2nd Quarter Provider Webinar

Housekeeping

- Please mute your phone.
- Please do not place this call on hold as all attendees will hear your hold music.
- Please hold all questions until the end of the presentation.
- This presentation will be posted to the Arkansas Health & Wellness website soon.

Disclaimer

- Arkansas Health & Wellness has produced this material as an informational reference for providers furnishing services in our contract network. Arkansas Health & 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 program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice.
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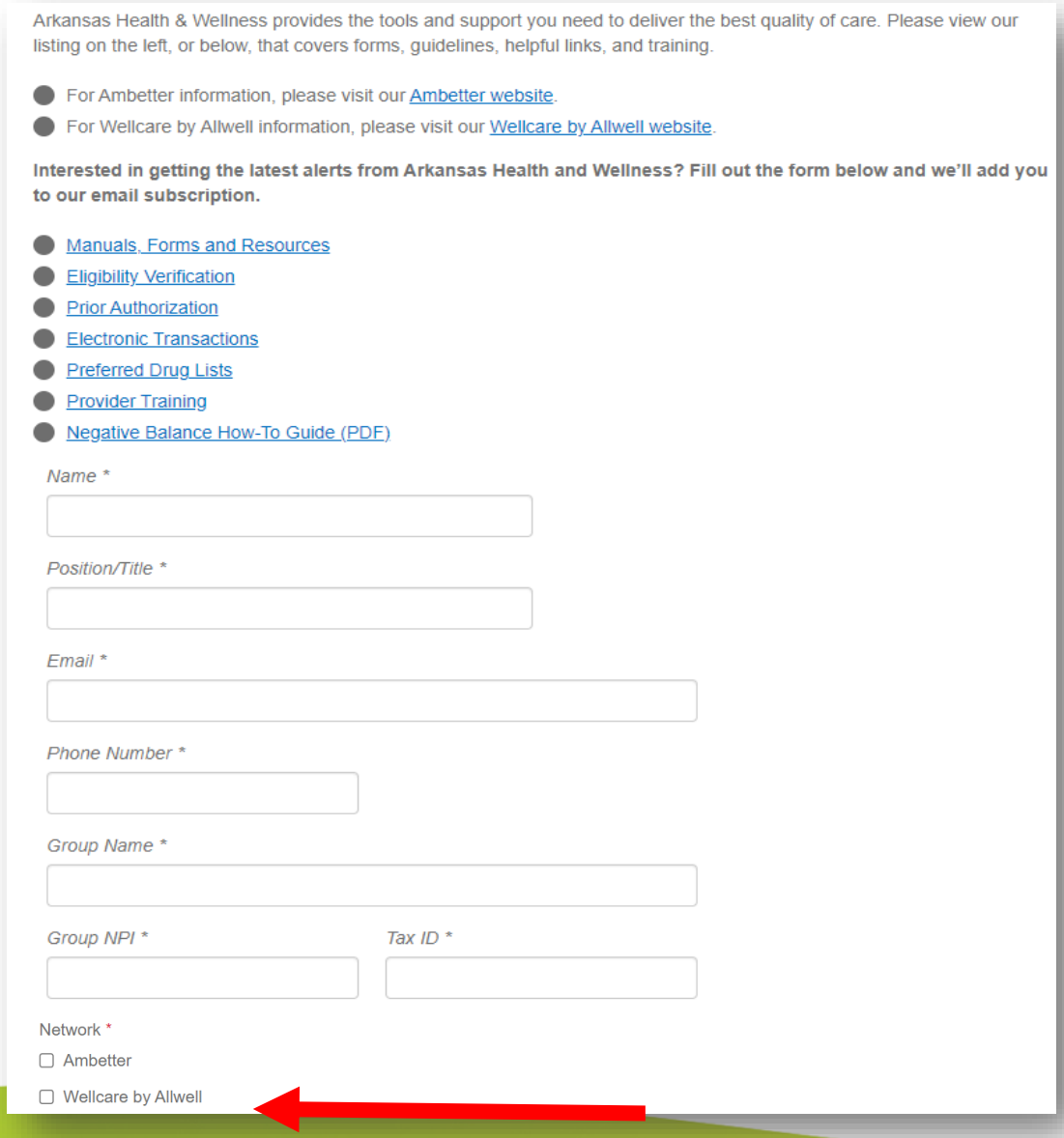
Agenda

- Provider Relations Territories
- How to Join Our Email List
- Appointment Availability and Wait Times
- Clinical and Payment Policy Updates
- Benefit Inquiry Request
- Notice of Pregnancy Report
- Vision Changes
- Prior Authorizations
- Provider-Led Trainings
- Risk Adjustment
- Quality
- Upcoming Webinars
- Contact Information



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Join Our Email List Today

- Receive current updates: ARHealthWellness.com/Providers/Resources
- Choose the network you wish to receive information on:
  Ambetter
  or
  Wellcare by Allwell

Appointment Availability and Wait Times

Appointment Availability and Wait Times

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Ambetter follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Ambetter monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table below depicts the appointment availability for members:

Appointment Type	Access Standard
PCPs – Routine visits	15 business days
PCPs – Adult Sick Visit	48 hours
PCPs – Pediatric Sick Visit	24 hours
Behavioral Health – Non-Threating Emergency	6 hours
Specialist Routine Visit	Within 30 business days
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	48 hours
After Hours Care	Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician.
Emergency Providers	24 hours a day, 7 days a week

Appointment Availability and Wait Times

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Wellcare by Allwell's Appointment Availability

The following standards are established regarding appointment availability:

Type of Care	Accessibility Standard*
PRIMARY CARE	
Emergency	Same day or within 24 hours of member's call
Urgent care	Within 2 days of request
Routine	Within 21 calendar days of request
SPECIALTY REFERRAL	
Emergency	Within 24 hours of referral
Urgent care	Within 3 days of referral
Routine	Within 45 days of referral
MATERNITY	
1st trimester	Within 14 days of request
2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request
High-risk pregnancies	Within 3 days of identification or immediately if an emergency exists
DENTAL	
Emergency	Within 24 hours of request
Urgent care	Within 3 days of request
Routine	Within 45 days of request

The in-office wait time is less than 45 minutes, except when the provider is unavailable due to an emergency.

