



## 2<sup>nd</sup> Quarter Provider Webinar

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# 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

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- 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

# Provider Relations Territories

|                                                                                     |                 |
|-------------------------------------------------------------------------------------|-----------------|
|    | Kari Murphy     |
|    | Faye Washington |
|    | Randal Bailey   |
|    | Rachel Baney    |
|    | Rose Pennick    |
|   | Tamesa Sutton   |
|  | Valinda Perkins |



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 Wellcare by Allwell information, please visit our [Wellcare by 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.

- [Manuals, Forms and Resources](#)
- [Eligibility Verification](#)
- [Prior Authorization](#)
- [Electronic Transactions](#)
- [Preferred Drug Lists](#)
- [Provider Training](#)
- [Negative Balance How-To Guide \(PDF\)](#)

Name \*

Position/Title \*

Email \*

Phone Number \*

Group Name \*

Group NPI \*

Tax ID \*

Network \*

- ☐ Ambetter
- ☐ Wellcare by Allwell



## Join Our Email List Today

- Receive current updates:  
[ARHealthWellness.com/Providers/Resources](https://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

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-Threatening 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



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](http://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](mailto:Providers@ARHealthWellness.com)

# Clinical & Payment Policy Updates



## FOR PROVIDERS

Login

Become a Provider

Pre-Auth Check



Provider Financial Support & Resources

Pharmacy

Provider Resources



Manuals, Forms and Resources

Provider Training

Eligibility Verification

Incentives Statement

Integrated Care

Provider Webinars

Prior Authorization

National Imaging Associates (NIA)

Report Fraud, Waste and Abuse

Patient Centered Medical Home Model

Electronic Transactions



Clinical & Payment Policies

## Provider Resources

### Coronavirus (COVID-19)

Currently we are experiencing some issues and long wait times with on our Teledoc and Referral lines. Please be patient with us as we work through this busy period.

To receive the fastest response on referrals, please submit authorization requests through our provider portal or via fax at:

- Ambetter from Arkansas Health & Wellness Fax: 1-866-884-9580
- Wellcare by Allwell Fax: 1-866-279-1358, Behavioral Health Fax: 1-866-279-1358

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.

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- [Preferred Drug Lists](#)
- [Provider Training](#)
- [Negative Balance How-To Guide \(PDF\)](#)

Name \*

# 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.



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## 15



# **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

ambetter.

The screenshot shows the Ambetter Provider Analytics dashboard. At the top, there's a header with 'Viewing Dashboard For: TIN' and 'Plan Type: Medicaid'. Below this, there are two informational boxes: one about 'Explanation of Payments Issues' and another about 'Information for patients who are former WellCare members'. The main content area is titled 'Welcome, [redacted]!' and includes a 'Useful Links' section. In this section, 'Provider Analytics' is circled in red. Below the links, there's a step 3 instruction: '3. From the Provider Analytics page, select Notice of Pregnancy to access the report. See Reference Materials and Data Dictionary for additional information.' The bottom part of the screenshot shows the 'Provider Analytics' page for 'TWIN PEAKS FAMILY PRACTICE PC' with ID '76352'. It features a 'Resources' section with links to 'Case Study Support Resource', 'FAQ', and 'Tool Navigation Guide'. The main content area is divided into three tabs: 'Supplemental Reports', 'P4P and Quality Reporting', and 'Dashboards'. Under 'Supplemental Reports', there's a table with the following items: 'COVID-19 Detail' (No Report), 'Daily IP & Discharge' (10-18-2023), 'Notice of Pregnancy' (10-26-2023), 'Weekly Med Claims' (Coming Soon), and 'Weekly Rx Claims' (Coming Soon). The 'Notice of Pregnancy' row is highlighted with a red box. At the bottom, there are links for 'Reference Materials' and 'Data Dictionary'.

Viewing Dashboard For: TIN [redacted] Plan Type: Medicaid GO

**Explanation of Payments Issues**  
Users may have issues with accessing EOP (Explanation of Payments) PDFs and information on consolidated checks may be missing from the Payment History section. We'll be updating our network to fix this issue. Thank you for your patience.

