



2026 First Quarter
Provider Webinar

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Agenda

- ▶ How to Join our Email List
- ▶ Clinical & Payment Policy Updates
- ▶ Coverage Changes for ARHOME
- ▶ Appointment Availability
- ▶ Prior Authorizations
- ▶ Pre-Auth Check Tool
- ▶ Provider Portal
- ▶ Availability Essentials
- ▶ Sober Sidekick Program
- ▶ Transitional Care Management (TCM)
- ▶ Provider Self-Led Trainings
- ▶ Risk Adjustment
- ▶ Quality
- ▶ 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*

Ambetter

[MEDICARE]



Receive current updates:

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

Clinical & Payment Policy Updates

Clinical and Payment Policy Updates

Arkansas Health & Wellness is amending or implementing new policies that can be viewed at [ARHealthWellness.com](https://www.ARHealthWellness.com).

Clinical Policies for Ambetter

- ▶ Applied Behavior Analysis CP.BH.104 — Effective February 1, 2026

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

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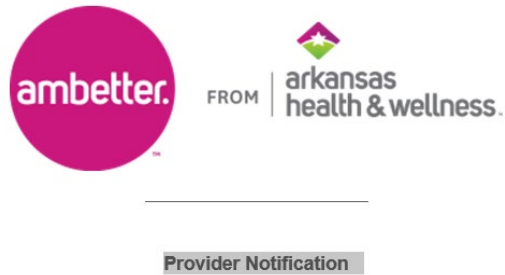
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- [Provider Training](#)
- [Negative Balance How-To Guide \(PDF\)](#)

Name *

2026 Ambetter Other Insurance 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 ways you can check to see if a member has an ARHOME plan.

Ambetter Other Insurance 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:

Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name *

Member Date of Birth 

Select Action Type * 

Eligibility History

Start Date	End Date	Product Name	Product Description
Jan 1, 2025	Dec 31, 2025	PO Bal C7 94-61-80%FPL	Connected Silver - 94% AV Level Silver Plan 61% - 80% FPL
Apr 1, 2024	Dec 31, 2024	PO Bal C7 94-61-80%FPL	Connected Silver - 94% AV Level Silver Plan 61% - 80% FPL

[more](#)

Ambetter Other Insurance 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.



ambetter | arkansas health & wellness. **ARHOME**
REFERRAL NOT REQUIRED

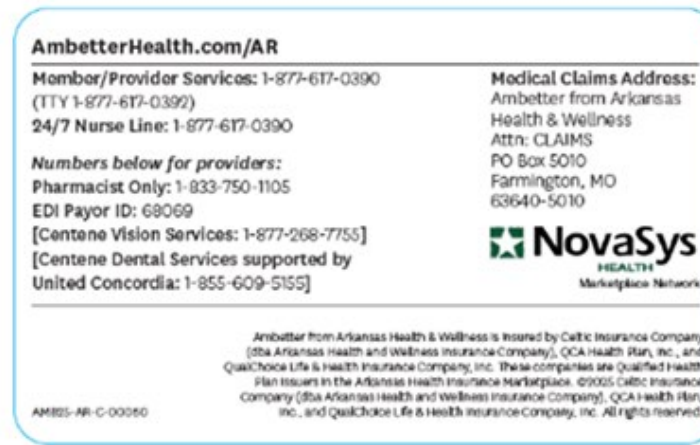
MEMBER: [Jane Doe]
Subscriber: [John Doe]
Subscriber ID: [xxxxxxxxxx] **Member ID:** [xxxxxxxxxxxxxxxxxx]
Plan: [Plan name]
[Network Name] Network Coverage
RXBIN: 003858 **RXPCN:** A4 **RXGROUP:** 2CRA **Effective Date:** [00/00/00]

PREMIER

COPAYS
PCP: [\$10 copay after ded.]
Specialist: [\$25 coin. after ded.]
Urgent Care: [20% coin. after ded.]
ER: [\$250 copay after ded.]