Clinical & Payment Policy Updates

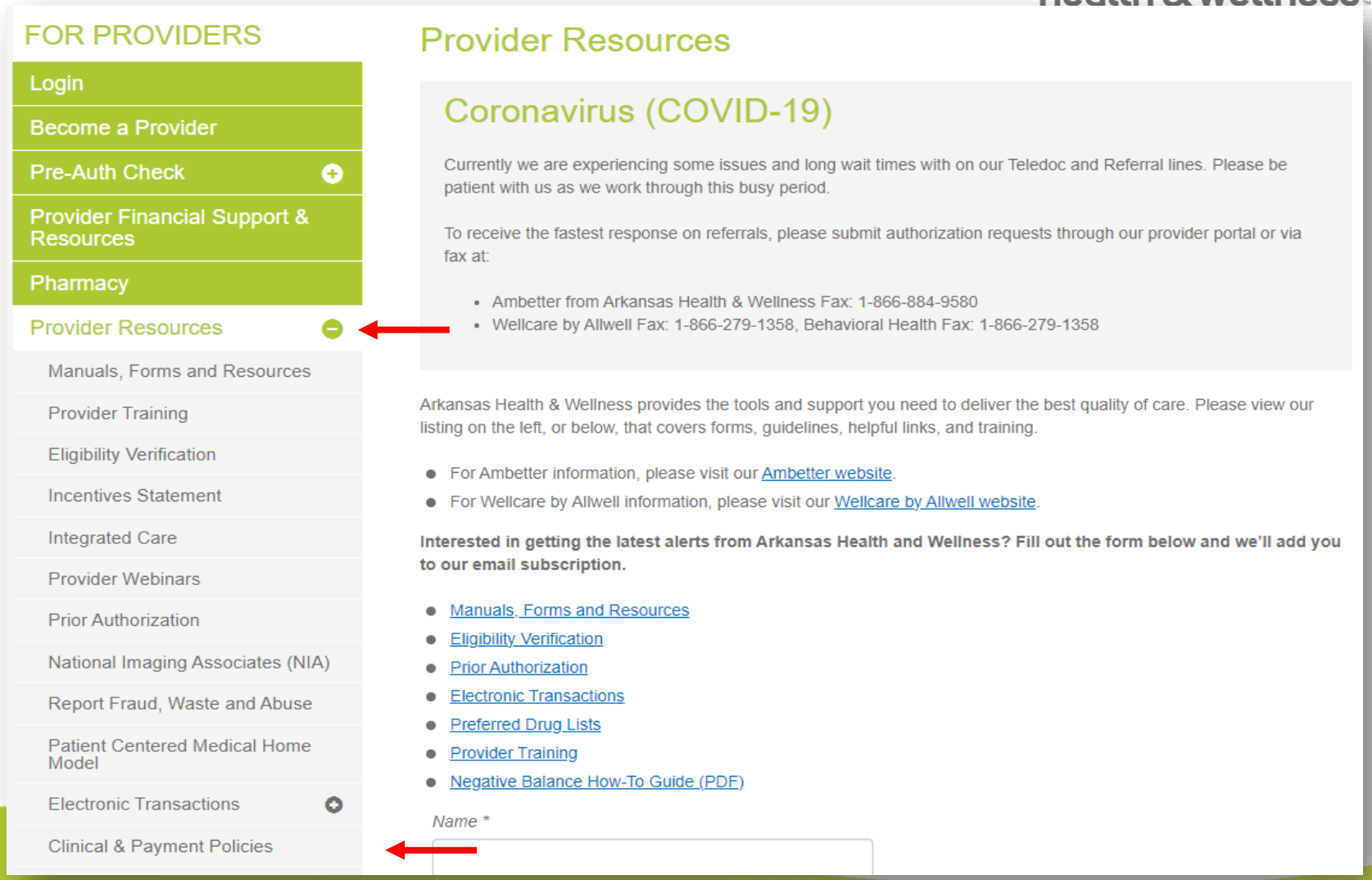
Clinical & Payment Policy Updates

- **Arkansas Health & Wellness is amending or implementing new policies that can be found on the public website.**

- The Clinical, Payment and Pharmacy policies can be found by going to:
  ARHealthWellness.com
  - Select the “For Providers” tab at the top of the screen
  - Select “Clinical & Payment Policies” from the drop-down menu
  - Select Ambetter or Allwell Clinical, Payment, or Pharmacy policies
  - Use the Ctrl+F (Command+F on Mac) function on your keyboard to search by keyword, policy number, or effective date.

If you have questions, please call 1-877-617-0390 (TTY: 1-877-617-0392) or email Providers@ARHealthWellness.com

Clinical & Payment Policy Updates



Benefit Inquiry Request

Benefit Inquiry Request

Per the Arkansas State Prior Authorization Transparency Act effective December 2023, Arkansas Health & Wellness is providing physicians and other healthcare providers the option to request a benefit inquiry.

What is a benefit inquiry? An inquiry by an Arkansas Licensed healthcare provider to a utilization review entity related to medical necessity, coverage or payment for prospective healthcare services, including prescription drugs, for an enrolled member of a healthcare plan of the applicable healthcare insurer for services or prescription drugs which are not subject to prior authorization requirements of the utilization review entity.

When to request a benefit inquiry? An in-network or out-of-network healthcare provider may submit a benefit inquiry to a healthcare insurer or utilization review entity for a healthcare service not yet provided to determine whether or not the healthcare service meets medical necessity and all other requirements for payment under a health benefit plan if the healthcare service were to be provided to a specific subscriber.

What is the difference between a prior authorization request and a benefit inquiry? A benefit inquiry is only applicable to services or prescription drugs which are not subject to prior authorization requirements. A prior authorization must be obtained by physicians and other health care providers from a health plan before a specific service is delivered to the patient to qualify for payment coverage.

Where can I find a benefit inquiry form? The request form can be found on the health plan's site located in provider resources under Medical Management.

What is the turnaround time for a benefit inquiry? A healthcare insurer shall respond to a benefit inquiry authorized within ten (10) business days of receipt of information required to make a decision.

How will I receive final determination? Responses to a benefit inquiry shall be provided in the same form and manner as responses to requests for prior authorization.

Benefit Inquiry Form

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Provider Resources

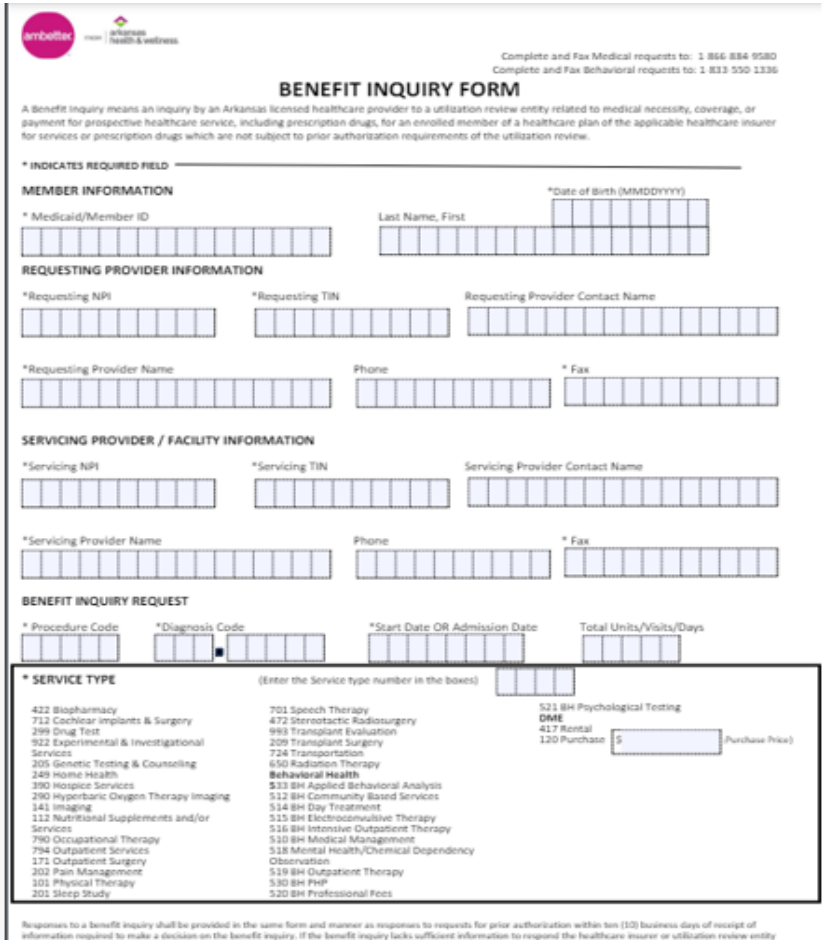
Ambetter Health provides the tools and support you need to deliver the best quality of care.

