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2025 Fourth Quarter
Provider Webinar

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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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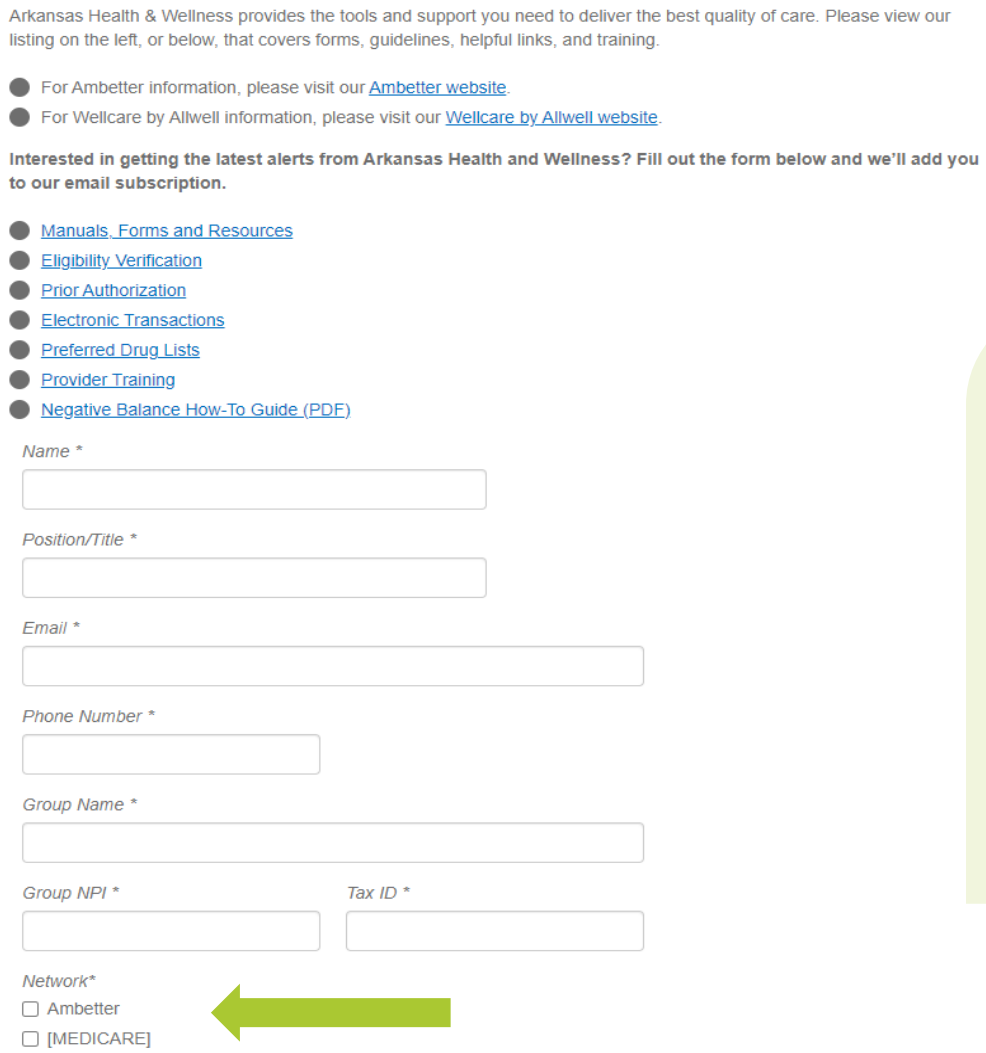
Agenda

- How to Join Our Email List
- Clinical and Payment Policy Updates
- Coverage Changes for ARHOME
- Appointment Availability & Wait Times
- Prior Authorizations
- Pre-Auth Check Tool
- Secure Provider Portal
- Availity Essentials
- Sober Sidekick Program
- Transitional Care Management (TCM)
- Provider Self-Led Trainings
- Risk Adjustment
- Quality Improvement
- Contact Information

How to Join Our Email List



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

☐ [MEDICARE]