COST SHARES
INN DED Ind/Fam: [\$7,965/\$18,000]
OON DED Ind/Fam: [\$22,500/\$45,000]
QUARTERLY INN MOOP Ind/Fam: [\$11,500/n/a]
OON MOOP Ind/Fam: [\$25,000/\$45,000]

For detailed benefit information, please visit AmbetterHealth.com/copays



AmbetterHealth.com/AR

Member/Provider Services: 1-877-617-0390
(TTY 1-877-617-0392)
24/7 Nurse Line: 1-877-617-0390

Medical Claims Address:
Ambetter from Arkansas
Health & Wellness
Attn: CLAIMS
PO Box 5010
Farmingington, MO
63640-5010

Numbers below for providers:
Pharmacist Only: 1-833-750-1105
EDI Payor ID: 69069
[Centene Vision Services: 1-877-268-7755]
[Centene Dental Services supported by
United Concordia: 1-855-609-5155

NovaSys
HEALTH
Marketplace Network

Ambetter from Arkansas Health & Wellness is insured by Celtic Insurance Company (dba Arkansas Health and Wellness Insurance Company), QCA Health Plan, Inc., and QuikChoice Life & Health Insurance Company, Inc. These companies are Qualified Health Plan issuers in the Arkansas Health Insurance Marketplace. ©2025 Celtic Insurance Company (dba Arkansas Health and Wellness Insurance Company), QCA Health Plan, Inc., and QuikChoice Life & Health Insurance Company, Inc. All rights reserved.

AMB25-AR-C-00050

Ambetter Other Insurance Coverage Changes for ARHOME

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)**.

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. 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 on the right 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 on the right 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

▶ Provider.ARHealthWellness.com



Phone

▶ Ambetter: 1-877-617-0390

▶ Wellcare by Allwell: 1-855-565-9518



Fax — IP and OP paper forms are available on the Provider Resources page at ARHealthWellness.com

▶ 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



Home Find a Doctor Login Careers Contact

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](#)

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

Pre-Auth Check Tool

Are Services being performed in the Emergency Department?

Yes No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility for transplant services?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for dental surgeries?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving Gender Affirming services?	<input type="radio"/>	<input checked="" type="radio"/>

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

99214

N
No

99214 - OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN
No authorization required.

Secure Provider Portal

Secure Provider Portal — Create an Account



Registration is free and easy
Provider.ARHealthWellness.com



Log In

Username (Email)

LOG IN

[Create New Account](#)



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.
- ▶ Option to receive push notifications regarding reconsideration status changes
- ▶ Void/Recoup option on claims already adjudicated by the health plan
(see page 92 of the portal manual for instructions on using this feature)

Patient Overview — Document Resource Center

[Back to Eligibility Check](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Document Upload | **Document Review**

1. Document Category:
 - Medical Necessity
 - Quality Management
 - Long Term Services And Support
2. Document Type:
3. Upload File: No file chosen
4.

Documents for the member can be uploaded here based on Document Category options.

Availity Essentials

Our Secure Provider Portal Is Changing to Availity Essentials

- ▶ Arkansas Health & Wellness has chosen a new platform for the Secure Provider Portal. Started Nov.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>I am the designated Availity administrator for my organization.</i>	Visit <u>Register and Get Started With Availity Essentials</u> to enroll for training and access other helpful resources.
I am NOT the administrator. <i>I am NOT the designated Availity administrator for my organization.</i>	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>I am not sure who will be the designated Availity administrator for my organization.</i>	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
- ▶ Scalable Recovery Support
- ▶ Reducing Relapse Rates
- ▶ 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 The 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 Initiative

Improved Member Outcomes:

- ▶ Coordinated care before discharge helps members receive more comprehensive support, leading to better health outcomes.

Reduced Readmission Rates:

- ▶ Ensuring that members have the necessary resources and follow-up care reduces the likelihood of readmission.

Enhanced Care Coordination:

- ▶ Facilitating better communication between providers helps ensure that all aspects of the member's care are addressed.

Member Empowerment:

- ▶ Members take an active role in their care by getting 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.



To learn more, contact the
TCM team at 1-800-575-2763 or
Providers@ARHealthWellness.com.

Provider Self-Led Trainings

Provider Self-Led Trainings

Home Find a Doctor Login Careers Contact

arkansas health & wellness. For Members ▾ For Providers ▾ Get Insured

For Providers

- Login
- Become a Provider ▾
- Pre-Auth Check ▾
- Provider Financial Support & Resources
- Pharmacy
- Provider Resources** ^
- Ambetter Clinical Coverage/Medical Policy Updates

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](#).

