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 intellectual/developmentally disabled (IDD) persons and persons with behavioral health (BH) needs. Arkansas Total Care empowers our members to achieve their health goals through care coordination, goal setting, and connecting members to community resources.

What You Need to Know

Key Contact Information

Arkansas Total Care

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

Web
ArkansasTotalCare.com

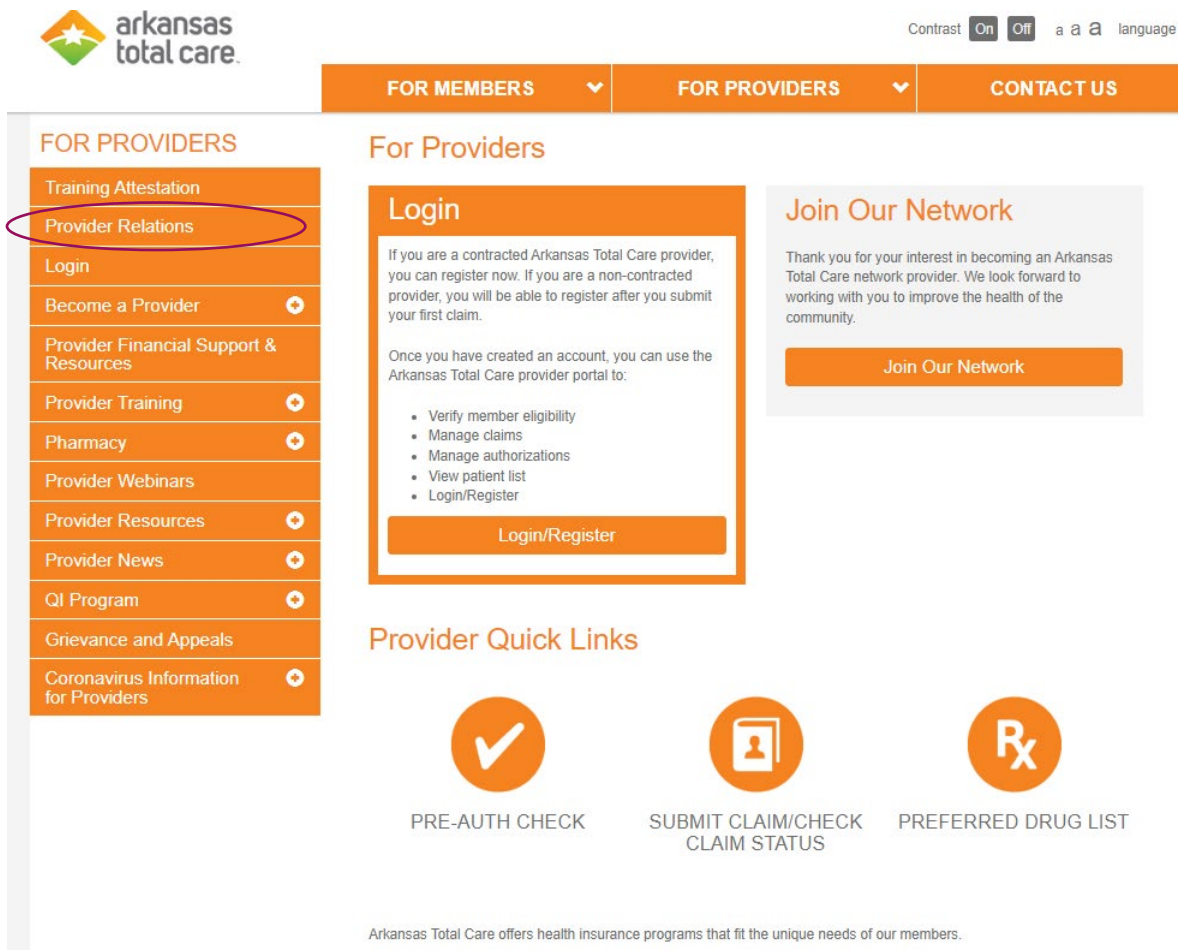
Portal
Provider.ArkansasTotalCare.com

Provider Relations Territories

To find your provider relations territory, follow these steps:

1. Visit ArkansasTotalCare.com
2. From the For Providers menu, select Provider Relations.
3. There you will find a map of the territories and the contact information for the representative of those territories.

