Arkansas Health & Wellness Provider Newsletter
Fall 2021

Allwell Adding Penny Charge for Codes

Ensuring accurate documentation is essential to helping our members achieve their health goals, and using CPT® II and HCPCS codes helps us do that by identifying gaps in patient care. When you verify that you have closed gaps in a patient's care, you are affirming your commitment to helping Arkansas live better.

Arkansas Health & Wellness is committed to helping our members reach their best health. That's why, on June 1, 2021, we implemented a new payment policy in an effort to help close quality gaps in care for our Allwell members. The new policy incorporates a penny charge for CPT II and HCPCS codes that allows them to be billed without the hassle of receiving a claim denial due to a non-payable code.

Our hope is that this penny charge will benefit both you and our members by ensuring better reporting of the care needs of our members, resulting in fewer dropped codes by billing companies. This change also will increase the incentives available to you through our Continuity of Care (CoC) program as additional codes are submitted. The penny charge will result in a more hassle-free and accurate collection of HEDIS® data year-round, meaning that you can expect fewer chart requests during those collection seasons.

The penny charge affects CPT II and HCPCS codes for the following measures:

- Blood pressure control
- Comprehensive diabetes care
- Care of older adults, including advanced care planning, pain assessment, medication review and more
- Post-discharge medication reconciliation

It's important to note that, when submitting CPT II codes for diabetic retinal eye exams, you may be entitled to a $10 bonus payment per member per year. You must bill $10 in the claim filing in order to receive reimbursement.

In this Issue:

arkansas health & wellness

HEDIS® Measures: Well Woman Visits

Several HEDIS measures assess the efficacy of preventive women's health screenings and can help identify performance gaps that providers can close to improve patient outcomes. These are breast cancer screenings (BCS), cervical cancer screenings (CCS), and chlamydia screenings (CHL). Refer to the chart below for measurement criteria, CPT codes and exclusions.

Screening Type	Measure Requirements	CPT Codes	Exclusions	Notes
Breast Cancer Screenings (BCS)	This measure evaluates women 50–74 years of age as of December 31 who had a mammogram to screen for breast cancer between October 31 two years prior to the measurement year and December 31 of the measurement year.	**CPT Codes:** 77055, 77056, 77057, 77061, 77062, 77063, 77065, 77066, 77067**HCPCS Codes:** G0202, G0204, G0206	**CPT Codes:** 19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307 **ICD-10-CM Codes:** Z90.11, Z90.13 **ICD-10-PCS Codes:** 0HTT0ZZ, 0HTU0ZZ, 0HTV0ZZ	The BCS measure assesses the use of imaging to detect early breast cancer in women. · All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) meet this measure. · MRIs, ultrasounds or biopsies do not count.
Cervical Cancer Screenings (CCS)	This measure evaluates women who were screened for cervical cancer using any of the following criteria: · Women ages 21–64 who had cervical cytology performed within the last three years · Women ages 30–64 who had cervical high-risk human papilloma virus (hrHPV) testing within the last five years · Women ages 30–64 who had cervical cytology/ hrHPV cotesting within the last five years	**Cervical Cytology Ages 21-64** **CPT Codes:** 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175 **HCPCS Codes:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091 **HPV Codes Ages 30-64** **CPT Codes:** 87620, 87621, 87622, 87624, 87625 **HCPCS Codes:** G0476	**CPT Codes:** 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135 **ICD-10-CM Codes:** Q51.5, Z90.710, Z90.712 **ICD-10-PCS Codes:** 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ	Documentation must include a note indicating the date the test was performed and the result or finding. **Excludes:** Women who had a prior hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year. Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

arkansas health & wellness

HEDIS® Measures: Well Woman Visits Continued

Screening Type	Measure Requirements	CPT Codes	Exclusions	Notes
Chlamydia Screening (CHL)	This measure evaluates women ages 16–24 who are sexually active* and had at least one test for chlamydia during the measurement year. Chlamydia tests can be completed using any method, including a urine test. Documentation must include a note indicating the date the test was performed and the result or finding.	**CPT Codes:** 87110, 87270, 87320, 87490, 87491, 87492, 87810		*Sexually active is defined as a woman who has had a pregnancy test, testing or diagnosis of any sexually transmitted disease, is pregnant, or has been prescribed birth control.