Reference Materials

- 2024 Provider and Billing Manual (PDF)
- 2023 Provider and Billing Manual (PDF)
- Quick Reference Guide (PDF)
- ICD-10 Information
- Payspan (PDF)
- Secure Portal (PDF)
- Provider Portal Initiative FAQ (PDF)
- Envolve Vision Plan Specifics (PDF)
- Ambetter Reimburses for Substance Use Services (PDF)
- Long-Acting Medications as First-Line Treatment in Schizophrenia (PDF)
- Provider Data Change Form (PDF)
- Non-Formulary And Step Therapy Exception Request Form (PDF)
- Opioid Resources for Prescribers
- Adult Immunization (PDF)
- METS (Members Empowered to Succeed) (PDF)
- METS Frequently Asked Questions (PDF)

Medical Management/Behavioral Health

- Pre-Auth Needed?
- Prior Authorization Guide (PDF)
- Inpatient Prior Authorization Fax Form (PDF)
- Outpatient Prior Authorization Fax Form (PDF)
- Grievance and Appeals
- Discharge Consultation Form (PDF)
- Turning Point Prior Authorization
- Benefit Inquiry Form (PDF)



Complete and Fax Medical requests to: 1 866 884 9580
Complete and Fax Behavioral requests to: 1 833 550 1336

BENEFIT INQUIRY FORM

A Benefit Inquiry means an inquiry by an Arkansas licensed healthcare provider to a utilization review entity related to medical necessity, coverage, or payment for prospective healthcare service, including prescription drugs, for an enrolled member of a healthcare plan of the applicable healthcare insurer for services or prescription drugs which are not subject to prior authorization requirements of the utilization review.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

* Medicaid/Member ID | Last Name, First | *Date of Birth (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI | *Requesting TIN | Requesting Provider Contact Name

*Requesting Provider Name | Phone | * Fax

SERVICING PROVIDER / FACILITY INFORMATION

*Servicing NPI | *Servicing TIN | Servicing Provider Contact Name

*Servicing Provider Name | Phone | * Fax

BENEFIT INQUIRY REQUEST

* Procedure Code | *Diagnosis Code | *Start Date OR Admission Date | Total Units/Visits/Days

*** SERVICE TYPE** (Enter the Service type number in the boxes)

422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Test
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
290 Hyperbaric Oxygen Therapy Imaging
141 Imaging
112 Nutritional Supplements and/or Services
790 Occupational Therapy
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
101 Physical Therapy
201 Sleep Study
701 Speech Therapy
472 Stereotactic Radiosurgery
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation
650 Radiation Therapy

Behavioral Health
533 BH Applied Behavioral Analysis
512 BH Community Based Services
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
510 BH Medical Management
518 Mental Health/Chemical Dependency Observation
519 BH Outpatient Therapy
530 BH PHP
520 BH Professional Fees
521 BH Psychological Testing

DME
417 Rental
120 Purchase $ (Purchase Price)

Responses to a benefit inquiry shall be provided in the same form and manner as responses to requests for prior authorization within ten (10) business days of receipt of information required to make a decision on the benefit inquiry. If the benefit inquiry lacks sufficient information to respond the healthcare insurer or utilization review entity

Notice of Pregnancy Report

Notice of Pregnancy Report

The Notice of Pregnancy (NOP) is an essential component of complete prenatal care for patients, helping to identify risk factors as early in pregnancy as possible, and establishing a relationship between the patient, provider, and health plan team. By collating NOPs completed by our care management team, claims and lab data, we can identify members who are pregnant or likely pregnant and could benefit from a prenatal visit. To support our providers, we have established a real-time NOP reporting process through our Provider Analytics Portal.

Benefits of using the new report for patients and providers:

- Patients who complete the NOP are three times more likely to be compliant with prenatal care and are less likely to have low-birth-weight babies.
- Helps providers and payers to meet the HEDIS® Prenatal Postpartum Care (PPC) timeliness measure, which tracks the percentage of deliveries where patients had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with their health plan.

The provider analytics NOP report provides the following information when available:

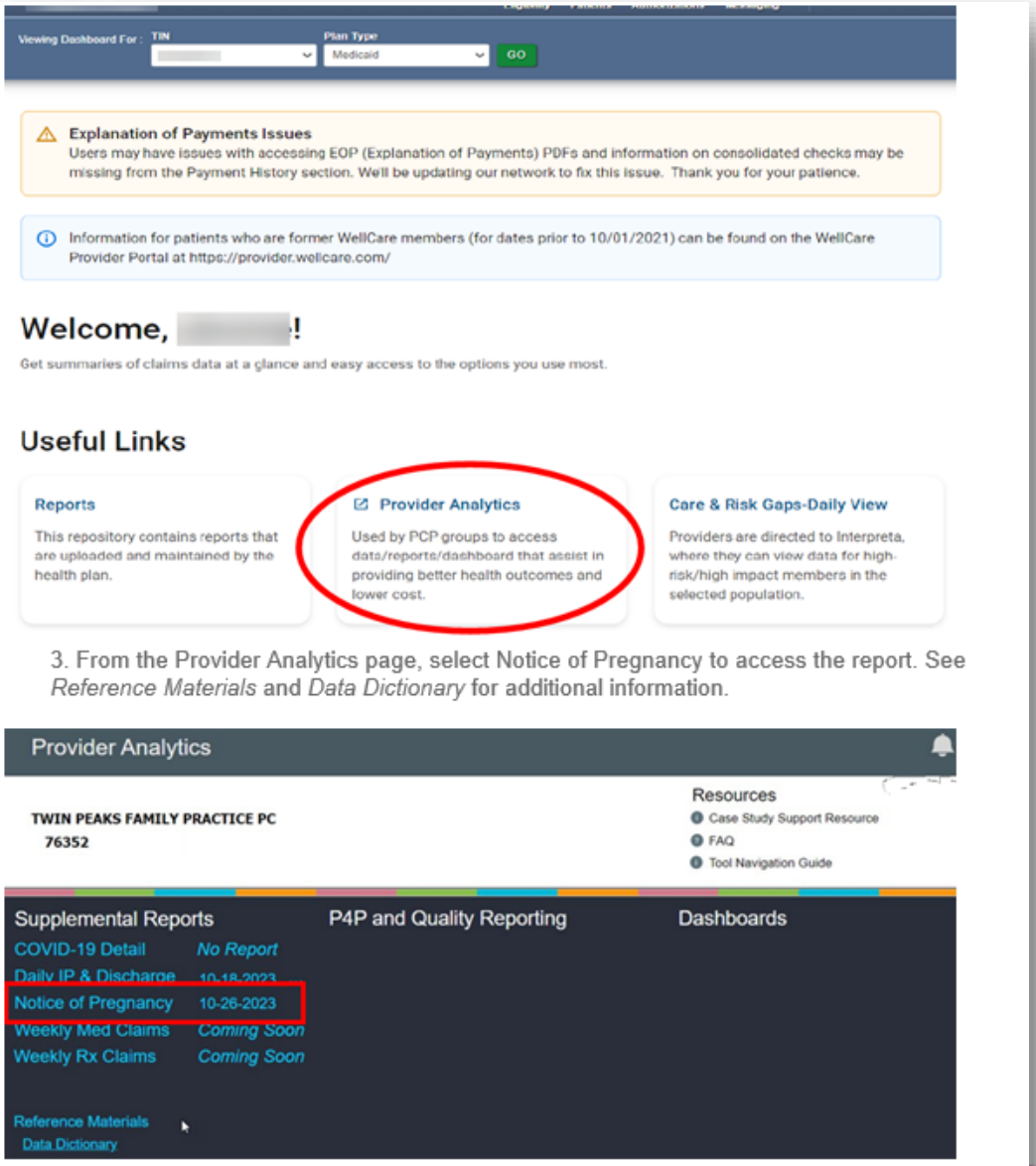
- Date the member was identified as pregnant
- Estimated date the member is due to give birth
- Member's name, date of birth, address, phone number, race, ethnicity, and primary language
- Member's Care Manager, the identified PCP, and OBGYN, including their contact information

This new report is updated daily within Provider Analytics, and your health plan partners can help address any questions you may have.

Key features:

- Immediate access from the secure Provider Portal home page
- Simple user interface
- Daily updates
- Last refresh date is shown
- Links to communications and education materials

Notice of Pregnancy Report



How to access the Provider Analytics NOP Report

1. Begin by logging in to our Secure Provider Portal
2. Click on “Provider Analytics”

Vision Changes

Ambetter Vision Changes

Effective January 1, 2024

Ambetter has assumed the management of medical eye care services.

