ProviderReport

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Clinical practice guidelines

Our clinical and quality programs are formed from evidence-based preventive and clinical practice guidelines. Ambetter of Arkansas adopts guidelines based on the health needs of the membership and opportunities for improvement identified as part of the Quality Improvement Program. These guidelines are based on valid and reliable clinical evidence formulated by nationally recognized organizations, government institutions, state-wide collaboratives and/or a consensus of healthcare professionals in the applicable field.

Clinical practice guidelines are reviewed annually and updated to reflect the current standard of care. These guidelines are used for preventive services, as well as for the management of chronic diseases. Ambetter of Arkansas providers are expected to follow these guidelines and adherence is evaluated at least annually as part of the Quality Improvement Program.

These guidelines are:

- Crafted considering the needs of the members
- Adopted in consultation with network providers
- Reviewed and updated periodically, as appropriate

Preventive and chronic disease guidelines and recommendations include:

- Adult, adolescent and pediatric preventive care guidelines
- Guidelines for diagnosis and treatment of asthma, ADHD, hypertension, diabetes and major depressive disorders

For the most up-to-date version of preventive and clinical practice guidelines, go to **AmbetterofArkansas.com**. A copy may be mailed to your office as part of disease management or other QI initiatives. Members also have access to these guidelines.

Building our network

Ambetter of Arkansas offers a network of primary care providers (PCPs) to ensure every member has access to a medical home within the required travel distance standards. Physicians who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, physician assistants and advanced registered nurse practitioners.

Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the state Department of Health and Human Services (HHS) network adequacy requirements for managed care organization networks. We will develop and maintain a network of qualified providers in sufficient numbers and locations. Providers will be adequate and reasonable in number, in specialty type and in geographic distribution to meet the medical needs of members, both adults and children, without excessive travel requirements, and will be in compliance with HHS access and availability requirements.

An accurate directory

Have you moved or changed contact information? Or maybe your practice is not listed accurately in our Provider Directory? You can request changes via our secure **Provider Portal** or by calling Ambetter of Arkansas. If you need to change your Tax ID please provide a W-9. Send these changes to **ambetterARproviders@ambetterhealth.com**. Please let us know at least 30 days before you expect a change to your demographic information.

Healthcare Independence Program: **Redetermination**

The Arkansas Department of Human Services is in the process of eligibility redetermination for all recipients enrolled in the Healthcare Independence Program (private option), across all carriers. In order to continue with the program, some members need to verify their income to ensure they are still eligible. Members who need to verify their income should receive a letter in the mail. Those who have not verified their income, or have otherwise been deemed ineligible and terminated from the HCIP, will also receive notification.

It is very important that you check the HCIP eligibility status of your patients. To receive the most up-to-date information regarding their eligibility, please check the Medicaid eligibility system.

To help ensure your patients do not lose their health insurance coverage, please review the **redetermination flyer** that details the steps they need to take to verify their income. We encourage you to share this information with those who might need to submit additional information to DHS.

ICD 10 compliance effective October 1, 2015

The U.S. Department of Health and Human Services (HHS) has issued a rule finalizing October 1, 2015, as the new compliance date for healthcare providers, health plans and healthcare clearinghouses to transition to ICD-10.

This new deadline allows providers, insurance companies and others in the healthcare industry time to ramp up their operations to ensure their systems and business processes are ready to go on October 1, 2015.

Ambetter of Arkansas is actively performing ICD-10 testing. Claims billed for dates of service on and after October 1, 2015, must utilize ICD-10 codes in place of ICD-9 codes. Claims not billed with ICD-10 codes will be rejected. For dates of service prior to October 1, 2015, submission of ICD-9 codes will be accepted. An FAQ with more information can be found **here**.

PCP Pay 4 Performance program

The Pay for Performance (P4P) Incentive Program is designed to reward you for ensuring your Ambetter patients receive preventive services according to clinically recommended schedules, and for helping with the management of their chronic conditions. This is an opportunity for additional reimbursement with no downside to you.

- This program is only being offered to participating primary care providers.
- As a participating Ambetter PCP, you are automatically enrolled in this program.
- The incentive amount is in addition to the contractual reimbursement you receive for providing services to your Ambetter members.
- The program is effective with dates of service of January 1, 2015 thru December 31, 2015.
- Incentive payments will be made on a quarterly basis beginning in July 2015.

Click for more information on our P4P Incentive Program.

CLIA NOTIFICATION

Ambetter of Arkansas will be implementing CLIA Phase II (Clinical Laboratory Improvement Amendment) to ensure the accuracy and reliability of all laboratory testing, as defined by CMS guidelines. All providers that bill laboratory services must have CLIA certification equal to the procedure code being billed. Please note if a procedure is billed without appropriate CLIA certification, reimbursement will be denied. We will be implementing this certification verification and it will apply to all providers. This verification will ensure that we are compliant with the CMS guidelines.

