arkansas health & wellness™

2018 Third Quarter Provider Updates

September 20, 2018

Provider Inquiries

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Questions about today's presentation can be submitted electronically by emailing us at

Providers@ARHealthwellness.com

Today's Presenters

arkansas health & wellness

Kari Murphy

Provider Relation Specialist
Northwest Region

Tanya Brooks

Provider Relation Specialist
Southwest Region

Join Our Email List Today

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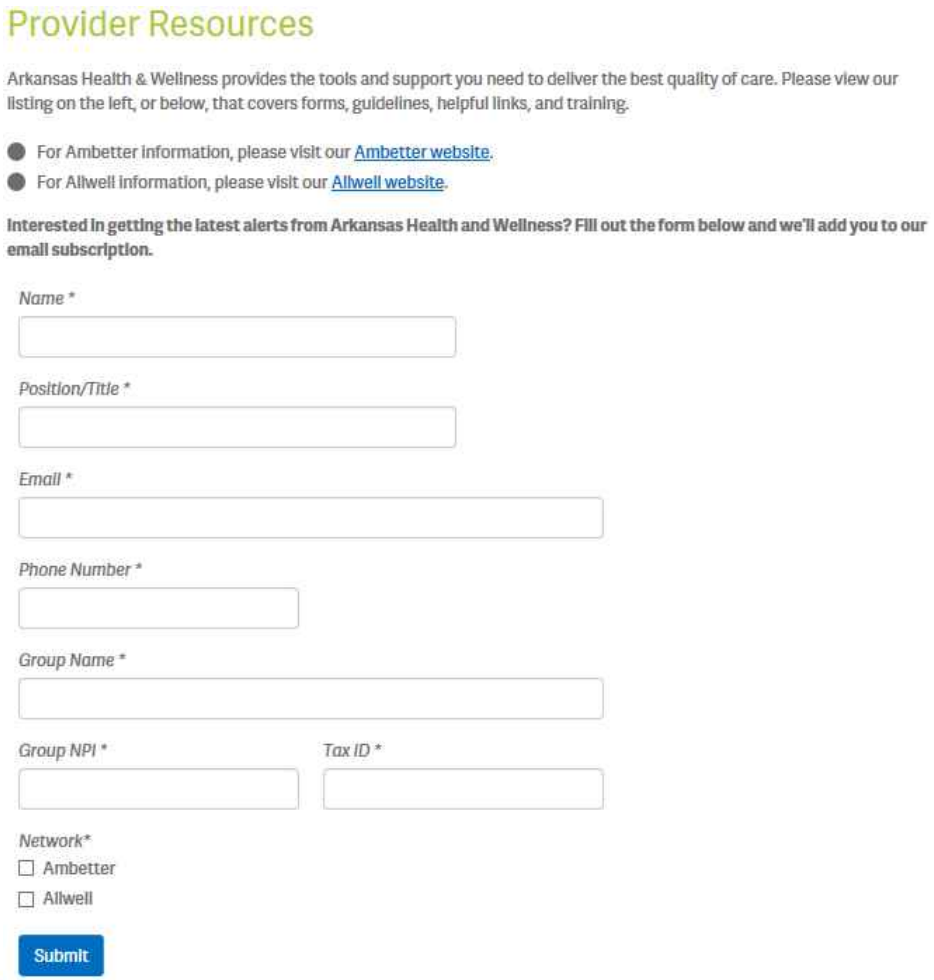
- Receive current updates:
  - https://www.arhealthwellness.com/providers/resources.html
- Choose the network you wish to receive information for



Provider Resources

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

- For Ambetter information, please visit our Ambetter website.
- For Allwell information, please visit our Allwell website.

