arkansas health & wellness™

2025 Third Quarter

Provider Webinar

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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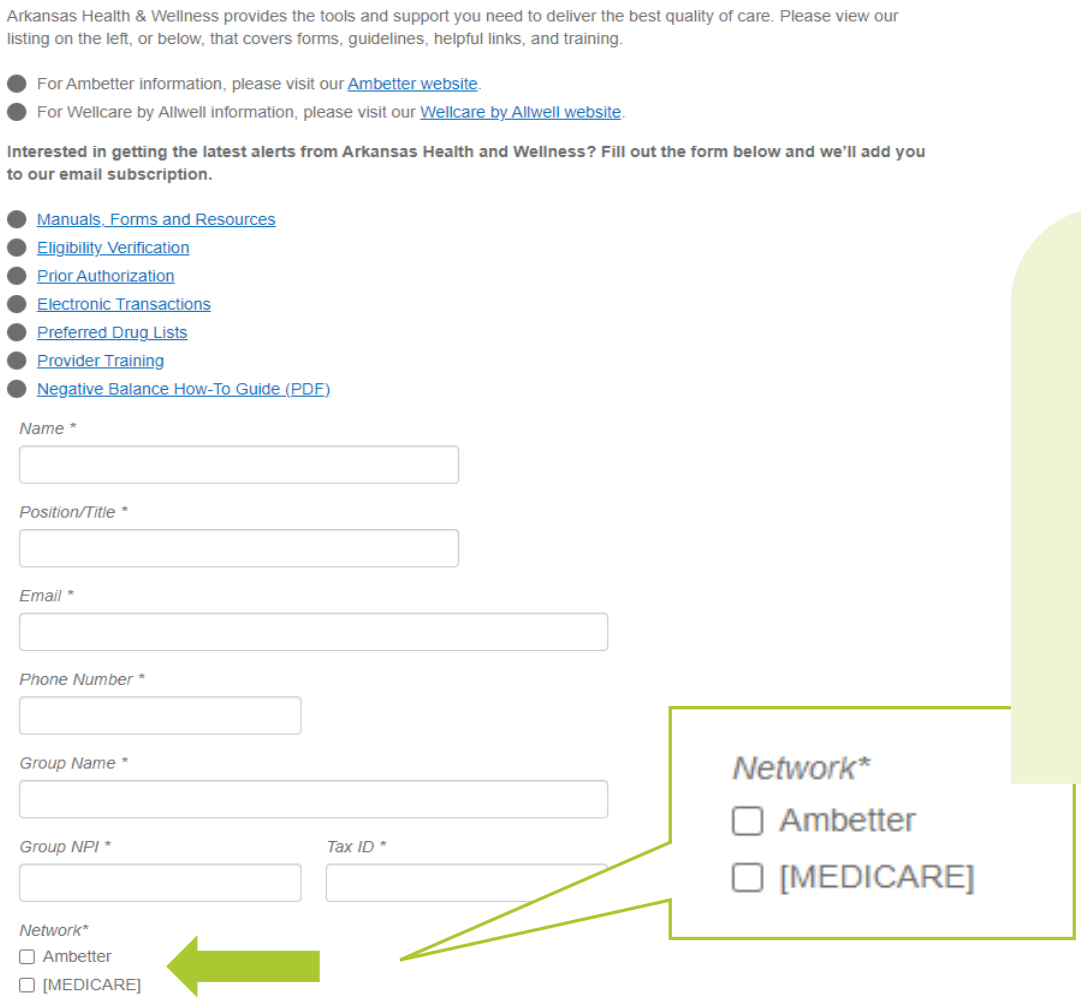
Agenda

- How to Join Our Email List
- Clinical and Payment Policy Updates
- Appointment Availability & Wait Times
- Prior Authorizations
- Transparency Act 575
- Secure Provider Portal
- Availity Essentials
- Sober Sidekick Program
- Transitional Care Management (TCM)
- Provider Self-Led Trainings
- Risk Adjustment
- Quality Improvement
- Contact Information

Join Our Email List Today



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**

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Sign up to receive updates:

- https://www.arhealthwellness.com/providers/resources.html
- Choose the network you wish to receive information on: Ambetter or Wellcare by Allwell

Clinical and Payment Policy Updates

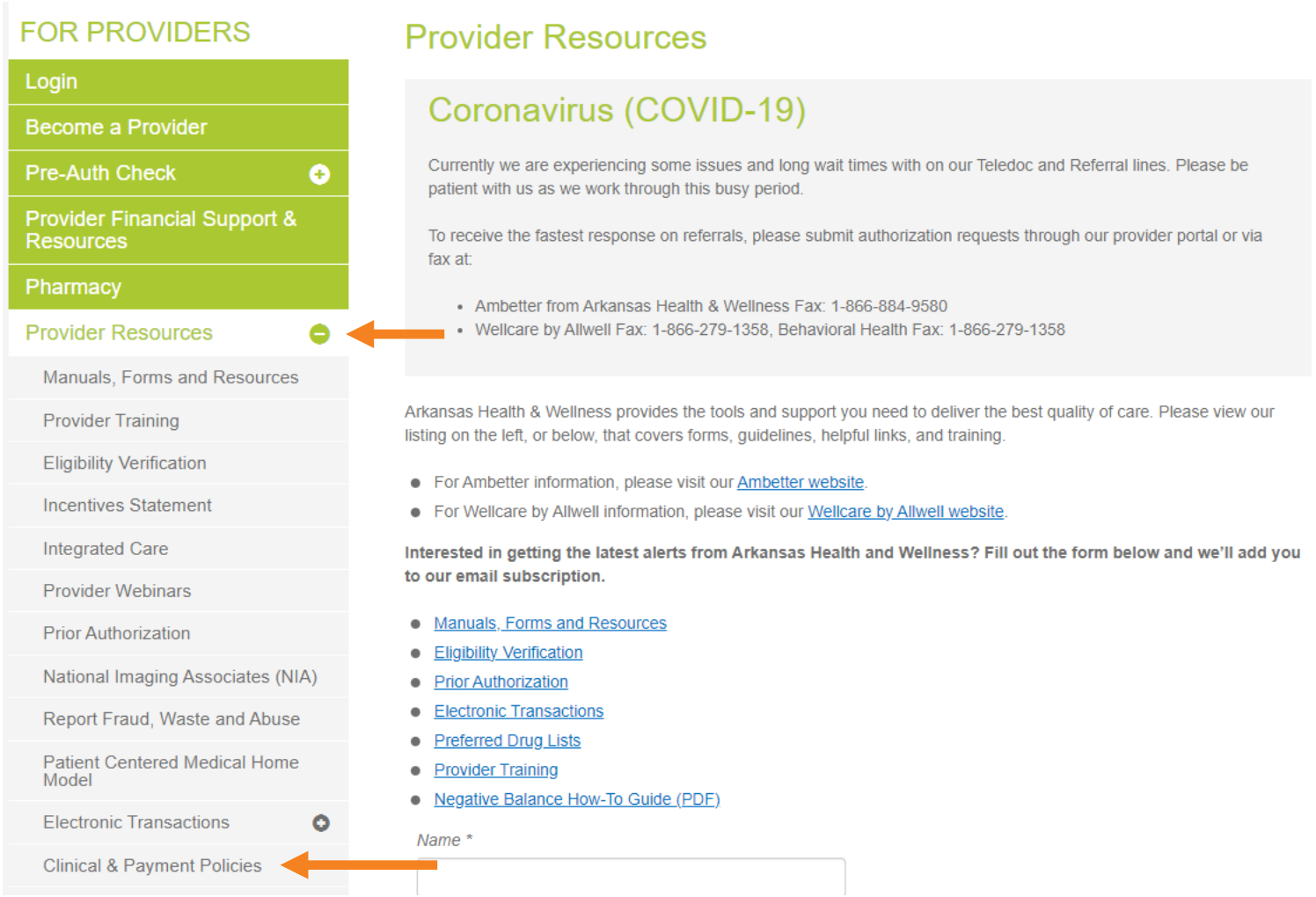
Clinical and Payment Policy Updates

Arkansas Health & Wellness routinely amends or implements new policies that can be found on our website.

