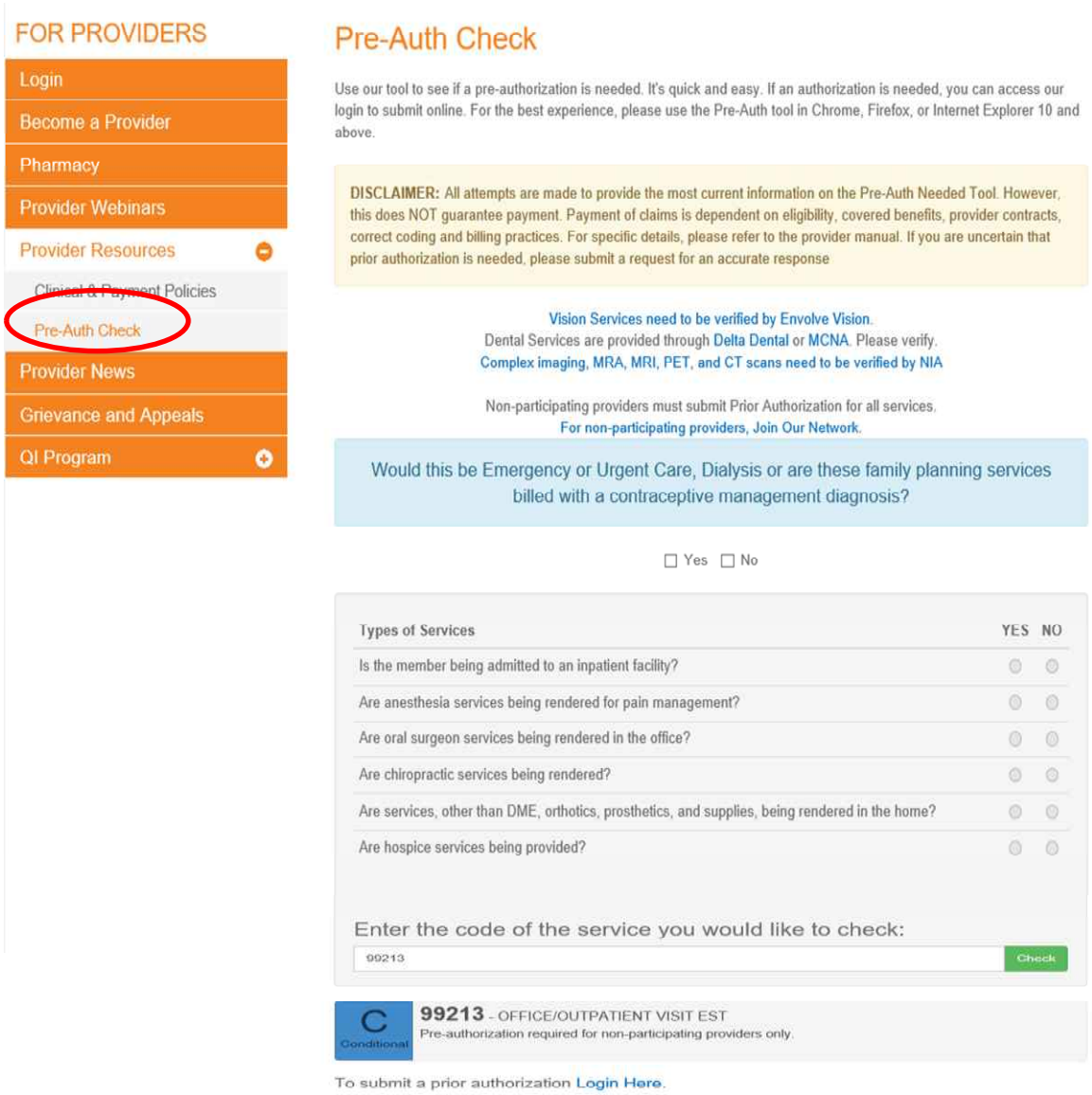
FAX

1-833-249-2342

ARTC19-H-109

Pre-Auth Check Tool

- Pre-Auth Needed Tool- Check to see if a service needs a Prior Authorization
- You will need to answer 6 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.



Do You Need a Prior Authorization as of 9/1/19?

Inpatient Services

Acute Facility	YES - PA Needed
Residential Treatment Facility	YES - PA Needed
Intermediate Care Facility	YES - PA Needed

Outpatient & Prescription Services

IDD Waiver services with existing authorizations from AR Medicaid (end dates are extended to 12/31/2019)	NO - PA Not Needed
All other outpatient services & prescriptions with existing authorizations from AR Medicaid (end dates are extended to 8/31/2019)	NO - PA Not Needed **YES – Beginning 9/1/19**
All new services & prescriptions that are not included in an existing authorizations from AR Medicaid	YES - PA Needed
Non-waiver authorized services that member will exhaust prior to 9/1/2019	YES - PA Needed

Existing Authorizations from AR Medicaid

- Effective 9/1/19, all existing AR Medicaid authorizations expired:
  - Providers need to request a Prior Authorization
- There is no limitation on the number of days a provider can request an outpatient authorization in advance of services performed
- Behavioral Health outpatient authorizations can be requested up to 21 days in advance

Prior Authorization Turnaround Timeframes

Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices.

All out-of-network providers will be required to request a prior authorization for services performed starting 9/1/2019.

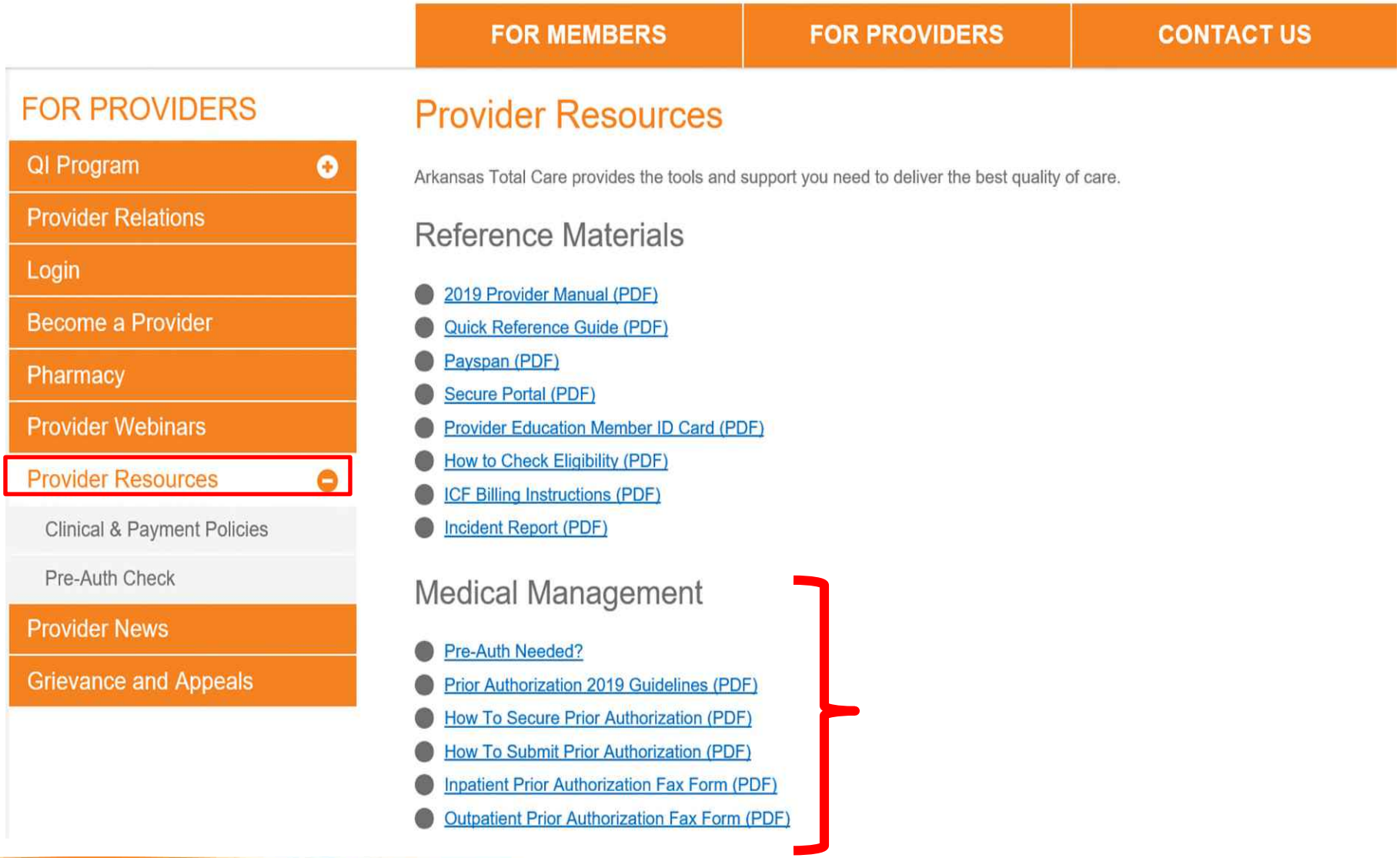
TURNAROUND TIME* FOR AUTHORIZATIONS	
Urgent review	1 Business Day
Non-urgent review	2 Business Days
Prescription	24 Hours