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

*Name **

*Position/Title **

*Email **

*Phone Number **

*Group Name **

*Group NPI **

*Tax ID **

*Network**

☐ Ambetter

☐ Allwell

Submit

Website Home Page

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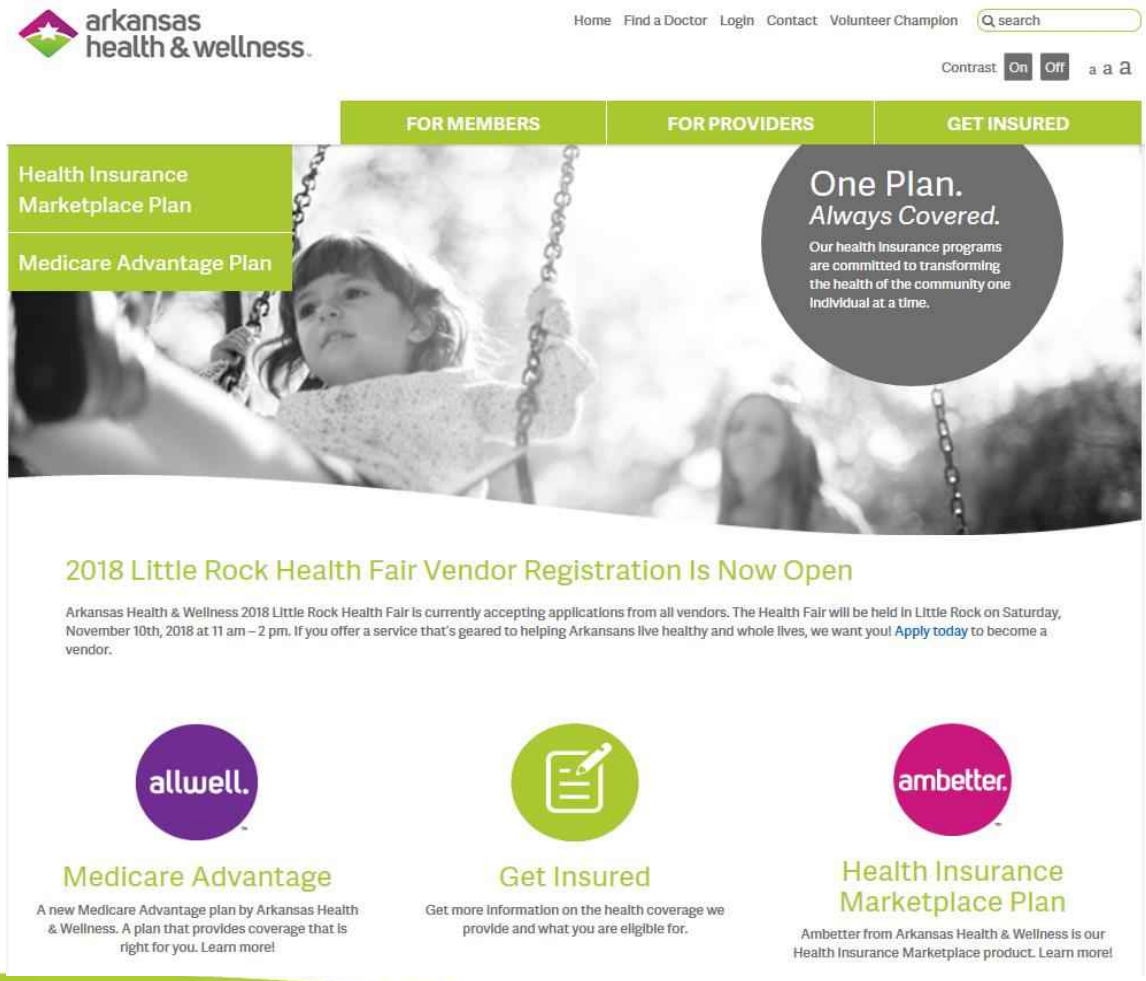

Electronic Funds Transfer through PaySpan

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Setup is easy and takes about five minutes to complete

Please visit https://www.payspanhealth.com/nps or call your Provider Relations representative

or PaySpan at 1-877-331-7154 with any questions.

We will only deposit into your account, not take payments out.

Education Requests

Would you like training for you and your staff?

You can submit your requests to

Providers@ARHealthwellness.com

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Needing to Contact Us?

Arkansas Health and Wellness Contracting

Phone Number: 1-844-631-6830

Hours of Operation: 8am-4:30pm

Provider Contracting Email Address:

ArkansasContracting@centene.com

Regular contracting inquiries and contract requests

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Arkansas Health and Wellness Credentialing

Phone: 1-844-263-2437

Fax: 1-844-357-7890

Email: arkcredentialing@centene.com

Ambetter from Arkansas Health and Wellness

Provider Services

Phone: 1-877-617-0390
TTY/TDD: 1-877-617-0392
ambetter.arhealthwellness.com

Allwell from Arkansas Health and Wellness

Provider Services

Phone: 1-855-565-9518
TTY/TDD: 711
allwell.arhealthwellness.com

Arkansas Total Care

Provider Services

Phone: 1-866-282-6280

arkansastotalcare.com

Email inquiries to:

Providers@ArkansasTotalCare.com

2018 Third Quarter Provider Updates

September 20, 2018

Disclaimer

- Arkansas Health and Wellness has produced this material as an informational reference for providers furnishing services in our contract network Arkansas Health and Wellness employees, agents and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material.
- The presentation is a general summary that explains certain aspects of the program, but is not a legal document.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice.
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Acronyms

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Acronym	Definition
CPC+	Comprehensive Primary Care Plus
DHS	Department of Human Services
HEDIS	Healthcare Effectiveness Data and Information Set
HMO	Health Maintenance Organization
ID	Identification
MAPD	Medicare Advantage Prescription Drug
NPI	National Provider Identifier
P4P	Pay for Performance
PCMH	Patient Centered Medical Homes
PCP	Primary Care Physician
TIN	Tax Identification Number

Agenda

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- Ambetter Updates
  - AR Works – Work Requirement
  - Secure Portal
  - Prior Authorizations
- Allwell Updates
  - 2019 Expansion
  - Secure Portal
  - Prior Authorizations
- Arkansas Total Care Updates
  - Phase 1 and Phase 2
- Important Reminders
  - Opioid Policy

Ambetter Updates

AR Works - Work Requirement

- According to state guidelines, members must meet the work requirements or exemption qualifications and report them to the state in order to keep their coverage.
- Our call center has dedicated representatives to walk the members through their attestation and explain how the members can keep their coverage
- Literature is available for your office to hand out to members if they have questions about the program

