



Arkansas Medical Society 2021 Virtual Insurance Conference

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Agenda

- COVID-19 Updates
- Arkansas Health & Wellness (AHW) Updates
 - Clinical & Payment Policies
 - No Surprises Act
 - Depression Screenings
 - Allwell Name Change
 - D-SNP
 - Prior Authorizations
- Arkansas Total Care (ARTC) Updates
- Important Reminders
 - Open Enrollment
- Contact information

Join Our Email List Today

- Receive current updates:
- Ambetter and Allwell
 - <https://www.arhealthwellness.com/providers/resources.html>
- Arkansas Total Care
 - <https://www.arkansastotalcare.com/providers.html>
- Choose the network you wish to receive information for

Interested in getting the latest alerts from Arkansas Health and Wellness? 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 *

Network*

Ambetter

Allwell

Submit

COVID-19 Updates

Coronavirus Info for Providers



Helping Arkansas Live Better

FOR MEMBERS

FOR PROVIDERS

FOR PROVIDERS

Login

Become a Provider

Pre-Auth Check



Pharmacy

Provider Resources



QI Program



Provider News



Provider Relations

Coronavirus Information for Providers

Provider Financial Support & Resources

Risk Adjustment



For Providers

Login

If you are a contracted Arkansas Health & Wellness provider, you can register now. If you are a non-contracted provider, you will be able to register after you submit your first claim.

Once you have created an account, you can use the provider portal to:

- Verify member eligibility
- Manage claims
- Manage authorizations
- View patient list
- Login/Register

login/register

COVID-19

Post-Acute Transfer Policy Extension

- In an effort to help facilities accept patients during the COVID-19 pandemic, Arkansas Health & Wellness and ARTC will auto-approve the initial seven days for lower levels of care for patients moving from an inpatient hospital setting
- We request that facilities provide notification of admission by submitting an authorization request within the first five days of a patient's admission. We will continue to provide concurrent review after the initial seven-day approval. This waiver will be in effect for the duration of the reinstated public health emergency
- The end date for this waiver may be changed. Please be sure to sign up for our provider emails so that you can receive notifications from us.
- The waiver includes skilled nursing facilities, long-term acute care and acute rehab for all lines of business. Acute transfers from medical stays to behavioral health facilities are included in this waiver. Acute transfers from psychiatric stays at behavioral health facilities are excluded.

Monoclonal Antibody

Coding for Monoclonal Antibody COVID-19 Infusion

CMS identified specific code(s) for the monoclonal antibody product and specific administration code(s) for Medicare payment:

GSK: Q0247, M0247, M0248 effective 5/26/21

Genentech: Q0249, M0249, M0250 effective 6/24/21

During the COVID-19 public health emergency (PHE):

Allwell will deny these codes with direction to submit to FFS for 2021 Dates of Service.

AS OF 8/19: Admin Should forward to FFS. No changes to current setup needed.

- Ambetter*
- ARTC will follow the direction of DHS.

Ambetter Covid-19 Vaccine and Administration

- **National State of Emergency Extension Now through 10/18/21 Sequester Moratorium Now Through 12/31/21**
- Ambetter from Arkansas Health & Wellness has configured its systems to properly adjudicate COVID-19 vaccine-related claims, both for the vaccine and its administration.

Line of Business	Provider Status	Service Type	Prior Authorization	Cost Share
Ambetter	PAR or NONPAR	Prevention	NO	NO
Ambetter	PAR or NONPAR	Screening	NO	NO
Ambetter	PAR	Treatment	YES	YES
Ambetter	NONPAR	Treatment	YES/NO Except when required per member's benefit	YES

Allwell Covid-19 Billing

As we continue address the COVID-19 pandemic, we want to update you on important Medicare benefit information as it relates to currently expanded coverages. For dates of service June 1, 2021 onward, Medicare member liability (copayments, coinsurance and/or deductible cost sharing) will be reinstated as according to their benefits for the applicable Treatment services.

Line of Business	Provider Status	Service Type	Prior Authorization	Cost Share
Allwell	PAR or NONPAR	Prevention	NO	NO
Allwell	PAR or NONPAR	Screening	NO	NO
Allwell	PAR or NONPAR	Treatment	YES	YES

Covid Billing cont.

Ambetter and Allwell

- Any services that can be delivered virtually will continue to be eligible for telehealth coverage for the duration of the public health emergency (PHE).
- Providers should reflect telehealth care on their claim form by following standard telehealth billing protocols in their state.

Allwell Only

- Providers should resume collecting Medicare member liability at the point of service on June 1, 2021 onward.

Arkansas Health & Wellness Updates

Clinical and Payment Policy Updates

- **Arkansas Health & Wellness is amending or implementing new policies that can be found on the public website.**
- The Clinical, Payment and Pharmacy policies can be found by going to: ARHealthWellness.com
 - Hover over the “For Providers” tab at the top of the screen
 - Select “Clinical and Payment Policies” from the drop-down menu
 - Select Ambetter or Allwell Clinical, Payment, or Pharmacy policies.
- Use the Ctrl+F (Command+F on Mac) function on your keyboard to search by keyword, policy number or effective date.

If you have questions, please call 1-877-617-0390 (TTY: 1-877-617-0392) or email Providers@ARHealthWellness.com

Coding Tip Sheets and Forms

FOR MEMBERS **FOR PROVIDERS** GET INSURED

FOR PROVIDERS

- Login
- Become a Provider
- Pre-Auth Check
- Pharmacy
- Provider Resources**
- Manuals, Forms and Resources
- Provider Training
- Eligibility Verification
- Incentives Statement
- Integrated Care
- Provider Webinars
- Prior Authorization
- National Imaging Associates (NIA)
- Report Fraud, Waste and Abuse
- Patient Centered Medical Home Model
- Electronic Transactions
- Clinical & Payment Policies
- Coding Tip Sheets And Forms**

Provider Resources

Coronavirus (COVID-19)

Currently we are experiencing some issues and long wait times with on our Teledoc and Referral lines. Please be patient with us as we work through this busy period.

To receive the fastest response on referrals, please submit authorization requests through our provider portal or via fax at:

- Ambetter from Arkansas Health & Wellness Fax: 1-866-884-9580
- Allwell from Arkansas Health & Wellness Fax: 1-866-279-1358, Behavioral Health Fax: 1-866-279-1358

Arkansas Health & Wellness provides the tools and support you need to deliver the best quality of care. Please view our listing on the left, or below, that covers forms, guidelines, helpful links, and training.

- For Ambetter information, please visit our [Ambetter website](#).
- For Allwell information, please visit our [Allwell website](#).

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

- [Manuals, Forms and Resources](#)
- [Eligibility Verification](#)
- [Prior Authorization](#)
- [Electronic Transactions](#)
- [Preferred Drug Lists](#)
- [Provider Training](#)

Name *

No Surprises Act

No Surprises Act

The No Surprises Act, signed into law as part of the Consolidated Appropriations Act of 2021, prohibits surprise medical billing and implements an independent dispute resolution process to determine out-of-network rates for emergency care and certain non-emergency situations.

- Emergency care at out-of-network facilities;
 - Note: The potential inclusion of urgent care centers is dependent upon whether state licensure laws permit urgent care centers to provide emergency services.
- Post-stabilization care at out-of-network facilities, unless specific conditions are met;
- Non-emergency services provided by out-of-network providers at in-network facilities, unless notice and consent is given; and
- Out-of-network air ambulance services
- **Effective Date:** January 1, 2022



Allwell Name Change

New National Branding Alignment Strategy



By

allwell.TM



Wellcare by Allwell



January 2022, Allwell from Arkansas Health & Wellness will become Wellcare by Allwell.

- Providers contracted with Allwell will continue with the same reimbursements and contract, just under a new brand name.
- **Being a Wellcare by Allwell provider does not mean you are in network for Wellcare.**
- Current Allwell Members received letters explaining the change in name.