**Information for patients who are former WellCare members** (for dates prior to 10/01/2021) can be found on the WellCare Provider Portal at <https://provider.wellcare.com/>

**Welcome, [redacted]!**  
Get summaries of claims data at a glance and easy access to the options you use most.

**Useful Links**

- Reports**  
This repository contains reports that are uploaded and maintained by the health plan.
- Provider Analytics**  
Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.
- Care & Risk Gaps-Daily View**  
Providers are directed to Interpreter, where they can view data for high-risk/high impact members in the selected population.

3. From the Provider Analytics page, select Notice of Pregnancy to access the report. See *Reference Materials* and *Data Dictionary* for additional information.

**Provider Analytics**

**TWIN PEAKS FAMILY PRACTICE PC**  
76352

**Resources**

- Case Study Support Resource
- FAQ
- Tool Navigation Guide

**Supplemental Reports**

| Report               | Date        |
|----------------------|-------------|
| COVID-19 Detail      | No Report   |
| Daily IP & Discharge | 10-18-2023  |
| Notice of Pregnancy  | 10-26-2023  |
| Weekly Med Claims    | Coming Soon |
| Weekly Rx Claims     | Coming Soon |

**P4P and Quality Reporting**

**Dashboards**

**Reference Materials**  
Data Dictionary

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

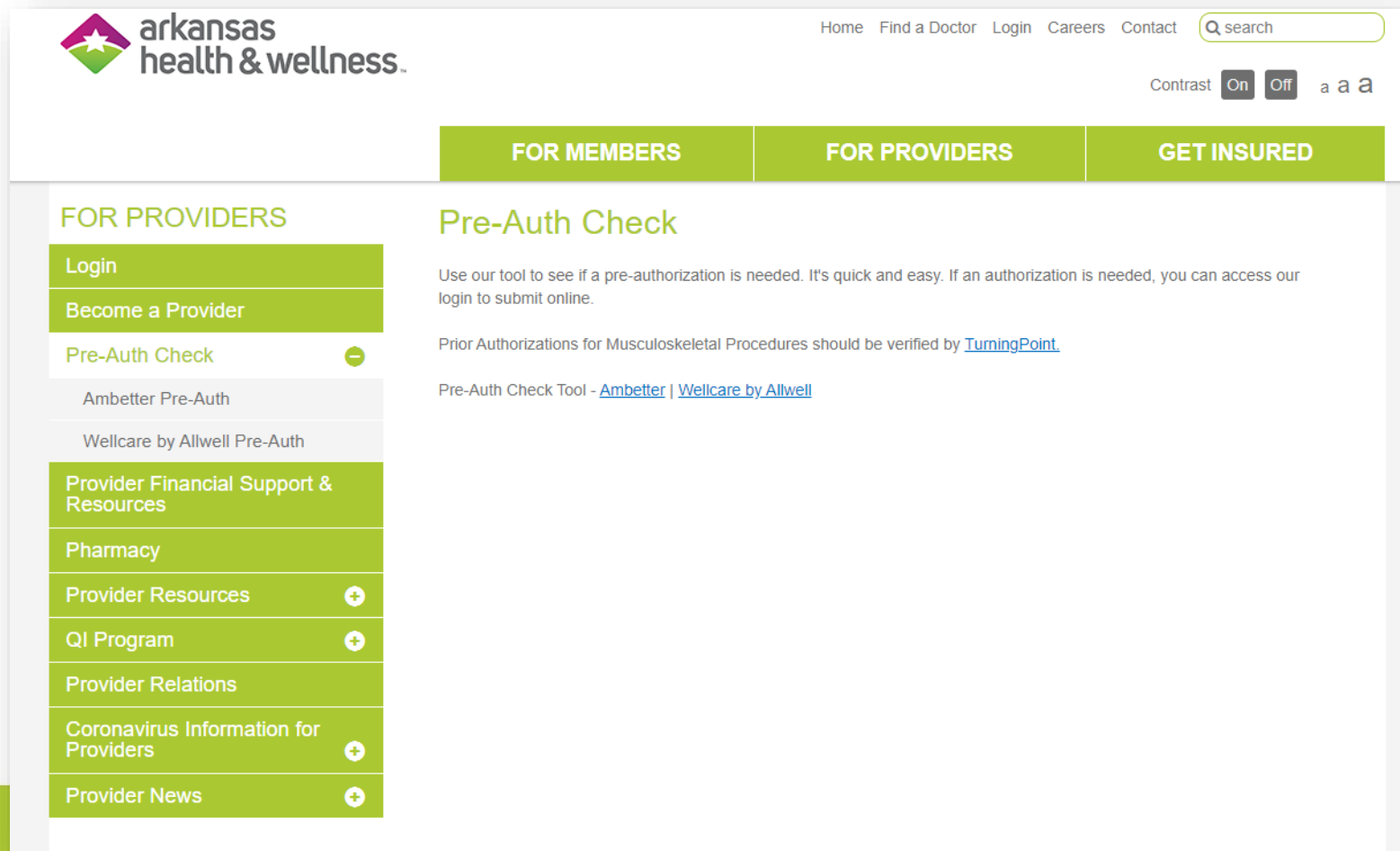
Effective January 1, 2024



- 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



The screenshot shows the Arkansas Health & Wellness website. The header includes the logo, navigation links (Home, Find a Doctor, Login, Careers, Contact), a search bar, and contrast settings. A green navigation bar contains links for 'FOR MEMBERS', 'FOR PROVIDERS', and 'GET INSURED'. The 'FOR PROVIDERS' section is active, displaying a sidebar with links like 'Login', 'Become a Provider', 'Pre-Auth Check' (highlighted), 'Ambetter Pre-Auth', 'Wellcare by Allwell Pre-Auth', 'Provider Financial Support & Resources', 'Pharmacy', 'Provider Resources', 'QI Program', 'Provider Relations', 'Coronavirus Information for Providers', and 'Provider News'. The main content area is titled 'Pre-Auth Check' and contains text explaining the tool's purpose, a note about musculoskeletal procedures, and links to 'Ambetter' and 'Wellcare by Allwell'.

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Home Find a Doctor Login Careers Contact Q search

Contrast On Off a a a

