# CARE1ST PROVIDER FORUM



# AGENDA

- Plan Overview
- Plan Resources
- AHCCCS Updates
- Medical Claims
- Prior Authorization
- Opioid Review
- Behavioral Health Screening and Referrals
- Quality Improvement
- Member No-Shows
- Care Management Referrals
- Dental Resources, Updates and Claims
- Dental Prior Authorization and Tips
- Prize!

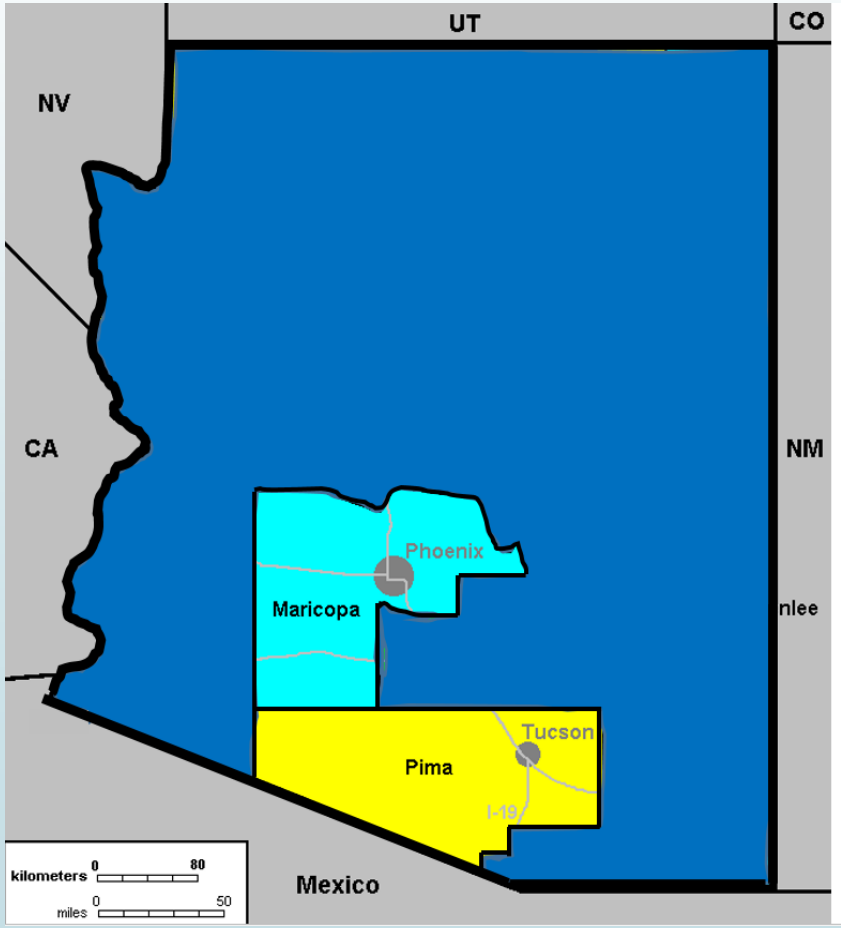
# Care1st Overview

# Care1st Overview

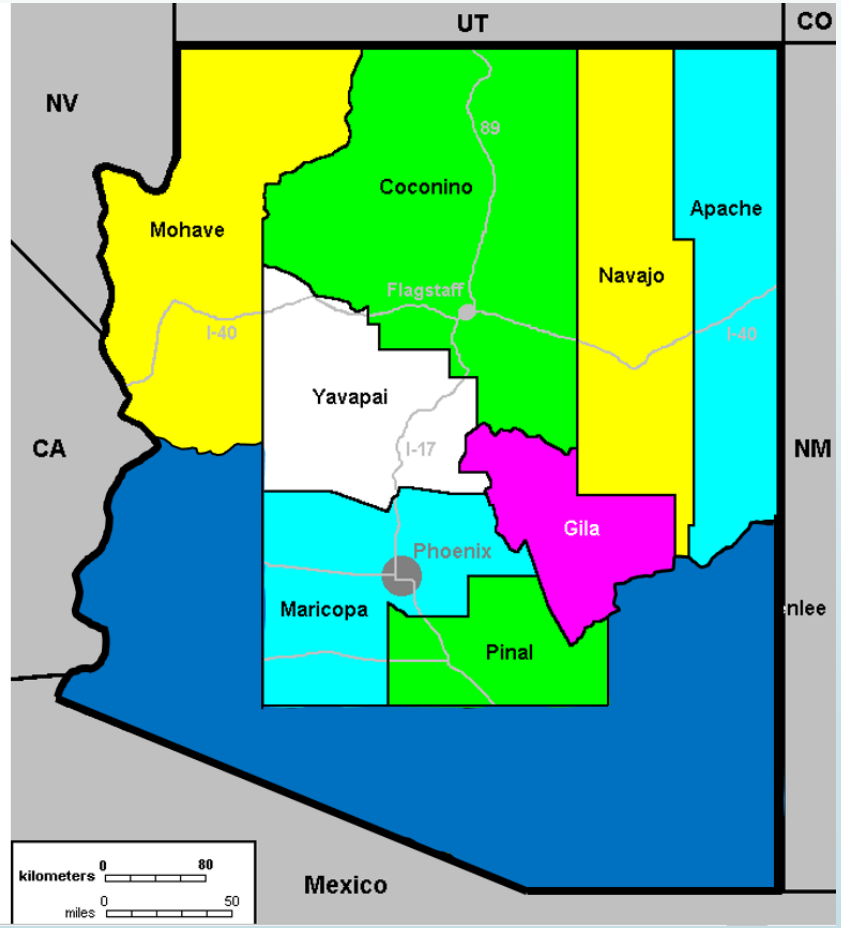
- In 2003, Care1st Health Plan began serving Maricopa County
- In 2013, Care1st expanded service to include Pima County
- In January 2017 WellCare became Care1st's parent organization
- WellCare focuses exclusively on providing government sponsored managed care services
- The priority is to ensure that we provide timely and quality service
- As we continue to integrate, we are looking to partner with you to ensure a smooth transition and grow our relationships