*Turnaround time is based on receipt of all necessary information

Inpatient Scenario

- Member gets admitted to the hospital on a **Friday** and remains in the hospital until the following Thursday:
  1. You must obtain authorization no later than close of business **Tuesday**:
     a. Notification can be sent in on Monday, but the completed authorization MUST be received by Arkansas Total Care on Tuesday
     b. Authorization should include all clinical information available to support medical necessity (i.e. History and Physical, x-ray reports, labs, doctor's progress notes including Plan of Care)
  2. ARTC will make a decision within 1 business day of the completed authorization and will provide you notification **no later** than 2 business days

Prior Authorization Documents



New Behavioral Health Policies

- Effective 9/1/19, most Behavioral (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
- Behavioral Health Outpatient (BHOP) – no authorization is required*
- Prior Authorization requirements for all codes can be verified on our Pre-Auth Check Tool located at www.ArkansasTotalCare.com under Provider

*new change from last ARTC presentation

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 = 15 Minutes
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 – Effective 9/1/19 - *UPDATED*

- 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.
  - ARTC will review providers who appear to be outliers in performance against this standard.
  - 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.

Prior Auth – FAQ 1

If a member is currently receiving Physical Therapy with an initial start date prior to 9/1/19, and therapy is continuing beyond the 9/1/19 date, will an authorization be required for the member's remaining visits?

NO

Prior Auth – FAQ 2

What can a provider do when they disagree with the determination of a Prior Authorization request?

A provider should file an Appeal

Prior Auth – FAQ 3

If a member received therapy from more than one location/provider, is the 90 minute limit an accumulative total from both locations?

Members can receive up to 90 minutes of therapy per therapy disciplines per week. Therefore, if they are receiving Speech Therapy from 2 locations, the combined total cannot exceed 90 minutes per week

Prior Auth – FAQ 4

Can a non-par provider see an ARTC member?

Conditional. Non-par providers must receive a prior authorization before providing any services to an ARTC member. Authorizations will be approved on a case by case basis.

Claim Updates

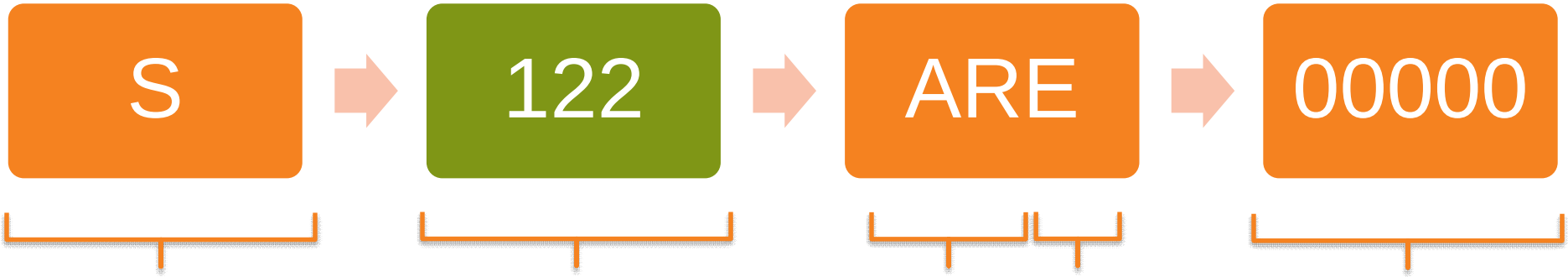
Clean vs. Non-Clean Claim

- Clean Claim Definition:
  - A clean claim means a claim received by ARTC for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by ARTC
- Unclean Claim Definition:
  - Unclean claims are submitted claims that require further documentation or development beyond the information contained therein
  - The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies
  - In addition, unclean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines
- **Reference:**
  - Payment Policy: Clean Claims CC.PP.021
    - ✓ https://www.arkansastotalcare.com/content/dam/centene/policies/payment-policies/CC.PP.021.pdf

Rejected and Denials

- Rejection:
  - A rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These should be corrected and resubmitted as a first time claim.
- Denial:
  - A denial is defined as a claim that has passed minimum edits and is entered into the system for processing, but has been billed with invalid or inappropriate information causing the claim to deny. An EOP (Explanation of Payment) will be sent including the denial reason. These should be corrected and resubmitted as a corrected claim.

Characteristics of a Claim Number



Year claim was submitted

	Year		Year
A	2001	N	2014
B	2002	O	2015
C	2003	P	2016
D	2004	Q	2017
E	2005	R	2018
F	2006	S	2019
G	2007	T	
H	2008	U	
I	2009	V	
J	2010	W	
K	2011	X	
L	2012	Y	
M	2013	Z	