2022 ID Cards Will Be Clearly Distinguished

 <p style="text-align: right;"><Year>⁷¹</p> <p><Company Name> <Plan_Contract_PBP>³⁶</p> <p>Member: <MbrFullName>¹⁵ Member ID: <12345678>⁴ <small><Submit claims under this number></small>^{L32} Issuer: 80840 <Policy #:>^{L1} <XX123>²⁵ <CIN #:>^{L6} <AZ12345F>⁹⁶ <Primary Care Provider (PCP):>^{L7} <PhyFullName>¹⁶ <PCP Phone:>^{L2} <1-XXX-XXX-XXXX>³¹ <IPA/LPO:>^{L8} <IPA Name>⁹² <IPA ID>³²</p> <div style="text-align: center;">  </div> <p>RXBIN: <XXXX>⁵⁶ RXPCN: <XXXX>⁵⁸ RXGRP: <XXXX>⁵⁷</p> <p><IPA LOGO></p> <p style="text-align: right;">Card Issued: <XX/XX/XXXX>¹²⁰</p>	 <p>Wellcare by Allwell <Product Name> CMS#: <H9630-XXXX> Effective Date: <MM/DD/YYYY></p> <table border="1"> <tr> <td data-bbox="1004 721 1429 1099"> <p>MEMBER INFORMATION</p> <p>Name: <First MI Last> Member ID#: <XXXXXXXXXX-XXX> Issuer ID: <{80840}> <9151014609></p> <p>PROVIDER INFORMATION</p> <p>PCP Name: <> PCP Phone: <></p> </td> <td data-bbox="1439 721 1835 1099"> <p>PHARMACY INFORMATION</p> <p style="text-align: center;">MedicareRx <small>Prescription Drug Coverage</small></p> <p>Rx Claims Processor: <CVS Caremark®> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8909></p> </td> </tr> </table>	<p>MEMBER INFORMATION</p> <p>Name: <First MI Last> Member ID#: <XXXXXXXXXX-XXX> Issuer ID: <{80840}> <9151014609></p> <p>PROVIDER INFORMATION</p> <p>PCP Name: <> PCP Phone: <></p>	<p>PHARMACY INFORMATION</p> <p style="text-align: center;">MedicareRx <small>Prescription Drug Coverage</small></p> <p>Rx Claims Processor: <CVS Caremark®> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8909></p>
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Wellcare by Allwell D-SNP



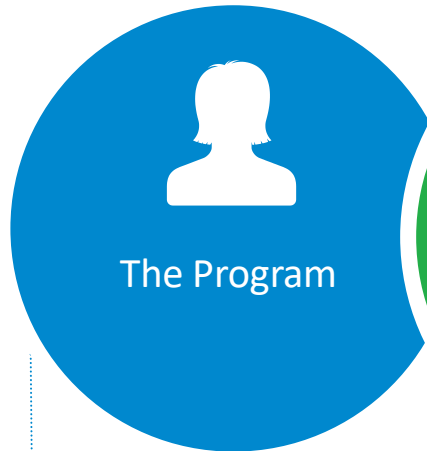
Wellcare by Allwell Dual Liberty D-SNP Full Benefit Dual Eligibles.

- Available in 54 counties in January 2022.
 - Wal-Mart Over The Counter \$430 qtr.
 - Flex Card \$1,000 yr
 - SSBCI UTILITY \$50 mo.
 - In-Home Chores & Personal SVCs
 - Personal Emergency Response System
 - Unlimited Transportation
 - \$3,000 dental

Arkansas, Baxter, Bradley, Calhoun, Carroll, Chicot, Clark, Clay, Cleburne, Cleveland, Conway, Craighead, Crittenden, Cross, Dallas, Desha, Drew, Fulton, Garland, Grant, Greene, Hot Spring, Independence, Izard, Jackson, Jefferson, Lawrence, Lee, Lincoln, Lonoke, Marion, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Phillips, Pike, Poinsett, Polk, Prairie, Pulaski, Randolph, Saline, Searcy, Sharp, St. Francis, Stone, Van Buren, White, Woodruff, Yell

National Imaging Associates, INC (NIA)

NIA's Physical Medicine Prior Authorization Program – Ambetter Only



The Program

- Ambetter from Arkansas Health & Wellness will begin a prior authorization program through NIA for the management of Physical Medicine Services.
- The program includes both rehabilitative and habilitative care.



Important Dates

- Program start date: January 1, 2021
- Begin obtaining authorizations from NIA on December 14, 2020 for services rendered on or after January 1, 2021



Disciplines & Settings Included

Disciplines:

- Physical Therapy
- Occupational Therapy
- Speech Therapy

Settings:

- Office
- Outpatient Hospital
- Home Health



Membership Included

- Exchange Programs

Registering on RadMD.com To Initiate Authorizations

Everyone in your organization is required to have their own separate user name and password due to HIPAA regulations.

STEPS:

1. Click the “New User” button on the right side of the home page.
2. Select “Physical Medicine Practitioner”
3. Fill out the application and click the “Submit” button.
 - You must include your e-mail address in order for our Webmaster to respond to you with your NIA-approved user name and password.

NOTE: On subsequent visits to the site, click the “Sign In” button to proceed.

Offices that will be both ordering and rendering should request ordering provider access, this will allow your office to request authorizations on RadMD and see the status of those authorization requests.

When to Contact NIA



Providers:

<p>Initiating or checking the status of an authorization</p>	<ul style="list-style-type: none">▪ Website, www.RadMD.com▪ Toll-free number 1-877-617-0390 - Interactive Voice Response (IVR) System
<p>Initiating a Peer to Peer</p>	<ul style="list-style-type: none">▪ Call 1-888-642-7649
<p>Technical Issues</p>	<ul style="list-style-type: none">▪ RadMDSupport@magellanhealth.com▪ Call 1-800-327-0641
<p>Provider Education requests or questions specific to NIA</p>	<ul style="list-style-type: none">▪ Leta Genasci Provider Relations Manager 1-800-450-7281 Ext. 75518 lgenasci@magellanhealth.com

Turning Point

Our clinical policies and processes are easily accessible to the market via several access points



Authorization Submission:

- **Web:** <https://myturningpoint-healthcare.com>
- **Fax:** 501-588-0994
- **Phone:** 501-263-8850 | 866-619-7054

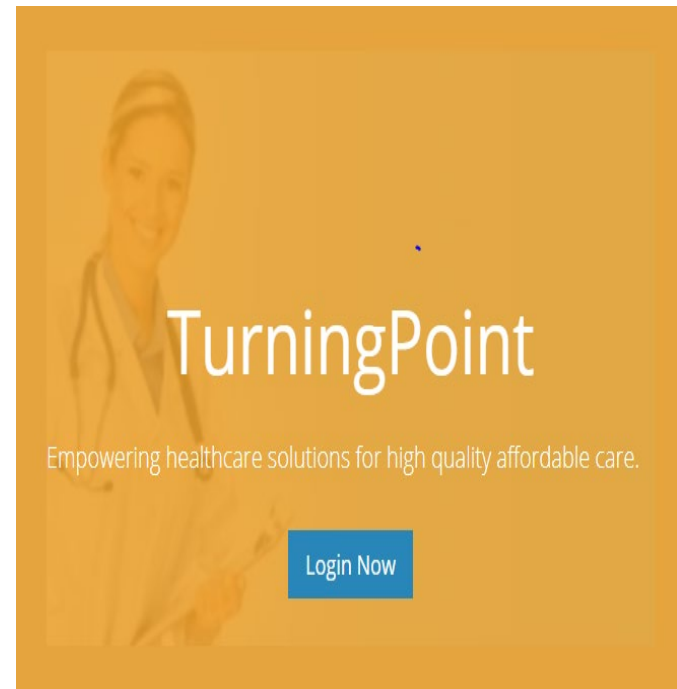
Provider Resources:

- **Provider Relations Team**
- **Frequently Asked Questions (FAQ) document**
- **TurningPoint Provider Manual**

TurningPoint Provider Portal Access

- **Portal users must be registered before submitting requests**
- **All providers will receive a notification of staff registered for portal access**
- **Portal demonstrations can be set-up for your practice upon request**

*NOTE: To become a registered user of TurningPoint's Web Portal, please contact their Provider Relations Team:
Phone: 866-422-0800
Email: providersupport@turningpoint-healthcare.com*



Post Service Change Review (PSCR)

- Allows for a coding change on an authorization after the surgery based on changes during surgery
- PSCR will be performed if the additional procedure codes are subject to prior authorization and are within TurningPoint scope of services
- Must submit PSCR form and supporting post op notes to initiate review
- Must submit request prior to submitting claim

Reminders

- Email the request to : centeneumappeals@turningpoint-healthcare.com
- Please include all pertinent clinical information, including but not limited to operating notes.

Post Service Changes Review Form

This form is only to be used for review of a request post service, where an authorization was obtained, however the procedure codes performed differ from the initial authorization request. Post service reviews will be performed if the additional procedure codes are subject to prior authorization and fall within the TurningPoint Scope of Services. Submit only one form per patient.

This process can only be applied if a claim has not yet been submitted to Centene.

****Inquiries received without the required information below may not be reviewed****

Authorization Number:		Member ID#:	
Member DOB:	Prefix:	Group #:	
Patient Name: (Last, First)			
Date(s) of Service:		Provider TIN:	
Provider Name:		NPI:	
Contact Person:		Phone Number:	
Provide detailed information about your review request, including what was initially authorized and what procedure(s) changed with the updated CPT codes:			



Arkansas Total Care - Updates



Behavioral Health Outpatient Coding

Behavioral Health Outpatient (BHOP) Coding



- Psychotherapy times are for face-to-face services with the patient and/or family member
- Patient must be present for all or some of the service
- Reporting guidelines:
 - Choose the code closest to the actual time
 - Do not report psychotherapy of less than 16 minutes duration
 - Duration of a course of psychotherapy must be individualized for each patient

The psychotherapy code is chosen on the basis of the time spent providing psychotherapy, not inclusive of paperwork time without the member present:

- Code 90832 (or + 90833): 16 to 37 minutes,
 - Code 90834 (or + 90836): 38 to 52 minutes, or
 - Code 90837 (or + 90838): 53 minutes or longer
- Upcoding occurs when a healthcare provider submits codes for more serious diagnosis or more intensive/costly procedures than the provider actually diagnosed or performed.

