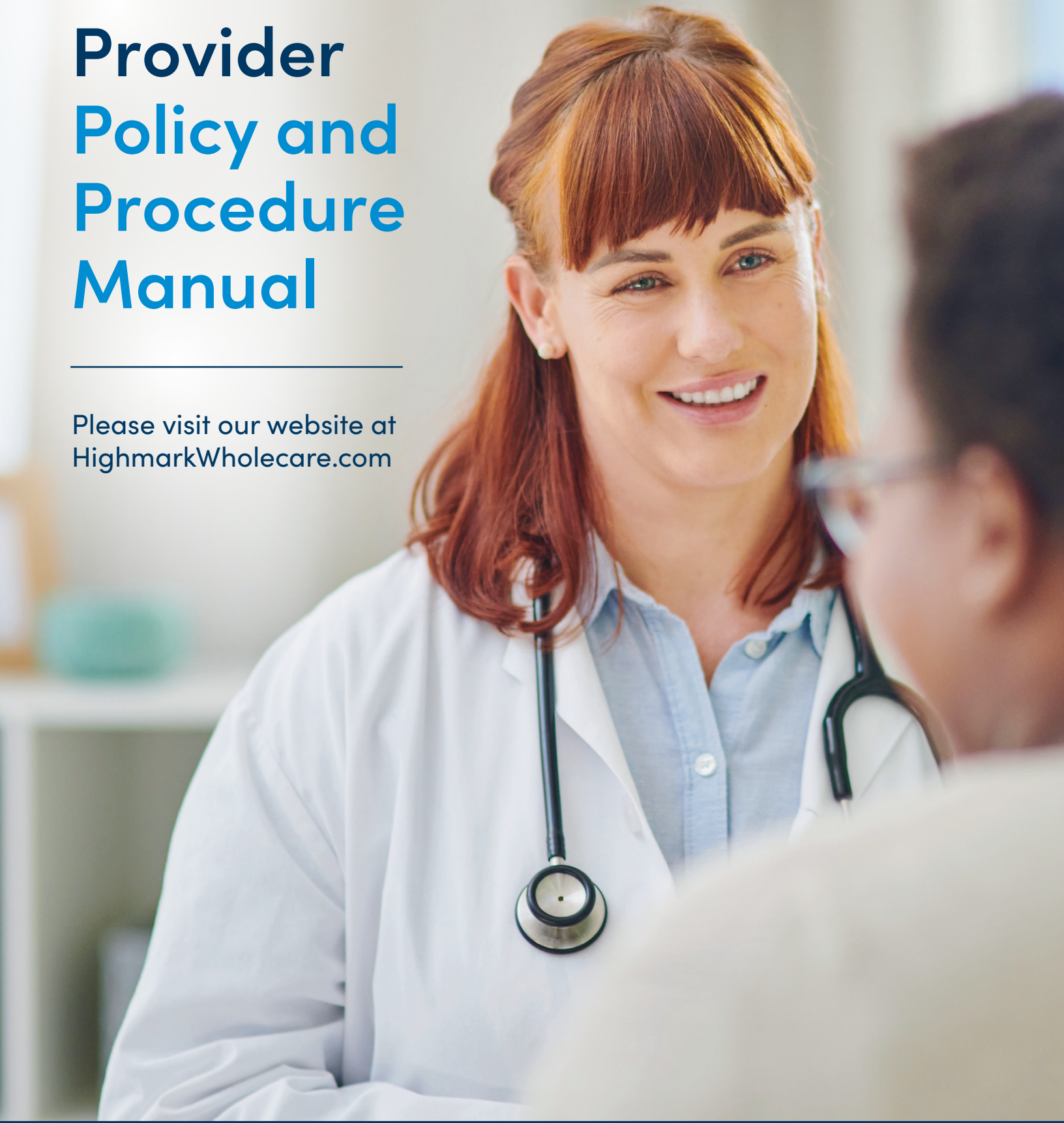
Medicaid

Provider Policy and Procedure Manual

Please visit our website at HighmarkWholecare.com



HIGHMARK WHOLECARE

Fall 2022 Edition

For inquiries, please call Provider Services at 1-800-392-1147.

Contents

Quick Reference

Important Phone Numbers for Highmark Wholecare Medicaid

Call to Inquire About:	Telephone Number	Hours of Operation
CareManagement	1-800-392-1147	Monday-Friday 8:30 AM to 4:30 PM
Highmark Wholecare Interactive Voice Response System (IVR) (Eligibility Check)	1-800-642-3515 1-800-392-1147	Twenty-four (24) hours a day/seven (7) days a week
Fraud, Waste, and Abuse Concerns/Inquiries	412-255-4340 or 1-844-718-6400	Twenty-four (24) hours a day/seven (7) days a week
Medical Management (Utilization Management (UM))	1-800-392-1147	Monday-Friday 8:30 AM to 4:30 PM (Voicemail during off hours. The call will be returned the next business day.) **Please do not leave multiple voicemail**
Member Services	1-800-392-1147	Monday-Friday 8:00 AM to 8:00 PM
Pharmacy (Non-Formulary Requests and Prior Authorization)	1-800-392-1147	Monday-Friday 8:30 AM to 5:00 PM
Practice Change Information	Fax:1-855-451-6680	Twenty-four (24) hours a day, seven (7) days a week
Provider Services (Claims Inquiries and Eligibility Verification)	1-800-392-1147	Monday-Friday 7:00 AM to 5:00 PM
Regulatory Affairs (Provider and Member Appeals)	1-800-392-1147	Monday-Friday 8:30 AM to 4:30 PM
TTY/TDD (for all departments)	711 or 1-800-232-5460	Monday-Friday 8:00 AM to 5:00 PM

Additional Helpful Telephone Numbers:

Call to Inquire About:	Telephone Number	Hours of Operation
Adagio Health (Authorization/Family Planning)	1-800-532-9465	
Davis Vision – Provider Servicing	1-800-773-2847	Monday-Friday 8:00 AM to 6:00 PM Saturday: 9:00 AM to 4:00 PM
Eligibility Verification System (EVS)	1-800-766-5EVS(5387)	
MA Provider Compliance Hotline (Fraud and Abuse Reporting)	1-866-379-8477	Monday-Friday 8:30 AM to 3:30 PM
MA Provider Enrollment Applications	In-process (Inpatient and Outpatient Provider Only) 1-717-772-6140 Long Term Care Provider 1-717-772-2571	Monday-Friday 8:30 AM to 3:30 PM Monday-Friday 8:30 AM to 5:00 PM
National Imaging Associates (NIA) Authorizations for Radiology Management, PT, OT, ST, Musculoskeletal Surgery Procedures (MSK), Trigger Point Injections, and Interventional Pain Management	1-800-424-4890 -or- www.RadMD.com	Monday-Friday 8:00 AM to 8:00 PM
United Concordia Dental (Dental benefit provider)	1-866-568-5467	Monday-Friday 8:00 AM to 8:00 PM
HealthHelp authorizations for certain Sleep Studies, Radiation Oncology and Cardiology services for members 18 years and older.	1-800-546-7092 -or- www.healthhelp.com	8:00 am – 6:00 pm EST M-F Website is available 7 days a week, 24 hours a day.

Important Addresses & Fax Numbers

Reason for Mailing	Address
Highmark Wholecare Medicaid Claims	Attention: Claims Processing Department P.O. Box 211713 Eagan, MN 55121
Administrative Claims Reviews Fax to: 1-844-207-0334	Attention: Claims Department Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222
Clinical Provider Appeals Fax to: 1-855-501-3904	Attention: Appeals & Grievance P.O. Box 22278 Pittsburgh, PA 15222-1222
Credentialing	Attention:Credentialing Department Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222
Practice Change Information Fax to: 1-855-451-6680	Attention: Provider Information Management Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222
Dental Claims	Attention: Claims P.O. Box 2190 Milwaukee, WI 53201
Dental Claims Corrected (Adjusted)	Attention: Corrected Claims P.O. Box 1613 Milwaukee, WI 53201
Dental Prior Authorizations	Attention: Pre-Authorizations PO Box 2170 Milwaukee, WI 53201
Dental Orthodontic Prior Authorizations	Attention: Pre-Authorizations PO Box 2170 Milwaukee, WI 53201
Vision Claims	Attention: Vision Card Processing Unit P.O. Box 1525 Latham, NY 12110

Mental Health/Substance Abuse Contact Information

Please note that these numbers are for members to call. Practices do not need to send a referral or authorize mental health/substance abuse services.

County	BH-MCO	Single County Authority for Substance Treatment
Adams	Community Care Behavioral Health 1-866-738-9849	York Adams Drug and Alcohol Commission 717-771-9222
Allegheny	Community Care Behavioral Health 1-800-553-7499	Allegheny County Department of Human Services – Office of Behavioral Health - Bureau of Drug and Alcohol Services 412-350-3328
Armstrong	Beacon Health Options 1-877-688-5969	Armstrong/Indiana/Clarion Drug and Alcohol Commission, Inc. 724-354-2746
Beaver	Beacon Health Options 1-877-688-5970	Beaver County Behavioral Health Drug and Alcohol Program 724-847-6225
Bedford	Community Care Behavioral Health 1-866-483-2908	Personal Solutions Inc Bedford- 814-623-5009
Berks	Community Care Behavioral Health 1-866-292-7886	Berks County Council on Chemical Abuse 610-376-8669
Blair	Community Care Behavioral Health 1-855-520-9715	Blair County Drug and Alcohol Program, Inc 814-381-0921
Butler	Beacon Health Options 1-877-688-5971	The Butler County Drug and Alcohol Program 724-284-5114
Cambria	Magellan 1-800-424-0485	Cambria County Drug and Alcohol Program 814-536-5388
Cameron	Community Care Behavioral Health 1-866-878-6046	Cameron/Elk/McKean Counties Alcohol and Drug Abuse Services Inc 814-642-2910
Clarion	Community Care Behavioral Health 1-866-878-6046	Armstrong/Indiana/Clarion Drug and Alcohol Commission, Inc. 724-354-2746
Clearfield	Community Care Behavioral Health 1-866-878-6046	Clearfield/Jefferson Drug and Alcohol Commission 814-371-9002
Crawford	Beacon Health Options 1-866-404-4561	Crawford County D&A Executive Commission, Inc. 814-724-4100
Cumberland	Performcare 1-888-722-8646	Cumberland/Perry Drug and Alcohol Commission 717- 240-6300
Dauphin	Performcare 1-888-722-8646	Dauphin County Department of Drug and Alcohol Services 717-635-2254
Elk	Community Care Behavioral Health 1-866-878-6046	Cameron/Elk/McKean Counties Alcohol and Drug Abuse Services Inc 814-642-2910
Erie	Community Care Behavioral Health 1-855-224-1777	Erie County Office of Drug and Alcohol Abuse 814- 451-6877
Fayette	Beacon Health Options 1-877-688-5972	Fayette County Drug and Alcohol Commission Inc. 724- 438-3576

County	BH-MCO	Single County Authority for Substance Treatment
Forest	Community Care Behavioral Health 1-866-878-6046	Forest/Warren Human Services D&A Program 814- 726-2100
Franklin	Performcare 1-866-773-7917	Franklin/Fulton County Drug and Alcohol Program 717- 263-1256
Fulton	Performcare 1-866-773-7917	Franklin/Fulton County Drug and Alcohol Program 717- 263-1256
Greene	Community Care Behavioral Health 1-866-878-6046	Greene County Human Services Program 724- 852-5276
Huntingdon	Community Care Behavioral Health 1-866-878-6046	Juniata Valley Tri-County Drug and Alcohol Abuse Commission 717- 242-1446
Indiana	Beacon Health Options 1-877-688-5969	Armstrong/Indiana/Clarion Drug and Alcohol Commission, Inc. 724-354-2746
Jefferson	Community Care Behavioral Health 1-866-878-6046	Clearfield/Jefferson Drug and Alcohol Commission 814-371-9002
Lancaster	Performcare 1-888-722-8646	Lancaster County Drug and Alcohol Commission 717- 299-8023
Lawrence	Beacon Health Options 1-877-688-5975	Lawrence County Drug and Alcohol Commission Inc. 724- 658-5580
Lebanon	Performcare 1-888-722-8646	Lebanon County Commission on Drug and Alcohol Abuse 717- 274-0427
Lehigh	Magellan 1-866- 238-2311	Lehigh County Drug & Alcohol Services 610-782-3555
McKean	Community Care Behavioral Health 1-866-878-6046	Cameron/Elk/McKean Counties Alcohol and Drug Abuse Services Inc 814-642-2910
Mercer	Beacon Health Options 1-866-404-4561	Mercer County Behavioral Health Commission Inc. 724- 662-1550
Northampton	Magellan 1-866-238-2312	Northampton County D&A Division 610- 829-4725
Perry	Performcare 1-888-722-8646	Cumberland/Perry Drug and Alcohol Commission 717- 240-6300
Potter	Community Care Behavioral Health 1-866-878-6046	Potter County Drug and Alcohol 814- 544-7315
Somerset	Community Care Behavioral Health 1-866-483-2908	Somerset County Drug and Alcohol 814- 445-1530
Venango	Beacon Health Options 1-866-404-4561	Venango County Substance Abuse Program 814- 432-9744
Warren	Community Care Behavioral Health 1-866-878-6046	Forest/Warren Human Services D&A Program 814- 726-2100
Washington	Beacon Health Options 1-877-688-5976	Washington D&A Commission, Inc. 724- 223-1181
Westmoreland	Beacon Health Options 1-877-688-5977	Westmoreland Drug and Alcohol Commission, Inc. 724- 243-2220
York	Community Care Behavioral Health 1-866-542-0299	York Adams Drug and Alcohol Commission 717-771-9222

Medication Assisted Treatment Providers			
County	**Name**	**Phone**	**Address**
Allegheny	Gateway Rehabilitation Center	412-604-8900	311 Rouser Road, Moon Township, PA
	West Penn Allegheny Health System	412-858-2000	30 Isabella Street, Pittsburgh, PA 15212
	Tadiso Inc.	412-906-9812	1425 Beaver Avenue, Pittsburgh, Pa 15233
	WPIC of UPMCPS	412-246-5376	3811 O'Hara Street, Pittsburgh, PA 15213
	University of Pittsburgh Physicians: General Internal Medicine Clinic- Oakland	412-692-4822	200 Lothrop Street, Pittsburgh, PA 15213
	Magee-Women's Hospital of UPMC	412-641-5725	300 Halket Street, Pittsburgh, PA 15213
Berks	Reading Hospital and Health System	484-628-8827	6th Avenue and Spruce Street, West Reading, Pa 19611
	New Directions Treatment Services	610-478-0646	20-22 North 6th Avenue, West Reading, PA 19611
Blair	Pyramid Healthcare, Inc.	814-940-0407	1896 Plank Road, PO Box 967, Duncansville, PA 16635
Bradford	CASA of Livingston County, Inc./Trinity	585-991-5012	100 Henry Street, Sayre, PA 18840
Bucks	Family Service Association of Bucks County	215-757-6919	4 Cornerstone Drive, Langhorne, PA 19047
	Penn Foundation, Inc.	215-257-9999	807 Lawn Ave., Sellersville, PA 18960
Butler	Butler Memorial Hospital	724-284-4274	One Hospital Way, Butler, PA 16001
Cambria	Alliance Medical Services- Johnstown	814-269-4700	1425 Scalp Ave., Suite 175, Johnstown, PA 15904
Centre	Crossroads Counseling, Inc.	570-323-7535	444 East College Avenue, Suite 460, State College, PA 16801
Clearfield	Clearfield-Jefferson Drug and Alcohol Commission	814-371-9002	135 Midway Drive, DuBois, PA 15801
Clinton	Crossroads Counseling, Inc.	570-323-7535	8 North Grove Street, Suite 4, Lock Haven, PA 17745

Dauphin	Pennsylvania Counseling Services - Allison Hill	717-230-1361	548 South 17th Street, Harrisburg, PA 17104
	Hamilton Health Center	717-230-3910	110 S. 17th Street, Harrisburg, PA 17104
Delaware	AIDS Care Group/Sharon Hill	610-715-0127	2304 Edgemont Avenue, Chester, PA
	Crozer-ChesterMedical Center - Community Hospital	610-497-7459	2600 West 9th Street, Chester, PA 19013
Erie	Esper Treatment Center	814-459-0817	25 West 18th Street, Erie, PA 16501
Fayette	HighlandHospital	724-626-2356	401 East Murphy Avenue, Connellsville, PA 15601
Jefferson	Clearfield-Jefferson Drug and Alcohol Commission	814-371-9002	135 Midway Drive, DuBois, PA 15801
Lackawanna	The Wright Medical Group, PC	570-591-5146	501 Madison Avenue, Lackawanna, PA 18510
	Habit OPCO Dunmore Comprehensive Treatment Center	570-344-5327	118 Monahan Avenue, Dunmore, PA 18512
	Total Wellness Center, LLC	413-341-1787	1020 West Lackawanna Avenue, Scranton, PA 18504
Lancaster	Lancaster General Hospital	717-544-4292	555 N. Duke Street, Lancaster, PA 17604
	TW Ponessa & Associates Counseling Services, Inc.	800-437-5405	410 North Prince Street, Lancaster, PA 17603
Lehigh	Neighborhood Health Centers of Lehigh Valley	610-820-7605	333 West Union Street, Allentown, PA 18102
	Treatment Trends, Inc.	610-432-7690	24 South Fifth St., P.O. Box 685, Allentown, PA 18105
Luzerne	Total Wellness Center, LLC	413-341-1787	189 E. Market Street, Wilkes-Barre, PA 18702
	Pennsylvania Care LLC DBA Miners Medical	570-822-5145	43 Main Street, Ashley, PA 18706
Lycoming	Crossroads Counseling, Inc.	570-323-7535	501 East Third Street, Williamsport, PA 17701
	Total Wellness Center, LLC	413-341-1787	329 Pine Street, Williamsport, PA 17701
Monroe	Mt. Pocono Medical	570-839-7246	1151 Pocono Blvd., Mt. Pocono, PA 18344

Montgomery	Resources for Human Development, Inc. Montgomery County Methadone Center	215-951-0300	316 DeKalb Street, Norristown, PA 19401
	Community Health and Dental Care Inc.	610-326-9460	800 Heritage Drive, Pottstown, PA 19464
Montour	Geisinger Clinic/GIM Danville	570-214-7021	100 North Academy Avenue, Danville, PA 17822
Northampton	Neighborhood Health Centers of Lehigh Valley	610-432-7690	24 South Fifth St., P.O. Box 685, Allentown, PA 18105
	New Directions Treatment Services	610-758-8011	2442 & 2456 Brodhead Road, Bethlehem, PA 18020
Philadelphia	Pathways to Housing PA	215-390-1500	5201 Old York Road, Philadelphia, PA
	Public Health Management	215-985-6886	1500 Market Street, Philadelphia, PA 19102
	Penn Presbyterian Medical Center	215-662-9758	5 N 39th Street, Philadelphia, PA 19104
	Maternal Addiction Treatment, Education, and Research	215-955-8419	1233 Locust Street, Philadelphia, PA 19107
	Temple University-Of the Commonwealth System of Higher Education	215-707-7547	3340 North Broad Street, Philadelphia, PA 19140
	Wedge Medical Center, Inc.	215-276-3922	6711 Old York Road, Philadelphia, PA
Schuylkill	Clinical Outcomes Group, Inc.	570-628-6990	437 North Centre Street, Potsville, PA 17901
Tioga	Crossroads Counseling, Inc.	570-323-7535	1873 Shumway Hill Road, Wellsboro, PA 16901
Washington	The CARE Center, Inc.	724-489-9100	75 East Maiden Street, Washington, PA 15301
Westmoreland	Mon Valley Health Services Inc.	724-489-9100	2 Eastgate Avenue, Monessen, PA 15062
York	Family First Health Corporation	717-801-4804	116 South George Street, York, PA 17401
	Pennsylvania Counseling Services – York Psychiatric	717-315-0763	128 North George Street, York, PA 17402

Medication Assisted Treatment Providers Accessible Recovery Services Warm handoff phone number for all locations: 724-591-5236 Ext. 101	
County	**Address**
Allegheny	9400 McKnight Rd., Suite 103, Pittsburgh, PA 15237
	5601 Stanton Ave., Pittsburgh, PA 15206
Berks	401 Arch St., Suite 706, Philadelphia, PA 19102
Butler	220 South Main St., Holly Pointe Bldg., Suite C, Butler, PA 16001
	301 Smith Drive, Unit 1, Cranberry Township, PA 16066
Cambria	132 Walnut St., Suite A, Johnstown, PA 15901

Medication Assisted Treatment Providers Opioid Addiction Recovery Services (OARS) Warm handoff phone number for all locations: 724-912-OARS (6277)	
County	**Address**
Allegheny	2360 Hospital Drive, Aliquippa, PA 15001
Butler	315 Liberty Street, Butler, PA 16001

Introduction

About This Manual

Highmark Wholecare's successes, measured by member and provider satisfaction and assessments by the Centers for Medicare and Medicaid Services (CMS), and the Pennsylvania Department of Human Services (DHS) are dependent upon strong educational processes. Understanding Highmark Wholecare's policies and procedures is essential. The entire Highmark Wholecare team is committed to providing accurate, up-to-date, and comprehensive information to our member and provider populations through prompt and dedicated service. The Provider Manual is one way of sharing information regarding Highmark Wholecare's policies and procedures with participating practitioner offices, hospitals, and ancillary providers, and is considered an extension of your contractual agreement. This manual should be used as a general guideline by Highmark Wholecare's provider network. The manual is a reference, and is designed to be updated as needed. Please retain all updates with your manual.

This manual and any updates are available in the Provider section of our website at: https://www.HighmarkWholecare.com/provider under Medicaid Resources.

Corporate Overview

At Highmark Wholecare, we believe in caring for the whole person in all communities where the need is greatest. We see a future in which everyone has equal opportunity to achieve their best health. Through our leading Medicaid and Medicare programs, Highmark Wholecare is coordinating health care that goes beyond doctors and medicine including health care that helps members achieve not just physical health, but also delivers whole person care. Our associates are helping to drive this new kind of health care in collaboration with a network of twenty-nine thousand (29,000) primary care physicians (PCPs), specialists, hospitals, and other ancillary providers. Highmark Wholecare is also committed to supporting our neighbors through our many community outreach and engagement programs.

Highmark Wholecare offers Medicare and Medicaid HMO plans in Pennsylvania. Enrollment in these plans depends on contract renewal. Highmark Wholecare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Highmark Wholecare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Philosophy and Social Determinants of Health

Our legacy of addressing Social Determinants of Health (SDoH), which refers to the conditions in which people are born, grow, live, work, and age can be traced back to the start of our company.

Highmark Wholecare offers a wide variety of programs and demonstrations focused on delivering whole person care and addressing SDoH for our members. Many of these initiatives are available by member referral through our care management program.

More than fifteen (15) years ago, we recognized that health is about more than just physical health and developed our proprietary BEEMSS Assessment. This tool provides our team with the framework to assess relevant medical-social factors impacting our members – all while tailoring their individualized care plans: behaviorally, environmentally, economically, medically, socially, and spiritually.

Highmark Wholecare's Wholecare Resource Center

The Wholecare Resource Center is a new, free support resource tool supported by the "findhelp" technology platform. It is an easy way to quickly search for community support resources online. Users can find food, housing, and transportation resources. They can also search for employment and mental health support programs.

History

Highmark Wholecare began as Gateway Health Plan in 1992. The company started out as an alternative option to the Pennsylvania DHS. We quickly became a leading health plan, a status that has remained during our thirty (30)-year history. Our focus has always been on the total health of our members. Our members have benefited from our services such as:

- ✓ Disease management.
- ✓ Health and wellness programs.
- ✓ Preventative care.
- ✓ SDoH initiatives.

Mission

Our mission is to care for the whole person in all communities where the need is greatest.

Products

In addition to its PA Medicaid product, Highmark Wholecare offers two Dual Special Needs Plans (D-SNP), serving those with Medicare Parts A and B, among other qualifying factors. These plans are:

Highmark Wholecare Medicare Assured Diamond℠ (HMO SNP) – A Dual Eligible Special Needs Plan, (D-SNP); serving those who have BOTH Medicare Parts A and B and who receive full assistance from the state.
Highmark Wholecare Medicare Assured Ruby℠ (HMO SNP) – A Dual Eligible Special Needs Plan, (D-SNP); serving those who have BOTH Medicare Parts A and B and who receive specified levels of assistance from the state.

We offer the following benefits to members enrolled in Highmark Wholecare Medicare Assured:

- ✓ All the benefits of original Medicare.
- ✓ Prescription drug coverage.
- ✓ Hearing (including hearing aids), vision (including eyewear), and dental benefits (including dentures)*.
- ✓ Health and wellness education, such as heart disease, diabetes, and smoking/tobacco cessation.
- ✓ Bathroom andhomesafety products*.
- ✓ A fitness program to help members stay active (including a @Home Pak for home-bound members)*.
- ✓ Transportation*.
- ✓ Meals benefits*.
- ✓ Lifeline (Personal Response System)*.

*Benefit coverage varies by product. Refer to the Evidence of Coverage booklet for each healthcare option located on our website at: https://www.HighmarkWholecare.com/medicare.

Highmark Wholecare is dedicated to providing benefits to the Medicaid and Medicare populations to meet their medical and social needs. The specific needs of our membership have led to the development of wellness, education, and outreach programs at Highmark Wholecare. These programs identify needs and provide effective case management for members with chronic conditions such as asthma, diabetes, cardiovascular disorders, chronic heart conditions, and HIV/AIDS.

Continuing Quality Care

Health care is an ever-changing field and Highmark Wholecare strives to stay on top of its members' needs. Highmark Wholecare is committed to continually improving and providing high standards of quality in every aspect of service. This commitment is led by Highmark Wholecare's Quality Improvement/Utilization Management (QI/UM) Committee, comprised of experts from a wide variety of medical fields. The QI/UM Committee evaluates Highmark Wholecare's ongoing efforts as well as new protocols and quality initiatives in order to improve service and care for members.

Wellness and Disease Management

We are committed to improving the life of our members and is working to find new ways to promote wellness, illness prevention, and health education as demonstrated by the following:

- Preventive health care.
  - Annual Flu Vaccinations.
  - Annual Wellness Visit (age eighteen (18) and older).
  - Breast Cancer Screening (women ages fifty (50) to seventy-four (74) years).
  - Colorectal Cancer Screening (ages fifty (50) to seventy-five (75) years).
  - Diabetes tests as needed, such as HbA1C, dilated retinal eye exam, and microalbumin (for members with diabetes).
- Tobacco cessation education and benefits.
- Pediatric and adult immunization reminders.
- Highmark Wholecare Lifestyle Management℠.
  - Asthma Program.
  - Cardiac Program.
  - COPD Program.
  - Diabetes Program.
  - Hypertension Program.
  - Mom Matters Maternity Program.
  - Healthy Weight Management
- Wellness Coaches.
  - Registered Dietitian Nutritionist.
  - Certified Diabetes Care and Education Specialist.
  - Certified Rehabilitation Counselor.

Healthcare Disparities

Highmark Wholecare understands that in order to help improve our members' quality of life, we must consider racial, ethnic, cultural, and linguistic differences. For this reason, addressing disparities in health care is high on our leadership's agenda. We believe a strong patient-provider relationship is the key to reducing the gap in unequal health care access and health care outcomes due to cultural, language, and/or geographic barriers.

In an effort to develop a strong patient-provider relationship, Highmark Wholecare, via the Highmark Wholecare Cultural Competency Data Form, voluntarily collects all provider race, ethnicity, and language information in order to connect members to the appropriate practitioners, deliver better provider-patient communication, and improve patients' health, wellness, and safety. Disclosing this information is strictly voluntary and will not be used for credentialing, contracting, or for any discriminatory purposes. Additionally, Highmark Wholecare is encouraging all providers to take cultural competency training and to inform Highmark Wholecare about the various trainings taken by providers and their office staff throughout the year. Providers can access the Cultural Competency Data Form on the Highmark Wholecare website.

Another example of how we are working to close a quality gap can be seen in our diabetes disease management programs. In order to improve interventions at the point of care, Highmark Wholecare pays for Primary Care Practitioners (PCPs) to perform in-office HbA1c tests. Test results can be available in as little as five (5) minutes. Highmark Wholecare also has cross-cultural education programs in place to increase awareness of racial and ethnic disparities in health care among our employees, members, and providers. A provider cultural toolkit is available on our website: Cultural Toolkit.

The cultural toolkit includes facts about health care disparities from the Institute of Medicine, tips on how to better communicate with patients, tools to evaluate how well the practice is delivering quality care to culturally diverse populations, information about communication regulations and resources from the Title VI of the Civil Rights Act of 1964, facts about various cultures to enable the advocacy of high-quality, culturally competent services to multi-ethnic populations, and web-based modules for physicians to practice responding to situations where culturally competent care is needed and more.

Lastly, Highmark Wholecare assesses our member populations' language profile at least every three (3) years and makes the Population Assessment Language Profile Report available to practitioners through updates in Provider Newsletters.

Community Involvement

Highmark Wholecare is an active partner in the community that:

- Participates in community events and sponsorships.
- Assists community and social services agencies that serve high-risk, vulnerable populations.
- Develops outreach programs for adults and children to educate about health, wellness, and safety issues at no cost to the community.
- Carries out its Health Literacy Initiative with individuals and organizations in the communities we serve. The goal of this initiative is to help people better understand and navigate the healthcare system.

Benefits of Highmark Wholecare

Members receive improved access to primary medical care, health, and wellness programs. Providers receive timely payments, simplified administrative procedures, and dedicated provider servicing. Highmark Wholecare fulfills its mission and ensures the availability of high-quality medical care for the dual eligible population to positively affect the personal health of individuals.

How Does Highmark Wholecare Work?
Highmark Wholecare Provider Network

The Plan contracts directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide care for our membership. The Plan's provider network includes more than one hundred fifty (150) hospitals, over twenty thousand (20,000) providers, over five thousand (5,000) ancillary locations, a network of pharmacies, home healthcare agencies, and other related healthcare providers. Practitioners and other healthcare providers are chosen in such a manner that existing patterns of care, including patterns of hospital admissions, can be maintained. Participating practitioners treat patients in their offices as they do their non-Highmark Wholecare patients, and agree not to discriminate in the treatment of or in the quality of services delivered to Highmark Wholecare's members on the basis of race, sex, age, religion, place of residence, or health status. Because of the cultural diversity of our membership, participating providers must be culturally sensitive to the needs of our members. Participation in the Plan in no way precludes participation in any other program with which the provider may be affiliated.