Julian Date

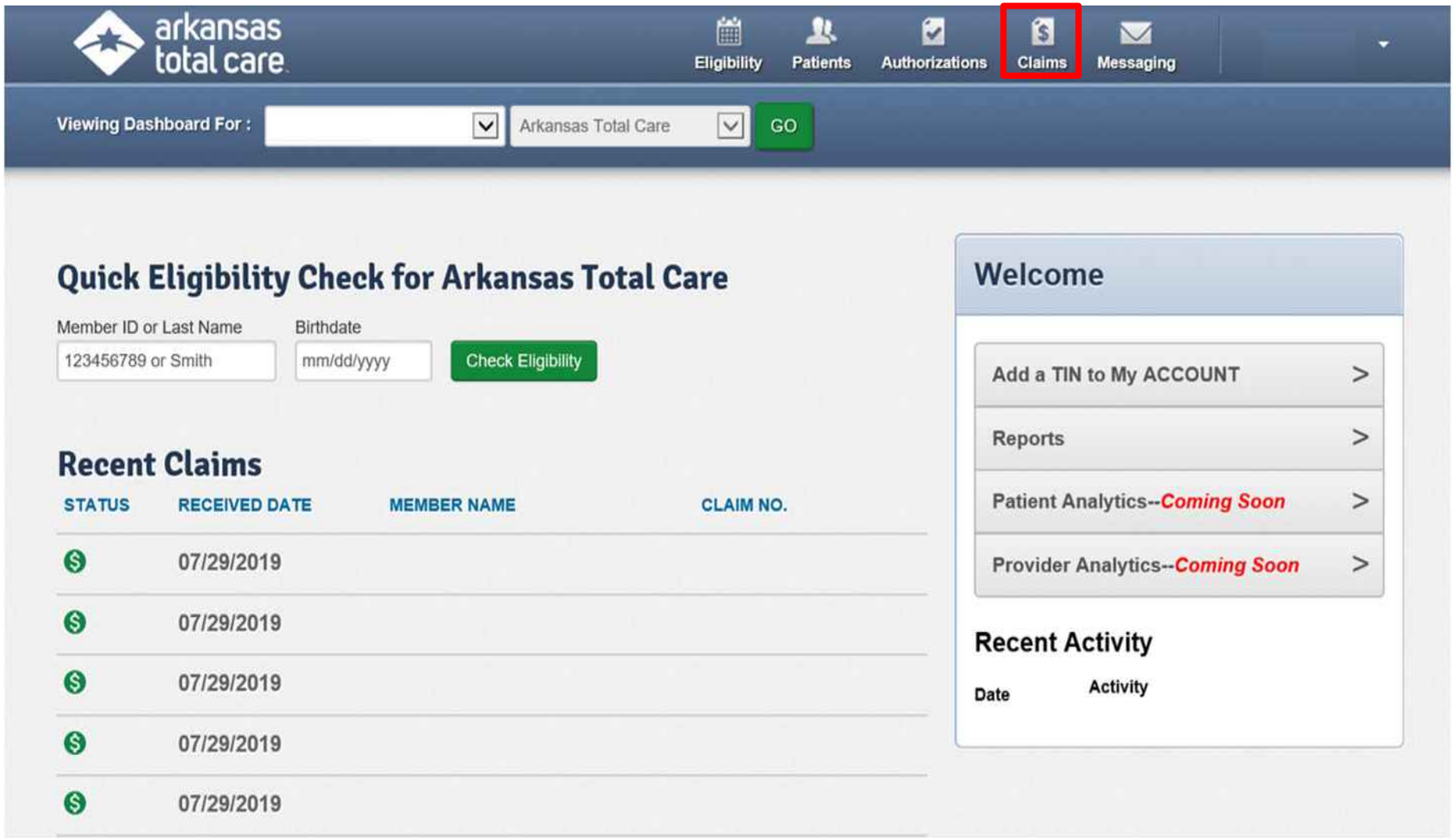
1st & 2nd digits = State the claim is processed

3rd digit = Method of submission

E = EDI Submission
P = Paper Submission
R = Paper Submission with HIPAA or Upfront Rejection
C = Paper Submitted Correspondence

Claim sequence number

Secure Provider Portal Claim Submission – Preferred Method



Electronic Clearinghouse Claim Submission

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

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

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

Paper Claim Submission Reminder

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

  Mail paper claims to:

  Arkansas Total Care

  Attn: Claims

  PO Box 8020

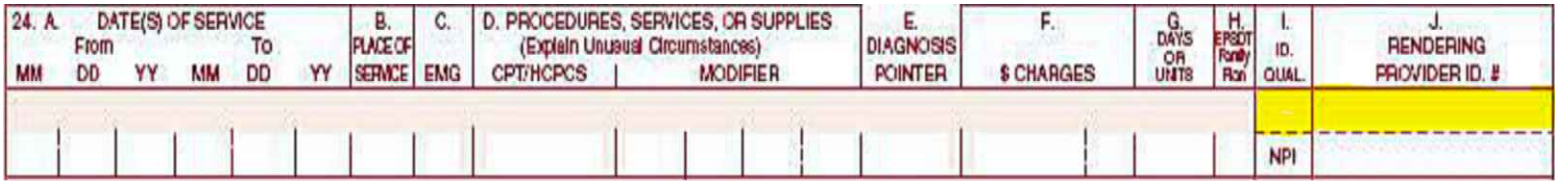
  Farmington, MO 63640-8020

Claim Form Requirements

- Information submitted on provider's claim must be current and match the state active Provider File:
  - Provider name must match what is noted on the current W-9 form
  - National Provider Identifier (NPI)
    - ✓ Atypical providers are not required to have a NPI and will need to use their Medicaid ID
  - Medicaid Identification Number
  - Tax Identification Number (TIN)
  - Taxonomy code
  - Physical location address
  - Billing name and address

Taxonomy Code

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



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

EFT - Payspan

Electronic Funds Transfer

Payspan
A Faster, Easier Way to Get Paid

arkansas total care

Arkansas Total Care offers Payspan, a free solution that helps providers transition into electronic payments and automatic reconciliation.

- **Improve cash flow** by getting payments faster
- **Settle claims electronically** through Electronic Fund Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- **Maintain control over bank accounts** by routing EFTs to the bank account(s) of your choice
- **Match payments to advices quickly** and easily re-associate payments with claims
- **Manage multiple payers**, including any payers that are using Payspan to settle claims
- **Eliminate re-keying of remittance data** by choosing how you want to receive remittance details
- **Create custom reports** including ACH summary reports, monthly summary reports, and payment reports sorted by date

SET UP YOUR **PAYSPAN ACCOUNT** TODAY

Visit Payspanhealth.com and click Register.

You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN).

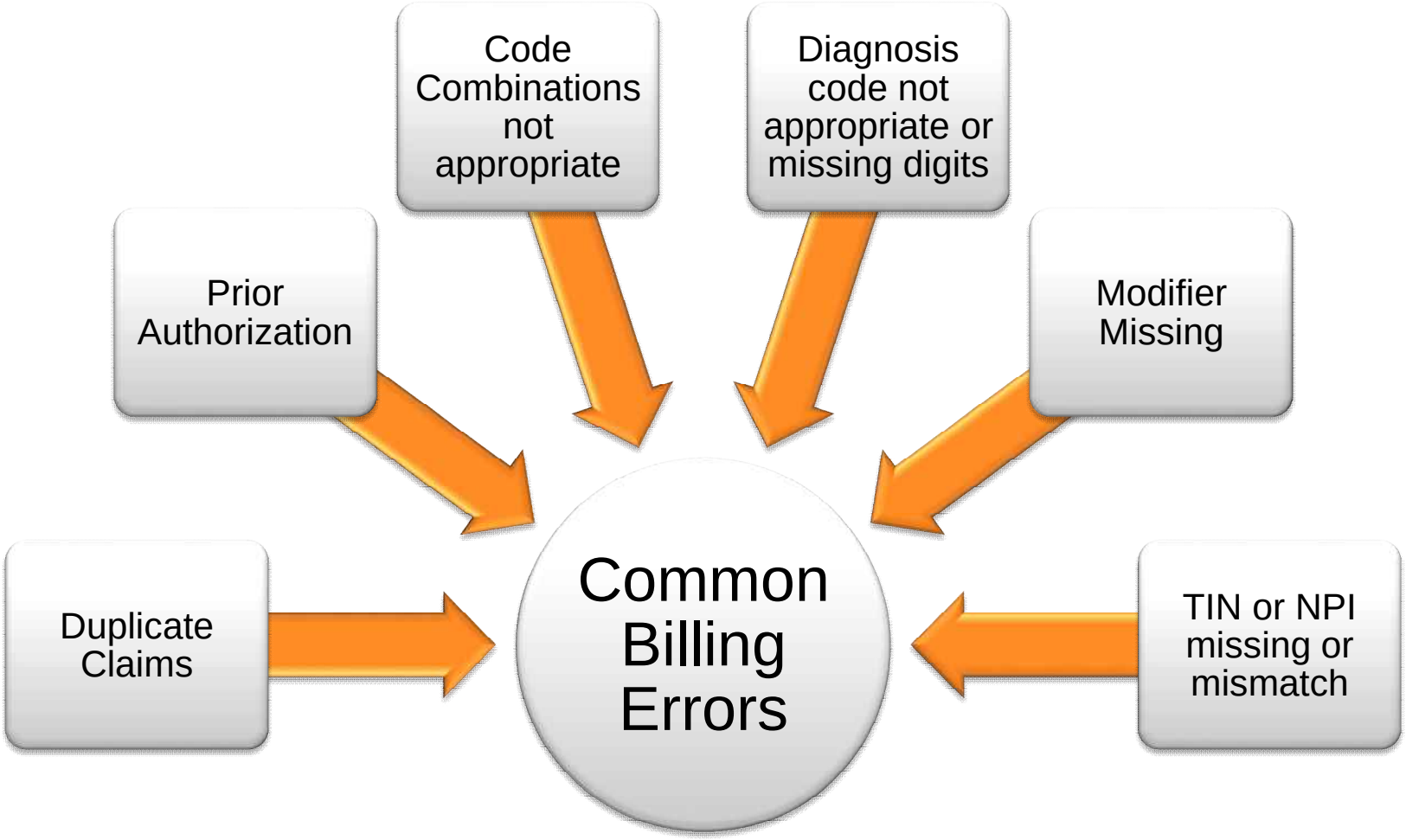
Claim Payment TAT

* Must be received in-house by 5:00 p.m. | **Must be payable by 5:00 a.m. on the previous day