- **Recent Clinical Policies for Ambetter**
  - CP.MP.94 Clinical Trials Effective August 1, 2025

- **Recent Payment Policies for Ambetter**
  - Newborn Inpatient Stays CC. PP. 075 Effective January 1, 2026
  - Electrodes for Transcutaneous Electrical Nerve Stimulation (TENS) PDF, effective July 1, 2025

Clinical and Payment Policy Updates



Appointment Availability & Wait Times

Appointment Availability & 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. This table depicts the appointment availability for members:

Appointment Type	Access Standard
PCPs — Routine visits	30 calendar days
PCPs — Adult Sick Visit	48 hours
PCPs — Pediatric Sick Visit	24 hours
Behavioral Health — Non-Threatening Emergency	6 hours
Specialist	Within 30 calendar 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 & Wait Times

Wellcare by Allwell follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Wellcare by Allwell 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. This table depicts the appointment availability for members:

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 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.

Prior Authorizations

How to Secure Prior Authorization

Prior Authorizations can be requested in the following ways:

Secure Provider Portal — preferred and fastest method:

- **Ambetter** and **Wellcare by Allwell**:

  Provider.ARHealthWellness.com

Phone:

- **Ambetter**: 1-877-617-0390 (TTY: 1-877-617-0392)
- **Wellcare by Allwell**: 1-855-565-9518 (TTY: 711)

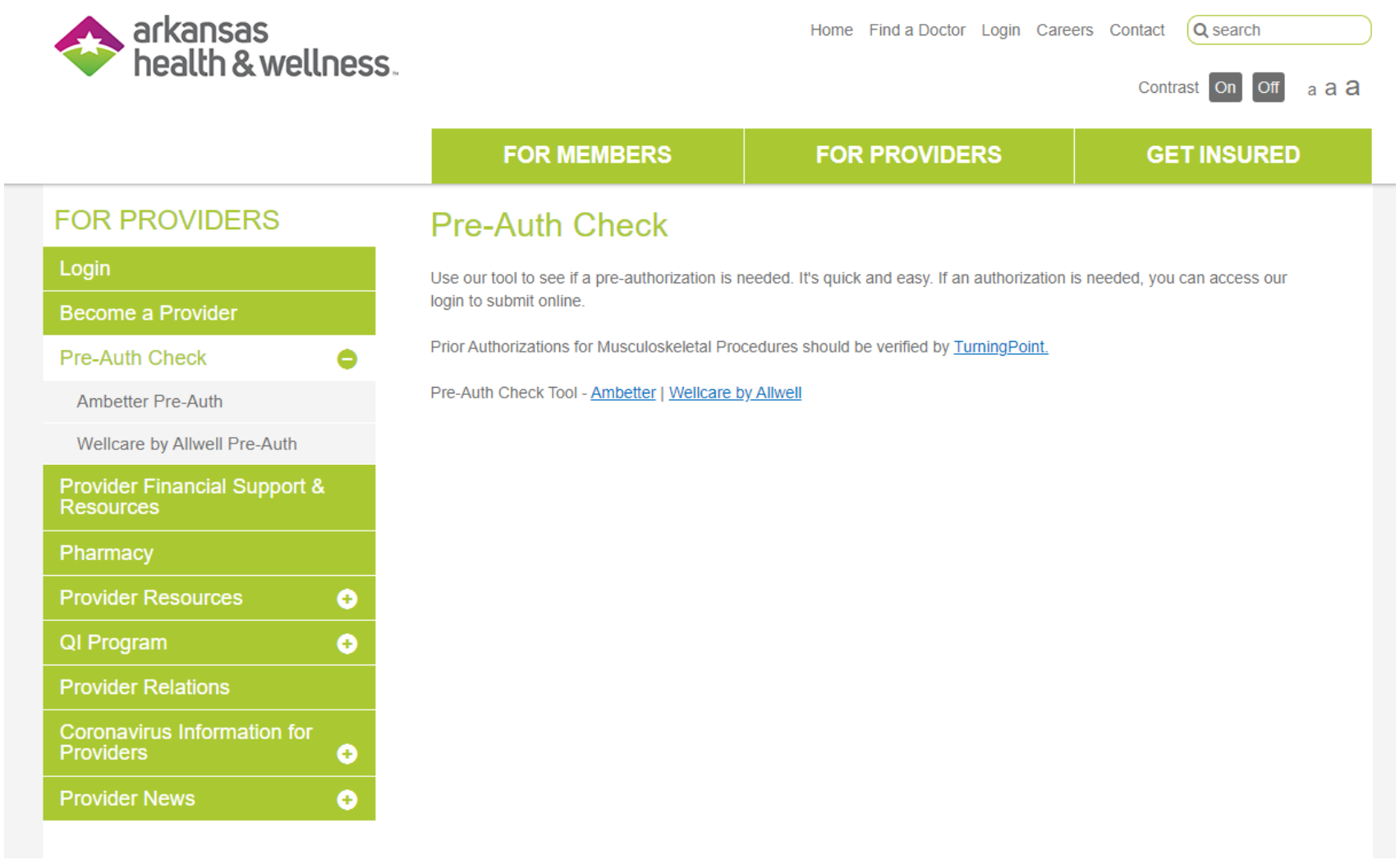
Fax:

IP and OP paper forms are available on the website under Provider Resources.