Behavioral Health Outpatient Coding



- When evaluating all BHOP services both by units utilized and paid claims, the predominant code being utilized is for 90837, which is the longer duration therapy code
- Data indicates that there are a significant volume of providers using the 90837 code exclusively:
 - ARTC population - 90837 is being used for approximately 75% of all BHOP visits
 - Generally we would expect to see more variety in the codes utilized for BHOP services (90837, 90834, 90832)
- Any billing practices that appear as an outlier as part of claims-based audits will be referred for Quality Assurance review and potential chart audits for adherence to the above billing guidelines



Depression Screenings

Major Depression Disorders & Screening Tips



Depression screening and follow-up for adolescents and adults (DSF-E)

Members 12 years and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care

Two rates are reported:

<p>Depression screening: Members with a documented result of a depression screening performed using an age-appropriate standardized instrument between January 1 and December 1 of the measurement period</p>	<p>Follow-up on positive screen: Members who received follow-up care up to 30 days after the date of the positive screening</p>
--	--

Clinical recommendation: The U.S. Preventive Services Task Force (USPSTF)¹ recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. The USPSTF² also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

CPT® Codes	HCPCS Codes
90791, 90792, 90832-90834, 90836-90839, 90846, 90849, 90853, 90870, 90887, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99343, 99345, 99347-99350, 99381-99385, 99391-99395, 99401-99402	G2012, H0034, H0035, H2000, H2011- H2017, H2019, H2020, T1015-T1017, T2022

Follow-up on positive screen on same day or 30 days after the first positive screen:

- An outpatient, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition;
- A behavioral health encounter, including assessment, therapy, collaborative care, or medication management;
- A dispensed antidepressant medication; OR
- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.

Depression Screenings cont.



Attention, billers:

Arkansas Total Care will be paying \$0.01 for the below HCPCS codes. This will allow billing of important codes without a denial of non-payable code. The following codes should be billed on all claims and encounters when applicable.

Codes to identify outpatient visits	
CPT® Codes	HCPCS Codes
59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444, G0502, G0503, G0504, G0505, G0507

HCPCS codes to document depression screening	
Code	Description
G8431	Screening for depression is documented as being positive, and a follow-up plan is documented
G8510	Screening for depression is documented as negative, and a follow-up plan is not required

Exclusions: ICD-10 codes to identify active diagnosis of depression
Codes
F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345

Exclusions: ICD-10 codes to identify diagnosed bipolar disorder
Codes
F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9

Exception: HCPCS code	
Code	Description
G8433	Screening for depression not completed; documented reason

NOTE: The information listed here is not all-inclusive and should be used as a reference only. Please refer to current ICD-10 coding and billing documentation guidelines at [cms.gov](https://www.cms.gov).



Clinical and Payment Policies

Clinical & Payment Policies



- **Arkansas Total Care is amending or implementing new policies that can be found on the public website.**
- The Clinical, Payment and Pharmacy policies can be found by going to:
Arkansastotalcare.com
 - Hover over the “For Providers” tab at the top of the screen
 - Select “Provider Resources” from the drop-down menu
 - Select Clinical and Payment Policies on the left.
- Use the Ctrl+F (Command+F on Mac) function on your keyboard to search by keyword, policy number or effective date.

If you have questions, please call 1-866-282-6280.

ARTC Clinical Policies



Located at <https://www.arkansastotalcare.com/providers/resources/clinical-payment-policies.html>

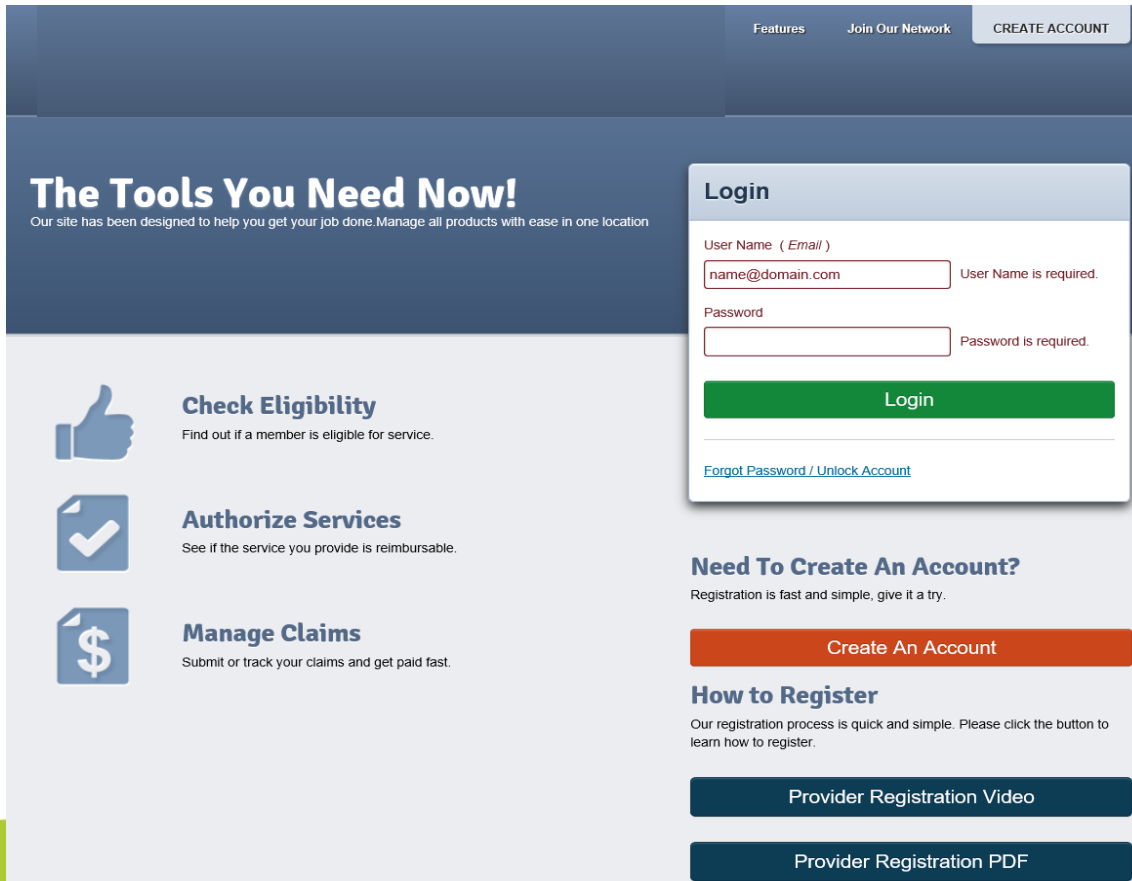
The screenshot shows the Arkansas Total Care website interface. At the top left is the logo. Navigation links include Home, Find a Doctor, Contact, and a search bar. There are also contrast and language settings. The main navigation bar has three tabs: FOR MEMBERS, FOR PROVIDERS, and CONTACT US. The FOR PROVIDERS tab is active, showing a sidebar menu with options like Provider News, QI Program, Provider Relations, Login, Become a Provider, Pharmacy, Provider Webinars, Provider Resources, Clinical & Payment Policies (highlighted with a red box), Pre-Auth Check, and Coding Tip Sheets And Forms. The main content area is titled 'Clinical & Payment Policies' and contains expandable sections for 'WHAT ARE CLINICAL POLICIES?' and 'WHAT ARE PAYMENT POLICIES?'. Below these is the 'Arkansas Total Care Policies' section, which includes a sub-section for 'ARTC CLINICAL POLICIES'. A large red arrow points from the 'WHAT ARE PAYMENT POLICIES?' section down to the 'ARTC CLINICAL POLICIES' section. This section contains a table with the following data:

POLICY TITLE	POLICY NUMBER	EFFECTIVE DATE
AbobotulinumtoxinA (Dysport) (PDF)	CP.PHAR.230	6/1/2020
Adopted Clinical Practice and Preventive Health Guidelines (PDF)	N/A	6/1/2020

Secure Provider Portal Updates

Secure Provider Portal – Create An Account

- Registration is free and easy



The screenshot shows the 'Secure Provider Portal' registration page. At the top, there are navigation links for 'Features', 'Join Our Network', and 'CREATE ACCOUNT'. The main heading is 'The Tools You Need Now!' with a subtext: 'Our site has been designed to help you get your job done. Manage all products with ease in one location'. Below this, there are three main service areas: 'Check Eligibility' (with a thumbs up icon), 'Authorize Services' (with a checkmark icon), and 'Manage Claims' (with a dollar sign icon). On the right side, there is a 'Login' form with fields for 'User Name (Email)' and 'Password', both with error messages 'User Name is required.' and 'Password is required.' respectively. Below the login form is a green 'Login' button and a link for 'Forgot Password / Unlock Account'. Further down, there is a section titled 'Need To Create An Account?' with the text 'Registration is fast and simple, give it a try.' and a prominent orange 'Create An Account' button. Below this is a 'How to Register' section with the text 'Our registration process is quick and simple. Please click the button to learn how to register.' and two buttons: 'Provider Registration Video' and 'Provider Registration PDF'. A red arrow points to the 'Create An Account' button.

