2026 Conway PHO Insurance Forum

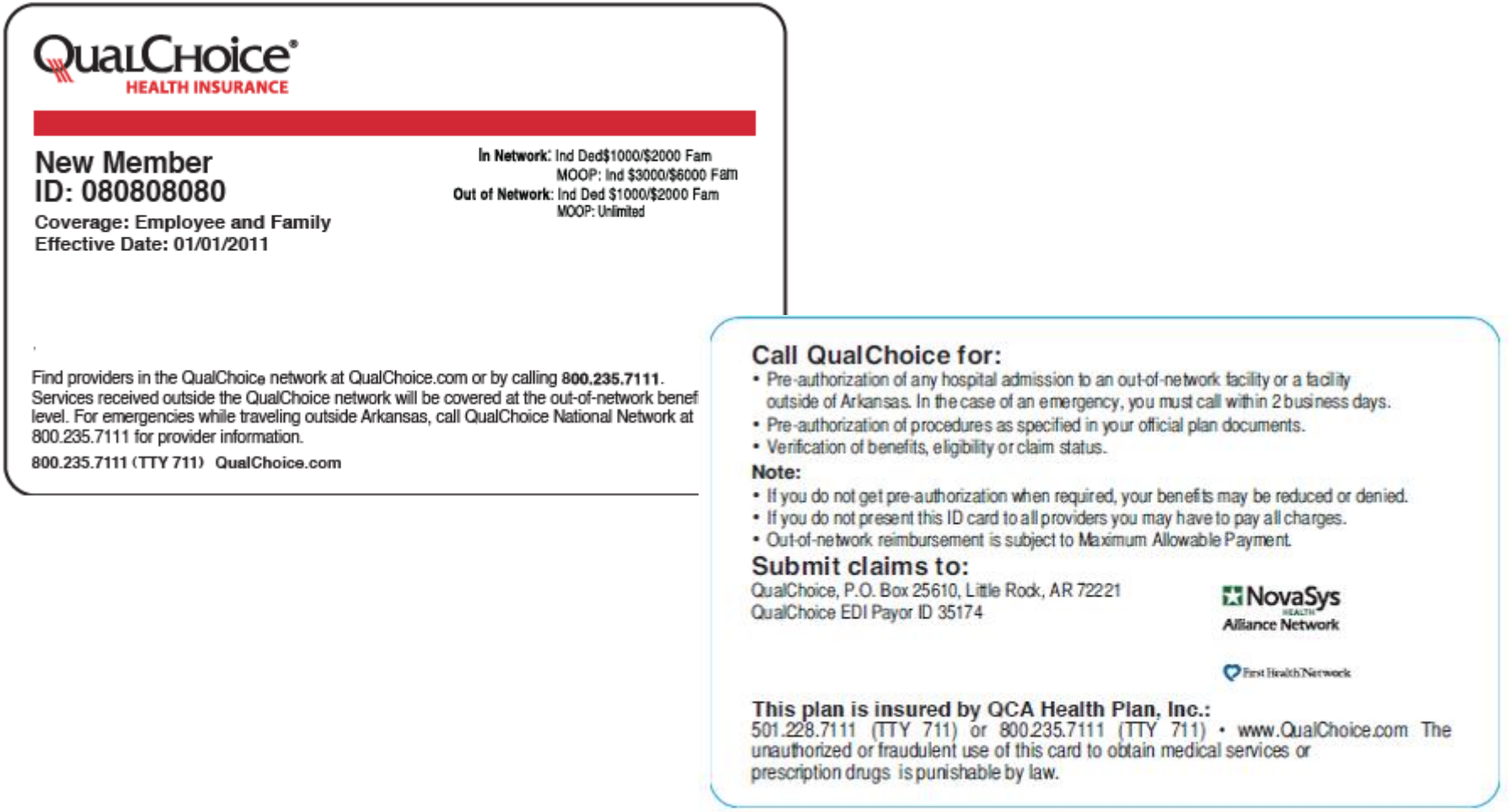
March 03, 2026

QualChoice® HEALTH INSURANCE

Agenda

- Member ID Cards
- Provider Gold Card
- Using *My Account – Tools for Providers*
- Medical Policies
- Prior Authorization Check Tool
- Online Authorizations
- Clear Claim Connection
- Modifier Usage
- Top Denials and How to Prevent Them
- Appeal vs. Request for Reconsideration
- Provider Newsletters and Quick Alerts
- Important Contacts
- Provider Relations Representatives

Member ID cards



QualChoice®
HEALTH INSURANCE

New Member
ID: 080808080
Coverage: Employee and Family
Effective Date: 01/01/2011

In Network: Ind Ded$1000/$2000 Fam
MOOP: Ind $3000/$6000 Fam
Out of Network: Ind Ded $1000/$2000 Fam
MOOP: Unlimited

Find providers in the QualChoice network at QualChoice.com or by calling **800.235.7111**. Services received outside the QualChoice network will be covered at the out-of-network benef level. For emergencies while traveling outside Arkansas, call QualChoice National Network at 800.235.7111 for provider information.