New Highmark Wholecare Technology Including a New Claims Processing and Clinical Platform

GateTech is an operations and technology transformation initiative, which was implemented October, 2021.

GateTech brings efficiencies to claims processing by implementing a modernized claims system and changes how we review and process UM prior-authorizations.

What has changed for providers?

1. Streamlined claims processing.
2. Simplified authorization processing and resolution.
3. Enhanced call servicing experience.
4. Improved provider portal capabilities.

Highmark Wholecare Provider Self-Service

NaviNet is a web-based solution securely linking providers nationwide through a single website. This service is available at no cost to our participating providers. NaviNet is the preferred tool for inquiring about member information.

Highmark Wholecare encourages our participating providers to access the NaviNet secure Provider Portal to utilize the self-service tools available, including:

- Secure Messaging and Document Exchange for direct and secure bi-directional communication and submission of documentation.
- Claims search including remittance advice data search option that displays all claims that have been paid to a specific check number.
- Batch claims search which allows the user to view all claims for a specific provider office.

- Authorization requests.
- Code Authorization Look-Up Tool.
- Substance Use Disorder Resource Page.

Highmark Wholecare Provider Relations Role

Highmark Wholecare uses dedicated, highly trained Provider Account Liaisons (PALs), Lead Provider Relations Representatives, or Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Contracting and Servicing Consultants. We are keenly aware that it is essential that our providers and their staff have a solid understanding of the members' needs, our contract requirements, protocols, and Federal and/or State regulations in order to provide exceptional access and quality health care to our members.

PALs and FQHC/RHC Contracting and Servicing Consultants give initial orientation training to providers and their office staff within thirty (30) calendar days of successfully gaining approval to participate in our network. During that training the Provider Manual is reviewed. The training familiarizes new providers and their staff with our policies and procedures.

All provider in-service training materials are located on the Highmark Wholecare website at https://www.HighmarkWholecare.com/provider/provider-resources/in-service-materials.

FQHC/RHC In-Service resources are located at: https://www.HighmarkWholecare.com/provider/provider-resources/fqhc-rhc-resources.

Each participating primary care practice, specialty care practice, and hospital is assigned a PAL or FQHC/RHC Contracting and Servicing Consultant who is responsible for ongoing education. As a follow-up to the initial orientation, each assigned PAL and FQHC/RHC Contracting and Servicing Consultant regularly contacts providers and their staff to ensure full understanding of the responsibilities outlined in the Provider Agreements and Manual.

PCP's Role

The definition of a PCP is a specific practitioner, practitioner group, or a certified registered nurse practitioner (CRNP) operating under the scope of his/her licensure, who is responsible for supervising, prescribing, and providing primary care services, locating, coordinating, and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of a member. The PCP is responsible for the coordination of a member's healthcare needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other healthcare services.

To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the members designated PCP. By focusing all of a member's medical decisions through the PCP, members are given comprehensive and high-quality care in a cost-effective manner.

One of Highmark Wholecare's goals is to work together with a dedicated group of practitioners to make a positive impact on the health of our membership and truly make a difference.

DHS Master Provider Index Number

All network practitioners must have a DHS issued identification number/Master Provider Index (MPI). Enrollment applications may be found at: https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx.

Information about DHS' Office of Medical Assistance (MA) Programs may also be found on the Internet at: https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/OMAP-Information.aspx.

Revalidation of MA Providers

Section 6401 (a) of the Patient Protection and Affordable Care Act (ACA), as amended by the Health Care and Education Reconciliation Act of 2010 (together known as the ACA) and the implementing regulation at 42 C.F.R. § 455.414 require states to revalidate the enrollment of participating providers every five (5) years.

Per our HealthChoices Agreement (HCA) we are required to ensure that all providers operating within the PH-MCO's network who provide services to recipients must be enrolled in the Commonwealth's MA program and possess an active Medical Management Information System (MMIS) Provider ID for each location in which they provide services to our members. Furthermore, we are required by the HCA to reconcile monthly our provider file against DHS' provider file to ensure all service locations are enrolled with MA.

If a provider does not have a valid MMIS ID and service location (together forming the thirteen (13) digit MAID) they will not be set up in our systems and will not be in our directory for members to choose. Additionally, on January 1, 2018, the additional Ordering, Referring, and Prescribing (ORP) requirements went into effect which will also prevent payment for providers at service locations that do not have a valid MAID for that location.

Beginning in July, 2019, we began requiring the Claim Service Facility (2310C) information to be reported on a claim when:

- The claim Place of Service (2300 CLM05-1) equals twenty-one (21), twenty-two (22), twenty-three (23), twenty-four (24), thirty-one (31), or thirty-two (32) and the service line Date of Service is greater than/equal to 07/01/2019.
- The claim Service Facility National Provider Identifier (NPI) (2301C NM109) equals the Billing Provider NPI (2010A A NM 109) and the service Line Date of Service is greater than/equal to July 1, 2019 on all professional claims.

Claims received on or after July 1, 2019 with a date of service on or after July 1, 2019 will be rejected if the above requirements are not met.

As a reminder, we require providers to submit a rendering provider on their claim when the billing provider is a group only provider. Billing providers who can be identified as an individual provider or who are registered with DHS as Home Health, Hospice, Clinic, Pharmacy (when billing Medical supplies), Durable Medical Equipment (DME), Transportation, Laboratory, X-Ray Clinic, Renal Dialysis, Birthing Center, or Vendor/Environmental Investigation are not required to submit a rendering provider at this time.

EDI Technical Guidance for Submitting a Rendering Provider:
Professional and Dental:
Rendering Header Loop 2310B Rendering Detail Loop 2420A

Institutional claims:
Rendering Header Loop 2310D Rendering Detail Loop 2420C

Unsure of your enrollment status with DHS?
Instructions for providers who have applied for enrollment and want to check the status:

- First, check the status of the portal enrollment application to verify the application has been approved or has been pended in the event FFS has reached out for additional information.
- Second, if the provider already has an existing enrollment, check ePEAP to determine if the new service location address has been added.

Contracts/No Gag Clause

Highmark Wholecare allows open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care for the patient. All of Highmark Wholecare's contracts with practitioners and providers include an affirmative statement indicating that the practitioner can freely communicate with patients regarding the treatment options available to them, including medication treatment options regardless of benefit coverage limitations. There is no language in Highmark Wholecare's contracts that prohibits open clinical dialogue between practitioner and patient.

Highmark Wholecare Value-Based Programs

Highmark Wholecare continues its efforts to improve quality, enhance the member experience, and reduce the overall cost of health care by providing Value-Based programs to both PCP and Specialty Care Physicians (SCP).

Highmark Wholecare's value-based program offers the potential for significant outcomes-based reimbursement by rewarding providers for managing their Highmark Wholecare member population toward high value, both quality and efficiency, and outcomes of care. Highmark Wholecare continues its work to improve the health of its members by encouraging care coordination across all aspects of care delivery and aligning Value-Based goals and objectives. Highmark Wholecare's current Value-Based Programs are Advanced Patient Centered Medical Home (APCMH), Shared Savings, Bundled Payments, or Episodes of Care.

APCMH

The APCMH program was started in late 2017 and offers providers a first (1st) step into the Value- Based world. The APCMH model of care includes key components such as whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team-based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care.

The responsibilities of the provider participating in the APCMH program are:

1. Will be a high-volume Medicaid practice already participating in the PH-MCO provider pay for performance program or a defined set of practices willing to share care management resources.
2. Will accept all new patients or be open for face-to-face visits at least forty-five (45) hours per week.
3. Will join a Pennsylvania Patient and Provider Network (P3N) Certified health Information Organization (HIO) by 12/31/2021 in order to share health related data.
4. Will deploy a community-based care management team as described below: The PCMH must deploy a Community-Based Care Management (CBCM) team that consists of licensed professionals such as nurses, pharmacists or social workers and unlicensed professionals such as peer recovery specialists, peer specialists, community health workers or medical assistants. The CBCM teams' activities can replicate but not duplicate already existing and CBCM reimbursed care management services. The care management team will work within their local community to accept individuals with complex care needs from local emergency departments, physical and behavioral health hospitals, specialty providers, and PH-MCO.

Through actively engaging patients and considering their preferences and personal health goals, the CBCM team will develop care plans that help individuals with complex chronic conditions to stay engaged in comprehensive treatment regimens that include, but are not limited to physical health, substance use disorder, and mental health treatments. The CBCM team will also connect individuals as needed to community resources and social support services through "warm hand off" referrals for assistance with problems such as food insecurity and housing instability.

5. Will collect and report annual quality data and outcomes pertinent to their patient population as defined by the current PH-MCO provider pay for performance program, the Integrated Care Plan pay for performance program, and additional population specific measures defined by DHS0.
6. Will conduct internal clinical quality data reviews on a quarterly basis, report results and discuss improvement strategies with the PH-MCO.
7. Will measure patient satisfaction using a validated low literacy appropriate tool to assess individual and family/caregiver experience.
8. Will include as part of the health care team patient advocates or family members to support the patients' health goals and advise practices.
9. Will see seventy-five percent (75%) of patients within seven days of discharge from the hospital with an ambulatory sensitive condition.
10. Will participate in a PCMH learning network.
11. Will complete a SDoH assessment, at least annually and more frequent for patients who screen positive, using a Nationally recognized tool focusing on the following domains: food insecurity, health care/medical access/affordability, housing, transportation, childcare, employment, utilities, clothing, and financial strain and submit ICD-10 diagnostic codes for all patients with identified needs. For patients with identified needs, the PCMH must assist the member with obtaining the needed services and monitor the outcome of the referral. The PCMH must track referrals and outcomes and be able to submit to the PH-MCO via claims submission the outcome of every SDoH assessment performed using the HCPCS codes of G9919 (positive screening result) or G9920 (negative screening result) as well as providing the PH-MCO and Department a report of the SDoH assessment outcomes as may be requested.
12. Will educate and disclose to patients through low-literacy appropriate material the practice is a PCMH that has a community-based care management team available to help patients manage complex care needs.

All of these items will be reviewed by your PAL when they come to your office for their quarterly visit.

Shared Savings Program

Highmark Wholecare offers a Shared Savings Program that will reward improved performance, reward quality, reward patient centered care, and share in lowered cost savings. This next step in the value-based process focuses on patient care while lowering costs and improving quality. The requirements to participate in the program are as follows:

- One thousand (1,000) eligible members as of October first (1st) in the year prior to the effective date of January first (1st).
- Providers that drop below one thousand (1,000) members in the program year will still be eligible to continue for the duration of that program year.
- Reporting, performance assessments, and any value-based reimbursements are based upon claims submitted by provider during the program year.
- Providers must be contracted for the program no later than March thirty-first (31st) of the program year.
- Any provider contracted for the program after March thirty-first (31st) will automatically roll to the next January first (1st) or their effective date.

- Additions to any provider practice must be made by and notification sent to Highmark Wholecare must be made by March thirty-first (31st) of the program year.

All additions made after March thirty-first (31st) will be rolled into the next program year with no exception.

Bundled Payments / Episodes of Care

Like other value-based options, bundled payments, or Episodes of Care (EOC), focus on quality care while lowering costs. Highmark Wholecare uses historical utilization and claims information to determine the typical costs of an episode while highlighting which are potentially avoidable or due to complications. During the Program Period, Highmark Wholecare and the provider work together to increase the quality outcomes related to the episode as well as find efficiencies in the costs. A provider organization can keep the money it saves through reduced spending on some components of care included in the bundle.

Quality Improvement

Purpose of the QI/UM Program

The purpose of the QI/UM program is to ensure that members have access to and receive safe, appropriate, timely, and equitable quality medical and behavioral health care services. The QI program monitors and evaluates the quality and appropriateness of care provided by Highmark Wholecare's provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality improvement methodologies and industry-accepted quality measurement tools, Highmark Wholecare evaluates its performance outcomes to:

- Identify opportunities to improve the provision and delivery of health care and health plan services.
- Identify opportunities to improve member and provider satisfaction with care delivery and services.
- Achieve optimum member health outcomes.

The QI Program centers on these key areas: (a) preventive health care, (b) prevalent chronic health care conditions, (c) service indicators, (d) quality of clinical care, (e) safety of clinical care, (f) quality of service, and (g) members' experience. The QI program strives to improve members' adherence to preventive care guidelines, disease management strategies, and therapies that are essential to the successful management of certain chronic conditions. The program also strives to improve patient safety through:

- Educating members and providers in regards to safe practices.
- The assessment and identification of opportunities to improve patient safety throughout the provider network.
- Communication to members and providers of safety activities and provisions that may be in place throughout the network.

To ensure that all these efforts impact all members equitably, the QI program endeavors to continually identify opportunities to impact racial and ethnic disparities and language barriers in health care.

In addition, the QI department maintains a catalog of policies and procedures that guide the execution of the QI program. QI policies and procedures are reviewed and updated annually to reflect changes in requirements, government regulations, and the needs of the membership and provider network.

Goal of the QI/UM Program

The goal of the QI/UM program is to ensure the provision and delivery of high-quality medical and behavioral health care, pharmaceutical, and other covered health care services and quality health plan services. Additional goals for the QI program are to serve members with complex health needs and to serve a diverse membership. The QI/UM program focuses on monitoring and evaluating the quality and appropriateness of care provided by Highmark Wholecare's provider network, and the effectiveness and efficiency of systems and processes that support the healthcare delivery system.

Highmark Wholecare's performance is assessed through utilizing quality improvement concepts and appropriately recognized quality measurement tools and reports, such as qualitative, quantitative, and root/cause barrier analyses. Highmark Wholecare focuses on assessing its performance outcomes to identify opportunities for improvement in the provision and delivery of health care and health plan services, patient safety, satisfaction with care and services, and achieving optimum member health outcomes.

Of specific importance, the QI/UM Program focuses on three (3) key areas:

- Preventive health care.
- Prevalent chronic health care conditions.
- Service indicators.

The QI/UM program strives to:

- Improve members' compliance with preventive care guidelines, disease management strategies, and therapies that are essential to the successful management of certain chronic conditions.
- Identify opportunities which address disparities in healthcare.
- Improve patient safety by:
    - Providing member and practitioner education about safe practices.
    - Assessing the identifying opportunities to improve patient safety throughout the practitioner/ provider network.
    - Communicating to members and practitioners about the safety and provisions in place throughout the network.

By considering population demographics and health risks, utilization of healthcare resources, and financial analysis, Highmark Wholecare ensures that the major population groups are represented in QI/UM activities and health management programs chosen for assessment and monitoring. This information, along with high-volume/high-cost medical and pharmaceutical reports, health risk appraisal data, disease and care management data, satisfaction survey information, and other utilization reports, will be used to identify members with special needs and/or chronic conditions and to develop programs and services to assist in managing their condition.

Objective of the QI/UM Program

The objectives of the QI/UM program are consistent with Highmark Wholecare mission, as well as its commitment to the effective use of healthcare resources, and continuous quality improvement in order to positively affect the members' Wholecare and their social determinants of health.

An annual QI/UM work plan is developed to ensure that the current needs of the population are being evaluated, changes are tracked and trended , programs are enhanced or implemented to address the needs of members, and to ensure continuous quality improvement. The QI/UM program is evaluated quarterly and annually to determine the status of all activities and identify opportunities which align with the QI/UM program objectives.

Objectives of the QI Program are as follows:

- Development and implementation of an annual QI/UM work plan to assure completion of planned activities. The current needs of the population are evaluated and demonstrated continuous quality improvement. The work plan is updated quarterly to track progress of goals and initiatives for each year.
- The provision of appropriate, timely, and quality health care services.
- Develop guidelines and studies which address the member population.
- Assess practitioner performance.
- Delegation oversight.

Scope of the QI/UM Program

The scope of the QI/UM program includes a comprehensive evaluation, quantitative, and qualitative barrier analysis of the utilization of health care services and programs, access and availability to those services, the needs of the members served, the quality of the care provided, and establishment of utilization criteria and review processes. Implementation and evaluation of the QI/UM program is embedded into Highmark Wholecare's daily operations. The QI/UM program leverages internal information, systems, practitioners, and community resources to monitor and evaluate use of healthcare services, continuous improvement, and to assure implementation of positive change. The responsibility of implementing the QI/UM program is a Highmark Wholecare corporate responsibility, not only that of the QI and UM departments.

The scope of the QI/UM Program focuses on the following areas:

- **Quality of Clinical Care**
  The QI/UM program focuses on delivering to members clinical services that are safe, appropriate, and meet professional standards. This is ensured through the monitoring of key indicators including, but not limited to, HEDIS measures, Preventive and Clinical Practice Guideline studies, and review of Quality of Care concerns such as Preventable Serious Adverse Events (PSAE), Never Events, and reportable conditions. Initiatives are designed and implemented to address any indicators that have not been achieved or are negatively deviating from goals.
- **Quality of Service**
  The QI/UM program focuses on delivering customer service to members that is professional, accessible, available, and meaningful. This is ensured through the monitoring of key indicators including, but not limited to, the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS), member satisfaction survey, member complaints, appeals and grievances, and member and provider call center statistics. Initiatives are designed and implemented to address any indicators that have not been achieved or are negatively deviating from goals.
- **Safety of Clinical Care**
  The QI/UM program works to improve patient safety by monitoring for member and practitioner education regarding safe practices, by assessing and identifying opportunities to improve patient safety throughout the practitioner/provider network, and by ensuring that members and practitioners have been informed about safety activities and provisions which may be in place throughout the network.
- **Member Experience**
  The QI/UM program focuses on creating and maintaining a positive member experience through taking initiative based on the results of the annual CAHPS survey, and the trending of member inquires, complaints, appeals, and grievances to identify areas of opportunity. Experience is also monitored through the quality and availability of provider services.

  This is ensured through the monitoring of network PCP and specialist availability and accessibility, the

conduct of medical record reviews, including documentation standards, the assessment of continuity and coordination of care, and the conduction of an annual Member and Provider Satisfaction Survey.

Furthermore, the QI/UM program utilizes appropriate internal resources, race/ethnicity data, information systems, practitioner data, and community resources. These data and resources are used to monitor and evaluate utilization of health care patterns, the continuous improvement process, and to ensure implementation of positive change. The scope of the program includes:

- Analysis and evaluation of the quality of clinical services provided to members.
- Monitoring of service quality.
- Delivery of a multicultural health care program to improve and ensure services provided to members are culturally and linguistically appropriate.
- Monitoring and evaluation of network availability and accessibility.
- Monitoring and evaluation of practitioner activities.
- Review of activities falling within the scope of UM.
- Oversight to ensure the goals of the population health management activities are being met.
- Monitoring and evaluation of care management/complex care management activities.
- Ensuring appropriate oversight of those QI and UM functions which have been delegated by monitoring activities of the Delegation Oversight Committee.
- Monitoring of activities falling within the scope of the Pharmacy Department and Pharmacy and Therapeutics (P&T) Committee.
- An evaluation of risk management and patient safety.

Lastly, the scope of the QI Program comprises a comprehensive quantitative and qualitative evaluation and barrier analysis of:

- The utilization of health care services and programs.
- Access and availability to health care services.
- The needs of the members served.
- The quality of the care provided.
- Establishment of utilization criteria and review processes.

To request a copy of the quality improvement program, work plan, or annual evaluation, please contact Highmark Wholecare's Provider Services Department at 1-800-392-1147.

Clinical Practice Guidelines

The Clinical Practice Guidelines are designed as a resource to assist practitioners in caring for Highmark Wholecare members. The clinical practice and preventive health guidelines have been developed using either evidence-based clinical guidelines from recognized sources, or through involvement of board-certified practitioners from appropriate specialties. The guidelines are evaluated on an ongoing basis and are developed based on the prevalent diseases or conditions of Highmark Wholecare members, as well as applicable regulatory and accrediting body requirements. The use of guidelines permits Highmark Wholecare to measure the impact of the guidelines on outcomes of care and may reduce inter-practitioner variation in diagnosis and treatment.

Clinical guidelines are not meant to replace individual practitioner judgment based upon direct patient contact. Information on the following guidelines may be found on the website at: https://www.HighmarkWholecare.com/provider/medicaid-resources/pa-medicaid-guidelines.

- Pediatric Preventive/EPSDT/Lead Screening (Birth to 21 Years Old).
- Adult Preventive.
- Asthma.
- ADHD.
- Cardiac.
- COPD.
- Cystic Fibrosis.
- Depression.
- Diabetes.
- Healthy Weight Management for Children and Adolescents.
- Health Weight Management.
- HIV.
- Hypertension.
- Opioids – Prescribing for Chronic Pain.
- Palliative Care.
- Prenatal Care – Routine and High Risk.
- Preventive Dental Care – Pediatric.
- Schizophrenia (Children and Adolescents).
- Sickle cell disease.
- Substance Use Disorder.

A paper copy of the individual guidelines is available upon request.

Medical Record Requests

From time to time, Highmark Health will submit an ad-hoc request for medical records. It is imperative that providers in our participating network respond to these requests within fifteen business days, with the exception of Quality of Care cases which require a response within three (3) business days, as dictated per contractual obligations. **If Highmark Wholecare request medical records, the provider must provide copies of those records at no cost. This includes notifying any third party who may maintain medical records of this stipulation as well as the time constraints. This includes notifying any third party who may maintain medical records of this stipulation as well as the time constraint.** These requests are made to comply with regulatory requirements, requests, audits, or for operational purposes (e.g. to investigate quality of care issues, complaints/grievances, or Serious Adverse Event cases).

Highmark Wholecare also regularly conducts a review of our providers' medical records to assure compliance with criteria as specified in the Medical Record Review Standards. The standards, which incorporate a core set of critical factors, were developed and approved by the QI/UM Committee, and adhere to regulatory requirements as prescribed by the National Committee for Quality Assurance (NCQA), State, and Federal agencies.

These standards can be provided upon request or via the Highmark Wholecare website at: https://www.HighmarkWholecare.com/provider/provider-resources/quality-improvement.

A score of eighty (80) percent is required to pass the medical record review; standards identified as critical are required to be present. Practitioners whose medical records do not comply may undergo remediation in the form of education and additional reviews. Continued non-compliance could result in possible practitioner sanctioning.

Potential Preventable Serious Adverse Events/Hospital Acquired Conditions and Never Events

Potential Preventable Serious Adverse Events, Hospital Acquired Conditions, and Never Events are identified by several internal and external mechanisms such as, but not limited to; case management review, credentialing/recredentialing activities, claims payment retrospective review, UM case review, complaint and grievance review, Fraud, Waste, and Abuse (FWA) investigations, practitioner/providers, delegates, and state and/or federal agencies.

Once a potential event has been identified, an extensive review is conducted by the Highmark Wholecare QI and Medical Management Departments. The process includes, when necessary, a medical record review and possible telephonic or mail communication with the practitioner/provider. Once it has been determined if an actual event has been discovered, Highmark Wholecare will, when necessary, verify if payment denial or retraction needs to take place, and notify the practitioner/provider by mail if that is required. Should you have any question, please contact Highmark Wholecare's Provider Services Department at 1-800-392- 1147.

Patient Safety

Patient safety is the responsibility of every healthcare professional. Healthcare errors can occur at any point in the healthcare delivery system and can be costly in terms of human life, function, and healthcare dollars. There are the indirect costs of healthcare errors, such as, a loss of trust and patient/practitioner dissatisfaction.

There are ways practitioners can develop a culture of patient safety in their practice. Clear communication is key to safe care. Collaboration between members of the interdisciplinary care team, hospitals, other patient care facilities, and the patient is critical. Safe practices include, but are not limited to, providing instructions to patients in terms they can easily understand, writing legibly when documenting orders or prescribing, and avoiding abbreviations that can be misinterpreted. Read all communications from specialists and send documentation to other providers, as necessary, to assure continuity and coordination of care. When calling orders over the telephone, have the person on the other end repeat the information back to you.

Collaborate with hospitals and support their safety culture. Bring patient safety issues to the committees you attend. Report errors to your practice or facilities risk management department. Offer to participate in multidisciplinary work groups dedicated to error reduction. Ask Highmark Wholecare's QI department how you can support compliance with our safety initiatives.

Highmark Wholecare also works to assure patient safety by monitoring and addressing quality of care issues identified through several internal and external sources such as; pharmacy, care management, utilization data, continuity and coordination of care standards, sentinel/adverse event data, disease management program follow-up, fraud waste and abuse investigations, practitioner/provider delegates, state and/or federal agencies, and member complaints.

If you would like to learn more about patient safety visit these web sites:

- Institute of Medicine report: *To Err is Human-Building a Safer Health Care System* https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system
- The Joint Commission National Patient Safety Goals https://www.jointcommission.org/
- National Patient Safety Foundation – Institute for Healthcare Improvement http://www.npsf.org/
- The Leapfrog Group for Patient Safety http://www.leapfroggroup.org/
- Agency for Healthcare Research and Quality https://www.ahrq.gov/

Reportable Conditions

Highmark Wholecare's practitioners are contractually required to follow Highmark Wholecare QI programs, including, but not limited to, reporting certain diseases, infections, or conditions in accordance with 28 Pa. Code § 27.21a. Highmark Wholecare's Reportable Conditions Policy, QI-050- MD-PA, has been established to detail this requirement and the methods by which practitioners will be notified of its necessity.

To request additional information or to obtain a copy of the Reportable Conditions Policy, please contact Highmark Wholecare's Provider Services Department at 1-800-392-1147. The regulations, which include the complete list of reportable conditions, can be found via the Pennsylvania Code website at: http://www.pacodeandbulletin.gov/.

Living Will Declaration

Advance Directives

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a new law that has come to be known as the Patient Self-Determination Act. It became effective on December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home health care or personal care services, hospice programs and health maintenance organizations that receive Medicare or Medicaid funds.

The primary purpose of the act is to make sure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute an advance directive if they so desire. The Act also prevents discrimination in health care if the member chooses not to execute an advance directive.

As a participating provider within the network, you are responsible for determining if the member has executed an advance directive and for providing education about advance directives when it is requested. While there is no specific governmentally mandated form, you can request a copy of a Living Will form from our Provider Services Department by calling 1-800-685-5209, or by visiting our website at Medicaid Provider Forms and Reference Materials (highmarkwholecare.com).

A copy of the "Living Will" form should be maintained in the member's medical record. Medical Record Review Standards state that providers should ask members age twenty-one (21) and older whether they have executed an advance directive and document the member's response in their medical records. Providers will receive educational materials regarding a member's right to advance directives upon entering the practitioner network.

Member Outreach

Highmark Wholecare's Member Outreach Navigators help members better understand their healthcare benefits and to appropriately access services within a managed healthcare plan. Highmark Wholecare practitioners can request assistance to provide additional education to members who need further explanation on such issues as utilizing the emergency room appropriately.

Practitioners can refer members for additional education regarding adhering to their treatment plan, of keeping scheduled appointments, understanding their benefits, and resources available by completing a Member Outreach Form, which can be found in the Forms and Reference Material Section of this Manual. A Highmark Wholecare representative will contact the member and follow-up with the practitioner at the practitioner's request.

For more information or to request member outreach, please call Highmark Wholecare's Case Management Department at 1-800-392-1147. You can also fax the Member Outreach Form to the fax number listed on the Form.

Provider Engagement Team (PET)

Highmark Wholecare's PET is a dedicated team of Clinical Transformation Consultants (CTCs) who partner with our providers to improve the overall outcomes of our members. The PET provides information regarding best practices in quality improvement programs, information regarding performance compared to national benchmarks and peers, as well as assistance with achieving incentive goals for our Highmark Wholecare Provider Excellence pay-for-performance program. Our PET is a strategic partner with our providers in achieving their quality goals.

Member

The Enrollment Process

Enrollment in Highmark Wholecare's health plan is offered to MA recipients within Highmark Wholecare's service area. Highmark Wholecare serves medical MA recipients as an option in the HealthChoices mandatory program.

DHS employs a Pennsylvania Enrollment Services Contractor. An Enrollment Specialist explains the benefits offered by Highmark Wholecare and other PH-MCO's and helps the recipient choose a PH-MCO that meets their needs. Potential members are encouraged to select a PCP from a list of participating practitioners. The Pennsylvania Enrollment Services Contractor electronically submits all applications to DHS to validate. DHS then electronically notifies the Pennsylvania Enrollment Services Contractor and Highmark Wholecare that a recipient will be enrolled in Highmark Wholecare.

MA recipients approved by DHS are added to Highmark Wholecare's information system, with the effective date assigned by DHS. It typically takes two (2) to six (6) weeks from the time a recipient calls the Pennsylvania Enrollment Services until they are enrolled with the PH-MCO.

Newly enrolled members receive a new Member Handbook and a Highmark Wholecare Identification Card. (See sample Highmark Wholecare ID Card below.)

MA ACCESS Cards

DHS issues a Pennsylvania ACCESS card to all eligible MA recipients, including those recipients that choose to join Highmark Wholecare. All Highmark Wholecare members will have both a DHS ACCESS card and a Highmark Wholecare identification card. If a patient presents an ACCESS card, the member's eligibility can be verified through DHS' Eligibility Verification System (EVS). Practitioners must participate with the MA program in order to use the EVS.

To access DHS' EVS, call 1-800-766-5EVS (5387). Please have your thirteen (13) digit Master Provider Index (MPI) Number and the members State ID (also known as Recipient Number) from the members ACCESS card available when you call. Since important information is provided throughout the verification process, please listen to the entire message. If the recipient is covered by a managed care plan, such as Highmark Wholecare, their eligibility with the plan is indicated immediately following the member's demographic information (name, date of birth, etc.).

The Point of Service (POS) swipe-box provided by DHS confirms all of the information provided through the EVS phone system and provides printed verification for your records.

The following information is available from the EVS 1-800 number/POS device/PC Software:

Managed Care Information	If the recipient is enrolled in an MCO, EVS will provide the name and telephone number of the MCO as well as the recipient's PCP name, telephone number, TPL, and benefit package information and category of assistance. The system will inform you if the recipient has managed care coverage extending beyond the period of his/her MA coverage.
Recipient Restriction Information	If the recipient has been restricted to certain practitioners, EVS alerts the practitioner to whom the recipient is restricted.
ACCESS Card Information	When an invalid card number is entered, EVS will indicate so by returning a message that the recipient is not eligible.