*Received Day	**Pay Day	Turnaround Time	Example Received Date	Example Paid Date
Sunday	Following Friday	5 day turnaround	3/24/2019	3/29/2019
Monday	Following Friday	4 day turnaround	3/25/2019	3/29/2019
Tuesday	Following Tuesday	7 day turnaround	3/26/2019	4/2/2019
Wednesday	Following Tuesday	6 day turnaround	3/27/2019	4/2/2019
Thursday	Following Tuesday	5 day turnaround	3/28/2019	4/2/2019
Friday	Following Tuesday	4 day turnaround	3/29/2019	4/2/2019
Saturday	Following Wednesday	4 day turnaround	3/30/2019	4/3/2019

ArkansasTotalCare.com | 1-866-282-6280 (TDD/TTY: 711) | | ARTC18-H-094

Common Billing Errors



For a complete list of common billing errors refer to the provider manual

Common Billing Errors - Explanation

- **Duplicate claims**: Wait until a claim has adjudicated before submitting another claim
- **Prior Authorization(s)**: Obtain the necessary approval prior to providing service(s)
  - Make sure the correct prior authorization number is entered on the claim
- **Code Combination not appropriate:** Refer to NCCI edits
- **Diagnosis code(s) not appropriate or missing digits:** Make sure services are coded to highest level of specificity
- **Modifier Missing**: Utilize the appropriate modifier when applicable
- **TIN or NPI missing or mismatch:** Make sure you are a registered provider with Arkansas Medicaid and enter your Medicaid ID on your claim
  - Verify you are in network

Timely Filing Guidelines – Effective 9/1/19

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

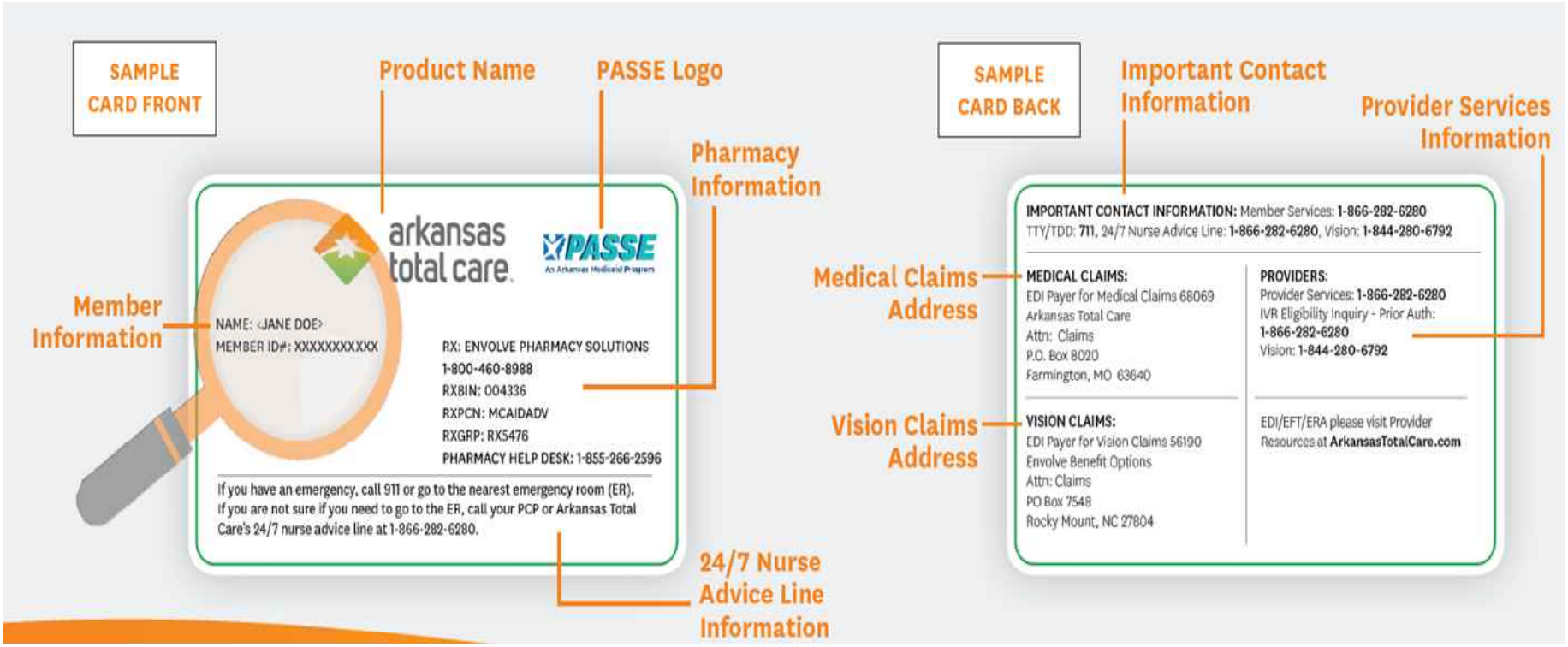
  - **Medical records may be necessary**