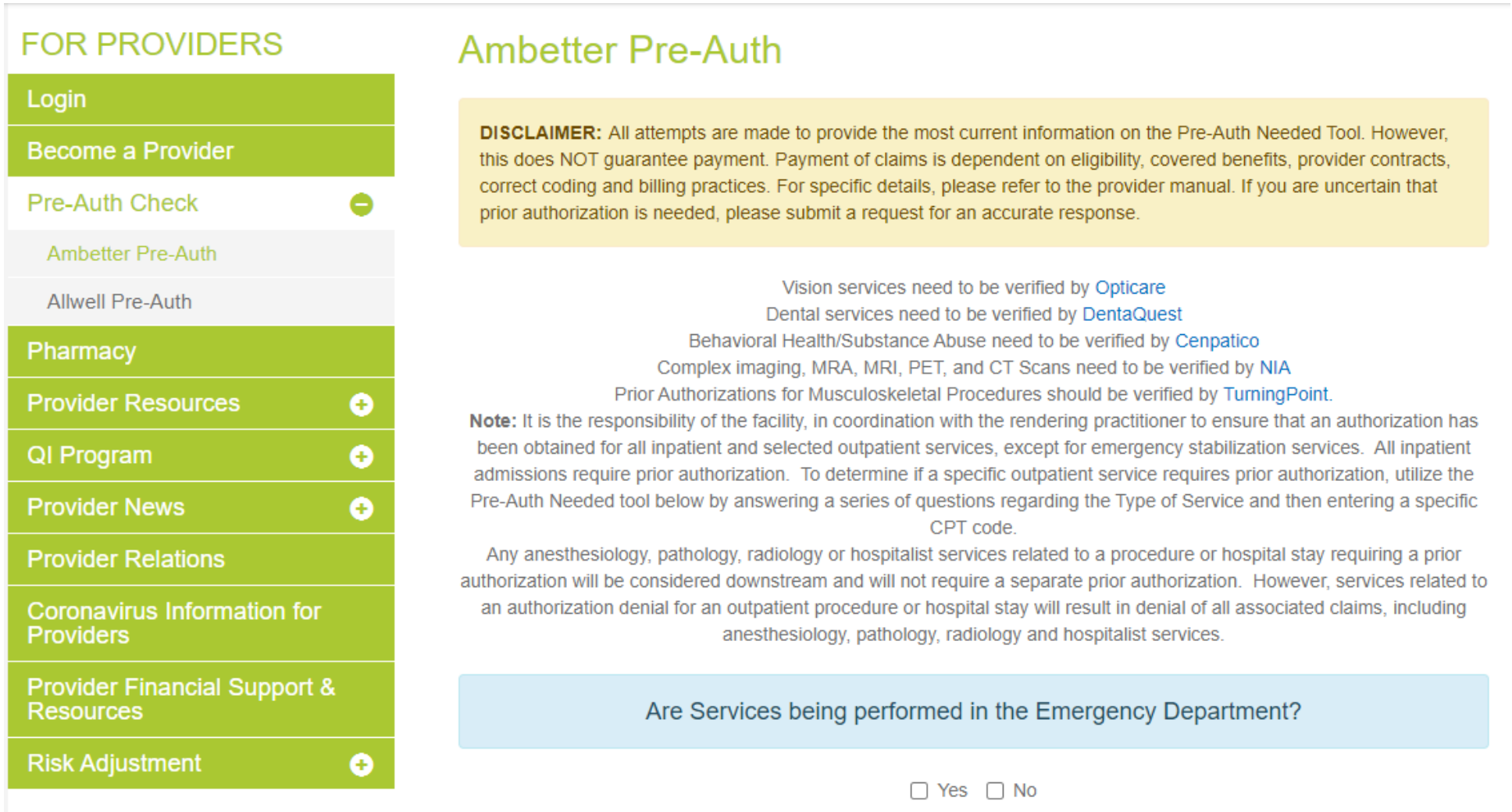
- **Ambetter**: 1-866-884-9580
- **Wellcare by Allwell**: 1-833-562-7172

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.

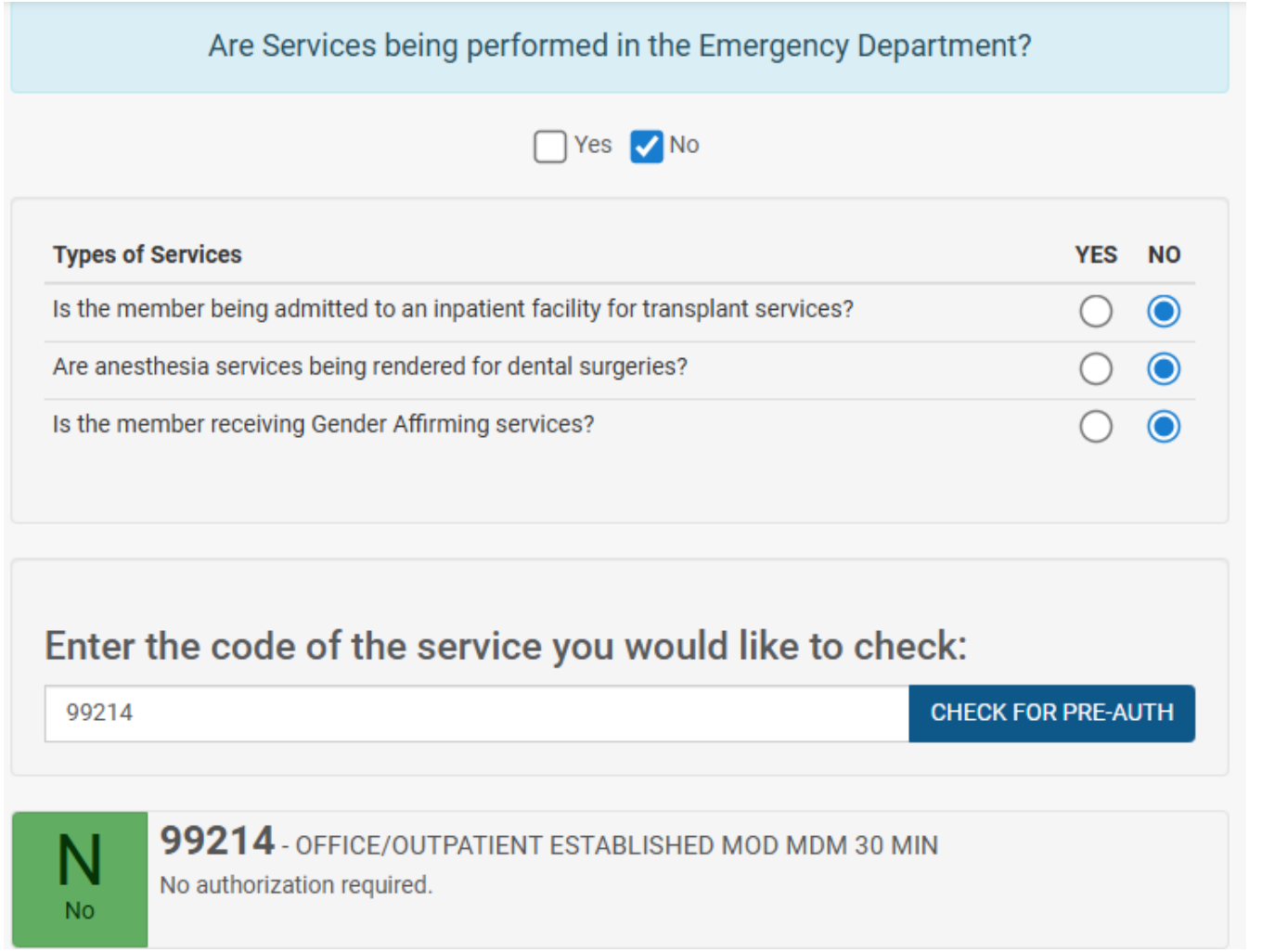
Pre-Auth Check Tool



How to Use Pre-Auth Check Tool



Pre-Auth Check Tool Cont.