Envolve Vision will continue to manage routine eye care services and full scope of licensure optometric services for our members. However, effective January 1, 2024, Ambetter is responsible for the following functions for medical eye care services:

- Contracting and credentialing
- Claim processing and appeals
- Provider services
- Provider partnership management
- Provider education and resource materials (e.g. provider manual, training)
- Provider web portal
- Prior authorization, retrospective utilization review, and medical necessity appeals
- Provider complaints

Wellcare by Allwell Vision Changes

Effective January 1, 2024

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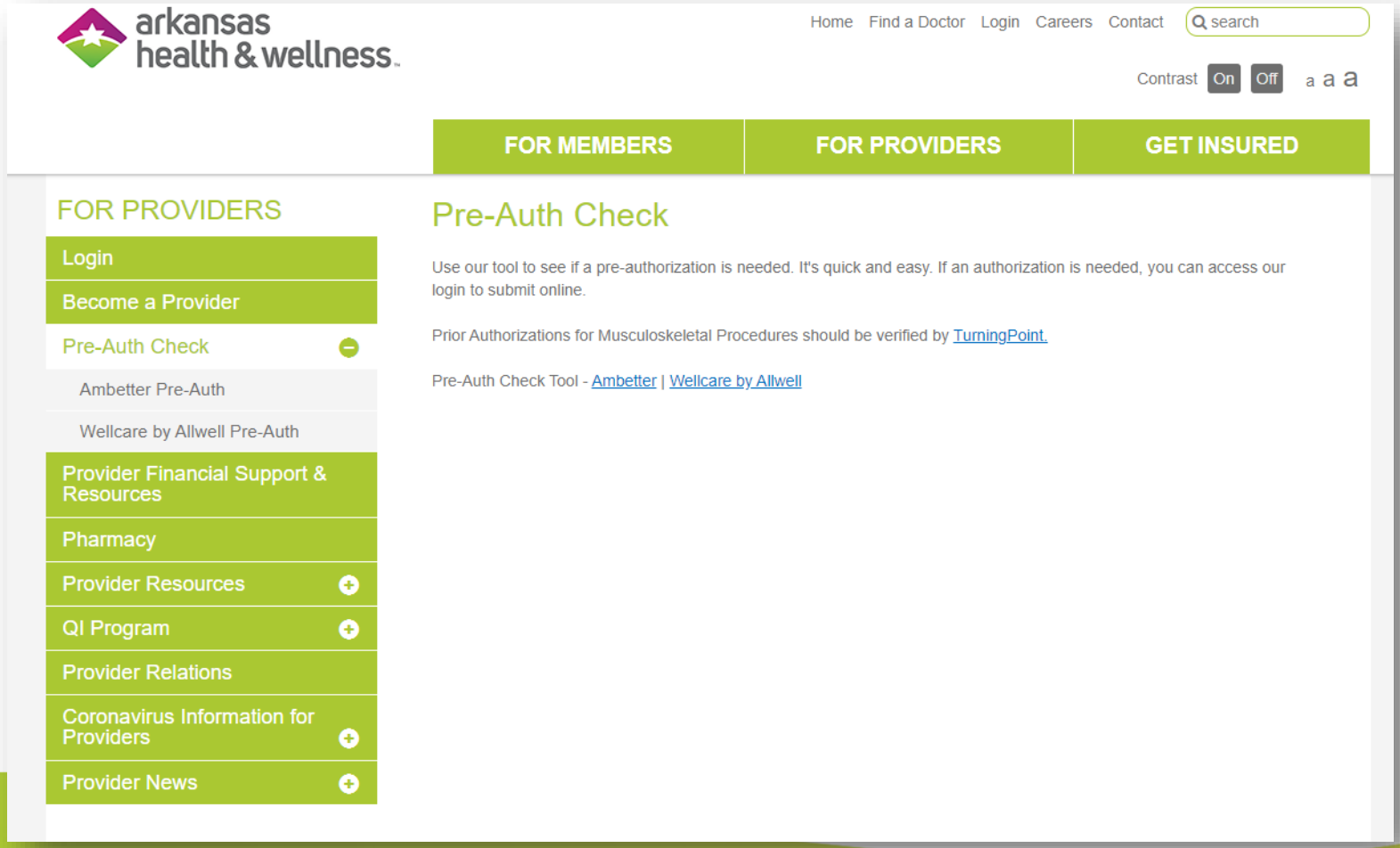
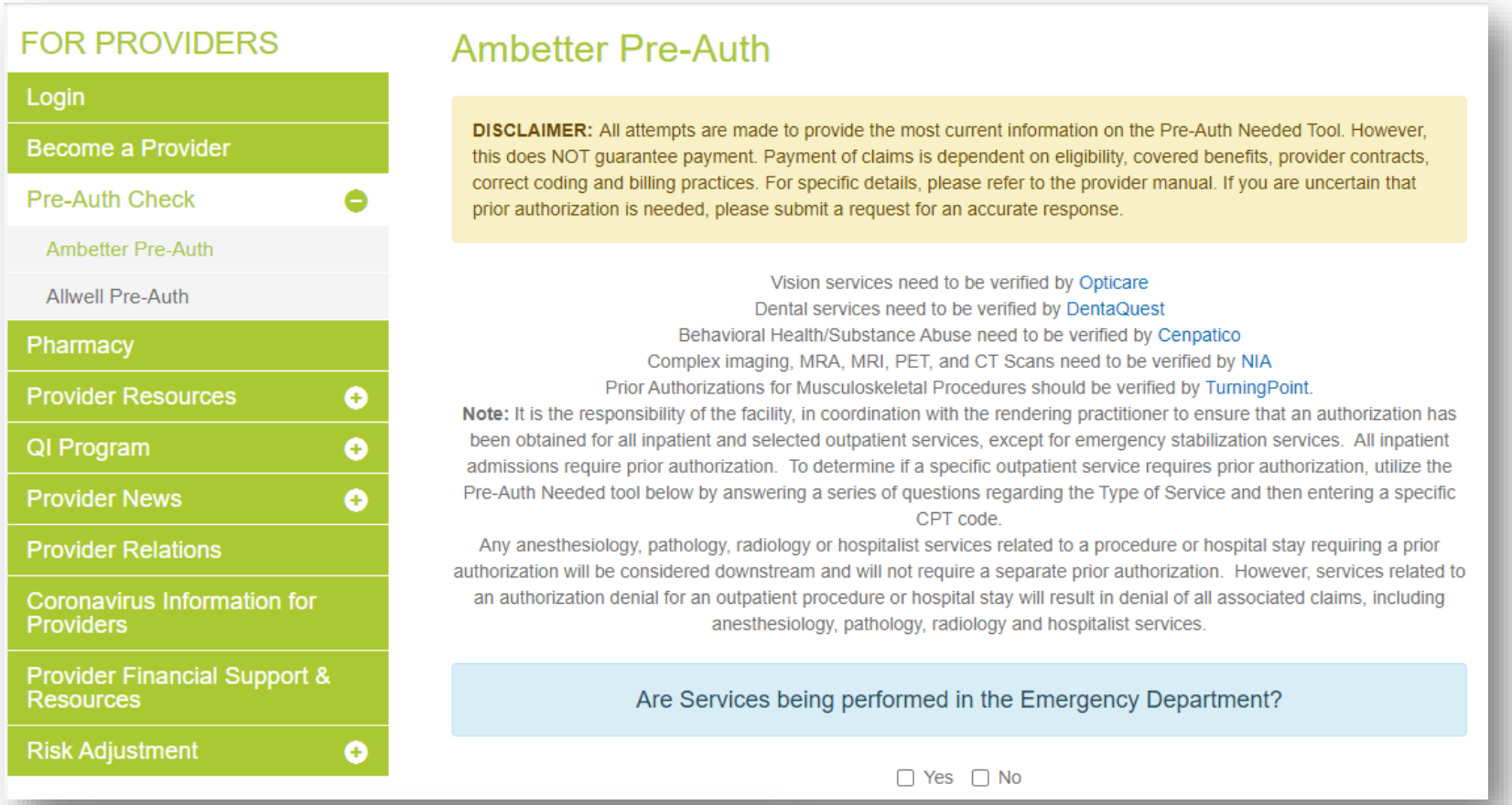
- Effective January 1, 2024, Wellcare by Allwell has assumed the management of medical eye care services.
- Premier Eye Care will manage routine eye care services and full scope of licensure optometric services for our members.
- Beginning January 1, 2024, Wellcare by Allwell is responsible for the following functions for medical eye care services:
  - Contracting and credentialing
  - Claim processing and appeals
  - Provider services
  - Provider partnership management
  - Provider education and resource materials (e.g. provider manual, training)
  - Provider web portal
  - Prior authorization, retrospective utilization review, and medical necessity appeals
  - Provider complaints