Once the verification has been successfully implemented, some providers will observe that if a certification is not on the file provided by CMS, or the certification is not valid for the procedure code/dates of service submitted, the claim will be denied. There are two new denials codes that will appear on your Explanation of Payment:

EXc1 DENIED: INVALID CLIA NUMBER
EXc2 DENIED: PROCEDURE NOT ALLOWED FOR CLIA CERTIFICATION TYPE

Please click here to read more or contact us with any questions or concerns.

How we measure **quality**

Ambetter of Arkansas strives to provide quality healthcare to our members as measured through HEDIS quality metrics.

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows direct, objective comparison of quality across health plans. NCQA develops the HEDIS measures through a committee composed of purchasers, consumers, health plans, healthcare providers and policy makers.

HEDIS allows for standardized measurement and reporting, and accurate, objective, side-by-side comparisons. Learn more here: **www.ncqa.org**.

How to improve the scores

To help your practice increase its HEDIS rates, we review key HEDIS measures in each issue of this newsletter. We also offer guidance on how to bill appropriately. Please always follow the state and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission.

Other ways to help your scores include:

- Submit claim/encounter data for each and every service rendered.
- Ensure chart documentation reflects services billed.
- Bill (or report by encounter submission) for services delivered, regardless of contract status.
- Ensure that claim/encounter data is the most clean and efficient way to report HEDIS.
- Do not include services that are not billed in the calculation.
- Submit accurate and timely claim/encounter data, which will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Consider including CPT II codes to reduce medical record requests. These codes provide details currently only found in the chart, such as BMI screenings and lab results.

Please take note of the following HEDIS measures regarding women's health screenings.

Women's health screenings

- **Chlamydia screening in women measure:** Evaluates the percentage of women ages 16 to 24 who are sexually active and who have had at least one test for chlamydia per year. Chlamydia tests can be completed using any method, including a urine test. "Sexually active" is defined as a woman who has had a pregnancy test or testing for any other sexually transmitted disease or has been prescribed birth control.
- **Breast cancer screening measure:** Evaluates the percentage of women ages 50 to 74 who had a mammogram at least once in the past two years. Women who have had a bilateral mastectomy are exempt from this measure.
- **Cervical cancer screening measure:** Evaluates the percentage of women ages 21 to 64 who were screened for cervical cancer using either of the following criteria:
  1) Cervical cytology performed every three years for women ages 21-64;
  2) Cervical cytology/human papillomavirus (HPV) co-testing performed every five years (must occur within four days of each other) for women ages 30-64. (Women who have had a hysterectomy without a residual cervix are exempt from this measure.)
- **Postpartum visits measure:** Evaluates the percentage of women who delivered a baby and who had their postpartum visit on or between 21 and 56 days after delivery (three and eight weeks).
- **Prenatal visits/timeliness of first visit and frequency of visits measure:** Evaluates the percentage of pregnant women who had their first prenatal visit in the first trimester or within 42 days of enrollment with the plan. The frequency of prenatal visits is also assessed.

Click here for a full list of codes.

DID YOU KNOW that our members with a diagnosis of diabetes can use their medical insurance to have their eyes examined?

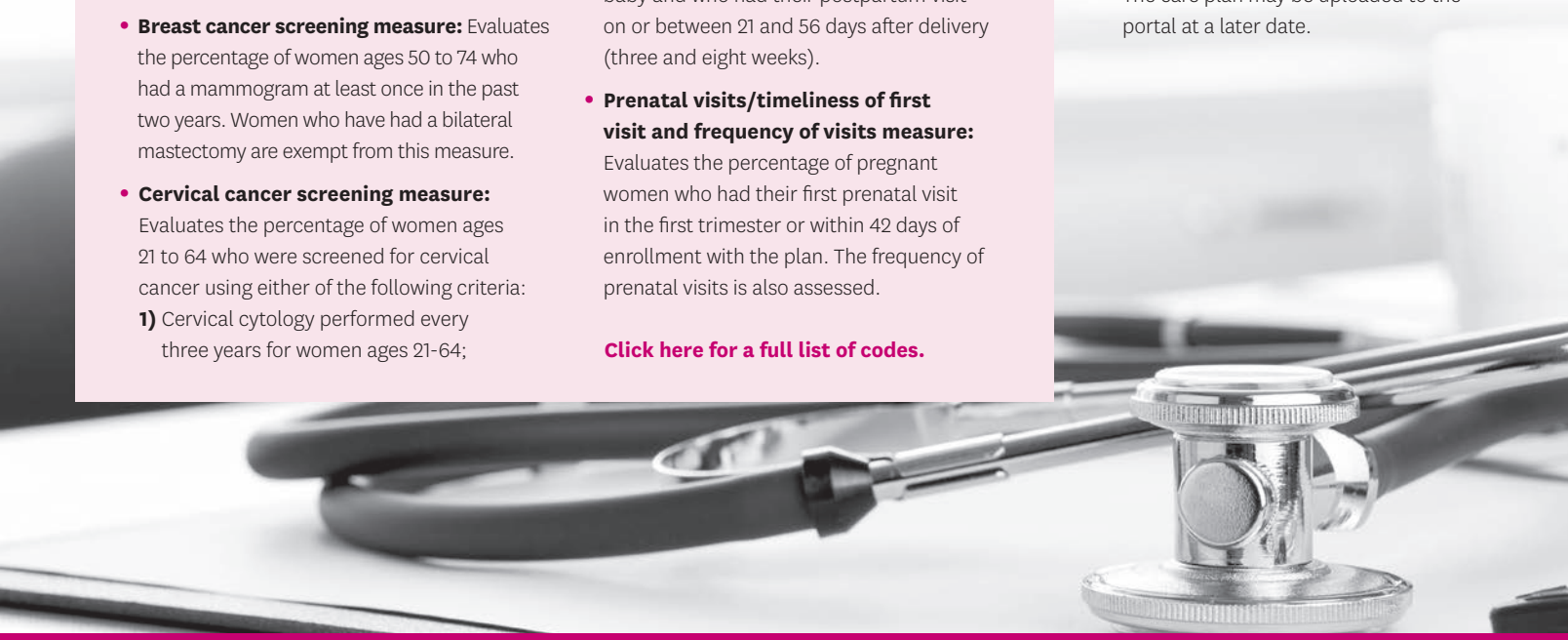
Even if they don't have a vision plan, their benefits with Ambetter of Arkansas will cover annual vision exams.