# Care1st Overview

- Previous Geographical Service Areas




- Geographical Service Areas effective 10/1/18



# Care1st Overview

## Approximate Membership Overview effective 10/1/2018

- Maricopa – 123,000
- Gila - 15
- Pinal - 41
- Yavapai – 31,851
- Mohave – 19,762
- Coconino – 9,721
- Navajo – 7,883
- Apache – 2,439

# Care1st Overview

## Dedication to service levels

- Network Management Representatives
  - Maricopa
    - Previously have 3 Network Management Reps
    - Will have 6 Network Management Reps
  - The following counties have a Network Management Rep assigned
    - Mohave/Apache
    - Coconino/Navajo
    - Yavapai
    - Gila/Pinal
    - Pima
- Additional Support Staff across the organization
  - We are also adding additional staff to assist with increased phone calls, provider adds, changes and terms as well as loading staff

# Care1st Resources

## Changes to the Practice

- Please communicate any changes to the practice to ensure accurate processing of claims, payment and directory information
- Includes providers joining or exiting, address changes, fax or phone numbers, etc.
- Please send notification by fax 602-778-1875 or by email SM_AZ_PNO@Care1staz.com.
- You may also contact your Network Management Rep directly

# Care1st Overview

## Provider Loading Process

- A request (AzAHP Practitioner Data Form) is received by the Network Management Team to add a provider to your group
  - Reminder – all elements must be completed
- That request is added to the Network Management database and forwarded to credentialing
- Credentialing cannot begin unless the CAQH application is updated and complete
- When credentialing is completed, the provider is loaded into our claims payment system and
- A welcome letter is sent notifying the practice of the effective date

https://az.care1st.com/az/providers/network_o

Network Overview | Provider...

File Edit View Favorites Tools Help

Convert Select

Free Hotmail Suggested Sites Web Slice Gallery PNO Database

Page Safety Tools

Arizona

Provider Login | ONECare

CARE1ST HEALTHPLAN

Select Language


Care1st Home

**For Providers**

- Blast Faxes
- Compliance Resources
- Community Resources
- Dental
- Disease Management
- E-Prescribing
- Filing a Claim
- Forms
- Formulary
- Forums
- ICD-10
- Login
- Mailings & Reference Materials
- Manual
- Our Network
- Practice & Preventive Health Guidelines
- Prior Authorization Guidelines & Criteria
- Provider Rep Contact Info
- Quality Measure Results

## Welcome Providers

You play a very important role in the delivery of health care services to our members. Care1st is committed to working closely with you. We continually work to remove administrative barriers so that you can focus on caring for our members.

Medical administration including Member Services, Prior Authorization, Claims, Provider Network Operations, Case Management, Disease Management, Concurrent Review, Quality Management and Behavioral Health are housed in the same central location in Phoenix, fostering close communication and coordination between all areas.

We look forward to partnering with you to achieve better outcomes and to increase patient satisfaction and access to preventive care.

To learn how to participate in our network, please contact our Provider Network Operations Team at (602)778-1800 (Options in order: 5,7).

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# Mailings & Reference Materials



Care1st and ONECare produces network mailings and reference materials for our provider network. The network mailings are designed to provide updates, helpful reminders and tools. Updated forms, copies of recent blast fax communications and our Quick Reference Guide (specifically designed to be a useful reference tool for you and your staff) are included.

Below is the most recent Network Mailing and Reference Materials.

## Mailings

- Provider Network Mailing
- Quick Reference Guide

## Reference Materials

- Care1st Provider Billing Education Tool
- FQHC Billing Reminder
- EPSDT & E&M Billing Reminders

# Forms

## Prior Authorization

- Pharmacy Prior Authorization Request PDF
- Medical Prior Authorization Form PDF
- Sterilization Consent PDF
- Authorization/ Pregnancy Risk Assessment PDF
- RSV Prophylaxis Eligibility Assessment PDF

## Case Management / Behavioral Health

- Care1st Case Management Referral Form PDF
- MMIC Referral for Behavioral Health Services Form 3.3.1 Effective 4-1-14 PDF
- CIC Referral for Behavioral Health Services Form - Pima County Effective 10-1-15 PDF

## Credentialing & Contracting

- AzAHP Practitioner Data Form PDF
- AzAHP Organizational Data Form PDF
- AzAHP Facility Application PDF