There has been an update to the Provider Relations Territory Map as we continue to add new team members! If your county falls into the unassigned area, you will continue to use the Providers@ArkansasTotalCare.com email until your assigned representative is announced.



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 including:

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

The Provider Manual

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

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

- 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:

- 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

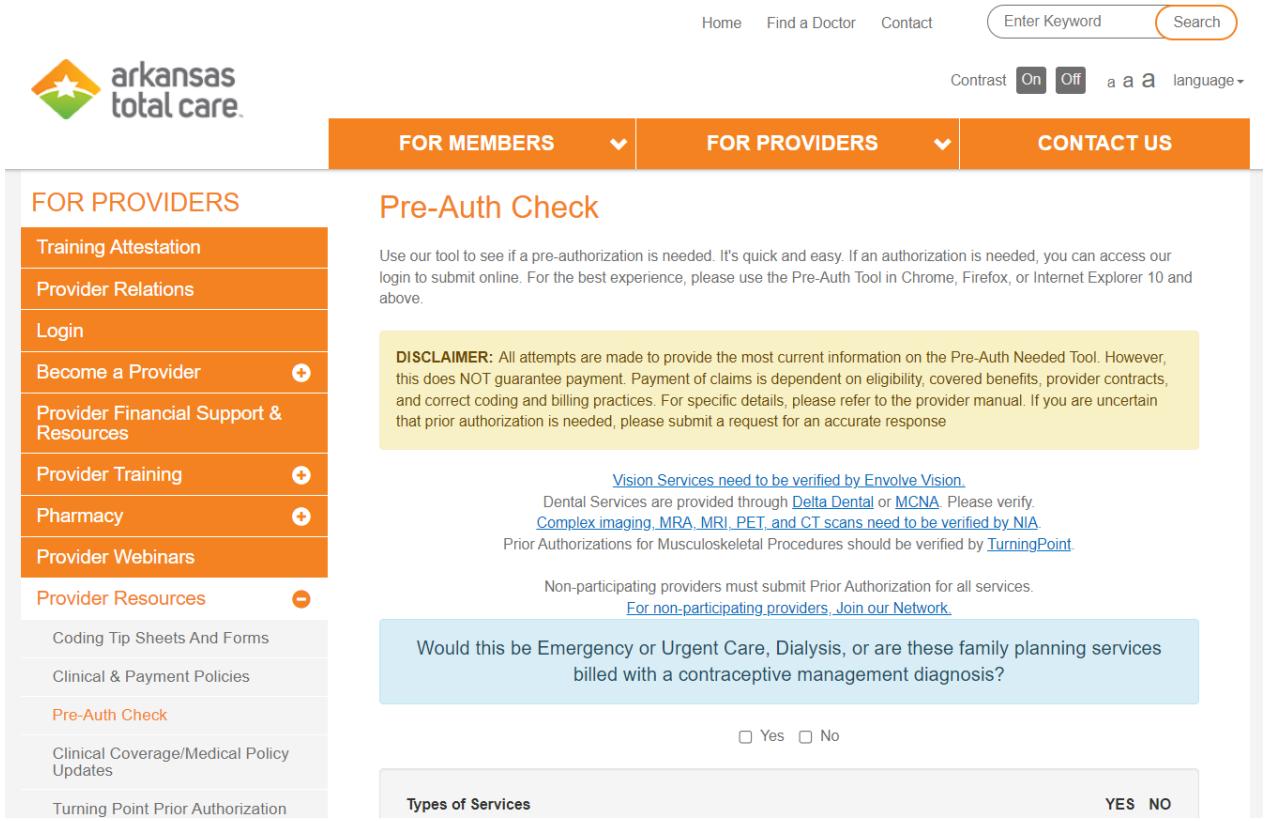
- As an **Arkansas Total Care** provider, you will have a dedicated Provider Relations Specialist available to assist you.
- Our Provider Relations Specialists serve as the primary liaisons between our health plan and provider network.
- Your Provider Relations Specialist is here to help with things like:
  - Inquiries related to administrative policies, procedures, and operational issues
  - Performance pattern monitoring
  - Secure Portal registration and training
  - Provider education
  - Financial analysis
  - EHR utilization
  - Demographic information updates
  - Escalation assistance