*It's important to be mindful of the frequency that screenings are needed, in addition to which tests and screenings fulfill specific HEDIS requirements.

Earn Incentives for Performing Retinal Eye Screenings

We're committed to helping members with diabetes lead healthier lives. Preventive health and screenings are vital to positive health outcomes, and we appreciate your efforts to facilitate annual diabetic retinal eye exams. These exams are recommended to reduce the risk of diabetes-related blindness. These exams don't require prior authorization, but be mindful and follow our clinical policies regarding medical necessity. Please reference plan specifics and applicable billing guidelines when selecting the most appropriate CPT® code for services rendered. Using the codes below where appropriate may help reduce the need for medical record review.

CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114, 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245

CPT II:* 2022F-2026F, 2033F, 3072F HCPCS: S0620, S0621
Diagnosis Code (diabetes without complications): E10.9, E11.9, E13.9

*Note: When submitting CPT II codes, you may be entitled to a $10 bonus payment per member per year. Providers must bill $10 in the claim filing to receive reimbursement.

arkansas health & wellness

Cold & Flu Season

The arrival of autumn marks the beginning of cold and flu season. According to the Centers for Disease Control and Prevention (CDC), persons 6 months of age and older and who do not have life-threatening allergies to the flu vaccine or any of its ingredients are encouraged to get the vaccine.[1] The cost of an annual flu shot is covered in member benefits, and in some cases, members may earn reward points for getting the shot. In addition to getting the flu vaccine, many of the precautions encouraged by the CDC regarding COVID-19, such as frequent hand washing, social distancing and wearing masks indoors, will also slow the spread of the common cold and flu. If you or your staff would like member education materials regarding the vaccine, the CDC hosts a page on flu vaccine safety information that you, your patients and staff can access.

[1] https://www.cdc.gov/flu/prevent/vaccinations.htm

Upcoming Provider Webinars

Our provider webinars present an opportunity for providers and staff to connect with us on a variety of topics. While our provider relations team is available to troubleshoot issues and provide resources on an individual basis, webinars offer a lively environment to review important Arkansas Health & Wellness policies, online tools and quarterly updates. To register for any of our scheduled courses,* or for more information, visit our Provider Webinars page.

2021 Quarter 4 Webinars

All webinars are scheduled on Central Time

Arkansas Health & Wellness Quarter 4 Updates
Two sessions available
December 7, 2021 — 10 a.m.
December 14, 2021 — 2 p.m.

Cultural Competency Training
Two sessions available
November 18, 2021 — 10 a.m.
December 9, 2021 — 10 a.m.

Secure Provider Portal Training
Two sessions available
November 16, 2021 — 10 a.m.
December 20, 2021 — 10 a.m.

Office Manager Meeting
December 16, 2021 — 10 a.m.

*Course schedule may change. Always refer to our Provider Webinars page for the most up-to-date listings.

Appointment Availability Standards

Timeliness can be key in many health situations, and we recognize the importance of getting the right care at the right time. We maintain appointment access standards that serve as guidelines for all of our provider partners, and we audit adherence to these standards at least once per year. Audits are performed by Faneuil, and providers will be notified via mail if found non-compliant with these standards. For comprehensive information about what these standards entail, as well as details regarding phone call protocol, please refer to our Manuals, Forms and Resources page and navigate to the provider manual for the appropriate line of business.

arkansas health & wellness

Behavioral Health Upcoding: What You Need to Know

When coding and billing individual psychotherapy services (90837) and the associated range of codes, please ensure your staff are following proper documentation procedures. Follow applicable Centers for Medicare and Medicaid Services (CMS) guidelines for all therapy visits.

Timed codes should reflect the exact start/stop times of the direct patient contact rendered to the member. If billing psychotherapy codes with an evaluation and management (E&M) service (90833 (30 min), 90836 (45 min) or 90838 (60 min)) guide, the E&M visit time should **not** be included in the time billed for the therapy visit. Psychotherapy times are for direct patient contact with the patient and/or patient's family member. The patient must be present for all or some of the service.