## Other

- Claim Dispute PDF
- Electronic Funds Transfer Authorization Form (ETF) PDF
- EPSDT Order PDF
- EPSDT Tracking PDF
- No Show Log PDF
- Newborn Reporting PDF
- Primary Care Physicians Change Request PDF
- Provider Directory Correction Request PDF


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## Provider Manual

Click on the appropriate section title below to view and/or print the contents of a particular section or view the entire manual

TABLE OF CONTENTS:



# Provider Manual Sections

# Provider Blast Faxes

## 2018

- **10/17/2018** - UPDATES TO THE PRIOR AUTHORIZATION REQUEST FORM TREATMENT AUTHORIZATION REQUEST
- **10/09/2018** - PROVIDER FORUM INVITATION - 10/29/2018 OR 10/30/2018
- **10/03/2018** - TIPS TO HELP YOUR PATIENTS FOLLOW THEIR TREATMENT PLAN
- **10/01/2018** - CARE1ST ACC OCTOBER 1, 2018 UPDATES
- **09/27/2018** - UPDATES TO PRIOR AUTHORIZATION GUIDELINES EFFECTIVE OCTOBER 1, 2018
- **09/21/2018** - UPDATES TO PRIOR AUTHORIZATION GUIDELINES EFFECTIVE OCTOBER 1, 2018
- **09/21/2018** - CARE1ST AHCCCS COMPLETE CARE NEW COUNTIES UPDATE
- **09/19/2018** - IMPORTANT PROVIDER NOTICE REGARDING AHCCCS ELIGIBILITY AND ENROLLMENT VERIFICATION
- **09/18/2018** - PROVIDER MANUAL UPDATES
- **09/17/2018** - PROVIDER FORUM INVITATION - 9/25/2018
- **09/13/2018** - WHAT YOU NEED TO KNOW ABOUT THE BREAST CANCER SCREENING MEASURE
- **09/11/2018** - REDUCING DENIALS BILLING EDUCATION TOOL
- **09/07/2018** - UPCOMING BRANDING, EFT, REMITTANCE ADVICE, CLAIM SUBMISSIONS &



Care1st Home

**For Providers**

- Blast Faxes
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## We're transitioning to WellCare Health Plans! in

October 2016, the company behind Care1st and ONECare was acquired by WellCare was acquired by WellCare Health Plans Inc. As a result, we will be transitioning to a new Provider Portal beginning with 2019 ONECare plans.

Please use Wellcare's secure Provider portal to access 2019 ONECare plans.

You may continue to use this portal to access **2018 Care1st and ONECare plans.** (2018 ONECare plans will be available until **(12/31/2018)**

We are committed to making the process of submitting a claim, gathering information on member eligibility, tracking claims, and payment for services

# Provider Login

**Username**

Username

**Password**

Password

Passwords are case sensitive

TERMS OF USE ; DISCLAIMER

☐ I have read and understood the Terms of Use

Login Reset

Not registered? Click here to Request Access.

# Welcome Providers!

Welcome to the Provider Area, where you can access Member Eligibility, Status Claims, search for Providers, view and print Remittance Advices and more.

Please select an area from your choices below:

MEMBERS

CLAIMS

PROVIDERS

REMITTANCE

# Claims Search

Instructions | By Member Number | By Claim Number | By Authorization Number | List Claims

## Instructions

There are four search methods to locate a claim:

1. **Search Claims by Member Number**
   Member Number Formats:
   - AHCCCS and DDD Members = Axxxxxxxx
   - Health Care Group Members = H000xxxxxx
   - ONECare Members = xxxxx*01
2. **Search by Claim Number**
   - Enter Claim Number and Search
3. **Search by Authorization Number**
   - Enter Authorization Number and Search
4. **List Claims for the Past**
   - Enter the number of days for which you wish to display claims

# Care1st Overview

- Care1st is transitioning to WellCare and will take place in two steps
  - ONECare (Medicare) line of business on 1/1/2019
  - Care1st (Medicaid) line of business on 4/1/2019
- Branding: Our name will change from Care1st and ONECare to WellCare
- Claims Submissions – Notification of effective date will be sent in November 2018
  - Electronic Data Interchange (EDI) – The payer ID will be updated
  - Paper claims – the mailing address will also be updated
- Electronic Funds Transfer (EFT) and Remittance Advices
  - Electronic and Paper Remittance Advices will be handled by PaySpan
  - EFT – Moving from CHANGE Healthcare to PaySpan Health
    - Please register for PaySpan now to continue seamlessly
- See attachments for detailed instructions

# Care1st Overview

- Web Portal
  - Care1st will be moving to the WellCare Web Portal
  - This will offer some of the same benefits and additional capabilities
    - Review Care Gaps
    - View member eligibility
- Phone System Updates
  - What is NOT changing
    - Phone Prompts will remain the same
    - Phone numbers will remain the same
  - What is changing
    - Our ability to monitor service levels
- Provider Manual has been updated to reflect the ACC changes

# AHCCCS Updates

# AHCCCS Updates

## AHCCCS Complete Care (ACC)

- March 5, 2018
  - ACC Contracts Awarded
- Spring 2018
  - AHCCCS held public forums
- June 2018
  - AHCCCS sent letters to members with assigned plan information and choices
- July 31, 2018
  - AHCCCS members selected a health plan
- October 1, 2018
  - Services begin under the integrated ACC Health Plans