Determining Eligibility

Because of frequent changes in a member's eligibility, each participating practitioner is responsible to verify a member's eligibility with Highmark Wholecare before providing services. Verifying a member's eligibility along with the applicable authorization will assure proper reimbursement for services. To verify a member's eligibility, the following methods are available to all practitioners:

- Highmark Wholecare Identification Card - The card itself does not guarantee that a person is currently enrolled in Highmark Wholecare. Members are only issued an ID card once upon enrollment unless the member changes their PCP or requests a new card. Members are not required to return their identification cards when they are no longer eligible for Highmark Wholecare.
- Highmark Wholecare Interactive Voice Response System (IVR), which is available twenty-four (24) hours a day, seven (7) days a week at 1-800-642-3515. Practitioners can also call 1- 800-392-1147 and Press two (2) for provider to access the following service prompts:
- Press 1: Retail Pharmacy.
- Press 2: Eligibility.
- Press 3: Claims and Authorization Issues.
- Press 4: Utilization Management.
- Press 5: Special Needs Unit.
- Press 6: Contractual Issues.

Providers follow a few simple steps once connected, which are listed below:

Press 1 If you are calling regarding retail or specialty pharmacy questions you will be connected to RX Pharmacy Services.

Press 2 If you are calling to verify eligibility you will be connected to Highmark Wholecare's twenty-four (24) hours a day, seven (7) days a week IVR. Participating providers also have the capability to verify eligibility via NaviNet.

Press 3 If you are calling regarding claims, to verify benefits, or authorization on file questions you will be connected to Provider Service. Participating providers have the capability to check claim status and to verify benefits via NaviNet.

Press 4 If you are calling regarding authorization requests you will be connected to UM. Participating providers have the capability to submit certain authorization requests electronically via NaviNet.

Press 5 If you are calling regarding care management you will be connected to the Special Needs Unit (SNU).

Press 6 If you are calling regarding credentialing status.

- NaviNet - Participating providers can verify eligibility, benefits, and check claim status via NaviNet. Participating providers have the capability to submit certain authorization requests electronically via NaviNet.

ACCESS Cards

- Showing a MA ACCESS card does not indicate membership in Highmark Health.
- Use the swipe-box or call EVS at 1-800-766-5EVS (5387) to verify a patient's eligibility before providing services.

Highmark WholecareSM Verification of Eligibility

Disclaimer: The eligibility information provided through this automated information system represents updates processed as of the last business day. Eligibility information is provided to Highmark Wholecare and is subject to change. Please note that this information is being sent at the request of the provider.

Confidential Information: The documents accompanying this tele copier transmission contain information that is confidential and/or privileged. The information is intended only for the use of the individual or entity named on the cover sheet. If you are not the intended recipient, you are hereby notified that the documents should be returned to the sender immediately and that any disclosure, copying or distribution or tacking of action in reliance upon the contents of this transmission is strictly prohibited. In this regard, if this transmission has been received in error, please notify the sender by telephone immediately to arrange for the return of the original documents at no cost to the unintended recipient.

Eligibility Information

Entered ID Number:	12345678
Member Name:	Doe, John
Member Gender:	Male
Birthday:	12-02-1994
Member Address1:	123 Main Street
Member City:	Anywhere, PA 12345
Member Telephone:	0000000000
PCP Code:	7654321
PCP Name:	Pediatric Practice
PCP Telephone:	1234567891
PCP Address1:	111 Center Street
PCP City:	Somewhere, PA 54321
PCP Zip code:	54321
Plan Enroll Date:	01-01-2011
Benefit Plan:	400
Elig. For Benefits?	Yes
Date of Service:	05-06-2011
Member Region Description:	Allegheny County
Lab Code:	2345678
Lab Name:	Lab Provider
TPL:	
TPL Address1: TPL City:	
TPL Enrollment Date:	
TPL Contract Num:	

For additional information call:
1-800-392-1147

PCPs Role in Determining Eligibility

PCPs verify eligibility by consulting their panel listing in order to confirm that the member is a part of the practitioner's panel. The panel list is distributed on or about the first (1st) of every month. The PCP should check the panel list each time a member is seen in the office. If a member's name is on the panel list, the member is eligible with Highmark Wholecare for that month.

If members insist they are effective, but do not appear on the panel list, the practitioner should call the Provider Services Department for help in determining eligibility at 1-800-392-1147.

Addition of Newborns

When a member selects Highmark Wholecare, the member's effective date is usually the first (1st) or the fifteenth (15th) of the month. However, when the member is a newborn, the member may be added at any time during the month. Because newborn information is reported to Highmark Wholecare retroactively, newborns will show up as a retrospective addition to the PCPs next monthly panel listing. Newborns will be effective on their date of birth or the date the newborn was added to the members grant.

Member Benefit

Highmark Wholecare members are eligible for all of the benefits covered under the Pennsylvania DHS Medicaid program. Members obtain most of their healthcare services either directly from or upon coordination by their PCP, except for services available on a self-referral basis. PCP is responsible for the coordination of a member's healthcare needs and access to services provided by hospitals, specialty care practitioners, ancillary providers, and other healthcare providers as needed.

Benefits and Special Services

Highmark Wholecare members that are age twenty-one (21) or older may have copayments and applicable service limits. Service limits do not apply for members under twenty-one (21) or if member is pregnant. Copayments do not apply to members under twenty-one (21) or any member who is pregnant (through the post-partum period beginning on the last day of the pregnancy and extending through the end of the month in which the sixty (60) day period following termination of the pregnancy ends) or in a nursing home. **Members cannot be denied a service if they are unable to pay their copayment.**

The provider is required to submit in field twenty-nine (29) of the CMS-1500 form and field fifty-four (54) of the UB-04 form the patient responsibility amount. Highmark Wholecare's system automatically deducts the copayment from the provider's reimbursement and reflects this on the provider's remittance advice. Highmark Wholecare tracks the applicable copayments on each claim and through a retrospective analysis will identify members that reach the thresholds and issue member reimbursements as necessary. Please contact Highmark Wholecare's Provider Services Department at 1-800-392-1147 with any questions regarding services not listed.

Below is an excerpt from the Highmark Wholecare Member Handbook which describes some of the services that are covered by Highmark Wholecare at no cost to members:

- Visits to your PCP.
- Visits to the doctor while you are pregnant.
- Yearly physical examination.
- Well child care, including regular check-ups and shots.
- Non-emergency dental care, if eligible for non-emergency dental care under MA.
- Topical fluoride varnish treatments for members under the age of sixteen (16).
- Braces for teeth for members under age twenty-one (21), if medically necessary.

- Eye exams.
- Contraceptives (birth control), insulin, insulin syringes, and certain over-the- counter medicines when prescribed by a doctor.
- Drugs for members under age twenty-one (21) when prescribed by a doctor.
- Orthopedic shoes and hearing aids for members under age twenty-one (21), if medically necessary.
- Emergency care twenty-four (24) hours a day, seven (7) days a week.
- Twenty-four (24) hour toll-free member telephone service for non-emergency and urgent needs, through Member Service.
- Surgery and anesthesia, if medically necessary.
- EPSDT expanded services for members under age twenty-one (21).
- Extended home nursing services for members under age twenty-one (21), if medically necessary.
- Nursing facility care (limited to thirty (30) days), if medically necessary.
- Home health care visits, if medically necessary and ordered by your doctor.
- Molded shoes, if medically necessary.
- Any other medical services for members under age twenty-one (21) determined to be medically necessary.
- Laboratory Services.
- Tobacco Cessation Counseling.

Some of the services that are covered by Highmark Wholecare that may require members to pay a co-payment include: See page 41 and 42

MEDICALASSISTANCE		
BENEFIT	**COPAY*/LIMITS**	**COMMENT**
Brand Name RX	$3.00	Applicable to age twenty-one (21) and older.
Generic Drug RX	$1.00	Applicable to age twenty-one (21) and older.
Inpatient Hospital (General or Rehab)	$3/per day, up to $21/per admission	Applicable to age twenty-one (21) and older.
Surgical Procedures Any Setting	$3/per covered service	Applicable to age twenty-one (21) and older.
Office Visits (Not applicable to PCPs, OBs, GYNs and B/GYNs)	$2/per visit	Applicable to age twenty-one (21) and older.
Radiology Services	$1/per covered service	Applicable at age twenty-one (21) and older at hospital or physician office.
Chiropractor Outpatient Visits	$2/per visit	Applicable to age twenty-one (21) and older.
Podiatrist Outpatient Visits	$2/per visit	Applicable to age twenty-one (21) and older.
Vision	Highmark Wholecare covers all medically necessary vision services for children. Children may go to a participating provider. Children are covered for the following each calendar year: • Two (2) pairs of standard frames and eyeglass lenses, or • Two (2) pairs of standard contact lenses, or • One (1) pair of standard frames and eyeglass lenses and one set of standard contact lenses Members under the age of twenty-one (21) are given a twenty dollar ($20) allowance for non-standard frames and eyeglass lenses. Members will be required to pay for any amount over	Applicable to members under twenty-one (21) years of age.

Vision	Highmark Wholecare covers some vision services for adults. Members must go to a participating provider. Children are covered for the following each calendar year: Two (2) medically necessary eye exams. Members are given a One hundred dollar ($100) credit for each calendar year to be used toward standard frames, eyeglass lenses and contact lenses combined. If medically necessary, members age twenty-on (21) and older who are diagnosed with Aphakia are covered for the following each calendar year: Two (2) pairs of standard frames and eyeglass lenses, or Two (2) pairs of standard contact lenses, or one (1) pair of standard frames and eyeglass lenses and	Applicable to age twenty-one (21) and older.
Dental	Highmark Wholecare covers all medically necessary dental services for children. Children may go to a participating	Applicable to members under twenty-one (21) years of age.
Dental	Two (2) exams, and two (2) Cleanings, (one (1) every six (6) months). X-rays. Limited lifetime benefits for: One (1) partial upper denture or one (1) full upper denture; and one (1) partial lower denture or one (1) full lower denture. Benefit Limit Exception (BLE) is required for the below services: Crowns and related services; Root canals and other endodontic services; Periodontal services.	Applicable to age twenty-one (21) and older.
Tobacco Cessation	Seventy (70) visits per calendar year	
Home Health Care including Nursing, Aide, and Therapy Services	Twenty-eight (28) days unlimited/fifteen (15) days per monththereafter.	Applicable to age twenty-one (21) and older.

*Copayments do not apply to:

- Services or items provided to a terminally ill individual who is receiving hospice care.
- Services provided to individuals of any age eligible under Titles IV-B and IV-E Foster Care and Adoption Assistance.
- Services provided in emergency situations.
- Family planning services and supplies.
- Home health agency services.
- Renal dialysis services.
- Blood and blood products.
- Oxygen.
- Rental of DME.
- Outpatient services when the MA Fee is under two dollars ($2.00).
- Medical exams requested by the department.
- More than one of a series of a specific allergy test provided in a twenty-four (24) hour period.
- Targeted case management services.
- Members under twenty-one (21).
- Members who are pregnant (through the post-partum period beginning when pregnancy ends and extending through the last day of the twelfth (12th) month in which the postpartum period ends.
- Members in a nursing home.
- Specific drugs in the following categories:
    - Drugs, including immunizations, dispensed in the physician's office.
    - Anti-hypertensive agents.
    - Anti-diabetic agents.
    - Anti-convulsant.
    - Cardiovascular preparations.
    - Anti-psychotic agents, except those that are also schedule C-IV antianxiety agents.
    - Anti-neoplastic agents.
    - Anti-glaucoma agents
    - Anti-Parkinson drugs.
    - HIV/AIDS.
    - Naloxone.
    - Smoking cessation products.

The pharmacy will inform the member of any applicable copay for a prescription.

Members cannot be denied a service or drug if they cannot pay the co-payment. If a member cannot afford to pay, the provider may bill later for co-payments not paid at the time of service.

Members' Rights and Responsibilities

All Highmark Wholecare members have the following rights and responsibilities. The Members' Rights and Responsibilities statement is reviewed and revised annually, or as needed, and is distributed to new members and practitioners, and existing members and practitioners upon request. Highmark Wholecare does not and is prohibited from excluding or denying benefits to, or otherwise discriminating against, any eligible and qualified individual regardless of race, color, national origin, religious creed, sex, sexual orientation, gender identify, disability, English proficiency, or age. Highmark Wholecare regularly monitors compliance related to members' rights and responsibilities, including those rights defined by Section 1557 of the ACA of 2010.

Member Rights

As a Highmark Wholecare Member, you have the right to:

- Be treated with respect, recognizing your dignity and need for privacy, by Highmark Wholecare staff and network providers.
- Get information in a way that you can easily understand and find help when you need it.
- Get information that you can easily understand about Highmark Wholecare, its services, and the doctors and other providers that treat you.
- Pick the network health care providers that you want to treat you.
- Get emergency services when you need them from any provider without Highmark Wholecare's approval.
- Get information that you can easily understand and talk to your providers about your treatment options, risks of treatment, and tests that may be self-administered without any interference from Highmark Wholecare.
- Make all decisions about your health care, including the right to refuse treatment, and to express preferences about future treatment decisions. If you cannot make treatment decisions by yourself, you have the right to have someone else help you make decisions or make decisions for you.
- Talk with providers in confidence and to have your health care information and records kept confidential.
- See and get a copy of your medical records and to ask for changes or corrections to your records.
- Ask for a second opinion.
- File a grievance if you disagree with Highmark Wholecare's decision that a service is not medically necessary for you.
- File a complaint if you are unhappy about the care or treatment you have received.
- Ask for a DHS Fair Hearing.
- Be free from any form of restraint or seclusion used to force you to do something, to discipline you, to make it easier for the provider, or to punish you.
- Get information about services that Highmark Wholecare or a provider does not cover because of moral or religious objections and about how to get those services.
- Exercise your rights without it negatively affecting the way DHS, Highmark Wholecare, and network providers treat you.
- Create an advance directive.
- Make recommendations about the rights and responsibilities of Highmark Wholecare's members.

Member Responsibilities

As a Highmark Wholecare member you have a responsibility to:

- Provide, to the extent you can, information needed by your providers.
- Follow instructions and guidelines given by your providers.
- Be involved in decisions about your health care and treatment.
- Work with your providers to create and carry out your treatment plans.
- Tell your providers what you want and need.
- Learn about Highmark Wholecare's coverage, including all covered and non- covered benefits and limits.
- Use only network providers unless Highmark Wholecare approves an out-of-network provider or you have Medicare.
- Get a referral from your PCP to see a certain specialist, if applicable.
- Respect other patients, provider staff, and provider workers.
- Make a good-faith effort to pay your co-payments.
- Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

Benefit Limits

Exception for Service Limits

Members and practitioners may request an exception for services above the service limits by calling Highmark Wholecare's UM department at 1-800-392-1147 and press two (2) for Provider and press four (4) for UM. All exception requests are reviewed for medical necessity and can be granted if:

- The member has a serious chronic illness or other serious health condition and denial of the exception will jeopardize the life of the member.
- The member has a serious chronic illness or other serious health condition and denial of the exception would result in the serious deterioration of the members' health.
- The exception is a cost-effective alternative to the MA program.
- Granting the exception is necessary in order to comply with Federal law.

Any exception request received prior to the service being rendered will get a response within twenty-one (21) days of the date Highmark Wholecare received the request. Prospective urgent exception requests will be responded to within twenty-four (24) hours of the date and time Highmark Wholecare received the request. Requests received after the service has been rendered will be responded to within thirty (30) days of the date that Highmark Wholecare received the request.

A retrospective request for an exception must be submitted no later than sixty (60) days from the date Highmark Wholecare rejects the claim because the service is over the benefit limit. Retrospective exception requests made after sixty (60) days from the claim rejection date will be denied.

Both the recipient and the provider will receive written notice of the approval or denial of the exception request. For prospective exception requests, if the provider or recipient is not notified of the decision within twenty-one (21) days of the date the request is received, the exception will be automatically granted.

Highmark Wholecare denials of requests for exception are subject to the right of appeal by the provider or recipient.

A provider may not hold a Highmark Wholecare member liable for payment for services rendered in excess of the limits established unless the following conditions are met:

- The provider has requested an exception to the limit and Highmark Wholecare denied the request.
- The provider informed the member before the service was rendered that the recipient is liable for payment if the exception is not granted.

Prescription Drug Coverage

Highmark Wholecare provides coverage for prescription drugs when the drug labeler participates in the Federal Drug Rebate Program and the medication is included on the DHS Statewide Preferred Drug List (PDL) or Highmark Wholecare Supplemental Formulary. The Supplemental Formulary consists of drug classes not covered by the Statewide PDL that have been approved by Highmark Wholecare's Pharmacy and Therapeutics (P&T) Committee after a review of clinical evidence, effectiveness, safety, and cost of the pharmaceuticals. Prescribers are requested to prescribe medications included in the Statewide PDL or Supplemental Formulary whenever possible.

The Statewide PDL/Supplemental Formulary is updated on a regular basis and can be accessed online at: https://www.HighmarkWholecare.com/medicaid/member-tools/find- medications/medicaid-drug-search. Statewide PDL/Supplemental Formulary Changes are also listed on the website. These changes are additions, deletions or quantity limits that are either made by DHS for the Statewide PDL or by Highmark Wholecare's P&T Committee for the Supplemental Formulary. If a medication deletion affects one of your patients, we will provide you with notification thirty (30) days prior to the change.

The Statewide PDL/Supplemental Formulary may be printed directly from our website or requested through Provider Services by calling 1-800-392-1147.

Prescribers may request the addition of a medication to the Supplemental Formulary if the drug does not fall within a therapeutic class listed on the Statewide PDL. Requests must include the drug name, rationale for inclusion on the Supplemental Formulary, role in therapy and formulary medications that may be replaced by the addition. Highmark Wholecare's P&T Committee will review requests. All requests should be forwarded in writing to:

Highmark Wholecare
Attn: Pharmacy Department
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

Some medications, although listed on the Statewide PDL/Supplemental Formulary, may require prior authorization or step therapy to be covered. All prior authorization and step therapy criteria can be found on our website. Highmark Wholecare allows access to all non-formulary drugs, other than drugs excluded by DHS' Fee-for-Service program, through the exception process based on medical necessity. If use of a preferred/ formulary medication is not medically advisable for a member, the prescriber must initiate a Request for Drug Exception. The exceptions process allows for a twenty-four (24) hour turnaround time for all requests. If a member's medication is not filled when a prescription is presented to the pharmacist due to a prior authorization requirement, the pharmacist may dispense up to a five (5) day supply for new medications or a fifteen (15) day supply for an ongoing medication (the pharmacist must contact Highmark Wholecare to obtain a manual override for a fifteen (15) day supply).

Prescription medications are covered when at least one of the following is met:

- Medication is prescribed for an FDS approved indication(s).
- Prescribed for indications, dosages, and formulations that are part of nationally developed standards.
- Prescribed for indications, dosages, and formulations that have been shown to demonstrate both efficacy and safety based on pertinent clinical evidence, expert opinion, and relevant findings from applicable governmental agencies, medical associations, national commissions, peer-reviewed journals, and authoritative compendia.

Any other prescription is considered off-label use and therefore not covered without specific authorization by Highmark Wholecare for an individual member based on a demonstration of medical necessity.

Select over-the-counter (OTC) products are a covered benefit for all members. Members must have a written prescription for each OTC product.

All prescriptions must be filled by a participating pharmacy in order to be covered. Highmark Wholecare utilizes the CVS Caremark Network which is limited to pharmacies who are participating with Pennsylvania MA.

A list of participating pharmacies can be obtained by contacting Member Services at 1-800- 392-1147 or by searching Find a Pharmacy located on the upper banner of our webpage, at: www.HighmarkWholecare.com.

Please refer to the Member Benefit Packages and Copayments section of this manual for information regarding prescription copayments.

Specialty Pharmacy Medications

Highmark Wholecare contracts with specialty pharmacies who are equipped to supply specialty medications to meet the unique needs of our members. Specialty drugs are prescription medications that require special handling, administration, and monitoring. These drugs are used to treat complex, chronic, and often costly conditions. Designated specialty medications are required to be authorized and dispensed through a specialty pharmacy network. Prescribers can call the Pharmacy Services Department to confirm whether a pharmacy is contracted with Highmark Wholecare as a specialty pharmacy provider. A list of participating specialty pharmacies is available by accessing the MA Medicaid Specialty Pharmacy tab on our website at: https://www.HighmarkWholecare.com/provider/pharmacy-tools.

Prescribers can also search for a specialty pharmacy by location using the "Find a Pharmacy" button at the top of the Highmark Wholecare website. Specialty pharmacies are identified under "Pharmacy Type".

Specialty Pharmacy Drug List

The Specialty Pharmacy Drug List indicates all of the specialty medications that are available through the specialty pharmacy network. The Specialty Pharmacy Drug List can be found on our website under the Provider tab, Pharmacy Tools section by selecting the Specialty Pharmacy Drug List link under the MA Medicaid Specialty Pharmacy tab. Once the prescriber sends a prescription to the specialty pharmacy, the pharmacy will outreach to the member to coordinate delivery of the medication and services needed.

If you have additional questions about obtaining a specialty medication please call Pharmacy Services at 1-800-392-1147.

Drugs Covered Under thePharmacy Benefit

Prescription drugs are "covered drugs" under the pharmacy benefit at participating retail pharmacies or specialty pharmacies, as applicable, when they are:

- Approved by the Federal Food and Drug Administration (FDA).
- Distributed by a manufacturer that entered into a Federal Drug Rebate Program agreement with CMS.
- Listed on the Statewide PDL/Supplemental Formulary. Drugs not included on the Statewide PDL/Supplemental Formulary are available through the exceptions process described above.
- Prescribed by a licensed Prescriber within the scope of the Prescriber's practice.
- Dispensed or administered in an outpatient setting.
- Authorized by Highmark Wholecare, if needed.
- Not otherwise excluded.

Pharmacy Benefit Exclusions

- Drugs and other items prescribed for obesity or appetite control.
- Over the counter drugs in the form of troches, lozenges, throat tablets, cough drops, chewing gum, mouthwashes, and similar items.
- Pharmaceutical services provided to a hospitalized person.
- Drugs and devices classified as experimental by the FDA or whose use is classified as experimental by the FDA.
- Drugs and devices not approved by the FDA or whose use is not approved by the FDA.
- Placebos.
- Prescription and over the counter soaps, cleansing agents, dentifrices, mouthwashes, douche solutions, diluents, ear wax removal agents, deodorants, liniments, antiseptics, irrigants, emollients, and other personal care items.
- DME items (with the exception of preferred diabetic supplies, syringes, lancets, spacers, and condoms).
- Items prescribed or ordered by a physician who has been barred or suspended from participating in the MA program.
- Prescriptions or orders filled by a pharmacy other than the one to which a recipient has been restricted.
- DESI drugs and identical, similar, or related products or combinations of these products.
- FDA approved pharmaceutical products whose indicated use is not to treat or manage a medical condition, illness, or disorder.
- Prescription and over-the-counter pharmaceutical products distributed by a company that has not entered into a national rebate agreement with the federal government.
- Fertility promoting agents.
- Erectile dysfunction drugs unless used for an FDA approved indication other than for the treatment of sexual or erectile dysfunction.
- Agents prescribed for cosmetic purposes or approved by the FDA for cosmetic purposes only.

Days' Supply Dispensing Limitations

Members may receive up to a thirty-four (34) day supply of a pharmaceutical product per prescription or refill. A thirty-four (34) day supply shall be interpreted to mean consecutive thirty-four (34) day supply, i.e., if a physician prescribes a medication b.i.d. (two (2) times a day), a thirty-four (34) day supply corresponds to a quantity of sixty-eight (68). The dispensing pharmacist must accurately calculate the days' supply. A ninety (90) day supply is available for select maintenance medications. This list is available by accessing the MA ninety (90) Day Generic Medication Supply tab on our website at: https://www.HighmarkWholecare.com/provider/pharmacy-tools.

Drug Recalls and Drug Safety Monitoring

Highmark Wholecare is dedicated to providing our prescriber with access to the most up-to-date medication safety information. Drug recall and drug safety updates can occur on a daily basis due to newly published research or to the FDA's Adverse Event Reporting Program. In order to provide the latest information, Highmark Wholecare has posted links to the FDA website displaying the latest recalls and drug safety alerts under the Drug and Safety Recalls tab on our website at: https://www.HighmarkWholecare.com/drug-safety-recalls.

Coverage Arrangements

All participating practitioners must ensure twenty-four (24) hour, seven (7) day-a-week coverage for members. Coverage arrangements should be made with another Highmark Wholecare participating practitioner or practitioners who have otherwise been approved by the Plan. Also, all participating practitioners must ensure that the hours of operation for Medicaid patients are no less than what the practice offers to commercial members. When a participating PCP has arranged, on a permanent basis, cross coverage arrangements with another participating PCP, the PCP should contact their PAL to set up a Provider Association between the two (2) practitioners. All encounters must be billed under the name of the rendering practitioner, not the members assigned PCP. Any services paid per the members assigned PCP contract will be paid directly to the participating covering PCP.

Covering practitioners, whether participating or not, must adhere to all of Highmark Wholecare's administrative requirements. Additionally, covering practitioners must agree not to bill the member for any covered services. The covering practitioner should report all calls and services provided to the member's PCP. To request approval of a non-participating covering practitioner, a non-participating authorization would need to be requested by the PCP through the UM Department. All encounters must be billed under the name of the rendering practitioner. Reimbursements will be paid directly to the covering practitioner. Participating practitioners will be held responsible for the actions of their non-participating coverage practitioners.

PCPs agree that, in their absence, timely scheduling of appointments for members shall be maintained.

Locum Tenens

Highmark Wholecare recognizes that from time to time a provider or practice may need to utilize the services of a Locum Tenens to aid in practice coverage for its patient population.

Offices should follow CMS regulations with regard to locum tenens – they are recognized for services up to a sixty (60) calendar day time frame. During that time, claims are to be billed under the participating supervising/lead physician NPI number and group NPI number along with the appropriate modifier once the sixty (60) calendar day time frame has elapsed, if the locum providers services are still needed, the provider should become an employee of the group and would be required to be credentialed.

Laboratory Services

As of February 1, 2022, Highmark Wholecare Medicaid members are required to have all of their outpatient laboratory work completed through the appropriate PCP designated lab. Failure to do so will result in non-payment of services. Referrals can no longer be granted. We will honor existing referrals until January 31, 2022. As a reminder, members cannot be billed for covered services.

The PCP is required to select a designated laboratory based upon the office's location and the lab used most frequently. Should you wish to change your laboratory, please complete the Provider Change Request form located on our website at: https://highmarkwholecare.com/Portals/8/provider_forms/Practice%20Change%20Request%20Form.pdf.

The PCP's designated laboratory is listed on the member's Highmark Wholecare ID card and on Highmark Wholecare's on-line provider directory located at Highmark Wholecare Provider Directory Go to Medicaid, then follow the remaining steps. Or, utilize the Eligibility and Benefits feature on NaviNet or contact Provider Services at 1-800-392-1147.

Additional information:
Laboratory testing for Rh incompatibility during pregnancy (related to Rhogam treatment) can be conducted at any participating laboratory.

All other requirements remain the same.
Note: Genetic testing requires prior authorization.

Primary Care and OB/GYN Practitioner

All outpatient laboratory testing should be ordered with a prescription according to the PCPs designated laboratory. Specialists and OB/GYN practitioners can order laboratory testing directly, but must send the member to the members' PCPs designated laboratory listed on the members' Highmark Wholecare ID Card with an order for the lab procedure to be performed. Practitioners are encouraged to perform venipuncture in their office and arrange for the specimens to be picked up by the laboratory provider.

Participating PCPs and OB/GYN practitioners who do not perform venipuncture in their office should send members to the appropriate designated laboratory.

Specialty Care Practitioner

Certain Specialists are permitted to perform lab work in their offices as part of the authorized office visit.

Preadmission Laboratory Testing

Highmark Wholecare requires preadmission laboratory testing be completed by the practitioner through the members designated laboratory. Failure to utilize the designated laboratory will result in the denial of the claim. Members cannot be billed for covered services. The PCP's designated laboratory is listed on the member's Highmark Wholecare ID card and on Highmark Wholecare's on-line provider directory located at Highmark Wholecare Provider Directory, then follow the remaining steps. Or, utilize the Eligibility and Benefits feature on NaviNet or contact Provider Services at 1-800-392-1147.

Blood Lead Screening

The Pennsylvania EPSDT Periodicity Schedule requires that all children under age seven receive a minimum of two (2) blood lead screenings as part of EPSDT well child screenings, regardless of the individual child's risk factors. The first (1st) test for lead should be conducted during the nine (9) month EPSDT visit and the second test for lead should be conducted during the twenty-four (24) month EPSDT visit. Please refer to the Pennsylvania EPSDT Periodicity Schedule for further screening information during these visits for additional clarification.

The PCP can use either their designated laboratory or Kirby Health Center Laboratory to process blood lead samples. If you choose to send blood lead samples to Kirby Health Center, you must use the sample Lead Analysis ID Form. The form is only for Highmark Wholecare members, and when completing the form please verify the member's eligibility. All demographic information, including the practitioner name, member name, member address, member date of birth, Highmark Wholecare member identification number, and the date of service must be completed for the sample to be processed.

A supply kit of Highmark Wholecare Lead ID Forms, postage-paid mailers, instructions, capillectors or filter papers for sample collection, and supply reorder forms may be requested through Kirby Health Center Laboratory by calling 1-888-841-6699. When ordering a supply kit, please identify yourself as a participating Highmark Wholecare practitioner.

Members with a venous lead draw showing an Elevated Blood Lead Level of ≥3.5 µg/dL, should be referred for an Environmental Lead Investigation (ELI).