The Arkansas Total Care Public Website

The Arkansas Total Care Public Website

What is on the public website?

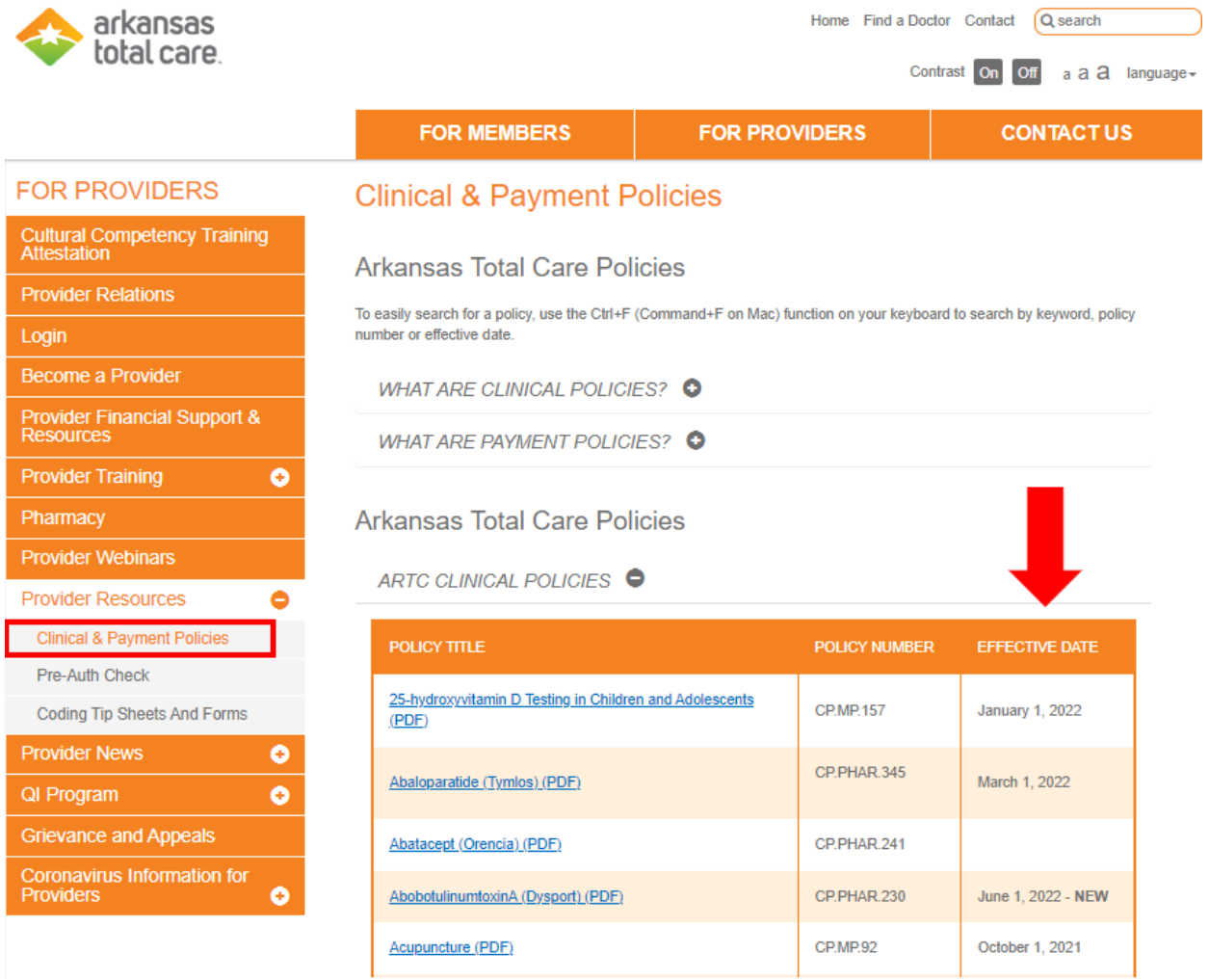
- The Provider and Billing Manual
- Quick Reference Guides
- Important Forms (Claim Dispute Form, Prior Authorization Fax forms, etc.)
- The Pre-Auth Check Tool
- Clinical and Payment Policies
- The Pharmacy Preferred Drug Listing
- And much more!



