Housekeeping Rules

- Please make sure your phone is on mute.
- Please ask questions that are pertaining to the webinar topics only.
- Please make sure you type your questions in the Q and A box and not the chat box.
- Questions will be answered during the webinar.
New Provider Workshop

Karen Young, Training and Program Developer, MMIS, AFMC

June 2019
Agenda

• Introduction

• Provider enrollment tools

• Who’s who at Medicaid

• Billing matters – Eligibility strip, Provider Manual, websites, resources

• Things to know

• Contacts (PAC, EDI, rep map)

• Healthcare Portal – Features and brief demo (eligibility strip, how to access RA, check status, request PA)
Let’s Get Started

• Nine-digit provider ID and what it means
• National provider ID (NPI)
• Atypical providers (not needing an NPI)
• Additional things to know at the beginning
• Provider enrollment information
Provider Enrollment

https://medicaid.mmis.arkansas.gov/Provider/Enroll/Enroll.aspx

What do you need?  |  ARKids First  |  Quick Links  |  Front Line  |  System Status  |  Site Map

View for Arkansas Medicaid Providers

Content updated March 5, 2019

View system status.

Jump to

- Provider-led Arkansas Shared Savings Entity (PASSE) UPDATE
- IMPORTANT UPDATE: Entry of Electronic PAAs Using AFMC ReviewPoint Portal to Continue
- Provider-led Arkansas Shared Savings Entity (PASSE) Will Go Live on March 1, 2019
- PRMU Deadline for 2016 Attestations
- Electronic Funds Transfer Required for All Providers Billing All Claims
- New Provider Manual Updates
- New RA Messages

Provider-led Arkansas Shared Savings Entity (PASSE) UPDATE

Added 3/4/19
Provider Enrollment Information

- Watch this video to learn how to complete your online application.
- Need help to determine which documentation is required for your provider enrollment application? View or print this required documentation guide!
- View or print Arkansas Medicaid Provider Portal application instructions
- Here is the link to Provider Enrollment Revalidation Webinar landing page: https://afmc.org/health-care-professionals/arkansas-medicaid-providers/mmis-outreach-specialists/mmis-training-education/mmis-provider-enrollment-revalidation-webinar/
Who’s Who at Medicaid

• Division of Medical Services (DMS)
• County offices (DCO)
• AFMC [www.afmc.org](http://www.afmc.org)
  o MMIS Outreach Specialists 501-906-7566 (refer to map for extension #) [www.afmc.org/mmis](http://www.afmc.org/mmis)
  o ConnectCare 1-800-275-1131 [www.seeyourdoc.org](http://www.seeyourdoc.org)
  o Provider Relations Outreach specialists - email [www.afmc.org/providerrelations](http://www.afmc.org/providerrelations)
  o AFMC review department 479-649-8501
• eQHealth prior authorization and extension of benefits
• Health Management Systems (HMS) [www.hmsy.com](http://www.hmsy.com) 1-877-HMS-0184
• Office of Medicaid Inspector General (OMIG) 1-855-527-6644
• Magellan Medicaid Administration Pharmacy Help Desk (800) 424-7895, Option 2 for Prescribers
• DXC Technology 1-800-457-4454
DHS Division of Medical Services (DMS) – Administers Arkansas Medicaid

- DMS establishes policy for all Medicaid programs
- Provider reimbursement establishes reimbursement rates
- TPL validates third-party liability information
- Program development and quality assurance distributes Medicaid policy and monitors waiver programs
- Utilization review assists with claims and makes coverage determinations
- Medical assistance manages program communications plus dental and visual programs
- Pharmacy makes coverage determination and manages all drug-related issues
DHS County Offices

- Work directly with beneficiaries
- Determine eligibility, plan description and eligibility timeframe
- Assist with primary care physician (PCP) selection
AFMC

- Arkansas’ leading health care quality improvement organization
- Serves as a liaison for Medicaid and most providers, including primary care, specialty providers, PCMH-PT and hospitals
- Manages Medicaid quality improvement projects, including the Inpatient Quality Incentive (IQI) program
- Operates beneficiary service center, which handles complaints, Arkansas Works, transportation, etc.
- Provides utilization and quality review for various Medicaid programs
- Authorizes extensions of benefits
AFMC - MMIS Provider Outreach Specialist

