Arkansas Total Care Provider Newsletter

Fall, 2021

HEDIS® Chart Chase: Data Collection to Improve Member Outcomes

The National Committee for Quality Assurance (NCQA) develops and manages the Healthcare Effectiveness Data Information Set (HEDIS) to measure performance of care and service. Each year, Arkansas Total Care conducts a medical record review to collect and evaluate HEDIS data. We have collaborated with Ciox Health, a health information management company, to streamline data collection. By conducting this HEDIS review, we hope to continue to improve patient outcomes and satisfaction, and we value your cooperation with Ciox as they coordinate medical record collection.

Ciox staff will reach out to you to coordinate data retrieval by fax, mail or electronic medical record (EMR). Should they need to visit your practice, they will coordinate a time that is convenient for your staff. All patient protected health information (PHI) that is collected will be handled carefully and confidentially. Ciox is a business associate of covered entities as defined by the Health Insurance Portability and Accountability Act (HIPAA), and is ethically and legally bound to protect, preserve and maintain the confidentiality of PHI.

If you have any questions, or if you would like more information about this process, please reach out to the Ciox Health Provider Support Center at 1-877-445-9293 or chartreview@cioxhealth.com. If you would like to speak to our quality improvement team, please call 501-954-6104.

In this Issue:

Provider Accessibility Initiative

In November of last year, we launched our Provider Accessibility Initiative (PAI) to collect and assess the accessibility of provider locations based on current state and federal Americans with Disabilities Act (ADA) requirements. In order to collect this information, we have created a survey that asks detailed questions about your practice, such as number of handicapped parking spaces, accessible exterior routes, signage, elevators, and resources you have for scheduling assistance. We appreciate your participation in this initiative and are looking forward to making this information available to our members on our Find-A-Provider platform.

The PAI Provider Self-Reporting Form can be accessed and submitted online. Our contracting team is conducting outreach to our provider network to encourage staff to fill out and submit their accessibility information. If you have questions, or if you would like assistance, please reach out to our contracting team at ArkansasContracting@Centene.com.

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HEDIS Measures: Well Woman Visits

Several HEDIS measures assess the efficacy of preventive women's health screenings and can help identify performance gaps that providers can close to improve patient outcomes. These are breast cancer screenings (BCS), cervical cancer screenings (CCS) and chlamydia screenings (CHL). Refer to the chart below for measurement criteria, CPT® codes and exclusions.

Screening Type	Measure Requirements	CPT Codes	Exclusions	Notes
Breast Cancer Screening (BCS)	This measure evaluates women 50–74 years of age as December 31 who had a mammogram to screen for breast cancer between October 31 two years prior to the measurement year and December 31 of the measurement year.	**CPT Codes:** 77061, 77062, 77063, 77065, 77066, 77067	**CPT Codes:** 19303, 19305, 19306, 19307 **ICD-10-CM Codes:** Z90.11, Z90.13 **ICD-10-PCS Codes:** 0HTT0ZZ, 0HTU0ZZ, 0HTV0ZZ	The BCS measure assesses the use of imaging to detect early breast cancer in women. • All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) meet this measure. • MRIs, ultrasounds or biopsies do not count.
Cervical Cancer Screenings (CCS)	Measure evaluates women who were screened for cervical cancer using any of the following criteria: • Women ages 21–64 who had cervical cytology performed within the last three years • Women ages 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing within the last five years • Women ages 30–64 who had cervical cytology/hrHPV cotesting within the last five years.	**Cervical Cytology Ages 21–64** **CPT Codes:** 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175 **HPV Ages 30–64** **CPT Codes:** 87621, 87624, 87625	**CPT Codes:** 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135 **ICD-10-CM Codes:** Q51.5, Z90.710, Z90.712 **ICD-10-PCS Codes:** 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ	Documentation must include a note indicating the date the test was performed and the result or finding. **Excludes:** Women who had a prior hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year. Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

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HEDIS Measures: Well Woman Visits, Continued

Screening Type	Measure Requirements	CPT Codes	Exclusions	Notes
Chlamydia Screening (CHL)	This measure evaluates women ages 16–24 who are sexually active* and had at least one test for chlamydia during the measurement year. Chlamydia tests can be completed using any method, including a urine test. Documentation must include a note indicating the date the test was performed and the result or finding.	**CPT Codes:** 87110, 87270, 87320, 87490, 87491, 87492, 87810		*Sexually active is defined as a woman who has had a pregnancy test, testing or diagnosis of any sexually transmitted disease, is pregnant, or has been prescribed birth control.