800.235.7111 (TTY 711) 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

NovaSys Health Alliance Network

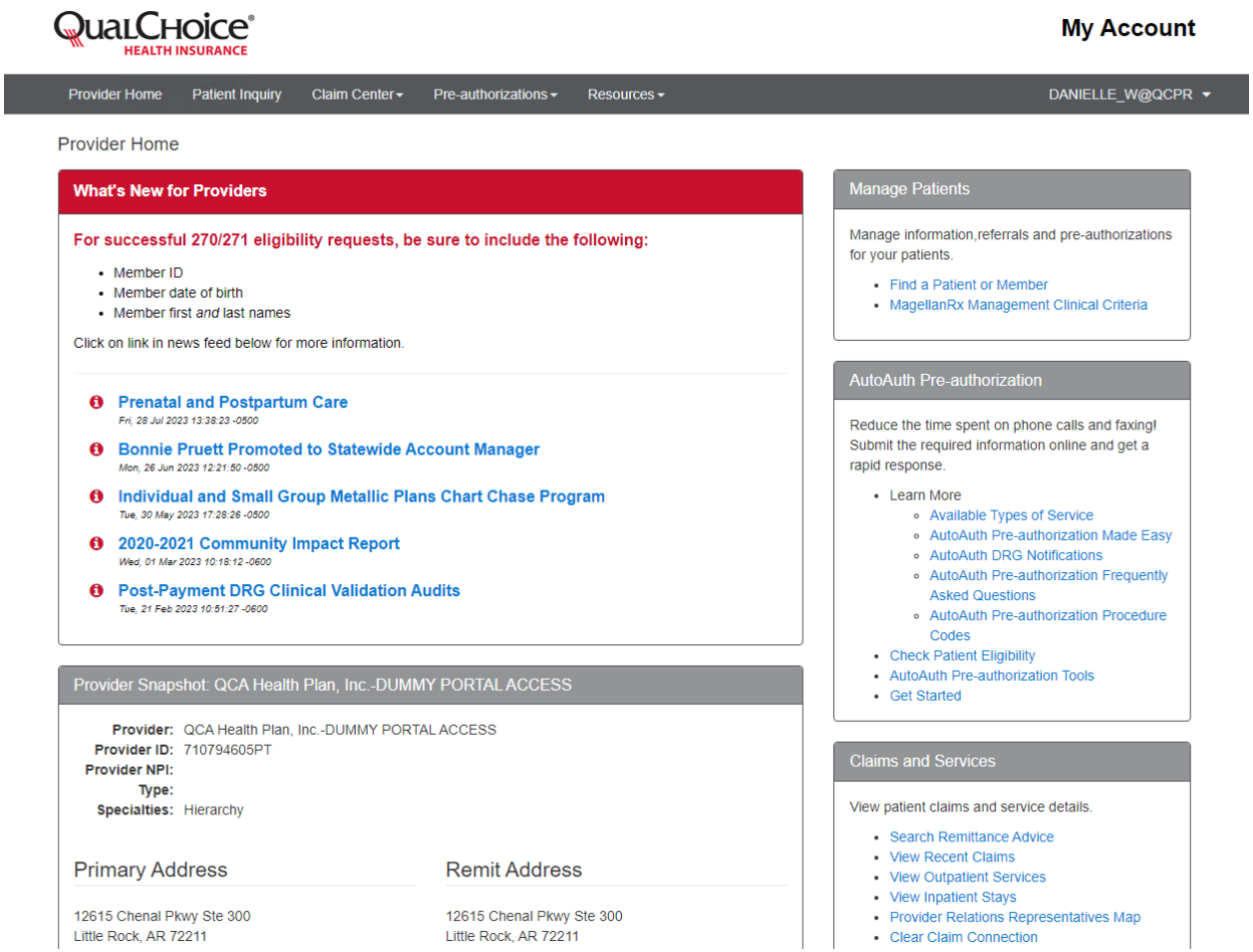
First Health Network

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.

Prior Authorization Gold Card Status

- Effective January 1, 2026, providers with a historical Prior Authorization (PA) approval rate over 90% will receive a PA Gold Card. This status will exempt them from obtaining PA for medical services.
- Providers who meet the criteria will be notified of their Gold Card status by letter.
- Providers that do not have a Gold Card will be required to obtain PA as required today – nothing changes.
- Provider Gold Card status is reviewed and updated annually.
- Gold Card status will apply to any medical services that require PA.
- If you have a Gold Card from previous years, you will keep that Gold Card.

My Account – Home page

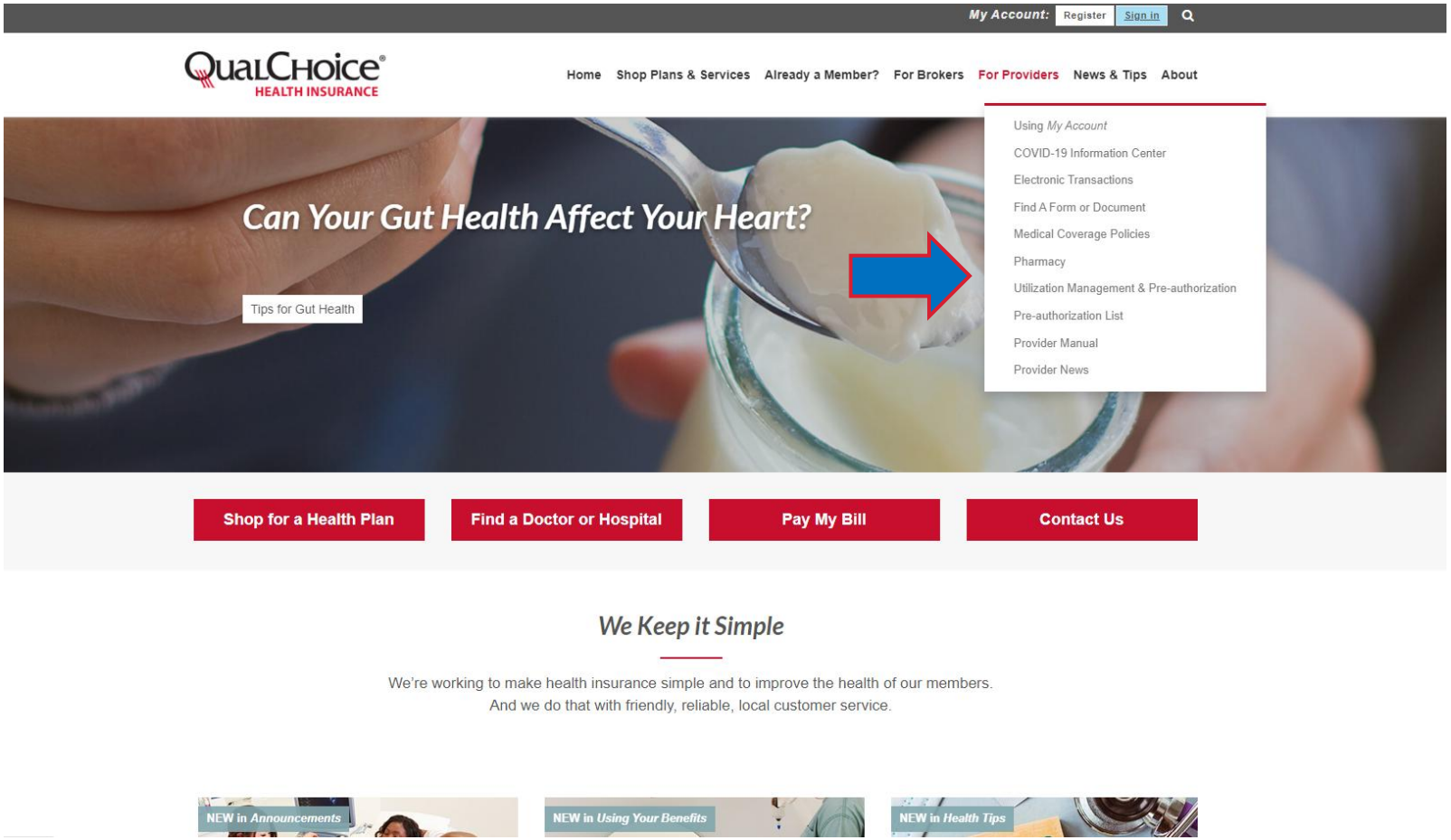


Using *My Account – Tools for Providers*

Sign in to the mobile-friendly provider portal to manage your account. Within My Account you can:

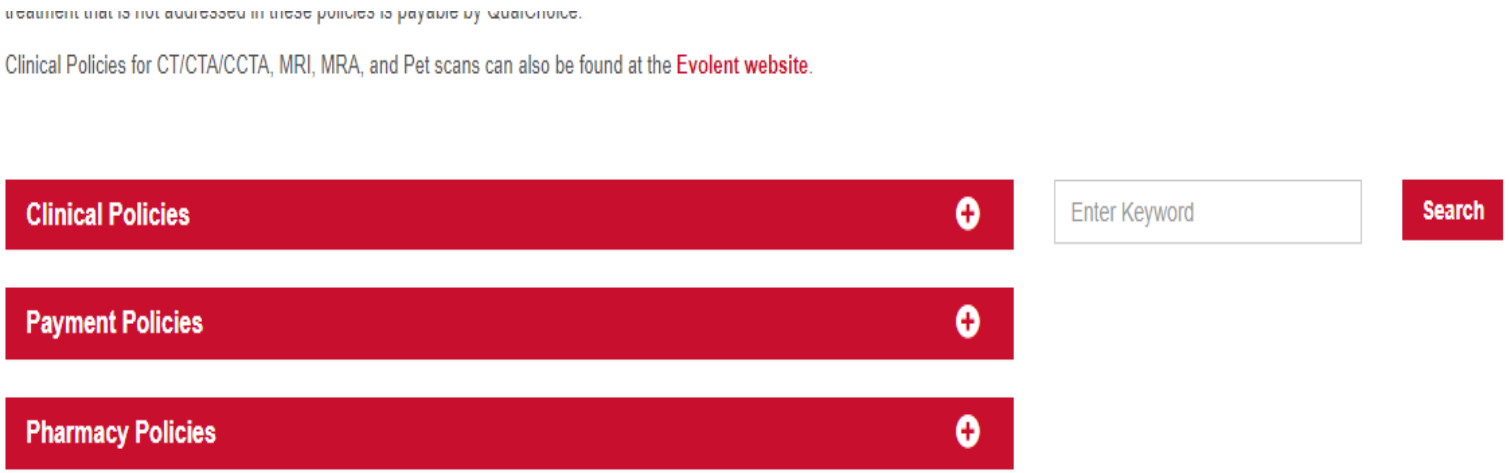
- Check member eligibility and benefits
- Search and view claims and remittance advice (RA)
- Search and view referrals and pre-authorizations
- View our Provider Manual
- Access Clear Claim Connection
- Read more about important provider updates

Tools for Providers



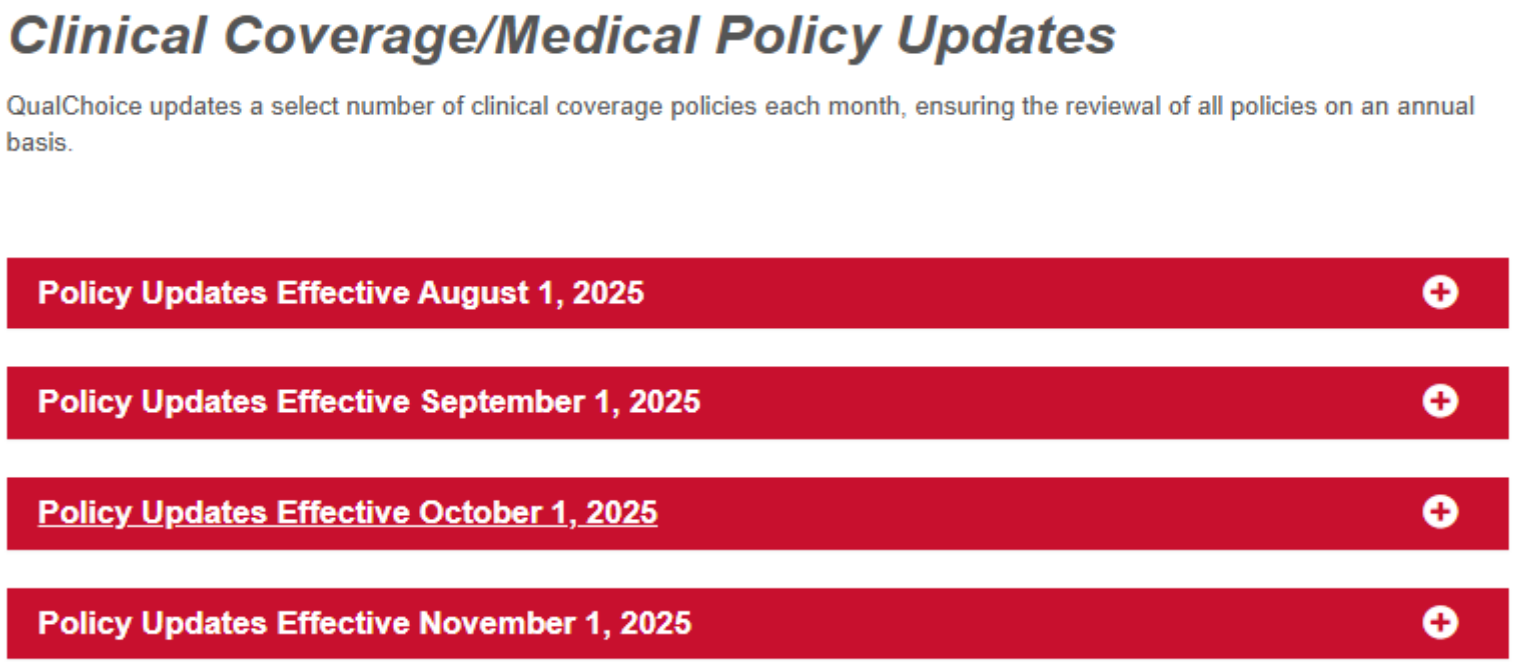
QualChoice Clinical, Payment, and Pharmacy Policies

- All policies are published at https://www.qualchoice.com/for-providers/clinical-and-payment-policies.
- Search all policies by code.