Arkansas Total Care Clinical Policies

To find clinical and payment policy updates, follow these steps:

1. Visit ArkansasTotalCare.com.
2. Select Provider Resources.
3. Select Clinical & Payment Policies.
4. There, you will find the latest policies and their effective dates.

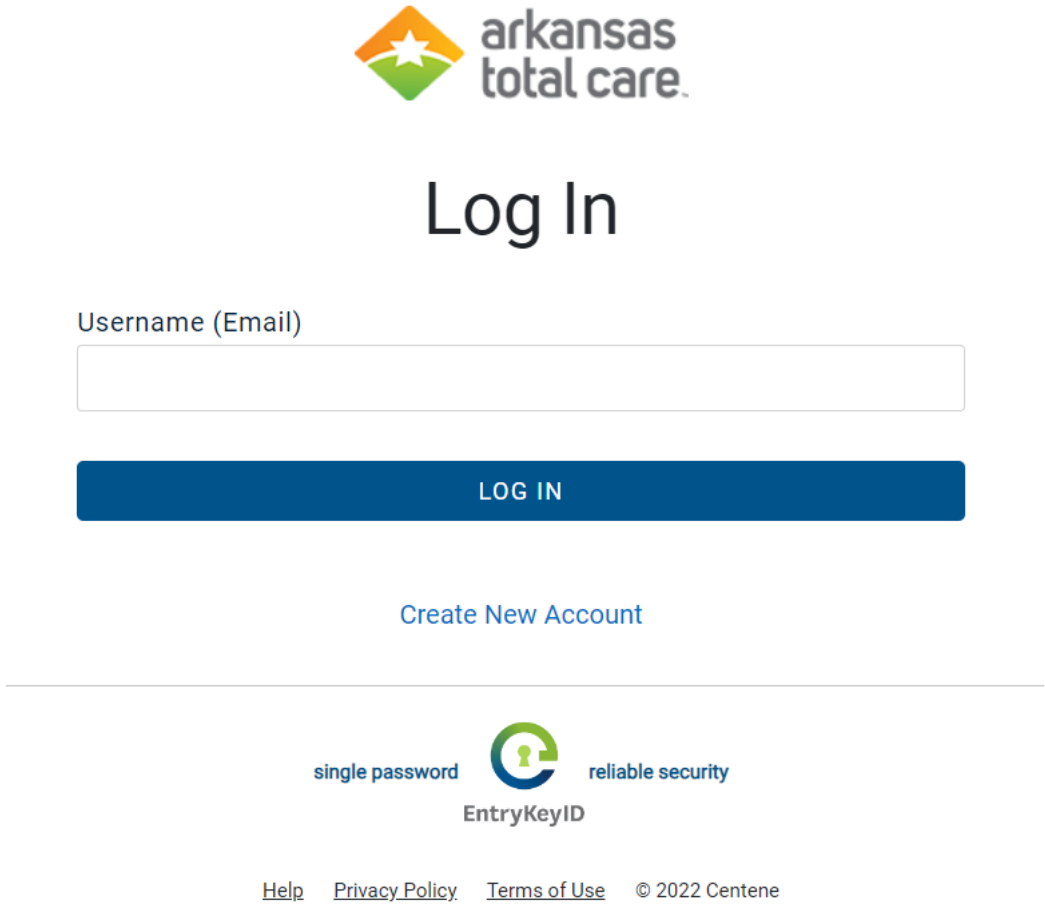


Secure Provider Portal

Registration is free and easy!

A registration video and PDF are available to assist you.

Contact your Provider Relations Specialist if you have questions.



Secure Provider Portal

What's on the Secure Provider Portal?

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