*It's important to be mindful of the frequency that screenings are needed in addition to which tests and screenings fulfill specific HEDIS requirements.

Cold & Flu Season

The arrival of autumn marks the beginning of cold and flu season. According to the Centers for Disease Control and Prevention (CDC), persons 6 months of age and older, and who do not have life-threatening allergies to the flu vaccine or any of its ingredients, are encouraged to get the vaccine.[1] The cost of an annual flu shot is covered in member benefits, and in some cases, members may earn reward points for getting the shot. In addition to getting the flu vaccine, many of the precautions encouraged by the CDC regarding COVID-19, such as frequent hand washing, social distancing and wearing masks indoors, will also slow the spread of the common cold and flu. If you or your staff would like member education materials regarding the vaccine, the CDC hosts a page on flu vaccine safety information that you, your patients and staff can access.

[1] https://www.cdc.gov/flu/prevent/whoshouldvax.htm

Upcoming Provider Webinars

Our provider webinars present an opportunity for providers and staff to connect with us on a variety of topics. While our provider relations team is available to troubleshoot issues and provide resources on an individual basis, webinars offer a lively environment to review important Arkansas Total Care policies, online tools and quarterly updates. To register for any of our scheduled courses,* or for more information, visit our Provider Webinars page.

*The dates, times and course offerings are subject to change — please refer to our Provider Webinars page for the most up-to-date course offerings and schedule.

2021 Quarter 4 Webinars

All webinars are scheduled on Central Time

Arkansas Total Care Quarter 4 Updates
Two sessions available
December 2, 2021 — 10 a.m.
December 9, 2021 — 10 a.m.

Arkansas Total Care Web Wizard
November 9, 2021 — 10 a.m.

Cultural Competency Training
Two sessions available
November 18, 2021 — 10 a.m.
December 9, 2021 — 10 a.m.

Office Manager Meeting
December 16, 2021 — 10 a.m.

Secure Provider Portal
Two sessions available
November 16, 2021 — 10 a.m.
December 21, 2021 — 10 a.m.

Earn Incentives for Performing Retinal Eye Screenings

We're committed to helping members with diabetes lead healthier lives. Preventive health and screenings are vital to positive health outcomes, and we appreciate your efforts to facilitate annual diabetic retinal eye exams. These exams are recommended to reduce the risk of diabetes-related blindness. These exams don't require prior authorization, but be mindful of our clinical policies regarding medical necessity. Please reference plan specifics and applicable billing guidelines when selecting the most appropriate CPT code for services rendered. Using the codes below where appropriate may help reduce the need for medical record review.

CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114, 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245
CPT® II: 2022F-2026F, 2033F, 3072F HCPCS: S0620, S0621
Diagnosis Code (diabetes without complications): E10.9, E11.9, E13.9

Note: When submitting CPT II codes, you may be entitled to a $10 bonus payment per member per year. Providers must bill $10 in the claim filing to receive reimbursement.

Behavioral Health Upcoding: What You Need to Know

When coding and billing individual psychotherapy services (90837) and the associated range of codes, please ensure your staff are following proper documentation procedures. Follow applicable Centers for Medicare and Medicaid Services (CMS) guidelines for all therapy visits.

Timed codes should reflect the exact start/stop times of the direct patient contact rendered to the member. If billing psychotherapy codes with an evaluation and management (E&M) service (90833 (30 min), 90836 (45 min) or 90838 (60 min)) guide, the E&M visit time should **not** be included in the time billed for the therapy visit. Psychotherapy times are for direct patient contact with the patient and/or patient's family member. The patient must be present for all or some of the service.