FOR MEMBERS FOR PROVIDERS GET INSURED

FOR PROVIDERS

Login

Become a Provider

Pre-Auth Check

Ambetter Pre-Auth

Wellcare by Allwell Pre-Auth

Provider Financial Support & Resources

Pharmacy

Provider Resources

QI Program

Provider Relations

Coronavirus Information for Providers

Provider News

## Pre-Auth Check

Use our tool to see if a pre-authorization is needed. It's quick and easy. If an authorization is needed, you can access our login to submit online.

Prior Authorizations for Musculoskeletal Procedures should be verified by [TurningPoint](#).

Pre-Auth Check Tool - [Ambetter](#) | [Wellcare by Allwell](#)

# Pre-Auth Check Tool

## FOR PROVIDERS

Login

Become a Provider

Pre-Auth Check



Ambetter Pre-Auth

Allwell Pre-Auth

Pharmacy

Provider Resources



QI Program



Provider News



Provider Relations

Coronavirus Information for Providers

Provider Financial Support & Resources

Risk Adjustment



## Ambetter Pre-Auth

**DISCLAIMER:** All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by [Opticare](#)

Dental services need to be verified by [DentaQuest](#)

Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)

Complex imaging, MRA, MRI, PET, and CT Scans need to be verified by [NIA](#)

Prior Authorizations for Musculoskeletal Procedures should be verified by [TurningPoint](#).

**Note:** It is the responsibility of the facility, in coordination with the rendering practitioner to ensure that an authorization has been obtained for all inpatient and selected outpatient services, except for emergency stabilization services. All inpatient admissions require prior authorization. To determine if a specific outpatient service requires prior authorization, utilize the Pre-Auth Needed tool below by answering a series of questions regarding the Type of Service and then entering a specific CPT code.

Any anesthesiology, pathology, radiology or hospitalist services related to a procedure or hospital stay requiring a prior authorization will be considered downstream and will not require a separate prior authorization. However, services related to an authorization denial for an outpatient procedure or hospital stay will result in denial of all associated claims, including anesthesiology, pathology, radiology and hospitalist services.

Are Services being performed in the Emergency Department?

☐ Yes ☐ No

### Types of Services

YES NO

Is the member being admitted to an inpatient facility?

☐ ☐

Are anesthesia services being rendered for pain management or dental surgeries?