Children should be retested when lead levels are ≥3.5 µg/dL

CDC guidelines must be followed for retesting when children have elevated blood lead levels. This calls for confirmatory testing as well as retesting any time a child has a blood lead level of ≥3.5 µg/dL.
https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm

Children should be referred for an Environmental Lead Investigation

A provider should submit an order to an enrolled ELI provider for a comprehensive environmental lead investigation for a Highmark Wholecare member under twenty-one (21) years of age with a venous blood lead screening result of at least ≥3.5 µg /dL to assess for environmental influences of lead contamination. The order for a comprehensive environmental lead investigation must include a primary diagnosis code of toxic effect of lead and its components. Please refer to Highmark Wholecare website, Provider Resources, EPSDT page for a current list of ELI providers and instructions on how to make referrals.

Highmark Wholecare will cover ELI for members under twenty-one (21) years of age who are enrolled on Highmark Wholecare Pennsylvania Medicaid within the following parameters:

- Services must be provided by a participating Highmark Wholecare ELI provider.
- Member must have a venous BLL result of at least ≥3.5 µg /dL based on venous draw.
- Limited to one ELI per household / address.
- A provider order is required. No prior authorization from Highmark Wholecare is needed.

Questions regarding Highmark Wholecare's EPSDT program can be directed via email to an EPSDT Coordinator at EPSDTinfo@HighmarkWholecare.com.

Unusual Circumstances

Should circumstances arise where it is impossible to follow the laboratory procedures outlined above, please contact Highmark Wholecare's UM Department at 1-800-392-1147 and press two for provider and press four (4) for UM for assistance.

PCP

Each member in a family has the freedom to choose any PCP and a member may change to another PCP should a satisfactory patient-practitioner relationship not develop. A PCP agrees to accept a minimum number of Highmark Wholecare members, as specified by their practitioner agreement, to their patient panel at each authorized office location without regard to the health status or healthcare needs of such members and without regard to their status as a new or existing patient to that practice or location. The PCP must maintain at least twenty (20) weekly appointment hours per marketed location.

The PCP, after meeting their contract minimum may, upon ninety (90) days prior written notice to Highmark Wholecare, state in writing that they do not wish to accept additional members. The written request excludes members already assigned to the PCPs practice, including applications in process.

Through Highmark Wholecare's model of Prospective Care Management (PCM®), we emphasize the importance of extensive member outreach, community involvement, and physician practice engagement. We support the efforts of physician practices in delivering the highest quality of care to members.

Highmark Wholecare Provider Excellence Program

The provider Pay-For-Performance and Improvement Program recognizes and rewards excellent practices for improving the health of Highmark Wholecare members. Practice resources are provided such as a CPT II code reference guide, HEDIS definitions, and Dashboard Reports.

Provider Incentive Program Objectives:

- Improve member experience.
- Increase physician satisfaction.
- Supports PCMH.
- Supports accurate and complete coding.
- Incentivize quality care.

Who is eligible?

- PCP practices.
- Obstetrical care providers.
- Dentists (Medicaid).

Performance Measures

The provider incentive program focuses on data driven measures to evaluate practice performance in the areas of:

- Well Child Visits (ages three (3) to twenty-one (21).
- Annual dental visit (ages six (6) months-twenty (20) years).
- Controlling high blood pressure.
- Diabetes care - HbA1c poorly controlled >9%.

- Asthma Medication Ratio.
- Obstetrical care: timeliness of prenatal care and postpartum care.
- Plan all cause readmissions.
- Lead Screen for Children.
- Developmental Screening in the first three (3) years of life.
- Well child visits in the first fifteen (15) months of life.
- Electronic medical record data sharing.

For a complete listing of the measures and program details, please visit our website at: https://www.HighmarkWholecare.com/.

Scorecards and PCP Dashboard Reports

Scorecards and their associated payments are made annually, followed by a true-up payment to allow for claims lag.

Scorecards

The provider incentive scorecard provides a summary of the services and payments the practitioner received, broken down by measure.

Dashboard Reports

The dashboard report provides primary care practices with member specific care gaps on provider incentive measures. The purpose of the dashboard report is to provide supplemental information for care and clinical opportunities for the physician practice.

Practitioner/Staff Education and Communication

Highmark Wholecare assures that practitioners and their staff are well informed of the provider incentive program. Various approaches engage PCPs and Obstetrical Care Providers throughout the year that may include Physician Advisory Workgroups and practice visits by Provider Relations, Medical Directors, Operational Leads, Provider Engagement, and/or Provider Management. Webinars are also made available throughout the year. Dentists are educated through Highmark Wholecare's dental benefit provider. In addition, Highmark Wholecare's website and newsletter articles provide education on the Program.

Encounters

PCPs are required to report to Highmark Wholecare all services they provide for Highmark Wholecare members by submitting complete and accurate claims regardless of expected reimbursement.

Accurate Submission of Encounter/Claim Data

Claim/encounter data provides the basis for many key medical managements and financial activities at Highmark Wholecare:

- ✓ Quality of care assessments and studies.
- ✓ Access and availability of service evaluation.
- ✓ Program identification and evaluation.
- ✓ Utilization pattern evaluation.
- ✓ Operational policy development and evaluation.
- ✓ Financial analysis and projection.

To effectively and efficiently manage members health services, encounter submissions must be comprehensive and accurately coded. All Highmark Wholecare providers are contractually required to submit encounters for all member visits. Under reporting of encounters can negatively impact all stakeholders.

For PCPs, encounter data is essential as many of Highmark Wholecare's quality indicators are based on this information. Highmark Wholecare evaluates PCP encounter data in two (2) ways. The rate of submitted encounters per member for individual PCP practices is measured and compared to a peer average based on specialty (family practice, pediatrics, and internal medicine). Additionally, Highmark Wholecare extracts dates of service during on-site medical record review and compares the visit dates to encounters submitted to the health plan. This rate is also compared to peer averages.

The expected rate of submission for encounters is one hundred percent (100%). Highmark Wholecare provides support and education to practices as indicated by their encounter submission rates.

DHS uses the Chronic Illness & Disability Payment System (CDPS) model to assign a risk score to each Medicaid recipient who meets certain eligibility criteria. Accurate and complete reporting of diagnosis codes on encounters is essential to the CDPS model. Physicians must establish the diagnosis in the medical record and coders must use the ICD-10-CM coding rules to record each diagnosis. Chronic illnesses should be evaluated on a complete physical exam each year. Reporting complete conditions present in the member will help to assure that DHS has complete data when determining the members risk score.

If you would like to learn more about the importance of complete and accurate coding visit these web sites:

Official Coding Guidelines on CDC Website: http://www.cdc.gov/nchs/icd/icd10cm.htm.

Coding Clinic for ICD-10-CM available through the American Hospital Association (AHA), CMS, the American Health Information Management Association (AHIMA), and the National Center for Health Statistics (NCHS) together have developed official coding guidelines. The guidelines can be found at: https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf.

There are two (2) volumes which consist of:

- ✓ **The Disease Tabular (Numeric)** and is known as Volume I of ICD-10-CM. Numeric listing of codes organized by body system. This volume provides more detail than the Alphabetic Index on conditions included and excluded in the code selected. Another code in the same category may represent the diagnostic description better than the one indicated in the Disease Index.
- ✓ **The Disease Index (Alphabetic)** and is known as Volume II of ICD-10-CM. This volume is an index of all diseases and injuries categorized in ICD-10-CM. When a code is listed after the description, it means the reader should look up that code in the Disease Tabular section to determine if that is the most specific code to describe the diagnosis.
- ✓ The index is organized by main terms and sub terms that further describes or specifies the main term. In general, the main term is the condition, disease, symptom, or eponym (disease named after a person), not the organ or body system involved.

Vaccines for Children

Children eighteen (18) years of age and younger who are receiving MA are eligible for the Vaccines for Children (VFC) Program. All PCPs will be reimbursed for the administration of any vaccine covered under the VFC Program when a claim is received with the appropriate immunization code. Any procedures for immunizations not covered under the VFC Program, but covered by Highmark Wholecare, will be reimbursed fee-for-service. Please reference the PCPs agreement for fee schedules or additional information.

Oral Health Risk Assessment

Tooth decay remains one of the most common childhood diseases and is also one of the most preventable. PCPs can help prevent tooth decay by providing topical fluoride varnish in the office for their Highmark Wholecare patients under the age of five (5).

Since April, 2010, Highmark Wholecare has reimbursed those PCPs properly certified for the application of topical fluoride varnish a fee-for-service payment for rendering this service. Only those PCPs who received a certificate for completing the on-line training module titled Oral Health Risk Assessment qualified for the fee-for-service reimbursement. The Oral Health Risk Assessment training module has been discontinued and replaced with the Society of Teachers of Family Medicine's Smiles for Life Continuing Medical Education (CME) course. Refer to MA Bulletin 09-12-27, 31-12-27). If you've already completed the Oral Health Risk Assessment on-line training, recertification through Smiles for Life is not required.

Physicians interested in providing topical fluoride varnish in the office for their Highmark Wholecare patients under the age of five (5) and receive the eighteen-dollar ($18.00) reimbursement must submit a copy of the training certificate to:

Highmark Wholecare
Attention: Provider Information Management
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

Addition of Newborns

When a member selects Highmark Wholecare, the member's effective date is usually the first or the fifteenth (15th) of the month. When the member is a newborn, the member may be added any time of the month. Because newborn information is reported to the Plan retroactively, newborns will show up as a retroactive addition to the PCPs monthly panel listing. Newborns will be effective on their date of birth or the date the newborn was added to the members grant.

Services rendered during the newborn hospital stay are paid on a fee-for-service basis.

Processing PCP Change Requests

When a member wishes to change his or her PCP, the change is processed under the following guidelines:

- When the request is received prior to the twenty-fifth (25th) of the current month, the new effective date will be the first (1st) of the following month. For example, if a member's request is received on October seventh (7th), the member will be effective November first (1st) with the new PCP.
- When the request is received on or after the twenty-fifth (25th) of the current month, the new effective date will be the first of the subsequent month. For example, if a member's request is received on October twenty-eighth (28th), the member will be effective December first (1st) with the new PCP.
- If the member requests to change his or her PCP immediately, an exception to the above guidelines can be made if the situation warrants.

FQHC/RHC Provider Changes Process

The Plan's physician agreement indicates that participating providers must submit written notice ninety (90) calendar days prior to the date the provider intends to terminate. There is also sixty days' notice required if you plan to close your practice to new patients and thirty (30) days' notice required for a practice location change. Whenever a FQHC/RHC has a New Add (physician or group), Demographic Change and/or Termination, a FQHC/RHC Provider Change Form or FQHC/RHC Roster Template must be completed and sent to Highmark Wholecare within the timeframes indicated above.

Please refer to the FQHC/RHC Provider Change Form for instructions on how to report all changes. The FQHC/RHC Provider Change Form and FQHC/RHC Roster Template can be found on the Highmark Wholecare website at www.HighmarkWholecare.com under the Provider section, Provider Resources, FQHC-RHC Resources.

FQHC/RHC HRSA Approval Reminder

If HRSA approves a request for a change in scope of services involving the addition of a service that has never been provided or the discontinuance of an existing service, the FQHC must notify the Plan of the change in scope of services within thirty (30) days of the issue date identified in block one (1) of HRSA's Notice of Grant Award. Additionally, any interim rate letter(s) received from PA DHS must be forwarded to the Plan within ten (10) days of receipt. These notifications should be directed via email to the attention of the assigned FQHC/RHC Contracting and Servicing Consultant at Highmark Wholecare.

Transfer of Non-Compliant Members

PCPs agree:

- Not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Highmark Wholecare members on the basis of race, sex, age, religion, place of residence, health status, or source of payment.
- To observe, protect and promote the rights of members as patients.

Consultant at Highmark Wholecare. PCPs shall not seek to transfer a member from his/her practice if such a transfer would violate these rules. However, a member whose behavior precludes delivery of optimum medical care may be transferred from the practitioner's panel. The Plan's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given practitioner.

Additionally, in order to assist our practitioners in the management of members who violate office policy in regard to scheduled appointments, the Plan has instituted the following Member No-Show Policy: **The Plan will recognize the individual practitioners written office policy in regard to scheduled appointments. The Plan practitioners are responsible for recording no-show appointments in the member's medical record.**

When a transfer is being conducted due to member no-show, the practitioner's notification should indicate that the practitioner wants to transfer the member to another PCPs practice. Per DHS Policy #99-10-14, practitioners may not bill MA recipients for missed appointments.

Should an incidence of inappropriate behavior or member non-compliance with no-show policies occur, and transfer of the member is desired, the practitioner must send a letter requesting that the member be removed from his/her panel including the members name and Highmark Wholecare ID Number, and, when applicable, state their no-show policy, and the member(s) who has (have) violated the policy to the Provider Relations Department at:

Highmark Wholecare
Attention: Enrollment Department
Four Gateway Center
444 Liberty Avenue
Suite 2100
Pittsburgh, PA 15222-1222

All written requests are forwarded to the Enrollment Department within forty-eight (48) hours of receipt. The Enrollment Department notifies the original practitioner in writing when the transfer has been completed. If the member requests not to be transferred, the PCP will have the final determination regarding continuation of primary care services.

When the request is received prior to the twenty-fifth (25th) of the month, the new effective date will be the first of the following month. When the request is received on or after the twenty-fifth (25th) of the current month, the new effective date will be the first of the subsequent month. An exception to the above guidelines can be made if the situation warrants an immediate transfer. PCPs are required to provide emergency care for any Highmark Wholecare member dismissed from their practice until the member transfer has been completed.

Transfer of Medical Records

PCPs are required to transfer member medical records or copies of records to newly designated PCPs within seven (7) business days from receipt of the request from DHS, its agent, the member, or the member's new PCP, without charging the member.

Coordination of Behavioral Health and Physical Health Services

No mental health or drug and alcohol services are covered by Highmark Wholecare except for emergency room services, home healthcare, pharmacy services, and emergency transportation services. Highmark Wholecare is responsible for all emergency and non-emergency transportation in an ambulance to an emergency room and to a behavioral health facility. All prescribed medications are dispensed through the Highmark Wholecare pharmacy network.

This includes drugs prescribed by both physical health and behavioral health practitioners. Exceptions are that the Behavioral Health Managed Care Organization (BH-MCO) is responsible for the payment of Methadone and LAAM when used in the treatment of a substance abuse disorder, and when prescribed and dispensed by BH-MCO service practitioners.

Emergency services provided in general hospital emergency rooms are the responsibility of Highmark Wholecare regardless of the diagnosis or services provided. An exception is emergency room evaluations for voluntary or involuntary commitments pursuant to the 1976 Mental Health Procedures Act (50 P.S. Section 7101, et seq), which are the responsibility of the BH-MCO.

Both PCPs and behavioral health clinicians have the obligation to coordinate care of mutual patients in accordance with state and federal confidentiality laws and regulations. This includes, but is not limited to:

- Obtaining appropriate releases to share clinical information.
- Making referrals for social, vocational, education, or human services when a need is identified through assessment.
- Notifying each other of prescribed medications.
- Being available for consultation when necessary.

Referrals are not necessary for members to receive the services of a behavioral health practitioner.

Highmark Wholecare may cover home healthcare services ordered by a BH-MCO practitioner if the order meets the regulatory requirements found in 55 Pa. Code § 1249, et seq. (relating to Home Healthcare Services) and meets Highmark Wholecare coverage requirements.

Please refer to the Quick Reference section of this manual for a listing of BH-MCO's or behavioral health agencies and their corresponding telephone number, county serviced, and services provided.

Members are identified for integrated care plans when they have complex physical and behavioral health care needs. We are working with their BH-MCO to assist in coordinating care to ensure that the patient's physical and behavioral health needs are addressed to support them in achieving optimum health.

We are asking for your support and input into the development of the integrated care plan that is being developed with your patient.

The first step that you can take to supporting your patient and their integrated care plan is to ask your patient, if they have not already done so, to sign a Highmark Wholecare release of information/ consent to exchange information with their BH-MCO.

Providers are encouraged to contact their patient's BH-MCO if you have any concerns about your patient's behavioral health, their behavioral health treatment, or would like to relay information about your patient or make a referral for treatment. If you have any questions, need a copy of your member's integrated care plan or release of information or would like to share additional information regarding this patient with us please call 1-800-392-1147.

Telehealth

Overview

Services should be provided face-to-face with Highmark Wholecare members whenever possible. The Plan recognizes there are instances when face-to-face consultations are not feasible. Telemedicine seeks to improve a patient's health by permitting two (2) way, real time interactive communication between the patient and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment. An exception will be made for audio-only telecommunication when the member does not have access to video capability or for an urgent medical situation, provided that the use of audio-only telecommunication technology is consistent with state and federal requirements, including guidance by CMS with respect to Medicaid payment and OCR with respect to compliance with Health Insurance Portability and Accountability Act (HIPAA). Telemedicine is viewed as a cost- effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations) between provider and patient. This definition is modeled on CMS definition of telehealth services. The Plan does not restrict the performance of telehealth/telemedicine services to rural locations only and allows for both PCPs and Specialists to provide this service. Any eligible member can receive telemedicine/telehealth primary care services regardless of where they are located. PCPs are able to render services using interactive telecommunication technology to their Highmark Wholecare assigned members. Providers much obtain consent from members, or their legal guardian, prior to performing any services via telemedicine.

The claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

Place of Service 02: The location where health services and health-related services are provided or received through a telecommunication system.

The claim must include the appropriate modifier when billing for audio and video: Modifier GT:
Via Interactive Audio and Video Telecommunications systems.

Modifier 95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

Providers should fully document the services rendered and the telecommunication technology used to render the service, in the Highmark Wholecare member's medical record. If the service was rendered using audio-only technology, providers are to document that the services were rendered using audio-only technology and the reason audio/video technology could not be used.

Appointment Standards

PCPs agree to meet appointment standards, as follows:

APPOINTMENT TYPE/PROTOCOL	STANDARD
Emergent Appointment	Immediately seen or referred to an emergency facility.
Urgent Care Appointment	Within twenty-four (24) hours.
Routine Appointments	Within ten (10) business days.
Health Assessment/General Physical Examinations and First Examinations	Within three (3) weeks of enrollment.
After-hours Care	After hour calls from members with an emergent or urgent medical condition will be handled within one hour of the member contacting the practice- through immediate instruction or member receives call back from practice site with instruction, within one hour. *Instructions provided by the practice will include one or more of the following options:* *Call 911 or go to nearest emergency room *Direct patient to go to an urgent care center *See patient same day *See patient at another location same day **Important reminders:** Practice sites must be accessible to members 24 hours a day/seven (7) days a week Our members must be instructed to call 911 or go directly to the emergency room in case of a true emergency. Answering services or machines must instruct members on how to reach an on-call physician. The member must receive a phone call within one hour with instructions.
Waiting time in the Waiting Room and exam room for a routine care appointment	Average office wait time is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated urgent medical condition visit or is treating a member with a difficult medical condition need.
New member EPSDT Screens (Applies to PCPs who treat members under age of twenty-one (21)	Within forty-five (45) days from the effective date of enrollment unless the child is already under the care of a PCP and is current with screens and immunizations.
First time Appointment with Persons known to be HIV Positive or Diagnosed with AIDS	Within seven (7) days from the effective date of enrollment, unless member is already in active care with a PCP or specialist.
First time appointment with member who is a Supplemental Security Income (SSI) or SSI-related consumer	Within forty-five (45) days of enrollment unless the member is already in active care with a PCP or specialist.
First trimester visit (Applies to PCPs who provide prenatal care)	Within ten (10) business days of the member being identified as being pregnant.
Second trimester visit (Applies to PCPs who provide prenatal care)	Within five (5) business days of the member being identified as being pregnant.
Third trimester visit (Applies to PCPs who provide prenatal care)	Within four (4) business days of the member being identified as being pregnant.
High-risk pregnancies (Applies to PCPs who provide prenatal care)	Within twenty-four (24) hours of identification of high risk, or immediately if an emergency exists.
Missed Appointment	Conduct outreach whenever a member misses an appointment and document in the medical record. Three (3) attempts with at least one attempt to include a telephone call.

EPSDT – Growing Up with Highmark Wholecare

General Information

Highmark Wholecare's Growing Up with Highmark Wholecare Program is based upon the federally mandated EPSDT Program for MA eligible children under the age of twenty-one (21) years. Through the EPSDT Program, children are eligible to receive regular medical, developmental, dental, vision, hearing screens, and laboratory services to assure that they receive all medically necessary services, without regard to MA covered services.

Helpful Guidelines

- The required screens, tests, and immunizations are outlined by the Pennsylvania EPSDT Program Periodicity Schedule, which is reflective of the AAP Periodicity Schedule. PCPs are required to follow this schedule to determine when the necessary screens, tests, and immunizations are to be performed.
- PCPs are required to ensure all children under the age of twenty-one (21) have timely access to EPSDT services and are responsible for ensuring continued coordination of care for all members due to receive EPSDT services.
- New members must be seen within forty-five (45) days from the effective date of enrollment, unless the child is already under the care of a PCP and is current with screens and immunizations.
- PCPs are required to arrange for medically necessary follow-up care after a screen or encounter.
- If a PCP is unable to comply with the requirements of the EPSDT program, they must plan for EPSDT screens to be performed elsewhere by a Highmark Wholecare participating provider.
- Alternative PCPs and specialists should forward a copy of the completed progress report to the PCP so it can be placed in the members chart.

Care Coordination

Growing Up with Highmark Wholecare staff work collaboratively in coordinating medically necessary services for members. Staff provides outreach via telephone and mail, to members to provide education and assistance with scheduling appointments, transportation, and other issues that prevent access to healthcare. Staff is available to outreach to members identified by the PCP offices who are delayed with screens and/or immunizations or who are non-adherent with appointments.

Each Highmark Wholecare PCP/specialist is responsible for providing the health screens for Highmark Wholecare members. Each practitioner must report the results of the screens to Highmark Wholecare, as well as communicate demographic information (e.g. telephone number, address, alternate address) to staff to assist with scheduling, locating, and addressing compliance issues. Highmark Wholecare verifies that PCP and specialists for special needs are able to provide EPSDT services at the time of the practitioner's office site visit.

For any member with abnormal findings, or who needs assistance with any issue, please complete and fax to Highmark Wholecare the Member Outreach Form, located in the Forms and Reference Material Section of this manual, so Highmark Wholecare may attempt to contact and assist the member.

Highmark Wholecare provides a quarterly report to assist providers in identifying members who are due or overdue for their EPSDT visit. It is the PCP's responsibility for contacting both new members that are identified on encounter lists and members identified as not adhering to EPSDT periodicity and immunization schedules. PCPs should contact these members upon identifying the non-compliance to schedule an appointment. If the provider is unable to reach the member after three attempts, they should refer the member to Highmark Wholecare for outreach through the Member Outreach Form, located in the Forms and Reference Material Section of this manual, so Highmark Wholecare may attempt to contact and assist the member in scheduling

an appointment with the PCP office.

To contact the Growing Up with Highmark Wholecare Unit please call 1-800-392-1147.

Required Screens, Tests, and Immunizations

Highmark Wholecare follows the Pennsylvania EPSDT Program Periodicity Schedule and Coding Matrix, as developed by DHS and approved by the American Academy of Pediatrics, based on the Bright Futures Periodicity Schedule. Please reference these updated guidelines on the Highmark Wholecare website.

To determine the appropriate age range for required screens and tests, please refer to the Pennsylvania EPSDT Age Range Requirements for Screening Visits Desk Guide, located in the Forms and Reference Material Section of this manual or on the Highmark Wholecare website.

Highmark Wholecare Follows recommended childhood immunization schedules approved by the CDV and Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

To facilitate distribution of the most current version of these schedules, they can be found on Highmark Wholecare's website under Provider Resources/EPSDT.

A Complete Screen must include the following:

- A comprehensive history.
- Physical examination.
- Relevant measurements (for assessment of growth); Documentation must include height, weight and BMI percentile during the measurement year. The height, weight, and BMI must be from the same data source. Age appropriate nutrition counseling should be provided regarding promotion of healthy weight, healthy nutrition, and physical activity.
- Anticipatory guidance/counseling/risk factor reduction interventions.
- All assessments/screenings as indicated on the Periodicity Schedule and the ordering of appropriate laboratory/diagnostic procedures as recommended by the current AAP guidelines.
- Newborn metabolic/hemoglobin screening and follow-up consistent with the Pennsylvania Newborn Screening Panel: newborn bilirubin screening, growth measurements, and head circumference. A hearing screen is to be performed during the newborn screening (prior to their discharge from the hospital), and if not must be completed by three (3) months of age.
- Ordering of appropriate laboratory tests including but not limited to:
- Anemia: The American Academy of Pediatrics and the American Family Physician identify Anemia Screening as a Universal Screening. Iron deficiency and iron- deficiency anemia continue to be of concern.
- Dyslipidemia: Universal Screening that occurs in two (2) timeframes and at other times if indicated by history and/or symptoms. This should be completed between ages nine (9) and eleven (11) and again between ages seventeen (17) and twenty (20).
- Sickle cell anemia screening.
- Urinalysis.
- Psychosocial/Behavioral Assessments: Assessments should be family centered and may include an assessment of the child's social-emotional health, social determinants of health, and caregiver's anxiety/depression/substance use disorder. Please refer to the EPSDT section of the Highmark Wholecare Provider Page for a list of validated screening tools available. Refer to behavioral health or medical providers to correct or ameliorate any problems discovered upon the screen, including those

not on the MA fee-for-Service program.

- Vision Screening: Includes diagnosis and treatment for defects in vision and eye exams for the provision of eye glasses. Screening for visual acuity may be completed using traditional methods (Snellen chart) or instrument-based screening. Instrument based screening may be used to detect amblyopia, strabismus, and/or high refractive error in children who are unable or unwilling to cooperate with traditional screening.
- Hearing Screening: Includes diagnosis and treatment for defects in hearing and exams for the provision of hearing aids.
- Adolescent Depression Screening: Universal screening for depression during adolescence. This screening begins at age twelve (12). Screening tools should be validated for the age that it is being used.
- Tobacco, Alcohol and Drug Use Assessment: Universal screening for use of Tobacco, Alcohol and Drug Use starting at age eleven (11). Screening tools should be validated.
- Ordering of/referral to all other medically necessary health care, diagnostic services, and treatment measures to correct or ameliorate any problems discovered upon the screen, including those not covered on the MA fee-for-service program.
- Screening for sexually transmitted infections.
- Testing for HIV and annual reassessment per the EPSDT Periodicity Schedule and for those at increased risk for HIV infections. This includes those who are sexually active, participate in injection drug use or are being tested for other STIs.

Maternal Depression Screening

The screening should be completed as part of the one (1), two (2), four (4), and six (6) month visits. Postpartum depression occurs in up to twenty (20) percent of women who have recently given birth and it is estimated that fewer than half of the cases are recognized. Additionally, studies have found that PPD is more common among women who are disadvantaged and is highly prevalent in low-income black mothers. Since as many as forty (40) percent of women do not attend their postpartum care visit, this screening is particularly important for identifying new mothers with postpartum depression.

Screening for postpartum depression increases opportunities for identification and intervention for both mother and baby. Physicians are encouraged to be familiar with their community resources available for mothers who may test positive on a maternal depression screening.

PCPs should administer a caregiver-focused health risk assessment with scoring and documentation per standardized screening tool that is most suitable for the provider's practice.

Validated screening tools are available on the EPSDT section of the Highmark Wholecare Website.

Developmental Surveillance

Per the Periodicity Schedule, developmental surveillance should be performed at all EPSDT visits. Developmental surveillance and structured screening for developmental delays and Autism Spectrum Disorders (ASD) are separate elements of a comprehensive health assessment performed during every preventive care office visit or EPSDT screening visit. Surveillance is the observation of a child to identify whether the child may be at risk of developmental delay. The AAP recommends that providers perform and document the following as part of surveillance:

- Elicit and attend to parent concerns about their child's development.
- Update the child's developmental progress.

- Make accurate and informed observations of the child in the areas of language and cognitive abilities, social, and emotional health, and physical development which are appropriate to the child's age and developmental stage.
- Identify the presence of risk and protective factors.
- Document all surveillance activities and findings.

Any developmental issues identified through surveillance should be addressed by conducting a structured screening for developmental delays or ASDs, or both. Structured screenings differ from surveillance in that a validated tool is used to conduct the structured screening.

Structured Developmental Screenings

Structured screening for developmental delays and ASDs is the use of standardized, scientifically validated tools to identify and refine a recognized risk. Structured screening focused on the identification of additional risk factors by targeting specific developmental milestones in language and cognitive abilities, fine and gross motor skills, and social interactions as well as signs and symptoms of ASDs. Providers should also conduct structured screening outside of the recommended screening periodicities if medically necessary.

It is the provider's responsibility for ensuring that they continue to use tools that are validated at the time they conduct the structured screening. Providers may select a specific validated screening tool that is the most suitable tool for the providers practice.

There are several resources available to assist providers in identifying structured screening tools to use in practice and remaining up to date on validated screening tools. These resources can be found on Highmark Wholecare's website.

Developmental Screening

Per the Periodicity Schedule, developmental screening should be completed at the following visits:

- Nine (9) to eleven (11) month visit.
- Eighteen (18) month visit.
- Thirty (30) month visit.

Children with Elevated Blood Lead Levels (EBLL) should receive additional developmental screenings by their PCP outside of the recommended time frames.

Autism Screening

Per the Periodicity Schedule, autism screening should be completed during the following visits:

- Eighteen (18) and twenty-four (24) month visit.

When the validated screening tool identifies a child as needing further evaluation, a diagnostic evaluation should be performed by the provider. If unable to provide the diagnostic evaluation, the PCP should refer to an appropriate specialist or the early intervention program.

Providers should refer for early intervention services through the CONNECT Helpline at 1-800- 692-7288.

Providers may additionally refer members for care coordination services when a structured Developmental or Autism Screening indicates the need for further evaluation. For this referral, please complete and fax/mail the Member Outreach Form, located in the Forms and Reference Material Section of this manual, so the Special Needs Unit may contact the member.

The provider must maintain the completed structured developmental/ASD screening in the member's medical record.

Blood Lead Level Screening

The Pennsylvania EPSDT Periodicity Schedule requires that all children under age seven (7) receive a minimum of two blood lead screenings as part of EPSDT well child screenings, regardless of the individual child's risk factors. The tests for lead screening should be conducted during the nine (9) to eleven (11) month screening and the second test for lead should be conducted during the twenty-four (24) months screening. Please refer to the Pennsylvania EPSDT Periodicity Schedule for further testing clarification.