When reporting, choose the code closest to the actual time. Do not report psychotherapy with a duration that is less than 16 minutes. The duration of a course of psychotherapy must be individualized for each patient. The psychotherapy code is chosen based on the **time spent providing psychotherapy** and is not inclusive of paperwork time without the member present.

- Code 90832 (or + 90833): 16–37 minutes,
- Code 90834 (or + 90836): 38–52 minutes, OR
- Code 90837 (or + 90838): 53 minutes or longer

A provider may be audited if the provider bills a higher percentage of psychotherapy services in comparison to their peers. If an audit does occur, please ensure documentation meets the criteria below.

- The member's name appears on each document in the clinical record.
- All entries in the clinical record are dated and include the responsible clinician's name, professional degree and relevant identification number, if applicable.
- The record is clear and legible.
- Exact start and stop times of the direct patient contact with the member present are included. This cannot include time for collaboration, documentation, case management, etc., and the appointment time will not suffice.
- The duration of the exact patient contact time spent with the member must match the CPT service definition.
- Progress notes describing patient strengths and limitations in achieving treatment plan goals and objectives, and reflecting treatment interventions that are consistent with those goals and objectives, are included. Progress notes must also include clinical interventions (not treatment modality), member response to the interventions provided and a plan for ongoing care.
- Treatment plan updates include the member's progress toward the goals/objectives, barriers to meeting the goals/objectives and any changes/additions to the goals/objectives/interventions. Goals/objectives listed are SMART.
- Each service is signed and dated by the rendering provider. The signature must include the rendering provider's credentials, and the date must be the date the note was written and signed.
- Documentation is completed and entered into the chart in a timely manner. Please refer to your state guidelines to determine the timeframe that is allowed. According to guidance from CMS, "Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead make use of the signature authentication process."
- Clinical documentation to support the necessity of the service rendered is included.

arkansas health & wellness

Behavioral Health Upcoding: What You Need to Know, Continued

If the original entry is incomplete, follow the guidelines for making a late entry, addendum or clarification. When making an addendum:

- Document the current date and time.
- Write "addendum" and state the reason for the addendum, referring back to the original entry.
- Identify any sources of information used to support the addendum.
- Complete the addendum as soon after the original note as possible.

According to CMS, "Be sure the EHR system has the capability to identify changes to an original entry, such as 'addendums, corrections, deletions, and patient amendments.' When making changes, the date, the time, the author making the change and the reason for the change should be included. Some systems automatically assign the date an entry was made. Others allow authorized users to change the entry date to the date of the visit or service. Some systems allow providers to make undated amendments without noting that an original entry was changed. If there is no date and time on the original entry or subsequent amendments, providers cannot determine the order of events, which can impact the quality of patient care provided.

If you have any questions or would like further guidance on outpatient behavioral health billing, please contact our provider relations department at 1-800-294-3557.

Ambetter Continuity of Care Incentive Program Now Working with Specialists

Earlier this year we launched our Ambetter 2021 Continuity of Care (CoC) Specialist Program, which runs from July 1 to December 31, 2021. This program rewards specialists for assessing all conditions identified on the CoC appointment agenda (valid/present or resolved/not present) and for returning the completed appointment agenda form and a claim using applicable ICD-10 codes that supports valid condition. Specialists that participate and fulfill all the requirements above will receive a $300 incentive. Providers are encouraged to complete appointment agendas on the Arkansas Health & Wellness provider portal. Participating specialists will receive detailed program information from their risk adjustment coordinator. Participating specialists will have access to a member roster that will detail which members need assessments and which conditions to assess.

In addition to submitting appointment agendas through the secure provider portal, agendas can be faxed to 813-464-8879 or emailed to centene@agenda.com.

If you have questions regarding this program or how to navigate to the CoC appointment agenda through the provider portal, please contact RiskAdjustment@ARHealthWellness.com.