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**

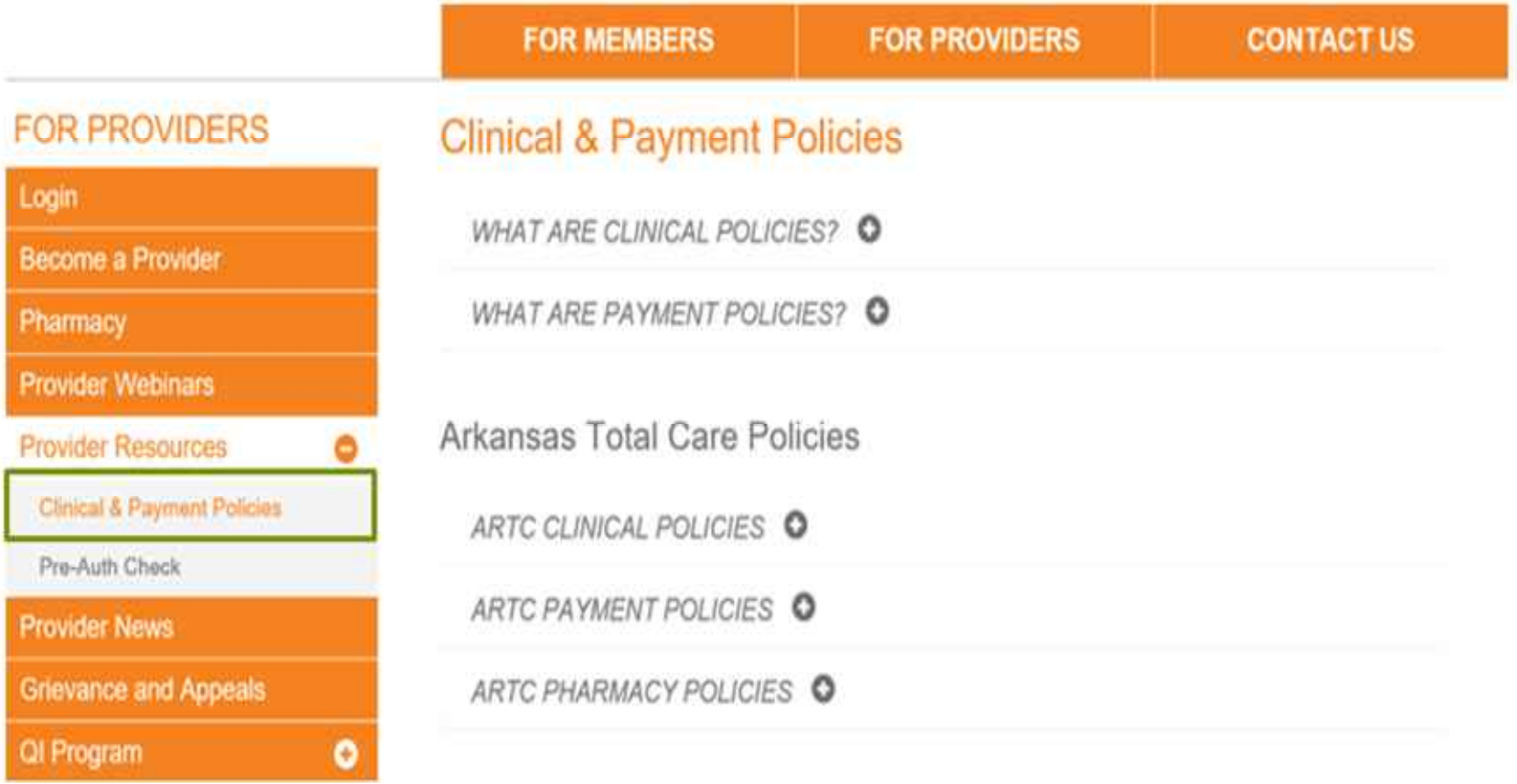
  - **Medical records may be necessary**