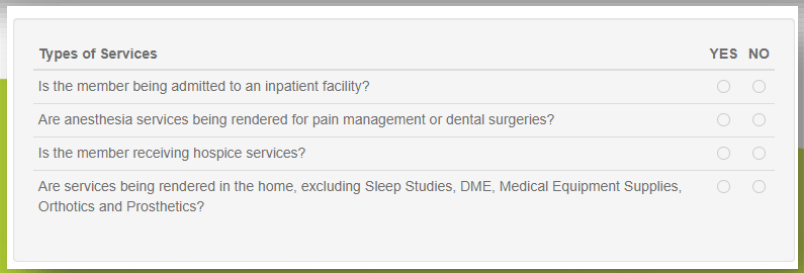
Prior Authorizations

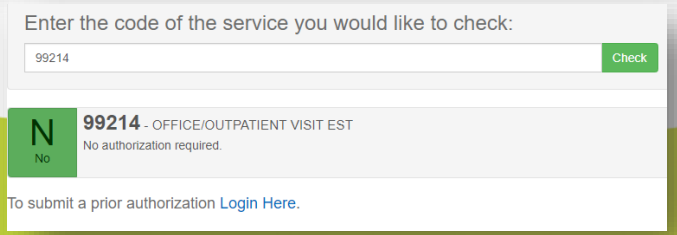
Pre-Auth Check Tool



Pre-Auth Check Tool







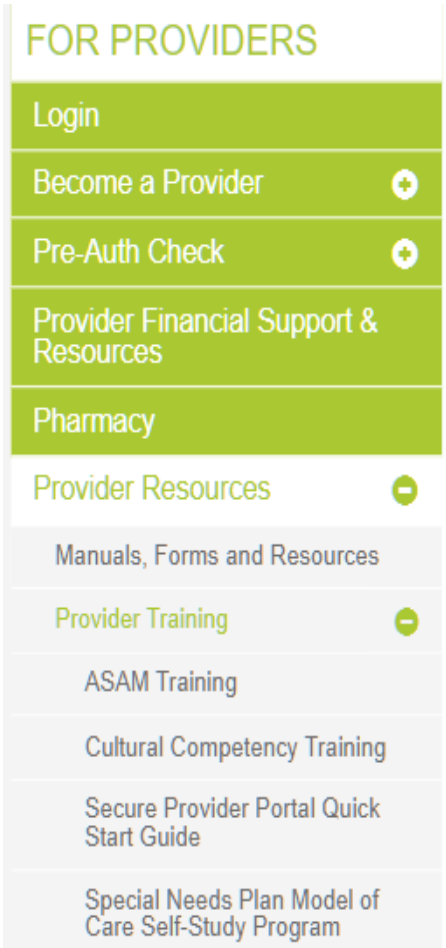
How to Secure Prior Authorization

- Prior Authorizations can be requested in the following ways:
  - **Secure Web Portal: This is the preferred and fastest method**
    - Ambetter and Wellcare by Allwell: Provider.ARHealthWellness.com
  - **Phone**
    - Ambetter: 1-877-617-0390
    - Wellcare by Allwell: 1-855-565-9518
  - **Fax — IP and OP paper forms available on the website under Provider Resources**
    - Ambetter: 1-866-884-9580
    - Wellcare by Allwell: 1-833-562-7172

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 via phone, fax or web.

Provider Self-Led Trainings

Provider Self-Led Trainings



Provider Training

Welcome to Arkansas Health & Wellness. We thank you for being part of our network of participating physicians, hospitals and other healthcare professionals.

Arkansas Health & Wellness provides several self-led provider trainings. This is an annual training that is offered to every provider and is available 24/7 on the Provider Training Page. After completion of the training, providers will then need to complete the Attestation Form.

- Cultural Competency Training
- Secure Provider Portal Quick Start Guide
- Special Needs Plan Model of Care Self-Study Program
- Allwell 2023 Annual Model of Care Provider Training Letter (PDF)

Provider Self-Led Trainings

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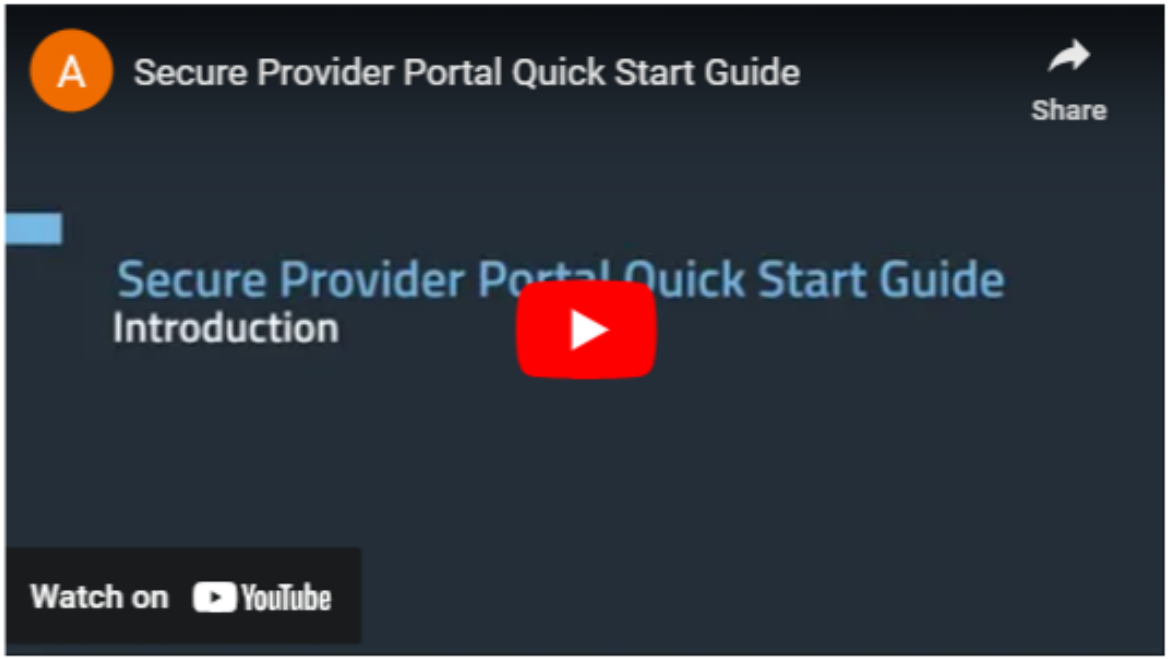
Secure Provider Portal Quick Start Guide

Arkansas Health & Wellness provides a Secure Provider Portal quick start guide that delivers a comprehensive overview of the Secure Provider Portal, including registration and account setup, member eligibility and patient listings, health records and care gaps, prior authorizations, claim submission and status, and corrected claims and adjustments. This training is offered to every provider and is available 24/7 on the Provider Training Page. After completion of the training, providers will then need to complete the Attestation Form.