Secure Portal Features

- A member eligibility overview page that reflects all critical data in a single view
- Ability to submit and track the status of claim reconsiderations online
- Expanded free text fields for reconsideration comments and explanations
- Attach required documentation when filing a reconsideration
- Upload records for care gap information.
- Receive push notifications regarding reconsideration status changes
- Void/Recoup option on claims already adjudicated by the health plan. The manual inside the portal has instructions for this new feature on page 92

Patient Overview – Document Resource Center

Back to Eligibility Check

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Document Upload

Document Review

1. Document Category:
 - Medical Necessity
 - Quality Management
 - Long Term Services And Support
2. Document Type:
3. Upload File: No file chosen
4.

Documents for the member can be uploaded here based on Document Category options.

Prior Authorization

Pre-Auth Check Tool



Helping Arkansas Live Better

FOR PROVIDERS

- Login
- Become a Provider
- Pre-Auth Check -
- Ambetter Pre-Auth
- Allwell Pre-Auth
- Pharmacy
- Provider Resources +
- QI Program +
- Provider News +
- Provider Relations
- Coronavirus Information for Providers
- Provider Financial Support & Resources
- Risk Adjustment +

Ambetter Pre-Auth

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 [Opticare](#)
 Dental services need to be verified by [DentaQuest](#)

Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)
 Complex imaging, MRA, MRI, PET, and CT Scans need to be verified by [NIA](#)

Prior Authorizations for Musculoskeletal Procedures should be verified by [TurningPoint](#).

Note: It is the responsibility of the facility, in coordination with the rendering practitioner to ensure that an authorization has been obtained for all inpatient and selected outpatient services, except for emergency stabilization services. All inpatient admissions require prior authorization. To determine if a specific outpatient service requires prior authorization, utilize the Pre-Auth Needed tool below by answering a series of questions regarding the Type of Service and then entering a specific CPT code.

Any anesthesiology, pathology, radiology or hospitalist services related to a procedure or hospital stay requiring a prior authorization will be considered downstream and will not require a separate prior authorization. However, services related to an authorization denial for an outpatient procedure or hospital stay will result in denial of all associated claims, including anesthesiology, pathology, radiology and hospitalist services.

Are Services being performed in the Emergency Department?

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 or dental surgeries?	<input type="radio"/>	<input type="radio"/>
Is the member receiving hospice services?	<input type="radio"/>	<input type="radio"/>
Are services being rendered in the home, excluding Sleep Studies, DME, Medical Equipment Supplies, Orthotics and Prosthetics?	<input type="radio"/>	<input type="radio"/>

Enter the code of the service you would like to check:

99214

Check

N
No

99214 - OFFICE/OUTPATIENT VISIT EST
 No authorization required.

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

How to Secure Prior Authorization

- Prior Authorizations can be requested in the following ways:
 - Secure Web Portal: This is the preferred and fastest method
 - Ambetter and Allwell: Provider.Arhealthwellness.com
 - Arkansas Total Care: Provider.arkansastotalcare.com
 - Phone
 - Ambetter: 1-877-617-0390
 - Allwell: 1-855-565-9518
 - Arkansas Total Care: 1-866-282-6280
 - Fax- IP and OP paper forms available on the website under Provider Resources.
 - Ambetter: 1-866-884-9580
 - Allwell: 1-833-562-7172
 - Arkansas Total Care: 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

Important Reminders

Open Enrollment

- ARTC- October 1st – 31st
- Wellcare by Allwell- October 15th
- Ambetter- November 1st

Contact Information

Contacting the Provider Service Center

- Provider Services Call Center can assist with the following provider inquiries:
 - Member Eligibility
 - Claim Inquiry
 - Prior Authorization Request
 - Network Verification
 - Appeal Status
 - Payment Inquiries
 - Check Stop Pay or Check Reissues
 - Negative Balance Report Request
 - Provider Demographic Change Request
 - Secure Portal Password Reset

Provider Services Call Center



- **First line of communication**

- Ambetter Provider Services Call Center 1-877-617-0390
TTY/TDD: 1-877-617-0392
- Allwell Provider Services Call Center 1-855-565-9518
TTY/TDD: 711
- ARTC Provider Services Call Center 1-866-282-6280
TTY/TDD: 711

- Representatives are available Monday through Friday, 8AM to 5PM (Central Standard Time)

Provider Inquiries

- After speaking with a Provider Service Representative you will receive a reference number, which will be used to track the status of your inquiry.
- If you need to contact your assigned Provider Relations Representative, please include the information below in your email:
 - Reference number assigned by the Provider Services Center
 - Provider's Name
 - Tax ID
 - National Provider Identifier (NPI)
 - Summary of the issue
 - Claim numbers (if applicable)

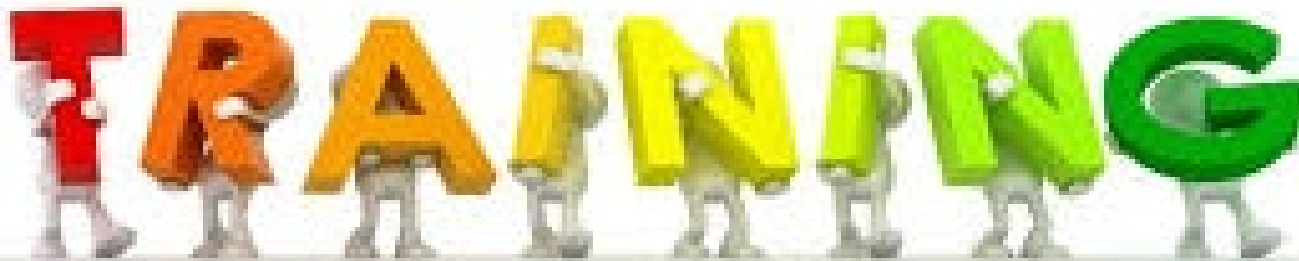
Education Requests

Would you like training for you and your staff?

You can submit your requests to

Providers@arhealthwellness.com

Providers@arkansasotalcare.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



Presented by Cheryl Allison
Provider Relations Specialist II

Agenda

- New Branding for WellCare
- Provider Portal
- Secure Portal Authorization Features
- Provider Access and Support
- Provider Relations Contact information

Beginning January 1, 2022- Two Separate Networks



= **WellCare Network**



WWW.WELLCARE.COM



= **Allwell Network**

<https://allwell.arhealthwellness.com>

2022 ID cards will be clearly distinguished

 <p style="text-align: right;"><Year>⁷¹</p> <p><Company Name> <Plan_Contract_PBP>³⁶</p> <p>Member: <MbrFullName>¹⁵ Member ID: <12345678>⁴ <small><Submit claims under this number></small>^{L32} Issuer: 80840 <small><Policy #:></small>^{L1} <XX123>²⁵ <small><Primary Care Provider (PCP):></small>^{L7} <small><CIN #:></small>^{L6} <AZ12345F>⁹⁶ <small><PhyFullName></small>¹⁶ <small><PCP Phone:></small>^{L2} <1-XXX-XXX-XXXX>³¹ <small><IPA/LPO:></small>^{L8} <small><IPA Name></small>⁹² <small><IPA ID></small>³²</p> <p style="text-align: center;">MedicareRx <small>Prescription Drug Coverage</small></p> <p>RXBIN: <XXXX>⁵⁶ RXPCN: <XXXX>⁵⁸ RXGRP: <XXXX>⁵⁷</p> <p><IPA LOGO></p> <p style="text-align: right;">Card Issued: <XX/XX/XXXX>¹²⁰</p>	 <p>Wellcare by Allwell <Product Name> CMS#: <H9630-XXXX> Effective Date: <MM/DD/YYYY></p> <table border="1"> <tr> <td data-bbox="969 688 1367 859"> <p>MEMBER INFORMATION</p> <p>Name: <First MI Last> Member ID#: <XXXXXXXX-XXX> Issuer ID: <(80840)> <9151014609></p> </td> <td data-bbox="1375 688 1734 859"> <p>PHARMACY INFORMATION</p> <p>MedicareRx <small>Prescription Drug Coverage</small></p> </td> </tr> <tr> <td data-bbox="969 865 1367 945"> <p>PROVIDER INFORMATION</p> <p>PCP Name: < > PCP Phone: < ></p> </td> <td data-bbox="1375 865 1734 945"> <p>Rx Claims Processor: <CVS Caremark®> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8909></p> </td> </tr> </table>	<p>MEMBER INFORMATION</p> <p>Name: <First MI Last> Member ID#: <XXXXXXXX-XXX> Issuer ID: <(80840)> <9151014609></p>	<p>PHARMACY INFORMATION</p> <p>MedicareRx <small>Prescription Drug Coverage</small></p>	<p>PROVIDER INFORMATION</p> <p>PCP Name: < > PCP Phone: < ></p>	<p>Rx Claims Processor: <CVS Caremark®> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8909></p>
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<p>PROVIDER INFORMATION</p> <p>PCP Name: < > PCP Phone: < ></p>	<p>Rx Claims Processor: <CVS Caremark®> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8909></p>				