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

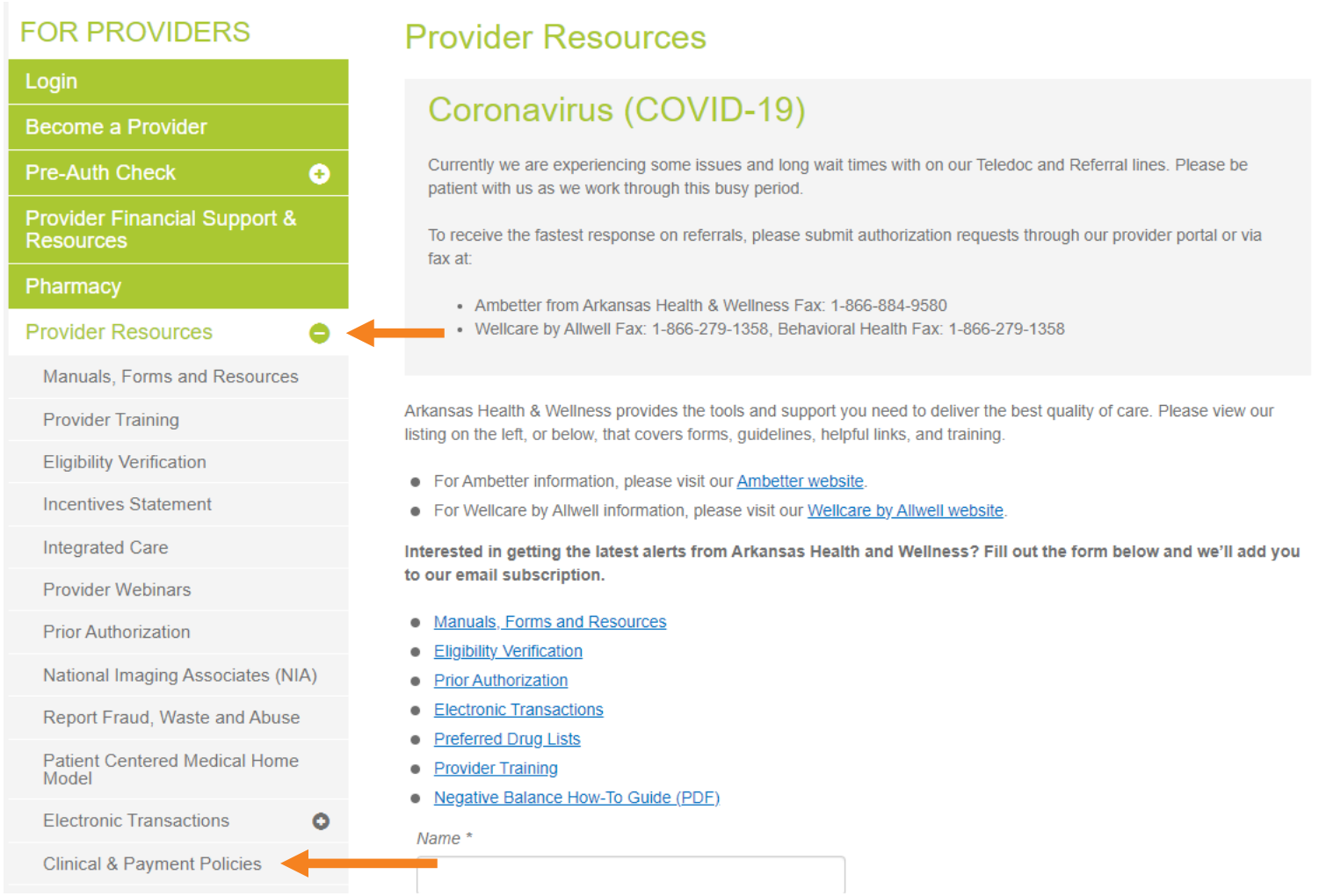
Clinical and Payment Policy Updates

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

Clinical Policies for Ambetter

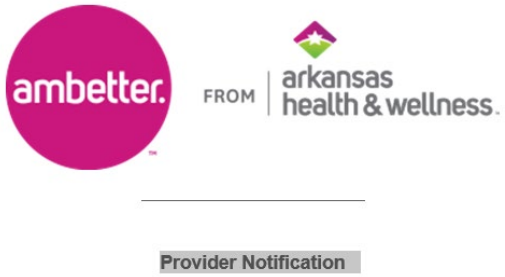
- CP.MP.94 Clinical Trials, Effective August 1, 2025

Clinical and Payment Policy Updates



Coverage Changes for ARHOME

Coverage Changes for ARHOME



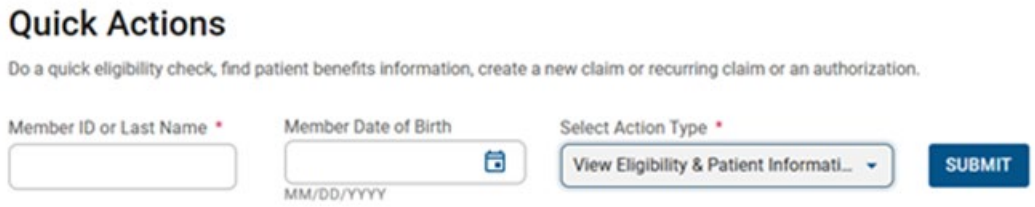
Effective January 1, 2026, Ambetter's ARHOME coverage will become the payer of last resort for coordination of benefits purposes. This means that if members have any other insurance, it must pay first and Ambetter will pay claims as secondary.

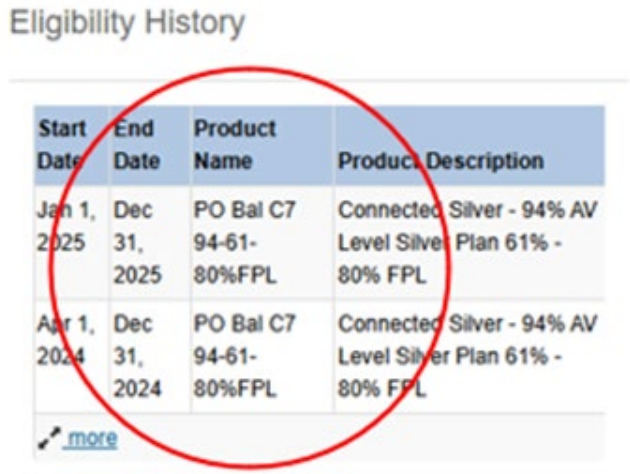
There are three main ways you can check to see if a member has an ARHOME plan.