• Provider outreach specialists handle billing that has been escalated from the Provider Assistance Center (PAC). They are also available to visit your office by appointment. **This can be done virtually or face-to-face.**

• You can find your provider outreach specialist at [www.afmc.org](http://www.afmc.org) or on the Medicaid website [https://medicaid.mmis.arkansas.gov](https://medicaid.mmis.arkansas.gov) under What do you need? Provider information> Support> AFMC Outreach Specialists

• You may contact your representative by calling **501-906-7566** and entering their extension (please refer to the map)
AFMC ConnectCare Helpline

- Assigns and changes beneficiaries’ PCP
- Educates beneficiaries about Medicaid
- Emails confirmation notices, PCP lists, and outreach materials to beneficiaries
- Processes PCP dismissals
- Coordinates with caseworkers to assign PCPs for foster children
- [www.seeyourdoc.org](http://www.seeyourdoc.org)
- 1-800-275-1131
AFMC – Provider Relations Outreach Specialist

• Provider relations outreach specialists are policy experts and educators who work with health care providers. They help practices navigate the Medicaid system and stay up-to-date on policy and procedures. During visits, the specialists will educate on state initiatives, provide educational tools to implement best practices and gather feedback for the state. Some of the current initiatives include:
  • Episodes of Care
  • Patient-centered Medical Home (PCMH)
  • PASSE

• You can find your provider relations outreach specialist map and provider packets with updated information at www.afmc.org/providerrelations.

• You can also visit the Medicaid website https://medicaid.mmis.arkansas.gov. Specialists are listed under Medicaid Managed Care Services (MMCS) Outreach Specialists
eQHealth

- **Phase 1 – January 1, 2019**
  - U21 Inpatient (IP) acute
  - Outpatient (OP) behavioral health for non-Tier 2 or Tier 3 beneficiaries
  - Outpatient (OP) SBMH (School-based Mental Health)
  - Outpatient (OP) IMH (Infant Mental Health)
  - Independent assessment referrals
  - Occupational therapy
  - Physical therapy
  - Speech therapy
  - ADDT (Adult Developmental Day Treatment)
  - EIDT (Early Intervention Day Treatment)
  - 640 validations

- **Phase 2 – February 1, 2019**
  - ABA (Applied Behavior Analysis)
  - Retroactive authorizations for BH

- **Phase 3 – March 1, 2019**
  - >=21 Personal Care (PC)
  - Independent assessment screening
  - PAs and EOBs for non-PASSE Tier 2 and Tier 3 beneficiaries
  - Retrospective reviews for each of the following:
    - OT, PT, ST
    - ADDT
    - EIDT
    - IP Acute <21
    - OBH for all non-PASSE beneficiaries
Health Management Systems (HMS) – Third-party Recovery

- Health management systems (HMS) provides services that identify third-party payment sources (such as commercial insurance and health plans, Medicare and TRICARE) and recovers public health plan expenditures when third-party liability exists

- info@hmsy.com
- www.hmsy.com
- 1-877-HMS-0184
OMIG detects schemes of fraud, curbs unacceptable practices, and improves quality of care as it relates to Medicaid fraud, waste and abuse. **Medicaid fraud can be reported by calling:**

- Arkansas Medicaid Inspector General's Hotline: 1-855-5AR-OMIG (1-855-527-6644), or
DXC Technology – Fiscal Agent

- Provider enrollment
- Claims processing
- Remittance advice
- Provider Assistance Center (PAC)
- Electronic Data Interchange (EDI)
- Medicaid Management Information System (MMIS)
Billing matters

• Importance of checking eligibility (see slide)
• Benefits plans (crosswalk helps determine coverage)
• Benefit limits (see slide)
• Timely filing guidelines (see slides)
• How to submit pseudo claims
• Ways to submit claims
  o Portal (see slide)
  o PES (*PES will be going away soon*)
  o Vendor
  o Paper
• Where/when to send paper claims (see slide)
## Eligibility Verification