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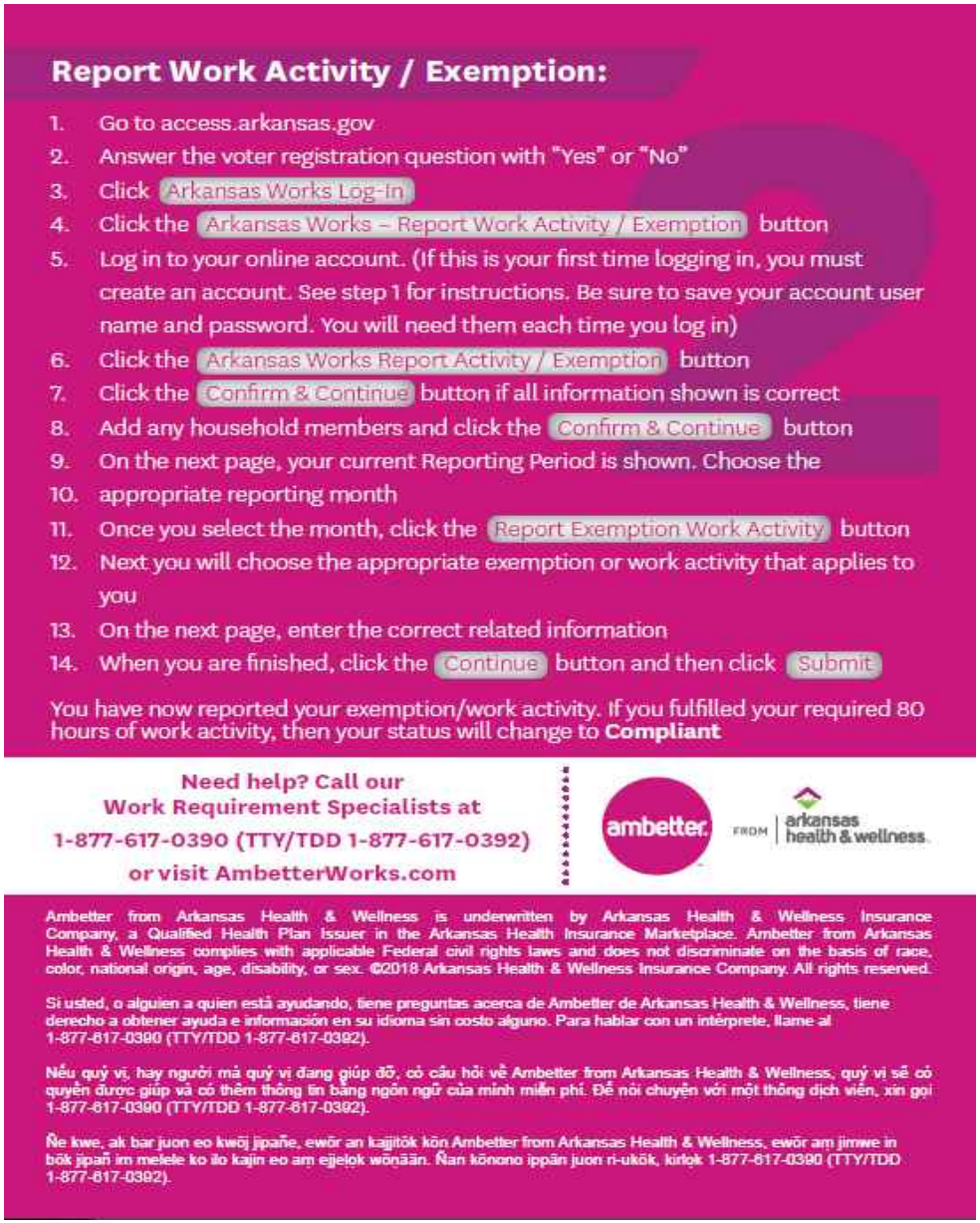
Arkansas Works 2.0

Report Monthly Activities/Exemptions Flyer

(Front)



Report Work Activity / Exemption:

1. Go to access.arkansas.gov
2. Answer the voter registration question with "Yes" or "No"
3. Click Arkansas Works Log-In
4. Click the Arkansas Works – Report Work Activity / Exemption button
5. Log in to your online account. (If this is your first time logging in, you must create an account. See step 1 for instructions. Be sure to save your account user name and password. You will need them each time you log in)
6. Click the Arkansas Works Report Activity / Exemption button
7. Click the Confirm & Continue button if all information shown is correct
8. Add any household members and click the Confirm & Continue button
9. On the next page, your current Reporting Period is shown. Choose the
10. appropriate reporting month
11. Once you select the month, click the Report Exemption Work Activity button
12. Next you will choose the appropriate exemption or work activity that applies to you
13. On the next page, enter the correct related information
14. When you are finished, click the Continue button and then click Submit

You have now reported your exemption/work activity. If you fulfilled your required 80 hours of work activity, then your status will change to **Compliant**

Need help? Call our Work Requirement Specialists at 1-877-617-0390 (TTY/TDD 1-877-617-0392) or visit AmbetterWorks.com

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Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Arkansas Health & Wellness, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-617-0390 (TTY/TDD 1-877-617-0392).

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Arkansas Health & Wellness, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-617-0390 (TTY/TDD 1-877-617-0392).

Ñe kwe, ak bar juon eo kwōj jipañe, ewōr an kajjitōk kōn Ambetter from Arkansas Health & Wellness, ewōr am jimwe in bōk jipañ im melele ko ilo kajin eo am ejjeļok wōnāān. Ñan kōnono ippān juon ri-ukōk, kiriok 1-877-617-0390 (TTY/TDD 1-877-617-0392).

ambetter.