Coverage Changes for ARHOME

1. Secure Provider Portal

Log in to your Ambetter Provider Portal at Provider.ARHealthWellness.com and use the Quick Actions tool to search for the appropriate member. If they have an ARHOME plan, the plan product name will start with a “PO Bal” identifier:

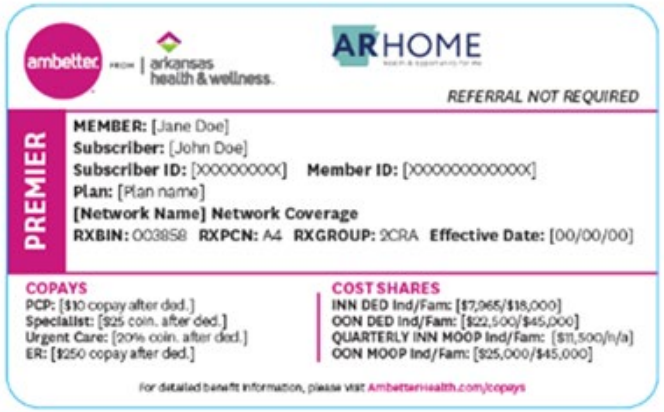




Coverage Changes for ARHOME

2. Member ID Card

Check the member's Ambetter ID card. If it has a blue ARHOME logo on the front, beside the Ambetter logo, that member is part of an ARHOME plan.



Coverage Changes for ARHOME

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3. Call Center

Our call center is available to assist you in reviewing a member's plan division to determine whether they are an ARHOME member. Give us a call at 1-877-617-0390 (TTY: 1-877-617-0392).

What do I need to do?

For Ambetter members with ARHOME coverage, file claims with the primary insurance carrier first. You should file with Ambetter only after the claim has been filed with the primary carrier.

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. 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. The table below depicts the appointment availability for members:

Appointment Access Calendar

Appointment Type	Access Standard
PCPs – Routine Visits	15 business days
PCPs – Adult Sick Visit	48 hours
PCPs – Pediatric Sick Visit	48 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 & 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. The table below 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

Prior Authorizations

How to Secure Prior Authorization

Prior Authorizations can be requested in the following ways

- **Secure Web Portal**: This is the preferred and fastest method
  - Ambetter and Wellcare by Allwell: Provider.ARHealthWellness.com

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

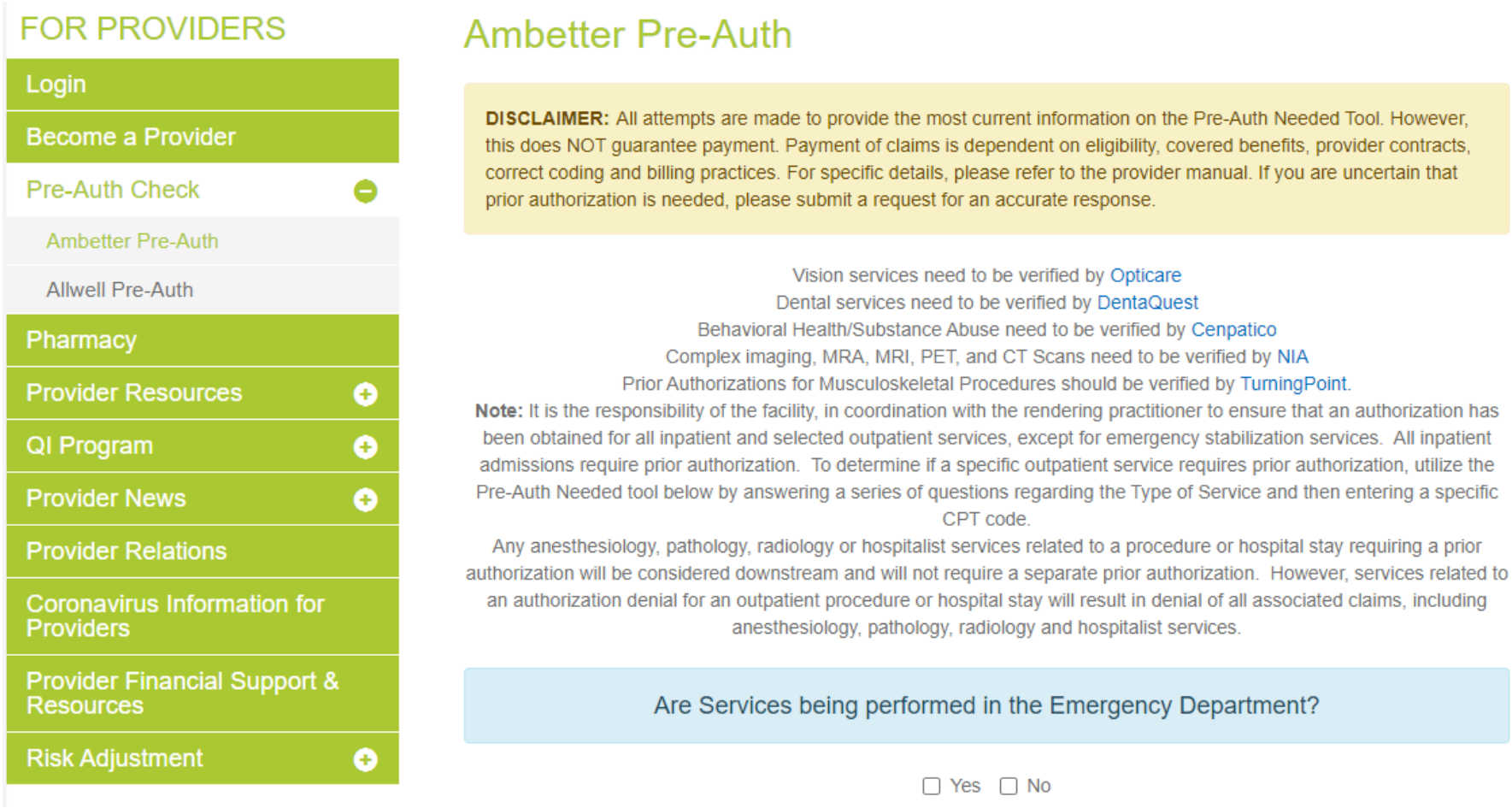
- **Fax** — IP and OP paper forms available on the website under Provider Resources
  - Ambetter: 1-866-884-9580
  - Wellcare by Allwell: 1-833-562-7172