When reporting, choose the code closest to the actual time. Do not report psychotherapy with a duration shorter than 16 minutes. The duration of a course of psychotherapy must be individualized for each patient. The psychotherapy code is chosen based on the **time spent providing psychotherapy**, not inclusive of paperwork time without the member present.

- Code 90832 (or + 90833): 16–37 minutes,
- Code 90834 (or + 90836): 38–52 minutes, OR
- Code 90837 (or + 90838): 53 minutes or longer

A provider may be audited if they bill a higher percentage of psychotherapy services in comparison to their peers. If an audit does occur, please ensure documentation meets the criteria below.

- The member's name appears on each document in the clinical record.
- All entries in the clinical record are dated and include the responsible clinician's name, professional degree and relevant identification number, if applicable.
- The record is clear and legible.
- Exact start and stop times of the direct patient contact with the member present are included. This cannot include time for collaboration, documentation, case management, etc., and the appointment time will not suffice.
- The duration of the exact patient contact time spent with the member matches the CPT service definition.
- Progress notes describing patient strengths and limitations in achieving treatment plan goals and objectives, and reflecting treatment interventions that are consistent with those goals and objectives, are included. Progress notes must also include clinical interventions (not treatment modality), member response to the interventions provided and a plan for ongoing care.
- Treatment plan updates include the member's progress toward the goals/objectives, barriers to meeting the goals/objectives and any changes/additions to the goals/objectives/interventions.
- Goals/objectives listed are SMART.
- Each service is signed and dated by the rendering provider. The signature must include the rendering provider's credentials, and the date must be the date the note was written and signed.
- Documentation is completed and entered into the chart in a timely manner. Please refer to your state guidelines to determine the timeframe that is allowed. According to CMS, "Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead make use of the signature authentication process."
- Clinical documentation to support the necessity of the service rendered is included.

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Behavioral Health Upcoding: What You Need to Know, Continued

If the original entry is incomplete, follow the guidelines for making a late entry, addendum or clarification. When making an addendum:

- Document the current date and time.
- Write "addendum" and state the reason for the addendum, referring back to the original entry.
- Identify any sources of information used to support the addendum.
- Complete the addendum as soon after the original note as possible.

According to CMS, "Be sure the EHR system has the capability to identify changes to an original entry, such as "addendums, corrections, deletions, and patient amendments." When making changes, the date, the time, the author making the change and the reason for the change should be included. Some systems automatically assign the date an entry was made. Others allow authorized users to change the entry date to the date of the visit or service. Some systems allow providers to make undated amendments without noting that an original entry was changed. If there is no date and time on the original entry or subsequent amendments, providers cannot determine the order of events, which can impact the quality of patient care provided.

If you have any questions or would like further guidance on outpatient behavioral health billing, please contact our provider relations department at 1-800-294-3557.

Appointment Availability Standards

Timeliness can be key in many health situations, and we recognize the importance of getting the right care at the right time. We maintain appointment access standards that serve as guidelines for all of our provider partners, and we audit adherence to these standards at least once per year. Audits are performed by Faneuil, and providers will be notified via mail if found noncompliant with these standards. For comprehensive information about what our appointment availability standards entail, as well as details regarding phone call protocol, please refer to our 2021 Provider and Billing Manual.

Crisis Stabilization and Prior Authorization Rules

Crisis stabilization plays an important role in behavioral healthcare, and we want to be sure our members receive services that help them reach their best health. Effective July 1, 2021, we are offering crisis stabilization services as a covered benefit. See the chart below for service codes, descriptions and rates. This service is limited to 12 units per day with a maximum of 72 units per year. Additional units will require prior authorization.

Crisis Stabilization Services		
Code	**Description**	**Rate**
H2011, U4/U5	Crisis stabilization service per 15 minutes (para-professional)	$18.00
H2011, U4/U6	Crisis stabilization per 15 minutes (professional)	$23.19

Allowable performing providers:

- Independently Licensed Clinicians (Master's/Doctoral)
- Non-Independently Licensed Clinicians (Master's/Doctoral)
- Qualified Behavioral Health Provider (Bachelor's)
- Qualified Behavioral Health Provider (Non-degree)
- Advanced Practice Nurse
- Physician
- Registered Nurse

Approved Locations: 03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72, 99

If you have questions or would like more information, please reach out to our provider relations team at 1-866-282-6280 or providers@ArkansasTotalCare.com.