### Benefit Details

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Description</th>
<th>County</th>
<th>Effective Date</th>
<th>End Date</th>
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</thead>
<tbody>
<tr>
<td>41-Medicare</td>
<td>Full Medicare</td>
<td>601 PULASKI</td>
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<td>05/09/2019</td>
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### Copayments

<table>
<thead>
<tr>
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<th>Description</th>
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<tr>
<td>1 (Medical Care)</td>
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<td>30 (Chiropractic)</td>
<td>15 (Dental Care)</td>
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<td>47 (Hospital)</td>
<td>48 (Hospital - Inpatient)</td>
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<tr>
<td>50 (Hospital - Outpatient)</td>
<td>66 (Emergency)</td>
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<td>88 (Pharmacy)</td>
<td>50 (Professional (Physician) Visit - Office)</td>
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<td>5 (Vision)</td>
<td>MH (Mental Health)</td>
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<td>UC (Urgent Care)</td>
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### Limit Details

### Managed Care Assignment Details

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<tbody>
<tr>
<td>PCP NOT REQUIRED</td>
<td>05/09/2019 - 05/09/2019</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Tools to determine eligibility

• Benefit plan crosswalk

• https://medicaid.mmis.arkansas.gov/Download/Provider/Insider/MMIS_BenefitPlans.pdf

• Section I (124.000) of your Provider Manual

• https://medicaid.mmis.arkansas.gov/Download/provider/provdocs/Manuals/SectionI/Section_I.doc

• Eligibility Verification Job Aid

• MMIS_JobAid_Eligibility.pdf

• *Enhancements coming soon!*
Arkansas Medicaid administers more than **50 programs**. Here are just a few of the many benefits available to eligible beneficiaries (see Section II of the Physician Manual):

- Physician services
- Inpatient hospital
- Outpatient hospital
- Lab/X-ray
- Prescription
- Therapy (OT/PT/speech)
- Mental health
- Emergency room
- Long-term care
- Hospice
- Medical equipment
Timely Filing

Medicaid requires providers to submit all claims no later than 12 months (365 days) from the date of service. The 12-month (365 days) filing deadline applies to all claims, including:

- Claims for services provided to recipients with joint Medicare/Medicaid eligibility
- Adjustment requests and resubmissions of claims previously considered
- Claims for services provided to individuals who acquire Medicaid eligibility retroactively

*Section 302.000 of the Provider Manual*
Timely Filing – Medicare/Medicaid Crossover Claims

Federal regulations dictate that providers must file the Medicaid portion of claims for dually eligible beneficiaries within 12 months (365 days) of the beginning date of service.

The Medicare claim will establish timely filing for Medicaid:

- If the provider files with Medicare during the 12-month (365 days) Medicaid filing deadline.
- Medicaid may then consider payment of a Medicare deductible and/or coinsurance, even if more than a year has passed since the date of service.
- Federal regulations permit Medicaid to pay its portion of the claim within six months after notice of the disposition of the Medicare claim.

*Providers may not electronically transmit any claims for dates of service over 12 months (365 days).*
Timely Filing – Claims With Retroactive Eligibility (Pseudo Claims)

Providers have 12 months (365 days) from the approval date of the beneficiary’s Medicaid eligibility to resubmit a clean claim after filing a pseudo claim. After the filing deadline (12 months/365 days from the Medicaid approval date), claims will be denied for timely filing and will not be paid. It is the responsibility of the provider to verify the eligibility approval date.

Once a beneficiary receives retro eligibility, the provider must submit: “With the claim, proof of the initial filing and a letter or other documentation sufficient to explain that administrative processes.” Please see Section 302.400 for complete details.