# AHCCCS Updates

Changes effective October 1, 2018

- General Mental Health and Substance Use Disorder
  - Members will transition to ACC health plan
    - Excludes SMI, ALTCS, CMDP
- Autism Spectrum Disorder (ASD)
  - Services covered by ACC health plan
- Child Rehabilitative Services (CRS)
  - Members will have the option of an ACC health plan

# AHCCCS Updates

- What's **NOT** Changing
  - Availability of multiple health plans in each GSA
  - Covered Services will remain the same
  - Regional Behavioral Health Authorities (RHBA) will continue to cover crisis services
  - RHBAs will continue to cover Serious Mental Illness (SMI) and children in foster care enrolled in Comprehensive Medical and Dental Program (CMDP)
  - Arizona Long Term Care System (ALTCS) plans will remain the same

# AHCCCS Updates

- Central GSA (Maricopa, Pinal, Gila)
  - Arizona Complete Health
  - Banner-University Family Care Plan
  - Care1st Health Plan (WellCare)
  - Magellan Complete Care of Arizona
  - Mercy Care
  - Steward Health Choice Arizona
  - UnitedHealthcare Community Plan
- North GSA (Mohave, Coconino, Apache, Navajo, Yavapai)
  - Care1st Health Plan
  - Steward Health Choice Arizona
- South GSA (Pima, Cochise, Graham, Greenlee, La Paz, Santa Cruz, Yuma)
  - Banner-University Family Care Plan
  - Arizona Complete Health
  - UnitedHealthcare Community Plan (Pima Only)

# AHCCCS Updates

- Appointment Availability Updates
  - Specialty/Dental Specialty
    - Urgent care appointments as expeditiously as the members' health condition requires but no later than 2 business days
    - Routine care appointments within 45 calendar days
  - Dental
    - Urgent care appointments as expeditiously as the members' health condition requires but no later than 3 business days
    - Routine care appointments within 45 calendar days

# Medical Claims

# Medical Claims

## Top 5 Claim Denials last month

1. Exact Duplicate – 6,135
2. Primary Insurance on file – 4,793
3. Provider not contracted –2,123
4. Timely Filing Denials – 2,073
5. Patient not eligible on date of service – 1,897

Sonora Quest is Care1st's exclusive provider of laboratory services

- Top provider specialties by volume with out-of-network lab referrals
  - Urgent Cares
  - Pain Management
  - OB GYN

# Medical Claims

- Outreach, Partnership and Resources
  - Weekly high volume denial report
  - Denial trend reports (JOC, high volume, or by request from SM_AZ_DashboardRequest@Care1stAZ.com)
  - Customer service and audit trending
  - Billing and Utilization Workgroups

Available resource material (Encounter Keys, Claims Clues, Biller's Corner)

- Coverage code Changes
- New edits for age parameters
- Updates to Lab codes requiring CLIA certification when billed in office
- Modifier additions to BH codes and Drugs/Biologicals
- September 2018 Claims Clues https://www.azahcccs.gov/PlansProviders/Downloads/ClaimsClues/2018/ClaimsCluesSep2018.pdf
- July-August encounter keys https://www.azahcccs.gov/PlansProviders/HealthPlans/encounterkeysnewsletter.html
- Care1st billers Corner https://www.care1staz.com/az/providers/newsletter.asp

# Medical Claims

## Billing example with modifiers for EPSDT visit

Billing sick visit, EPSDT visit and vaccine code(s) for single date of service:

Patient (under the age of 19) makes appointment because of an earache. Office determines it is time for EPSDT evaluation and vaccine. Office bills:

- Both the sick and well diagnosis codes
- Sick visit is billed with appropriate E&M (99201-99245) with modifier 25
- EPSDT visit is billed with appropriate E&M (99381-99385 or 99391-99395) with modifier 25 and modifier EP
- Vision screening is performed as part of the EPSDT visit (92015) with modifier EP
- VFC vaccine code is billed with the applicable NDC and the SL modifier
- Vaccine administration code is billed with the SL modifier

**Link to Current VFC eligible vaccines**

https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/immunization/vaccines-for-children/forms/list-of-vaccine-names-best-asiis-selection.pdf

# Medical Claims

| Codes requiring records when billed with modifier 59, XE, XS or XU | |
|---|---|
| **CPT Code** | Brief Description |
| **36600** | Blood Draw/Arterial Catherization |
| **43210 - 43239** | Upper Gastrointestinal - Diagnostic |
| **45380 - 45398** | Colonoscopy - Diagnostic |
| **45900 - 45999** | Rectal/Colon - Diagnostic |
| **46600 - 46615** | Anoscopy - Rectal/Colon - Diagnostic |
| **49560 - 49568** | Hernia Repair |
| **51600 - 51720** | Bladder - Diagnostic |
| **51725 - 51798** | Cysometrogram – Bladder - Diagnostic |
| **52000 - 52318** | Cystourethroscopy – Bladder - Diagnostic |
| **58100 - 58120** | Endometrial Biopsy - Diagnostic |
| **62310 - 64640** | Lumbar and Sacral Pain Management |
| **69100 - 69999** | Ear Procedures |
| **94640 billed with 94060 on same date of service** | |
| **96372 when billed with pain management procedures** | |

