



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.**

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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.

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

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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Christopher
Ishmael



Kari
Murphy



Meghan
Hunt



Patrice
Eackles



Tanya
Brooks



Valinda
Perkins



CHRISTOPHER ISHMAEL +

KARI MURPHY +

MEGHAN HUNT +

PATRICE EACKLES* +

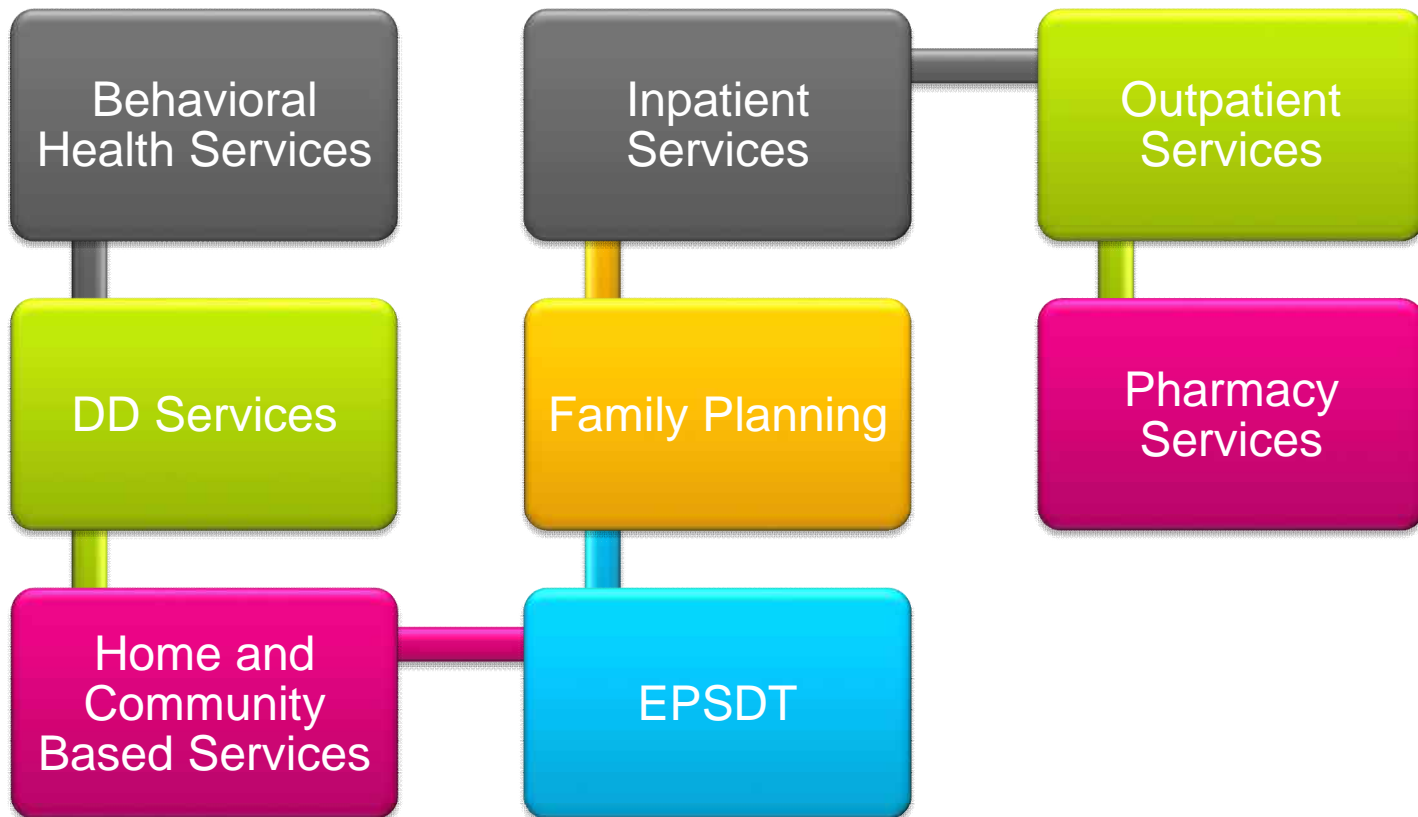
TANYA BROOKS +

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](https://www.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

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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.