Verification of Eligibility, Benefits and Cost Share

Member ID Card

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

Verification of Eligibility, Benefits and Cost Share

Providers MUST verify member eligibility:

- Prior to rendering services
- On the date services are rendered

Panel status:

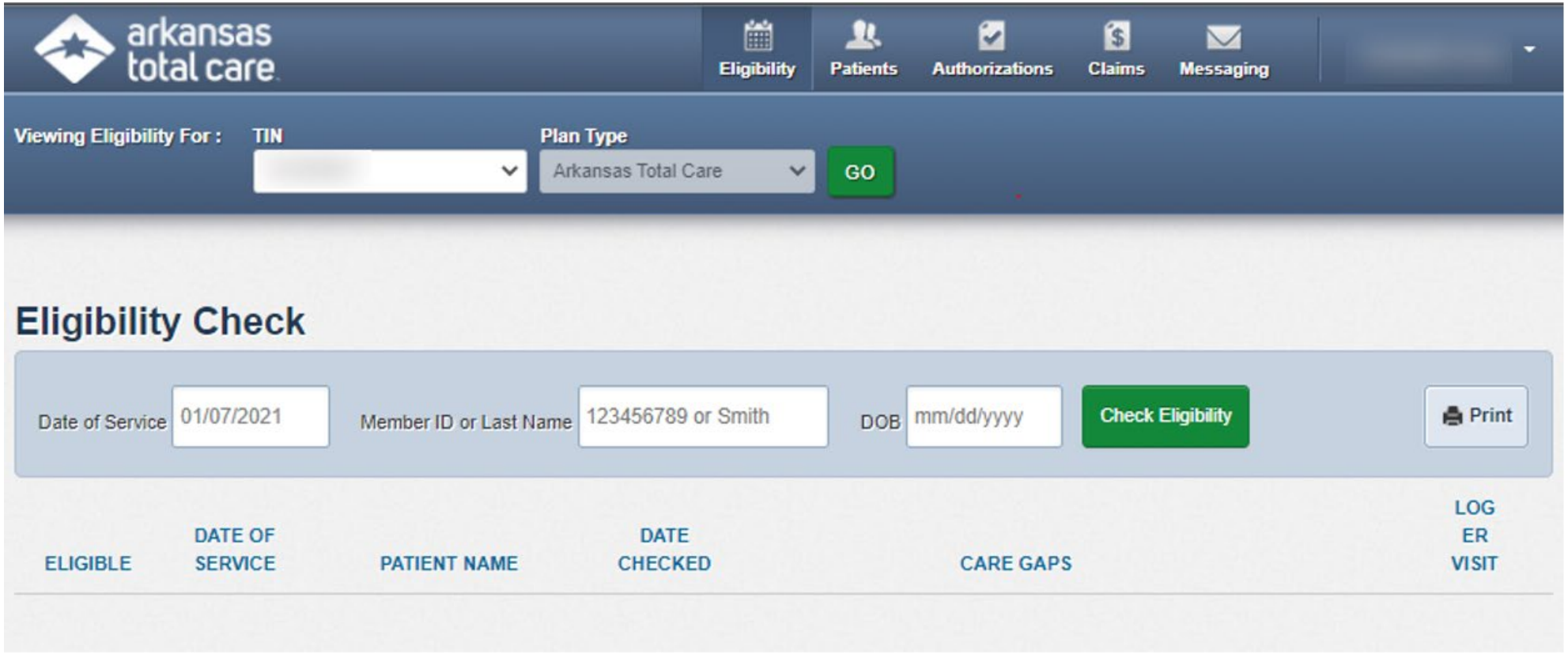
- PCPs should confirm that a member is assigned to their patient panel. This can be done via our Secure Provider Portal.
- PCPs can still administer services if the member is not on their panel and they wish to have member assigned to them for future care.