Transparency Act 575

Transparency Act 575

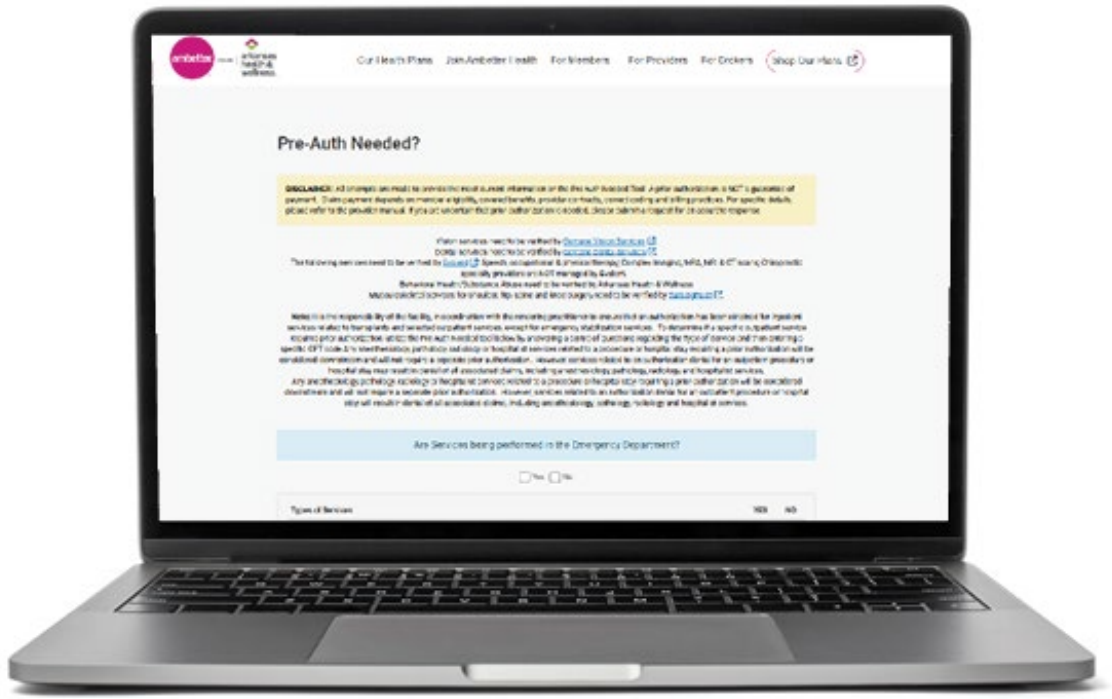
In 2023, the Arkansas General Assembly passed Act 575, amending the 2015 Prior Authorization Transparency Act.

Act 575 exempts certain healthcare providers who provide healthcare services from certain prior authorization requirements. Arkansas Health & Wellness has developed a plan to reduce previously required prior authorizations. This plan will be implemented on April 1, 2025, for the Marketplace product, Ambetter. This includes both the ARHOME and Federally Facilitated Marketplace members.

To ensure members are receiving medically appropriate services, Ambetter will continue to require prior authorization for certain outpatient services and transplants in 2025.

Transparency Act Implementation

- Ambetter's Pre-Auth Check tool, available on our public website, can be utilized to determine if a service requires a prior authorization.
- As a reminder, all services are still subject to medical necessity requirements utilizing InterQual guidelines and Arkansas Health & Wellness clinical policies. Additionally, these changes are governed by Arkansas state law and the terms and conditions in your provider agreement.



Transparency Act 575 and Ambetter

As of April 1, 2025, Ambetter will no longer require prior authorizations for the following services:

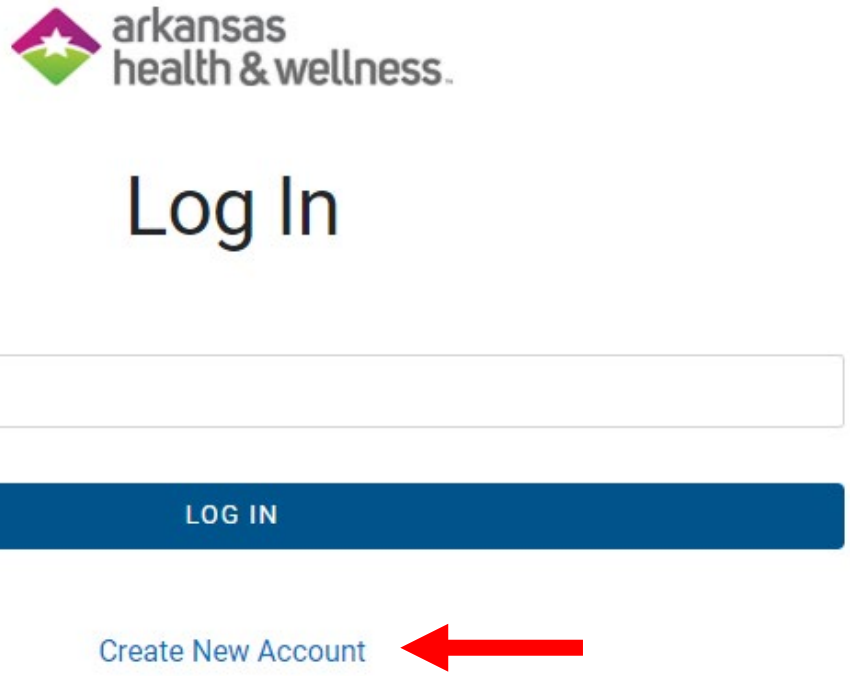
- Inpatient services, including medical and behavioral health acute stays (excluding transplants)
- Sleep studies
- Quantitative urine drug testing
- Pain management
- Genetic testing and molecular pathology
- Neurostimulators
- Laboratory and pathology, general code
- Hearing aids and related supplies
- Wheelchairs
- Medical equipment and supplies otherwise classified
- CPAPS and BIPAPS
- Nursing visits
- PET scans
- Oxygen equipment and supplies
- Diabetic drugs and supplies