Eligibility - Member ID Card



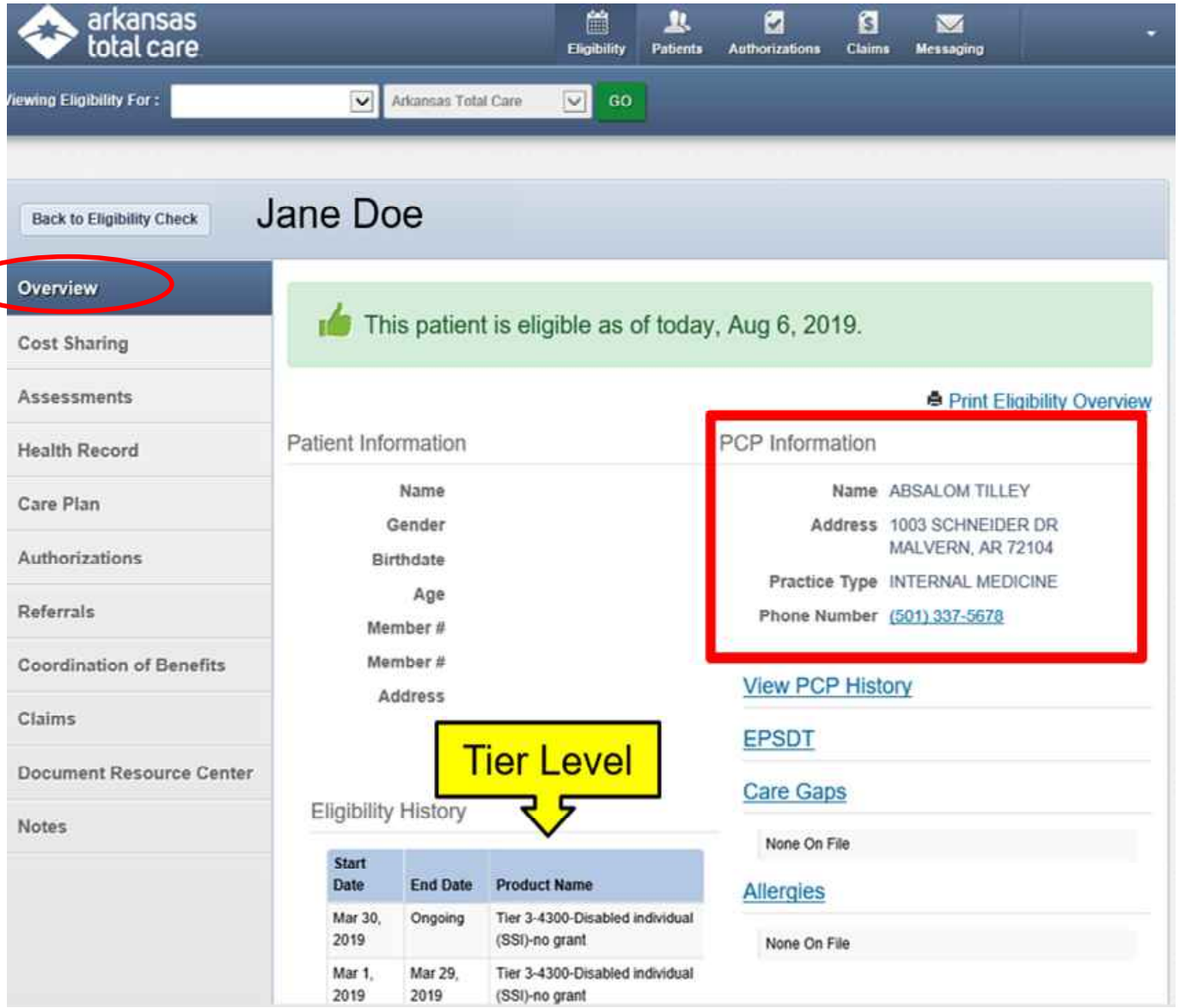
Clinical and Payment Policies

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



Secure Provider Portal Updates

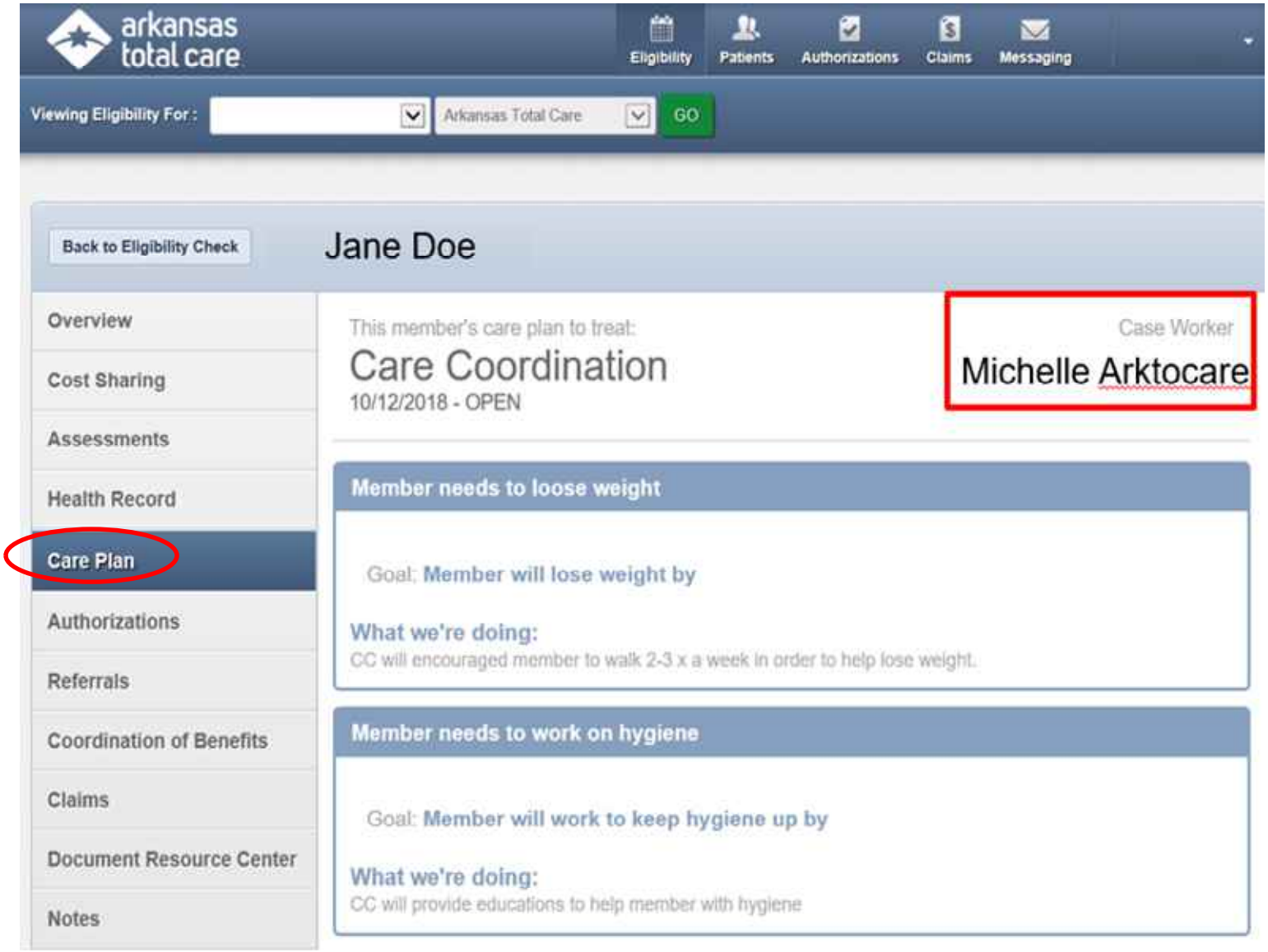
PCP Assignment and Tier Level



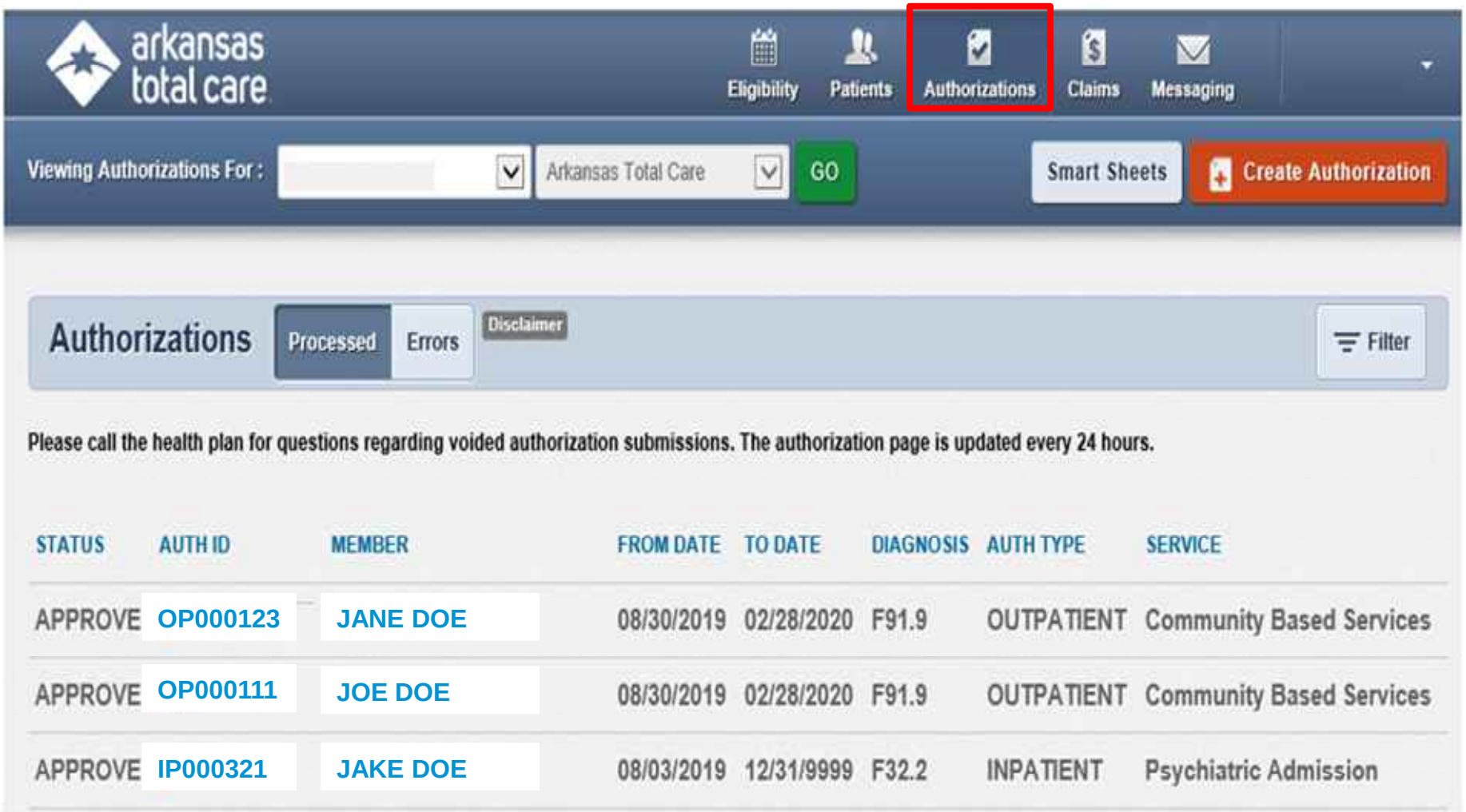
Tier Level Assignment

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

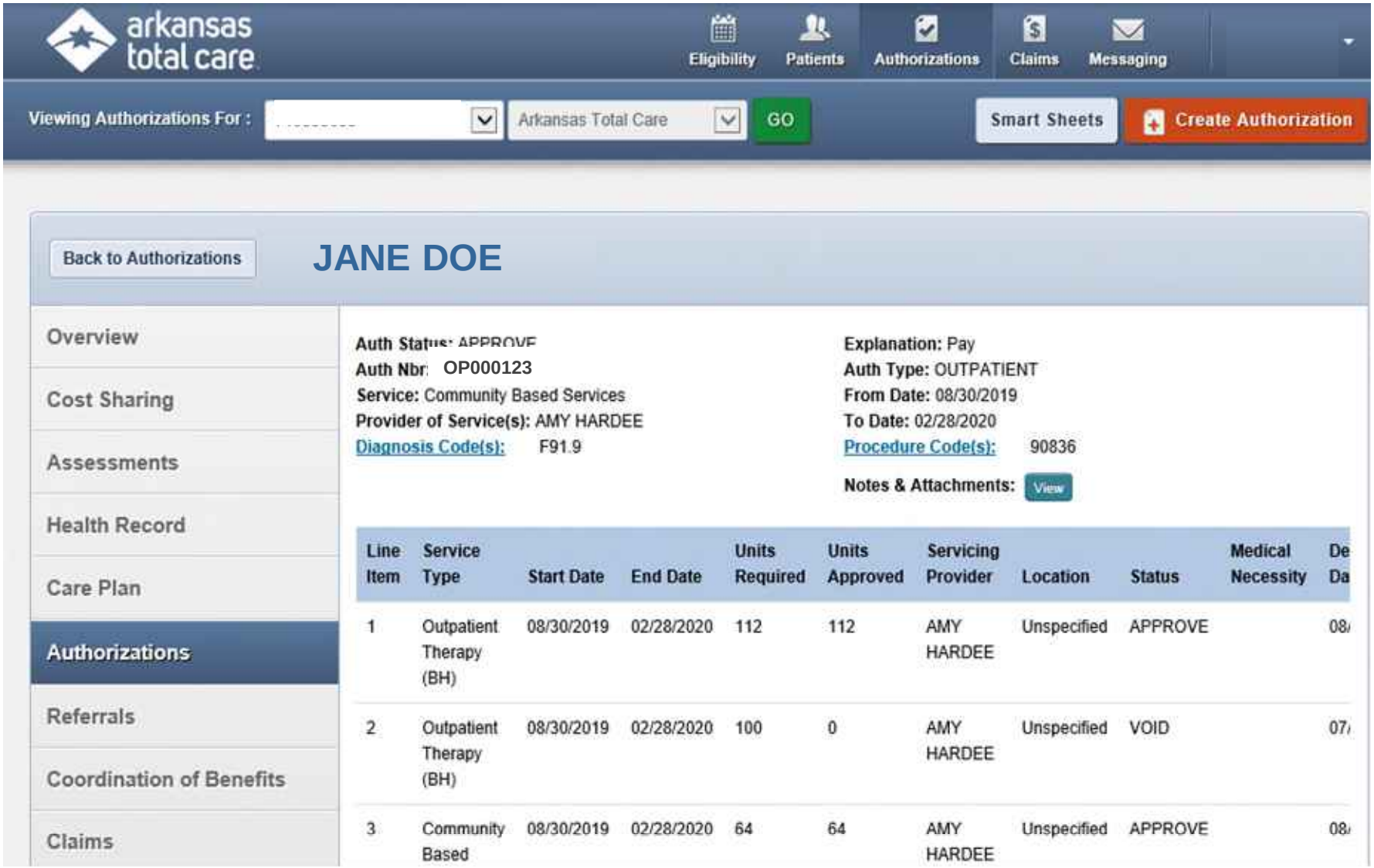
Care Coordinator Assignment



Prior Authorization Display



Member's Prior Authorizations Display



Secure Provider Portal - Updates

- **Person-Centered Service Plan:**
  - ARTC will supply each of the member's applicable service providers with a copy of the PCSP through the ARTC provider portal

Waiver Services Updates

Revision Request to Supportive Living Waiver Plan

- Provider requesting for change in Waiver Services prior to Arkansas Total Care Personal Care Service Plan (PCSP) development must adhere to the following:
  - Provider must submit:
    - CES 703 Waiver PCSP Form:
      - ✓ https://humanservices.arkansas.gov/images/uploads/ddds/CES-703_Waiver_PCSP_Forms.docx
    - CES 110 Pro-Rated Staff Worksheets:
      - ✓ https://humanservices.arkansas.gov/images/uploads/ddds/CES-110_Pro-Rated_Staff_Worksheets.xlsx
    - Copy of narrative/revision summary
    - Change amount and include a justification:
      - ✓ This should include change requested and the reason for the change in order to support the request
- **Submit all forms and documentation via fax at: 1-833-249-2342**