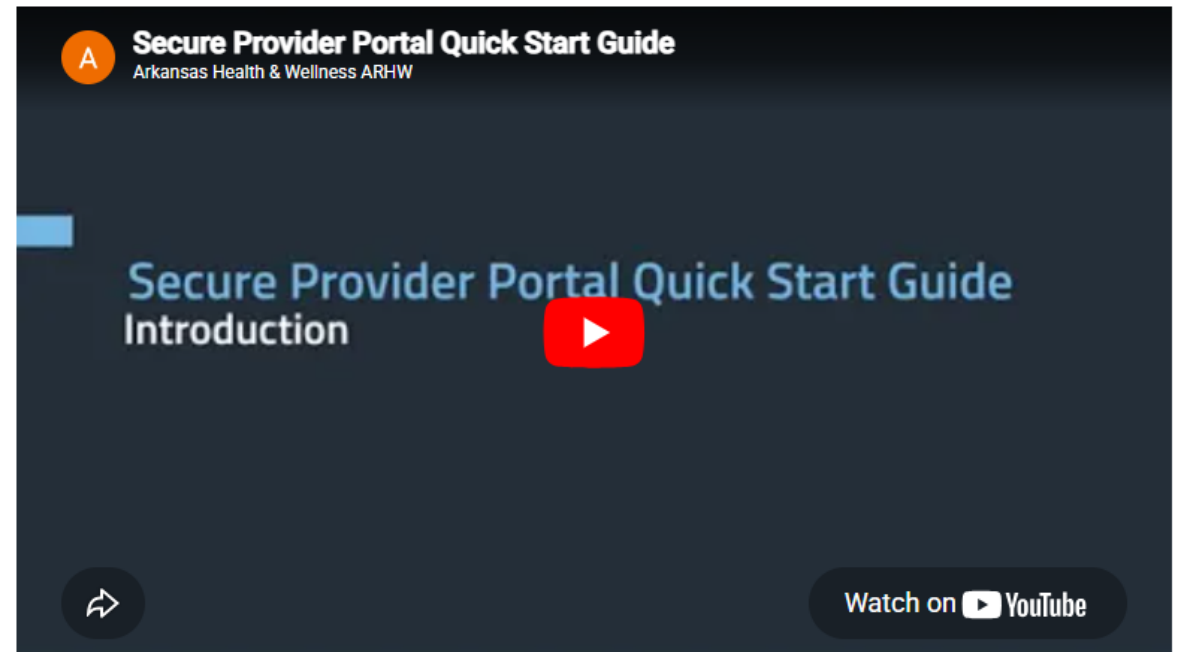
- [Cultural Competency Training](#)
- [Secure Provider Portal Quick Start Guide](#)
- [Special Needs Plan Model of Care Self-Study Program](#)
- [Allwell 2023 Annual Model of Care Provider Training Letter \(PDF\)](#)
- [Sober Sidekick 2025 Intro to Sober Sidekick Provider Training \(PDF\)](#)

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 & Providers



Risk Adjustment Overview

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

Importance of Risk Adjustment

Health Status



Identifies the actual disease burden of member populations and captures changes in patient's condition status or severity

Quality of Care



Improves chronic condition monitoring and management through earlier identification of care gaps and proactive care planning

Appropriate Funding



Ensures accuracy of healthcare premiums and coverage of expenditures incurred by members with varying health needs.

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 captured annually

- ▶ Reporting period is 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.

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

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).

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**

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.

2026 Continuity of Care Plus (CoC+)

1 Risk Adjustment Insight

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
- ▶ 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

2 Comprehensive Insights

Additional incentive opportunity:

\$150

per Medicare
Agenda

\$100

per Marketplace
Agenda

All boxes related to the high complexity, Quality, clinical, and/or drivers of health Insights must be checked and verified, where applicable

2026 CoC+ New & Improved Features

Centene Clinical Action (CCA) Portal

- ▶ Access the 2026 CoC+ Program dashboard from the CCA Portal
- ▶ Electronically submit completed appointment agendas in CCA Portal
- ▶ Easily access from Availity, Centene, and Wellcare portals with Single Sign-On (SSO) option.

PDF Appointment Agenda

- ▶ New table-style format for streamlined display of available insights
- ▶ Additional checkbox response options added for more defined insight assessment selection

New Fax Number for Paper Agenda Submissions

- ▶ FAX: 844-608-0465
- ▶ Exclusively for CoC+ Appointment Agendas (no medical records or other document types, please)

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

Risk Adjustment & Behavioral Health Providers

Medical record requests may 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

- Documentation should include client name, gender, date of birth, the current status of all mental and/or behavioral health diagnoses, and date(s) of service.
- 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, signed by the provider rendering the services, and include the 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

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:

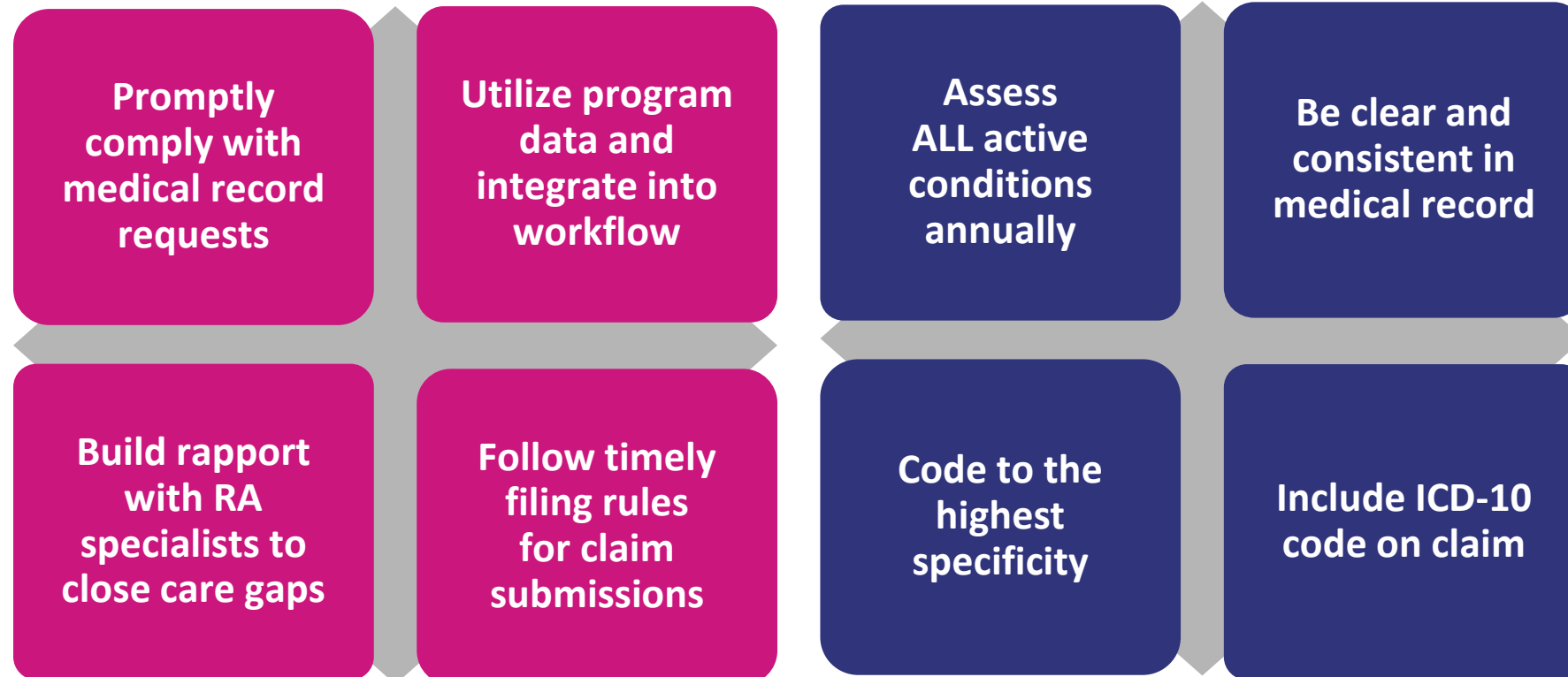
- ▶ Increased data accuracy
- ▶ Improved workflow
- ▶ Decreased administrative burden
- ▶ Enhanced patient care
- ▶ Better health outcomes

Bi-directional feed and point of care alerts can be integrated into EMR:

Athena	Epic	eClinical Works
Allscripts	Practice Fusion	Cerner
Office Ally	NextGen*	Meditech*

*Future Connections

Summary of Best Practices



Clinical Documentation Improvement Webinars

Join Centene Corporation's CDI Webinar Series designed to enhance your understanding of:

- ▶ Risk adjustment methodologies
- ▶ Accurate and compliant documentation practices
- ▶ Coding strategies aligned with regulatory standards

Who Should Attend?

Providers, non-physician practitioners, coders, billers, and administrative staff involved in clinical documentation and coding.

Advanced registration is required. Utilize the corresponding registration link provided for each topic (links are unique to each webinar). If you have questions or need assistance with registration, email CDIWebinars@centene.com.