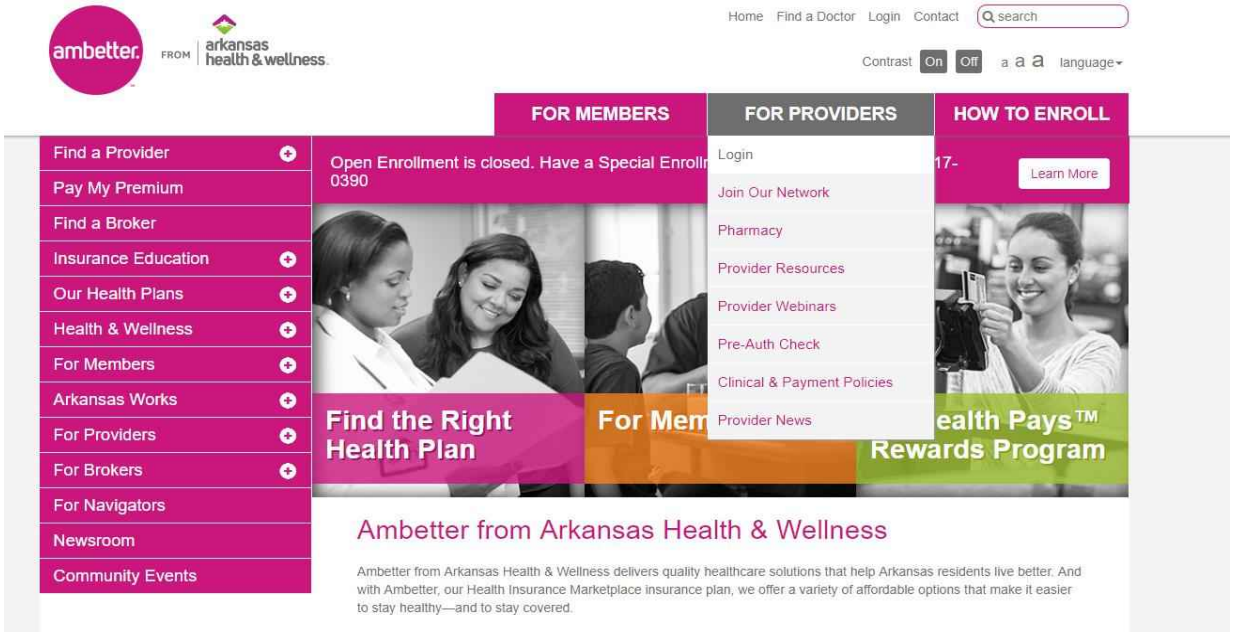
Arkansas Works 2.0

Report Monthly Activities/Exemptions Flyer

(Back)