Envolve Vision

Eye Health Manager Provider Portal

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

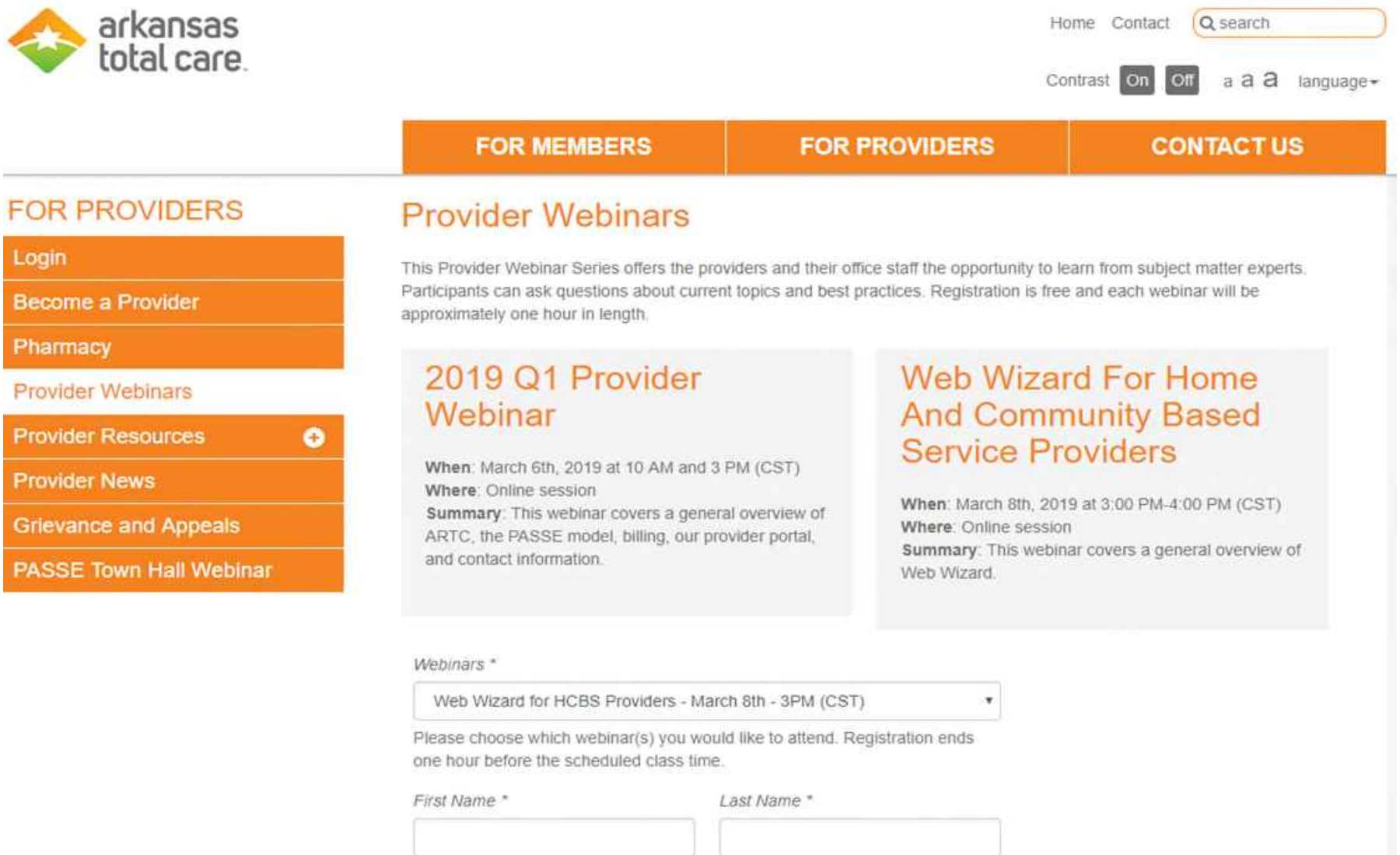
Claim Submission

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

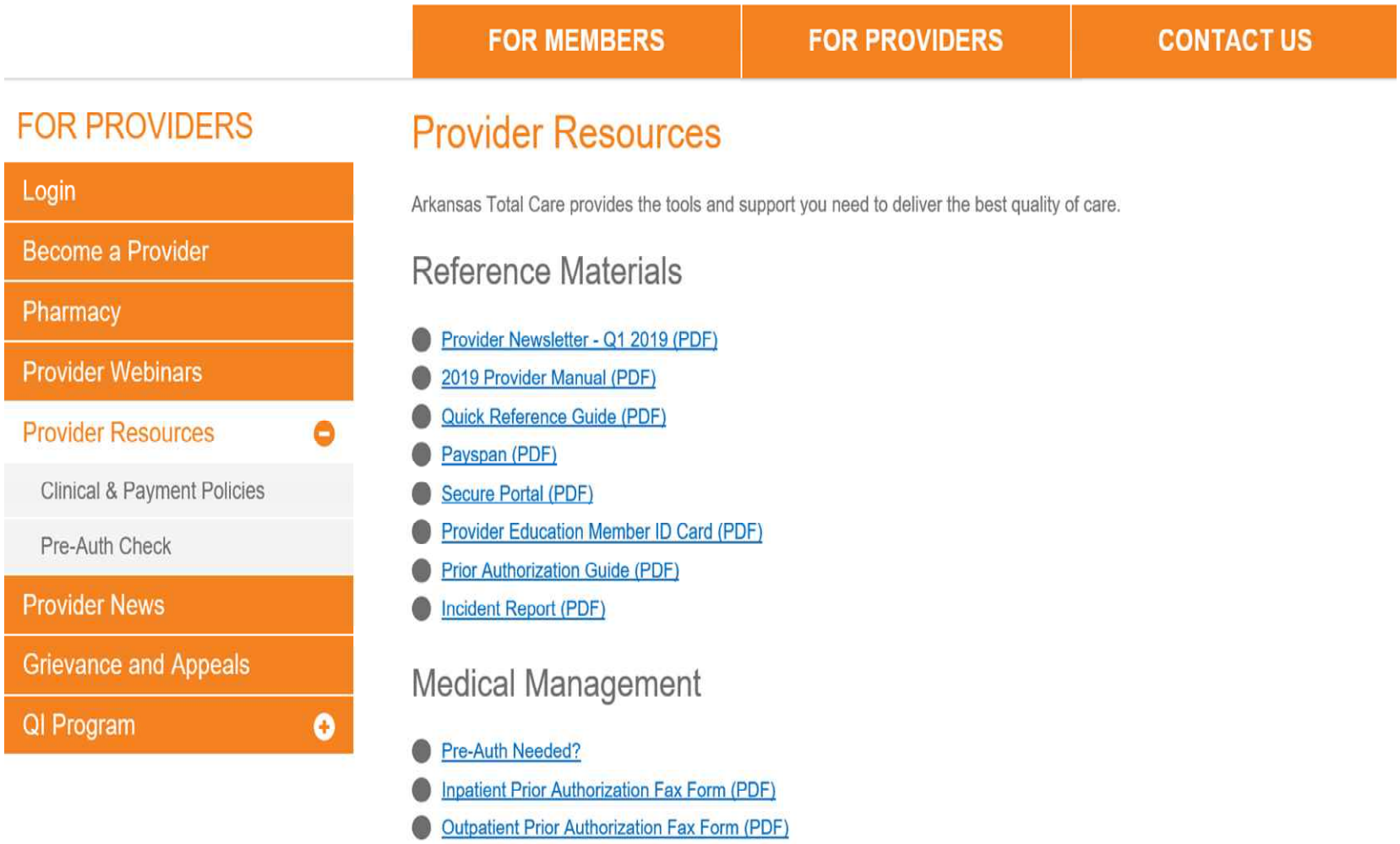
- The following options to submit claims to Envolve Vision:
  - Eye Health Manager at https://visionbenefits.envolvehealth.com/logon
  - Electronic Claim Submission:
    - ✓ Change Healthcare Payer ID#: 56190
  - Paper Claim Submission:
    - ✓ Envolve Vision, Inc.
      P.O. Box 7548
      Rocky Mount,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

Important Tips and Reminders

Provider Webinars

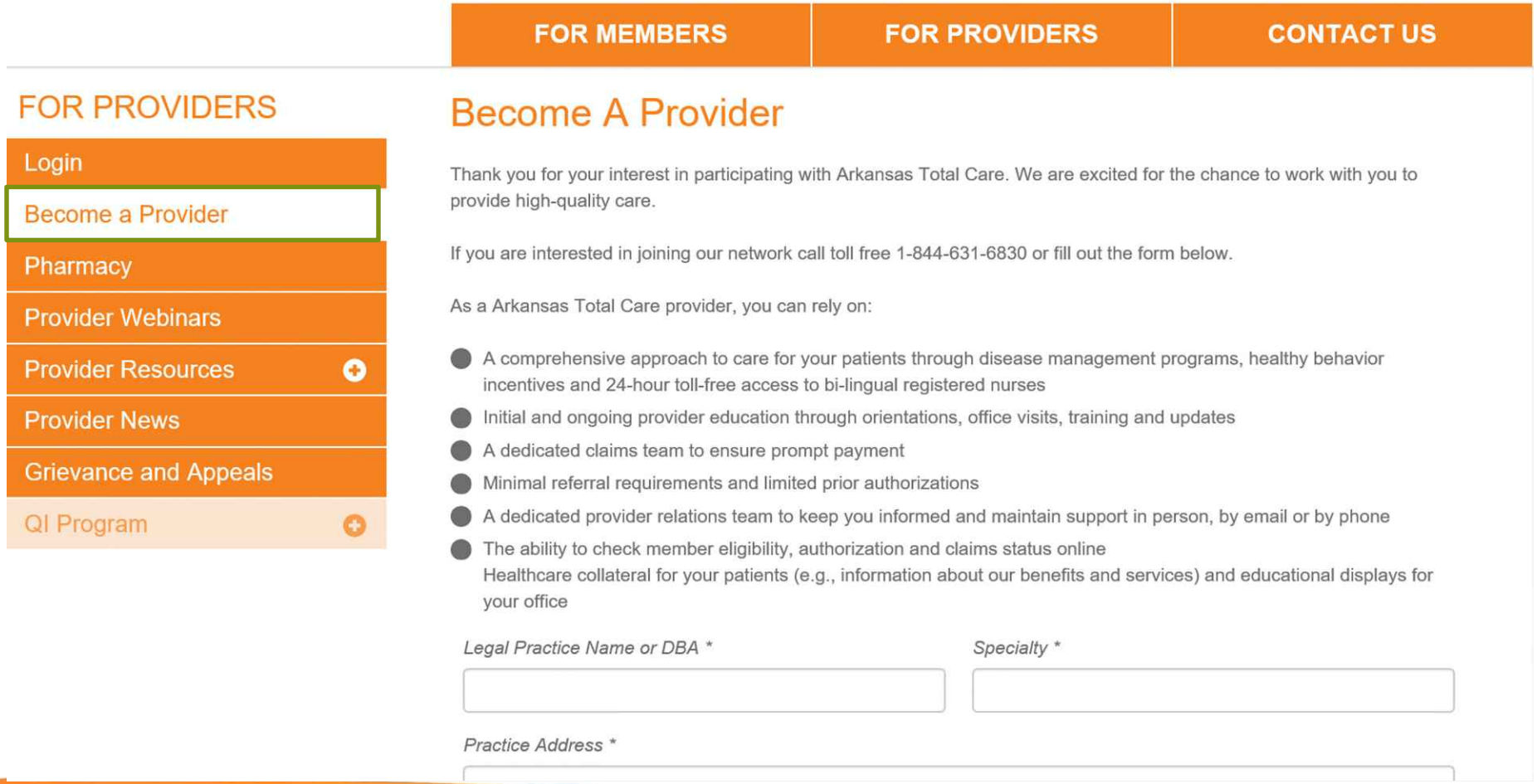


Provider Resources



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.



Waste, Abuse, and Fraud Program

ARTC takes the detection, investigation, and prosecution of fraud and abuse very seriously and has a WAF program complies with the federal and state laws. ARTC, in conjunction with Centene, operates a WAF unit. Centene's Special Investigation Unit (SIU) performs back end audits which may result in taking appropriate action against those who commit waste, abuse, and/or fraud either individually or as a practice. 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

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

Some of the most common WAF submissions seen are:

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

Contact Information

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

Arkansas Total Care

Provider Services

Phone: 1-866-282-6280

Website: arkansastotalcare.com

Email inquiries to:

Providers@ArkansasTotalCare.com

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

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

Thank you for joining us!