2026 Webinar Series

Registration Link: January–November



[Register here!](#)

Contacts

Send secure email to RiskAdjustment@ARHealthWellness.com
or contact your assigned Risk Adjustment Specialist.

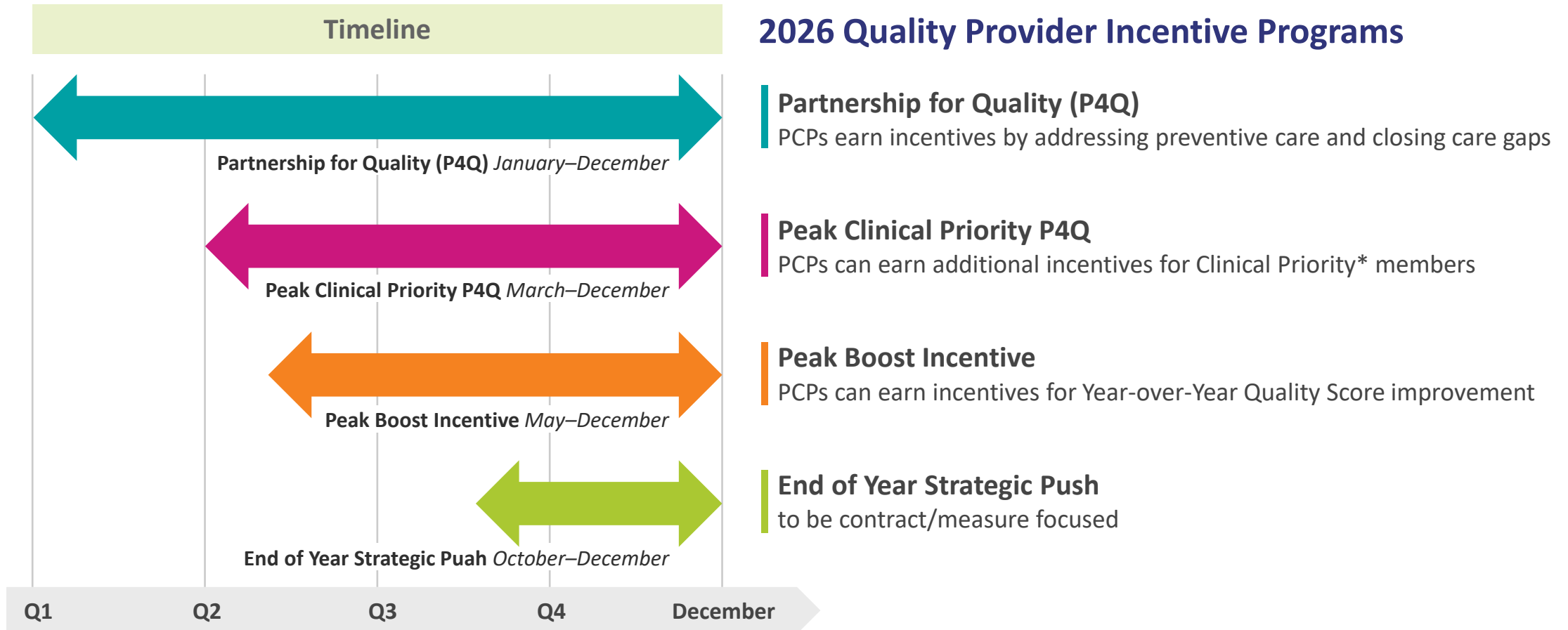
Risk Adjustment Coding & Documentation

Coding documentation guidance for providers, coders, and support staff are available on our website at the URLs listed below.

- ▶ Wellcare by Allwell: https://www.arhealthwellness.com/providers/resources/Allwell_CODING_TIP_SHEETS_AND_FORMS.html
- ▶ Ambetter from Arkansas Health & Wellness:
https://www.arhealthwellness.com/providers/resources/Ambetter_CODING_TIP_SHEETS_AND_FORMS.html

Quality Improvement

2026 Partnership for Quality (P4Q)



*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. Note: additional provider incentive programs are available (Rx Effect, MFIP, local health plan programs, etc.). This is not a comprehensive list of all incentive programs.