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

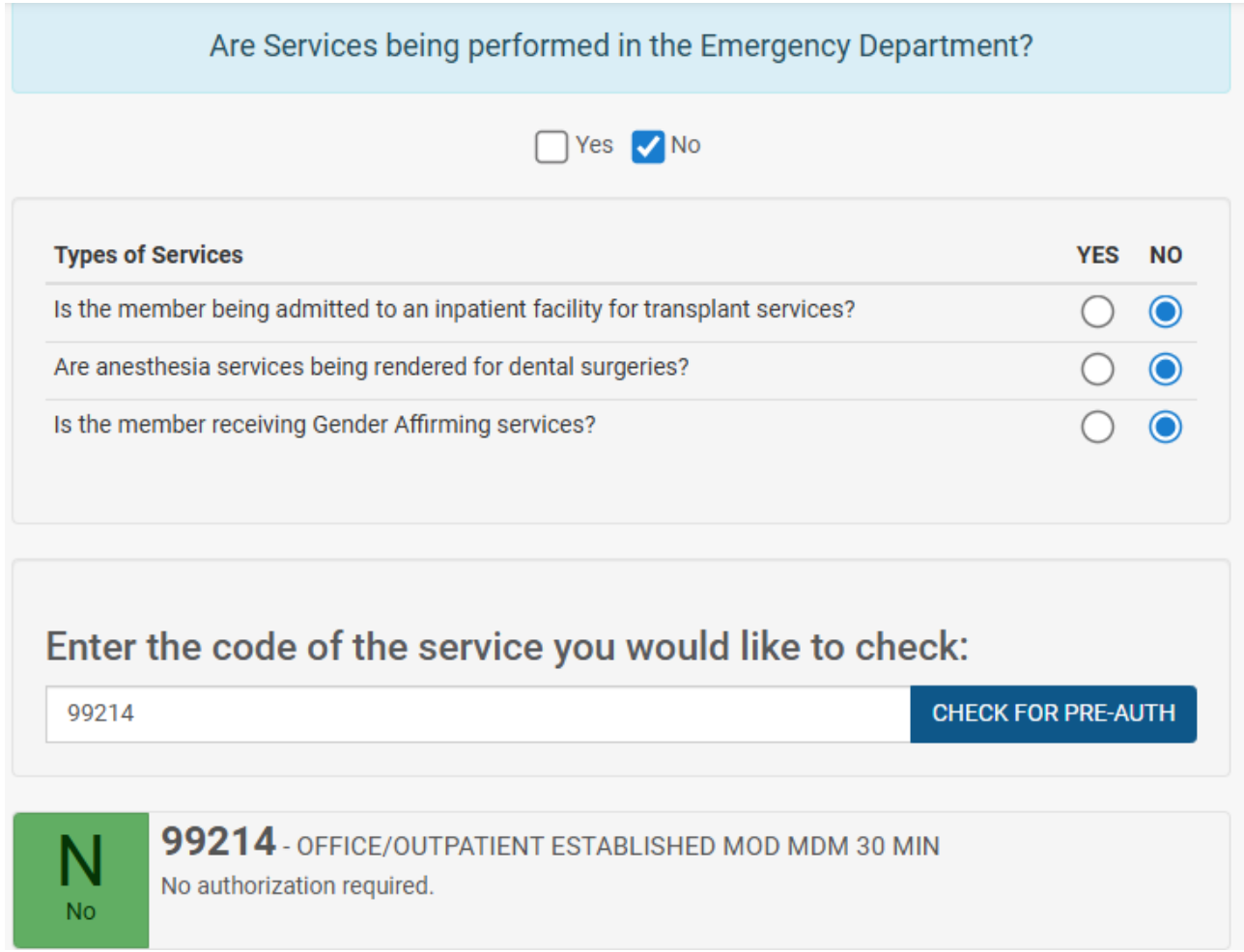
Pre-Auth Check Tool

Pre-Auth Check Tool

To access the Pre-Auth Check tool online, visit: Provider.ARHealthWellness.com and click Pre-Auth Check