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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

C
Conditional

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

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

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

SEPTEMBER 2019						
SUN	MON	TUE	WED	THU	FRI	SAT
1 	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

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



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

Reference Materials

- [2019 Provider Manual \(PDF\)](#)
- [Quick Reference Guide \(PDF\)](#)
- [Payspan \(PDF\)](#)
- [Secure Portal \(PDF\)](#)
- [Provider Education Member ID Card \(PDF\)](#)
- [How to Check Eligibility \(PDF\)](#)
- [ICF Billing Instructions \(PDF\)](#)
- [Incident Report \(PDF\)](#)

Medical Management

- [Pre-Auth Needed?](#)
- [Prior Authorization 2019 Guidelines \(PDF\)](#)
- [How To Secure Prior Authorization \(PDF\)](#)
- [How To Submit Prior Authorization \(PDF\)](#)
- [Inpatient Prior Authorization Fax Form \(PDF\)](#)
- [Outpatient Prior Authorization Fax Form \(PDF\)](#)



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

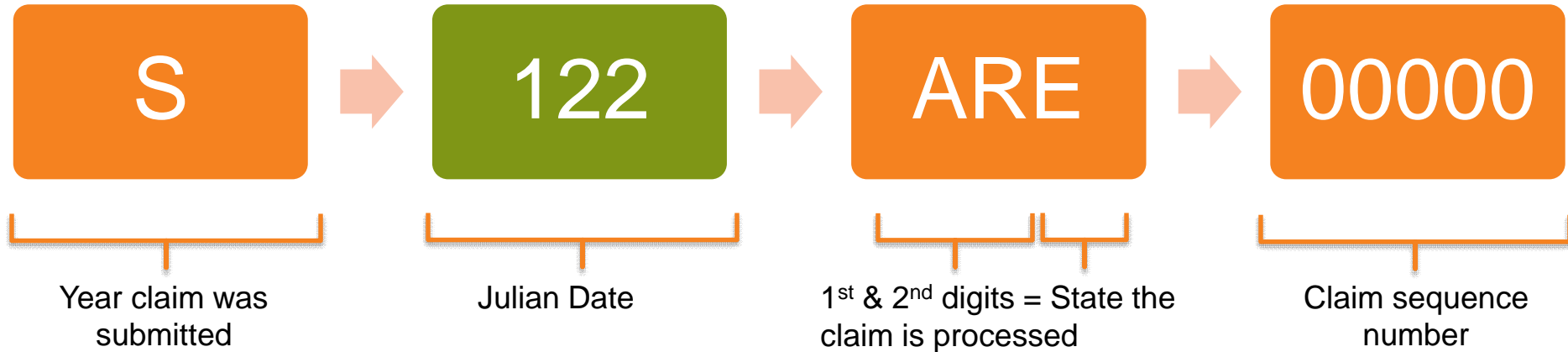
Clean vs. Non-Clean Claim

- **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		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	

3rd digit = Method of submission
E = EDI Submission
P = Paper Submission
R = Paper Submission with HIPAA or Upfront Rejection
C = Paper Submitted Correspondence

Secure Provider Portal Claim Submission – Preferred Method

 arkansas
total care

 Eligibility  Patients  Authorizations  Claims  Messaging

Viewing Dashboard For : Arkansas Total Care

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

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

- [illegible]