PCMH PROGRAM

If your practice is a participant within the Arkansas Medicaid Payment Improvement Initiative Program, a $5 PMPM will be paid for each member assigned to a PCP physician.

Under the Ambetter of Arkansas plan, PCPs are not required to provide written referrals or seek authorizations on behalf of members for services that don't normally require an authorization. We hope that physicians will look for opportunities to provide the needed care for our members who have more severe health conditions and make an effort to reach out and provide wellness benefits to our more healthy members.

Visit the secure **Provider Portal,** where you can find a list of all members assigned to each physician within the practice group. Just like the Arkansas Medicaid Program requirement, Ambetter of Arkansas requires that each physician review his or her panel of members, determine the top 10 percent of health severity and create a care plan. The care plan may be uploaded to the portal at a later date.



What's your **availability?**

Availability is defined as the extent to which Ambetter of Arkansas contracts with the appropriate type and number of practitioners necessary to meet the needs of its members within defined geographic areas. The availability of our network practitioners is key to member care and treatment outcomes.

We evaluate compliance with these standards on an annual basis and use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization.

APPOINTMENT TYPE	ACCESS STANDARD
PCPs – Routine visits	21 calendar days
PCPs – Adult sick visit	72 hours
PCPs – Pediatric sick visit	24 hours
Specialist	30 calendar days
Behavioral health non-life-threatening emergency	Within six hours
Behavioral health urgent care	48 hours
Behavioral health routine office visit	10 business days
Urgent care providers	24 hours
Emergency providers	Immediately, 24 hours a day, seven days a week and without prior authorization
Initial visit – pregnant women	14 calendar days

PCP Assignments

To help our members manage their health, Ambetter of Arkansas has recently assigned/attributed members who had not yet chosen a Primary Care Physician to a PCP for the 2015 plan year. Matching members with a PCP will help members feel they have an access point within the healthcare system. Members will always have the ability to select a different PCP if they wish.

Under the Ambetter of Arkansas plan, PCPs are not required to provide written referrals or seek authorizations on behalf of members for services that don't normally require an authorization. We hope that physicians will look for opportunities to provide the needed care for our members who have more severe health conditions and make an effort to reach out and provide wellness benefits to our more healthy members.

You can access the Provider Secure Portal on the Ambetter of Arkansas website to view a list of all members assigned to each physician within your practice group.

Additional information can be found in the Ambetter **Provider Manual** and **Billing Manual** on our website, **AmbetterofArkansas.com**, or by contacting Ambetter Provider Services at **1-877-617-0390**.

PCP after-hours access requirements

In order to provide the best possible healthcare for our members, we want to ensure that all Primary Care Physicians provide appropriate information to patients on how to access medical care for urgent and emergency care after hours.

If you have a designated answering service, please share the information below with them to ensure that they have a clear understanding of this important requirement.

Offices using an answering machine must:

- Provide a message directing the member to contact 911 or go to the nearest ER if he/she feels it is too emergent to wait for a doctor to call them back; and
- Provide instructions on how to page the doctor if the situation is urgent; or
- Instruct member to go to ER or urgent care if situation cannot wait until next business day

Please note: It is not mandatory to provide the member with the option to leave a message for the provider to return the call during business hours.

Offices using an answering service must:

- Direct the member to contact 911 or go to the nearest ER if he/she feels it is too emergent to wait for a doctor to call them back; and
- Provide an option to page or contact the provider on call with the member's contact information; or
- Offer to telephonically transfer member's call directly to doctor on call

If your call service fails to cooperate with our survey, the result is automatic failure.

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