Ambetter Notice of InterQual Changes

Beginning November 1, 2021, our InterQual criteria set will be upgraded to the InterQual 2021 criteria set. To view our clinical and payment policies, visit our policy page.

arkansas health & wellness

Screening for Depression

Depression among adolescents and adults can adversely affect their health and wellbeing. The National Committee for Quality Assurance (NCQA) has developed guidelines to navigate the screening and follow-up process. When screening for depression, two rates are reported for the HEDIS measurement. These are:

- Depression screening: Members with a documented result of a depression screening performed using an age-appropriate standardized instrument between January and December 1 of the measurement period
- Follow-up on positive screen: Members who received follow-up care up to 30 days after the date of the positive screening

The U.S. Preventative Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years of age and the general adult population, including pregnant and postpartum women.[1] The USPSTF also recommends that screenings be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.[2]

Follow-up on positive screenings occur on the same day or 30 days after the first positive screening. Follow-ups can be:

- An outpatient, telephone, e-visit or virtual check-in with a diagnosis of depression or other behavioral health condition;
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management
- A dispensed antidepressant medication; OR
- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (e.g., a negative screen) on the same day as a positive screen on a brief screening instrument. For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of a follow-up.

For relevant CPT codes, HCPCS codes, and codes to identify outpatient visits, depression screening, active diagnosis of depression, bipolar disorder, and exception codes, refer to our Provider Resources page and navigate to the appropriate "Coding Tip Sheets And Forms" section of the menu on the left side of the screen.

[1] U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." Annals of Internal Medicine 164:360–6.
[2] U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." Journal of the American Medical Association 315(4):380–7.

Risk Adjustment Data Validation

Ambetter from Arkansas Health & Wellness is conducting our annual risk adjustment chart review. CMS and the Department of Health and Human Services (HHS) use risk adjustment as the payment methodology for Medicare Advantage and commercial insurance members. These chart reviews help verify that the information we report includes all relevant diagnosis codes at the accurate levels of specificity.

This year, we've partnered with vendors to help with record retrieval, and we have entered into Business Associate Agreements (BAAs) and are covered under the Health Insurance Portability and Accountability Act (HIPAA). Any information our vendors collect will be treated with confidentiality.

For all records requested, please include information about dates of service from July 1, 2021, to November 30, 2021. We appreciate your cooperation with this process, and our vendors will work with you to ensure there is minimal disruption while they obtain documentation.

arkansas health & wellness

Oncology Solutions Program from Ambetter and New Century Health

Beginning February 1, 2022, Ambetter from Arkansas Health & Wellness is partnering with New Century Health (NCH), an oncology quality management company, to implement a new prior authorization program that will simplify the administrative process and support the delivery of quality patient care. All oncology-related infusions, oral chemotherapeutic drugs/supportive agents and radiation treatments will require a prior authorization from NCH before being administered in the provider's office, outpatient hospital, ambulatory setting or infusion center.

This partnership has many benefits, including increased collaboration with physician offices to foster a team approach, physician discussions with medical oncologists or radiation oncologists about treatment plans, and a robust web portal where you can get real-time approvals when selecting evidence-based NCH treatment plans. The portal will also allow you to determine which documentation is needed for medical necessity review, view all submitted requests for authorization in one place and check member eligibility.

We will still require prior authorization management for all chemotherapeutic drugs, symptom management drugs, and supporting agents for members with a cancer or hematology diagnosis code. Specialties included are:

- Medical oncology/hematology
- Pediatric medical oncology/hematology
  gyn-oncology
- Neurological oncology
- Surgical oncology
- Urology
- Pediatric urology (medications only)
- Radiation oncology, pediatric radiation oncology

Authorizations previously issued by Ambetter utilization management (UM) before February 1, 2022, will be effective until the authorization expiration date. Authorizations previously issued that expire on or after February 1, 2022, must be submitted to NCH to obtain a new valid authorization. Authorizations for a single drug regimen issued by Ambetter or Envolve Pharmacy Solutions before February 1, 2022, will remain valid until they expire.

We look forward to launching this program and hope that it will enhance your experience with your oncology service authorizations. Specialists that fall into this program will receive a letter via mail with more information and next steps on training. If you have questions or would like help, please contact NCH's network operations department at 1-888-999-7713, option 6.