- 42

EFT - Payspan

Electronic Funds Transfer

Payspan A Faster, Easier Way to Get Paid



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



Arkansas Total Care Claims Payment Tool

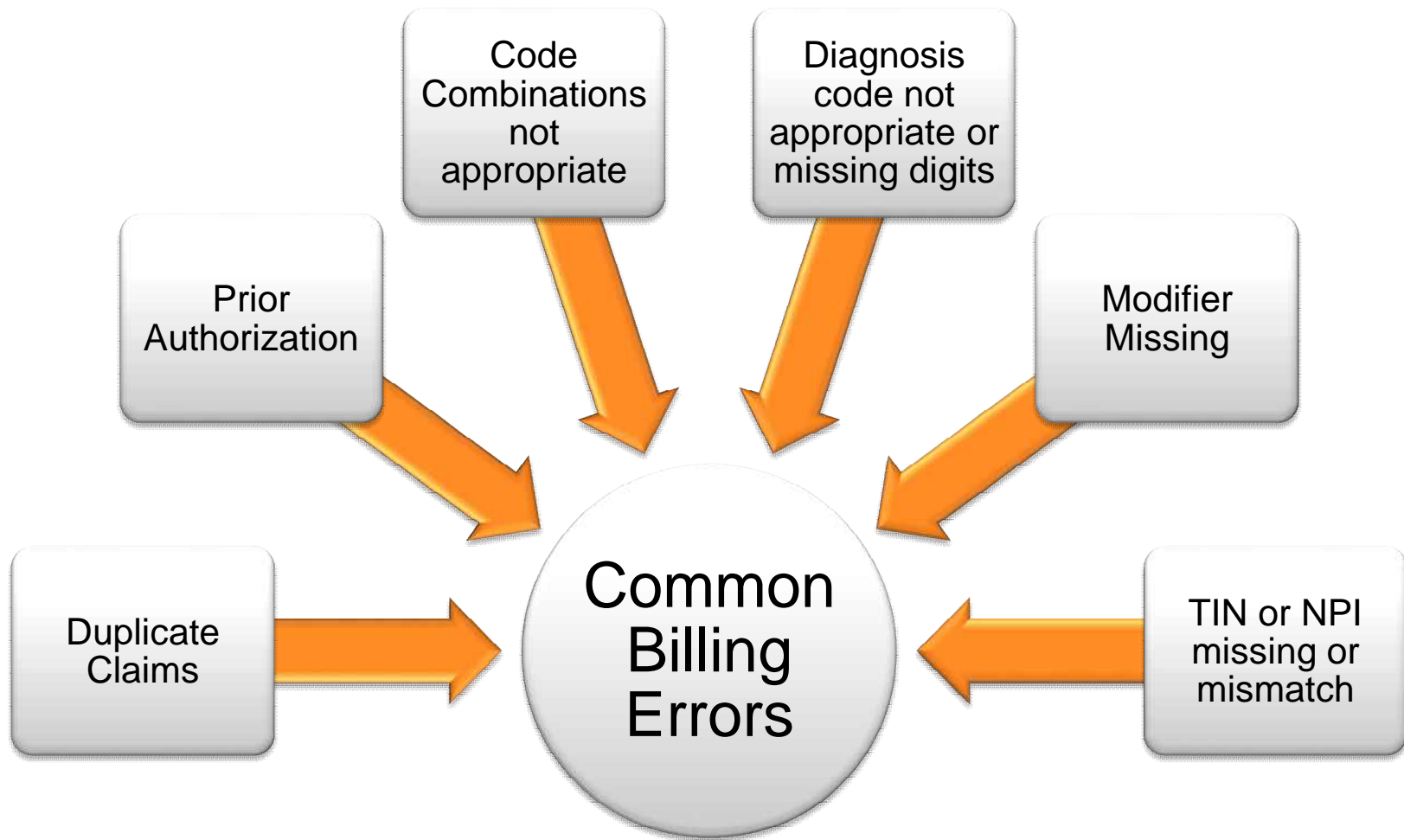
FOR CLEAN
CLAIMS ONLY

* 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

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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

**SAMPLE
CARD FRONT**

Product Name

PASSE Logo

Pharmacy Information

Member Information

24/7 Nurse Advice Line Information

Sample Card Front

NAME: <JANE DOE>
MEMBER ID#: XXXXXXXXXX

arkansas
total care

PASSE
An Arkansas Medicaid Program

RX: ENVOLVE PHARMACY SOLUTIONS
1-800-460-8988
RXBIN: 004336
RXPCN: MCAIDADV
RXGRP: RX5476
PHARMACY HELP DESK: 1-855-266-2596

If you have an emergency, call 911 or go to the nearest emergency room (ER).
If you are not sure if you need to go to the ER, call your PCP or Arkansas Total
Care's 24/7 nurse advice line at 1-866-282-6280.