Pre-Auth Check Tool

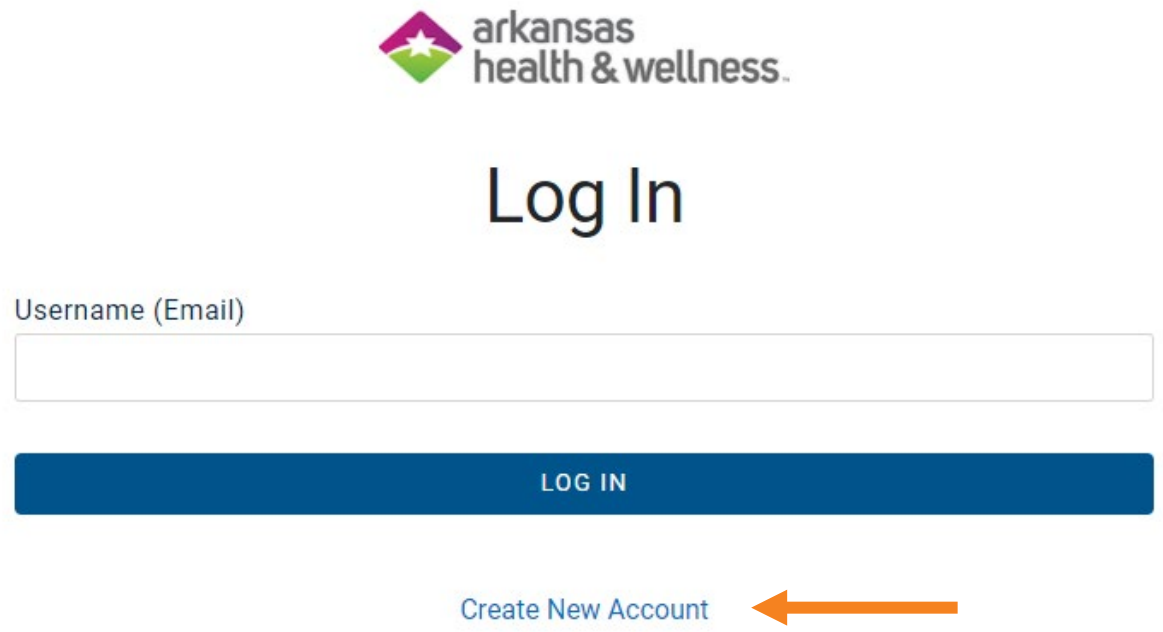


Secure Provider Portal

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
- Ability to attach required documentation when filing a reconsideration
- Ability to upload records for care gap information
- Push notifications regarding reconsideration status changes
- Void/Recoup option on claims already adjudicated by the health plan. The manual inside the portal has instructions for this feature on page 92.

Availity Essentials

Availity Essentials

- Arkansas Health & Wellness has chosen a new platform for the Secure Provider Portal. As of 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, you can 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. Our current Secure Provider Portal will still be available for other functions you may use now.
- 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

Getting Started: 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 for Arkansas Health & Wellness***, 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 Arkansas Health & Wellness at **1-800-294-3557 (TTY: 1-877-617-0392)**.

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.

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

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

Transitional Care Management (TCM)

Transitional Care Management (TCM)

- Arkansas Health & Wellness is introducing a new way to work in partnership with Transitional Care Management. 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 the 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

- **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.

