Summit COMMUNITY CARE

Provider Claims Resource Guide

Table of contents

- Setting up care provider identifiers in Availity Essentials
- Claim submission methods
- Monitoring claim submissions
- Billing tips and resources
- Corrected and voided claims
- Claim disputes and appeals
- Electronic payment services
- Contacts and resources

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Setting up care provider identifiers in Availity Essentials

Care provider identifiers in Availity Essentials

- All participating care providers must set up their care provider identifiers in Availity Essentials. This ensures information is captured accurately when you submit claims, check **Claim Status**, and use other Availity Essentials applications.
- Care providers who **do not have an NPI registered with Arkansas Medicaid** are considered atypical and should select the box to indicate they are atypical when setting up their Availity Essentials profile.
- Care providers who **have an NPI registered with Arkansas Medicaid** should only add their NPI number and TIN to their Availity Essentials profile.

Note: Care providers with the same NPI registered to more than one Medicaid ID should contact their assigned provider representative for assistance with setting up their care provider identifiers.

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Accessing the My Provider profile in Availity Essentials

Follow these steps to add identifiers under the **Manage My Organization** page:

- From the Availity Essentials dashboard, select:
  - **[User's] Account > Manage My Organization**
    - **Note:** The user will be the person's name who is logged into Availity Essentials.
- Scroll down and select **Manage Providers > Add Providers.**

Entering care provider information

- Select the **Tax ID Type** from the drop-down and enter the care provider Tax ID in the field.
- **Note:** If the care provider does not have an NPI registered with Arkansas Medicaid:
  - Select the checkbox next to the verbiage that states: “This is an atypical provider and does not provide healthcare, as defined under HIPAA regulations.” This will remove the NPI required field.
- Select **Find Provider** to continue adding care provider information.

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Adding care provider identifiers

Providers who do **not** have an NPI registered with Arkansas Medicaid should select **Add Identifier** and add the following fields:

- **ID Type:** Select the **Payer Assigned Provider ID (PAPI)** from the drop-down — this is the care provider's Medicaid ID.
- **Payer:** Select **Summit Community Care** as the payer from the drop-down.
- **ID Number:** Enter the provider **Medicaid ID** in this field.

Note: Care providers who **do** have an NPI registered with Arkansas Medicaid do not need to add any additional identifiers. The TIN and NPI should be the only identifiers listed.

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Claim submission methods

Claim submission — overview

Care providers have multiple methods to submit claims, including:

Availity Essentials

- Offers secure access to manage daily transactions with payers.
- Does not require special software.
- Eligibility can be verified within; claims can be submitted, and claim status can be checked.

Care Central

- Accessible through Availity Essentials' **Payer Spaces**, Care Central is an application designed specifically for LTSS care providers submitting professional claims.
- Reduces the fields within an LTSS claim to only those required for the type of service being provided.
- Claims can be monitored from the claims dashboard page or the **Claim Status** application in Availity Essentials.

Clearinghouse

- An institution that electronically transmits different types of claims data on behalf of the provider.
- May include fees charged to the provider for the claim submissions.

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Claim submission — Availity Essentials

From the Availity Essentials dashboard, select:

- **Claims & Payments > Claims and Encounters >** then complete the following required fields to begin submitting the claim:
  - **Organization:** Select your organization from the drop-down field.
  - **Claim Type:** Select **Professional Claim** or **Facility Claim**.
  - **Payer:** Choose **Summit Community Care** from the drop-down.
  - **Responsibility Sequence:** Select **Primary** to indicate that the payer listed in the payer field (Summit Community Care) is the primary insurance carrier on the claim.

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Claim submission — Care Central

To access Care Central:

From the Availity Essentials dashboard, select **Payer Spaces > Summit Community Care >** and complete the required fields.

To submit a claim:

- Select the **Members** tab.
- Check the box for each member needing a claim.
- Select **Create Claims**.

Note: If a member is not listed on the **Authorized Members** list, the care provider may add the member by choosing **Add Member**. This will allow the care provider to gain access to the member's profile for claim submission.

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Creating claims: configuring settings

If the **Settings** button is highlighted, complete the **Configure Settings** section for each indicated member to continue.

- Select **Configure Settings**.
- Complete the fields in the popup window.
- Select **Save** or **Save & Setup Next Member** where applicable.

Creating claims: same service and diagnosis for multiple members

To bill the **same service and diagnosis** for multiple members:

- Select **Yes** for question: Are you billing the same service and diagnosis for these members?
- Complete all required fields in the **Start Your Claims** section:
  - **Place of Service**
  - **Diagnosis Code**
  - **Line #**
  - **Procedure Code**
  - **Modifier(s)**
  - **Dates of Service**
  - **Units**
  - **Charges**
- Select **Review & Submit**.