Secure Provider Portal

Secure Provider Portal – Create An Account

Registration is free and easy

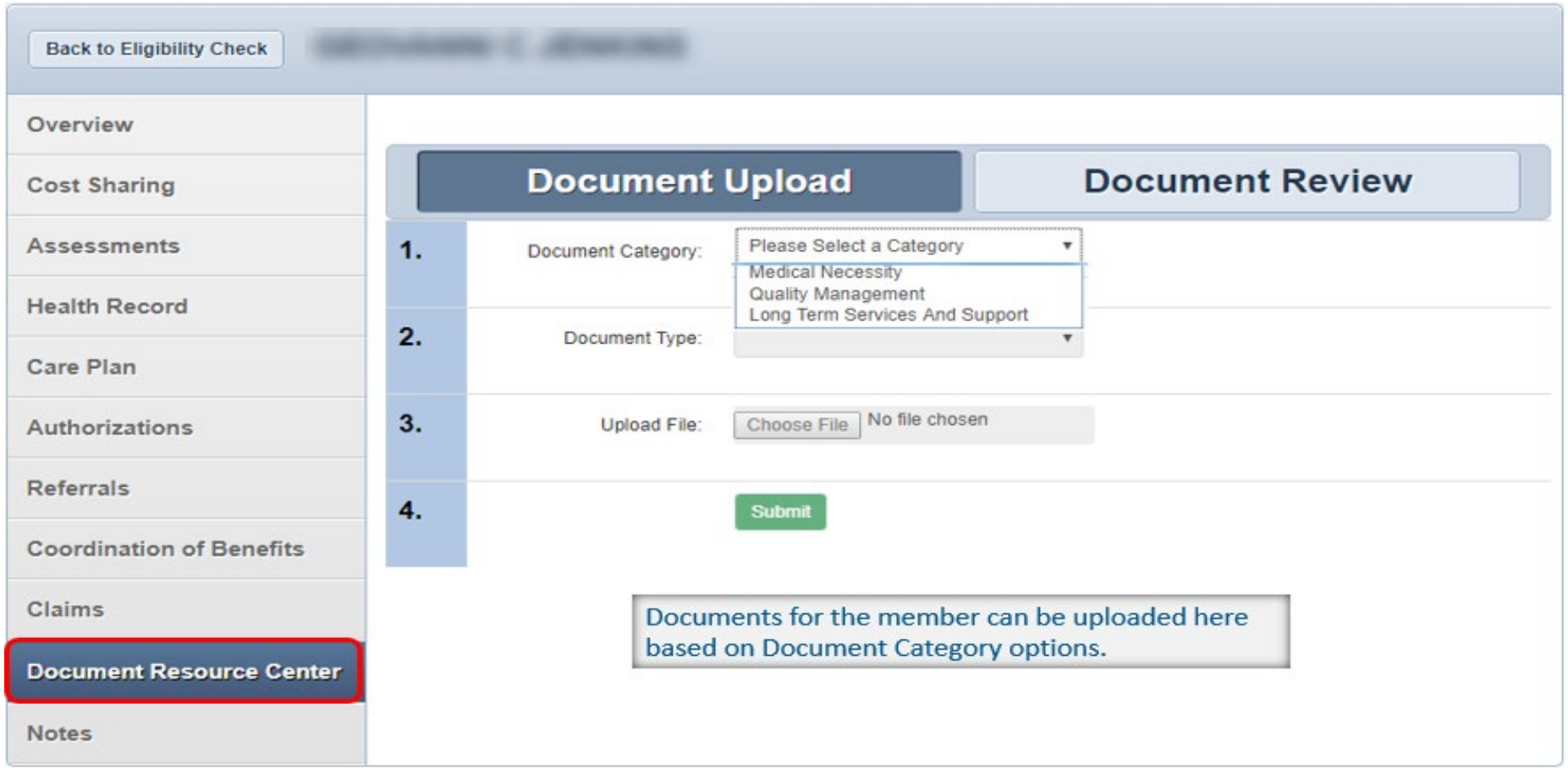
Provider.ARHealthWellness.com



Secure Portal Features

- A member eligibility overview page that reflects all critical data in a single view
- Ability to submit and track the status of claim reconsiderations online
- Expanded free text fields for reconsideration comments and explanations
- Attach required documentation when filing a reconsideration
- Upload records for care gap information
- Receive push notifications regarding reconsideration status changes
- Void/Recoup option on claims already adjudicated by the health plan
  (refer to page 92 of the manual available in the Portal for instructions)

Patient Overview – Document Resource Center



Availity Essentials

Availity Essentials

- Effective November 18, 2024, you can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access Arkansas Health & Wellness payer resources through Availity Essentials.
- If you are already working in Essentials, log in to your existing Essentials account to enjoy these benefits.
- Use Availity Essentials to verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and more.
- Look for additional functionality in Arkansas Health & Wellness' payer space on Essentials and use the heart icon to add apps to My Favorites in the top navigation bar. Access Manage My Organization — save provider information in Essentials and auto-populate it to save time and prevent errors.
- If you are new to Availity Essentials, getting your Essentials account is the first step toward working with Arkansas Health & Wellness on Availity.

Availity Designation

Designate an Availity administrator for your provider organization

Your provider organization's designated Availity administrator is the person responsible for registering your organization in Essentials and managing user accounts. This person should have legal authority to sign agreements for your organization.

How does this impact me?	What is my next best step?
I am the administrator. *I am the designated Availity administrator for my organization.*	Visit **Register and Get Started With Availity Essentials** to enroll for training and access other helpful resources.
I am not the administrator. *I am NOT the designated Availity administrator for my organization.*	Your designated Availity administrator will determine who needs access to Availity Essentials on behalf of your organization and will add user accounts in Essentials.
I am not sure. *I am not sure who will be the designated Availity administrator for my organization.*	Share this information with your manager to help determine who will be the designated Availity administrator for your organization.

Availity Contact Information

- Join one of our upcoming free webinars, Availity Essentials Overview, to learn additional tips for streamlining your workflow. We'll show you how to verify eligibility and benefits, submit claims, check claim status, submit authorizations, and more.

- We're excited to welcome you to Availity Essentials, helping you transform the way you impact patient care with Arkansas Health & Wellness . If you need additional assistance with your registration, please call Availity Client Services at 1-800-AVAILITY (1-800-282-4548). Assistance is available Monday through Friday from 7 a.m. to 7 p.m. CT.

- For general questions, please reach out to your Provider Relations Representative.

Sober Sidekick Program

Sober Sidekick Program

Sober Sidekick is a virtual platform designed to empower addiction by connecting individuals with tools and resources in their communities. This includes creating opportunities for connection, encouragement, and shared experiences through its peer-driven community.

By gathering and analyzing behavioral insights, the partnership will enable a deeper understanding of challenges and opportunities, allowing for more proactive and supportive care for those in recovery.

This resource is available to all Arkansas residents in partnership with Ambetter from Arkansas Health & Wellness.

This program is:

- **Bridging Gaps in Care**
- **Reducing Relapse Rates**
- **Scalable Recovery Support**
- **Available to all Arkansans**

Transitional Care Management (TCM)

Transitional Care Management (TCM)

- The TCM program is a new initiative by Arkansas Health & Wellness aimed at improving the care coordination and outcomes for high-risk behavioral health members with high-risk substance use disorders receiving inpatient treatment. By providing targeted support before discharge, we aim to reduce readmission rates and enhance the overall quality of care.

- The TCM team is here to assist members in coordinating medical, behavioral, and social needs prior to discharging and upon entry into the community. The team's goal is to ensure members are equipped with appropriate resources and support to facilitate an easy transition from your facility.

How TCM Program Works

1. **Identification**
   Care managers will identify high-risk behavioral health members who are receiving inpatient treatment.

2. **Assessment**
   A thorough assessment will be conducted to understand the members needs and develop a care plan.

3. **Coordination**
   The care manager will work closely with the member, facility, staff, and other providers to coordinate care and ensure a smooth transition.

4. **Follow-Up**
   After discharge, the care manager will continue to follow up with the member to monitor progress and address any issues that arise.

The TCM team will contact the treating provider to coordinate a meeting with the member while the member is still receiving inpatient care. This interaction is intended to support both the provider and the member. Some of the support provided can include assistance with discharge planning, coordinating resources, addressing social determinants of health (SDoH), and care gaps. The goal is to ensure all discharge needs are addressed prior to returning to their community setting.

Key Benefits of TCM Initiative

- **Improved Member Outcomes**
  Coordinating care before discharge, members receive more comprehensive support, leading to better health outcomes.

- **Reduced Readmission Rates**
  Aims to reduce the likelihood of members being readmitted to the hospital by ensuring they have the necessary resources and follow-up care.

- **Enhanced Care Coordination**
  Facilitates better communication between care providers, ensuring that all aspects of the members care are addressed.

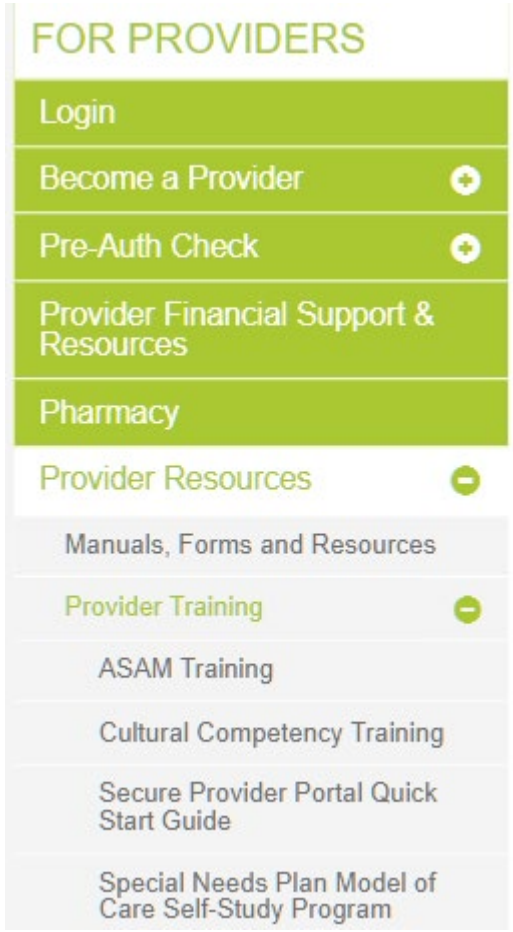
- **Member Empowerment**
  Empowers members to take an active role in their care by providing them with the resources and support they need.