Contact a 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

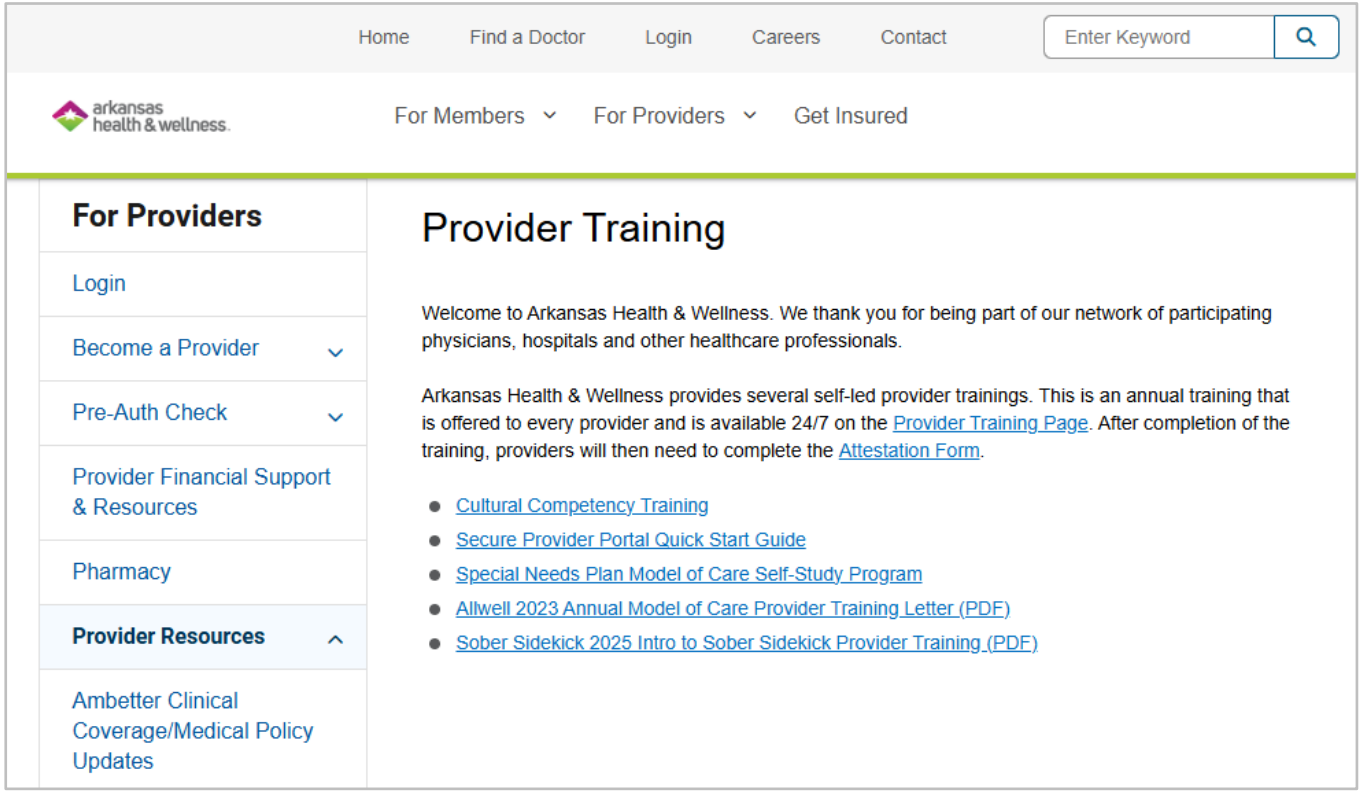
Welcome to Arkansas Health & Wellness. We thank you for being part of our network of participating physicians, hospitals, and other healthcare professionals.

Arkansas Health & Wellness offers several self-led provider trainings. These are annual in nature and are available 24/7 through the Provider Training Page on our website. After completing a training, providers should submit an Attestation Form.

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 on our website. After completing a training, providers should submit an Attestation Form.



Risk Adjustment

Risk Adjustment

Risk adjustment is a tool used to predict the likely use and cost of healthcare based on an individual's risk factors, including:

- Age
- Gender
- Community Status
- Severity of health conditions

RAF Score						
Age	+	Gender	+	Disease Conditions	+	Reason for Entitlement

Hierarchical Condition Categories (HCCs)

- 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

Risk Adjustment 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 Risk Adjustment 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

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 Programs run through December 31

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 HIPPAA contracted business partners or to the health plan directly is important to business operations.

Risk Adjustment & 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 a 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 (e.g., 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

CMS has implemented policy changes for RADV

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

Providers may experience:

- Higher volume of record requests
- Tighter turnaround windows

EMR Integration

Benefits of automated data exchange between payor and provider:

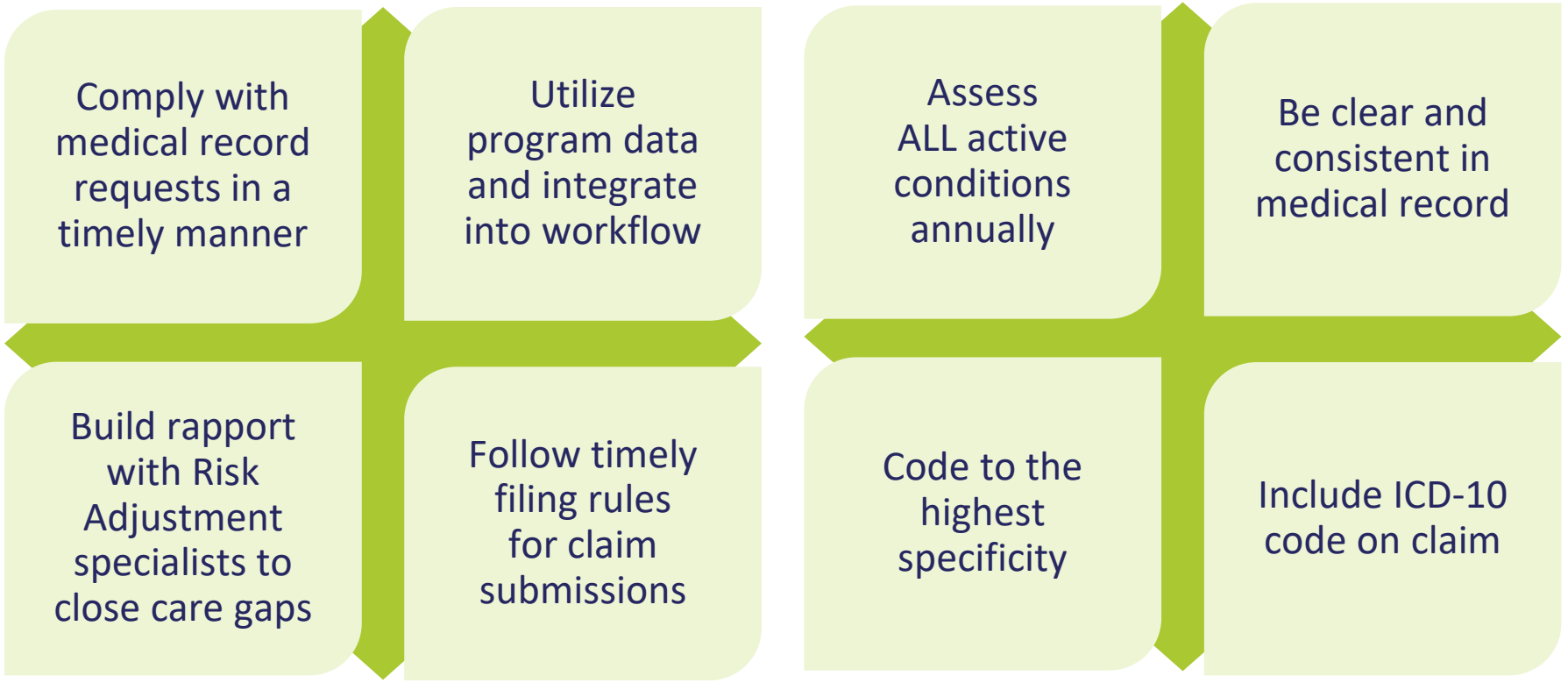
- Increased data accuracy
- Improved workflow
- Decreased administrative burden
- Enhanced patient care
- Better health outcomes