Note: If more than one procedure code is being billed, select **Add Transaction** to populate another row.

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Creating claims: different services or diagnoses for multiple members

To bill **different services or diagnoses** for multiple members:

- Select **No** for question: Are you billing the same service and diagnosis for these members?
- Complete all required fields in the **Start Your Claims** section:
  - **Place of Service**
  - **Diagnosis Code**
  - **Line #**
  - **Procedure Code**
  - **Modifier(s)**
  - **Dates of Service**
  - **Units**
  - **Charges**
- Select **Review & Submit**.

Note: If more than one procedure code is being billed, select **Add Transaction** to populate another row.

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Creating claims: review and submit

From the **Review & Submit** page:

- Review claims.
- Select **Edit** to make changes.
- After confirming the information is accurate, select **Submit Claims**.

A confirmation window will appear with a transaction ID acknowledging a successful claims submission.

From this window, you have the option to navigate to the **Members** or **Claims** dashboards.

Note: Keep a record of the Availity Essentials transaction ID for reference. This ID can be provided to Availity Essentials customer service for claim submission inquiries.

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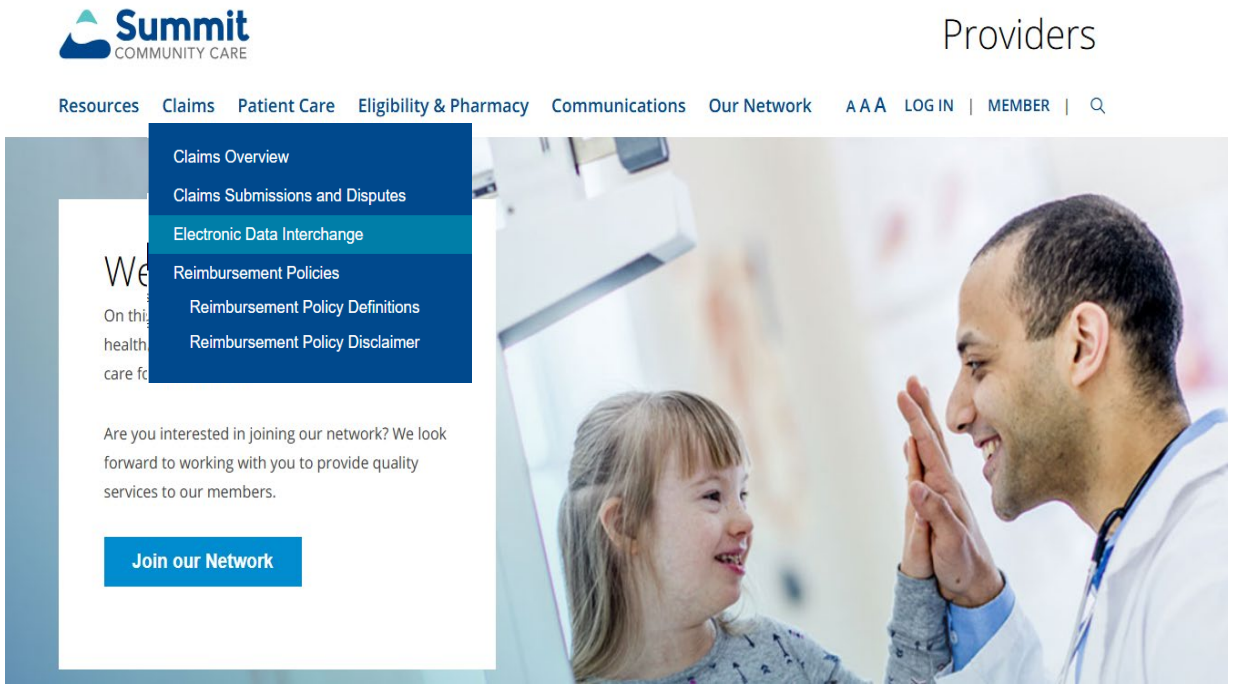
Claim submissions — clearinghouse

- Additional resources for electronic claim submissions are available on the **provider website**.
  - Select **Claims > Electronic Data Interchange** for resources, including:
    - **Summit Community Care | EDI**
    - **Availity Essentials EDI Guide**
  - For more information, call Availity Client Services at **800-282-4548**.

Note: Care providers who do not have an NPI registered with Arkansas Medicaid should read **this article**.