Benefits of the WellCare Provider Portal

www.wellcare.com

Service	Web Portal	Chat	IVR
Appeal Requests / Status (Rx)	✓ Fastest Results		
Appeals & Disputes	✓ Fastest Results		
Authorization Requests	✓ Fastest Results	✓	
Authorization Requirements	✓ Fastest Results	✓	✓
Authorization Status	✓ Fastest Results	✓	✓
Benefits & Eligibility	✓ Fastest Results	✓	✓
Claim Status	✓ Fastest Results	✓	✓
Claim Submission (and Corrections)	✓ Fastest Results	✓	
Co-payment Information	✓ Fastest Results	✓	✓
Coverage Determination Requests/Status (Rx)	✓ Fastest Results		✓
Form Requests	✓ Fastest Results	✓	✓
Provider Resources	✓ Fastest Results		

Secure Portal Authorization Features



New features include:

- **Authorization Edits:** Providers can now edit previously submitted authorizations online. You can also return and upload additional attachments (such as requested medical records) and review previously submitted documentation.
- **Real-time Authorization Status:** Quickly and easily look up status of any authorization request at any time. If you need any assistance, you can chat with a live agent.
- **New Status:** We've added a new **“Partially Approved”** authorization status to more accurately depict the determination of requests where a portion of services have been approved.

Not registered on our secure Provider Portal yet? It only takes a few moments to **sign up for an account** and start benefitting from the many useful features provided.

Provider Access & Support

Provider Portal Registration:

- <https://provider.wellcare.com/Provider/Accounts/Registration>

Provider Portal Training:

- <https://www.wellcare.com/arkansas/Providers/Medicare/Training/New-Provider-Portal-Overview-Training>

Bulletins/Announcements

- <https://www.wellcare.com/Tennessee/Providers/Bulletins>

Provider Relations

-Cheryl Allison cheryl.Allison@wellcare.com 501-515-9137

RX Affect-

- <https://auth.rxante.com>

Provider Manual & Quick Reference Guide

- Claims/Encounter Guides
- Authorization Instructions
- Disputes and Appeals
- <https://www.wellcare.com/arkansas/Providers/Medicare>

HEDIS tool Kit

- <https://www.wellcare.com/arkansas/Providers/Medicare/Quality>



QUALCHOICE Health Insurance



Agenda

- ▶ Network Transition/Credentialing
- ▶ QualChoice Group and Self-funded Membership
- ▶ Virtual Services Product
- ▶ ECHO eRemit
- ▶ COVID/Telemedicine
- ▶ NIA/RadMD
- ▶ No Surprises Act
- ▶ Tools for Providers
- ▶ Clear Claim Connection
- ▶ Medical Coverage Policies
- ▶ Online Authorizations
- ▶ Appeal vs. Request for Reconsideration
- ▶ Top Denials and How to Prevent Them
- ▶ Quick Provider eNewsletters and Quick Alerts
- ▶ New office location
- ▶ Provider Relations Representatives

Network Transition and Credentialing

- ▶ QualChoice members transitioned to Centene's Arkansas (NovaSys) network
- ▶ Became effective by January 1, 2021
- ▶ NovaSys network also supports these Centene companies:
 - Ambetter from Arkansas Health and Wellness
 - Wellcare by Allwell effective 1-1-2022
 - Arkansas Total Care
- ▶ Will support QCA Health Plan, Inc. and QualChoice Life and Health commercial and self-funded insurance (40,000 members)

Network Transition and Credentialing

- ▶ For contracting with Arkansas Health & Wellness, Arkansas Total Care, and QualChoice, contact pr@qualchoice.com or arkansascontracting@centene.com.
- ▶ For credentialing with Novasys/Centene, contact arkcredentialing@centene.com

QualChoice Group and Self-funded Membership

- ▶ QualChoice group and self-funded membership will remain with QualChoice.
- ▶ Continue your current processes for this QualChoice membership.

Call QualChoice for:

- Pre-authorization of any hospital admission to an out-of-network facility or a facility outside of Arkansas. In the case of an emergency, you must call within 2 business days.
- Pre-authorization of procedures as specified in your official plan documents.
- Verification of benefits, eligibility or claim status.

Note:

- If you do not get pre-authorization when required, your benefits may be reduced or denied.
- If you do not present this ID card to all providers you may have to pay all charges.
- Out-of-network reimbursement is subject to Maximum Allowable Payment.

Submit claims to:
 QualChoice, P.O. Box 25610, Little Rock, AR 72221
 QualChoice EDI Payor ID 35174

Administered by QualChoice:
 501.228.7111 or 800.235.7111 • www.QualChoice.com

NovaSys
 HEALTH
 Alliance Network


First HealthNetwork
 Complementary

The unauthorized or fraudulent use of this card to obtain medical services or prescription drugs is punishable by law.

QualChoice
 HEALTH INSURANCE

New Member
ID: 080808080

Coverage: Employee and Family QualChoice **Complete** Network
Effective Date: 4/7/11

RXBIN: 005947 PCN: CLAIMCR RXGRP: QCA 


Pharmacy Help Desk: 877.629.3118

Find providers in the QualChoice Complete network at QualChoice.com or by calling 855.865.9108. Services received outside the QualChoice Complete network will be covered at the out-of-network benefit level. For emergencies while traveling outside Arkansas, call QualChoice National Network at 855.450.7825 for provider information.
 800.235.7111 (TTY 711) QualChoice.com

QualChoice
 HEALTH INSURANCE

New Member
ID: 080808080

Coverage: Subscriber Only QualChoice Complete Network
Effective Date: 08/01/2016
 PPO Complete - C5000

RXBIN: 005947 PCN: CLAIMCR RXGRP: QCAPP0 

Pharmacy Help Desk: 877.629.3118

Find providers in the Complete network at QualChoice.com or by calling 855.865.9108. Services received outside the Complete network will be covered at the out-of-network benefit level. For emergencies while traveling outside Arkansas, call QualChoice National Network at 855.450.7825 for provider information.
QualChoice 800.235.7111 (TTY: 711) • qualchoice.com

QualChoice

New Member QualChoice Signature Network
ID: 080808080

Coverage: Subscriber Only
Effective Date: 07/01/2015
PCP Co-payments: \$40

 **Pharmacy Help Desk: 877.629.3118**
BIN: 005947 PCN: CLAIMCR RXGRP: QCAAS0

Traveling or attending school outside service area, use QualChoice National Network. Call 855.450.7825 for providers.
 Administered by QualChoice 855.823.2251 (TTY: 711) • qualchoice.com

New Virtual Services Product

Product effective January 1st 2022

Members will initiate PCP visits virtually – cards will indicate Virtual First



Member Name

ID Number: 080808080

Coverage: Employee and Family

Effective Date: 01/01/22

PCP Selection Required:

Co-Payments: Virtual Visit: \$0 In Office: \$45 Specialist: \$65

In Network: Individual Deductible \$1000/\$2000 Family

MOOP: Individual \$3000/\$6000 Family

Out of Network: Individual Deductible \$1000/\$2000 Family

MOOP: Unlimited

RXBIN: 0174499 RXPCN: 6792000 RXGRP: MRHQCH

Pharmacy Help Desk: XXX-XXX-XXXX

www.magellanrx.com

Traveling or attending school outside service area, use QualChoice National Network at 855.450.7825 for providers.
501.228.7111 . 800.235.7111 . qualchoice.com



Call QualChoice for:

- Pre-authorization of any hospital admission to an out-of-network facility or a facility outside of Arkansas. In the case of an emergency, you must call within 2 business days.
- Pre-authorization of procedures as specified in your official plan documents.
- Verification of benefits, eligibility or claim status.

Note:

- If you do not get pre-authorization when required, your benefits may be reduced or denied.
- If you do not present this ID card to all providers you may have to pay all charges.
- Out-of-network reimbursement is subject to Maximum Allowable Payment.