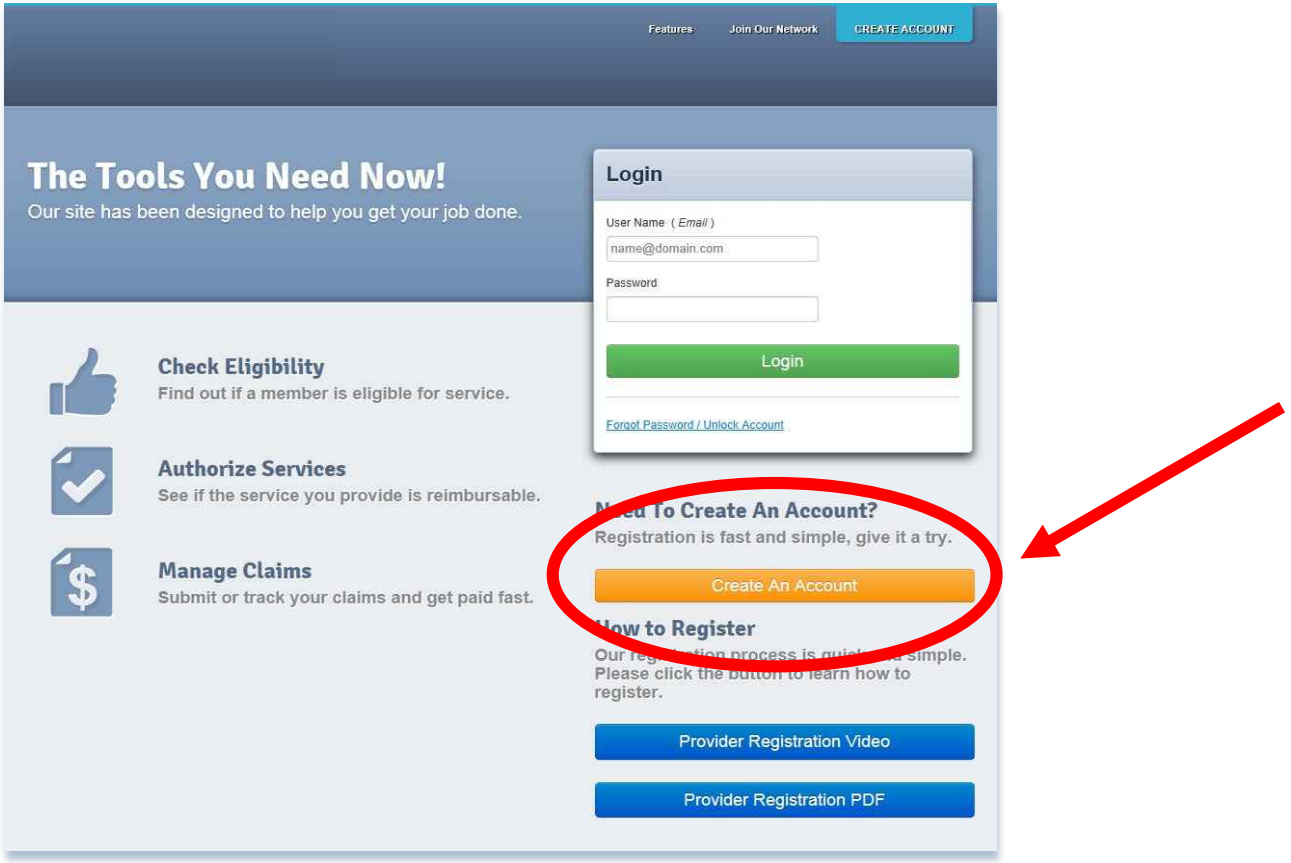
Secure Provider Portal

- Arkansas Health & Wellness is here to provide the tools and support you need to deliver the best quality of care. Our Secure Provider Portal offers an easy way for you to manage patient administrative tasks quickly
- Visit the portal at Provider.ARHealthWellness.com



Secure Provider Portal – Create An Account

- Registration is free and easy



Secure Provider Portal - Features

- Information contained on our Secure Provider Portal includes:
  - Member Eligibility
  - Patient Listings
  - Health Records & Care Gaps
  - Authorizations
  - Case Management Referrals
  - Claims Submissions & Status
  - Corrected Claims & Adjustments
  - Payments History
  - PCP Reports
- A login is required to access the secure portal
- If you have not logged in for more than 90 days, your account will automatically lock and require you to contact us for a password reset

Secure Portal - PCP Reports

- PCP Reports:
  - PCP reports available on Ambetter's secure provider web portal are generated on a monthly basis and can be exported into a PDF or Excel format
- PCP Reports Include:
  - Patient List with Care Gaps
  - Emergency Room Utilization
  - Rx Claims Report
  - Members flagged for Disease and Case Management

Ambetter Provider Incentives

- CPC+ and PCMH providers earn:
  - Per Member Per Month care management fee
  - $100 bonus for each Annual Wellness Visit performed

- All Ambetter providers are part of the HEDIS gap closure program:
  - 13 gaps are paid to the attributing PCP and range from $30 to $100 per measure
  - Minimum rates set at ½ of 3 star performance
  - Achievement of first threshold pays 75% of max
  - Achievement of second threshold pays remainder up to 100%
  - Paid quarterly 3x per year
  - Reports of gap closures are available on the secure provider portal

HEDIS

HEDIS measures final rates for all Ambetter reports. Please note that the anchor date for closing these gaps is December 31, 2018

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)		18.6%	1 Star
Low Back Pain (LBP)		61.3%	1 Star
Medication Management for People with Asthma (MMA)		41.6%	1 Star
Annual Monitoring for Patients on Persistent Medications (MPM)		85.9%	3 Star
Controlling Blood Pressure (CBP)		41.2%	1 Star
Comprehensive Diabetes Care (CDC)	Retinopathy Eye Exams	37.5%	2 Star
	A1C value less than 8.0	34.4%	1 Star
	A1C Testing Done	84.2%	1 Star
	Nephropathy Monitoring	87.3%	1 Star
Cervical Cancer Screening (CCS)		46.1%	1 Star
Breast Cancer Screening (BCS)		49.4%	1 Star
Colorectal Screening (COL)		40.1%	1 Star
Adult BMI Assessment (ABA)		84.6%	3 Star

Pre-Auth Needed?

- Payment of claims is dependent on:
  - Eligibility
  - Covered benefits
  - Provider contracts
  - Correct Coding and billing practices
- Prior authorizations should be obtained for all inpatient services and selected outpatient services, except for emergency stabilization services
  - Use the Pre-Auth Needed tool to determine if a specific outpatient service requires prior authorization

Ambetter Pre-Auth Check

All authorizations are done at the procedure code level. The Pre-Auth Needed tool is found on the public website and does not require a login to use.

Prior Authorization Submission

If a service requires authorization, submit via one of the following ways:

SECURE WEB PORTAL

Provider.ambetterofarkansas.com

This is the preferred and fastest method.

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned phone, fax, or web.

PHONE

1-877-617-0390

FAX

MEDICAL

1-866-884-9580

BEHAVIORAL HEALTH

1-866-279-1358

Services & Procedures Requiring Prior Authorization

THE FOLLOWING LIST IS NOT ALL-INCLUSIVE

Ancillary Services

- Air ambulance transport (non-emergent fixed wing airplane)
- Durable Medical Equipment (DME)
- Home health care services
- Hospice
- Furnished medical supplies
- Orthotics/prosthetics
- Genetic testing
- Quantitative urine drug screen

Procedures/Services

- Reconstructive Surgery
- Experimental or investigational
- High Tech Imaging administered by NIA (CT, MRI, PET):
  - Submit requests to RadMD.com
- Pain management
- Cardiac and respiratory therapy

Inpatient Authorization

- All inpatient admissions (within 1 business day of admission)
- Observation stays exceeding 48 hours
  - Notification is required within one (1) business day if admitted
- Transplants (not including evaluations)
- Urgent/emergent admissions
- Partial inpatient, PRTF, and/or intensive outpatient programs
- All elective/scheduled admission notifications requested at least five (5) days prior to the scheduled date of admit including but not limited to:
  - Medical admissions
  - Surgical admissions
  - Hospice care
  - Rehabilitation facilities