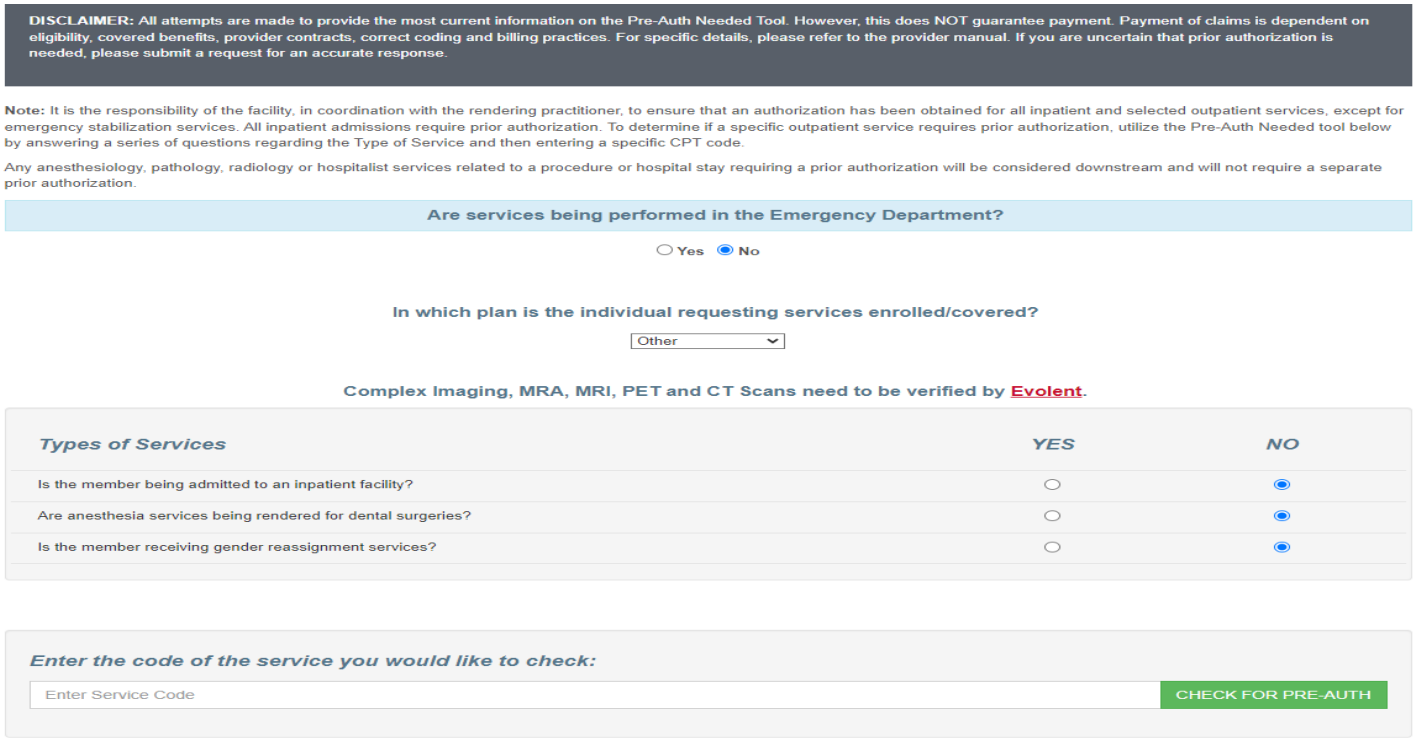
Future Policy Updates

- All future policies are published at https://www.qualchoice.com/for-providers/policy-updates



Prior Authorization Tool

- Prior Authorization Tool
  https://documents.qualchoice.com/area/shared/preauthorizationlist.aspx
- Search all policies by code.



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

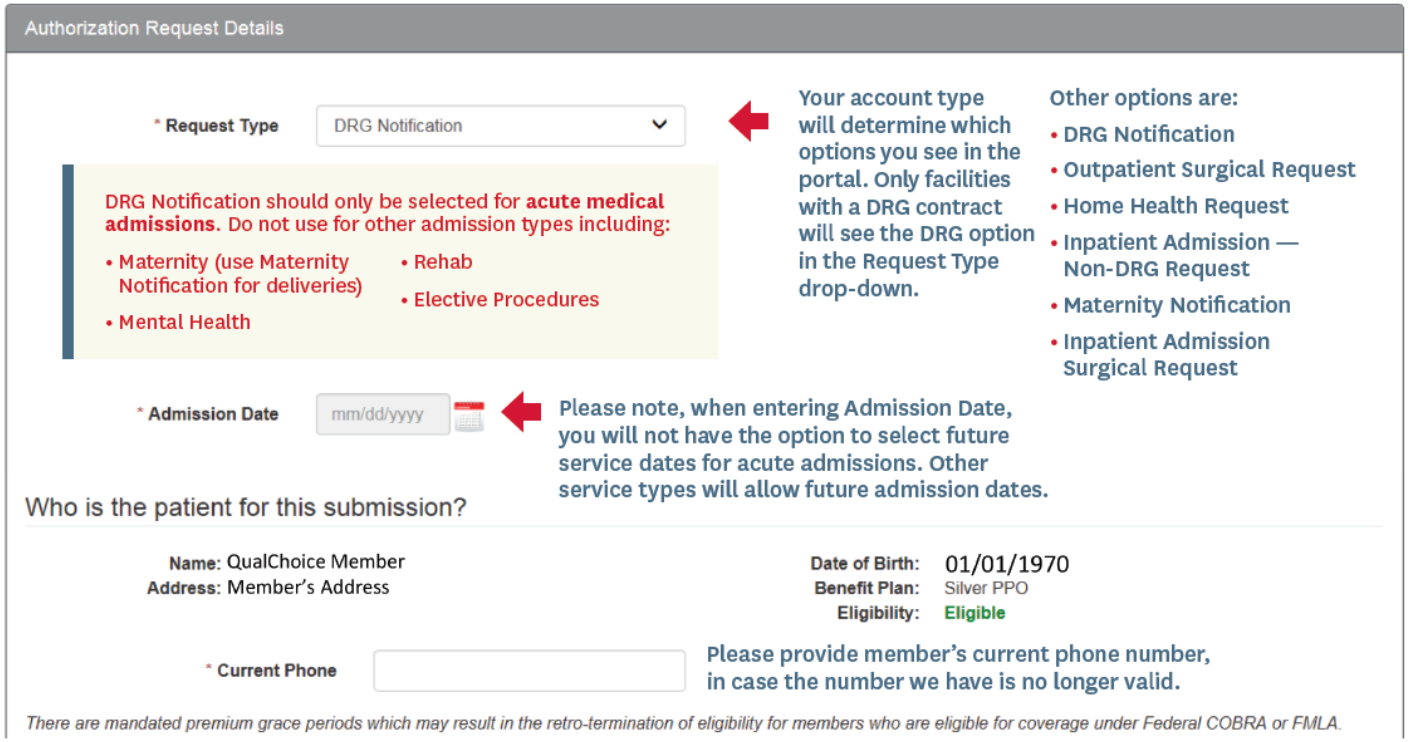
Reduce the time spent on phone calls and faxing! Submit the required information online and get a rapid response.