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 Partnership for Quality (P4Q)

Program Measure	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
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

2025 P4Q Bonus Instructions

- 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.
- 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.
- Review and counsel on results of tests and screening with patients.

2025 Peak 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.*

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 for Older Adult – Functional Status Assessment**	$25	$10	$15	$50
COA	Care for 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
FMC	F/U ED Multiple High Risk Chronic Conditions	$50	$15	$35	$100

2025 Peak Performance

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	$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

**Special Needs Plan (SNP) patients only*

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 P4Q Payment Information

The 2025 P4Q program has four payment cycles. Earnings in cycles one through three that are less than $100 will automatically be rolled to the next payment cycle. Any balances under $100 will be disbursed in cycle four. Payments for Medication Adherence measures, CBP – Controlling High Blood Pressure, and GSD – Diabetes HbA1c ≤ 9 will only be included in cycle four.

2025 Ambetter Pay for Performance (P4P) Program

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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

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 • 1124F Advance care planning discussed and documented; patient did not wish or was not able to name a surrogate decision maker • 1157F Advance care plan or similar legal document present in medical record • 1158F Advance care planning discussion documented	• S0257–Advance care planning; counseling and discussion regarding advance directives or end-of-life decisions
Medication Review (Review and List)	• 1159F Medication list documented (bill with 1160F) • 1160F Review of all medications documented by practitioner or pharmacist	• G8427–Medication list attestation by clinician
Medication Reconciliation	• 1111F Discharge medications reconciled with medication list	
Functional Status Assessment	• 1170F Functional status assessed	
Pain Assessment	• 1125F Pain present; severity quantified • 1126F No pain present; severity quantified	

CPT II Codes and HCPCS Billing for Medicare Advantage

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 reviewed; with evidence of retinopathy • 2023F Dilated retinal exam reviewed; without evidence of retinopathy • 2024F Seven standard field stereoscopic photos; with retinopathy • 2025F Seven standard field stereoscopic photos; without retinopathy • 2026F Eye imaging validated; with retinopathy • 2033F Eye imaging validated; without retinopathy • 3072F Low risk for retinopathy (no evidence in prior year)	• S0620 Diabetic Retinal Screening – established patient • S0621 Diabetic Retinal Screening – new patient • S3000 Diabetic retinal screening; bilateral

Medicare Annual Wellness Visit (AWV)

Wellcare members are covered for:	Description	Codes / Frequency
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.	One 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.	One per calendar year 99381–99387* (new patient) 99391–99397** (established patient)

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

AWV Topic Discussions

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, 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

arkansas health & wellness

For People with Diabetes

- Annual diabetic retinal eye exam
- Review adherence of diabetes medications and evaluate statin needs
- Blood pressure monitoring
- Testing and control of HbA1c
- Kidney function tests
- Medical attention for nephropathy

Care for Older Adults

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

As Needed

- Osteoporosis screening and management after fracture

Adult Vaccinations

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

Important Cancer Screenings:

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

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 ICD 10 codes
- Leverage CPT Category II codes to ensure outcomes and reduce chart collection events