The CDC requires the use of a blood lead test when screening children for lead poisoning. The CDC recommends that a provider use venous blood samples for the blood lead screening, when feasible as elevated initial blood lead results obtained on capillary screening specimens are presumptive and should be confirmed using a venous specimen.

A blood lead screening should be done by a blood lead measurement of either a venous or capillary (finger stick) blood specimen. If screening is collected via capillary and is ≥3.5 µg/dL, a second venous blood lead measurement should be taken to confirm the results.

If a child has a blood lead level of ≥3.5 µg/dL, providers should refer for early intervention services through the CONNECT Helpline at 1-800-692-7288.

The PCP can use either their designated laboratory or Kirby Health Center Laboratory to process blood lead samples. If you choose to send blood lead samples to Kirby Health Center, you must use the sample Lead Analysis ID form. The form is only for Highmark Wholecare members, and when completing the form please verify the member's eligibility. All demographic information, including the practitioner name, member name, member address, member date of birth, Highmark Wholecare member identification number, and the date of service must be completed for the sample to be processed.

A supply kit of Highmark Wholecare Lead ID Forms, postage-paid mailers, instructions, capillectors or filter papers for sample collection, and supply reorder forms may be requested through Kirby Health Center Laboratory by calling 1-888-841-6699. When ordering a supply kit, please identify yourself as a participating Highmark Wholecare practitioner.

Blood Lead Levels of ≥3.5 µg/dL require retesting

Children should be retested when lead levels are ≥3.5 µg/dL. CDC guidelines should be followed for retesting when children have elevated blood lead levels. This calls for confirmatory testing as well as retesting any time a child has a blood lead level of ≥3.5 µg/dL. https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm

Environmental Lead Investigation (ELI)

In accordance with guidance from the CDC, a provider should manage the condition of a child who is found to have an elevated blood lead level that is greater than or equal to 3.5
µg/dL.

Management should include follow-up blood tests and consideration of possible sources of contamination including housing, food, and toys. Locating the source of lead contamination is an integral part of the management and treatment of lead toxicity.

A provider should submit an order to an enrolled ELI provider for a comprehensive ELI for a Highmark Wholecare member under twenty-one years of age with a blood lead screening result of at least 3.5 µg /dL and where there is suspicion of environmental influences for lead contamination. The order for a comprehensive ELI must include a primary diagnosis code of toxic effect of lead and its components.

Highmark Wholecare will cover ELI for members under twenty-one (21) years of age who are enrolled on Highmark Wholecare Medicaid within the following parameters:

- Services must be provided by a participating Highmark Wholecare ELI provider.
- Member must have a venous BLL result of at least 3.5 µg /dl based on venous draw.
- Limited to one ELI per household.
- A provider order is required. No prior authorization from Highmark Wholecare is needed.

Immunizations

Both state and federal regulations require that immunizations be brought up to date during health screens and any other visits the child makes to the office. The importance of assessing the correct immunization status cannot be overly stressed. In all instances, the practitioner's records must show immunization history and documentation must include the date of the immunization, the signature of the person administering the immunization, and the name and lot number of the antigen. This will provide the necessary basis for further visits and immunizations.

HEDIS evaluates the timely administration of all recommended childhood and adolescent immunizations. The measures assess the percentage of children who have the dose(s) in accordance with the Recommended Child and Adolescent 2022 Immunization Schedules. The immunization schedules are broken out into three (3) separate tables to include by age, a catch-up schedule, by medical indications.

Highmark Wholecare follows recommended childhood immunization schedules approved by the CDC Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics, and the American Academy of Family Physicians. To facilitate distribution of the most current version of the new schedules, it is available on Highmark Wholecare's website under Medicaid guidelines. A paper copy is available upon request. For a paper copy, please contact the Provider Services Department at 1-800-392-1147.

Dental

The Pennsylvania Periodicity Schedule follows the American Academy of Pediatric Dentistry. A dental assessment at every well-child visit, through observation, should be conducted. In addition, an oral health risk assessment is recommended at the twelve (12) month, eighteen month through six (6) year well-child visits. Fluoride varnish assessment is also recommended at this age. The child should be referred to a dental home when the first tooth erupts, but no later than twelve (12) months of age and the child should see the dentist every six (6) months thereafter. The dentist must check for the following and initiate treatment or refer as necessary:

- Caries.
- Fillings present.
- Missing teeth (permanent).
- Oral infection.

EPSDT Screening and Billing Guide

***A complete coding and billing matrix based on the PA EPSDT Schedule can be found on the Highmark Wholecare EPSDT website.**

Highmark Wholecare follows the schedule of the Pennsylvania DHS EPSDT Periodicity Schedule and Coding Matrix for well-child screening and health assessments and requires all HCPCS, modifiers, and diagnoses as indicated by the state.

To be considered a Complete EPSDT Screen, providers must bill all of the individual age-appropriate procedure codes, including immunizations. Please consult *Pennsylvania's Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix (Periodicity Schedule)* and the *Age Range Requirements for Screening Visits Desk Guide* as well as the *Recommended Childhood and Adolescent Immunization Schedules*

(Immunization Schedules) for screening eligibility and the services required to bill for a complete EPSDT screen. Please refer to the most current version published in Pennsylvania MA Bulletins (MABs).

Incomplete EPSDT screens are office visits where the provider did not complete all of the components listed on the Periodicity Schedule for the child's screening period. This includes use of applicable modifier, diagnosis codes, and required referral codes.

- All EPSDT screening services including vaccine administration fees should be submitted to Highmark Wholecare either on a CMS-1500 or the corresponding 837P format for EDI claims within sixty (60) days from the date of service. (Highmark Wholecare cannot accept an EPSDT screen on a UB-04 or the corresponding 837I format.)
- EPSDT evaluations (CPTs 99381 – 99385, 99391 – 99395, 99460, and 99463) should be billed with modifier EP and should include all screenings required by the State for that visit.
- If an EPSDT evaluation is billed with the EP modifier and no screenings required for the periodicity are included on the claim, Highmark Wholecare will deny the claim and the provider can resubmit the claim with the appropriate screenings.
    - Denial Code: D196 – EPSDT visit inappropriately coded.
    - CARC = 96 – Non-covered charges; RARC = N78 - the necessary components of the child and teen checkup (EPSDT) were not completed.
- If an EPSDT evaluation is billed with the EP modifier and not all required screenings are included on the claim, Highmark Wholecare will deny the claim and the provider can resubmit the claim with the appropriate screenings.
    - Denial Code: D196 – EPSDT visit inappropriately coded.
    - CARC = 96 – Non-covered charges; RARC = N78 - the necessary components of the child and teen checkup (EPSDT) were not completed.
- If the provider cannot complete one of the screenings, modifier fifty-two (52) should be added to the individual screening code and a zero-dollar ($0) amount should be billed.
- If a screening code is reported with modifier fifty-two (52), the provider must complete the screening during the next opportunity according to the Periodicity Schedule.
- Modifier fifty-two (52) use must be supported through documentation in the medical record.
- When laboratory procedures are performed by a party other than the treating or reporting physician, use CPT code plus CPT modifier ninety (90) Reference Outside Lab and a zero-dollar ($0) amount should be billed by the provider.
- If a screening is required for a periodicity and has been previously completed (ex. Lead, Dyslipidemia, Hearing screening in adolescence ex. ages eleven (11) and fourteen (14)) add the CPT code and fifty-two (52) modifier with zero-dollar ($0) bill to indicate complete claim.

- With the exception of the dental component for clinics that do not offer dental services, FQHCs/RHCs may not bill for partial screens.
- Highmark Wholecare uses fully automated coding review software. The software programmatically elevates claim payments in accordance with CPT-4, HCPCS, ICD- 10, AMA and CMS guidelines as well as industry standards, medial policy and literature, and academic affiliations.

CMS-1500 Paper Format Requirements

- All EPSDT screening services must be reported with the age-appropriate E&M code (99381-99385, 99391-99395, 99431, and 99435) along with the EP modifier.
- The EP modifier must follow the evaluation and management code in the first line of block 24D on the claim form. Use CPT Modifier (fifty-two (52) or ninety (90)) plus CPT code when applicable.
- Appropriate ICD-10 diagnosis codes must be noted in box twenty-one (21).
- Report visit code '03' in box twenty-four (24) (h) of the CMS-1500 form when providing EPSDT screening service.
- Report two (2) character EPSDT referral code for referrals made or needed as a result of the screen in box ten (10) (d) on the CMS-1500. Codes for referrals made or needed as a result of the screen are:

YO – Other	YV – Vision	YH – Hearing
YB – Behavioral	YM – Medical	YD – Dental

CMS-1500 EDI Format Requirements

- All EPSDT screening services must be reported with the age-appropriate E&M code (99381-99385, 99391-99395, 99431, and 99435) along with the EP modifier.
- The EP modifier must follow the E&M code in the first position on the claim form. Use CPT Modifier (fifty-two (52) or ninety (90)) plus CPT code when applicable.
- Appropriate ICD-10 diagnosis codes must be noted in box twenty-one (21).
- Populate the SV111 of the 2400 loop with a 'yes' for an EPSDT claim (this is a mandatory federal requirement).
- Populate the Data Element CLM12 in the '2300' Claim Information Loop with '01' (meaning EPSDT).
- Populate NTE01 of the NTE segment with 'ADD'. This means that additional information is available in field NTE02 (see below).
- Populate NTE02 of the NTE segment of the '2300' Claim Information Loop with appropriate referral codes:

YO – Other	YV – Vision	YH – Hearing
YB – Behavioral	YM – Medical	YD – Dental

EPSDT Authorization for Specialty Care

If a member needs to be referred for specialty care as a result of an EPSDT screening, coordination of services must be managed by the PCP.

Hospital admissions and some outpatient surgical procedures require authorization from the UM Department. Please refer to Referral and Authorization Section for additional information.

Behavioral Health

Members under age twenty-one (21) who require behavioral health services should be referred to the appropriate BH-MCO serving the members county of residence.

Specialty Care Practitioner

Verifying Eligibility

Due to frequent changes in a member's eligibility, specialty care practitioners must verify eligibility prior to rendering services to assure reimbursement. This can be done by calling The Plan's telephonic eligibility verification system (IVR). IVR can be reached by calling 1-800-642-3515 and is available twenty-four (24) hours a day, seven (7) days a week. The Pennsylvania MA Member EVS can be reached at 1-800-766-5EVS (5387) twenty-four (24) hours a day, seven (7) days a week.

Referrals

Referrals are no longer required for the Medicaid product. The PCP is responsible for the coordination of a member's healthcare needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other healthcare services. To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member's designated PCP.

All Highmark Wholecare UM prior-authorization requirements remain in place. Examples include but are not limited to:

- Advanced imaging services (requires NIA prior-authorization).
- Therapies (requires NIA prior-authorization).
- Chiropractic visits.
- Out of network requests.
- Interventional spine pain management procedures and MSK surgeries (requires NIA prior-authorization).
- Chemotherapeutic drugs, symptom management drugs and supportive agents, and radiation therapy drugs (requires Oncology Analytics prior-authorization).

Please be sure to check the Prior-Authorization procedure code search tool, available within NaviNet, to confirm if the service requires prior authorization. If you are still unsure which services require an authorization, please contact the Provider Services Department at 1-800-392-1147.

***IMPORTANT NOTE:** The Plan reserves the right to reinstate the referral requirements if any untoward increase in over utilization of these services is observed.

As of February 1, 2022, Highmark Wholecare Medicaid members are required to have all of their outpatient laboratory work completed through the appropriate PCP designated lab. Failure to do so will result in non-payment of services. Referrals can no longer be granted. We will honor existing referrals until January 31, 2022. As a reminder, members cannot be billed for covered services.

The PCP is required to select a designated laboratory based upon the office's location and the lab used most frequently. Should you wish to change your laboratory, please complete the Provider Change Request form located on our website at:
https://highmarkwholecare.com/Portals/8/provider_forms/Practice%20Change%20Request%20Form.pdf.

The PCP's designated laboratory is listed on the member's Highmark Wholecare ID card and on Highmark Wholecare's on-line provider directory located at Highmark Wholecare Provider Directory. Go to Medicaid, then follow the remaining steps. Or, utilize the Eligibility and Benefits feature on NaviNet or contact Provider Services at 1-800-392-1147.

Additional information:
Laboratory testing for Rh incompatibility during pregnancy (related to Rhogam treatment) can be conducted at any participating laboratory.

All other requirements remain the same.
Note: Genetic testing requires prior authorization.

Reimbursement

Payment by the Plan is considered payment in full. Under no circumstance, including but not limited to non-payment by the Plan for approved services may a provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Highmark Wholecare member.

This provision does not prohibit collection of copayments. Refer to the Member Benefit Section of this manual for information on copayments. Members cannot be denied a service if they are unable to pay their copayment. Members are responsible up to a maximum of ninety dollars ($90) for adult MA and one hundred eighty dollars ($180) for adult General Assistance (GA) every six (6) months. Highmark Wholecare will reimburse the member for any applicable copays based upon claims submission that exceed the maximum from January through June and again from July through December of each year.

This provision shall not prohibit collection of copayments on Highmark Wholecare behalf made in accordance with the terms of the enrollment agreement between Highmark Wholecare and the member/subscriber/enrollee.

Practitioners may directly bill members for non-covered services; provided, however, that prior to the provision of such non-covered services, the practitioner must inform the member:

- Of the service(s) to be provided.
- That Highmark Wholecare will not pay for or be liable for said services.
- Of the members rights to appeal an adverse coverage decision as fully set forth in the Provider Manual.
- Absent a successful appeal, that member will be financially liable for such services.

Refer to the Claims and Billing Section of this manual for additional information regarding submission of claims.

Emergency Services

All Highmark Wholecare members are informed that they must contact their PCP for authorization prior to seeking treatment for non-life or limb threatening conditions in an emergency room. However, the Plan realizes that there are situations when a member is under the care of a specialty care practitioner for a specific condition, such as an OB/GYN during pregnancy, and the member may contact the specialist for instructions.

If a specialty care practitioner directs a member to an emergency room for treatment, the specialty care practitioner is required to immediately notify the hospital emergency room of the pending arrival of the patient for emergency services. The specialty care practitioner is required to notify the PCP of the emergency services within one (1) business day when the emergency room visit occurs over a weekend. Every effort should be made to direct members to participating hospitals.

Specialists Functioning as PCP's

As a result of the Commonwealth of Pennsylvania's HealthChoices Program, specialists in the HealthChoices counties may function as a PCP for members with special needs, complex illnesses, or conditions. In order for a specialist to function as a PCP, the specialist must be approved by the Plan's Medical Director and agree to act as a PCP.

Appointment Standards

Specialty care practitioners agree to meet appointment standards, as follows:

Provider Type	Appointment Type/Protocol	Standard
All Specialist	Emergent Care	Immediately seen or referred to an emergency facility.
All Specialist Specialist/ Specialty Types: Dermatology, Dentist, Orthopedic Surgery, Otolaryngology, Pediatric Allergy & Immunology, Pediatric Endocrinology,Pediatric Gastroenterology,Pediatric General Surgery, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Pediatric Neurology, Pediatric Oncology, Pediatric Pulmonology, Pediatric Rehab Medicine, Pediatric Rheumatology, Pediatric Urology	Urgent Care Routine Care	Within twenty-four (24) hours. Within fifteen (15) business days from the date of referral.
Specialties not listed above	Routine Care	Within ten (10) business days.
All Specialist	Wait Time in the Waiting Room and exam room for a routine care appointment	Average office wait time no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a member with a difficult medical condition need.

All Specialist	First time appointment with Persons known to be HIV positive or diagnosed with AIDS.	Within seven (7) days from the effective date of enrollment, unless member is already in active care with a PCP or specialist.
All Specialist	First time appointment with member who is a Supplemental Security Income (SSI) or SSI-related consumer.	Within forty-five (45) days of enrollment unless the member is already in active care with a PCP or specialist.
All Specialist	MissedAppointment	Conduct outreach whenever a member misses an appointment and document in the medical record. Three (3) attempts with at least one attempt to include a telephone call.

OB/GYN Services

General Information

To eliminate any perceived barrier to accessing OB/GYN services, Highmark Wholecare allows all female members to self-refer to any participating OB/GYN for any OB/GYN related condition, not just for an annual exam or suspected pregnancy. When a member self-refers to the OB/GYN, the OB/GYN's office is required to verify eligibility of the member. Highmark Wholecare members may also self-refer for family planning services.

The Plan permits its PCPs to perform routine gynecological exams and pap tests and provide care during pregnancy if they are so trained and equipped in their office. PCPs who provide obstetrical services must bill in accordance with Highmark Wholecare guidelines and may only provide obstetrical services to those patients assigned to their panel.

As you are caring for our members, and you feel additional support or assistance is needed, please refer members back to the Special Needs Unit (SNU) for ongoing case management and support. To refer back to the SNU, please call 1-800-392-1147.

Obstetrical Needs Assessment Form (ONAF)

The first visit with an obstetrical patient is considered to be the intake visit, or if a patient becomes a Highmark Wholecare member during the course of her pregnancy, her first visit as a Highmark Wholecare member is considered to be her intake visit. At the intake visit, an ONAF (MA552), the DHS statewide form, is available at http://www.dhs.pa.gov and under the Medicaid Forms & Reference Materials section at www.highmarkwholecare.com .

Providers are able to submit the ONAF via the NaviNet online form submission tool and through the online submission process by logging in here. Providers till have the option to fax completed ONAFs. The fax number is 1-888-225-2360. The form should immediately be submitted and then filed in the member's medical record. The ONAF should be updated at the twenty-eight (28) to thirty-two (32) week visits and also at the post-partum visit. These two (2) updates should also be submitted to the Plan immediately following completion.

The purpose of the ONAF is to help identify risk factors early in the pregnancy and engage the woman in care management. For that reason, the ONAF MUST be submitted to the MOM Matters Team within two to five (5) business days of the intake visit. The ONAF is not a claim. However, the ONAF must be received by the Plan in order to process the claim for the intake visit. Please submit claims on a CMS-1500 form within one hundred eighty (180) calendar days from the date of service to receive payment for the intake package. Please refer to the coding subsection of OB/GYN for appropriate billing of ONAF regarding the prenatal provider incentive.

Coding

Under the per visit reimbursement structure, the following procedure codes should be used when billing Highmark Wholecare. All prenatal visits and dates of service must be included on the CMS-1500 form and identified with the appropriate E&M codes (99202 – 99205 and 99211 – 99215) only. The U9 pricing modifier must follow the code in the first position on the claim form. Please do not use the State's pricing or informational modifiers on any other Healthy Beginning codes for submission to Highmark Wholecare. Delivery charges must be identified with CPT codes.

Highmark Wholecare will reimburse providers a payment of two hundred dollars ($200) plus the contracted percentage increase for initial prenatal visits rendered within the first trimester. Please bill as indicated below to receive payment:

1. The initial prenatal visit must be rendered within the first trimester and the ONAF must be completed during the visit and submitted to Highmark Wholecare's MOM Matters department within two (2) to five (5) business days of the visit.
2. To receive the bonus payment, providers must report the following: 99429-HD (First Trimester Outreach), T1001-U9 (Initial Risk Assessment), an E&M code (99202 – 99205 and 99211-99215) with a U9 modifier. All three (3) codes must be reported together on the same claim form, along with a diagnosis of pregnancy, to allow the bonus payment. Additionally, FQHC's must use the T1015 code with the above-mentioned guidelines.
3. **Payment will NOT be made, unless all codes/modifiers referenced above are reported on the same claim**. The ONAF is not a claim form; however, the ONAF must be received by Highmark Wholecare and documented in our claims system prior to receipt of the claim to allow the appropriate payment.
4. If the member's first (1st) prenatal visit doesn't occur within the first (1st) trimester then code 99429-HD should not be billed. However, the first visit with an obstetrical patient is considered to be the intake visit. If a patient becomes a Highmark Wholecare member during the course of her pregnancy, her first (1st) visit as a Highmark Wholecare member is considered to be her intake visit and should be completed within the first (1at) forty-two (42) days of the enrollment with Highmark Wholecare. At the intake visit, an ONAF must be completed and a claim submitted with code T1001-U9, pregnancy diagnosis code and an E&M code (99202 – 99205 and 99211-99215) with a U9 modifier for reimbursement.

Highmark Wholecare recognizes the need for multiple services on one date of service for a pregnant member. Please follow CPT guidelines and usage of modifier twenty-five (25) for reimbursement of multiple distinct services. For example, a member can receive a prenatal office visit and a fetal non-stress test on the same day. In this instance, the appropriate fetal NST CPT can be submitted and a modifier of twenty-five (25) should be applied to the distinct E&M service provided on the same day.

Additionally, all applicable encounter diagnosis codes should be submitted to capture all services rendered.

Other Maternity Services			
Fetal Non-stress Test	59025	Fetal Biophysical Profile (Global Fee)	76818
Comprehensive Childbirth Preparation	S9436	Childbirth Preparation Review	S9437
Initial Risk Assessment	T1001	NutritionalCounseling	S9470
SmokingCessation Counseling	G9016	Substance Abuse Problem Identification and Referral	H0004
Genetic Risk Assessment	99205 TF or HD (as modifiers)	ParentingProgram	S9444
Outreach Visit (maximum of three (3)	H1002	Urgent Transport (car)	A0425
In-depthPsycho-social Counseling	H0004	Prenatal Exercise Series	S9451
Urgent Transport (Public Carrier)	T2003	Mileage Additional Allowance	A0425

OB/GYN Referrals

Referrals are not required for services rendered by participating providers. The OB/GYN is responsible for the coordination of a pregnant member's healthcare needs including access to services provided by hospitals, specialty care practitioners, ancillary services and other healthcare services. To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member's designated PCP.

Highmark Wholecare members are able to self-refer to any participating OB/GYN for any OB/GYN related condition, not just for an annual exam or suspected pregnancy. When a member self-refers to the OB/GYN, the OB/GYN's office is required to verify eligibility of the member. Highmark Wholecare members may also self-refer for family planning services.

The OB/GYN practitioner is responsible for providing written correspondence to the members PCP for coordination and continuity of care.

All Highmark Wholecare UM prior-authorization requirements remain in place. Examples include but are not limited to:

- Advanced imaging services (requires NIA prior-authorization).
- Therapies (requires NIA prior-authorization).
- Chiropractic visits.
- Out of network requests.
- Interventional spine pain management procedures and MSK surgeries (requires NIA prior-authorization).
- Chemotherapeutic drugs, symptom management drugs and supportive agents, and radiation therapy drugs (requires Oncology Analytics prior-authorization).

Please be sure to check the prior-authorization procedure code search tool, available within NaviNet to confirm if the service requires prior authorization. If you are still unsure which services require an authorization, please contact the Provider Services Department at 1-800-392-1147.

As of February 1, 2022, Highmark Wholecare Medicaid members are required to have all of their outpatient laboratory work completed through the appropriate PCP designated lab. Failure to do so will result in non-payment of services. Referrals can no longer be granted. We will honor existing referrals until January 31, 2022. As a reminder, members cannot be billed for covered services.

The PCP is required to select a designated laboratory based upon the office's location and the lab used most frequently. Should you wish to change your laboratory, please complete the Provider Change Request form located on our website at:
https://highmarkwholecare.com/Portals/8/provider_forms/Practice%20Change%20Request%20Form.pdf.

The PCP's designated laboratory is listed on the member's Highmark Wholecare ID card and on Highmark Wholecare's on-line provider directory located at Highmark Wholecare Provider Directory. Go to Medicaid, then follow the remaining steps. Or, utilize the Eligibility and Benefits feature on NaviNet or contact Provider Services at 1-800-392-1147.

Additional information:
Laboratory testing for Rh incompatibility during pregnancy (related to Rhogam treatment) can be conducted at any participating laboratory. All other requirements remain the same.
Note: Genetic testing requires prior authorization.

Diagnostic Testing

Fetal non-stress tests and obstetrical ultrasounds can be performed in the OB/GYNs office or at a participating hospital without an authorization from the Plan. Please follow above mentioned CPT billing guidelines and use modifier twenty-five (25) when billing two (2) distinct services on same date of service.

A script is not required for a screening mammogram performed at a participating hospital.

MA Sterilization/Hysterectomy Consent Forms

DHS requires that Highmark Wholecare members sign a MA Sterilization Consent Form (MA-31), or a MA Patient Hysterectomy Consent Form (MA-30), at least thirty (30) days prior to receiving the requested procedure.

Newborns

Newborns of Highmark Wholecare mothers will be covered by Highmark Wholecare for services rendered during the neonatal period. DHS requires that the hospital submit the MA-112 Form for each newborn to the mother's assigned County Assistance Office. All charges for newborns that become enrolled in the plan, other than hospital bills covering the confinement for both mom and baby, are processed under the newborn name and newborn Highmark Wholecare identification number.

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Universal OB Access Program Follow-up Requirements

Item	OB Referral?	Authorization?	Type of PCP Follow- up
IN OFFICE SERVICES			
Annual Gynecological Exam	No	No	Summary Report
Other Related Gynecological Services	No	No	Summary Report
SuspectedPregnancy	No	No	None
Initial Intake	No	No	OB Risk Assessment Form
Prenatal Visits	No	No	None
Identification of New Risk Factors	No	No	Updated Risk Assessment
Other Related OB Services	No	No	None
Prenatal Support Services	No	No	None
Family Planning Services	No	No	None
Fetal Non-Stress Test	No	No	None
OUT OF OFFICE SERVICES			
SPU/Ambulatory Surgery Services*	No	Yes	Summary Report
Inpatient Hospitalization	No	Yes	Summary Report
HomeHealthcare /Hospice Services/IV Infusion	No	Yes	None
Mammogram	No	No	Summary Report
OB Ultrasound	No	No	None
Fetal Non-Stress Test	No	No	None
STAT Laboratory Services**	No	No	None
Other Outpatient Diagnostic	No	No	Summary Report
Delivery and Discharge Services	No	No	Summary Report

*These services can be authorized by calling Highmark Wholecare's UM department at 1-800-392-1147. Home Health visits should be offered to all newborns.

** As of February 1, 2022, we will no longer accept referrals to non-designated labs. The PCP designated lab, which is listed on the member's ID card, must be used. Members cannot be billed for covered services.

***Highmark Wholecare will cover four (99501) postpartum home visits in three hundred sixty-five (365) days.

Family Planning Guidelines

All family planning benefits provided under Highmark Wholecare are administered by Adagio Health, Inc. If a Highmark Wholecare patient presents for family planning benefits, practitioners need to be aware of the following:

- The patients Highmark Wholecare eligibility can be verified by calling 1-800-642-3515.
- Family planning patients DO NOT need a referral from their PCP under federal mandate.
- If a family planning patient becomes pregnant, she may self-refer to her OB/GYN for prenatal care. DHS permits members to see any participating or non-participating practitioner for family planning services only.
- The Sterilization Consent Form (MA-31) must be obtained from the patient thirty (30) days prior to the procedure.
- The appropriate documentation must be obtained for abortion services.
- The appropriate documentation must be PREAUTHORIZED at least five (5) business days prior to the procedure by calling Adagio Health, Inc. at 1-800-532-9465.

Pregnancy termination may be covered under the specific provisions for coverage provided by the Pennsylvania DHS and the federal DHS. Only those cases that are related to rape, incest, or endangerment to the life of the mother are covered. A provider must complete the appropriate DHS physician certification forms, i.e. MA-3, MA-368 or MA-369 and submit the completed form to Adagio Health, Inc. Adagio Health, Inc. will issue an approval for payment once the appropriate forms are received and reviewed. Adagio Health, Inc. may be contacted at 1-800-532-9465. The appropriate forms may be faxed to 412-201-4701.

Post-partum tubal ligations must be preauthorized by Adagio Health, Inc. All outpatient laboratory testing should be ordered with a prescription through the members PCP or OB/GYN practitioner according to the PCPs designated laboratory.

Reversals of tubal ligations, vasectomies, and infertility treatments ARE NOT covered by Highmark Wholecare.

Highmark Wholecare covers long acting reversible contraceptive (LARC) placement in the inpatient setting.

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Appointment Standards

Appointment standards for OB/GYN practitioners are as follows:

FirstTrimester	Within ten (10) business days of the member being identified as being pregnant.
SecondTrimester	Within five (5) business days of the member being identified as being pregnant.
Third Trimester	Within four (4) business days of the member being identified as being pregnant.
High-Risk Pregnancies	Within twenty-four (24) hours of identification of high-risk by our health plan or the maternity care provider, or immediately if an emergency exits.

Additional standards that apply to all specialists including OB/GYNs:

Appointment Type/Protocol	**Standard**
Emergent Care	Immediately seen or referred to an emergency facility.
Urgent Care	Within twenty-four (24)hours.
Routine Care	Within ten (10) business days.
Wait Time in the Waiting Room and exam room for routine care	Average office wait time no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated urgent medical condition visit or is treating a member with a difficult medical condition need.
First time appointment with Persons known to be HIV positive or diagnosed with AIDS	Within seven (7) days from the effective date of enrollment, unless member is already in active care with a PCP or specialist.
First time appointment with member who is a Supplemental Security Income (SSI) or SSI-related consumer	Within forty-five (45) days of enrollment unless the Member is already in active care with a PCP or specialist.
MissedAppointment	Conduct outreach whenever a member misses an appointment and document in the medical record. Three (3) attempts with at least one (1) attempt to include a telephone call.

Policies and Procedures

The Plan has developed policies and procedures to provide guidelines for identifying and resolving issues with practitioners who fail to comply with the terms and conditions of the applicable practitioner agreement, policies and procedures, or accepted UM standards, and QI guidelines.

Please know the Plan makes decisions concerning coverage of healthcare services for members based on medical necessity and appropriateness of care. The Plan facilitates the delivery of appropriate, medically necessary care to members and has mechanisms in place to monitor and address the potential over- or under-utilization of services. For example, utilization data from provider sites for PCPs and high-volume specialists is monitored to detect potential over and underutilization.

The Plan then implements appropriate interventions whenever it identifies potential problems with the utilization of services. The Plan does not align its financial incentives to employees and providers in order to encourage decisions on the coverage of healthcare services to members. Employees are advised that: UM decision-making is based upon existence of coverage, medical necessity, and appropriateness of care and service.