# Medical Claims

## Submitting Corrected claims

- Identifying a corrected billing on paper claims can be done with either stamps, or handwritten indicators. Please include the original claim number if available
- Corrected claims submitted electronically must contain indicator 7 (replacement claim) in field 22 along with the original claim number

## General Claims overview for integration

- AHCCCS has released a special edition of claims clues devoted to integration https://www.azahcccs.gov/PlansProviders/Downloads/ClaimsClues/2018/ClaimsCluesSpecialEditionIntegration.pdf
- Members impacted by the change
- Dates for training/open houses provided by AHCCCS through the week of 10/22/18
- Billing for non-registered AHCCCS Providers
  - Field 24J must contain the location NPI
  - Field 31 blank
  - Field 33 Location NPI if billing electronically

# Prior Authorization and Updates

Pharmacy and Medical

# Medical Prior Authorizations
## Turn Around Times

- Routine/Standard requests are processed within 14 calendar days
- Urgent/Expedited requests are processed within 72 hours

Up to an additional 14 days when additional information is required to assess if meeting medical necessity criteria

Please refer to the Treatment Authorization Request Form and Prior Authorization Guidelines posted on the Care1st website for prior authorization requirements for Medical and Behavioral Health services.

https://www.care1staz.com/az/pdf/provider/forms/MedicalPriorAuthorizationForm.pdf?ver=1018

https://www.care1staz.com/az/PDF/provider/PriorAuthReferenceGrid/2018/0904.pdf

# Pharmacy Updates

- Old TAT for Standard Requests
  - 14 business days with the ability to extend for 14 additional days if information is needed. Total of 28 days
- Old TAT for EXPEDITED Requests
  - 3 business days with the ability to extend for 14 additional days if information is needed. Total of 17 days
- NEW TAT
  - 24 hours regardless of Expedited or Standard designation
  - Expedited requests can be held for 72 hours to obtain information
  - Standard requests can be held for 7 days to obtain information
  - Request for information must be made within 24 hours of receipt

# Urgent Requests

AHCCCS defines an URGENT request as follows:

"A request for services in which either the requesting provider indicates or the contractor determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function".

- By marking a request Urgent when it does not meet the above definition, we may have less time to obtain any information required on your request

# How can you help us be more efficient? (How to Speed up PA Responses)

- Fill out Prior Authorization form completely
  - (Note: avoid third party programs such as Cover my Meds as the information is almost always incomplete)

- Always include documentation that justifies the request.
  - Including information such as formulary (PDL) medications tried and failed (include dose and duration of therapy, if possible) speeds up the approval process
  - Good rule to follow: If you needed a diagnostic test or labs in order to make a decision on the requested treatment, please include it in your request.

# Pharmacy Network & Contact Information

## PHARMACY NETWORK:

- Primarily comprised of CVS Pharmacy and Fry's Pharmacies
- Retail Pharmacy Locator:
  - https://azonline.care1staz.com/az/care1stpharmacies

## CONTACT INFORMATION:

- Contact number for members or providers
  - 1-866-560-4042

## DIABETIC SUPPLIES:

- Preferred products are Lifescan One Touch Ulta/Verio
  - Quantity limits apply

# Formulary Updates & Changes

## FORMULARY UPDATES:

- Combined physical health (acute care) and behavioral health (BH) formulary effective 10/1
- Care1st follows the AHCCCS Medicaid Formulary and does cover some additional products that are not on the AHCCCS formulary
- Primary care prescribers can prescribe for behavioral health medication(s) within their scope of practice – antidepressants, anxiolytics, stimulants and MAT (for practitioners with waivers)
- Antipsychotics & lithium will require PA for Non-BH practitioners; QLL and Age edits will apply to all providers

## HEMOPHILIA NETWORK:

- All outpatient hemophilia factor/Ceprotin will be dispensed through CVS Specialty Pharmacy effective 10/1.
- CVS Specialty Pharmacy contact number: 1-800-237-2767.

# EXTENDED RELEASE OPIOID PA REQUIREMENTS

AZ Opioid Epidemic Act 2018:

- Minimum trial of 2 weeks of short acting opioids
- Pain Contract signed by both member and provider
- Drug Screen (Urine or Blood) from within the previous 90 days AND Drug Screen (RX and Illicit drugs) is completed at least twice a year
- Evidence that the provider has reviewed the CSPMP
- If member is on a benzodiazepine, a transition plan to wean off or medical justification for continuation

NOTES:

- An initial fill of an Immediate Release Narcotic can be no more than 5 day supply (exclusions do apply) with max 2 fills in 30 days.