DXC Technology
Attn: Research Analyst
P.O. BOX 8036
Little Rock, AR 72203
Mail Paper Claims To:

**DXC Technology**  
Attn: Claims  
P.O. Box 8034  
Little Rock, AR 72203

**Special Claims**  
Attn: Research Analysts  
P.O. Box 8036  
Little Rock, AR 72203

**Crossover Claims**  
DXC Technology  
P.O. Box 34440  
Little Rock, AR 72203

*Please do not send claims to AFMC*
Healthcare Provider Portal

What can you do in the Provider Portal

Through this secure and easy to use internet portal, healthcare providers can submit claims and inquire on the status of their claims, inquire on a patient's eligibility, upload files containing EFT transactions, and search for another provider. In addition, healthcare providers can use this site to locate claim forms, provider participation materials and other health plan information and resources.
Healthcare Portal Features

- Online provider enrollment application
- Eligibility verification
- Submit all claim types (professional, institutional, dental, crossover and third party)
- Ability to edit (adjust), void and copy claims
- View status of claims
- Attachments for claims and prior authorizations
- Prior authorization request and status check
- Real-time claims processing
- Remittance advise held up to seven years
- Secure correspondence
### Eligibility Strip

**Primary Care Provider**
- **PCP Name:** PCP NOT REQUIRED
- **Effective Dates:** 03/09/2019-05/05/2019
- **Phone:** ___

#### Benefit Details

<table>
<thead>
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#### Copayments

| Medicaid | 
|----------|--------|----------|----------|
| 1 (Medical Care) | 0.00 |
| 30 (Health Benefit Plan Coverage) | 0.00 |
| 52 (Chiropractic) | 0.00 |
| 35 (Dental Care) | 0.00 |
| 47 (Hospital) | 0.00 |
| 48 (Hospital - Treatment) | 0.00 |
| 50 (Hospital - Outpatient) | 0.00 |
| 06 (Emergency) | 0.00 |
| 88 (Pharmacy) | 0.00 |
| 55 (Professional (Physician) Visit - Office) | 0.00 |
| 61 (Vision) | 0.00 |
| 89 (Medical) | 0.00 |
| 1C (Urgent Care) | 0.00 |

#### Limit Details

#### Managed Care Assignment Details

<table>
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<tr>
<th>Plan</th>
<th>Effective Dates</th>
<th>Provider Name</th>
<th>Provider Phone</th>
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#### Tier Level Details

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<td>Med Assistance</td>
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<td>Med (Health)</td>
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#### EPSDT Well Child Services Details

#### Adult Dental Services

#### Demographic Details
Submitting a Crossover Claim on the Portal

Submit Professional Claim: Step 1

The * (in red) indicates required fields when the ADD button is selected.

Claim Type
- Professional
- Crossover Professional

Medicare Crossover Details

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<table>
<thead>
<tr>
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<table>
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<tr>
<th>Medicare Payment Amount</th>
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<tbody>
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</table>

*Medicare Payment Date

Continue  Cancel
Submitting a Third-Party Liability (TPL) Claim on the Portal

Submit Professional Claim: Step 1

The * (in red) indicates required fields when the ADD button is selected.

### Claim Type

**Professional**

**Crossover Professional**

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<tr>
<th>#</th>
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<th>Policy ID</th>
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<tbody>
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<td>CI1</td>
<td>321654</td>
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<td>_</td>
<td>Remove</td>
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**Carrier Name**: SOUTHWARE AND AFFILIATES  
**Policy Holder in Person**:  
**Policy Holder Last Name**: RUFF  
**First Name**: PATTI  
**Policy Holder Address**: 1234 MAIN STREET  
**City**: LITTLE ROCK  
**Zip Code**: 72255  
**Policy Holder ID**:  
**Policy ID**: 321654  
**Group Name**:  
**Responsibility**: U-UNKNOWN  
**Patient Relationship to Insured**: 18-Ref  
**Paid Amount**:  
**Claim Filing Indicator**:  
**Release of Information**:  
**Assignment of Benefits**:  

[Images and logos]: ARKANSAS DEPARTMENT OF HUMAN SERVICES

[Note]: Click to add a new other insurance.
If you are a provider of services to a Medicaid-eligible member, but the services you provide are not covered by the Member’s primary insurance company, please see below for documentation and billing guidelines.