- 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

Submitting Auto Authorization Requests

QualChoice HEALTH INSURANCE

Auto Authorizations Made Easy ▶ Complete the request as prompted by each field. Please note that DRG submissions will appear within the portal with an "approved" status. All other request types will display as "pending review" and you will be notified by a member of the Utilization Management team once the review is complete.



Who is the reviewer completing this submission?

* **Name**
* **Phone**
* **Fax**
* **Email**

This should be the person completing the notification, or the person we should contact regarding the admission.

At which facility does the service need to be performed?

Servicing Hospital: Facility Name
ID: 9999999999
Address: Facility Address

This will show the information for your facility.

What is the patient's diagnosis?

* Enter ICD-10 Diagnosis Code

Search for diagnosis by description or code, then add it by clicking here. Add Diagnosis Code

Primary Code		Description	Documentable	Action
◉	I219	Acute myocardial infarction, unspecified	☐	🗑
○	E11	Type 2 diabetes mellitus	☐	🗑

To remove a diagnosis, just click the trash can.

What is the clinical reason for admission?

* **Clinical Reason for Admission**

Submit to complete the notification of admission.

Cancel Submit

You can print the approval letter at this point.

Create Authorization Confirmation

Print Confirmation | Save Confirmation | Save Approval Letter

Notification Summary

Authorization Id: AA0000000 — AutoAuth ID's begin with "AA".
Patient Name: Member
Type: DRG Notification
Subscriber Id: 55555555
Status: Approved

Patient

Subscriber ID:
Name:
Address:

Member Info

Date of Birth:
Gender:
Benefit Plan:
Eligibility:

Member Info

Ordering Provider

Provider ID:
Provider Name:
Address:

DRG Facility Info

Business Phone:
Fax Phone:

Servicing Facility

Facility ID:
Facility Name:
Address:

DRG Facility Info

Facility Type:
Business Phone:
Fax Phone:

Reviewer Details

Name:
Email:

Reviewer Info

Phone:
Fax:

Reviewer Info

Diagnosis & Service

Date of Admission : 9/27/2018
Approved Level of Care: Inpatient - Acute Medical

Submit Date: 9/27/2018
Complete Date: 9/27/2018

The Body of the Approval Letter

The Care Management Department has been notified that the above mentioned member has been admitted to the above facility. This authorizes the following:

Approved Service	Inpatient Admission
Date of Admission	9/27/18

Concurrent review may be required during this admission. Based on your DRG contract with QualChoice, subsequent days may or may not fall within the outliers for your facility. If there are outliers on this confinement, QualChoice will request medical records for a clinical review at that time.

Authorization is for medically necessa ry services only and is not a guarantee of benefits or payment. Benefits or payment is based upon eligibility status and available benefits at the time service is rendered and is subject to all contractual exclusions and limitations. Reimbursement will be based upon the method in which care is accessed. Please note: Payment will be based upon financial responsibility for services provided. Benefits may be verified with the Customer Service Department at 800.235.7111 or 501.228.7111.

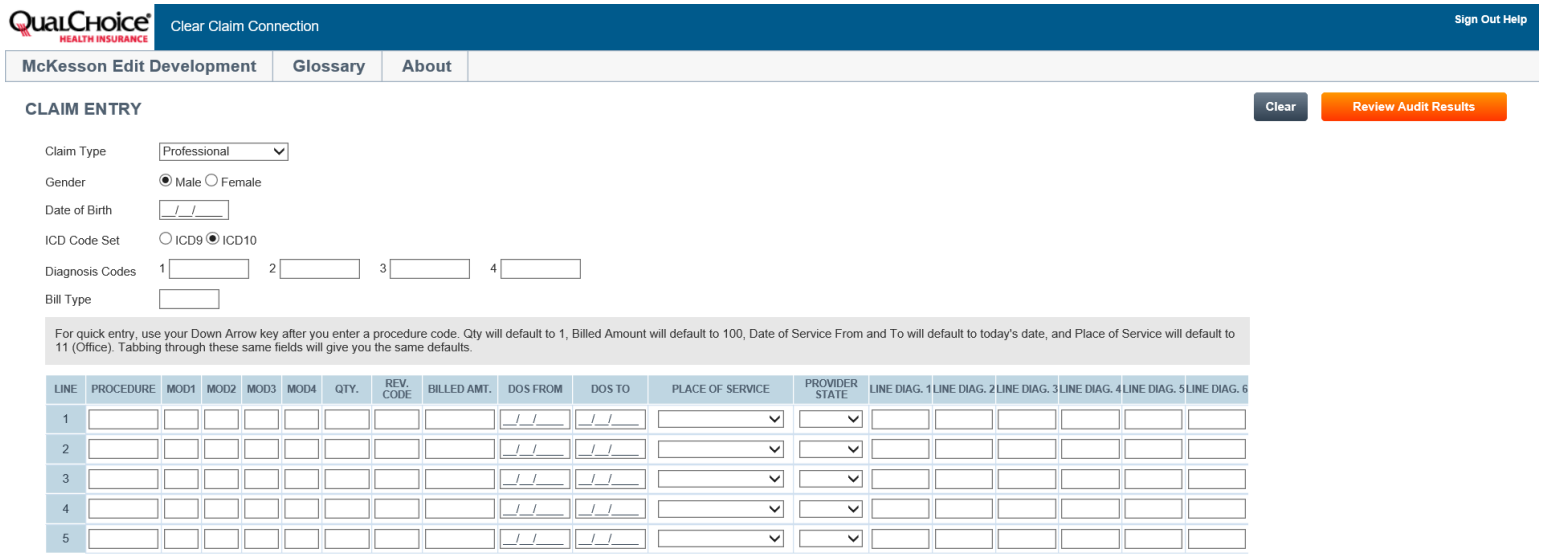
Clear Claim Connection

- 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.