**SAMPLE
CARD BACK**

Important Contact Information

Provider Services Information

Medical Claims Address

Vision Claims Address

Sample Card Back

IMPORTANT CONTACT INFORMATION: Member Services: 1-866-282-6280
TTY/TDD: 711, 24/7 Nurse Advice Line: 1-866-282-6280, Vision: 1-844-280-6792

MEDICAL CLAIMS:
EDI Payer for Medical Claims 68069
Arkansas Total Care
Attn: Claims
P.O. Box 8020
Farmington, MO 63640

VISION CLAIMS:
EDI Payer for Vision Claims 56190
Envolve Benefit Options
Attn: Claims
PO Box 7548
Rocky Mount, NC 27804

PROVIDERS:
Provider Services: 1-866-282-6280
IVR Eligibility Inquiry - Prior Auth:
1-866-282-6280
Vision: 1-844-280-6792

EDI/EFT/ERA please visit Provider
Resources at ArkansasTotalCare.com

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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WHAT ARE CLINICAL POLICIES?

WHAT ARE PAYMENT POLICIES?

Arkansas Total Care Policies


ARTC CLINICAL POLICIES

ARTC PAYMENT POLICIES

ARTC PHARMACY POLICIES

Secure Provider Portal Updates

PCP Assignment and Tier Level


 arkansas
total care

Eligibility Patients Authorizations Claims Messaging

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 ABSALOM TILLEY
Address 1003 SCHNEIDER DR
MALVERN, AR 72104
Practice Type INTERNAL MEDICINE
Phone Number [\(501\) 337-5678](tel:(501)337-5678)

[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


Care Coordinator Assignment


 arkansas
total care

 Eligibility

 Patients

 Authorizations

 Claims

 Messaging

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 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


Prior Authorization Display


 arkansas
total care

 Eligibility

 Patients

 Authorizations

 Claims

 Messaging


Viewing Authorizations For : Arkansas Total Care

Authorizations






ProcessedErrorsDisclaimer

Filter

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	AMY HARDEE	Unspecified	APPROVE		08/
2	Outpatient Therapy (BH)	08/30/2019	02/28/2020	100	0	AMY HARDEE	Unspecified	VOID		07/
3	Community Based	08/30/2019	02/28/2020	64	64	AMY HARDEE	Unspecified	APPROVE		08/

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**

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

Provider Webinars

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

FOR PROVIDERS

[Login](#)[Become a Provider](#)[Pharmacy](#)[Provider Webinars](#)[Provider Resources](#)[Provider News](#)[Grievance and Appeals](#)[PASSE Town Hall Webinar](#)

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 *

Web Wizard for HCBS Providers - March 8th - 3PM (CST) ▼

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

First Name *

Last Name *

Provider Resources

FOR MEMBERS

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Pharmacy

Provider Webinars

Provider Resources



Clinical & Payment Policies

Pre-Auth Check

Provider News

Grievance and Appeals

QI Program



Provider Resources

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

Reference Materials

- [Provider Newsletter - Q1 2019 \(PDF\)](#)
- [2019 Provider Manual \(PDF\)](#)
- [Quick Reference Guide \(PDF\)](#)
- [Payspan \(PDF\)](#)
- [Secure Portal \(PDF\)](#)
- [Provider Education Member ID Card \(PDF\)](#)
- [Prior Authorization Guide \(PDF\)](#)
- [Incident Report \(PDF\)](#)

Medical Management

- [Pre-Auth Needed?](#)
- [Inpatient Prior Authorization Fax Form \(PDF\)](#)
- [Outpatient Prior Authorization Fax Form \(PDF\)](#)

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.

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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 **

Waste, Abuse, and Fraud Program

ARTC takes the detection, investigation, and prosecution of fraud and abuse very seriously and has a WAF program that 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

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

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



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!**