Risk Adjustment and Providers

1/10/2025

Risk Adjustment Overview

- Risk Adjustment is the method developed and used by the Department of Health & Human Services (HHS) to predict health costs of members
- The purpose of risk adjustment is to deter plans from developing products that only attract the healthiest members — protect against adverse selection
- Center for Medicaid and Medicare Services uses the Hierarchical Condition Category (HCC) grouping logic as basis of risk adjustment

Hierarchical Condition Categories

- HCCs – Assigns risk factor score based upon chronic health conditions, demographics detail
  - ❖ Age
  - ❖ Gender
  - ❖ If member is community-based or institution-based
  - ❖ Interaction between disease categories within the hierarchy
  - ❖ Chronic conditions
- HCCs help predict healthcare costs for plan enrollees
- HCCs are based on encounter or claims data collected from providers
- Not all diagnoses map to an HCC

Risk Adjustment Requirements

- CMS & HHS **REQUIRE** health plans to report complete **and** accurate diagnostic information on enrollees **ANNUALLY**
  - ❖ Conditions not documented annually do not exist
- Opportunity for providers to provide comprehensive care with every face-to-face encounter
  - ❖ Document chronic conditions, co-existing conditions, active status conditions, and pertinent past conditions

Risk Adjustment Projects

- **Medical Record Review**
  - Contracted vendors: Datafied and Ciox (Datavant)
  - Project Dates:

    Medicare: Scheduled to Launch May 2024

    Ambetter: September 2023 – May 2024
- **Prospective Provider Programs**
  - Continuity of Care Program — Internal
  - In-Office Assessment Program – **Contracted Vendor Optum**

Continuity of Care (CoC)

- CoC is a proactive provider engagement program incentivizing providers incrementally for their work on addressing chronic conditions that are risk adjusted. The goal is to recognize and reward providers who collaborate with Arkansas Health & Wellness to deliver quality care and improve documentation of care for members.
- CoC is a claims-based program requiring:
  - Targeted member to have a DOS with provider within assigned TIN during the program year (January through December)
  - Claim identifying any active condition with ICD-10 code on the claim
  - Active condition supported in the medical record
  - Completed agenda with all identified conditions assessed indicating if condition is valid/active or resolved/no longer present
- Providers are assigned a Risk Adjustment Specialist who serves as a resource to educate, train, and provide reporting to ensure success.

For more information on ways to increase revenue for your clinic while also providing quality care via the CoC program please reach out to the Risk Adjustment team.

Risk Adjustment Best Practices

- **Take a Comprehensive Care Approach**
  - Address all chronic conditions each visit
  - Code to the highest specificity
- **Document Diagnosis**
  - Place applicable ICD-10 codes on claims to document conditions that exist
  - Support diagnosis with proper documentation in the medical record
- **Utilize Health Data Proactively**
  - Provider Analytic Tool
  - Appointment Agenda Data for CoC Program
  - In Office Assessment Forms
  - Bidirectional Feed Data (Epic Payor Platform, Healow, Athena, Moxe)

Quality Improvement

Partnership for Quality Program

Ambetter from Arkansas Health & Wellness Q2 Quality Update 2024

Annual Physical Exam

Annual Physical Exams include an appropriate history/exam with risk counseling and/or quality intervention.

Extent of exam depends on the age and gender of the patient. This service is covered once per calendar year.

A successful Annual Wellness Visit will:

Identify patients who need disease management or intervention.

Improve meaningful data exchanges between health plan and providers.

Improve quality of care provided and patient health outcomes.

The medical record ***must*** support all diagnoses and all services billed on the claim

- Address all conditions that require or affect patient care, treatment or management
- Thoroughly document the specific diagnoses and care plan
- Code to the highest specificity using ICD-10 Guidelines
- Consider including CPT II® codes to provide additional details
- Submit claim/encounter data for each service rendered
- Ensure all claim/encounter data is accurate and submitted in a timely manner

Coding & Documentation

Exam Type	Initial CPT®	Subsequent CPT
Age 0	99381	99391
Age 1-4	99382	99392
Age 5-11	99383	99393
Age 12-17	99384	99394
Age 18-39	99385	99395
Age 40-64	99386	99396
Age 60+	99387	99397

Seperate Evaluation and Management[1]

- Provider may perform separately identifiable services 99202 - 99215, 99381 - 99387, 99391 - 99397, on the same day.
- The components of both the AWV and the Routine Physical Exam must be met and documented.
- Report E/M and routine physical with modifier -25 when performed on the same date.
- If the provider's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.
- A separately identifiable E/M service may be reported if prompted by symptoms or chronic conditions assessed during the annual physical. Select the appropriate level of E/M services based on the following:
  1. The level of the medical decision making as defined for each service; or
  2. The total time for E/M services performed on the date of the encounter.

Annual Physical Exam

Additional Services Refer to the current CPT Coding Manual	
Included with Exam	**Covered Seperately**
Preventive Medicine Counseling, Individual	**Screenings** Vision
	Hearing
Smoking / Tobacco Cessation	Developmental
	Vaccines
	Toxoid Administration
Alcohol / Substance abuse Screening and Intervention	Risk/benefit counseling
	Ancillary Studies
	Laboratory
	Radiology
Other additional preventive services	Other procedures

ICD-10: Encounter for general medical exam
Report the documented reason for the encounter as the primary diagnosis code and assign additional diagnosis codes if applicable. Follow the current year's Official ICD-10-CM Guidelines for Coding and Reporting.
...infant exam 7 days and younger, Z00.110 Use when identifying health supervision for newborn under 8 days old.
...infant exam 8 to 28 days, Z00.111 Use when identifying health supervision for newborn 8 to 28 days old.
...child exam with normal findings, Z00.129 Use when conditions are stable or improving. Report additional codes for chronic conditions.
...child exam with abnormal findings, Z00.121 Use when any abnormality is found during the visit. Report additional codes for all existing conditions.
...adult exam with normal findings, Z00.00 Use when conditions are stable or improving. Report additional codes for chronic conditions.
...adult exam with abnormal findings, Z00.01 Use when any abnormality is found during the visit. Report additional codes for all existing conditions.

HEDIS® Measures			
Prevention / Visits	**Schedule Screenings**	**Diabetes**	**Medication Management**
Blood Pressure Control	Colorectal Cancer	HbA1c Testing & Control	Asthma
Immunizations	Breast Cancer	Kidney Health Evaluation	Antidepressants
Well-Child Visit	Cervical Cancer	Nephropathy Screening	ACE/ARB
Weight Assessment and Counseling for Children & Adolescents	Diabetic Eye Exam		Statins
	Annual Dental Visit		Diabetes medications

For additional resources, contact our Provider Relations team at Providers@ARHealthWellness.com

NOTE: Follow ICD-10-CM/CPT/HCPS Guidelines for Coding and Reporting at https://www.cms.gov.
HEDIS measures can be found at https://www.ncqa.org

Notification of Pregnancy

About our new NOP Report

The Notification of Pregnancy (NOP) is an essential component of complete prenatal care for patients, helping to identify risk factors as early in pregnancy as possible, and establishing a relationship between the patient, provider, and health plan team. By collating NOPs completed by our care management team, claims and lab data, we can identify members who are pregnant or likely pregnant and could benefit from a prenatal visit. To support our providers, we have established a real-time NOP reporting process through our Provider Analytics Portal.

Benefits of Using the New Report for Patients and Providers

- ✓ Patients who complete the NOP are three times more likely to be compliant with prenatal care and are less likely to have low-birth-weight babies.
- ✓ Helps providers and payers to meet the HEDIS® Prenatal Postpartum Care (PPC) Timeliness measure, which tracks the percentage of deliveries where patients had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with their health plan.

What's included in the Report

The Provider Analytics NOP report provides the following information when available:

- ✓ Date the member was identified as pregnant.
- ✓ Estimated date the member is due to give birth.
- ✓ Member's name, date of birth, address, phone number, race, ethnicity and primary language. Member's Care Manager, the identified PCP and OBGYN, including their contact information.

This new report is updated daily within Provider Analytics, and your health plan partners can help address any questions you may have.

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Q2 Quality Update

Quick Reference — Medicare Advantage Care

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For People with Diabetes

- Annual diabetic retinal eye exam
- Review adherence of diabetes medications (consider 90-day fills for maintenance medications) and evaluate the addition of a statin to help prevent heart and blood vessel diseases
- Blood pressure monitoring
- Testing and control of HbA1c
- Kidney function tests
- Medical attention for nephropathy

Important Cancer Screenings:

- Colon cancer screening (Colonoscopy, Fit DNA test, Cologuard)
- Breast cancer screening
- Prostate cancer screening
- Lung cancer screening

As Needed

- Osteoporosis screening and management after fracture

Care for Older Adults

- Medication review and reconciliation by physician
- Functional status assessment
- Pain assessment
- Advance care planning
- Depression screening

Adult Vaccinations

- COVID-19 – initial and follow-up
- Influenza – yearly
- Pneumococcal – one time (may need booster)
- Meningococcal
- Tetanus, diphtheria, pertussis (Td/Tdap)
- Zoster (shingles)
- Hepatitis A
- Hepatitis B

Medicare Advantage Annual Preventative — Care

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Schedule a visit with your member today!