☐ ☐

Is the member receiving hospice services?

☐ ☐

Are services being rendered in the home, excluding Sleep Studies, DME, Medical Equipment Supplies, Orthotics and Prosthetics?

☐ ☐

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

99214

Check

N  
No

**99214 - OFFICE/OUTPATIENT VISIT EST**  
No authorization required.

To submit a prior authorization [Login Here](#).



# 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](http://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



## FOR PROVIDERS

Login

Become a Provider



Pre-Auth Check



Provider Financial Support & Resources

Pharmacy

Provider Resources



Manuals, Forms and Resources

Provider Training



ASAM Training

Cultural Competency Training

Secure Provider Portal Quick Start Guide

Special Needs Plan Model of Care Self-Study Program

## Provider Training

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

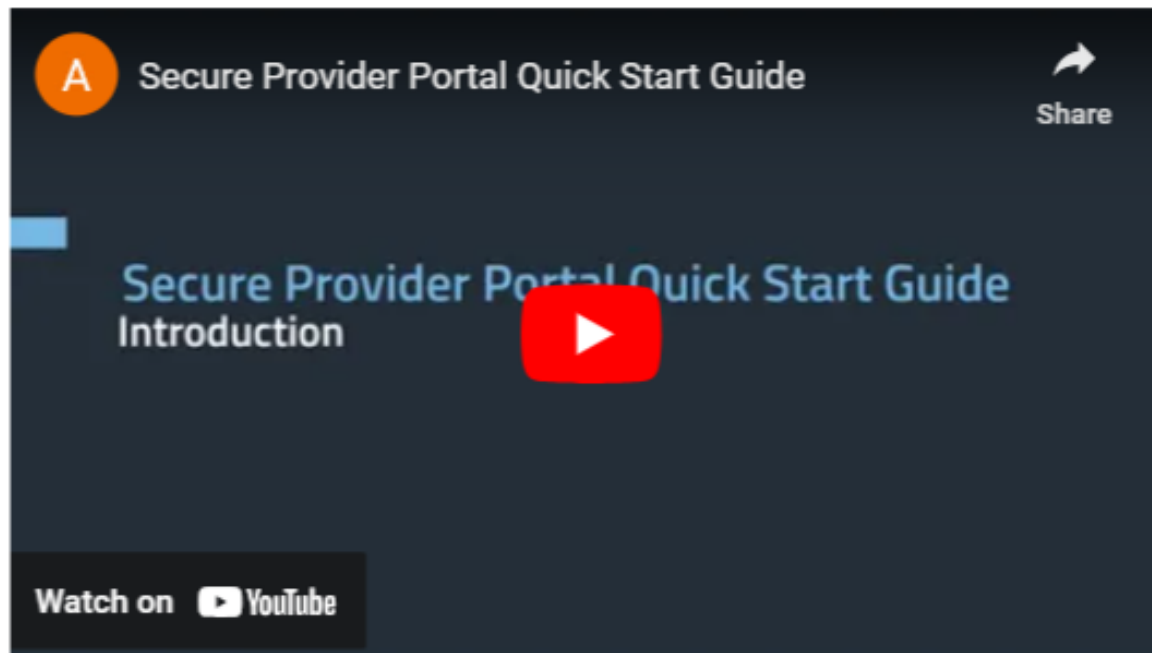
Arkansas Health & Wellness provides several self-led provider trainings. This is an annual training that is offered to every provider and is available 24/7 on the [Provider Training Page](#). After completion of the training, providers will then need to complete the [Attestation Form](#).

- [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

## 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](#).





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## Risk Adjustment and Providers

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7/10/2024

# 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)

# Risk Adjustment Contacts

- Operations and Management  
Sherrill Montgomery  
Director, Risk Adjustment  
[Sherrill.S.Montgomery@Centene.com](mailto:Sherrill.S.Montgomery@Centene.com)
- Project Initiatives  
Miranda Rowe  
Risk Adjustment Supervisor  
[Miranda.R.Rowe@Centene.com](mailto:Miranda.R.Rowe@Centene.com)
- Coding Education  
Haley Hicks  
Senior Coding Analyst, Risk Adjustment  
[Haley.M.Hicks@Centene.com](mailto:Haley.M.Hicks@Centene.com)