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 number 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 specialist providers.

Paper referrals are not required for members to seek care with in-network specialists.

How to Secure Prior Authorization

Need prior authorization? It can be requested in the following ways:

Secure Web Portal:
Provider.ArkansasTotalCare.com

- This is the preferred and fastest method.

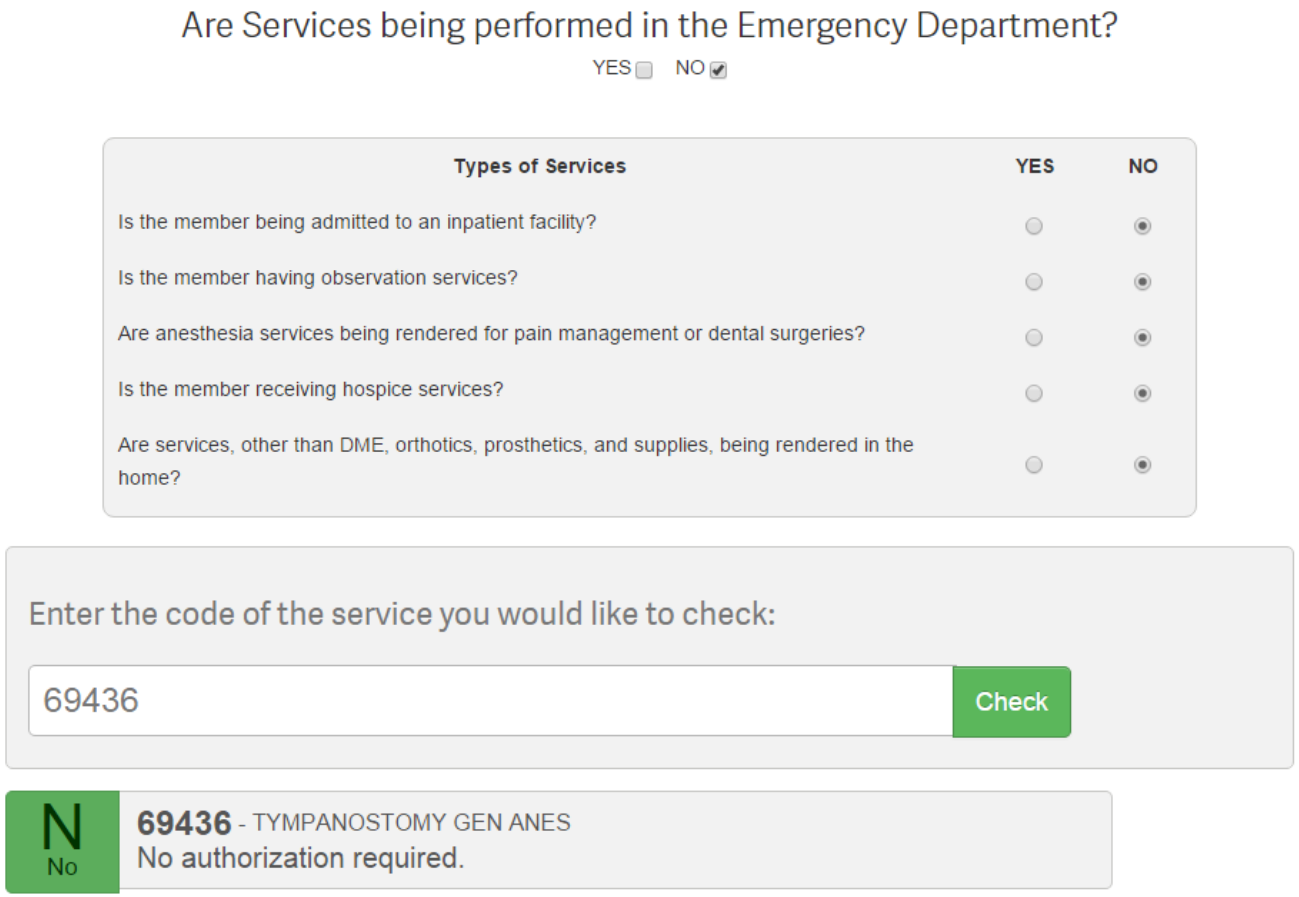
Phone:
1-866-282-6280

Fax:
1-833-249-2342

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

Is Prior Authorization Needed?

- Use the Pre-Auth Check Tool to quickly determine if a service or procedure requires prior authorization.
- Available on the Provider Resources section of the Arkansas Total Care website at ArkansasTotalCare.com



Prior Authorization Requirements

Procedures/services that need prior authorization include*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g., CT, MRI, PET)
- Infertility
- 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 check if a specific service or procedure requires prior authorization.*

Prior Authorization Requirements

Ancillary services that need prior authorization include*:

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

Prior Authorization Timeframes

Service Type	Time Frame
Scheduled admissions	Prior authorization is required a minimum of 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 is required a minimum of five business days before the elective outpatient service date.
Emergent inpatient admissions	Notification is required within 24 hours or by the next business day following a weekend or holiday.
Continued inpatient stay	Notification is required within 24 hours of the last approved day.
Maternity admissions	Notification within 24 hours or by the next business day following a weekend or holiday.
Clinical trials services	Prior authorization is required at least 30 days before receiving clinical trial services.