Wellcare members are covered for:			CODES
Annual Wellness Visit (AWV)	This unique to Medicare visit allows you and your patient to meet and discuss their health to create a personalized prevention plan.	**1 per calendar year**	**G0438, G0439***
Routine Physical Exam (RPE)	This Medicare Advantage Supplemental benefit is a comprehensive physical examination to screen for disease and promote preventative care.	**1 per calendar year**	**99381-99387* (new patient)** **99391-99397** (established patient)**

Contracted Federally Qualified Health centers (FQHC) must include G0468 when billing AWV.
****Can be billed with the AWV with a modifier 25.***

Topics to discuss during your patient's Annual Wellness Visit (AWV):

- Update patient's medical record: including demographics, other treating providers and family history
- Conduct a Social Determinants of Health assessment
- Discuss Advanced Care planning
- Screen for cognitive impairment, including depression, mental wellness and emotional health
- Conduct medication reconciliation and extend day fill opportunities (mail order or 90 days at retail)
- Complete pain and functional assessments; including use of Durable Medical Equipment (DME)
- Assess bladder leakage and care options
- Create a preventative screening schedule and refer members for tests, labs, X-rays (eye exams, colonoscopy, mammograms), counseling and care programs
- Complete the health risk assessment, including functional abilities, ADLS, instrumental ADLs and create an action plan
- Create patient's list of balance/fall risk factors and conditions; including interventions and treatment options
- Check routine measurements: height, weight, blood pressure, etc.
- Review current opioid prescription and screen for potential Substance Use Disorders (SUDs)

2024 PCP Medicare Incentive Programs

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Unlock the Benefits of Partnership!

Earn up to *$1,865* per member with Wellcare's Physician Medicare Incentive Programs.*

The physician-patient relationship is a key component in fostering good health and satisfaction among your patients. Quality care is at the heart of this relationship, and Wellcare is pleased to offer a variety of Incentive Programs that reward the superior care you provide your patients throughout the year.

**See program details.*

PCP Incentive Program	Maximum Incentive Opportunity**
Partnership for Quality (P4Q) Medicare	Earn up to $75 per HEDIS® measure gap by scheduling and conducting care gap closure (e.g., Care for Older Adult Assessments, Breast Cancer Screening, Diabetes Screenings, etc.) – 16 measures ranging between $25 and $75.
Continuity of Care (CoC)	Earn up to $400 per each completed Appointment Agenda (Health Condition History only) with a qualified claim.
RxEffect	Earn up to $600 per member by utilizing the RxEffect tool. Bonus amount depends on market & number of eligible adherence therapies per member.
Mock CAHPS Medicare Member Experience	Earn up to $40 per assigned member achieving an *aggregate* Mock CAHPS rating of 3.5 or higher across impactable CAHPS measures on the 2024 Mock CAHPS survey.

***Payment is dependent on program specific guidelines and physician practice eligibility.*

CPT II Coding Importance

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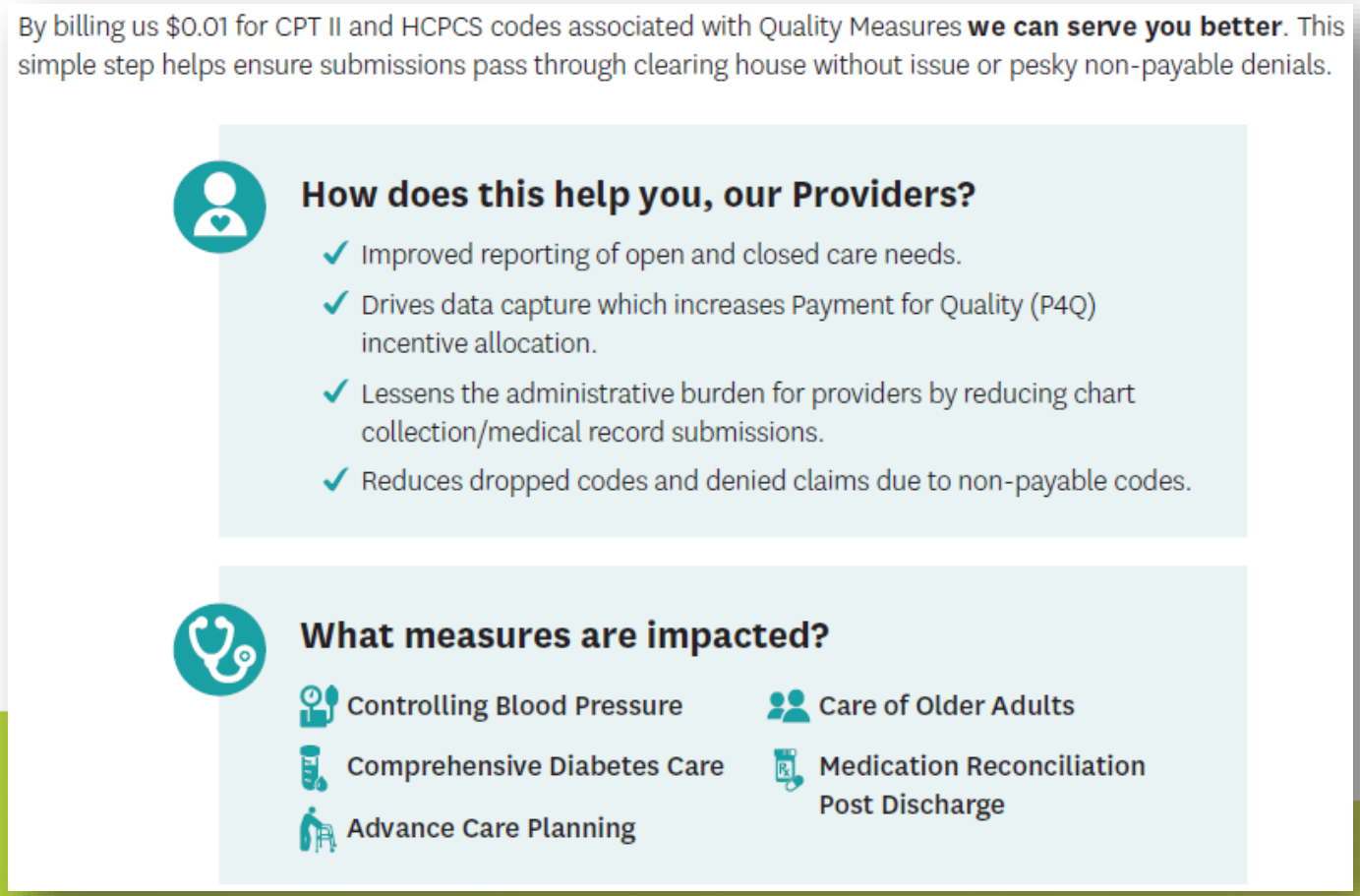
What are CPT II Codes?

- CPT Category II codes are tracking codes which facilitate data collection for the purposes of performance measurement.