- **Provider Collaboration**
  By engaging providers in a coordinated care approach, the program ensures that all stakeholders are informed and aligned on the members care plan.

TCM contact Care Manager for questions at 1-800-575-2763 or email Provider Relations at Providers@ARHealthWellness.com

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

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

Risk Adjustment Overview

Risk adjustment is a tool used to predict the likely use and cost of healthcare based on an individual's healthcare status or Risk Adjustment Factor (RAF) score, which is contingent on factors such as age, gender, community status, and severity of health conditions.

RAF Score								
Age	+	Gender	+	Demographic	+	Diagnosis	+	Original Reason for Entitlement

Hierarchical Condition Categories (HCC)

HCCs reflect hierarchies among related disease categories.

- Only the most severe HCC within a hierarchy is calculated in RAF.
- HCCs captured from unrelated diagnoses are cumulative.
- HCCs must be reported annually.
  - Reporting period is from January 1 – December 31.

CMS determines the qualifying ICD-10 diagnosis codes for each category and assigns the risk factor value.

- Not all diagnoses map to an HCC.
- Some diagnoses map to multiple HCCs.
- ICD-10 diagnoses that map to an HCC must be captured at least once per calendar year.

Importance of Risk Adjustment

Identify actual disease burden of member and patient population

Improved quality of care through disease management programs

Ensure coverage of health expenditures and appropriate risk premiums

Program Goals

We are committed to helping our provider partners:

- Understand Risk Adjustment concepts
- Apply best practices to workflow
- Increase HCC coding proficiency
- Improve quality of care provided

MEAT Documentation

M **Monitor**	Document signs, symptoms, disease progression, and ongoing surveillance of the chronic condition.
E **Evaluate**	Document current state of chronic condition, physical exam findings, test results, medication effectiveness, and response to treatment.
A **Assess**	Document discussion of chronic condition, review of records, counseling, how chronic conditions will be managed, and the need for further tests.
T **Treat**	Document care being offered for chronic condition(s), prescribing or continuing of medications, referring to specialists, ordering diagnostic studies, therapeutic services (therapies), other modalities, and planning for management of chronic condition(s).

Medical Record Requirements

- Face-to-face encounter
- Correct entry for date of service
- Two patient identifiers on every page
- Acceptable provider type
- Proper signature with credentials
- Acceptable service type
- Use of standard abbreviations
- Clear and legible handwriting

Risk Adjustment Program Initiatives

Continuity of Care (CoC)	Provider incentive program — Increases visibility into members' existing medical conditions for chronic condition management (PCP only).
In-Office Assessment (IOA)	Provider incentive program — Supports early detection and ongoing annual assessment of chronic conditions for patients to help improve health outcomes.
Clinical Documentation Improvement (CDI)	Complimentary review of provider coding and documentation trends with education tailored to review findings.
Annual Chart Review Projects	Vendor works with providers and health plan to retrieve medical records and accurately report members health status in compliance with RA guidelines.

2025 Continuity of Care Programs (CoC & CoC+)

CoC Program

Incentive Eligibility Requirements

Participating PCPs can earn up to $300 per member. Provider within assigned TIN must:

- Complete a qualified visit with member during the program year (January – December)
- Prospectively address patient conditions at the point of care utilizing appointment agenda
- Include ICD-10 code(s) for all active conditions (supported in the medical record) on claim for DOS
- Submit completed agenda with 100% of conditions assessed

CoC+ Program

Additional incentive opportunity:

$150	per Medicare Agenda
$100	per Marketplace Agenda

All boxes related to the high risk, care guidance, clinical, and/or drivers of health portions must be checked and verified, where applicable.

The submission deadline for CoC+ has been extended to January 31, 2026, with a DOS by December 31, 2025.

2025 Program runs through December 31st.

Medical Record Requests

- Members diagnostic data submitted by the health plan for risk adjustment purposes is subject to annual review. There must be documented evidence supporting every diagnosis reported through claims.
- To ensure ICD-10-CM codes obtained from claims submissions are accurate and conform to applicable risk adjustment regulation, annual medical record retrieval and review is required.
- Prompt compliance and cooperation in providing medical records requested through our HIPPA contracted business partners or to the health plan directly is important to business operations.

Risk Adjustment Medical Record Requests from Behavioral Health Providers

Medical record requests include:

- **Progress notes** — documentation should include session start and stop time, treatment type and frequency, diagnosis, treatment plan, symptoms, prognosis, and patient progress.

- **Mental Health Assessment** — document BRIEF summary to include client name, date of birth, diagnosis, dates of service, general reason for treatment, basic description of client symptoms, treatment plan goals, session modality/frequency (average), length of sessions, progress, and prognosis. A few sentences for each of these areas is fine.

Private psychotherapy notes should remain separate from the patient's chart and are not part of the medical record request for risk adjustment purposes. (45 CFR 164.501)

All documentation (progress notes, treatment summaries, etc.) must be legible and signed by the provider rendering the services and include provider's credentials.

Risk Adjustment Data Validation (RADV) Policy Updates

Centers for Medicare and Medicaid Services (CMS) has implemented policy changes for RADV

- Annual audits for all Marketplace and Medicare Advantage plans
- Expanded record samples
- Accelerated audit timelines through 2026

Due to CMS aggressive workplan, providers may experience:

- Higher volume of record requests
- Tighter turnaround windows

EMR Integration

Benefits of automated data exchange between payor and provider:

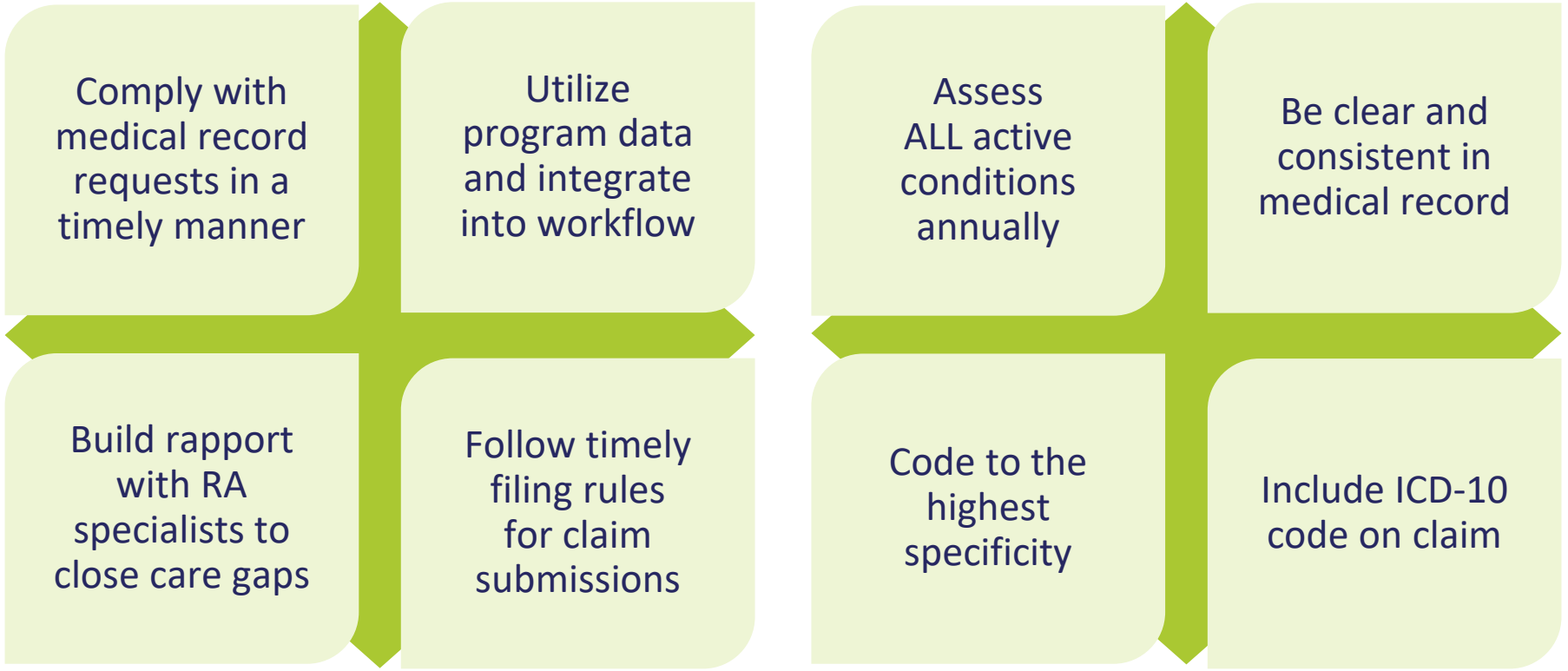
- Increased data accuracy
- Improved workflow
- Decreased administrative burden
- Enhanced patient care
- Better health outcomes