# Behavioral Health Referrals

# BH Screening and Referral

- PCPs screen adults for depression, anxiety, substance use/misuse, suicide risk annually
- PCPs use standardized screening tools e.g. ACES, PHQ-2, PHQ-9, CAGE, GAD-7
- Medical record reflects screening results and *timely* referral to BH provider if needed.
- PCP may initiate treatment within their scope of practice; must refer for behavioral therapy with MAT; some psychotropics will require PA.
- PCP must provide three culturally and linguistically appropriate BH provider referrals

# PCP to BH Referral

- Provider service line: 602.778.1800 or 1-866-560-4042 can assist with connecting to a par BH provider
- Provider directory can be found at www.care1staz.com > Providers > Our Network
- Care Coordination call line Monday-Friday 8am-5pm (602) 778-8301
- PCPs can submit a referral to Care Management by using the "Care1st Care Management Referral Form" found at https://care1staz.com/az/providers/frequentlyusedforms.asp
- PCPs encouraged to establish collaborative relationships with neighboring BH providers

# Quality Improvement

# Quality Improvement Program

- Objectively monitors and evaluates the:
  - quality, appropriateness and outcome of care and services
  - structures and processes by which they are delivered to members
- Continuously pursues opportunities for improvement and problem resolution.

# Quality Improvement Activities

- Access to and availability of care
- Provider satisfaction
- Clinical practice guidelines
- Under/over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- HEDIS and CAHPS results
- Performance Improvement Measures
- Performance Improvement Projects

# Quality Improvement Team

- QI Director
- QI Project Managers
- QI Manager, QPAs
  - Quality Practice Advisors
- QI Supervisor
  - Quality Gap Coordinators
  - Maternal Child Health Team
  - DDD Liaisons
- QI Specialist RNs
- QI Data Analyst

# Quality Practice Advisors

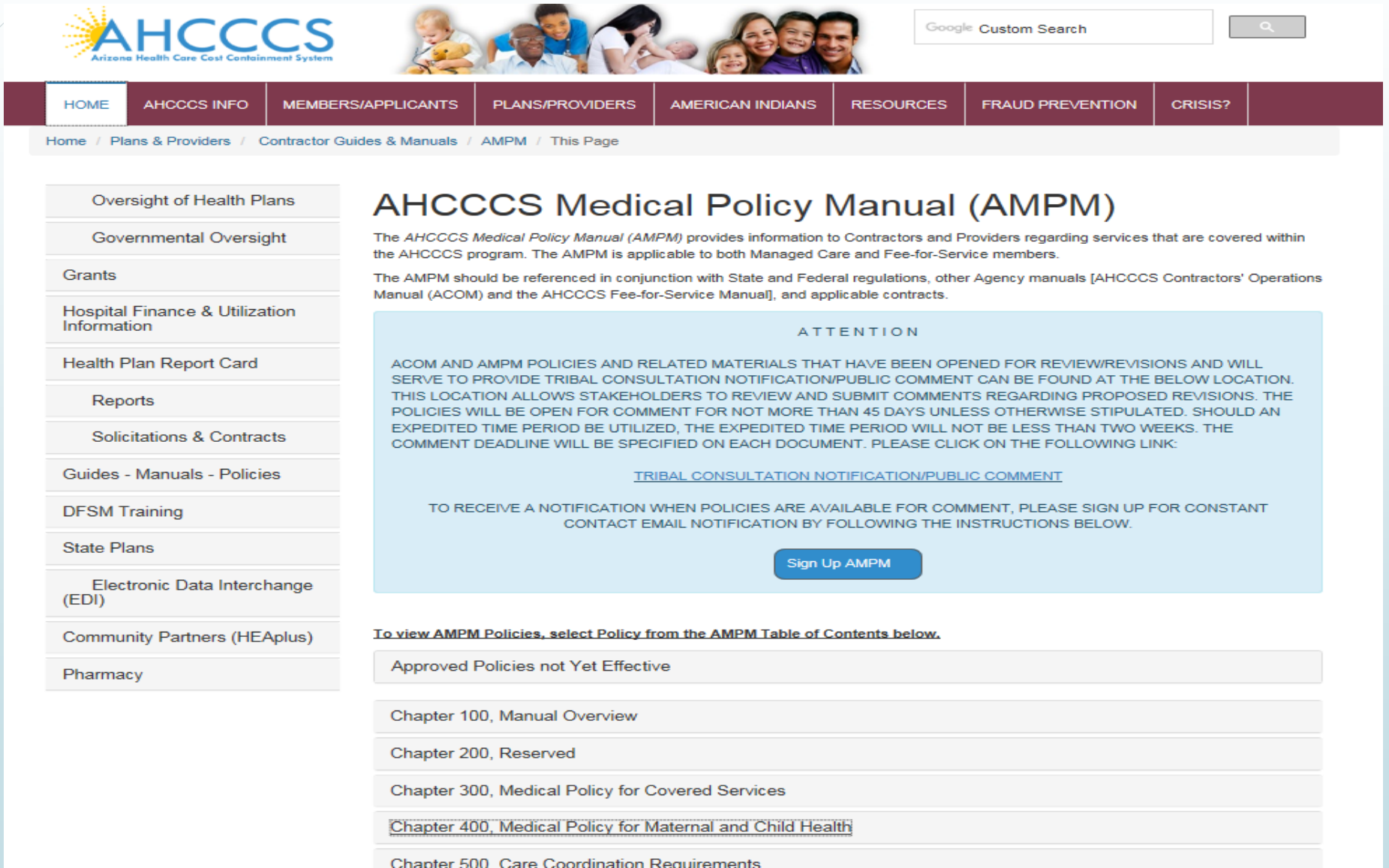
QPAs enhance the working relationship between provider practices and Care1st:

- Provides education on
  - HEDIS measures
  - CAHPS
  - Appropriate medical record documentation
  - Appropriate coding
- Supports the development & implementation of
  - Quality Improvement interventions
  - Audits in relation to providers

# Quality Practice Advisors

- Supports the development &implementation of
  - Quality Improvement interventions
  - Audits in relation to providers
- Tracks and trends provider performance data to identify and strategize opportunities for improvement
- Identifies specific practice needs where Care1st can offer support
- Partners with providers to increase member engagement

# AMPM Updates



# AMPM Updates

- All maternity care and EPSDT providers are encouraged to read Chapter 400 of the AHCCCS Medical Policy Manual (AMPM), to ensure they are up-to-date with AHCCCS requirements.
  - Chapter 400 Medical Policy for Maternal and Child Health
    - Policy 410 – Maternity Care Services
    - Policy 430 - ESDT Services

- **All AHCCCS medical policies may be accessed at https://azahcccs.gov/shared/MedicalPolicyManual/**

# REFERRAL TO OB CARE

- All OB care requires authorization within 30 days of pregnancy confirmation. To request a total OB authorization, fax a copy of the completed ACOG Form to 602.778.1838.
- The TOB form can be found:

  https://www.care1staz.com/az/pdf/provider/forms/2016/AuthorizationPregnancyRiskAssessmentForm.pdf?ver=9.0
- Call (602)778-8336 to speak with a MCH staff member.

# Maternity Reminder

All maternity care providers **must screen all pregnant members through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester.**

Members receiving opioids:

Appropriate intervention and counseling must be provided, including referral to Behavioral Health services per Substance Use Disorder (SUD) assessment and treatment.

# EPSDT Program

- Follow AHCCCS periodicity schedule as closely as possible
- Don't wait 12 months from last visit or for child's birthday
- Complete EPSDT visit during sick visit whenever possible.
- Reach out to members on GAPS in CARE report.
- EPSDT forms or electronic visit notes must be submitted to Care1st. They can be faxed or mailed.

  Fax: 602-224-4373

  Mail: 2355 E Camelback Rd, Suite 300, Phoenix, AZ 85016
- EPSDT questions: Call EPSDT Team at 602-474-1365

# Member "No – Shows"

Members are reminded of their responsibility to cancel medical and dental appointments at least 24 hours in advance:

- Phone conversations
- Articles in member newsletters
- Individual letters
- The Member Handbook

# “No-Show” Log

CARE1ST HEALTH PLAN ARIZONA
NO SHOW LOG
FAX COMPLETED FORMS TO: 602-224-4373

ONECARE
A WellCare Company

| PCP/Office Name: | | | PCP/Office Phone#: | |
|---|---|---|---|---|
| **Member Name** | **Member AHCCCS ID#** | **Member Phone Number** | **Date of Missed Appointment** | **Reason for Appointment ( EPSDT or Sick Visit, etc)** |
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| **Please report missed appointments on a regular basis.** | | | | |
| **Care1st/ONECare will provide education to members about the importance of keeping their appointments and the need to cancel and/or reschedule appointments.** | | | | |

C:\Users\dsobrino\Desktop\temp

# “No-Show” Log

- Found on Provider website under Forms
- Complete & fax to the number on form
- Submit as often as you like
- Primary reasons from members:
  - Forgot about the appointment
  - Work conflict
  - Illness
  - Family emergency / Out of town

# Reducing “No – Shows”

- Use multiple reminder methods –
  - Text messages
  - Phone calls
  - Postcard reminder
- Keep your wait room time to a minimum
- Follow a missed appointment with a “Sorry we missed you” message
- Thank patients who keep appointments and arrive on time

# How to Refer to Care Management

- How to refer to the Case Management Program:
  - Call **(602)778-8301**
  - Complete and fax the Case Management Referral Form to (602) 224-4372. The Case Management Referral Form is available on our website at: https://az.care1st.com/az/providers/frequentlyusedforms.asp

- The Care Management Department also manages the **AzEIP** (Arizona early Intervention Program) and **CRS** (Children's Rehabilitative Services) population
  - **AzEIP**: Please send requests to either the Care Coordination Fax Line: **602-224-4372 or** via e-Mail at **SM_AZEIP_Transition.** If you have questions, please contact Care Coordination at **602-778-8301**
  - **CRS**: For issues, please contact the CRS Coordinators via e-mail at **SM_AZ_CRS** or through the Care Coordination at **602-778-8301** and you will be routed to the CRS

# Dental

Resources, Updates, Claims and Prior Auth Tips

# Dental

https://www.advanticabenefits.com/

- Online Provider Portal
  - Providers > Provider Login
- Dental Clinical and Billing Guidelines
  - Providers > Provider Login > Log on > Reference Manuals
  - Guidelines also are available on Care1st website: www.care1staz.com Providers > Dental


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# Dental Claims

## Electronic Data Interchange (EDI)

- **CHANGE Healthcare (Emdeon)**
  - Contact your software vendor to set up electronic submissions to CHANGE Healthcare (Emdeon). Make sure you provide the Advantica Payer ID 43168.
- **EHG – EDI Health Group, Inc.–DentalXChange**
  - Enroll online http://www.dentalxchange.com/partners/WebClaim or call 800.576.6412, ext. 455
- **Tesia**
  - To enroll call 866.712.9584
- **Advantica Web Portal**
  - Register at www.advanticabenefits.com/providers