# Quality Improvement

## Partnership for Quality Program



TM

## 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.

## 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.

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

## 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          |

## Separate Evaluation and Management<sup>1</sup>

- Provider may perform separately identifiable services 99202 - 99215, 99381 - 99387, 99391 - 99397, on the same day.
- The components of both the AWW 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<br>Refer to the current CPT Coding Manual |                                                                         |
|---------------------------------------------------------------|-------------------------------------------------------------------------|
| Included with Exam                                            | Covered Separately                                                      |
| Preventive Medicine Counseling, Individual                    | <b>Screenings</b><br>Vision<br>Hearing<br>Developmental                 |
| Smoking / Tobacco Cessation                                   | <b>Vaccines</b><br>Toxoid Administration                                |
| Alcohol / Substance abuse Screening and Intervention          | Risk/benefit counseling                                                 |
| Other additional preventive services                          | <b>Ancillary Studies</b><br>Laboratory<br>Radiology<br>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. |
| <b>...infant exam 7 days and younger, Z00.110</b><br>Use when identifying health supervision for newborn under 8 days old.                                                                                          |
| <b>...infant exam 8 to 28 days, Z00.111</b><br>Use when identifying health supervision for newborn 8 to 28 days old.                                                                                                |
| <b>...child exam with normal findings, Z00.129</b><br>Use when conditions are stable or improving. Report additional codes for chronic conditions.                                                                  |
| <b>...child exam with abnormal findings, Z00.121</b><br>Use when any abnormality is found during the visit. Report additional codes for all existing conditions.                                                    |
| <b>...adult exam with normal findings, Z00.00</b><br>Use when conditions are stable or improving. Report additional codes for chronic conditions.                                                                   |
| <b>...adult exam with abnormal findings, Z00.01</b><br>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](mailto: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

ambetter.<sup>TM</sup>

## 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.



# **Wellcare by Allwell**

## **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

## Schedule a visit with your member today!

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

\*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**                                                                                                                                                                                                |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Partnership for Quality (P4Q) Medicare</b> | 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. |
| <b>Continuity of Care (CoC)</b>               | Earn up to \$400 per each completed Appointment Agenda (Health Condition History only) with a qualified claim.                                                                                                                 |
| <b>RxEffect</b>                               | Earn up to \$600 per member by utilizing the RxEffect tool. Bonus amount depends on market & number of eligible adherence therapies per member.                                                                                |
| <b>Mock CAHPS Medicare Member Experience</b>  | Earn up to \$40 per assigned member achieving an <i>aggregate</i> 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

## What are CPT II Codes?

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

By billing us \$0.01 for CPT II and HCPCS codes associated with Quality Measures **we can serve you better.** This simple step helps ensure submissions pass through clearing house without issue or pesky non-payable denials.



### How does this help you, our Providers?

- ✓ Improved reporting of open and closed care needs.
- ✓ Drives data capture which increases Payment for Quality (P4Q) incentive allocation.
- ✓ Lessens the administrative burden for providers by reducing chart collection/medical record submissions.
- ✓ Reduces dropped codes and denied claims due to non-payable codes.