The Plan does not specifically reward providers, employees or other individuals conducting utilization review for issuing denials of coverage or service. Highmark Wholecare does not provide financial incentives for UM decision makers to encourage decisions that result in lower utilization.

Reporting Suspected Abuse and Neglect

The Plan's Pennsylvania Medicaid Provider Agreements (Professional and Hospital Agreements, version February, 2017) address the requirement to ensure that ER staff and physicians know the procedures for reporting suspected abuse and neglect.

- Provider Agreement Language: Provider represents and warrants to MCO that emergency room staff and physicians providing covered services under the agreement, if any, know the procedures for reporting suspected abuse and neglect.

As a participating provider you are considered a Mandated Reporter. As a Mandated Reporter you are required by law to report suspected child abuse and/or neglect. It is vitally important that Mandated Reporters understand how to recognize child abuse and how to make reports that are timely, complete, and accurate. As a Mandated Reporter, you must report suspected abuse immediately, either by phone or electronically.

Child abuse is defined as when an individual acts or fails to prevent something that causes serious harm to a child under the age of eighteen (18). This harm can take many forms, such as serious physical injury, serious mental injury, or sexual abuse or exploitation. To learn more about Child Protective Services Law, 23 Pa.C.S. §§ 6301—6385 go to: https://www.dhs.pa.gov/KeepKidsSafe/Pages/Report-Abuse.aspx.

ChildLine provides information, counseling, and referral services for families and children to ensure the safety and well-being of the children of Pennsylvania.

To report:

- Call ChildLine at 1-800-932-0313. The toll-free intake line is available twenty-four (24) hours a day seven (7) days a week to receive reports of suspected child abuse. As a Mandated Reporter, you must provide your name and contact information when making the call.

- Electronic reports may be submitted directly to ChildLine via the Child Welfare Information Solution portal. This option is only available to Mandated Reporters.

Pennsylvania Family Support Alliance (PFSA) supports Mandated Reporters by offering education, training, and resources on their website. Go to https://pafsa.org/child-abuse-facts-and-prevention-in-pennsylvania/ to learn about:

- How PFSA Supports Mandated Reporters.
- Understanding Mandated Reporting.
- Recognizing Child Abuse & Neglect.
- Resources for Mandated Reporters.
- Mandated Reporters Training.

Obligation to Screen Employees for exclusion from Medicare and Medicaid

PA Medicaid Bulletin #99-11-05 requires all providers to screen employees, contractors, and subcontractors, individuals, and entities, against the exclusion databases as required by forty-two (42) CFR §455.436 to determine if they have been excluded from participation in Medicaid or Medicare. No Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded. 42 CFR § 1001.1901(b). DHS has advised providers to conduct self-audits to determine compliance with this requirement and report any discovered exclusion of an employee or contractor, either an individual or entity, to DHS' Bureau of Program Integrity (BPI).
Below are links to the exclusion databases:

1) Federal Department of Health & Human Services, Office of Inspector General – List of Excluded Individuals and Entities: https://exclusions.oig.hhs.gov/
2) Federal General Services Administration, System for Award Management: https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf
3) PA DHS – Medicheck System: https://www.humanservices.state.pa.us/Medchk/MedchkSearch/Index

Compliance with the Federal Deficit Reduction Act of 2005 and the Federal False Claims Act

Section 6032 of the Deficit Reduction Act of 2005, requires any network provider receiving annual Medicaid payments of at least five million dollars ($5,000,000 (cumulative, from all sources) to:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and the providers policies and procedures for detecting and preventing fraud, waste, and abuse.

Compliance with State and Federal Requirements

Per the provider agreement, providers shall:

- Provider will comply with The Labor Anti-Injunction Act (43 P.S. §§ 206a – 206r, and the Pennsylvania Labor Relations Act (43 P.S. §§ 211.1 – 211.13).
- Provider will notify Highmark Wholecare within ten (10) days of provider's receipt of a Charge of Unfair Labor Practice(s) as defined under the Pennsylvania Labor Relations Act and Act 111 (a "Charge") and provide Highmark Wholecare a copy of the Charge at the time of notification to Highmark Wholecare.
- Provider will submit a copy of any decisions, including any initial or appeal decision, issued in response to a Charge by the Pennsylvania Labor Relations Board, National Labor Relations Board, other applicable Pennsylvania governmental body, or court of law (collectively: Government Entity) to Highmark Wholecare within ten (10) days of any such decision's issuance date.
- Provider will submit a copy of any final settlement, adjustment, or order agreed to or ordered by any such Government Entity ("Final Order") within ten (10) days of the Final Decision along with proof of compliance with the Final Order or a detailed action plan, including action steps and timeline, under which provider will come into compliance with the requirements under the Order.
- Provider acknowledges that failure to comply with the Labor Anti-Injunction Act, 43 P.S. §§ 206a – 206r or the Pennsylvania Labor Relations Act (43 P.S. §§ 211.1 – 211.13) is a material breach of the Agreement for which Highmark Wholecare may require the submission and completion of a corrective action plan or for which Highmark Wholecare may terminate this agreement with no less than sixty (60) days advance written notice in Highmark Wholecare's sole and absolute discretion.
  Within ten (10) days of the Effective Date of the Highmark Wholecare Amendment, Provider will disclose to Highmark Wholecare in writing and in accordance with the Notice provisions of the Agreement.
- Provider understands and agrees that any such agreement, which is intended to prevent service disruption to Highmark Wholecare's members that may be caused by employee unrest or dissatisfaction must contain: (1) a provision prohibiting labor organization and its members, and in the case of a collective bargaining agreement, all employees covered by the agreement, from engaging in work stoppages, boycotts, or other interference with the providers provision of HealthChoices services at the facility for the duration of the Term of the Agreement, and (2) the procedures that the Provider and labor organization shall use to negotiate and resolve disputes relating to employment conditions, including but not limited to a requirement that all such unresolved disputes be submitted to final binding arbitration.
- Provider will not discriminate against employees by reason for participation in or decision to refrain from participating in labor activities protected under the Public Employees Relations Act (43 P.S. § 1101.201 et seq), Pennsylvania Labor Relations Act (43 P.S. §§ 211.1 – 211.13), or National Labor Relations Act (29 U. S. C. §§ 151-169), as applicable and to the extent determined by entities charges with such Acts' enforcement, and shall comply with any provision of the law establishing organizations as employees' exclusive representatives.

DHS Policy Changes

In order for the Plan to meet the standards set forth by the DHS' standard contract, Highmark Wholecare must promptly implement new policies or changes in policy at the request of DHS.

Provider manuals must be updated to reflect any program or policy change(s) made by DHS via MA Bulletin within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the MA Bulletin, whichever is later, when such change(s) affect(s) information that the PH-MCO is required to include in its provider manual. Highmark Wholecare is committed to notifying all appropriate practitioners, via any appropriate medium, within sixty (60) days of receipt of the notice of a new policy or policy change when sufficient notice is provided by DHS.

Additionally, practitioners need to be aware that no regulatory order or requirement of the Departments of Insurance, Health or Human Services shall be subject to arbitration with Highmark Wholecare.

Practitioner Education, Sanctioning, and Termination

Highmark Wholecare practitioners will be monitored for compliance with administrative procedures, guidelines, trends of inappropriate resource utilization, potential quality of care concerns, and compliance with medical record review standards. Practitioner education is provided through Quality Improvement Nurses, Provider Engagement staff, Provider Account Liaisons (PALs), and our Medical Directors. The company follows a tiered approach of education and sanctioning prior to implementing termination procedures.

Network practitioners who do not improve through the provider education process will be referred to the company's QI/UM Committee for evaluation and recommendations. Recommendations may include remediation or practitioner sanctioning.

Examples of repeated practitioner conduct that may be further reviewed for education and remediation include, but are not limited to:

- Member complaints.
- Reported occurrences of excluding or denying health care services to a member based on his or her race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age.
- Failure to obtain prior authorization for a referral to a non-participating practitioner.
- Failure to obtain prior authorization for those services requiring such.
- UM trends exceeding the peer group.
- Quality indicator outcomes below the peer group.
- Failure to cooperate with administrative aspects of the QI/UM Program.
- Failure to provide adequate practitioner coverage.
- Failure to be accessible to members via telephone or answering services.
- Repeated failure to be compliant with the established accessibility standards.
- Repeated failure to comply with Environmental Assessment (EA) standards.

Highmark Wholecare conducts ongoing monitoring of Medicaid and Medicare sanction information by utilizing the OIG report, CMS Preclusion Listing, and the DHS Medicheck Sanctions report. If a participating provider is found on the reports, the provider's file is pulled for further investigation and presented to the QI/UM Committee for a decision. Upon notification from DHS that a provider has been terminated due to loss of licensure and/or criminal convictions, Highmark Wholecare will immediately move forward with terminating the provider from its network. The effective date of termination will be the same date utilized by DHS.

Practitioner Due Process

Highmark Wholecare has established a policy and procedure to define the situations when due process procedures are afforded to practitioners, and to specify the due process procedures available in accordance with federal and state regulations, in particular the Healthcare Quality Improvement Act of 1986.

The Practitioner Due Process Policy will be updated in accordance with federal and state regulations. To request additional information or to obtain a copy of this policy, please contact Highmark Wholecare's Provider Services Department at 1-800-392-1147.

TITLE VI of the Civil Rights Act of 1964

Practitioners are expected to comply with Title VI of the Civil Rights Act of 1964 that prohibits race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation discrimination in programs receiving federal funds.

Practitioners are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of translator services as necessary for these members.

Access and Interpreters for Members with Disabilities

Practitioner offices are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each practitioner is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. Highmark Wholecare will assist practitioner in locating resources upon request. Highmark Wholecare offers the Member Handbook and other Highmark Wholecare information in large print, braille, cassette tape, or computer diskette at no cost to the member. Please instruct members to call Member Services at 1-800-392-1147 to request these other formats.

Practitioner offices are required to adhere to ADA guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time-to-time.

Practitioners may obtain copies of documents that explain legal requirements for translation services by contacting Highmark Wholecare's Provider Services Department at 1-800-392-1147. For interpreter services, please contact a qualified medical interpretation service such as Language Line Services. Practitioner offices can contact the AT&T Language Line at 1-800-874-9426 for assistance with Limited English Proficient (LEP) patients and the PA State Relay line at 711 or 1-800-682-8706 for patients with hearing impairments.

Confidentiality

All practitioners and providers participating with our company have agreed to abide by all our policies and procedures regarding member confidentiality.

Under these policies, the practitioner or provider must meet the following:

1) Provide the highest level of protection and confidentiality of members' medical and personal information used for any purposes in accordance with federal and state laws or regulations including the following:
    - The Mental Health Procedures Act, 50 P.S. §§ 7101 *et seq.*
    - Patient Medical Records, 28 Pa. Code § 115.27.
    - Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. §§ 1690.101—1690.115.
    - Pennsylvania Confidentiality of HIV-Related Information Act, 35 P.S. §§ 7601 et seq.
    - Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 162, and 164.
    - The Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub.L.No. 111-5 (Feb 17, 2009) and related regulations.
    - 42 U.S.C. § 1396a (a) (7) – State plan for MA.
    - 42 C.F.R. § 431.300 et seq. – MA – Safeguarding Information on Applicants and Recipients.
    - 55 Pa. Code Chapter 5100 – Mental Health Procedures General Provisions.
    - 42 C.F.R. Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.
    - 73 P.S. § 2301 et seq. – Pennsylvania Breach of Personal Information Notification Act.

2) This includes implementing policies and procedures for managing access to and use of race, ethnicity, and language data.
3) Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.
4) Assure that a member's individually identifiable health information as defined by HIPAA, also known as Protected Health Information (PHI), necessary for treatment, payment, or healthcare operations (TPO) is released to our company without seeking the consent of a member, unless federal or state laws require express written consent. This information includes PHI used for claims payment, continuity and coordination of care, accreditation surveys, medical record audits, treatment, quality assessment and measurement, quality of care issues, medical management, appeals, case management, and disease management. Further, providers will assure that PHI for TPO will be made available to Pennsylvania DHS, Department of Health, Department of Insurance or Business Associates of our company for use without member consent. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations. Our company follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the treatment, payment, or operational function.
5) The member, or a member's representative with appropriate authority under state and federal law, shall have access to view and/or receive copies of the medical record upon request. There is no charge for the copied medical record if the record is sent to another practitioner or provided directly to the member. The request must allow reasonable notice and follow the specific procedures of the practitioner or provider.
6) All providers are required to conduct environmental security of confidential information and monitor practice and provider sites. Provider and practitioner sites must comply with the Environmental Assessment (EA) standards that require that patient records be protected from public access.
7) Medical records must be available for all member visits for established patients.

Fraud, Waste, and Abuse (FWA)

Our Company has a comprehensive policy for handling the prevention, detection and reporting of fraud, waste and abuse (FWA). It is our policy to investigate any action by members, employees or practitioners that affects the integrity of our company and/or the MA program. We enforce all industry standard claim coding requirements including those from NCCI, AMA, CPT and ICD-10-CM.

Providers are responsible to know the following FWA definitions as applicable to Medicaid:

- **Fraud:** Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting, committed by an entity, including the health plan, a subcontractor, a provider, or a member, among others.
    - **Waste and Abuse:** Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid/Medicare Programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Medicaid contracts, Medicare manuals, and the requirements of state and federal regulations for health care in a managed care setting.
        - Abuse can be committed by the healthplan, subcontractor, provider, state employee, or a member, among others. Abuse also includes member practices that result in unnecessary cost to the Medicaid/Medicare Programs, the health plan, a subcontractor, or provider.
        - Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Overutilization of services, or other practices that, directly or indirectly, result in uneccesary costs.
- **Compliance Program:** To ensure compliance with FWA requirements of Medicaid contracts, our

Company and providers will have:

- Written policies, procedures, and standards of conduct readily available for all employees which outlines our commitment to a FWA program.
- Effective training and education related to FWA for all employees, first tier and downstream entities, or subcontractors.
- Mechanisms to report compliance issues or FWA.
- Enforcement standards through publicized disciplinary guidelines.
- Provisions for internal monitoring and auditing.
- Provisions to promptly take action to detected offenses and develop corrective action initiatives.

- **False Claims Act:** The False Claims Act (FCA) provides that any person who knowingly presents or causes to be presented a false or fraudulent claim for payment or approvals (among other activities) is liable to the United States Government for a civil penalty of five thousand dollars ($5,000) to ten thousand dollars ($10,000) plus three (3) times the amount of damages the Government sustains because of the act of that person (as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990). The FCA includes a qui tam provision, where individuals can bring claims on behalf of the government in exchange for a percentage of any recovery.
- **Fraud, Waste and Abuse Unit:** A multi-faceted unit within our Company that is involved in detecting and investigating FWA. In addition, the unit works to ensure that claims are paid correctly by both pre-pay and post-pay auditing methods and in accordance to recipient benefits and provider contracts.

As a participating practitioner with us, your contract requires you to comply with our policies and procedures for the detection and prevention of FWA. Such compliance may include referral of information regarding suspected or confirmed FWA to us and submission of statistical and narrative reports regarding FWA detection activities.

Providers can find FWA trainings created by our FWA Unit on the website at: https://highmarkwholecare.com/. All providers are required to have a representative review the Provider FWA Training upon contracting with our Company and annually thereafter. The provider representative will be responsible for communicating the information obtained from the Provider FWA Training to the entire staff of the provider. It is the provider's responsibility to either attend the annual Provider FWA Training or independently review the required materials. Providers will be expected to submit proof of their completion of the training when requested by our Company.

Further information and updates concerning the Provider FWA Training can be found on our Company Fraud & Abuse web page.

Our policies and procedures follow the guidelines set forth by CMS, where applicable. For further information on FWA, providers should refer to the CMS website: https://www.cms.gov/Outreach-and-Education/Look-Up-Topics/Fraud-and-Abuse/Fraud-page.html.

It is our policy to discharge any employee, terminate any practitioner, or recommend any member be withdrawn from the Medicaid program who, upon investigation, has been identified as being involved in fraudulent, wasteful, or abusive activities. If FWA is suspected, whether it is by a member, employee, or practitioner, it is your responsibility to immediately notify us at 412- 255-4340 or 1-844-718-6400.

Some common examples of fraud, waste and abuse are:

- Billing or charging MA recipients for covered services.
- Balance billing.
- Billing for services not rendered.
- Billing for supplies not being purchased or used.
- Billing separately for services in lieu of an available combination code.
- Billing more than once for the same service.
- Billing incorrect provider service or location.
- Billing for more time or units of service than provided.
- Billing for used items as new.
- Billing for services provided by unlicensed or qualified persons.
- Upcoding.
- Dispensing generic drugs and billing for brand name drugs.
- Falsifying records or submitting false data on any claims.
- Altering claims.
- Performing inappropriate or unnecessary services.

Some common examples of member fraud, waste, and abuse are:

- Failing to report income, ownership of resources or property, or who lives in the household.
- Loaning or using another person's ID.
- Changing or forging an order or prescription.
- Selling prescriptions/medications.
- Stealing provider's prescription pads.
- "Doctor shopping" for prescriptions.
- Trafficking SNAP benefits or taking advantage of the system in any way.

Fraud, Waste, and Abuse Recovery Requirements:

Our Company has fraud, waste and abuse recovery functions that are responsible for ensuring claims payment accuracy and to detect and prevent FWA which include:

- Pre-payment claims edits.
- Retrospective claims reviews.
- Provider education.
- FWA investigations and audits.

Our FWA recovery functions rely on reimbursement policies, medical record standards, and coding requirements that are outlined in the following: CMS, American Medical Association (AMA), National Correct Coding Initiative (NCCI), NCQA, and state Medicaid bulletins and regulations. Additionally, all claims should be coded and documented in accordance with the HIPAA Transactions and Code Sets which includes: ICD-10-CM, National Drug Codes (NDC), Code on Dental Procedures and Nomenclature, HCPCS Codes, CPT Code, and Other HIPAA code sets.

Our Company will conduct pre-payment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. We will recover claims payments that are contrary to national and industry standards. We will conduct progressive reviews, such that, providers may be requested to submit additional samples or documentation during the reviews. If any of the recovery efforts identify overpayments, the following activities will occur:

- We will comply with all federal and state guidelines to identify overpayments.
- We will pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within sixty (60) days.

- We will refer suspected FWA to appropriate agencies, such as Medicaid oversight and CMS Medics.
- We may recommend corrective actions that may include pre-payment review, payment suspension, and potential termination from Highmark Wholecare's provider network.

Our Company may pursue overpayments for the following reasons (but is not limited to):

NCCI Procedure to Procedure (PTP) edits.
NCCI Medically Unlikely (MUE) edits.
NCCI Add-On Code edits.
Retrospective coordination of benefits.
Retrospective termed member eligibility.
Retrospective rate adjustments.
Incorrect fee schedule applied to claim.
Provider excluded.
Provider license terminated or expired.
Provider does not meet the requirements to render services.
Different rendering provider.
No authorization or invalid authorization.
Inaccurate claim information.
Duplicate claims.
Non-covered service.
Outpatient services while member was inpatient.
Overlapping services.
Patient different than member.
Per diem services billed as separate or duplicate charges.
Services provided outside of practice standards.
Group size exceeds limitations.
No services provided including no-shows and cancellations.
Missing records.
Missing physician orders.
Missing medication records.
Missing laboratory results.
Invalid code or modifier.
Invalid code combinations
Diagnosis codes that do not support the diagnosis or procedure.
Add-on codes reported without a primary procedure code.
Clinical documentation issues.
Claims documentation issues.
Insufficient documentation.
Potentially fraudulent activities.
Excessive services.
Altered/forged records.

FWA Audits

At times, our FWA unit will conduct audits regarding FWA. If selected for an audit, the provider will receive a letter from the primary investigator, or delegates that have been contracted by us, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond.

Additionally, we partner with multiple vendors to conduct various post-payment audits or reviews. Such audits or reviews could include:

- Retrospective data mining review.
- Subrogation.
- Inpatient chart review.

Vendor specific questions should be directed to our Provider Services by calling 1-800-392-1145.

Overpayments

Our Company, its providers, and its members are responsible for the identification and return, regardless of fault, of overpayments. In the event that we make an overpayment to a provider, we must recover the full amount of that overpayment. Additionally, if a provider identifies an overpayment from us, the provider is responsible for returning the overpayment in full at the time of discovery.

Provider Self-Audit (Self-Identified Overpayment)

Federal and state regulations require providers to routinely audit claims for overpayments. We have a process in place for our network providers to report the receipt of a self-identified overpayment.

Providers must notify us in writing of the reason for the self-identified overpayment and should provide payment within sixty (60) calendar days in accordance with 42 U.S.C. §1320a7k (d) (2). If the claim is over two (2) years old, a check is preferred. If the claim is less than two (2) years old, retraction is preferred. For claims retractions, providers can submit the Provider Self-Audit form that is located on the provider portal. It is imperative that providers include the explanation of the self-audit and the claims they represent. If a listing of claims is not provided, we cannot guarantee that the claims will not be included in separate audits, for the same reason. Please provide a listing of claims as requested on the Provider Self-Audit/Overpayment Form located on our website. Conversely, if providers use an extrapolation calculation to determine payment, a description of that methodology and the calculation should be included with your submission.

Deposit of a provider check or retraction of the requested claims does not constitute complete agreement to the submitted self-audit results or overpayment amount. Our FWA Unit may contact the provider to discuss self-audit results as necessary. The overpayment letter and check (if applicable) should be sent directly to:

Highmark Wholecare
Attention: Fraud, Waste and Abuse Unit
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

Additionally, for more information on self-audits, please see the following resources:

- Self-Audit e-bulletin posted by CMS: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-self-audit.pdf.
- MA Provider Self-Audit Protocol posted by DHS: https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx

Information to Submit for Self-Identified Overpayment

When submitting information for an identified overpayment, please include the following:

- Provider information (i.e.; Name, NPI, TIN, Contact information, etc.).
- Self-audit/overpayment information.
- Period of claims.
  - For claims more than two (2) years old, please provide a check.
  - For claims less than two (2) years old, retraction of claims is preferred.
- List of affected claims and/or extrapolation calculation used to determine overpayment amount.
- Other information (as required).

Medical Record Requests and Standards

We may request copies of medical records from the provider in connection with claims overpayment or for cases involving alleged FWA. If we request medical records, the provider must provide copies of those records at no cost to us. This includes notifying any third party who may maintain medical records of this stipulation. In addition, the provider must provide access to any medical, financial, or administrative records related to the services provided to our members within thirty (30) calendar days of Highmark Wholecare's request or sooner. All required documentation must be submitted at the time of the original medical record request. Additional documentation will not be accepted after the review is complete.

Our Company requires providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations, and Medicare manuals as well as other applicable professional associations and advisory agencies. Providers should follow the below guidelines for basic medical records:

- Providers are responsible for following all requirements under federal and state regulations, publications, and bulletins that are pertinent to the treatment and services provided.
- Providers should follow the medical record standards as defined in Medicaid contracts, provider contracts, provider manuals, and all regulations.
- Providers are responsible for having compliance programs that prevent and detect FWA and report and return any overpayments within sixty (60) days of identification.
- Providers must have member records that include all Medicaid requirements, are individual and kept secure.
- Providers are responsible for obtaining the appropriate order, referral, or recommendation for service.
- All documentation must meet the requirements of the service codes that are submitted on the claims form.
- All progress notes and billing forms must be completed after the session.
- All documentation and medical record requirements must be legible.
- All amendments or changes to the documentation must be signed and dated by the clinician amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.
- Each medical record should be individualized and unique and should include a patient identifier on every page. (No clone or copying and pasting of medical records.)

Consent to Treatment	Valid for dates of service.
	Identifies the patient.
	Signed and dated by patient.
	Signed, dated, and credentialed by clinician.
	Lists the types of services and/or treatments.
	Includes the benefits and any potential risks.

	Includes alternative services and/or treatments.
	Must be easy to read and legible.
Release of Information for Payment	Valid for dates of service.
	Identifies the patient.
	Signed and dated by patient.
	Signed, dated, and credentialed by author/clinician.
	Lists the types of services and/or treatments.
	Must be easy to read and legible.
Privacy Practices	Valid for dates of service.
	Identifies the patient.
	Signed and dated by patient.
	Signed, dated, and credentialed by author/clinician.
	Must be easy to read and legible.
Medical Information	Must contain the minimum personal biographical data: DOB, gender, address, home telephone number, employer, occupation, work telephone number, marital status, name of next of kin, next of kin telephone number.
	Allergies and adverse reactions.
	Significant illnesses and medical conditions.
	Medical history, such as family history, psychosocial history, medical-surgical history, baseline physicals, and periodic updates.
	High risk behaviors (Tobacco/cigarette, alcohol, substance abuse, HIV/STD, nutrition, social and emotional risks, etc.).
	Laboratory and other studies ordered.
	Continuity of care is documented.
	Immunizations and dates.
	Must be easy to read and legible.
Treatment Plan	Valid for dates of service.
	Identifies the patient.
	Signed and dated by clinician (witness or authors identification).
	Documents that member or guardian reviewed or participated with the development of the treatment plan.
	Addresses the chief complaint and clinical finding with a plan of care consistent with standards of care and clinical practice.
	Identifies the diagnosis.
	Identifies interventions and goals of treatments.
	Documents necessity for treatment.
	Reviews are completed timely as applicable.
	Must be easy to read and legible.
Progress / Clinical Entry Note	Dates of Service.
	Identifies the patient.
	Signed, dated, and credentialed by author/clinician.
	Start and stop times for time-based services.
	Units of service.
	Place of service.
	Note is missing narrative/description of services.
	Note does not identify the treatment goals and objectives.

	Note does not list symptoms and behaviors.
	Note does not identify follow-up or next steps in treatment.
	Corresponding encounter or timesheets as applicable.
	Must be easy to read and legible.

Pennsylvania MA Hotline to Report Fraud and Abuse

DHS has established a MA Provider Compliance Hotline, 1-866-379-8477, to report suspected fraud and abuse committed by any entity providing services to MA recipients. The hotline operates between the hours of 8:30 A.M. and 4:00 P.M. (Eastern Time), Monday through Friday. Voicemail is available at all other times. Callers may remain anonymous and may call after hours and leave a voicemail if they prefer.

Suspected FWA may also be reported via the DHS website at using the MA Provider Compliance Hotline Response Form at: MA Provider Compliance Hotline Response Form. Information reported via the website or email can also be done anonymously. The website contains additional information on reporting fraud and abuse.

Recipient Restriction Program

In cooperation with DHS, Highmark Wholecare maintains a Recipient Restriction (lock-in) Program, which restricts members who misuse medical services or pharmacy benefits. Highmark Wholecare enforces and monitors these restrictions through the following process:

- Designating a Recipient Restriction Coordinator within Highmark Wholecare to manage processes.
- Identifying members who are over-utilizing and/or misutilizing medical services.
- Evaluating the degree of abuse including review of pharmacy and medical claims history, diagnoses, and other documentation, as applicable.
- Offering a voluntary restriction to a member to protect his/her medical card from alleged misuse. For example, a voluntary restriction can be imposed when a member loses their card or believes their benefits are being used by someone other than themselves. A voluntary restriction may end at any time.
- Proposing whether the member should be restricted to obtaining services from a single, designated provider for a period of five (5) years (restrictions may be lifted after a period of five (5) years if improvement in use of services is demonstrated).
- Forwarding case information and supporting documentation to Bureau of Program Integrity (BPI) at the address below or via secure electronic method, for review to determine appropriateness of restriction and to approve the action.
- Forwarding case information to BPI for allegations of member fraud.
- Upon BPI approval, sending notification via certified mail to member of proposed restriction, at least ten (10) days in advance, including reason for restriction, effective date, length of restriction, name of designated provider(s), and option to change provider, with a copy to BPI.

- Sending notification of member's restriction to the designated provider(s) and the County Assistance Office (CAO).
- Enforcing the restrictions through appropriate notifications and edits in the claims payment system.
- Preparing and presenting the case at a DHS Fair Hearing to support restriction action.
- Monitoring subsequent utilization to ensure compliance.
- Changing the selected provider per the member's or provider's request, within thirty (30) days from the date of the request, with notification within five (5) business days to BPI through the Intranet Provider change process.
- Continuing a member restriction from the previous delivery system as a member enrolls with Highmark Wholecare, with written notification to BPI.
- Reviewing the members services prior to the end of the five-year period of restriction to determine if the restriction should be removed or maintained, with notification of the results of the review to BPI, member, provider(s), and CAO.

Members have the right to appeal a restriction by requesting a DHS Fair Hearing. Members may not file a complaint or grievance with Highmark Wholecare regarding the restriction. A request for a DHS Fair Hearing must be in writing, signed by the member, and sent to:

Department of Human Services
Office of Administration Bureau of Program Integrity
Recipient Restriction Section
P.O. Box 2675, Harrisburg, PA 17105-2675
717-772-4627 (Office)
717-214-1200 (Fax)

Environmental Assessment (EA) Standards

The Plan has established specific guidelines for conducting EA Site Visits, including medical record keeping standards, at PCP practices. An initial EA will be conducted at all PCP and dental practitioner office sites as part of the credentialing process. The Plan's subcontracted vendor conducts all site visits for contracted dental providers. The purpose of the site visit is to assure that practitioners are in compliance with the Plan's EA standards.

A PAL will schedule an on-site or virtual visit at each office site to conduct an EA. The EA must be conducted with the office manager or with a practitioner of the practice. The PAL will complete the initial EA form and tour the office as well as interview staff and examine the appointment schedule. The Provider Account Liaison will assess the office for evidence of compliance with the EA standards.

Upon completion of the review, the PAL will conduct an exit interview with the office manager and/or practitioner. The results of the EA will be reviewed. Non-compliance issues must be addressed with a corrective action plan within thirty (30) days of receipt for non-compliant standards.

The PAL will conduct a follow-up visit within ninety (90) days or until the office site is compliant. The Medical Director will review the EA part of the initial credentialing process. If any of the standards are not met, the Medical Director will assess the potential impact of the discrepancy to patient care and evaluate the corrective action plan. If the plan is reasonable, the practitioner will continue with the credentialing process. If the plan is not acceptable, the Medical Director may suggest a different corrective action plan or delay the credentialing process until the issue is resolved. If the office is not agreeable to correcting the identified problem, the information will be presented to the QI/UM committee for review. Special circumstances may be granted based upon size, geographic location of the practice, and potential harm to members. The PAL will communicate the final results to the practitioners.