Submit claims to:

QualChoice, P.O. Box 25610, Little Rock, AR 72221

QualChoice EDI Payor ID 35174



This plan is insured by QCA Health Plan, Inc. :

501.228.7111 (TTY 711) or 800.235.7111 (TTY 711) • www.QualChoice.com

The unauthorized or fraudulent use of this card to obtain medical services or prescription drugs is punishable by law.

1 LEVEL

Virtual Services

Network Providers ► Select Arkansas Based PCP Providers + Teladoc providers

Benefits

- 24/7 Virtual Care
- No Member Cost
- Multi-Channel Access (Phone, App, Portal)

Services

- PCP Services
- Primary Behavioral Health
- Limited Diagnostic Testing (Lab, Imaging, Other)

- *Member will be required to select PCP from a defined group of PCPs.*
- *PCP visits must occur initially via telemedicine.*
- *PCP will refer for any services needed from specialist or facility.*

2 LEVEL

In-Person Physician Services

Network Providers ► Traditional QualChoice Network

Benefits

- No Cost Share, if Referred by PCP
- Traditional In-Person Visits
- Referral from PCP required
- Medical Policies, Pre-authorization and Health Plan Rules Apply

Services

- In Person PCP Visits
- In Person Specialist Visits
- Telemedicine Specialist Visits

- *Not covered if no referral from your designated PCP*
- *May need multiple referrals if utilizing multiple specialties*

2 LEVEL

In-Person Facility Services

Network Providers ► Traditional QualChoice Network

Benefits

- Normal member cost share applies
- Services may require a prior authorization
- Medical Policies and Health Plan Rules Apply

Services

- Inpatient Services
- Outpatient Facility Services
- Ancillary Facility Services (ASCs, Imaging Centers, etc)
- ER Visits/Urgent Care Visits

• *Referral is **NOT** a substitute for a prior authorization*

3 LEVEL

Out of Network

Out of Network Providers

Benefits

- OON Member Cost Share Applies
- OON Benefits

Services

- Specialty Services
- IP/OP Services

ECHO – Digitalizing Paper Checks with eRemits

With eRemit, instructions will be included with the check & point providers to the eRemit webpage

This link gives providers immediate access to view and download a PDF version of the EOP for this payment at no cost to the provider with optional multi-payer enrollment.

Provider address and return address here

If you have any questions or concerns about retrieving your Explanation of Payment documentation or to learn more contact us at 866-943-9579 Mon-Fri 8:00 am-4:30pm CST

To securely access your online Explanation of Payment (EOP) for this payment, please follow the below instructions:

1. Login: <https://remit.changehealthcare.com>
2. Enter Remit ID: (INSERT)
3. Enter check amount : (INSERT AMOUNT)
4. Save this Remit ID code for future reference.

If you would like to see all your EOPs in one place and receive payments electronically instead of via paper check, follow the enrollment instructions in the link above.

Contact us at: 866-943-9579 Monday-Friday 8:00am-4:30pm CST for assistance to access your EOP for this payment, enroll for electronic EOPs and payments or to opt for paper EOPs.

Paper check here

BASIC ONE-TIME DOWNLOAD

Standard, paper-based payments with basic web access to remittance data

- ✓ Review remits one-at-a-time
- ✓ Paper payment delivery


Download a one-time EOP by typing your Remit ID with the payment amount

REGISTRATION / REMIT ID * PAYMENT AMOUNT *

[DOWNLOAD SINGLE EOP](#)

MULTI-PAYER ACCESS

One set of credentials, one portal via one secure process



- ✓ Bulk download capability
- ✓ Locate remits from many payers
- ✓ Payment delivery via EFT
- ✓ Paperless process
- ✓ Access ERA/835 for auto-posting

[Learn More](#)

This requires just a few additional details and approximately 10 minutes

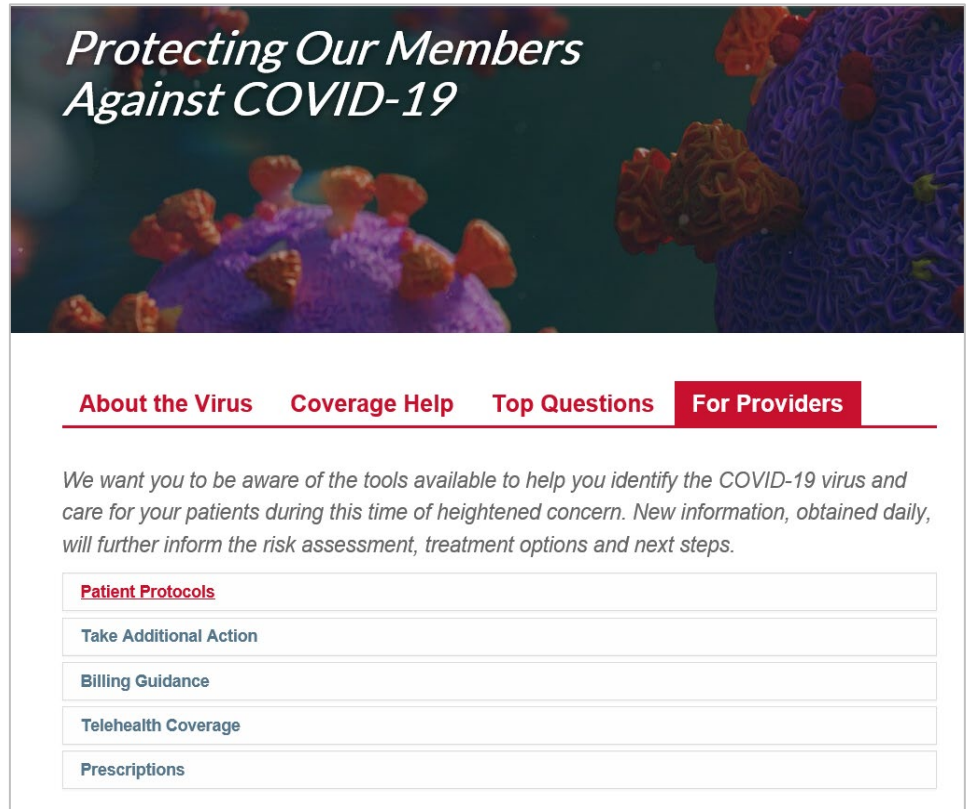
EMAIL *

[Sign Up to Access Portal](#)

Need help with enrollment? [Chat with us](#)

COVID-19 Benefits and Telehealth Coverage

- ▶ Telehealth Medical Coverage Policy – BI529
- ▶ Non Face-to-Face Medical Coverage Policy – BI063
- ▶ Providers can visit the website for specific billing guidelines
- ▶ COVID testing is covered at 100% with no cost to the member
- ▶ COVID treatment is covered at member cost share



Protecting Our Members Against COVID-19

[About the Virus](#) [Coverage Help](#) [Top Questions](#) [For Providers](#)

We want you to be aware of the tools available to help you identify the COVID-19 virus and care for your patients during this time of heightened concern. New information, obtained daily, will further inform the risk assessment, treatment options and next steps.

- [Patient Protocols](#)
- [Take Additional Action](#)
- [Billing Guidance](#)
- [Telehealth Coverage](#)
- [Prescriptions](#)

NIA – High Tech Imaging Change

Effective 3/1/2021

- ▶ High Tech Radiology Authorizations by NIA/RadMD.com
- ▶ Non-emergent Outpatient Diagnostic Imaging
 - MRI/MRA
 - CT/CCTA
 - Nuclear Cardiology/MPI
 - Stress Echo
 - Echocardiography

No Surprises Act

- Requires that health plans hold patients harmless from balance bills for emergency out-of-network care or care provided by an out-of-network provider at an in-network facility without informed consent, and that OON surprise bills are attributed to in-network deductibles.
- Prohibits certain out-of-network providers from balance billing patients unless the provider gives the patient notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services and the patient provides consent to receive out-of-network care.
 - The consent exceptions do not apply to certain types of ancillary providers, certain items and services, and in circumstances when another provider is not available.
- The bill includes an “Independent Dispute Resolution” (IDR) process, which allows for an arbitration process between providers and payers.
- Allows for OON services to be reimbursed at a market-based median in-network rate.

No Surprises Act

- Surprise billing is prohibited in the following situations:
 - Emergency services provided at out-of-network facilities;
 - Non-emergency services provided by an out-of-network provider at an in-network facility unless informed consent is obtained, when applicable; and,
 - Out-of-network air ambulance services
- In these circumstances, patient cost-sharing cannot exceed what it would be if services were received in-network, and must apply to a patient's in-network deductible and out-of-pocket maximum.
- The “out-of-network rate” is the total payment made by the plan to the out-of-network provider, less any cost-sharing from the enrollee:
 1. Plan provides an initial payment amount to the provider who may accept or deny the payment
 2. If denied, a 30-day negotiation period begins
 3. If an agreement cannot be reached, the issuer and provider begin the arbitration process (IDR)

Tools for Providers


- 1. My Account Provider Portal**
Check eligibility & benefits, claim status, review provider reports
- 2. Provider Manual**
Available online
- 3. Clear Claim Connection™**
Check clinical edits prior to submitting claims
- 4. Medical Coverage Policies**
Review policies for coverage & billing requirements
- 5. Auto Auth®**
Submit pre-authorization requests online
- 6. COVID-19 Information Center**
Coverage Help, Top Questions, For Providers

Using *My Account*

Sign in to the mobile-friendly provider portal to manage your account.