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Monitoring claim submissions

Monitoring claim submissions — Care Central

For LTSS care providers submitting professional claims through Care Central, claims can be monitored from the **Claims** dashboard.

- To access from the Care Central dashboard, select the **Claims** tab.
- View claims – pending and processed:
  - Select the **Pending and Processed** tab to display basic claim information.
  - All claims, regardless of submission method, will appear in this tab.
- View claims – submitted or rejected:
  - Select the **Submitted or Rejected** tab to view the status of recent claim submissions. Only claims submitted through Care Central will populate in this tab.

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Monitoring claim submissions — Care Central (cont.)

If claim information is not available in Care Central or if the care provider would like to view additional claim details, the **Claim Status** application is available.

- Select **Visit Claim Status** to be redirected to the **Claim Status** application.
  - A pop-up will advise that this will redirect the user to the **Claim Status** application.
    - Select **Continue to Claim Status** to be redirected.

Monitoring claim submissions — Availity Essentials Claim Status application

Care providers can access the **Claim Status** application from their Availity Essentials dashboard by selecting **Claims and Payments > Claim Status**.

Use the **Claim Status** application to:

- Review line-level details for claims, including denial codes.
- Start a claim dispute (if available).
- Send a message to the payer.

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Monitoring claim submissions — Availity Essentials Claim Status application (cont.)

Helpful tips for using the **Claim Status** application:

- If a field does not have a red asterisk (*) next to it, it is not a required field.
- When searching for claims, leave unrequired fields blank — this helps broaden the search results when no results are returned.
- There is an option to add attachments within the claim form **Availity|Add Attachment**:
  - Use the **Attachments** dashboard to:
    - Upload medical records, itemized bills, or other documents needed to process a member's claim once the claim has been completed.
    - Receive notification about needed claim documentation through the **Digital Request for Additional Information (Digital RFAI).**

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Billing tips and resources

Billing and reimbursement

Summit Community Care accepts electronic and paper claim submissions; however, electronic claim submissions are encouraged.

Per the PASSE agreement, claims must be processed in a timely manner and comply with all applicable federal and state requirements. The following standards regarding timely claims processing apply to all care providers, regardless of network status:

- Process seventy percent (70%) of all clean claims submitted within seven (7) days of receipt;
- Process ninety-five percent (95%) of all clean claims submitted within thirty (30) days of receipt;
- Process ninety-nine percent (99%) of all clean claims submitted within sixty (60) days of receipt.

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Billing and reimbursement (cont.)

Timely filing is within **365 calendar days** from the date of service, and corrected claims filed within 180 days of the original date of the Explanation of Payment notice.

What is the difference between a rejected claim and a denied claim?

Rejected: A rejected claim does not enter the adjudication system due to missing or incorrect information.

Denied: A denied claim goes through the adjudication process but is denied for payment. The claim status tool can identify the specific denial code(s) for more clarification.

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Billing and reimbursement (cont.)

Follow these tips when submitting claims directly through the Availity Essentials platform from the **Claims & Encounters** application:

- All fields indicated with a red asterisk (*) are required to be completed. Fields without a red asterisk can be left blank.
- Select **Watch a demo** at the top of the claims form for a recorded webinar on the step-by-step process of completing claims in Availity Essentials.
- For specific claim information, please review the **Provider Manual** or visit **Provider Manuals and Other Provider Notifications - Arkansas Department of Human Services**.

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Corrected and voided claims

Corrected claims

Why submit a correct claim?

- Incorrect information was billed, such as units, charges, or procedure codes.
- Rebilling without submitting it as a corrected claim could lead to a duplicate denial or a duplicate payment that must be recouped.
- Properly submitting a corrected claim replaces the original submission, allowing errors to be rectified, and triggers the reprocessing of the claim.

Corrected claims can be submitted:

- After the initial process.
- Up to 180 days from the date the claim was processed.

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Corrected claims (cont.)

Example: The original claim was billed at $1,000, however, it was later determined a charge of $200 was omitted from the original billing. The corrected claim should be submitted with a total charge of $1,200 and must include the original claim entry ($1,000) and the omitted charge ($200).

Submission of only the corrected entry ($200) would prompt the claims processing system to only take the $200 into consideration and the $1,000 submitted on the original claim would likely generate an offset or overpayment recovery.

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Voided claims

Submit a voided claim when:

- Services were not rendered.
- Wrong member information was submitted.
- The incorrect NPI was billed.
- The incorrect tax ID was billed.