An EA will not be conducted if a new practitioner joins an office site or if the practitioner relocates to an office that has already been reviewed and meets the Plan's standards. When credentialing a new practitioner who joins an existing office site, the documentation from that site visit for that office will be included in the new practitioners initial credentialing file prior to the QI/UM committee review. Site visits for relocated offices must be conducted prior to the practitioner's recredentialing date. The documentation of that site visit will be included in the recredentialing file.

PALs conduct site visits to assess practice compliance with the ADA and Section 504 of the Rehabilitation Act of 1973 for those practices as determined by DHS.

Primary Care Practitioner EA Standards

STANDARDS
Physical Accessibility/ADA Standards
1. Is there adequate parking available near the physician office?
2. Is handicapped parking available? (One (1) accessible space per every twenty-five (25) parking spaces.)
3. Are the accessible parking spaces clearly marked for people with disabilities?
4. Can person using a mobility aid (e.g. walker, scooter, or wheelchair) get from the accessible parking space to the office door?
5. Is there a wide enough (at least thirty-six (36) inch) ramp leading to the office?
6. Does the ramp have railings (if longer than six (6) feet)?
7. Are the patient entrance and exit clearly marked and unobstructed?
8. Are the hallways entrance/exits handicapped accessible?
9. If the office is not on the first or ground floor is there an elevator?
10. Is there a pathway through the provider's office wide enough for a person to maneuver a wheelchair?
11. Is the office, waiting room, restroom, and at least one exam room wheelchair accessible? (If not, are accommodations made for patients with mobility aids (e.g. walker, scooter, or wheelchair)?
12. Are there grab bars in the restroom?
13. Are the office hours displayed?
14. Are patient areas clearly marked as non-smoking?

STANDARDS

Accessibility

1. Is the waiting time to schedule a routine appointment less than or equal to ten (10) business days for Medicaid?
2. Is the waiting time to schedule a routine appointment less than or equal to fifteen (15) business days for Medicaid specialties: Dermatology, Orthopedic Surgery, Otolaryngology, Pediatric Allergy & Immunology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric General Surgery, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Pediatric Neurology, Pediatric Oncology, Pediatric Pulmonology, Pediatric Rehab Medicine, Pediatric Rheumatology, and Pediatric Urology?
3. Is the waiting time to schedule a preventive physical or first exam less than or equal to three (3) weeks of being placed on the practice's panel for Medicaid?
4. Is the waiting time to schedule an urgent care appointment less than or equal to twenty-four (24) hours?
5. Is the waiting time for an EPSDT screen for a new member less than or equal to forty-five (45) days?
6. Wait time in the waiting room is no longer than thirty (30) minutes or at any time no more than up to one hour when the physician encounters an unanticipated urgent medical visit or is treating a patient with a difficult need.
7. Does the practice have at least twenty (20) hours of patient scheduling per week per office? (N/A for Specialists)
8. Are there appointments on the schedule for emergencies?
9. Are emergent patients seen immediately or referred to an emergency facility?
10. The practice has physician coverage arrangements for vacations, etc.?
11. Is the waiting time for an appointment for a new patient diagnosed with HIV less than or equal to seven (7) days?
12. Is the waiting time for an appointment for SSI patients less than or equal to forty-five (45) days from date of enrollment?
13. Is the office able to perform EPSDT screens? (Offices whose panel limit is twenty-one (21) and under) Should the PCP be unable to conduct the necessary EPSDT screen, the PCP is responsible and willing to arrange to have the necessary EPSDT Screens conducted by another network practitioner and ensure that all relevant medical information, including the results of the EPSDT Screens, are incorporated into the member's PCP medical record.
14. Does the office have a recall system for patients who miss appointments and document in the medical record whether a postcard or telephone call was made? At least one attempt to contact the member must be made by telephone. At least three attempts must be made.
15. A physician is available twenty-four (24) hours a day, seven (7) days per week directly or through on-call arrangements for urgent or emergency care, and provides triage and appropriate treatment or referrals for treatment? This can be accomplished by answering machine or service.

Applicable for PCPs or Specialists Providing Prenatal Care

16. PCPs or Specialists providing Prenatal Care must be able to schedule a first trimester visit within ten (10) business days of the member being identified as being pregnant.
17. PCPs or Specialists providing Prenatal Care must be able to schedule a second trimester visit within five (5) business days of the member being identified as being pregnant.
18. PCPs or Specialists providing Prenatal Care must be able to schedule a third trimester visit within four (4) business days of the member being identified as being pregnant.
19. PCPs or Specialists providing Prenatal Care must be able to schedule an appointment for high-risk pregnancies within twenty-four (24) hours of the member being identified as a high-risk pregnancy or immediately if an emergency exists.

Medical Record Keeping
1. Are medical records maintained in a current and comprehensive fashion and d they confirm to standard medical practices? **2.** Are medical records protected from public access? **3.** Does the office have a written confidentiality policy that applies to all staff? **4.** Are records documented legibly? **5.** Does the office have an organized filing system for prompt retrieval of patient medical records? **6.** Is there a single medical record for each patient? (Family charts must clearly delineate individual records.) **7.** Do records identify the member on each page? **8.** Are all medically related patient phone calls documented in the medical record? **9.** Does the office recall missed appointments and make documentation in the medical record?
10. Is the allergy notation NKA visible in the same place on every record? **11.** Is the patient's history kept in the medical record? Is there a medical history in each patient report? **12.** Are there treatment/progress notes in each patient's record? **13.** Is there a problem list in the medical record? **14.** Is there a standard place in the medical record for preventive care/immunization information?

Highmark Wholecare requires all contracted PCPs to promptly see members who did not require or receive hospital emergency services for the symptoms prompting the attempted emergency room visit.

Hospital Services

Inpatient Admissions

In order for Highmark Wholecare to monitor the quality of care and utilization of services by our members, all Highmark Wholecare practitioners are required to obtain an authorization number for all hospital admissions and certain outpatient surgical procedures by submitting authorization requests electronically via NaviNet (Refer to Online Authorization section) or by contacting Highmark Wholecare's UM Department at 1-800-392-1147 in advance of services being rendered, except in urgent or emergent situations. In the event services are needed urgently and/or emergently, authorization must be requested no later than four (4) business days from arrival. Failure to obtain a timely authorization may result in the administrative denial of your claim without regard to medical necessity. Claims with an untimely authorization will be denied D170 - authorization not timely. This is not subject to appeal.

Highmark Wholecare will accept the PCP, ordering practitioner, or the attending practitioners request for an authorization of non-emergency hospital care; however, no party should assume the other has obtained authorization. Highmark Wholecare will also accept a call from the hospitals Utilization Review Department.

The UM representative refers to the Highmark Wholecare Medical Director if criteria or established guidelines are not met for medical necessity. The ordering practitioner is offered a peer review opportunity with the Highmark Wholecare Medical Director for all potential denial determinations.

Hospital Transfer Policy

When a Highmark Wholecare member requires hospitalization, Highmark Wholecare's policy is to have the service rendered in a Highmark Wholecare participating hospital. However, Highmark Wholecare recognizes that it may not be possible to follow this general policy when a member presents to the closest medical facility due to a medical emergency. When the medical condition of the member requires an admission to a non-participating hospital, the member will be transferred within twenty-four (24) hours of stabilization, when appropriate.

In order to determine that the member is medically stable for transfer the Highmark Wholecare UM staff will concurrently monitor the condition of the patient by communicating with the hospital's Utilization Review staff and the attending practitioner. Highmark Wholecare will coordinate all necessary transportation for the timely transfer of the member.

Outpatient Surgery Procedures

Highmark Wholecare practitioners may utilize a hospital's Short Procedure Unit (SPU) or Ambulatory Surgery Unit (ASU) for any authorized medically necessary procedure.

Medical necessity reviews may be required for certain procedures. To verify if authorization is required refer to the Code Lookup feature on NaviNet in advance of services being rendered, except in urgent or emergent situations.

In the event services are needed urgently and/or emergently, authorization must be requested within one business day from arrival. Please submit authorization requests electronically via NaviNet (refer to Online Authorization section) or call Highmark Wholecare's UM department. Claims with an untimely authorization will be denied D170-authorization not timely. This is not subject to appeal.

Emergency Room

The definition of an emergency is: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b) Serious impairment to bodily functions.
c) Serious dysfunction of any bodily organ or part.

The following conditions are examples of those most likely to require emergency treatment:

- Danger of losing life or limb.
- Poisoning.
- Chest pain and heart attack.
- Overdose of medicine or drug.
- Choking.
- Heavy bleeding.
- Car accidents.
- Possible broken bones.
- Loss of speech.
- Paralysis.
- Breathing problems.
- Seizures.
- Criminal attack (mugging or rape).
- Heart attack.
- Blackouts.
- Vomiting blood.

Highmark Wholecare members have been informed, through the Member Handbook, of general instances when emergency care is typically not needed. These are as follows:

- Cold.
- Sore throat.
- Small cuts and burns.
- Ear ache.
- Vomiting.
- Rash.
- Bruises.
- Swelling.
- Cramps.
- Cough.

In all instances, when a member presents to an emergency room for diagnosis and treatment of an illness or injury, the hospital's pre-established guidelines allow for the triage of illness and injury.

All follow-up care after an emergency room visit must be coordinated through the PCP. Members are informed via the Member Handbook to contact their PCP for a referral for follow-up care in instances such as:

- Removal of stitches.
- Cast check.
- Changing of bandages.
- Further testing.

Ambulance Services

Emergent transportation (302 or 911), including air ambulance, does not require authorization by Highmark Wholecare. Highmark Wholecare considers emergent transportation as transportation that allows immediate access to medical or behavioral healthcare and without such access could precipitate a medical or a behavioral health crisis for the patient. Either a participating or non-participating ambulance provider may render 302 or 911 transportation without an authorization from Highmark Wholecare.

Highmark Wholecare also considers the following situations emergent, and thus **does not require authorization**:

- ER to ER.
- ER to Acute Care or Behavioral Health Facility.
- Acute Care to Acute Care or Behavioral Health Facility.
- Hospital-to-Hospital, when a patient is being discharged from one hospital and being admitted to another.

Providers should bill the above types of transports with the appropriate non-emergent, basic life support code and the modifier HH.

Authorization for non-emergent ambulance transportation is not required by Highmark Wholecare's UM department in advance of services being rendered. Highmark Wholecare considers non-emergent transportation as transportation for a patient that does not require immediate access to medical or behavioral healthcare and/or if not provided would not result in a medical or a behavioral health crisis as non-emergent. Non-emergent transportation may include the following scenarios:

- Ambulance transports from one facility to another when the member is expected to remain at the receiving facility, which may include the following:
  - Hospital to SNF.
  - SNF to hospital (non-emergent).
  - Hospital to rehabilitation facility.
  - Rehabilitation facility to hospital (non-emergent).
- Ambulance transport to home upon discharge.
- Ambulance transport from home to a PCP office.

A Highmark Wholecare participating ambulance provider should be contacted to render non-emergent transportation when possible. Non-participating non-emergent ambulance trips would require authorization.

Ambulance transportation from one facility to another for diagnostic testing or services not available at the current facility, with the expectation of the member returning to the original facility upon completion of service, is the responsibility of the originating facility and does not require an authorization from Highmark Wholecare. The originating facility should assume the cost for this type of transport even if for unforeseen circumstances, the member remains at the receiving facility. The originating facility may contact any ambulance service of their choosing to provide transport in this scenario only.

Members who need non-emergency medical transportation services in order to secure medical care provided under the MA program should call the MA Transportation Program (MATP) in their county to see if they qualify. They can find the information about the county programs at MATP at http://matp.pa.gov.

Important Reminders Regarding the Submission of Implant Invoices

In an effort to assist providers in receiving appropriate compensation for implant services and/or high cost pharmaceuticals, it is imperative that providers abide by the following claim and invoice submission guidelines when submitting their claims for reimbursement.

Outlined below are some important reminders and steps that are often overlooked which can lead to delayed payments and claim denials for implant services and/or high cost pharmaceuticals.

When submitting an implant services claim and/or high cost pharmaceuticals, Highmark Wholecare asks that providers follow the important guidelines noted below:

- The original claim must be submitted timely and services must be billed in accordance with the facilities contract terms.
    - Please ensure the patients name and ID number are on every page associated with the claim that needs to be paid.
    - Please circle the number of units and cost associated with the services to be paid and provide a breakdown of the costs if necessary.
- Providers may fax the implant and/or high cost pharmaceuticals invoice to 1-844-207-0334 for processing. When submitting via fax, please include the following:
    - The fax cover sheet must include the phrase “Implant Invoice Claim” or “High Cost Pharmaceuticals” in the subject line.
    - A copy of both the claim and the invoice must be included in the fax.
    - A copy of the packing slip with the patient name circled should also be included.

Highmark Wholecare would like to take this opportunity to provide some additional reminders to facilities when submitting claims that include implant invoices:

- All claims, including implant invoices are subject to timely filing and follow up guidelines as well as the Highmark Wholecare coding edits.
- Providers MUST follow the appeals process if it is felt that the denial of the claim is Incorrect.
- If the surgery is denied, the implant charges will also be denied.
- Date of service, billed charges, etc. must match that of the invoice.
- Providers should expect to receive payment within approximately forty (40) days after submission of a clean claim and invoice. Provider Services can provide assistance with inquires on those claims and invoices that have been submitted but have received no response.

If there are any questions regarding this process, please do not hesitate to contact Provider Services.

Continuity and Coordination of Care

Specialists, hospital, and skilled nursing facilities must ensure compliance with the continuity and coordination of care requirements, by ensuring that all discharge summaries and progress reports are reported back to the members PCP. Highmark Wholecare monitors continuity and coordination of medical care across the health care network through data collection. Results of data collection helps identify where opportunities exist to improve care.

Coordination of medical care includes the movement of members between settings, such as the hospital to PCP as their health status changes and movement between practitioners such as the PCP and specialists.

Much of Highmark Wholecare's membership is made up of the most vulnerable individuals – some of whom suffer from severe or chronic illnesses. Enhanced communication is imperative across all the touch-points within these patients' care in order to make the informed decisions which will ensure their well-being. Failure to share information about the care of a patient can result in suboptimal outcomes, increased costs, and medical errors.

It is to the benefit of both the patient and healthcare professional to communicate any reports, therapies, medications, and concerns identified by providers across treatment settings.

DRG Post-Payment Audits

Our Company or a subcontractor, conducts monthly post-payment reviews of inpatient claims to verify the accuracy of DRG payments.

For reviews conducted by our subcontractors, you should expect the following:

- You will receive a letter requesting records for specific paid claims.
- You will have thirty (30) calendar days to provide the requested medical records for review.
- Failure to submit the requested records may result in an administrative denial by our Company and recoupment of the original payment.
- You will receive a determination letter from our subcontractor describing the outcome of the medical records and claim review.
- You will have thirty (30) calendar days to either accept the subcontractor's findings or request a reevaluation by providing supporting information for the paid claims to the subcontractor.
- If you disagree with the delegate reevaluation, our Medical Director can review your supporting information to make a final determination.
- If you do not respond to these notifications, we will proceed with a payment adjustment. Questions should be directed to our FWA Unit by calling 1-844-718-6400.

Technical Denials

Technical Denial determinations are not subject to reconsideration and further appeals, but may be subject to re-review/reopening. These types of denials include:

- Medical record not being submitted timely (42 CFR 476.90(b)); and
- Billing errors (including cost outlier denials due to duplicative billing for services or for services not actually furnished or not ordered by the physician.

You will receive correspondence from our Company indicating the specific claims and required documents required for review. If you do not respond to these notifications, we will proceed with a payment adjustment.

Questions regarding Technical Denials should be directed to our FWA Unit by calling 1-844-718-6400.

Referrals and Authorizations

Referrals

Referrals are not required for services rendered by participating providers. The PCP is responsible for the coordination of a member's healthcare needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other healthcare services. To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member's designated PCP.

All Highmark Wholecare UM prior-authorization requirements remain in place. Examples include but are not limited to:

- ✓ Advanced imaging services (requires NIA prior-authorization).
- ✓ Therapies (requires NIA prior-authorization).
- ✓ Chiropractic visits.
- ✓ Out of network requests.
- ✓ Interventional spine pain management procedures and MSK surgeries (requires NIA prior- authorization).
- ✓ Chemotherapeutic drugs, symptom management drugs and supportive agents, and radiation therapy drugs (requires Oncology Analytics prior-authorization).

Please be sure to check the prior-authorization procedure code search tool, available within NaviNet, to confirm if the service requires prior authorization.

***IMPORTANT NOTE:** Highmark Wholecare reserves the right to reinstate the referral requirements if any untoward increase in over utilization of these services is observed.

As of February 1, 2022, Highmark Wholecare Medicaid members are required to have all of their outpatient laboratory work completed through the appropriate PCP designated lab. Failure to do so will result in non-payment of services. Referrals can no longer be granted. We will honor existing referrals until January 31, 2022. As a reminder, members cannot be billed for covered services.

The PCP is required to select a designated laboratory based upon the office's location and the lab used most frequently. Should you wish to change your laboratory, please complete the Provider Change Request form located on our website at:
https://highmarkwholecare.com/Portals/8/provider_forms/Practice%20Change%20Request%20Form.pdf.

The PCP's designated laboratory is listed on the member's Highmark Wholecare ID card and on Highmark Wholecare's on-line provider directory located at Highmark Wholecare Provider Directory. Go to Medicaid, then follow the remaining steps. Or, utilize the Eligibility and Benefits feature on NaviNet or contact Provider Services at 1-800-392-1147.

Additional information:
Laboratory testing for Rh incompatibility during pregnancy (related to Rhogam treatment) can be conducted at any participating laboratory.

All other requirements remain the same.

Note: Genetic testing requires prior authorization.

Authorizations allow Highmark Wholecare to confirm:

- Eligibility of the member prior to receiving services.
- To assess the medical necessity and appropriateness of care.
- To establish the appropriate site for care.
- To identify those members who would benefit from care management.

For the following services, members can self-refer:

- OB/GYN Services.
- Family planning services (family planning services do not have to be rendered by a participating provider).
- Dental services.
- Routine vision.
- Chiropractic services (a prior-authorization must be obtained by the chiropractic office, including the initial evaluation).
- Mental health/substance abuse services (covered by the BH-MCO).

Out-of-Plan Referrals

Occasionally, a member may need to see a healthcare provider outside of Highmark Wholecare's provider network. When the need for out-of-plan services arises, the PCP must contact the UM department to obtain an authorization prior to making the referral and prior to services being rendered. The UM department will review the request and make arrangements for the member to receive the necessary medical services with an appropriate provider in collaboration with the recommendations of the PCP and for as long as the Plan is unable to provide the service with a participating, in-network provider. Every effort will be made to locate a healthcare provider within an accessible distance to the member. If the Plan makes arrangements for the member to receive out-of-network services, it will coordinate payment to ensure that the cost to the member is no greater than it would be if the service was furnished in-network.

Referrals for Second Opinions

Highmark Wholecare ensures member access to second opinions. Second opinions may be requested by Highmark Wholecare, the member, or the PCP. Highmark Wholecare will provide for a second opinion from a qualified health care provider within the network or arrange for the member to obtain one outside the network, at no more cost to the member than if the service was provided in-network. The second opinion specialist must not be in the same practice as the attending physician and must be a participating provider of Highmark Wholecare. A referral form is not required for in-network second opinion specialist visits. Out-of-network referrals may be authorized when no participating provider is accessible to the member or when no participating provider can meet the member's needs.

Referrals for Second Surgical Opinions

Second surgical opinions may be requested by Highmark Wholecare, the member, or the PCP. When requesting a second surgical opinion consultation, Highmark Wholecare recommends that you refer to a consulting practitioner who is in a practice other than that of the attending practitioner, or the practitioner who rendered the first opinion and possesses a different tax identification number than the attending practitioner. Highmark Wholecare provides for second opinions from an in-network provider or arranges for the member to obtain a second opinion outside of the network, at no more cost to the member than if the service was obtained in-network.

Specialty Care Practitioners

Referrals are not required for services rendered by participating providers. The PCP is responsible for the coordination of a member's healthcare needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other healthcare services. To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member's designated PCP.

All Highmark Wholecare UM prior-authorization requirements remain in place. Examples include but are not limited to:

- Advanced imaging services (requires NIA prior-authorization).
- Therapies (requires NIA prior-authorization).
- Chiropractic visits.
- Out of network requests.
- Interventional spine pain management procedures and MSK surgeries (requires NIA prior-authorization).
- Chemotherapeutic drugs, symptom management drugs and supportive agents, and radiation therapy drugs (requires Oncology Analytics prior-authorization).

Please be sure to check the Prior-Authorization procedure code search tool, available within NaviNet, to confirm if the service requires prior authorization.

*IMPORTANT NOTE: Highmark Wholecare reserves the right to reinstate the referral requirements if any untoward increase in over utilization of these services is observed.

As of February 1, 2022, Highmark Wholecare Medicaid members are required to have all of their outpatient laboratory work completed through the appropriate PCP designated lab. Failure to do so will result in non-payment of services. Referrals can no longer be granted. We will honor existing referrals until January 31, 2022. As a reminder, members cannot be billed for covered services.

The PCP is required to select a designated laboratory based upon the office's location and the lab used most frequently. Should you wish to change your laboratory, please complete the Provider Change Request form located on our website at:
https://highmarkwholecare.com/Portals/8/provider_forms/Practice%20Change%20Request%20Form.pdf.

The PCP's designated laboratory is listed on the member's Highmark Wholecare ID card and on Highmark Wholecare's on-line provider directory located at Highmark Wholecare Provider Directory. Go to Medicaid, then follow the remaining steps. Or, utilize the Eligibility and Benefits feature on NaviNet or contact Provider Services at 1-800-392-1147.

Additional information:
Laboratory testing for Rh incompatibility during pregnancy (related to Rhogam treatment) can be conducted at any participating laboratory.

All other requirements remain the same.

Note: Genetic testing requires prior authorization.

Since specialists cannot refer members to other specialists, the PCP must refer the member to another specialist. If a specialist recommends that the patient should be seen by another specialty care practitioner, the specialist must contact the PCP, and the PCP may then examine the patient and/or review the consult report prior to referring the patient to another specialist. In unusual situations, the specialist or PCP may contact Highmark Wholecare's UM department at 1-800-392-1147.

Renal Dialysis Services

If renal dialysis services are provided by a non-network provider, then an authorization is required; in addition to a referral from the PCP.

In-home renal dialysis services require an authorization from Highmark Wholecare's UM department.

Audiology

Highmark Wholecare members under the age of twenty-one (21) are eligible to receive audiology services including hearing aids and ear molds. Services must be provided by a participating, licensed practitioner, licensed audiologist, or an outpatient hospital clinic. Prior to dispensing aids and/or ear molds, the audiology practitioner must obtain authorization. Reimbursement rates for hearing aids, ear molds, repair parts, and any specialty items not covered on the MA Fee Schedule should be negotiated at the time of authorization, prior to rendering services.

Self-Referral

Members may refer themselves for the following types of care:

Dental

When a member joins Highmark Wholecare, the member may self-refer to any participating United Concordia Dental dentist directly without a referral from the PCP. Should specialty dental care be needed, the dentist can refer the member to a dental specialist.

Certain oral surgery procedures, such as removal of partial or total bony impacted wisdom teeth, and procedures which involve cutting of the jaw, are covered by Highmark Wholecare through Highmark Wholecare's panel of oral surgery providers. Members requiring these services must be referred by their PCP to a Highmark Wholecare participating oral surgeon. The primary care dentist may need to provide x- rays or other information to the PCP to facilitate the referral. The oral surgeon is responsible for authorizing surgical procedures with Highmark Wholecare prior to rendering the service (procedures provided in the oral surgeon's office are not subject to the authorization process). When a dental procedure requires the use of a Special Procedures Unit (SPU), the dental provider must contact United Concordia Dental for authorization prior to the services being rendered.

Emergency

Members are informed through the Member Handbook how and when to utilize emergency services.

Eye Examinations

Highmark Wholecare members may self-refer to any Davis Vision participating provider for a routine eye exam. Corrective lenses and frames may be obtained through any participating optician, optometrist, or ophthalmologist. Should the member require additional medical services, rendered by a participating ophthalmologist or optometrist, the member should coordinate with the PCP.

Mental Health/Substance Abuse

Members are permitted to self-refer for mental health and substance abuse services. Please refer to the Quick Reference section of this manual for the telephone numbers for members to call.

OB/GYN Services

Female Highmark Wholecare members may self-refer to any participating OB/GYN for any condition, not just for an annual exam or suspected pregnancy. When a member self-refers to the OB/GYN's office, the OB/GYNs office is required to verify eligibility of the member.

Standing Referrals

Highmark Wholecare allows for a standing referral to a specialist for sixty (60) days or to serve as a PCP in certain pre-authorized situations. The specialist must be an existing Highmark Wholecare practitioner, must be agreeable to following Highmark Wholecare's requirements for acting as a PCP, and must receive prior authorization by Highmark Wholecare's Medical Director. Practitioners interested in obtaining more information regarding this process should contact Provider Services at 1-800-392-1147.

Authorization Process

The function of an authorization is to confirm the eligibility of the member, verify coverage of services, assess the medical necessity and appropriateness of care, establish the appropriate site for care, and identify those members who would benefit from care management or disease management. Highmark Wholecare's UM department assesses the medical appropriateness of services using McKesson's InterQual Procedure Criteria, approval criteria based on a Medical Directors review of the latest medical literature and citations, and DHS/HealthChoices definition of medical necessity when authorizing the delivery of healthcare services to plan members.

The definition of medical necessity is:
A service or benefit is medically necessary if it is compensable under the MA program and if it meets any one of the following standards:

- The service, item, procedure or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.
- The service, item, procedure or level of care will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability.
- The service, item, procedure, or level of care will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing.
The determination is based on medical information provided by the member, the member's family/caretaker and the PCP, as well as any other providers, programs, or agencies that have evaluated the member.

All such determinations must be made by qualified and trained healthcare providers. A healthcare provider who makes such determinations of medical necessity is not considered to be providing a healthcare service under this agreement.

Requesting Precertification

The UM department is committed to assuring prompt, efficient delivery of healthcare services and to monitor quality of care provided to Highmark Wholecare members. Authorization is the responsibility of the admitting practitioner or ordering provider and can be obtained by submitting requests electronically (refer to Online Authorizations below) or by calling Highmark Wholecare's UM department at 1-800-392- 1147. If a service requires authorization and is being requested by a participating specialist, the specialist's office must call Highmark Wholecare to authorize the service. Hospitals may verify authorization by calling the Highmark Wholecare UM department.

When an authorization request is received, the information will be reviewed, and the member's eligibility verified. However, since a member's eligibility may change prior to the anticipated date of service, eligibility must be verified on the date of service.

If an authorized service is not able to be approved as proposed by the practitioner, alternate programs such as home healthcare, rehabilitation, or additional outpatient services may be suggested to the practitioner by the UM staff. If an agreement cannot be reached between the practitioner and the UM staff, the case will be referred to a Highmark Wholecare Medical Director for review. If the request is denied, a practitioner may appeal the decision. Please refer to the Practitioner Complaints and Grievances section of this manual for the process to appeal a decision.

The following services require a prior authorization from Highmark Wholecare or have a payment policy applied:

- Inpatient Admissions.
  - Hospital inpatient admissions.
  - All other inpatient admissions (e.g. acute, skilled nursing facility, and rehabilitation).
- Outpatient Services.
  - Potentially experimental, investigational, or cosmetic services.
  - DME and any non-standard (i.e. deluxe) DME.
  - Outpatient therapies (physical, occupational, speech- NIA) excluding evaluations.
  - Chiropractic.
  - Home health care.
  - Prosthetics.
  - Hospice.
  - Transplantation services.
  - Radiology management (NIA).
  - Sleep, Cardiology, and Radiation Oncology for members over eighteen (18) (HealthHelp).
  - Other covered procedures/codes.
- Non-Covered Benefits/Procedures.
  - Non-covered benefits will not be paid unless special circumstances exist. Always review member benefits to determine covered and non-covered services.

Authorization does not guarantee payment of claims. A service or supply will be reimbursed by Highmark Wholecare only if it is medically necessary, a covered service, and provided to an eligible member. The authorization process continues to be subject to the maximum unit and program exception policies.

Online Authorization

Highmark Wholecare providers now have the capability to submit authorization requests electronically via NaviNet for the following services:

- SNF admission and continued stay review – Medicaid only.
- Acute inpatient admission and continued stay review.
- Notification of discharge (acute IP discharge).
- Behavior health admission/psychology – Medicare only.
- Behavior health substance abuse admission/ review – Medicare only.
- Behavior health discharge – Medicare only.
- Behavior health outpatient requests – Medicare only.
- Chiropractic visits.
- DME requests.
- Obstetrical needs assessment form (ONAF)..
- Private Duty Nurse (PDN) standard Letter of Medical Necessity (LOMN) – Medicaid only.
- Rehab admission and continued stay review – Medicaid only.

Letters of Medical Necessity – Medicaid

- Discuss the need for a LOMN with the UM representative.
- LOMN can be faxed with any other supporting documentation such as progress notes, testing results or consultations by specialists.
- LOMN should be submitted by the appropriate licensed healthcare professional such as MD, DO, CRNP, NP, or PA (not all inclusive).
- LOMNs can be submitted for new and ongoing requests for services.
- LOMNs should outline the service requested, the setting, quantity, and duration of the service or item requested.
- LOMNs may outline the members overall condition and needs as well as any recent or expected changes to the members overall condition.
    - Explain why the service or item is medically necessary.
        - How the service or item may prevent onset of an illness, condition, or disability.
        - How the service or item may reduce or ameliorate the physical, mental, or developmental effects of the illness, injury, or disability.
        - How the service will assist the member to achieve or maintain maximum functional capacity in performing activities of daily living.
        - The member's functional capacity and the functional capacities that appropriate for members of the same age.
- Members receiving pediatric shift care services should have a new LOMN annually.
- Requests for admissions to a skilled facility for members under age twenty-one (21) should explain why the needed care cannot be provided in the home setting.