### What measures are impacted?



Controlling Blood Pressure



Comprehensive Diabetes Care



Advance Care Planning



Care of Older Adults



Medication Reconciliation  
Post Discharge

# CPT II Coding/Claims

| CATEGORY OF CODES                              | CPT II CODES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | HCPCS CODES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Blood Pressure Control<br>(Includes Diabetics) | <ul style="list-style-type: none"> <li>• 3074F Most recent Systolic &lt;130mm Hg</li> <li>• 3075F Most recent Systolic 130–139mm Hg</li> <li>• 3077F Most recent Systolic ≥140mm Hg</li> <li>• 3078F Most recent Diastolic &lt;80mm Hg</li> <li>• 3079F Most recent Diastolic 80–89mm Hg</li> <li>• 3080F Most recent Diastolic ≥90mm Hg</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| HbA1c Results                                  | <ul style="list-style-type: none"> <li>• 3044F Most recent hemoglobin A1c (HbA1c) &lt;7%</li> <li>• 3046F Most recent hemoglobin A1c (HbA1c) &gt;9%</li> <li>• 3051F Most recent hemoglobin A1c (HbA1c) ≥7% and &lt;8%</li> <li>• 3052F Most recent hemoglobin A1c (HbA1c) ≥8% and ≤9%</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Diabetic Retinal Eye Exams                     | <ul style="list-style-type: none"> <li>• 2022F Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy</li> <li>• 2023F Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy</li> <li>• 2024F Seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy</li> <li>• 2025F Seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy</li> <li>• 2026F Eye Imaging validated to match diagnosis from seven (7) standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy</li> <li>• 2033F Eye Imaging validated to match diagnosis from seven (7) standard field stereoscopic photos, results documented and reviewed; without evidence of retinopathy</li> <li>• 3072F Low risk for retinopathy (no evidence of retinopathy in the prior year)</li> </ul> | <ul style="list-style-type: none"> <li>• S0620 Diabetic Retinal Screening <ul style="list-style-type: none"> <li>– Routine ophthalmological examination including refraction; established patient</li> </ul> </li> <li>• S0621 Diabetic Retinal Screening <ul style="list-style-type: none"> <li>– Routine ophthalmological examination including refraction; new patient</li> </ul> </li> <li>• S3000 Diabetic Retinal Screening <ul style="list-style-type: none"> <li>– Diabetic indicator; retinal eye exam, dilated, bilateral</li> </ul> </li> </ul> |

# CPT II Coding/Claims



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| CATEGORY OF CODES                               | CPT II CODES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | HCPCS CODES                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Advance Care Planning                           | <ul style="list-style-type: none"> <li>• <b>1123F</b> Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record</li> <li>• <b>1124F</b> 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</li> <li>• <b>1157F</b> Advance care plan or similar legal document present in the medical record</li> <li>• <b>1158F</b> Advance care planning discussion documented in the medical record</li> </ul> | <ul style="list-style-type: none"> <li>• <b>S0257</b><br/>Advance care planning<br/>– 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)</li> </ul> |
| Medication Review<br>(2 codes: Review and List) | <p><b>Medication List</b></p> <ul style="list-style-type: none"> <li>• <b>1159F</b> (Bill with 1160F) Medication list documented in the medical record</li> </ul> <p><b>Medication Review</b></p> <ul style="list-style-type: none"> <li>• <b>1160F</b> (Bill with 1159F) Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record</li> </ul>                                                                                                                                                                                             | <ul style="list-style-type: none"> <li>• <b>G8427</b> Medication List<br/>– Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications</li> </ul>                                                                                              |
| Medication Reconciliation                       | <ul style="list-style-type: none"> <li>• <b>1111F</b> Discharge medications reconciled with the current medication list in the outpatient record.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                           |
| Functional Status Assessment                    | <ul style="list-style-type: none"> <li>• <b>1170F</b> Functional status assessed</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                           |
| Pain Assessment                                 | <ul style="list-style-type: none"> <li>• <b>1125F</b> Pain present; pain severity quantified</li> <li>• <b>1126F</b> No pain present; pain severity quantified</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                           |



# Medication Adherence



## 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

| 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

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



## 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.

# Questions/Training Requests

Sherene Woolcock, Quality Improvement Supervisor  
[Sherene.Woolcock@Centene.com](mailto:Sherene.Woolcock@Centene.com)

Caprice Brown, Director of Quality Improvement  
[Caprice.Brown@Centene.com](mailto:Caprice.Brown@Centene.com)

# 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](mailto:Providers@ARHealthWellness.com). If you have any questions, please reach out to us at [1-800-294-3557](tel:1-800-294-3557).

| Title                                                     | Date          | Time    |
|-----------------------------------------------------------|---------------|---------|
| <b>Arkansas Health &amp; Wellness Q2 Provider Updates</b> | June 13, 2024 | 10 a.m. |
| <b>Ambetter New Provider Orientation</b>                  | June 18, 2024 | 10 a.m. |
| <b>Wellcare by Allwell New Provider Orientation</b>       | 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](mailto: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](mailto:ARKCredentialing@Centene.com)**

# Education Requests

Would you like training for you and your staff?

You can submit your requests to

[Providers@ARHealthWellness.com](mailto:Providers@ARHealthWellness.com)



**THANK YOU**  
**for joining us!**