CPT II Coding/Claims

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CATEGORY OF CODES	CPT II CODES	HCPCS CODES
Blood Pressure Control (Includes Diabetics)	• **3074F** Most recent Systolic <130mm Hg • **3075F** Most recent Systolic 130–139mm Hg • **3077F** Most recent Systolic ≥140mm Hg • **3078F** Most recent Diastolic <80mm Hg • **3079F** Most recent Diastolic 80–89mm Hg • **3080F** Most recent Diastolic ≥90mm Hg	
HbA1c Results	• **3044F** Most recent hemoglobin A1c (HbA1c) <7% • **3046F** Most recent hemoglobin A1c (HbA1c) >9% • **3051F** Most recent hemoglobin A1c (HbA1c) >=7% and <8% • **3052F** Most recent hemoglobin A1c (HbA1c) >=8% and <=9%	
Diabetic Retinal Eye Exams	• **2022F** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy • **2023F** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence or retinopathy • **2024F** Seven (7) standard filed stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy • **2025F** Seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy • **2026F** Eye Imaging validated to match diagnosis from seven (7) standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy • **2033F** Eye Imaging validated to match diagnosis from seven (7) standard field stereoscopic photos, results documented and reviewed; without evidence of retinopathy • **3072F** Low risk for retinopathy (no evidence of retinopathy in the prior year)	• **S0620** Diabetic Retinal Screening – Routine ophthalmological examination including refraction; established patient • **S0621** Diabetic Retinal Screening – Routine ophthalmological examination including refraction; new patient • **S3000** Diabetic Retinal Screening – Diabetic indicator; retinal eye exam, dilated, bilateral

CPT II Coding/Claims

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CATEGORY OF CODES	CPT II CODES	HCPCS CODES
Advance Care Planning	• **1123F** Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record • **1124F** Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan • **1157F** Advance care plan or similar legal document present in the medical record • **1158F** Advance care planning discussion documented in the medical record	• **S0257** Advance care planning – Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
Medication Review (2 codes: Review and List)	**Medication List** • **1159F** (Bill with 1160F) Medication list documented in the medical record **Medication Review** • **1160F** (Bill with 1159F) Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record	• **G8427** Medication List – Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications
Medication Reconciliation	• **1111F** Discharge medications reconciled with the current medication list in the outpatient record.	
Functional Status Assessment	• **1170F** Functional status assessed	
Pain Assessment	• **1125F** Pain present; pain severity quantified • **1126F** No pain present; pain severity quantified	

Medication Adherence

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Quality Measures

Below are three examples of Centers for Medicare and Medicaid Service Star measures which use adherence to evaluate health plans.

Beneficiaries, ages 18 years and older, who had at least two fills of medication(s) listed below on different dates of service and were 80% or more adherent to their medications.

Quality Measure	Description
Medication Adherence for Diabetes (DIAB)*	Oral antidiabetic medications defined as Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV inhibitors, GLP-1 receptor agonists, Meglitinides, and SGLT2 inhibitors
Medication Adherence for Hypertension (RASA)**	Renin-Angiotensin System (RAS) antagonists defined as ACE inhibitors, ARBs, or Direct Renin Inhibitors
Medication Adherence for Cholesterol (Statins)	Statins

Exclusions

End-stage renal disease (ESRD), Hospice, *Insulin use (DIAB only), **Sacubitril/Valsartan use (RASA only).

Medication Adherence Tips

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Patient barriers	Talking points
Medications cost too much.	Check for medications in a lower tier on formulary.
Can't remember to refill their medications.	Talk to your patients about how they can enroll in a refill reminder program with their pharmacy. If a patient has a smart device, have them add calendar reminders (alerts) for medication refills.
Hard to get to the pharmacy.	Have the patient check if their pharmacy offers delivery service. Ask the patient to check with family members or a caregiver for help.
Too many medications to track.	Ask the patient's pharmacy to synchronize medications so they are all filled on the same day. Encourage the use of a pillbox or phone alarms to help patients take their medications each day at the correct time.

Best practices to promote medication adherence

Prescribe 90-day prescriptions supply

For chronic medications, prescribe a 90-day quantity.

Review medications regularly

During each visit, review all medications with the patient.

When possible, remove medications no longer needed and reduce dosages.

Check for understanding

Make sure your patients knows why you are prescribing a medication.

Clearly explain what they are, what they do and how to manage potential side effects.

Provider-Patient Experience

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WELLCARE UNDERSTANDS THAT THE PROVIDER-PATIENT RELATIONSHIP IS A KEY COMPONENT IN ENSURING EXCEPTIONAL HEALTHCARE AND SATISFACTION AMONG PATIENTS.

We are committed to partnering with our providers to deliver an outstanding patient experience. As a provider, you are the most critical component of that experience. We want to ensure that you know exactly how your patients are evaluating your care.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey tool that asks patients to evaluate their experience with their health plan and at providers' offices. The following are the provider-influenced measures and their weight.

Impactable Program Measures	Weight
Flu vaccine	1
Care coordination	4
Getting appointments and care quickly	4
Getting needed care	4
Rating of personal doctor	4
Rating of health care quality	4

Opportunities for Improving CAHPS Scores

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Effective Patient Communication

- ✓ Make a personal connection and demonstrate empathy.
- ✓ Use simple, easy-to-understand wording that matches the individual patient's ability.
- ✓ Explain why tests, treatments, or referrals are necessary.
- ✓ Be proactive with timely post-care communication about test or lab results, and if results are posted in a patient portal, reach out quickly for the patient's questions.
- ✓ Demonstrate cultural sensitivity and use interpreter services if needed.
- ✓ Involve patients in decision-making and share goals for treatment.
- ✓ Discuss tobacco cessation and treatment options, when appropriate.

Enhance Care Coordination

- ✓ Review the patient's medical record for details before entering the exam room; patients are surveyed if their doctor knew their medical history.
- ✓ Receive prior authorization for care ahead of appointment.
- ✓ Review medications together.
- ✓ Ask patients about other doctors or specialists they have seen, and provide recommendations as needed.
- ✓ Encourage patients to make routine and follow-up appointments in advance.

Opportunities for Improving CAHPS Scores

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Improve Access to Care

- ✓ Keep same-day appointment slots open for urgent visits.
- ✓ Provide clear instructions on how to access medical care after office hours, including extended hours, weekend availability, and use of urgent care centers.
- ✓ Expand the roles of non-physician staff, including medical assistants, physician assistants and nurse practitioners, to deliver care more resourcefully and sensitively.
- ✓ Implement daily office huddles to manage patient flow and maximize efficiency.

Flu Shot

- ✓ Help patients understand the value of the flu shot.
- ✓ Work with Wellcare on joint initiatives or programs that focus on flu education.
- ✓ Recommend your patients get flu vaccines.

Telehealth

- ✓ Improve access to care with virtual visits for established patients, when an in-office appointment may not be available right away, and create options for patients who may be unable or unlikely to come to an in-office appointment.
- ✓ Reduce healthcare costs.
- ✓ Improve the quality of care delivered by reducing hospital admissions and readmissions while advancing patient engagement.

Upcoming Webinars

Upcoming Webinars

Provider Webinars are designed to offer our providers and their office staff the opportunity to learn from subject matter experts and ask questions about topics and best practices. Registration is free, and each webinar will be one hour in length. If interested in previous webinars, please email Providers@ARHealthWellness.com. If you have any questions, please reach out to us at 1-800-294-3557.

Title	Date	Time
Arkansas Health & Wellness Q2 Provider Updates	June 13, 2024	10 a.m.
Ambetter New Provider Orientation	June 18, 2024	10 a.m.
Wellcare by Allwell New Provider Orientation	June 25, 2024	2 p.m.

Contact Information

Provider Services Call Center

- **First line of communication**
  - Ambetter Provider Services 1-877-617-0390 | TTY: 1-877-617-0392
  - Wellcare by Allwell Provider Services 1-855-565-9518 | TTY: 711

- **Provider Service Representatives can assist with questions regarding:**
  - Member Eligibility
  - Claim Inquiry
  - Prior Authorization
  - Network Verification
  - Appeal Status
  - Payment Inquiries
  - Check Stop Pay or Check Reissues
  - Negative Balance Report
  - Provider Demographic Change Request
  - Secure Portal Password Reset

Representatives are available Monday through Friday, 8:00 a.m. to 5:00 p.m. CST

Contracting Department

Phone Number: 1-844-631-6830

Hours of Operation: 8 a.m. – 4:30 p.m.

Provider Contracting Email Address:

ArkansasContracting@Centene.com

Regular contracting inquiries and contract requests

Arkansas Health & Wellness Credentialing Department

Phone: 1-844-263-2437

Fax: 1-844-357-7890

Provider Credentialing Email:

ARKCredentialing@Centene.com

Education Requests

Would you like training for you and your staff?

You can submit your requests to

Providers@ARHealthWellness.com

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THANK YOU
for joining us!