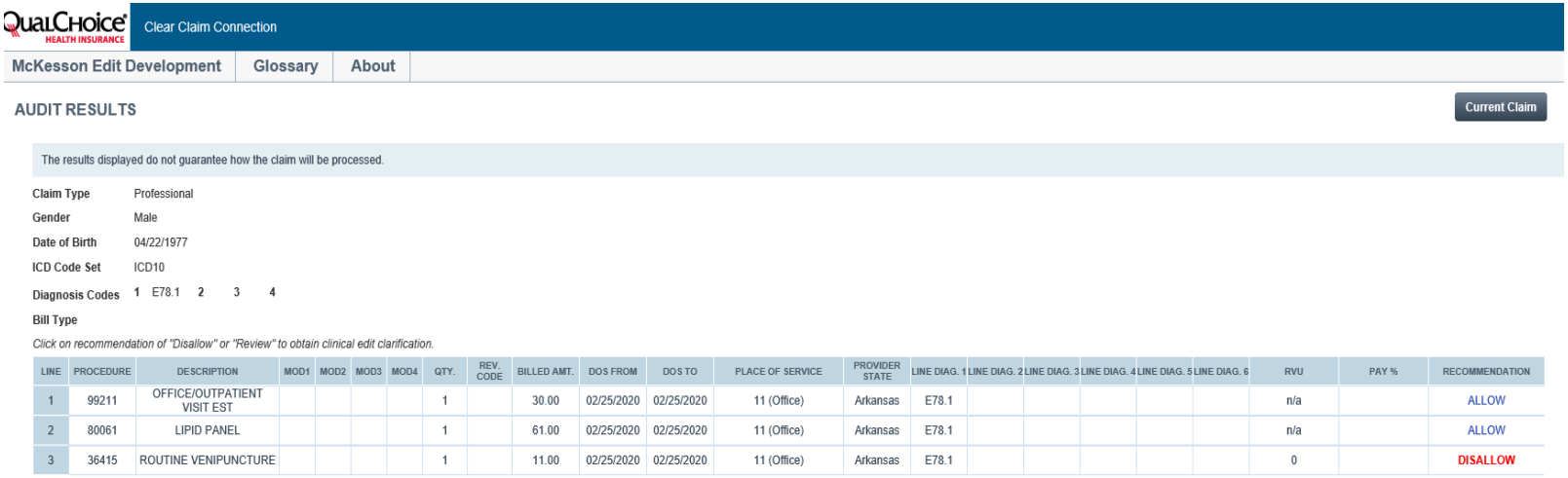
Claims and Services

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



Clear Claim Connection



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 in the “Recommendations” column to see why a service is allowed or disallowed.

Modifier Usage

- **Modifier 50: Qualchoice will no longer require mod 50 when billing of bilateral procedures.**
- **Bilateral procedures should be billed to allow the 1st procedure at 100% and the second procedure at 50%.**
  - Bilateral procedures should be billed on two claim lines
  - Claim Lines should include procedure code and descriptive modifier (Right or left)

For Example:

- Line 1 64483 LT
- Line 2 64483 RT

Modifier 25 and 59 Reviews

Providers may have claims with modifier 25 and 59 denied for medical records –

- If you are a statistical outlier in the use of modifier 25 and 59
- If you submit more than 100 claims annually to QualChoice and
- Over 40% of all submitted claims use modifier 25 and 59

Less than 25 network providers meet this criteria

Claims with modifier 25 and 59 will deny for records

Claims will be adjusted if records support appropriate modifier use

Modifier 25 Rules

Appropriate Use	Inappropriate Use
Appended only to E&M	Appended to major procedure
Indicates patient's condition on the day of the procedure a significant, separately identifiable E&M service beyond the usual preoperative/post operative care	Omission of Modifier w/minor procedure
Appended to procedures with 0-10 day global period	Labs or X-Rays are the only services provided about the E/M
If in the global for another procedure, and E&M & minor procedure append both 24 & -25 mod if appropriate	Sole reason for the visit was the procedure
	To bypass an edit
	Per Medicare procedure & office visits do not require sep DX codes.

Modifier 59 Rules

Appropriate Use	Inappropriate Use
Should only be used when there is no other appropriate modifier	E&M codes
Should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit	In Lieu of modifier 25 No edit in CCI
When the procedure are performed in different encounters on the same day	Exact same procedure was performed on the same day
For two services described by timed codes provided during the same encounters only when they are performed sequentially.	Lack of supporting documentation Submission of weekly radiation therapy management codes 77427

Top Reasons for Claim Denials and How to Prevent Them

1. Claim Was Not Filed Timely – Must submit clearinghouse report that shows claim was accepted by payer

- DO NOT submit medical records in lieu of claims. Qualchoice timely filing deadline is 6 months from date of service.

2. Pre-authorization Not Obtained

- Use prior authorization list and BI associated with prior authorization list.
- Use AutoAuth within the Provider Portal for a more streamlined prior auth process.

3. Clinical Edits Needed

- Clear Claim Connection can be used to review edits. You can access Clear Claim Connection on the Provider Portal.

Claim Resolution Tips

1. **Carefully review all notifications regarding the claim:** it is one of the most important steps in claims processing. One you have received your RA, EOB, or other notifications from any insurance regarding a claim, review it carefully.
2. **Be persistent:** If your resubmitted claim is denied and you believe the denial was improper, follow the reconsideration and appeals guidelines according your carrier.
3. **Don't Delay:** It is important to submit and resubmit claims in a timely manner. Qualchoice timely filing guidelines is 6 months.
4. **Get to know the reconsideration/appeals process:** Qualchoice forms are available on qualchoice.com/forms#providers, where you can scroll down to review the forms needed.
5. **Maintain records on disputed claims:** When calling an insurance carrier keep records of information given, name of representative, and reference number.
6. **Remember help is available:** We know that handling claim denials is frustrating. Ensuring billing procedures are consistent with the insurance company's requirements can save you time and money in the long run.