- ▶ Check member eligibility and benefits
- ▶ Search and view claims and RAs
- ▶ Search and view referrals and pre-authorizations
- ▶ View Provider Manual
- ▶ Clear Claim Connection
- ▶ Important Provider Updates

Using My Account

My Account

[Provider Home](#) [Patient Inquiry](#) [Claim Center](#) [Pre-authorizations](#) [Resources](#)

Provider Home

What's New for Providers

AutoAuth® Update: Beginning October 1, all OB Ultrasounds and DRG authorization requests should be made through AutoAuth.

EFT Payment Update: EFT payments will now be issued from ECHO Health instead of from QualChoice. This means faster payment for you!

- [Read Provider Quick Alert](#)
- Learn more about QualChoice [electronic transactions](#).

Provider Snapshot: Lynda S. Madison, Ph.D.

Provider:
Provider ID:
Provider NPI:
Type:
Specialties:

Primary Address Remit Address

Manage Patients

Manage information, referrals and pre-authorizations for your patients.

- [Find a Patient or Member](#)

AutoAuth Pre-authorization

Reduce the time spent on phone calls and faxing! Submit the required information online and get a rapid response.

- Learn More
 - [Available Types of Service](#)
 - [AutoAuth Pre-authorization Made Easy](#)
 - [AutoAuth Pre-authorization Frequently Asked Questions](#)
 - [AutoAuth Pre-authorization Procedure Codes](#)
- [Check Patient Eligibility](#)
- [AutoAuth Pre-authorization Tools](#)
- [Get Started](#)

Claims and Services

View patient claims and service details.

- [Search Remittance Advice](#)
- [View Recent Claims](#)

Clear Claim Connection

- ▶ This tool enables providers to access the editing tools and clinical rationale used for claims processing
- ▶ Determine appropriate coding prior to billing a claim or determine correct coding after receiving a denial

Claims and Services

View patient claims and service details.

- [Search Remittance Advice](#)
- [View Recent Claims](#)
- [View Outpatient Services](#)
- [View Inpatient Stays](#)
- [Provider Relations Representatives Map](#)
- [Clear Claim Connection](#)
- [View Provider Reports](#)

QualChoice
HEALTH INSURANCE
Clear Claim Connection [Sign Out Help](#)

McKesson Edit Development Glossary About

CLAIM ENTRY Clear Review Audit Results

Claim Type:

Gender: Male Female

Date of Birth:

ICD Code Set: ICD9 ICD10

Diagnosis Codes: 1 2 3 4

Bill Type:

For quick entry, use your Down Arrow key after you enter a procedure code. Qty will default to 1, Billed Amount will default to 100, Date of Service From and To will default to today's date, and Place of Service will default to 11 (Office). Tabbing through these same fields will give you the same defaults.

LINE	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5	LINE DIAG. 6
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Clear Claim Connection



Clear Claim Connection

McKesson Edit Development Glossary About

AUDIT RESULTS

Current Claim

The results displayed do not guarantee how the claim will be processed.

Claim Type Professional
 Gender Male
 Date of Birth 04/22/1977
 ICD Code Set ICD10
 Diagnosis Codes 1 E78.1 2 3 4

Bill Type

Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.

LINE	PROCEDURE	DESCRIPTION	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5	LINE DIAG. 6	RVU	PAY %	RECOMMENDATION	
1	99211	OFFICE/OUTPATIENT VISIT EST					1		30.00	02/25/2020	02/25/2020	11 (Office)	Arkansas	E78.1							n/a		ALLOW
2	80061	LIPID PANEL					1		61.00	02/25/2020	02/25/2020	11 (Office)	Arkansas	E78.1							n/a		ALLOW
3	36415	ROUTINE VENIPUNCTURE					1		11.00	02/25/2020	02/25/2020	11 (Office)	Arkansas	E78.1							0		DISALLOW

Click on hyperlinks to see why a service is allowed or disallowed

Medical Coverage Policies

The screenshot shows the QualChoice Health Insurance website interface. At the top left is the QualChoice logo with the tagline "HEALTH INSURANCE". A dark navigation bar contains the following links: "Provider Home", "Patient Inquiry", "Claim Center", "Pre-authorizations", and "Resources". The "Resources" dropdown menu is open, listing: "Provider Search", "Provider Reports", "Medical Coverage Policies", "Pre-authorization List", "Forms", "Newsletters", "Provider Relations Representatives", and "Track Transactions".

The main content area is titled "Provider Home" and features a red banner for "What's New for Providers". Below this banner are three news items, each with an information icon (i):

- We're Moving!**
Fri, 24 Jul 2020 15:52:49 -0500
- 270/271 Eligibility Verification Change**
Thu, 18 Jun 2020 00:00:00 -0500
- COVID-19 Coverage Updates**
Tue, 14 Apr 2020 13:23:05 -0500

Below the news items is an "INDEX:" section with a list of letters: **A B C D E F G H I J K L M N O P Q R S T U V W X Y Z**. To the right of the index is a search bar containing the text "BI529" and a red "SEARCH" button.

Under the "Policies" section, there are two links:

- [Non Face-to-Face Services](#) -- ...
- [Telemedicine Payment Policy](#) -- BI529:00

Medical Policy Changes

Telemedicine Policy – BI529 – High Level E&M codes (99205, 99215, & 99285) cannot be billed for telemedicine

Telemedicine Policy – BI529 – COVID-19 testing or screening is covered with no member expense – Vaccines should be billed through Pharmacy benefit

Physician Extenders – BI344 – High Level E&M codes (99205, 99215, & 99285) are not eligible for reimbursement

Non Face-to-Face – BI063 – Typically not covered – please see policy for specific details on billing these services

Online Authorizations

For these elective inpatient procedures:

- ▶ Spine, Joint Replacements and Fractures
- ▶ Cardiovascular, Thoracic and Pulmonary
- ▶ Gastroenterology
- ▶ Urology
- ▶ DRG Notifications
- ▶ Maternity Notification
- ▶ OB Ultrasound
- ▶ Home Health requests available for nurse and therapy visits (up to 20 visits)
- ▶ Wound Care in home
- ▶ Sleep Study in lab

AutoAuth Pre-authorization

Reduce the time spent on phone calls and faxing!
Submit the required information online and get a rapid response.

- Learn More
 - [Available Types of Service](#)
 - [AutoAuth Pre-authorization Made Easy](#)
 - [AutoAuth DRG Notifications](#)
 - [AutoAuth Pre-authorization Frequently Asked Questions](#)
 - [AutoAuth Pre-authorization Procedure Codes](#)
- [Check Patient Eligibility](#)
- [AutoAuth Pre-authorization Tools](#)
- [Get Started](#)

Appeal vs. Reconsideration Request

Appeal – Clinical Denials Only

- ▶ Not medically necessary
- ▶ Experimental and investigational
- ▶ Lack of pre-auth when the amounts are provider liability
- ▶ Use [Provider Appeal Form](#), found at QualChoice.com


Request for Reconsideration – Administrative Denials Only

- ▶ Timely filing
- ▶ Clinical edits
- ▶ Coding
- ▶ Reimbursement
- ▶ Use [Request for Reconsideration Form](#), found at QualChoice.com

Requests received on the wrong form will not be processed.

Appeal vs. Reconsideration Request

Provider Appeal Form



Network Provider Appeal Form
Adverse Determination

About Network Provider Appeals
Only denials related to medically necessary, experimental/investigational, lack of pre-authorization (when the amounts are provider liability) or benefit exclusions will be considered in the provider appeal process. Issues such as timely filing, clinical edits, coding disputes, contractual reimbursement, etc., will be handled through the [Provider Reconsideration Process](#).

Appeal requests must be received on the *Network Provider Appeal Form* within the timeframe outlined in your provider agreement. The request must be completed in its entirety and include QualChoice provider number, date(s) of service, claim number(s), reason for the appeal and any written comments, documents, records or other information relating to the case.

The Plan's decision is due within 30 calendar days from the receipt of the appeal request.

Please select the reason the claim or service was denied.