2026 Ambetter Pay-for-Performance (P4P) Program



2025 Measure List	Measure Incentive	Target 1 Pays 75% of Incentive	Target 2 Pays 100% of Incentive
Breast Cancer Screening (BCS-E)	\$25.00	73.20%	77.10%
Cervical Cancer Screening (CCS-E)	\$25.00	47.30%	57.50%
Child and Adolescent Well-Care Visits (WCV)	\$25.00	49.50%	60.30%
Chlamydia Screening in Women (CHL)	\$25.00	45.70%	52.80%
Colorectal Cancer Screening (COL-E)	\$25.00	54.10%	60.80%
Blood Pressure Control for Patients with Hypertension (BPC-E)	\$25.00	68.10%	73.80%
Eye Exam for Patients with Diabetes (EED)	\$25.00	44.60%	53.30%
Glycemic Status Assessment for Patients with Diabetes (<9) (GSD)	\$25.00	73.50%	79.10%
Kidney Health Evaluation for Patients with Diabetes (KED)	\$25.00	49.90%	56.90%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)*	\$25.00	42.30%	50.40%

2026 Ambetter P4P

Objective

- ▶ Enhance quality of care through a PCP-driven pay-for-performance program with a focus on preventative and screening services

Member Attribution

- ▶ Members who have been formally assigned to a provider's Tax ID Number (TIN)
- ▶ Performance Incentive
- ▶ Each measure has its own incentive amount paid after achieving its own target score.

Payout

- ▶ Three payouts per year (Q2/Q3/Q4/Final Reconciliation)
- ▶ Monthly reporting gaps in care
- ▶ Monthly performance scorecards

Requirements for Payout

- ▶ Payout 75% of measure incentive amount for reaching Target 1
- ▶ Payout 100% of measure incentive amount for reaching Target 2

Targeted Services

Selected measures are focused on PCP engagement, screening services, and medication adherence which align with QRS HEDIS® tech specs.

1. Breast Cancer Screening (BCS)
2. Cervical Cancer Screening (CCS)
3. Child and Adolescent Well-Care Visits (WCV)
4. Chlamydia Screening (CHL)
5. Colorectal Cancer Screening (COL-E)
6. Blood Pressure Control for Patients with Hypertension (BPC-E)
7. Eye Exam for Patients with Diabetes (EED)
8. Glycemic Status Assessment for Patients with Diabetes (<9) (GSD)
9. Kidney Health Evaluation for Patients with Diabetes (KED)
10. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

CPT II Codes and HCPCS Billing

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.

CPT II Codes and HCPCS Billing for Medicare Advantage

Advance Care Planning		
CPT II CODES	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
HCPCS CODES	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)
Pain Assessment		
CPT II CODES	1125F	Pain present; pain severity quantified
	1126F	No pain present; pain severity quantified

Medication Review (2 codes: Review and List)		
CPT II CODES	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
HCPCS CODES	G8427	Medication List–Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient’s current medications
Medication Reconciliation		
CPT II CODES	1111F	Discharge medications reconciled with the current medication list in the outpatient record.
Functional Status Assessment		
CPT II CODES	1170F	Functional status assessed

CPT II Codes and HCPCS Billing

Blood Pressure Control (Includes Diabetics)		
CPT II CODES	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		
CPT II CODES	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		
CPT II CODES	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)
HCPCS CODES	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

Annual Preventive Visit Discussion Points

- ▶ 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)

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

Annual Preventive Visit Tips

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

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

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

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 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

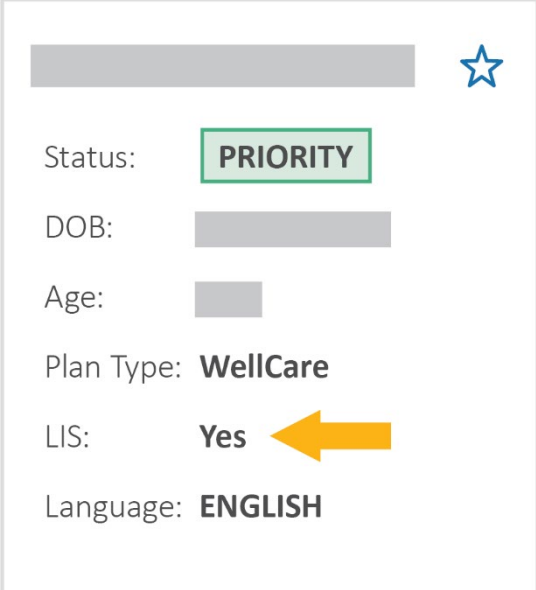
For chronic medications, prescribe a 90-day quantity.


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.



████████████████████ 

Status: **PRIORITY**

DOB: ██████████

Age: █████

Plan Type: **WellCare**

LIS: **Yes** ←

Language: **ENGLISH**

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.



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