LOG INTO OUR SECURE WEB PORTAL

Provider.ambetterofarkansas.com

Other Prior Authorization Types

- Vision services need to be verified by Envolve Vision:
  - https://visionbenefits.envolvehealth.com/
- Dental services need to be verified by Envolve Dental:
  - https://dental.envolvehealth.com/
- Behavioral Health/Substance Abuse need to be verified by AHW
- Complex imaging, MRA, MRI, PET and CT Scans need to be verified by NIA:
  - https://www1.radmd.com/radmd-home.aspx

Prior Authorization Request Timeframes

Service Type	Timeframe
Elective/Scheduled Admissions	**Required 5 business days** prior to the scheduled admission date
Emergent inpatient admissions	Notification **required** within **1 business day**
Emergency room and post stabilization, urgent care, and crisis intervention	Notification **requested** within **1 business day**
Maternity admissions	Notification **requested** within **1 business day**
Newborn admissions	Notification **requested** within **1 business day**
NICU admissions	Notification **required** within **1 business day**
Outpatient dialysis	Notification **requested** within **1 business day**

Prior Authorization Request Turn-Around Timeframes

Type	Timeframe
Prospective/Urgent	Within one (1) business day of receipt of all information needed to complete the review. If all information is not received by the end of the 72 hours a determination will be made based on available information
Prospective/Non-Urgent	Within two (2) business days of receipt of all information needed to complete the review. If all information is not received by the 14th day of the request a determination will be made based on available information
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day) Extension: A onetime extension may be granted up to 3 days. If all information is not received by the end of the 24 hours a determination will be made based on available information
Retrospective	Thirty (30) calendar days

Prior Authorization

- Prior Authorization will be granted at the CPT code level:
  - If a claim is submitted that contains CPT codes that were not authorized, the claim will be denied:
    - ✓ If during the procedure additional procedures are performed, in order to avoid a claim denial, the provider must contact the health plan to update the authorization. It is recommended that this be done within 72 hours of the procedure; however, it must be done prior to claim submission or the claim will deny
  - Ambetter will update authorizations but will not retro authorize services:
    - ✓ The claim will deny for lack of authorization. If there are extenuating circumstances that led to the lack of authorization, the claim may submitted for a reconsideration or a claim dispute

Failure to Obtain Prior Authorization

- All inpatient stays require an authorization
- Failure to obtain an authorization may result in administrative claim denials
- Urgent/emergent require notification within one (1) business day following the admit date
- Providers cannot bill a member for services for which they fail to obtain prior authorization as required

Please note:

- Emergency services DO NOT require prior authorization.
- Failure to complete the required authorization or certification may result in a denied claim.

Allwell Updates

Medicare Advantage Plan Expansion for 2019

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WE ARE EXPANDING TO 16 ADDITIONAL COUNTIES

As an Allwell provider, you can now serve all Allwell members in Arkansas regardless of the county they live in.

Eligible residents in your county will be able to enroll with Allwell this year during the Annual Enrollment Period.

Currently Serving

Benton
Crawford
Garland
Pulaski
Saline
Sebastian
Washington

2019 Additions

Faulkner
Conway
Lonoke
Craighead
Boone
Pope
Hot Spring
Scott
Logan
Carroll
Clark
Greene
Franklin
Baxter
Madison
Marion

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1-855-565-9518 (TTY: 711)
Allwell.ARHealthWellness.com

Allwell Identification Cards

Allwell offers plans that utilize two distinct networks of providers, Allwell Medicare HMO and Allwell Medicare HMO ***Select***. When searching for a participating provider on the Find A Provider tool, please make sure you select the network that corresponds to the network listed on the members identification card.

Secure Portal

- Arkansas Health & Wellness is here to provide the tools and support you need to deliver the best quality of care. Our Secure Provider Portal offers an easy way for you to manage patient administrative tasks quickly
- Visit the portal at Provider.ARHealthWellness.com

Allwell Provider Incentives

- Allwell offers a Care Management fee for CPC+ providers on Track 1 and Track 2
  - **ALL** Allwell providers received $100 bonus for each Annual Wellness Visit performed
  - Allwell also offers a Pay Per Measure program for Quality improvement with 10 HEDIS measures

Allwell Provider Incentives

Sub Measure	Measure Incentive	Score	Compliant	Qualified	Target 1	Target 2	Target Achieved	Max Target Gap	Bonus Amount
ANNUAL MONITOR RX 18 - COMBINED RATE	$100.00	80.00%	4	5	84.00%	87.00%	--	1	$0.00
AVOID ABX BRONCH 18 - AVOID ABX BRONCH 18	$80.00	66.67%	2	3	26.00%	33.00%	Target 2	0	$160.00
BRST CNCR N MCARE 18 - BRST CNCR N MCARE 18	$40.00	60.00%	3	5	70.00%	74.00%	--	1	$0.00
CERVICAL CANCER 18 - CERVICAL CANCER 18	$40.00	31.82%	21	66	56.00%	65.00%	--	22	$0.00
COLORECTAL CANCER 18 - COLORECTAL CANCER SCREENING	$40.00	20.00%	4	20	52.00%	60.00%	--	8	$0.00
COMP DIABETES 18 - A1C TEST	$30.00	57.14%	4	7	92.00%	94.00%	--	3	$0.00
COMP DIABETES 18 - NEPH ATTN	$30.00	100.00%	7	7	91.00%	93.00%	Target 2	0	$210.00
MED MGMT ASTHMA 18 - TOTAL 5 TO 64 75% COVERED	$85.00	0.00%	0	0	53.00%	58.00%	--	0	$0.00
QRS PDC - PDC ACE/ARB	$40.00	0.00%	0	0	75.00%	79.00%	--	0	$0.00
QRS PDC - PDC ORAL DIABETES RX	$30.00	0.00%	0	0	69.00%	74.00%	--	0	$0.00
QRS PDC - PDC STATINS	$40.00	0.00%	0	0	69.00%	74.00%	--	0	$0.00
USE IMG LOW BACK 18 - IMAGING FOR LOW BACK PAIN	$80.00	100.00%	3	3	74.00%	79.00%	Target 2	0	$240.00