Example: The procedure was billed under the NPI for Dr. Pierce, but Dr. Hunt rendered the service.

This claim cannot be corrected and must be voided and rebilled.

Note: Always wait until confirmation of the void is received before rebilling.

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How to submit corrected and voided claims in Availity Essentials

From the Availity Essentials dashboard, select **Claims & Payments > Claims and Encounters,** then complete the **Insurance Company/Benefit Plan Information** fields.

Filling out the claim form:

- Ensure the correction includes all appropriate information, including all lines of service.
- **Voided claims** should match the previous claim exactly.
- **Corrected claims** should replicate the initial claim but with necessary corrections.
- In the **Claims Information** section, there are two additional fields that need to be completed:
  - From the **Billing Frequency** drop-down, select one of the following:
    - Select 7 – **Replacement of Prior Claim** (for a corrected claim)
    - Select 8 – **Void Claim**
  - In the **Payer Control Number** field, enter the claim number being corrected or voided.

For assistance, select **Help** in the **Availity Essentials platform** or call **800-282-4548**.

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Claim disputes and appeals

Claim disputes

A claim payment dispute may be submitted for multiple reasons, including:

- Disagreement over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Contractual payment issues.
- Timely filing issues.

Claim disputes (cont.)

Please be aware that there are three (3) common, claim-related issues that are **not** considered claim payment disputes. To avoid confusion with claim payment disputes, they have been defined here:

- **Claim inquiry:** a question about a claim but not a request to change a claim payment
- **Claims correspondence:** occurs when Summit Community Care requests further information to finalize a claim — typically includes medical records, itemized bills, or information about other insurance a member may have
- **Medical necessity appeals:** a pre-service appeal for a denied service in which a claim has not yet been submitted

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Claim dispute process

The payment dispute process consists of two internal steps and a third external step. There is no penalty for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the initial request for an investigation into the claim's outcome, and most issues are resolved at this step.
2. **Claim payment appeal:** This is the second step of the process and should be used if the care provider disagrees with the initial reconsideration outcome.
3. **State fair hearing:** Arkansas Medicaid supports an external review process if the care provider has exhausted both internal steps in the claim dispute process but still disagrees with the outcome.

Note: Care providers should complete the dispute and/or appeal defined within the Summit Community Care provider manual prior to filing for a state fair hearing with Arkansas Medicaid.

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How to submit a claim payment dispute

Online:
Use the secure Availity Essentials **Payment Appeal Tool** at **https://Availity.com**.

*Reconsiderations and claim payment appeals only

Phone:
844-462-0022

*Reconsiderations only

Mail:
Payment Dispute Unit
Summit Community Care
P. O. Box 62429
Virginia Beach, VA
23466-2429

Claim appeals

Care providers who do not agree with the outcome of a finalized claim can use the **Claim Status** application in Availity Essentials to begin a claim dispute by following these steps:

- From the Availity Essentials dashboard, select **Claims & Payments > Claims Status**.
- Complete a **Claim Status** search for the claim to be disputed.
- From the top of the **Claim Status** results page, select **Dispute Claim** and follow the steps to complete the dispute submission.

Note: Please refer to the **Summit Community Care Provider Manual** and/or denial letter for the appeals process if you are unable to secure the claim to dispute.

Electronic payment services and reporting services

Electronic payment services

Care providers may sign up for electronic remittance advice (ERA) and electronic funds transfer (EFT), which will allow them to:

- Begin receiving ERAs and import information directly into their patient management or patient accounting system.
- Route EFTs to the bank account of choice.
- Create custom reports within their office.
- Access reports 24 hours a day, 7 days a week.

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Electronic payment services (cont.)

EFT enrollment is completed through EnrollSafe.

- Access EnrollSafe through **EnrollSafe Payee Hub**.
- EnrollSafe is the only option for care providers to enroll or make changes for EFT payment with Summit Community Care.

EnrollSafe help and resources:

- **EnrollSafe User Reference Manual**
- EnrollSafe contact support team:
  - **877-882-0384**
  - support@payeehub.org

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Electronic remittance advice

Care providers can enroll to receive electronic remittance advice (ERA) files (835 files) using the **Transaction Enrollment** application in Availity Essentials.

- In the Availity Essentials menu, click **My Providers > Enrollments Center > Transaction Enrollment.**
- Click the **Enroll** drop-down button and select **Enroll a Provider.**
- Complete each step of the form.
- Click **Continue** to move forward.
- Click **Submit Enrollments** to finalize

A confirmation page will display the status of your transactions.

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Electronic remittance advice (cont.)