Utilization Determination Timeframes

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

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

Correct Coding For Prior Authorization

Prior authorization will be granted at the CPT® code level

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider must contact the health plan to update the authorization in order to avoid a claim denial.
  - It is recommended that this be done within 72 hours of the procedure. However, it must be done prior to claim submission or the claim will deny.

Claims

What is a clean claim?

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

Are there any exceptions?

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

How to Submit a Claim

The timely filing deadline for initial claims is 365 days from the date of service or date of primary payment when Arkansas Total Care is secondary.

Claims may be submitted in three ways:

The Secure Provider Portal:

- Provider.ArkansasTotalCare.com

Electronic Clearinghouse:

- Payor ID 68069

Mail:

Arkansas Total Care

Attn: Claims

P.O. Box 8020

Farmington, MO 63640-8020

EVV/HHAeXchange

EVV (electronic visit verification) uses electronic means to verify provider visits for personal or home healthcare services. The information collected during such visits includes:

- The date of service
- The start time and end times for service provided
- The type of healthcare service performed
- The location of the service provided
- Information 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.

Providers must have valid Arkansas Medicaid Provider IDs to submit visits. Providers must send their rosters to Arkansas Total Care to correctly configure in the HHAeXchange system. Note that inaccurate or missing provider information may result in delayed payment. Rosters should be emailed to ArkCredentialing@centene.com.