Medication Reconciliation

- Medication Reconciliation Post Discharge (MRP):
  - MRP is a new CMS Stars measure which will affect the health plan's overall star rating:
    - ✓ MRP measure shows the percentage of Medicare members 18 years of age and older who are discharged from an acute or non-acute inpatient facility for whom medications were reconciled within 30 days of discharge
  - Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking:
    - ✓ It includes drug name, dosage, frequency, and route
    - ✓ It compares that list against the discharge orders, with the goal of providing correct medications to the patient
    - ✓ It helps to assure the quality of care coordination as well as member safety in their transition home
  - MRP measure is met by the following:
    - ✓ Completing and documenting a medication reconciliation which includes a medication list
    - ✓ This must be in the member's medical record within 30 days of discharge
    - ✓ Generally done at the time of an office visit after discharge from the hospital

Medication Reconciliation

- CPT Codes that satisfy the MRP Measure:
  - 1111F – CPT II code to submit at the time of visit if not submitting a Transitional Care Management Services CPT code
  - 99495 – Transitional Care Management Services, Moderate Complexity
  - 99496 – Transitional Care Management Services, High Complexity
- Examples of proper documentation:
  - “Reconciled current and discharge medications”
  - “No medications were ordered upon discharge”
  - Allwell staff will be outreaching to provider offices to request the following from members’ medical records:
    - ✓ A record of an office visit with a list of current medications prior to hospital stay OR
    - ✓ A record of an office visit with the completed medication reconciliation after discharge from the hospital (if completed within 30 days of hospital discharge)

Prior Authorization Submission

Pre-Auth Needed Tool

Use the Pre Auth-Needed Tool on the website to quickly determine if a service or procedure requires prior authorization.

Submit Prior Authorization

If a service requires authorization, submit via one of the following ways:

SECURE WEB PORTAL
Provider.ARHealthWellness.com

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned phone, fax, or web.

PHONE
1-855-565-9518

FAX
MEDICAL
1-833-526-7172

BEHAVIORAL HEALTH
1-855-565-9518

Pre-Auth Needed?

- Payment of claims is dependent on:
  - Eligibility
  - Covered benefits
  - Provider contracts
  - Correct Coding and billing practices
- Use the Pre-Auth Needed tool to determine if a prior authorization is needed

Allwell Pre-Auth Check

Are services being performed in the Emergency Department or Urgent Care Center, or are the services for dialysis or hospice?

☐ Yes ☑ No

Types of Services	YES	NO
IS THE MEMBER BEING ADMITTED TO AN INPATIENT FACILITY?	○	◉
ARE SERVICES OTHER THAN LAB, RADIOLOGY, DOMICILLIARY VISITS OR DME BEING RENDERED IN THE HOME?	○	◉
ARE ANESTHESIA SERVICES BEING RENDERED FOR PAIN MANAGEMENT, DENTAL SURGERY, OR SERVICES IN THE OFFICE RENDERD BY A NON-PARTICIPATING PROVIDER?	○	◉
IS THE MEMBER RECEIVING GENDER REASSIGMENT SERVICES?	○	◉

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

97810 Check

N
No

97810 - ACUPUNCT 1/> NDLES W/O E-STIM; INIT 15 MIN 1-1

This is not a Medicare Covered procedure or service.

Other Prior Authorization Types

- Complex imaging, MRA, MRI, PET and CT scans need to be verified by NIA:
  - https://www1.radmd.com/radmd-home.aspx
- Non-participating providers must submit Prior Authorization for all services

Procedures Requiring Prior Authorization

THE FOLLOWING LIST IS NOT ALL-INCLUSIVE

Please visit Allwell.ARHealthWellness.com
and use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.

Inpatient Admissions

All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admissions including but not limited to:

- Inpatient admission (elective or scheduled)
- Acute Rehabilitation
- Behavioral Health/Substance Abuse
- Long Term Acute Care (LTAC)
- Skilled Nursing Facility (SNF)

Outpatient Procedures/Services/Equipment

- Ambulance: Non emergent
- Behavioral health and substance abuse services
- Clinical trials: Notification
- Cosmetic procedures
- Drug testing for quantitative tests for drugs of abuse
- Durable medical equipment (DME)
- Experimental/investigational services and new technologies
- Gender reassignment services
- Genetic counseling/testing
- Home health services
- Infertility
- Maternity: Notification
- Observation stays greater than 48 hours
- Orthotics/prosthetics
- Outpatient Physical, Occupational and Speech Therapy services
- Pain management
- Radiation therapy
- Select Medicare Part B drugs
- Select radiology services
- Select surgeries
- Sleep studies
- Transplants
- Wound care

All out-of-network (non-par) services and providers require prior authorization, excluding emergency care, out-of-area urgent care, or out-of-area dialysis.