Bi-Directional Feed and Point-of-Care Alerts available with:

- Epic Payor Platform
- Healow
- Moxe
- Athena
- Veradigm

Future Connections: VIM, and Oracle

Summary of Best Practices



Quality Improvement

2025 Wellcare Partnership for Quality (P4Q) Program

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Program Measures	Amount Per
BCS — Breast Cancer Screening	$50
CBP — Controlling High Blood Pressure	$75
COA — Care for Older Adults — Functional Status*	$25
COL — Colorectal Cancer Screen	$50
EED — Diabetes — Dilated Eye Exam	$25
FMC — F/U ED Multiple High Risk Chronic Conditions	$50
GSD — Diabetes HbA1c ≤ 9	$75
KED — Kidney Health Evaluation for Patients with Diabetes	$50

Program Measures	Amount Per
Medication Adherence — Blood Pressure Medications	$50
Medication Adherence — Diabetes Medications	$50
Medication Adherence — Statins	$50
OMW — Osteoporosis Management in Women Who Had Fracture	$50
SPC — Statin Therapy for Patients with CVD	$25
SUPD — Statin Use in Persons With Diabetes	$25
TRC — Medication Reconciliation Post Discharge	$25

*Special Needs Plan (SNP) members only.

2025 Wellcare Partnership for Quality (P4Q) Program

The 2025 P4Q bonus program give providers the opportunity to earn an incentive by addressing preventive care measures and closing gaps in members' care.

1. **Contact patients to schedule an appointment to see you.**
   At the visit, order appropriate tests and preventive screenings, as applicable.
   Take action to help patients complete all preventive care and close care gaps by December 31, 2025.

2. **Upon completion of the examination, document care and treatment (not diagnosis)** in the patient's medical record and submit all applicable diagnoses codes on claims, encounter files and/or approved NCQA supplemental electronic flat files containing all relevant ICD-10, CPT and CPT II codes by January 31, 2026.

3. **Review and counsel on results of tests and screening with patients.**

2025 Peak P4Q Performance

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What is the Peak P4Q Performance Program?

- Wellcare's Partnership for Quality (P4Q) Performance Program rewards primary care providers for improving member health outcomes. Peak P4Q Bonus is an additional payment earned for quality care gaps closed for eligible members between August 1, 2025 through December 31, 2025. Peak payments can be earned two ways:

  ✓ Close a quality care gap for a member who is eligible for the Peak P4Q program.

  ✓ Earn an extra bonus if that member is also identified as a Clinical Priority Patient.

  * Bonuses are in addition to the compensation you may receive under the Partnership for Quality (P4Q) Program.

- All claims, encounter files and/or approved NCQA supplemental electronic flat files must be submitted by January 31, 2026.

2025 Peak P4Q Performance

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Target Measures and Bonus Amounts

For more than 20 years, Wellcare has offered a range of Medicare products, including affordable coverage beyond Original Medicare. Beginning Jan. 1, 2022, our affiliated Medicare product brands, including Allwell, Fidelis Care, Health Net Ruby, and Trillium Advantage, will transition to the Wellcare name brand. If you have any questions, please contact Provider Relations.

Measure	P4Q Bonus	Peak Bonus	Peak Clinical Priority Bonus	Earning Potential Total
BCS – Breast Cancer Screening	$50	$15	$35	$100
CBP – Controlling High Blood Pressure	$75	$25	$50	$150
COA – Care of Older Adult – Functional Status Assessment**	$25	$10	$15	$50
COA – Care of Older Adult – Medication Review**	N/A	$10	$15	$25
COL – Colorectal Cancer Screen	$50	$15	$35	$100
EED – Diabetes - Dilated Eye Exam	$25	$10	$15	$50
FMFC - F/U ED Multiple High Risk Chronic Conditions	$50	$15	$35	$100 (continued)

2025 Peak P4Q Performance

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Helping Arkansas Live Better

Target Measures and Bonus Amounts (continued)

Measure	P4Q Bonus	Peak Bonus	Peak Clinical Priority Bonus	Earning Potential Total
GSD – Diabetes HbA1c ≤ 9	$75	$25	$50	$150
KED – Kidney Health for Patients with Diabetes	$50	$15	$35	$100
Medication Adherence – Blood Pressure Medications (SNP patients only)	$50	N/A	N/A	$50
Medication Adherence – Diabetes Medications	$50	N/A	N/A	$50
Medication Adherence – Statins	$50	N/A	N/A	$50
OMW – Osteoporosis Management in Women Who Had a Fracture	$50	$15	$35	$100
SPC – Statin Therapy for Patients with CVD	$25	$10	$15	$50
SUPD – Statin Use in Persons with Diabetes	$25	$10	$15	$50
TRC – Medication Reconciliation Post Discharge	$25	$10	$15	$50

2025 Peak P4Q Performance

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Clinical Priority Patients

Clinical Priority patients may require a greater level of medical attention due to chronic illnesses, disabilities, age, or other factors that necessitate the need for more frequent provider visits, specialized treatments, and chronic care support. These patients are indicated in your Gap in Care Reports. For questions, please reach out to your Health Plan Provider Representative.

Peak Performance Bonus Instructions

1. Contact patients, order tests and screenings, schedule appointments as applicable to help ensure that the patient completes the needed tests/screenings by December 31, 2025.
2. Upon completion of the examination, document care and diagnosis in the patient's medical record and submit the claims encounter files and/or approved NCQA supplemental electronic flat files containing all relevant ICD-10, CPT, and CPT II codes by January 31, 2026.
3. Review tests and screening results with patients.

2025 Ambetter P4P

The 2025 P4P bonus program has four payment cycles. In Cycles 1–3, earnings less than $100 will automatically be rolled over to the next payment cycle. Any balances under $100 will be disbursed in Cycle 4. Payments for medication adherence measures CBP (controlling high blood pressure) and GSD (diabetes HbA1c ≤ 9) will be included only in Cycle 4.