Medication Adherence Tips

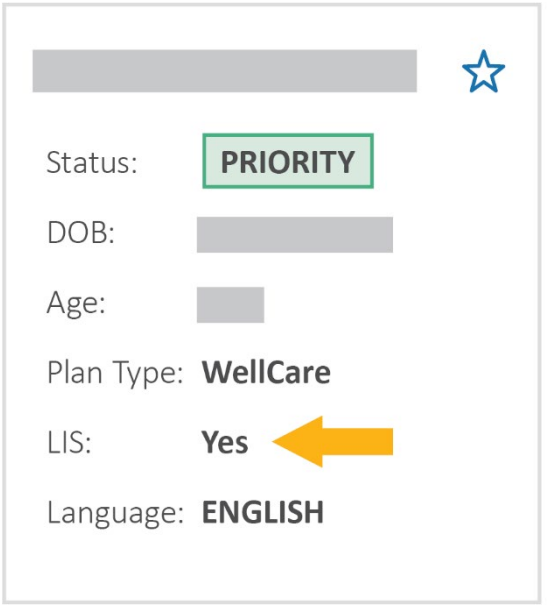
RxEffect LIS Indicator: If the LIS flag reflects 'Yes' your patient (our member) is eligible to fill a 90-day prescription for the same cost as a 30-day prescription.

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

Provider Service Representatives can assist with questions regarding:

- Payment Inquiries
- Member Eligibility
- Claim Inquiry
- Prior Authorization
- Network Verification
- Appeal Status
- Check Stop Pay or Check Reissues
- Negative Balance Report
- Provider Demographic Change Request
- Secure Portal Password Reset

Provider Inquiries

- After speaking with a Provider Service 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

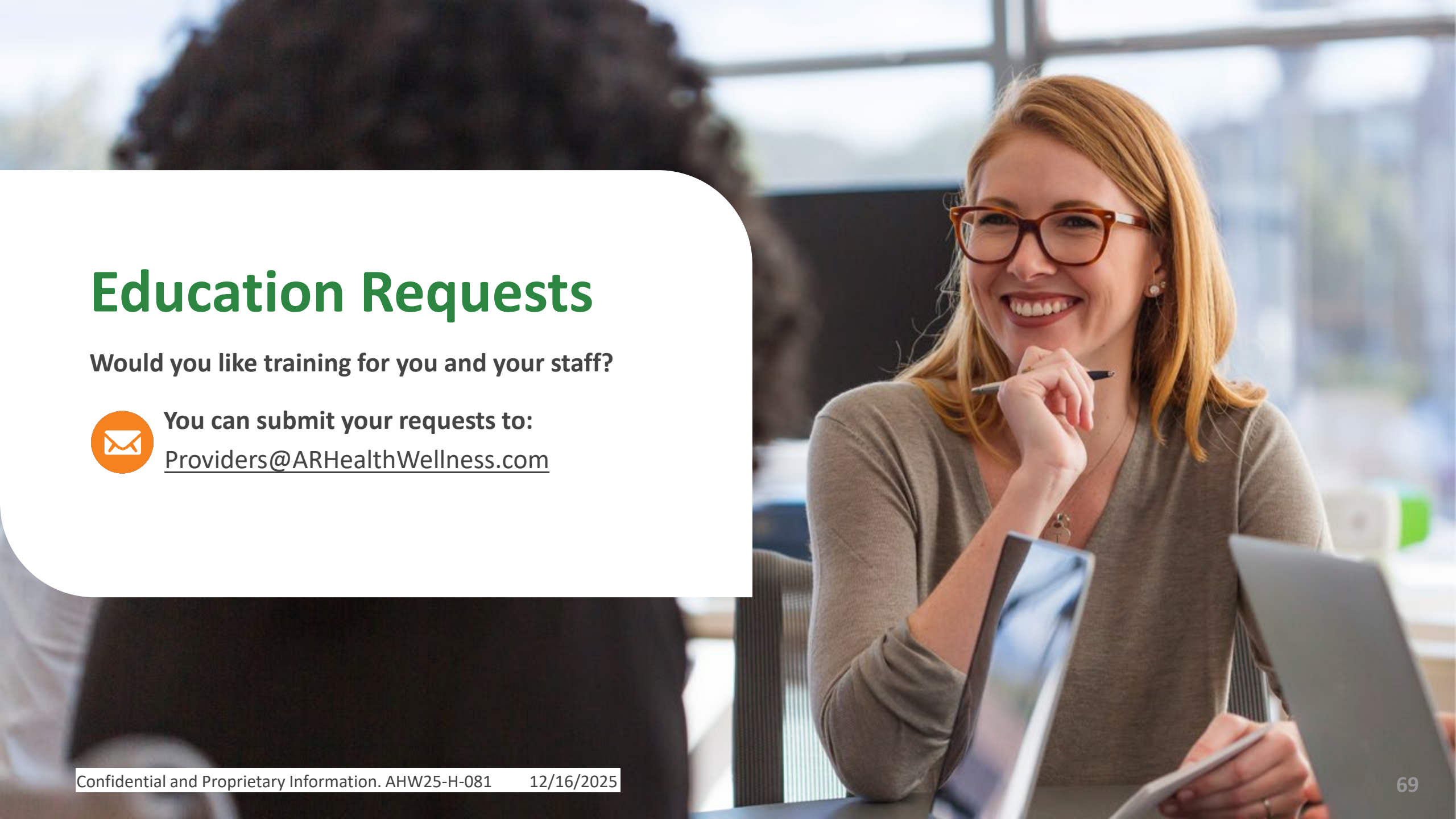
Arkansas Health & Wellness Credentialing Department

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