Reconsideration vs. Appeal Request

Request for Reconsideration – Administrative Denials Only

- Timely filing
- Clinical edits
- Coding
- Reimbursement
- Use Request for Reconsideration Form, found at QualChoice.com

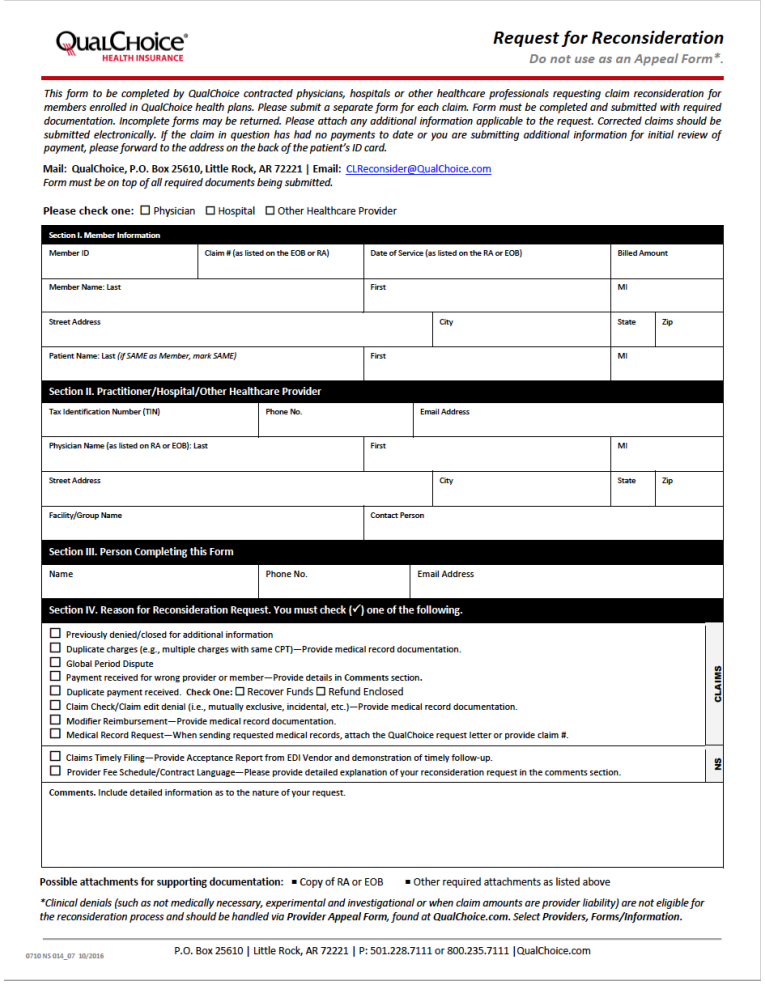
Appeal – Clinical Denials Only

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

Requests received on the wrong form or without the necessary form will not be processed.

Reconsideration vs. Appeal Request

Provider Request for Reconsideration



QualChoice HEALTH INSURANCE

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.

CLAIMS

- ☐ Previously denied/closed for additional information
- ☐ Duplicate charges (e.g., multiple charges with same CPT)—Provide medical record documentation.
- ☐ Global Period Dispute
- ☐ Payment received for wrong provider or member—Provide details in Comments section.
- ☐ Duplicate payment received. **Check One:** ☐ Recover Funds ☐ Refund Enclosed
- ☐ Claim Check/Claim edit denial (i.e., mutually exclusive, incidental, etc.)—Provide medical record documentation.
- ☐ Modifier Reimbursement—Provide medical record documentation.
- ☐ Medical Record Request—When sending requested medical records, attach the QualChoice request letter or provide claim #.

NS

- ☐ Claims Timely Filing—Provide Acceptance Report from EDI Vendor and demonstration of timely follow-up.
- ☐ Provider Fee Schedule/Contract Language—Please provide detailed explanation of your reconsideration request in the comments section.

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

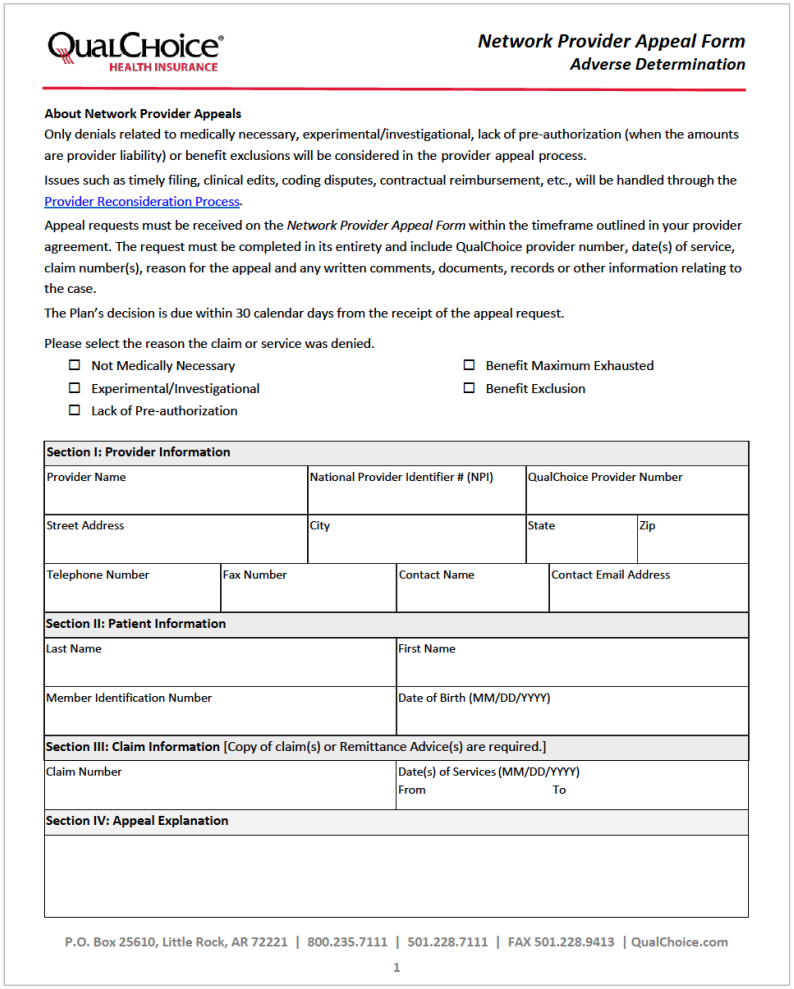
Clinical denials (such as not medically necessary, experimental and investigational or when claim amounts are provider liability) are not eligible for the reconsideration process and should be handled via **Provider Appeal Form, found at **QualChoice.com**. Select **Providers, Forms/Information**.*

0710 NS 014_07 10/2016

P.O. Box 25610 | Little Rock, AR 72221 | P: 501.228.7111 or 800.235.7111 | QualChoice.com