2025 Measure List	Measure Incentive	Target 1 Pays 75% of Incentive	Target 2 Pays 100% of Incentive
Cervical Cancer Screening (CCS)	$25	56.90%	65.00%
Colorectal Cancer Screening (COL)	$25	56.90%	62.80%
Child and Adolescent Well-Care Visits (WCV)	$25	50.50%	59.60%
Controlling High Blood Pressure (CBP)	$25	67.80%	72.90%
Glycemic Status Assessment for Patients with Diabetes <9 (GSD)	$25	72.50%	77.40%
Eye Exam for Patients with Diabetes (EED)	$25	42.40%	52.90%
Patients with Diabetes Kidney Health Evaluation (KED)	$25	46.70%	55.40%
Breast Cancer Screening (BCS)	$25	71.50%	75.70%
Chlamydia Screening in Women (CHL)	$25	43.80%	51.50%
Plan All-Cause Readmissions (PCR)	$25	64.00%	55.50%

CPT II Codes and HCPCS Billing for Medicare Advantage

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Submitting CPT II and HCPCS codes improve efficiencies in closing patient care gaps and in data collection for performance measurement. Wellcare has taken steps to help ensure submissions for the following select codes to the Medicare fee schedule at a price of $0.01.

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 Reviews (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, 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	

CPT II Codes and HCPCS Billing for Medicare Advantage

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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 of retinopathy • 2024F Seven (7) standard field 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

Medicare Annual Wellness Visit (AWV)

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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 of 25.

AWV Topic Discussions

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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 preventive 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)

Topics to discuss during your patient's Routine Physical Visit:

- Health history
- Vital signs
- Heart, lung, head/neck, abdominal, neurological, dermatological, extremities, and gender specific exam

AWV Quick Reference & Tips

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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

As Needed

- Osteoporosis screening and management after fracture

Important Cancer Screenings

- Colon cancer screening (colonoscopy, FIT-DNA test, Cologuard®)
- Breast cancer screening
- Prostate cancer screening

Care for Older Adults

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

AWV Quick Reference & Tips

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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

Tips to Ensure Healthy Outcomes

- Always share tests and screenings results with members, and discuss how they can access them, via a patient portal
- Be sure to submit all applicable conditions, via IDC-10 codes
- Leverage CPT Category II codes to ensure outcomes in order to reduce chart collection events

What To Do After You Are Admitted to the Hospital

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Getting Back to Your Best Health

After a hospital or emergency room (ER) visit, recovery can be challenging. There are many things you can do to improve your health. One of the most important is scheduling a follow-up visit with your doctor within 7 days after a hospital or ER visit, unless otherwise directed.

You should have a follow-up visit with your primary care doctor within 7 days of being released from the hospital. Your clinical team will try to call or contact you after you are discharged to help schedule this visit. It is helpful to bring a list of all current medications and your hospital discharge documentation to your follow-up visit.

What To Do After You Are Admitted to the Hospital

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We're Here to Help

Being admitted to the hospital or ER can be overwhelming. Your doctor may have prescribed new medications, follow-up treatment, or encouraged you to make lifestyle changes. We want to help you navigate these changes, through your recovery and beyond.

Our care management team has resources that can help you reach your health goals.

Following your ER visit or hospitalization, your care manager can help you with many things including scheduling your follow-up appointments and transportation assistance. They can also help keep track of your medication and help you manage multiple conditions. Annual wellness visits, virtual visits, and digital care management opportunities with your care manager are available upon request.

What To Do After You Are Admitted to the Hospital

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Did you know?

We provide In-Home Support Services to help you maintain your health and independence. We offer two options for this service:

1. **Chores Only:**
   Receive two-hour visits from a care professional who will help with chores and meal preparation.
2. **Personal Care Services and Chores:**
   Receive four-hour visits from a care professional who will help with dressing, bathing, feeding, and other day-to-day activities, as well as assist with chores and meal preparation.

See if you qualify today!

Call 1-866-635-7049 (TTY: 771) to learn more or to sign up for case management.

More helpful numbers:

- Member Services: 1-833-444-9088
- Nurse Advice Line: 1-800-581-9952 (available 24 hours, 7 days a week, 365 days a year)

Concurrent Use of Opioids and Benzodiazepines

Quality Measure	Description
Concurrent Use of Opioids and Benzodiazepines (COB)	Percentage of patients ages 18 years or older with 30 cumulative days of overlap with opioids and benzodiazepines
COB Exclusions	Patients diagnosed with cancer, sickle cell disease, or enrolled in hospice.
What qualifies a member for the COB measure?	Two fills of any opioids with at least 15 cumulative days' supply during the year.
What makes a member non-compliant with the COB measure?	At least two fills of any benzodiazepine(s) with 30 days of overlap with opioids during the year.

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults

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POLY-ACH Measure

The POLY-ACH measure in the Centers for Medicare & Medicaid Services (CMS) Star Ratings uses concurrent use of two or more anticholinergic medications for a significant period to evaluate health plans.

Quality Measure	Description
Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)	Percentage of patients ages 65 years or older with concurrent use of two or more unique anticholinergic medications for 30 cumulative days.
POLY-ACH Exclusions	Patients enrolled in hospice.
Who qualifies for the measure?	Members, ages 65 years and older, with at least two prescription claims for the same anticholinergic medication with different dates of service.
Who is considered to be non-compliant with the measure?	Members who have at least two prescription claims of at least two unique anticholinergic medications with 30 days of overlapping use.

Medication Adherence Tips

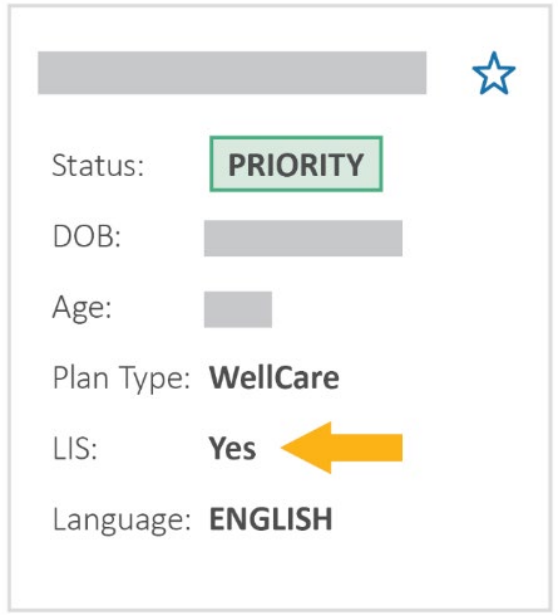
RxEffect LIS Indicator: If the LIS flag reflects 'Yes,' your patient is eligible to fill a 90-day prescription for the same cost as a 30-day prescription.

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.



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)

Representatives are available Monday through Friday from 8 a.m. to 5 p.m. CT

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

Provider Inquiries

- After speaking with a Provider Services Representative, you will receive a reference number, which will be used to track the status of your inquiry.
- If you need to contact your assigned Provider Relations Representative, you must have the following when submitting an email inquiry:
  - Reference number assigned by the Provider Services Center
  - Provider's Name
  - Tax ID
  - National Provider Identifier (NPI)
  - Summary of the issue
  - Claim numbers (if applicable)

Providers@ARHealthWellness.com

Contracting Department

Phone Number: 1-844-631-6830

Hours of Operation: 8 a.m.–4:30 p.m.

Press 1	If you know your party's extension	Press 2	Ambetter	Press 3	Wellcare by Allwell	Press 4	Arkansas Total Care	Press 5	To repeat prompts

Provider Contracting Email Address: ArkansasContracting@Centene.com

- Regular contracting inquiries and contract requests

Credentialing Department

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