- A provider can use either a certificate of benefits or a denial letter from insurance company (EOB with no payment to provider) or a payment to the provider (EOB with payment). They will need to keep this in the client file for auditing purposes.
- It will be good for one year for either the Certificate of Benefits or Denial EOB.
- Example: Get certificate or denial dated 01/01/2018. The provider could use it through 12/31/2018. They would say yes they billed the insurance using a denial date of in this example 01/01/2018 and $0.00 payment amount. Be sure to include Claim Filing Indicator.
Prior Authorization Process Types on the Portal

Only the following PA types are available on the Healthcare Provider Portal:

- Private Duty Nursing
- Adult Dental
- Child Dental
- Orthodontics
- Hearing Services
- Augmentative Communication Device Evaluation
- Disposable Medical Supplies
- Home Health Visit Extensions
- Other prosthetics
- Other medical service
- Specialized Service
- Independent Choices
- Vision
- DDS/ACS waiver
- DDS services
- Developmental Rehab Services
- Title V
- First Connections
Prior Authorization Process Types on the Portal

- Viscosupplementation
- Personal care – under age 21
- Personal care-under 21 Extension
- Inpatient services
- Inpatient services extension
- Anesthesia
- Assistant surgeon
- Lab and radiology
- Lab – molecular pathology
- Professional services
- Child Health Management Services
- Hyperbaric oxygen therapy
- Ventilators, equipment
- Targeted case management
- Orthotics and prosthetics
- Hyperalimentation
- Physician administered drugs
Training Tools and Resources

- Medicaid website: https://medicaid.mmis.arkansas.gov
- Provider manuals (see slides)
- FAQs
- Vendor specs
- Fee schedule
What’s New for Arkansas Medicaid Providers

Content updated March 5, 2019

View system status.

Jump to

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- Electronic Funds Transfer Required for All Providers Billing All Claims
- New Provider Manual Updates
- New RA Messages

Provider-led Arkansas Shared Savings Entity (PASSE) UPDATE

Added 3/4/19
Provider manuals

• **Section I**
  o General policy
  o General information, sources, beneficiary eligibility and responsibilities, provider participation, administrative (and non-compliance) remedies and sanctions, PCP case management program, and required services and activities

• **Section II**
  o Provider manual (varies by provider type)
  o Program or provider specific information, program coverage, prior authorization, reimbursement and billing procedures
Provider manuals

• **Section III**
  Billing information: general information, remittance advice and status report, adjustment request, additional or other payment sources, pseudo claims and reference books

• **Section IV**
  Glossary: Arkansas Medicaid acronyms and terms

• **Section V**
  Claim forms, Arkansas Medicaid forms, contacts and links
Provider manuals

• Appendix A
• Update log: Update number and effective date (formerly Appendix A)
• Number and release dates for updates
• Program publications/notifications: transmittal letters, official notices, remittance advice messages and notices of rule-making
Things to Know

• Claims submitted electronically must be entered by 6 p.m. on Friday
• Sign up for MMIS eblasts
• Adjustments and refunds (see slides)
• Not sure why claim denied on RA? Check Claim Search on the portal for details on denial
• Search Payment History-Choose “ALL” when pulling RA (see slide)
Refund Checks

Note: Electronic claims can not be voided or edited after 365 days
Search Payment History (Portal RA)

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<th>Provider Information</th>
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<tbody>
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<td><strong>Location ID</strong> _</td>
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[Search] [Reset]
DXC Technology – Provider Assistance Center (PAC) and Electronic Data Interchange (EDI)

Your first point of contact for billing, claim status general questions and technical issues:

Monday through Friday       6 a.m. – 6 p.m.
Toll-free in Arkansas        800-457-4454
Local or out-of-state       501-376-2211
Contact Information

—DXC Technology 1-800-457-4454
—Medicaid website [https://medicaid.mmis.arkansas.gov](https://medicaid.mmis.arkansas.gov)
—Provider Assistance Center (hours 6 a.m.–6 p.m.)
—Electronic Data Interchange (EDI)
—AFMC MMIS provider outreach representatives
—MMIS provider representative map at [afmc.org/mmis](http://afmc.org/mmis)
Evaluations

Your feedback is important to us!
Please take time to complete the evaluation that will be emailed to you.

Thank you for attending today!
Questions?