Appeal vs. Reconsideration Request

Provider Appeal Form



QualChoice HEALTH INSURANCE

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
- ☐ Experimental/Investigational
- ☐ Lack of Pre-authorization
- ☐ Benefit Maximum Exhausted
- ☐ Benefit Exclusion

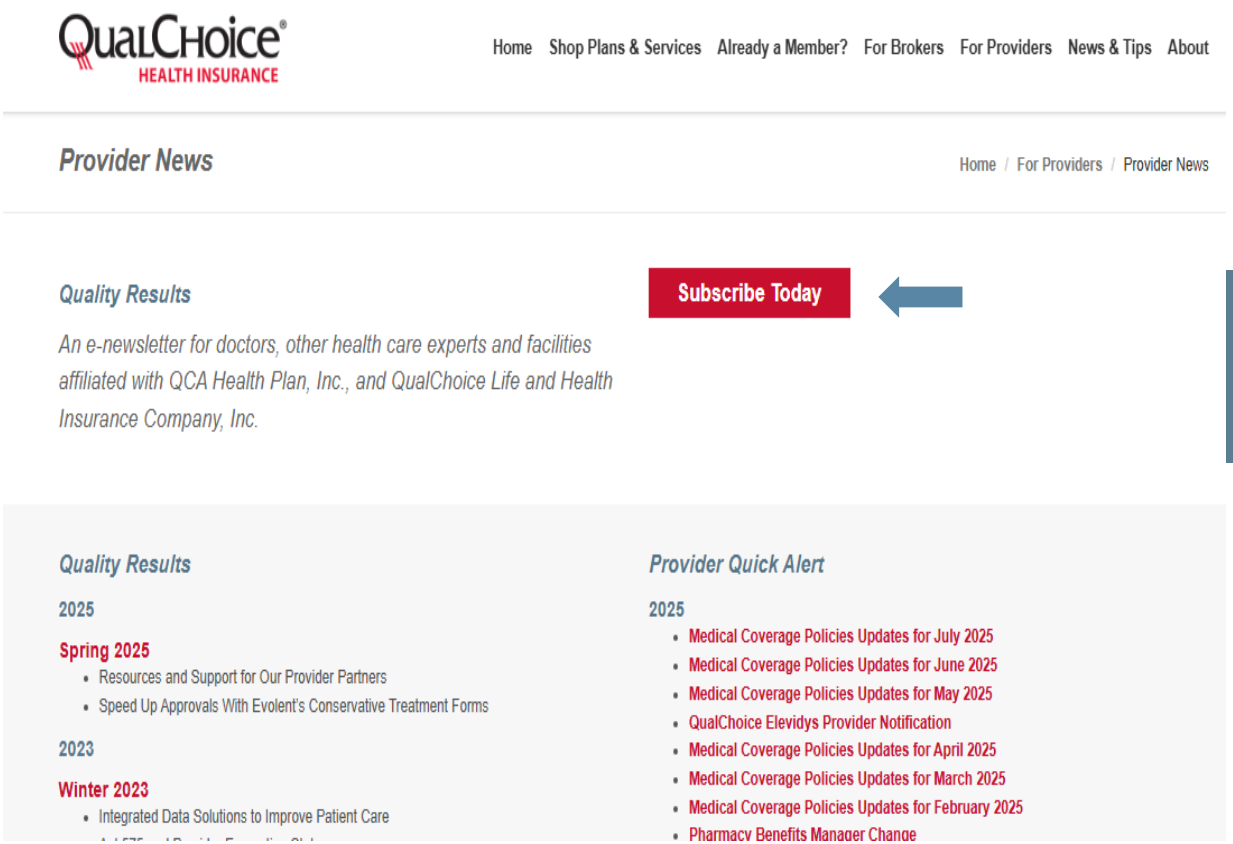
Section I: Provider Information			
Provider Name	National Provider Identifier # (NPI)	QualChoice Provider Number	
Street Address	City	State	Zip
Telephone Number	Fax Number	Contact Name	Contact Email Address
Section II: Patient Information			
Last Name	First Name		
Member Identification Number	Date of 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

1

Quarterly eNewsletter and Quick Alerts – update screen shot

Subscribe at QualChoice.com – For Providers, Provider News



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

Contact info

- **Credentialing: Arkcredentialing@centene.com**
  - All provider credentialing questions
- **Contracting: Arkansascontracting@centene.com**
  - Provider contracting questions
- **Business Service: QC_bu_pr@qualchoice.com**
  - For QualChoice Provider portal questions
- **Claim reconsideration email: CLReconsider@qualchoice.com**
  - For claim reconsiderations (not clinical appeals)
- **Customer Service: Customerservice3@centene.com**
  - General customer service or benefit questions
- **QC PR mailbox: PR@qualchoice.com**
  - All other QualChoice specific questions

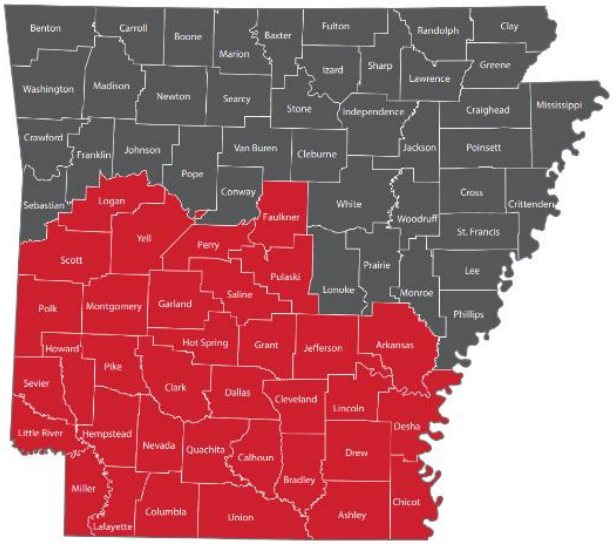
Provider Engagement Account Manager

Dani Wyrick
501-409-7853
Danielle.Wyrick@centene.com

Shannon Anderson
501-541-4146
Shannon.Anderson@qualchoice.com

Provider Network Territory Map

QualChoice® HEALTH INSURANCE



	Shannon Anderson shannon.anderson@qualchoice.com 501-541-4146	Dani Wyrick danielle.wyrick@centene.com 501-409-7853
Out-of-State Participating Providers	Mississippi, Missouri, Oklahoma, Tennessee	Texas
Statewide Allied Providers	By Region Location	By Region Location & National Offices

Provider Relations: 501-228-7111, ext. 7004 | Fax: 501-707-6811 | PR@qualchoice.com | QualChoice.com