Not Medically Necessary

Benefit Maximum Exhausted

Experimental/Investigational

Benefit Exclusion

Lack of Pre-authorization


Section I: Provider Information			
Provider Name		National Provider Identifier # (NPI)	QualChoice Provider Number
Street Address		City	State Zip
Telephone Number	Fax Number	Contact Name	Contact Email Address
Section II: Patient Information			
Last Name		First Name	
Member Identification Number		Date of Birth (MM/DD/YYYY)	
Section III: Claim Information [Copy of claim(s) or Remittance Advice(s) are required.]			
Claim Number		Date(s) of Services (MM/DD/YYYY) From To	
Section IV: Appeal Explanation			

P.O. Box 25610, Little Rock, AR 72221 | 800.235.7111 | 501.228.7111 | FAX 501.228.9413 | QualChoice.com

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Appeal vs. Reconsideration Request

Provider Request for Reconsideration



Request for Reconsideration
Do not use as an Appeal Form*

This form to be completed by QualChoice contracted physicians, hospitals or other healthcare professionals requesting claim reconsideration for members enrolled in QualChoice health plans. Please submit a separate form for each claim. Form must be completed and submitted with required documentation. Incomplete forms may be returned. Please attach any additional information applicable to the request. Corrected claims should be submitted electronically. If the claim in question has had no payments to date or you are submitting additional information for initial review of payment, please forward to the address on the back of the patient's ID card.

Mail: QualChoice, P.O. Box 25610, Little Rock, AR 72221 | **Email:** CLReconsider@QualChoice.com
Form must be on top of all required documents being submitted.

Please check one: Physician Hospital Other Healthcare Provider

Section I. Member Information					
Member ID	Claim # (as listed on the EOB or RA)	Date of Service (as listed on the RA or EOB)		Billed Amount	
Member Name: Last			First	MI	
Street Address			City	State	Zip
Patient Name: Last (if SAME as Member, mark SAME)			First	MI	
Section II. Practitioner/Hospital/Other Healthcare Provider					
Tax Identification Number (TIN)		Phone No.	Email Address		
Physician Name (as listed on RA or EOB): Last			First	MI	
Street Address			City	State	Zip
Facility/Group Name			Contact Person		
Section III. Person Completing this Form					
Name		Phone No.	Email Address		
Section IV. Reason for Reconsideration Request. You must check (✓) one of the following.					
<input type="checkbox"/> Previously denied/closed for additional information <input type="checkbox"/> Duplicate charges (e.g., multiple charges with same CPT)—Provide medical record documentation. <input type="checkbox"/> Global Period Dispute <input type="checkbox"/> Payment received for wrong provider or member—Provide details in Comments section. <input type="checkbox"/> Duplicate payment received. Check One: <input type="checkbox"/> Recover Funds <input type="checkbox"/> Refund Enclosed <input type="checkbox"/> Claim Check/Claim edit denial (i.e., mutually exclusive, incidental, etc.)—Provide medical record documentation. <input type="checkbox"/> Modifier Reimbursement—Provide medical record documentation. <input type="checkbox"/> Medical Record Request—When sending requested medical records, attach the QualChoice request letter or provide claim #.					CLAIMS
<input type="checkbox"/> Claims Timely Filing—Provide Acceptance Report from EDI Vendor and demonstration of timely follow-up. <input type="checkbox"/> Provider Fee Schedule/Contract Language—Please provide detailed explanation of your reconsideration request in the comments section.					NS
Comments. Include detailed information as to the nature of your request.					

Possible attachments for supporting documentation: • Copy of RA or EOB • Other required attachments as listed above

**Clinical denials (such as not medically necessary, experimental and investigational or when claim amounts are provider liability) are not eligible for the reconsideration process and should be handled via Provider Appeal Form, found at QualChoice.com. Select Providers, Forms/Information.*

0710 NS 014_07 10/2016 P.O. Box 25610 | Little Rock, AR 72221 | P: 501.228.7111 or 800.235.7111 | QualChoice.com

Top Denials and How to Prevent Them

1. Timely filing – Must submit clearinghouse report that shows claim was accepted by payer

- ▶ DO NOT submit Medical Records

2. Pre-authorization

- ▶ Use prior authorization list, BIs associated with prior authorization list
- ▶ Auto authorization usage

3. Clinical edits

- ▶ Clear Claim Connection can be used to review edits which is found on the Provider Portal

Quarterly eNewsletter and Quick Alerts

Subscribe at QualChoice.com – *For Providers, Provider News*

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HEALTH INSURANCE

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Provider News Home / For Providers / Provider News

Quality Results

An e-newsletter for doctors, other health care experts and facilities affiliated with QCA Health Plan, Inc., and QualChoice Life and Health Insurance Company, Inc.

Subscribe Today

Quality Results

2020

Summer 2020

- Eligibility Verification Change
- COVID-19 Coverage Update
- QualChoice Telehealth Services
- Value-Based Care Programs Performance Data
- Antibiotic Prescribing for Children
- We're Moving!
- Medical Coverage Policies Updates

Spring 2020

- COVID-19 Coverage Updates
- Telehealth Services During COVID-19 Outbreak
- Centene Announces Provider Support Program
- Network Change
- Helping Our Members Quit Tobacco and Nicotine
- Antibiotic Prescribing and Use for Outpatients
- Medical Coverage Policies Updates

Provider Quick Alert

2020

- Medical Coverage Policies Updates for September 2020
- Medical Coverage Policies Updates for August 2020
- Medical Coverage Policies Updates for July 2020
- 270/271 Eligibility Verification Change
- Medical Coverage Policies Updates for June 2020
- Medical Coverage Policies Updates for May 2020
- Medical Coverage Policies Updates for April 2020
- Telehealth Coverage for COVID-19
- Medical Coverage Policies Updates for March 2020
- Medical Coverage Policies Updates for February 2020
- Medical Coverage Policies Updates for January 2020

2019

- Individual Plans Moving to Ambetter
- Medical Coverage Policies Updates for December 2019
- Medical Coverage Policies Updates for November 2019
- Medical Coverage Policies Updates for October 2019
- Medical Coverage Policies Updates for September 2019

Add us to your address book so we'll be sure to land in your inbox!

New Office Location

- ▶ 1001 Technology Drive in West Little Rock
- ▶ Moved in August 2020
- ▶ Former AT&T building just off Chenal Parkway near the Promenade shopping center
- ▶ Will share with Arkansas Health & Wellness

Provider Relations Representatives



Lisa Baker

800.235.7111, ext. 5345

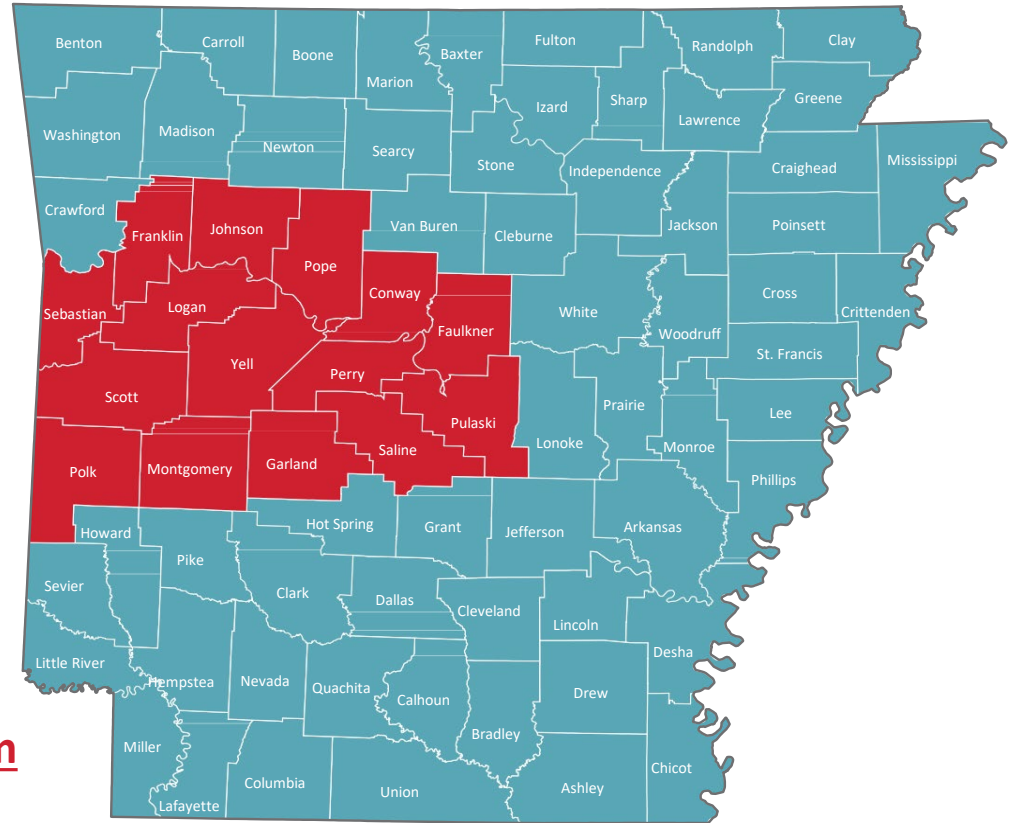
Lisa.Baker@qualchoice.com



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THANK YOU FOR JOINING US!