# Dental Claims

## Electronic Funds Transfer (EFT)

- Advantica partners with CHANGE Healthcare (Emdeon)
- Options for enrolling
  - Enroll online at https://www.emdeondental.com/
  - Enroll via phone at (888) 255-7293 Mon-Fri 8am-7pm EST
  - You no longer are required to enter an NPI to complete enrollment

## Electronic Remittance Advice (ERA)

- Advantica works with CHANGE Healthcare (Emdeon).
  - To enroll, go to: www.emdeon.com/epayment/enrollment.com and complete the online enrollment form. When prompted, enter Advantica Payer ID 43168. If you are already enrolled just link your Emdeon account with the Advantica Payer ID.

# Dental

## Top 5 Claims Denials, August 2018

1. Duplicate services previously submitted and processed
2. FQHC claims must be submitted with the facility NPI. Please resubmit.
3. Patient chart notes must be submitted for $1000.00 Emergency Adult Benefit consideration. Please refer to AHCCCS guidelines for additional radiograph submission requirements.
4. When multiple x-rays are performed on the same date of service where the allowable amount exceeds the dollars allowed for a full mouth survey (D0210) the services will be combined to the most comprehensive procedure code of D0210 (full mouth series) for benefit determination purposes.
5. Prior records indicate patient has COB. Please resubmit with EOB or denial from primary carrier.

# Dental

## Claim Tips

- Guidelines & documentation requirements are available at:
  - Advantica Website - https://www.advanticabenefits.com
    Providers > Provider Login > Log on > Reference Manuals
  - Care1st Website – https://www.care1staz.com
    Providers > Dental

- When submitting a COB claim – Please ensure primary carrier information is included on claim form:
  - Subscriber's Name
  - Date of Birth
  - Primary Insurance Member ID Number
  - Employer Group

# Dental

## Adult AHCCCS Acute Emergency Benefits

- Effective Date – October 1, 2017, Acute members are covered over the age of 21 for emergency dental services up to $1,000 per contract year (i.e. October 1-September 30)
  - Services such as repair of fractures to the facial structures are not subject to the $1,000 per contract year.
  - Services that fall in the exception for transplant cases are not subject to the $1000 per contract year.
  - Prescription drugs are not included in the $1,000 per contract year.
- A dental emergency is defined as an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma
- Covered Services
  - Emergency oral diagnostic examinations – **limited problem focused**
  - Radiographs limited to **symptomatic** teeth
  - Composite resin fillings due to recent tooth fracture for anterior teeth

# Dental

## Adult AHCCCS Acute Emergency Benefits - Continued

- Covered Services – continued
  - Prefabricated crowns to eliminate pain due to **recent tooth fracture only**
  - Re-cementation of crowns, inlays, onlays, and bridges
  - Pulp cap
  - Root canals and pulpotomies when indicated for the treatment of acute infection or to eliminate pain with a **favorable diagnosis**
  - Immediate an palliative procedures including extraction for the relief of pain
  - Tooth re-implantation of accidentally avulsed anterior teeth
  - Preoperative procedures and anesthesia – must meet GA requirements. Anesthesia services are inclusive of the $1,000 benefit
  - Permanent crowns limited to endodontically treated teeth

# Dental

## Adult AHCCCS Acute Emergency Benefits - Continued

- Not covered with this benefit
  - Fixed bridgework
  - Dentures
  - Diagnosis and treatment of TMD or TMJ
- Prior authorization is not required. Should you submit a prior authorization it will be returned (not processed) advising it is not required.
- All emergency dental services are subject to retrospective review by Advantica to determine if they satisfy the criteria for a dental emergency.
- Handling of services that exceed the $1,000 benefit limit:
  - The provider must supply the member a document describing the services and the cost of those services. Prior to delivery of services the patient must sign and date a document indicating responsibility for the cost beyond the $1,000 limitation.

# Dental

## Prior Authorization Tips

1. Services that require prior auth identified with an * on Clinical and Billing Guidelines.
2. Submit prior auth requests online for faster turnaround time *Standard* – Requests processed within 4 business days and *Urgent/Expedited - R*equests are processed within 72 hours of receipt of request.
3. Prior auth requests for general anesthesia should include name of anesthesiologist or anesthesia group and estimated treatment time.
4. Prior auth request for general anesthesia also should include detailed narrative as to why anesthesia is requested and chart notes that include previous experience with failed attempts to treat (i.e. Nitrous, OCS, etc). Medical and behavioral conditions should also be included.

# Dental

## Prior Authorization Tips Continued

5. Periodontal scaling and root planning prior auth submissions require X-rays, perio charting and documentation of patient's oral hygiene.
6. D4355 is not covered when perio charting is completed.
7. Prior auth appeals require an Appointment of Representation (AOR), if submitted by provider.
8. Prior auth appeals are to be submitted and handled by Care1st Claims Disputes & Appeals Team.
9. Guidelines & documentation requirements are available at:
   - Advantica Website - https://www.advanticabenefits.com Providers > Provider Login > Log on > Reference Manuals
   - Care1st Website – https://www.care1staz.com Care1st > Providers > Dental