For more information about the **Transaction Enrollment** application and process:

- Visit the **Availity Essentials Provider Help Center** by selecting **Help & Training > Find Help.**
- Search **Transaction Enrollment Overview**.
- For a training demo, go to the **Availity Essentials Learning Center**.
- Select **Help & Training > Get Trained.**
- Search **Transaction Enrollment — Training Demo**.

For additional assistance, contact Availity Essentials support.

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EDI Reporting Preferences application

Care providers can use the **EDI Reporting Preferences** application in Availity Essentials to set up and receive response files for their submitted claims. The **EDI Reporting Preferences** application allows care providers to:

- Set a preference to receive response files from claims submitted through Availity Essentials, including rejected claims.
- Specify delivery, schedule, and grouping options for types of responses care providers would like to receive.
- Download and view response files in an easy-to-read format that can be imported into an automated system.
- View and download files in the **Send and Receive Files** folder in Availity Essentials, which include acknowledgements of accepted and rejected claims.

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Accessing the EDI Reporting Preferences application

Follow these steps to access the **EDI Reporting Preferences** application in Availity Essentials:

- From the Availity Essentials dashboard, select **Claims & Payment,** then **EDI Reporting Preferences**.
- From the **EDI Reporting Preferences** dashboard, select the care provider organization from the drop-down menu, then the **Claims** tab to begin setting up the reporting preferences.

Note: Access and setup of the **EDI Reporting Preferences** application will require the administrative role. For assistance, please reach out to the organization's assigned administrator.

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Send and Receive Files folder — access and overview

Once the type of claim receiving reporting preferences have been configured, use the **Send and Receive Files** application to download the EDI response files.

- Access the **Send and Receive Files** application by selecting **Claims & Payments > Send and Receive EDI Files**.

Note: Access to this application will require the EDI Administrator role. Contact the administrator for the organization if access is needed.

Follow these steps to download the response files from the **Send and Receive Files** dashboard:

- Select the **Organization** from the drop-down menu and select **Submit**.
- Select **Receive Files** folder.
- Select the file to download under the **File Options** tab.

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Examples of received files

Received files include **electronic batch report (EBR/EBT)** and **delayed payer report (DPR/DPT)**.

EBR/EBT:

- Offered in two formats:
  - A pipe-delimited data file (.ebr extension) for importing into automated systems
  - A formatted-text report (.ebt extension)
- Contains summary counts of transactions received and accepted
- Lists detailed information for rejected transactions.
- Typically received from payer within 24 to 48 hours

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Examples of received files (cont.)

DPR/DPT:

- Offered in two formats:
  - A pipe-delimited data file (.dpr extension) for importing into automated systems
  - A formatted-text report (.dpt extension)
- Includes transaction receipt acknowledgement, transaction reject messaging, warning, and informational messages
- Adjudication responses returned by the destination payer
- Typically received from the payer within 30 days

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Additional resources — EDI reporting

Availity Essentials recorded webinar trainings:

- Help and training > Get trained > Training Demo – Send and Receive EDI Files
- Help and training > Get trained > EDI Reporting Preferences – Training Demo

Availity Essentials resources and tips:

- Electronic Data Interchange (EDI) Guide
  - **Availity EDI Guide**
  - Availity Essentials homepage > My Account dashboard
- Help and training > Find Help
  - Search for articles or resources such as EDI Report Preferences for claims or Send and Receive Files overview.

Availity Essentials customer support:

- Create a support ticket by selecting Help and training > Availity support > Contact support.
- Call **800-282-4548**.

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Contacts and resources

Contacts and resources

For billing and claim guides	
Arkansas Department of Human Services	**Provider Manuals and Other Provider Notifications - Arkansas Department of Human Services**
Additional billing guidelines and procedures	**Summit Community Care Provider Manual**
Summit Community Care claim resources and EDI information	**Summit Community Care – Providers**
Availity Essentials platform and claim support	**800-282-4548**
For Availity Essentials help and training	
Availity Essentials guides and documents	Availity > Help and Training > Find Help > Search
Availity Essentials recorded and live webinar trainings	Availity > Help and Training > Get Trained
Availity Essentials learning hub from Summit Community Care website	Summit > Provider > Resources > Learn about Availity > Launch Provider Learning Hub
For claim questions	
Summit Community Care Provider Services	**844-462-0022**
Summit Community Care Provider Relations	Brandon Boyd (Providers A-J) Brandon.Boyd@summitcommunitycare.com Rachelle Rose (Providers K-Z) Rachelle.Rose@summitcommunitycare.com

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