Claim Reconsiderations And Disputes

Claim reconsiderations:

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

  Arkansas Total Care
  P.O. Box 8020
  Farmington, MO 63640-5000

Claim Disputes

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

  Arkansas Total Care
  P.O. Box 8020
  Farmington, MO 63640-5000

Complaints, Grievances, and Appeals

Member Grievance and Appeal Process:

To ensure Arkansas Total Care members' rights are protected, all Arkansas Total Care members are entitled to a complaint/grievance and appeal process. The procedures for filing a complaint/grievance or appeal are outlined in the Arkansas Total Care member handbook. Additionally, information regarding the complaint/grievance and appeal process can be found on our website or by calling Arkansas Total Care at 1-866-282-6280.

If a member is displeased with any aspect of services rendered, they should contact our member services department at 1-866-282-6280. A representative will assist them.

If the member continues to be dissatisfied, they may file a formal complaint/grievance. Our member services department is available to assist with this process. Information regarding this process is available at ArkansasTotalCare.com.

- A member may designate in writing to Arkansas Total Care that an authorized representative is acting on their behalf regarding the complaint/grievance and appeal process.
- If an appeal results in an adverse determination, the grievances and appeals department must notify the appellant that a request for a fair hearing must be filed with the appropriate office within 30 calendar days of receipt of resolution of the appeal.

Complaints, Grievances, and Appeals

Site reviews are performed at provider offices and facilities when the member complaint threshold is met. A site review evaluates the following:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Adequacy of medical/treatment record keeping

The mailing address for non-claim-related complaints/ grievances and medical necessity appeals is as follows:

Arkansas Total Care
Attn: Grievances and Appeals
P.O. Box 25010
Little Rock, AR 72221

Members have the right to request to continue their benefits during an appeal or fair hearing if:

- The request is timely in accordance with 42 CFR 438.420.
- The appeal involves the termination, suspension, or reduction of previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not yet expired and the member or legal representative files for continuation in accordance with Arkansas Total Care policy.

Members may include a request to continue benefits in their appeal and fax it to 866-811-3255. If the final resolution of the appeal or hearing is adverse to the appellant, Arkansas Total Care may recover the cost of the continuation of benefits furnished during the appeal or fair hearing.

Other Helpful Information About Claims

Make Sure To Include The Taxonomy Code When an 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.

Don't Forget The CLIA Number!

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

Claims Payments: Electronic Funds Transfer

Payspan: A faster, easier way to get paid

- Arkansas Total Care offers Payspan Health, a free solution that helps providers transition into electronic payments and automatic reconciliation.
- If you currently utilize Payspan, you will need to register specifically for Arkansas Total Care.

Set up your Payspan account:

- Visit PayspanHealth.com and click Register.
- You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (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 the psychiatrist.

Incident Reporting:

All incidents should be reported to Arkansas Total Care in accordance with the standards outlined in the Arkansas Total Care 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.

Manage Vision Benefits

Arkansas Total Care manages medical eye services. Envolve Vision manages routine eye care services and full scope of licensure optometric services for our members. However, Arkansas Total Care is now responsible for the following functions for medical eye care services:

- Contracting and credentialing
- Claim processing and appeals
- Provider services
- Provider partnership management
- Provider web portal
- Provider education and resource materials (e.g., provider manual, training)
- Prior authorization, retrospective utilization review, and medical necessity appeals
- Provider complaints

If you have any questions about these changes, please reach out to our Provider Relations team at **Providers@ArkansasTotalCare.com** or call us at **1-866-282-6280 (TTY: 711).** You can also contact your Provider Relations Representative.

Key Contacts

Department	Phone/Website	Fax/Email
HHAeXchange Support	1-855-400-4429	HHA Client Support Portal
TurningPoint	501-263-8850 Toll-free: 1-866-619-7054	501-588-0994
NIA Advanced Imaging (MRI, CT, PET)	1-866-500-7685 RadMD.com	N/A
Envolve Vision	1-844-280-6792 VisionBenefits.EnvolveHealth.com	N/A
EDI Claims Assistance	1-800-225-2573 ext. 6075525	EDIBA@centene.com