TO REQUEST AN AUTHORIZATION, LOG INTO OUR SECURE WEB PORTAL
Provider.ARHealthWellness.com

Failure to Obtain Prior Authorization

- Failure to obtain an authorization may result in administrative claim denials
- Providers cannot bill a member for services for which they fail to obtain a timely authorization
- Emergent and post-stabilization services do not require prior authorization
- Urgent/emergent require notification within one (1) business day following the admit date

Please note:

- All out-of-network services require prior authorization except emergency care, out-of-area urgent care, and out-of-area dialysis.
- Failure to complete the required authorization or certification may result in a denied claim.

Reminders

- All inpatient stays require an authorization
- Allwell does not require a referral for specialist visits
- PCP visits do not require a co-pay
- Out of Network benefits are not available for Allwell members

Arkansas Total Care Updates

Arkansas Total Care – Overview

- Arkansas Medicaid created a new model of organized care called a Provider-led Arkansas Shared Savings Entity (PASSE):
  - This model forms a more organized system that will improve the health of Arkansans who need more intensive levels of specialized care
- PASSE will serve Medicaid beneficiaries who have behavioral health (BH) and/or intellectual and developmental disabilities (IDD) service needs
- ARTC has been certified by the Arkansas Insurance Department and will provide care coordination and management for individuals who have complex medical and social needs
- For more information contact us at 1-800-294-3557 (TDD/TTY:711)
- Visit the website at www.ArkansasTotalCare.com

Arkansas Total Care – Phase 1 and Phase II

- Phase One was launched February 2018:
  - The entities are responsible for care coordination services for those BH and IDD individuals who have been independently assessed to need Tier II or Tier III services
  - During this phase, Medicaid remains fee-for-service, and PASSE will only provide care coordination services
- Phase Two will launch January 2019:
  - During this phase entities are required to assume full risk of the Medicaid programs that are administered for this group of individuals
  - PASSE will be responsible for total healthcare management of Tier II and Tier III individuals who need BH or IDD services
    - Those who meet the Tier I level of care will be allowed to voluntarily enroll in a PASSE during Phase Two

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Important Reminders

Opioid Policy

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- Policy Title: Opioid Analgesics
- Policy Number: HIM.PA.139
- Effective Date: 1/1/2018

- Opioid analgesics are indicated for the management and treatment of moderate to severe pain.
- Reference:
  - Opioid Analgesics HIM.PA.139

Opioid Policy – New Prescribing Limits

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New Ambetter Opioid Prescribing Limits:

Effective 09/17/2018

Maximum 7 days' supply at one time	Maximum two 7 days' supply fills in any 28 day period	Maximum 28 days' supply in any 90 day period

Prior authorization will be required to prescribe opioids outside of those limitations

Impacted members:

Current members who have not previously had a claim for an opioid.

Exempt conditions:

Active cancer treatment, palliative care, end-of-life / hospice care

Opioid Policy FAQs

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Q1. Why are we adding this limit?

Answer: Opioid epidemic has claimed countless lives during last three years. Many states are starting to limit provider's ability to prescribe long term opioid medications. To help our providers better manage opioid overutilization we are instituting this edit. Our members who have legitimate medical need for long term opioid use will be able to obtain a Prior Authorization

Q2. Who is affected by this limit?

Answer: Current and future members that previously have not had an opioid claim

Opioid Policy FAQs

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Q3. Who will be exempt from this limit?

Answer: Current and future members who have a condition that can only be managed by long term opioid use. Such conditions include, but are not limited to cancer and sickle cell

Q4. Are there any other limits imposed?

Answer: Yes, the edit will also check for daily morphine equivalent. If the morphine daily equivalent is greater than 120 the edit will reject the claim and present the dispensing pharmacist option to override.

Opioid Policy FAQs

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Q5. How can dispensing pharmacist override the morphine equivalent rejection?

Answer: Dispensing pharmacist can use standard point of service (POS) rejection override codes PPS Professional Service Codes (M0, P0, PM, R0) and result of Service Codes (1B, 1C, 1D, 1F, 1G and 2A)

Q6. Can the dispensing pharmacist override maximum day limits?

Answer: No, maximum day limits require submission of prior authorization

Opioid Policy FAQs

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Q7. Please explain the maximum day limit

Answer: Member will be able to get up to a maximum 7 day supply of opioid medications for initial fill. Second fill will be limited to an additional 7 day supply. Member will be able to obtain up to 2 fills in any 28 day period and up to 28 day supply in any 90 day period.

Example: If member fills a 7 day supply on July 1st, member would be able to get another 7 day fill on the 8th. Member then would have to wait 2 weeks to obtain an additional 7 day fill or would require a PA override

Q8. How can member / provider obtain an override?

Answer: Overrides can be provided by submitting a PA request to the PA team

Fax: 866-399-0929 or Phone: 866-399-0928

Upcoming Webinars

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Course Title	Date	Time
2018 Fourth Quarter Provider Updates	12/13/2018	10:00 am CST
2018 Fourth Quarter Provider Updates	12/13/2018	3:00 pm CST
Allwell Updates	1/10/19	TBA
Arkansas Total Care	3/7/19	TBA

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Thank you for joining!