Home- and Community-Based Services and Atypical Provider Credentialing

When Arkansas Total Care launched in 2019, many home- and community-based services (HCBS) and atypical provider groups were added to our provider network based on credentialing that was completed by the state of Arkansas. However, that provision expired as of March 31 of this year. In order to continue to provide services to our members as part of our network, we ask that you fill out an Arkansas Total Care Atypical & HCBS Provider Application and return it via mail, email or fax to the corresponding address listed on the form.

Notice of InterQual® Changes

Starting November 1, 2021, our InterQual criteria set will be upgraded to the InterQual 2021 criteria set. To view our clinical and payment policies, visit our policy page.

Utilization Management

At Arkansas Total Care, we rely on our utilization management (UM) program to ensure we can continue providing affordable, clinically appropriate services that help our members reach their best health. UM staff evaluate whether covered services are medically necessary, relevant to the members condition, are provided in the correct setting and meet professionally recognized standards of care.

Medically necessary means any medical service, supply or treatment authorized by a physician to diagnose and treat a member's illness or injury that:

- Is consistent with the symptoms or diagnosis
- Is provided according to generally accepted medical practice standards
- Is reasonably expected to prevent the onset of an illness, condition, injury or disability
- Is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition or disability
- Is not custodial care
- Is not solely for the convenience of the physician or the member
- Is not experimental or investigational
- Is provided in the most cost-effective care facility or setting
- Does not exceed the scope, duration or intensity of the level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment
- When specifically applied to a hospitalization, the diagnosis and treatment of the medical symptoms or conditions cannot be safely provided as an outpatient service
- Will help the recipient achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and that those functional capacities are appropriate for recipients of the same age

UM decision-making is based on criteria from organizations such as InterQual, National Imaging Associates (NIA), the American Society of Addiction Medicine (ASAM), TurningPoint and other relevant entities. In some cases, providers must obtain prior authorization before the delivery of certain elective and scheduled services. Failure to secure authorization will result in denial of coverage. Neither our staff nor our provider network are rewarded in any way for issuing denials of service.

For more information on UM determinations, which utilization review criteria are used for each type of service, or the time frames required for each type of prior authorization, see our 2021 Provider and Billing Manual.

Depression Screenings in Adolescents and Adults

Depression among adolescents and adults can adversely affect their health and wellbeing. NCQA has developed guidelines to navigate the screening and follow-up process. When screening for depression, two rates are reported for the HEDIS measurement. These are:

- Depression screening: Members with a documented result of a depression screening performed using an age-appropriate standardized instrument between January 1 and December 1 of the measurement period
- Follow-up on positive screen: Members who received follow-up care up to 30 days after the date of the positive screening

The U.S. Preventative Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years of age and the general adult population, including pregnant and postpartum women.[1] The USPSTF also recommends that screenings be implemented with adequate systems in palce to ensure accurate diagnosis, effective treatment and appropriate follow-up.[2]

Follow-up on positive screenings should occur on the same day or 30 days after the first positive screening. Follow-ups can be:

- An outpatient, telephone, e-visit or virtual check-in with a diagnosis of depression or other behavioral health condition;
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management;
- A dispensed antidepressant medication; **OR**
- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (e.g., a negative screen) on the same day as a positive screen on a brief screening instrument. For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of a follow-up.

For relevant CPT codes, HCPCS codes, and codes to identify outpatient visits, depression screening, active diagnosis of depression, bipolar disorder, and exception codes, visit our Provider Resources page and navigate to the "Coding Tip Sheets and Forms" section of the menu located on the left-hand side of the page.

[1] U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." Annals of Internal Medicine 164:360–6.
[2] U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." Journal of the American Medical Association 315(4):380–7.