Note: You will be able to initiate authorization requests by selecting Highmark Wholecare under My Health Plans after logging in to NaviNet. Next, you'll select Authorization Submission from the Authorization Submission fly-out menu. Complete the Selection Form by filling in the patient's information and selecting the appropriate category.

Highmark Wholecare has enhanced the functionality of the electronic authorization feature of the Provider Portal to improve efficiency and by eliminating unnecessary requests for prior authorizations. You can now easily enter the procedure code(s) for the service(s) being requested to determine if a prior authorization is required.

Calling UM

The UM department can be contacted at 1-800-392-1147 between the hours of 8:30 AM and 4:30 PM, Monday through Friday. When calling before or after operating hours or on holidays, practitioners are asked to leave a voicemail message and an UM Representative will return the call the next business day. Prior authorization is required for scheduled or elective care prior to services being rendered. In the event of urgent or emergent services, the practitioner must notify the plan within four (4) business days from arrival.

The following information is needed to authorize a service. Please have this information available before placing a call to the UM department:

1. Member name.
2. Member's eight (8) digit Highmark Wholecare ID number.
3. Diagnosis (ICD Code or precise terminology).
4. Procedure code (CPT-4, HCPCS, or MA coding) or billing codes for DME requests.
5. Treatment plan.
6. Date of service.
7. Name of admitting/treating practitioner.
8. Name of the practitioner/provider requesting the authorized treatment.
9. NPI.
10. History of the current illness and treatments.
11. Any other pertinent clinical information.

Failure to follow the prior authorization process may result in the administrative denial of your claim regardless of medical necessity, except in the case of emergently provided services where you attempted to authorize services within four (4) business days from the admission. It is the responsibility of the provider to submit a request for a retrospective authorization when outside of their control, an authorization was not obtained. Along with the authorization the provider must submit justification as to why an authorization was not requested such as the member was incapacitated, the member provided the wrong insurance information at the time of service, or the procedure meets the definition of requiring emergency stabilization along with all relevant medical records to:

Highmark Wholecare Attention: Retrospective Authorization
P.O. Box 22278 Pittsburgh, PA 15222
Or by
Fax to: 1-855-501-3904

Outpatient Imaging Services

Requests for select outpatient radiological services require prior authorization. Prior authorization required for the following outpatient imaging procedures:

- CT/CTA.
- CCTA.
- MRI/MRA.
- PET scan.
- Nuclear cardiology/MPI.
- Muga scan.
- Stress echocardiography.

The ordering physician can obtain prior authorization through the NIA Magellan website at www.RadMD.com or by calling into the dedicated toll-free phone number, Monday through Friday 8:00 AM to 8:00 PM at 1-800-424-4890. A separate authorization number is required for each procedure ordered.

Chiropractic Services

Any participating practitioner must request prior authorization for chiropractic services by calling Highmark Wholecare's UM department at 1-800-392-1147. All visits require authorization by Highmark Wholecare and must be medically necessary. Member eligibility must be verified prior to rendering services by calling the Member Eligibility Verification Line at 1-800-642-3515. Members may self-refer for chiropractic services; however, the chiropractic office must call Highmark Wholecare for authorization including the initial evaluation.

All course of treatments are subject to medical necessity determination based on Highmark Wholecare's' criteria guidelines. All chiropractic services requested for children under the age of thirteen are referred to Highmark Wholecare's Medical Director for review. Only one (1) visit per day can be authorized.

Participating chiropractors may not render radiological services in the office. X-rays may only be done at a Highmark Wholecare participating facility, and no authorization will be given for these services to be done in a chiropractic office setting. Members requiring radiological services (including CT or MRI) or other diagnostic testing should be referred back to their PCP.

Durable Medical Equipment (DME)

Highmark Wholecare members are eligible to receive any covered and medically necessary DME. When ordering DME, these procedures are followed:

- An authorization by UM is always required for any item not covered by MA, services provided by non-participating DME vendor, or when a miscellaneous code is requested.
- Due to frequent interruptions of Pennsylvania MA coverage, Highmark Wholecare strongly recommends that all providers verify eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.
- All medical supplies including wound care, ostomy, enteral products, diapers, and incontinence products must be obtained through a contracted DME vendor as opposed to a participating pharmacy.
- Oral enterals must be obtained through a participating DME provider. Please do not direct members to retail pharmacies such as Giant Eagle, Rite Aid, etc. for these services.
- Incontinence items will be covered by Highmark Wholecare without requesting an EOB from any other plan.

The following information will provide assistance to offices when ordering DME services:

- Patient name, Highmark Wholecare ID number, prior authorization number (if applicable).
- DME vendor/provider NPI number.
- Ordering practitioner/provider, including NPI number.
- Diagnosis.
- Name of requested equipment, MA fee schedule code, cost.
- Indicate purchase or a rental request.
- Amount of items requested—over what period of time (if requesting rental).
- Clinical information to support the request.

To request a precertification for DME, please call Highmark Wholecare's UM department at 1-800-392- 1147.

Skilled Nursing Facility

Should a member need admission to a nursing facility, the PCP, attending practitioner, hospital Utilization Review Department, or the nursing facility must contact the Highmark Wholecare UM department at 1-800-392-1147 for new requests to obtain prior authorization. Highmark Wholecare will coordinate the necessary arrangements between the PCP and the nursing facility to provide the member with continuity and coordination of care.

At the time the SNF services are approved, the Highmark Wholecare UM reviewer will provide the name, phone, and fax number of the PCP in order to fax any discharge instructions to ensure coordination of discharge services.

Outpatient Therapy Services

All Outpatient Therapy treatment services including physical therapy, occupational therapy, and speech therapy, cardiac and pulmonary rehab require a prior authorization. Outpatient therapy services will request prior authorization through the NIA Magellan's website at www.RadMD.com or by calling into the dedicated toll-free phone number, Monday through Friday 8:00 AM to 8:00 PM at 1-800-424-4890. A separate authorization number is required for each procedure ordered. The therapy provider will be asked to fax the current progress notes, plan of treatment, and goals, which support the medical necessity of the therapy services.

In keeping with our commitment of promoting continuous quality improvement for services provided to Highmark Wholecare members, Highmark Wholecare has entered into an agreement with Magellan Healthcare to implement a MSK Management Program. This program includes prior authorization for non-emergent MSK procedures including: outpatient, interventional spine pain management services (IPM); and inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries and you would call NIA at the same number above.

Acute Inpatient Rehabilitation Facility

Should a member need admission to an Acute Inpatient Rehabilitation Facility, the PCP, attending practitioner, hospital Utilization Review Department, or the rehabilitation facility must contact the

Highmark Wholecare UM department at 1-800-392-1147 for new requests for a prior authorization. For ongoing reviews, contact your assigned reviewer.

Pediatric Shift Care Services

Highmark Wholecare's UM Department staff coordinate medically necessary shift care services for members under twenty-one (21) years of age with the ordering practitioner and the home healthcare provider through prior authorization.

Should a member need shift care services, the members PCP or a specialist rendering care to the member may submit a letter of medical necessity to Highmark Wholecare's Special Needs Unit Case Management via fax 1-888-245-2071 or email CMDeptDocs@HighmarkWholecare.com.

The following information will provide assistance to physicians when ordering shift care services:

- Specify the level of care being requested.
- Specify hours per day being requested and schedule.
- Outline care the member requires assistance with during hours services are being requested.
- Summary of the members past medical history including review of current conditions driving need for shift care services, along with prognosis and treatment plan.

- Outline of all caregiver's supporting the member's care.
- If caregiver's ability to render care is limited, detail, and provide documentation.
- If a caregiver's availability to render care is limited, detail and provide documentation.
- Caregiver work verification, if known.

Shift Care Case Managers can be reached at-1-800-392-1147 to answer questions. Follow the prompts to the SNU, Private Duty Team. Case Managers can be contacted between the hours of 8:30 AM and 4:30 PM, Monday through Friday.

Home Infusion

Nursing visits and supplies related to home infusion services do not require an authorization. Refer to the formulary regarding authorization requirements for infusion drugs.

Hospice Services

Should a member need hospice services including home hospice, inpatient hospice, continuous care, and respite, the PCP, attending physician, or hospice agency should contact Highmark Wholecare's UM department. Highmark Wholecare will coordinate the necessary arrangements between the PCP and the hospice provider in order to assure continuity and coordination of care.

Due to frequent interruptions of Pennsylvania MA coverage, Highmark Wholecare strongly recommends verification of eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.

New Technology

Any new technology identified during the UM review process, requiring authorization for implementation of the new technology will be forwarded to the Medical Director for authorization. If there is a question about the appropriate governmental agency approval of the technology, the Medical Director will investigate the status of the technology with the agency, consult appropriate specialists related to the new technology, and/or utilize the contracted services of Hayes, Inc. for information related to the new technology. If the technology has not been approved by the appropriate governmental regulatory bodies, the Medical Director will discuss the need for the specifically requested technology with the PCP and may consult with a participating specialist from the Highmark Wholecare expert panel regarding the use of the new technology.

If it is determined that no other approved technology is available and/or the Medical Director and consultants feel that the possibility for a positive outcome would be achieved with the use of the new technology, approval may be given with the stipulation that the provider obtain the necessary signatures from the member needed for any investigational treatment/procedures.

Claims and Billing

Member Billing Policy

As outlined in the Pennsylvania DHS MA bulletin 99-99-06 entitled Payment in Full. Providers requiring Medicaid recipients to make cash payment for Medicaid covered services or refusal to provide medically necessary services to a Medicaid recipient for lack of pre-payment for such services are illegal and contrary to the participation requirements of the Pennsylvania MA program. Payment by the Plan is considered payment in full. Under no circumstance, including but not limited to non-payment by Highmark Wholecare for approved services, may a provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Highmark Wholecare member.

As outlined in the Pennsylvania DHS MA Bulletin 99-10-14 entitled Missed Appointments, MA providers are prohibited from billing MA recipients for missed appointments, also known as No Show.

Refer to the Benefits and Special Services section of this manual for information on copayments. Members cannot be denied a service if they are unable to pay their copayment. The provider must provide the service and then bill the Member for the copayment. Members are responsible up to a maximum of ninety dollars ($90) for adult MA and one hundred eighty ($180) for adult GA every six (6) months. The plan will reimburse the member for any applicable copays based upon claims submission that exceed the maximum from January through June and again from July through December of each year.

This provision shall not prohibit collection of copayments on the Plans' behalf made in accordance with the terms of the enrollment agreement between the Plan and the member/subscriber/enrollee.

Practitioners may directly bill members for non-covered services; provided, however, that prior to the provision of such non-covered services, the practitioner must inform the member:

- Of the service(s) to be provided.
- That the Plan will not pay for or be liable for said services.
- Of the member's rights to appeal an adverse coverage decision as fully set forth in the Provider Manual.
- Absent a successful appeal, that member will be financially liable for such services.

Claims

New Technology Including a New Claims Processing and Clinical Platform
GateTech is an operations and technology transformation initiative, which was implemented in October 2021.

GateTech brings efficiencies to claims processing by implementing a modernized claims system and changes how we review and process UM prior-authorizations.

What has changed for providers?

- Streamlined claims processing.
- Simplified authorization processing and resolution.
- Enhanced call servicing experience.
- Improved provider portal capabilities.

General Information

Procedures for Highmark Wholecare are as follows:

- Payment for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes are covered to the extent that they are recognized by MA Correct coding (procedure, diagnosis, HCPCS) must be submitted for each service rendered. We utilize Centers for Medicare and Medicaid Services (CMS) place of service codes to process claims and they are the only place of service codes that are accepted.
- Our company will add new codes to the respective fee schedules effective the first of the month upon receipt of notification from DHS. The new fees/rates will be loaded into the Claims system for payment within thirty days (30) from the notification. If a provider would like the new rate considered, it is the providers' responsibility to resubmit a corrected claim with the appropriate coding within the timely allowance. Retroactive payments are not made to the provider.
- Institutional/Hospital providers should bill on an original UB-04 claim form, and Professional/Physician, including ancillary providers, should bill using an original CMS-1500 claim form. Both paper and electronic claims are accepted.
- Claims are accepted through Electronic Data Interchange (EDI). Facilities and providers are encouraged to submit claims via this format.
- Paper and EDI claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form. Paper claims will be handled just like rejected EDI claims and will not be loaded the claims system. Providers will be held to timely filing policies in regards to submission of the initial and corrected claims
- Correct/current practitioner information, including our company provider ID number, must be entered on all claims.
- Correct/current member information, including the eight(8)-digit member ID number, must be entered on all claims.
- Outpatient drug claims billed by dispensing prescribers must include correct and applicable National Drug Codes (NDCs) and units on the claim.
- Please allow four (4) to six (6) weeks for a remittance advice. It is the practitioner's responsibility to research the status of a claim.
- Hand written claims are not accepted.
- Payment by the plan is considered payment in full. In no circumstance, including but not limited to non-payment by the plan for non-approved services may a practitioner bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Highmark Wholecare member.
- Our company is the payer of last resort when any commercial or Medicare plan covers the member. We are obligated to process claims involving auto insurance or casualty services as the primary payer if bills do not include a notation or payment by any insurance that is not a commercial or Medicare plan. Claims must be submitted within timely filing guidelines.
- Any reimbursement or coding changes made by DHS to its current inpatient and outpatient fee schedules shall be implemented by the plan the month upon receipt of notification from DHS. There will be no adjustments made to previously processed claims due to any retroactive change implemented by DHS.
- Terminated providers must agree to meet the same terms and conditions as participating Providers to be eligible for payment for services provided to a member.

- Effective with dates of service on or after January 1, 2020 our Medicaid product line will no longer require referrals for most services rendered by participating providers. As of February 1, 2022, Highmark Wholecare Medicaid members are required to have all of their outpatient laboratory work completed through the appropriate PCP designated lab. Failure to do so will result in non-payment of services. Referrals can no longer be granted. We will honor existing referrals until January 31, 2022. As a reminder, members cannot be billed for covered services.

Timely filing criteria for original claims are one hundred eighty (180) calendar days from the date of service. Corrected claims or requests for review are considered if information is submitted within three hundred sixty-five (365) calendar days from the earliest date of service on the claim.

Provider Claims Educator

The Plan employs a Provider Claims Educator who is located in Pennsylvania and facilitates the exchange of information between the Grievances, Claims Processing, and Provider Relations systems. The primary functions of the Provider Claims Educator are to:

- Educate contracted and non-contracted providers regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available PH-MCO (Highmark Wholecare) resources such as provide manuals, website, fee schedules, etc.
- Interface with the Plan's call center to compile, analyze, and disseminate information from provider calls.
- Identify trends and guide the development and implementation of strategies to improve provider satisfaction.
- Communicate frequently (i.e., telephonic and on-site) with providers to provide for the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.

To request to speak with the Plan's Provider Claims Educator dial 1-800-392-1147.

Timely Filing

Practitioners must submit a complete original, initial CMS-1500 or UB-04 claims form within one hundred eighty (180) calendar days from the date of service. Claims are accepted through Electronic Data Interchange (EDI). Facilities and providers are encouraged to submit claims via this format. If you bill on paper, we will only accept paper claims on a CMS-1500, or a UB-04 claim forms. No other billing forms will be accepted. Paper claims that are not received on original forms with red ink may delay final processing as original forms are required for every claim submission.

Practitioners must bill within sixty (60) days from the date of an EOB from the primary carrier when Highmark Wholecare is secondary. An original bill along with a copy of the EOB is required to process the claim.

Corrected claims or requests for review are considered if information is submitted within three hundred sixty-five (365) calendar days from the earliest date of service on the claim. Claims submitted after these deadlines will be denied for untimely filing.

Any claim that has been submitted to our company but does not appear on a remittance advice within sixty (60) days following submission should be researched by the practitioner. Claims status inquiries can be researched via NaviNet.

Exceptions to timely filing criteria are evaluated upon receipt of documentation supporting the request for the exception. Upon approval, exceptions are granted on a one-time basis, and the claim system is noted accordingly.

Electronic Claims Submission

Claims are accepted through Electronic Data Interchange (EDI). Facilities and providers are encouraged to submit claims via this format. The EDI 837 Health Care Claim transaction is the electronic transaction for claims submissions.

Our company accepts claims electronically through Change Healthcare or RelayHealth. Highmark Wholecare encourages practitioners to take advantage of our electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster claims submission and processing.
- Reduced paperwork.
- Increased claims accuracy.
- Time and cost savings.

For submission of professional or institutional electronic claims for Highmark Wholecare, please refer to the following grid for Change Healthcare Payer IDs and RelayHealth CPIDs Clearinghouse Process ID):

CPID	PAYER NAME	PAYER ID	CLAIM TYPE
8472	Highmark Wholecare	25169	Professional
4569	Highmark Wholecare	25169	Institutional

Requirements for Submitting Claims to Highmark Wholecare through Change Healthcare and RelayHealth

When submitting claims please note the Pennsylvania Payer ID Number is 25169. Effective June 1, 2021, any claim submitted with an incorrect Payer ID Number will be denied.

Our company has a health plan specific edit through Change Healthcare and RelayHealth for electronic claims that differ from the standard electronic submission format criteria. The edit requires:

- The assigned eight (8)-digit member identification number. For practitioners who do not know the member's identification number it is acceptable to submit the member's Recipient Number on electronic claims.

In addition to edits that may be received from Change Healthcare and RelayHealth, we have a second level of edits that apply to procedure codes and diagnosis codes. Claims can be successfully transmitted to Change Healthcare and RelayHealth, but if the codes are not currently valid they will be rejected.

Practitioners must be diligent in reviewing all acceptance/rejection reports to identify claims that may not have successfully been accepted by Change Healthcare, RelayHealth, and our company. Edits applied when claims are received will appear on an EDI Report within the initial acceptance report or Claims Acknowledgment Report. A claim can be rejected if it does not include the practitioners ten (10)-digit NPI and current procedure and diagnosis codes.

We will use the NPI of the ordering, referring or prescribing provider included on the rendering providers claim to validate the provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering provider will be denied if it is submitted without the ordering/prescribing/referring providers Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA provider.

To assure that claims have been accepted via EDI, practitioners should receive and review the following reports on a daily basis:

- Change Healthcare - Provider Daily Statistics (RO22).
- Change Healthcare - Daily Acceptance Report by Provider (RO26).
- Change Healthcare - Unprocessed Claim Report (RO59).
- RelayHealth - Claims Acknowledgment Report (CPI 651.01).
- RelayHealth - Exclusion Report (CPI 652.01).
- RelayHealth - Claims Status Report (CPA 425.02).

If you are not submitting claims electronically, please contact your EDI vendor for information on how you can submit claims electronically. You may also call Change Healthcare directly at 1-877-469-3263 or RelayHealth at 1-800-545-2488.

Our company will accept electronic claims for services that would be submitted on a standard CMS-1500 or a UB-04 claim forms. We will accept electronic COB transactions via 837 processing in accordance with the implementation guides for both 837 Professional and Institutional processing.

Submitting COB claims electronically will save providers time and eliminate the need for paper claims with copies of the other payer's EOB attached. This will increase quality, consistency, and speed of payment.

Please consult with your software vendor to insure they have electronic COB submission capability and work with your EDI vendor to review the HIPAA implementation guide and submission requirements.

The following cannot be submitted as attachments along with electronic claims at this time:

- Services billed by report.
- The PCP referral form (paper version).
- The OB/GYN referral form (paper version).

Claim Payments Electronic Remittance Advice

Our company has engaged PNC Healthcare to migrate to a new claims payment platform, Claim Payments & Remittances (CPR) service, powered by Echo Health. This platform allows our company to make payments based on provider's preferences, maximizing electronic payment options and simplifying adoption.

Providers may register to receive payments electronically. The new CPR service enables providers to log into a web-based portal to manage their payment preferences and access their detailed explanation of payment (EOP) for each claim payment.

Outlined below are new payment options:

1. Virtual Card Payments – If you are not currently registered to accept payments electronically, you will receive virtual credit card payments with your EOP.

2. Electronic Funds Transfer (EFT) Payments – If you are interested in a more automated method of receiving payments, EFT is a fast and reliable payment method. You can also choose to automate the associated remittance information via an 835 Electronic Remittance Advice (ERA) sent directly to your organization or your clearinghouse.
    - To sign up to receive EFT payments only or 835 and EFT from our company, visit: https://enrollments.echohealthinc.com/EFTERAInvitation.aspx?ReturnUrl=%2f.
    - To sign up to receive EFT payments only or 835 and EFT from our company and from all Echo payers, visithttps://view.echohealthinc.com/EFTERA/efterainvitation.aspx.
3. Medical Payment Exchange (MPX) –provides the option to direct print an in-office check at no cost, receive virtual card payment or enroll for EFT.
4. Paper Checks – To receive paper checks and paper EOPs, you must contact CPR Customer Service to elect to opt out of virtual card payments or remove your EFT enrollment.

The Companion Documents provide information about the 835 Claim Remittance Advice Transaction that is specific to the plan and the plan's trading partners. Companion Documents are intended to supplement the HIPAA Implementation Guides. Rules for format, content, and field values can be found in the Implementation Guides available on the Washington Publishing Company's website at www.wpc-edi.com.

Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts or errors.

Claims Review Process

Our company will review any claim that a practitioner feels was denied or paid incorrectly. These are requests that are not regarding medical necessity rather are administrative in nature such as, but not limited to, disputes regarding the amount paid, denials regarding lack of modifiers, refunded claim payments due to incorrect payment, or coordination of benefit (COB) issues. The request may be conveyed via fax to 1-844-207-0334 if the inquiry relates to an administrative issue. The provider can also submit a request through the Provider Portal via NaviNet. Please forward all the appropriate documentation, i.e. the actual claim in order to expedite the review process. Initial claims that are not received within one hundred eighty (180) calendar days, will not qualify for review. All follow-up review requests must be received within three hundred sixty-five (365) calendar days from the earliest date of service on the claim.

We cannot accept verbal requests to retract claim overpayments. Providers may complete and submit a Refund Form or a letter that contains all of the information requested on this form. The refund form is located on the Highmark Wholecare website at: https://www.HighmarkWholecarehealthplan.com/provider/medicaid-resources/medicaid-provider-forms-and-reference-materials.

This form, together with all supporting materials relevant to the claim reversal request being made including but not limited to EOB from other insurance carriers and the refund check, should be mailed to the address below.

PNC Bank
C/O Highmark Wholecare Payments/Refunds Lock Box #645171
500 1st Avenue
Pittsburgh, PA 15219

Claims inquiries for administrative reviews should be mailed to:

Attention: Claims Review
Department Four Gateway Center
444 Liberty Ave., Suite 2100
Pittsburgh, PA 15222-1222
Or Fax: 1-844-207-0334

Third Party Liability and Coordination of Benefits (COB)

Third Party Liability (TPL) when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g. Medicare, commercial insurance) other than our company. Medicare or other health insurance is the primary insurance. TPL does not affect the Member's Medicaid eligibility. Members may report other health care coverage (TPL) by calling Member Services at 1-800-392-1147.

COB is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Some members have other insurance coverage. Our company, like the Pennsylvania MA program, is the payer of last resort on claims for services provided to members with other insurance coverage. This means that all other "primary" insurance carriers must consider the health care providers charges before a claim is submitted to us. We may not unreasonably delay nor deny payment of claims unless the existence of third-party liability is established at the time the claim is adjudicated.

We will process and pay EPSDT claims as primary even when our records indicate Highmark Wholecare is secondary and a primary plan exists. If an EOB is attached to the EPSDT then coordination of benefits will be applied. We will continue to coordinate benefits and require the primary EOB.

Note: In Compliance with the Bipartisan Budget Act of 2018 (Pub. L. 115-123) and the PA DHS cost avoidance for claims for prenatal services. Providers are required to utilize the member's third-party resource(s) prior to submitting claims for prenatal services to Highmark Wholecare. The CMS bulletin on this topic can be located at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib060118.pdf.

All prenatal claims must have the primary EOB attached for payment consideration. If a claim is received and no EOB is attached and the services are related to prenatal the claim will deny, D192 – **DENIED.**

RESUBMIT PRENATAL SERVICES WITH DELIVERY CHARGE AND PRIMARY EOB.

If the members primary pays globally all delivery claims will need to include office visits. The delivery charge must be on the first line and office visits should be billed on additional lines. Coordination will begin with the delivery line. No office visit will deny for timely filing when the delivery claim is received within the timely allowance for EOB submission. Procedure codes do not have to match the primary EOB. Please be aware that secondary coverage for covered fee-for-service items is provided according to a benefit-less-benefit calculation.

In order to receive payment for services provided to members with other insurance coverage, the practitioner must first bill the member's primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's EOB, the practitioner should submit a claim to Highmark Wholecare. The practitioner must:

- Follow all referral and authorization procedures.
- File all claims within timely filing limits as required by the primary insurance carrier.

- Submit a copy of the primary carriers EOB with the claim to us within sixty (60) days of the date of the primary carriers EOB.
- Be aware that secondary coverage for covered fee-for-service items is provided according to a benefit-less-benefit calculation.

The amount billed must match the amount billed to the primary carrier. We will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

In accordance with our agreement with DHS, we are considered the primary insurer when auto or casualty claims are involved.

When a claim is submitted by a practitioner without an EOB from the auto insurance or a casualty plan, and the original bill does not include any notation of a primary payer payment, we must take a primary position on the claim and not deny to the extent that plan criteria was followed. The practitioner has the option of submitting an original claim, however it must be submitted within 1one hundred eighty (180) calendar days from the date of service. Claims submitted after this deadline will be denied for untimely filing. The sixty (60) day rule for Third Party Liability does apply to auto and casualty when the practitioner attaches either an EOB or auto casualty exhaustion letter. If the practitioner submits the claim with the EOB, we will coordinate benefits, however, if the EOB is submitted after we paid as the primary insurance plan, we will return overpayment to DHS.

If a member indicates they no longer have primary coverage, but the State System contains information indicating other medical coverage is still active, the member should contact his or her caseworker to have the State System updated. If this is not possible, the practitioner may contact the primary carrier and request written verification of the coverage.

When our company receives letter from the primary carrier indicating that the member no longer has coverage, we will use the letter to investigate the situation and verify if the coverage is cancelled and if there is a new plan covering the member. If our investigation confirms that the member no longer has primary coverage, we will submit an electronic request to the state to update the system. We will update our system immediately and reprocess claims finalized within the one hundred eighty (180) day period prior to the date of the onset of the investigation.

We are the payer of last resort when any commercial or Medicare plan covers the member. We are obligated to process claims involving auto insurance or casualty services as the primary payer if bills do not include a notation or payment by any insurance that is not a commercial or Medicare plan. Claims must be submitted within timely filing guidelines.

Our claims processing procedures comply with the department's third-party liability requirements in neither delaying nor denying payment of otherwise covered treatment or services unless the probable existence of third-party liability is identified in Highmark Wholecare's records for the member at the time the claims are submitted.

Highmark Wholecare is obligated to pay and chase collection for services that may be covered by commercial plans when Highmark Wholecare has paid as primary and there is other insurance on the member record.

Primary Care Services

PCPs are required to report all the services they provide for our members to our company. To facilitate reporting, Highmark Wholecare will accept encounter information on the CMS-1500 claim form or electronically via Electronic Data Imaging (EDI). Charges for encounters/visits should be submitted within sixty days from the date of service but will be accepted up to one hundred eighty (180) calendar days from the date of service. The encounter information will be reported back to PCP on a remittance advice. Capitated services will show a payment amount of zero (0). Services reimbursed outside of the base capitation will indicate a payment amount and will include a check for the sum of the services provided.

Capitated PCPs will receive full capitation payment for those members with other insurance coverage. Secondary coverage for all primary care services, including any deductible or co-insurance amounts not covered by the primary carrier, will be covered by the capitation payment. Practitioners are required to report all services provided to our members by submitting a claim with a copy of the EOB regardless of whether or not additional payment is expected. Members seeking care, regardless of primary insurer, are required to contact their PCP and use participating practitioners or obtain appropriate authorization for practitioners outside of the network.

All MA eligible recipients under nineteen (19) years of age are eligible for Vaccines for Children (VFC) vaccines.

All PCPs will be reimbursed for the administration of any vaccine covered under the VFC Program when a claim is received with the appropriate immunization code. Any procedures for immunizations not covered under the VFC Program, but covered by Highmark Wholecare, will be reimbursed fee-for-service. Please reference the PCPs agreement for fee schedules or additional information."

Physicians and CRNPs with appropriate training and certification through Smiles for Life online training curriculum may administer and bill for fluoride varnish treatments for children less than five (5) years old. Fluoride varnish is a service that may be provided by a participating physician during which each tooth in a small child (less than five (5) years old) is painted with a fluoride solution to prevent tooth decay.

Physicians interested in providing topical fluoride varnish in the office for their Highmark Wholecare PA Medicaid patients under the age of five (5) and receive the eighteen-dollar ($18.00) reimbursement must submit a copy of the training certificate to:

Highmark Wholecare
Attention: Provider Information Management
444 Liberty Avenue, Suite 2100
Pittsburgh, Pa 15222-1222
Or fax to 1-855-451-6680

At the top of the certificate, please include your thirteen (13) digit MA provider identification number and/or the health plan's Individual Provider Number. Physicians will not be reimbursed for providing the topical fluoride varnish before we have a copy of the training certificate on file. Your practice will receive written notification confirming receipt of your certificate and provide a date when you may begin billing procedure code 99188 and receive reimbursement.

Specialty/Fee-For-Service Providers

If a member has other coverage, the other carrier is always the primary insurer. The specialist will bill the other insurer and the other insurer will issue payment with an EOB statement (EOB), which outlines the payment made for each procedure. The specialist will then submit a copy of the EOB with a copy of the claim to us for secondary coverage consideration. The claim must be received within sixty (60) days of the date of the EOB. If required, our authorization and referral requirements must be met in order for payment to be issued. If the member has commercial insurance, and the commercial carrier's payment is greater than our payment if we were primary, then the following reimbursement example would apply. The primary carrier amount is the basis for the benefit determination of Highmark Wholecare's liability when the practitioner is a participating practitioner with the primary plan. The primary carrier allowable paid amount is used as the basis for the benefit determination of our liability when there is a patient responsibility remaining after the primary carrier has processed the claim.

Example of Practitioner Participating with Primary Plan:

Practitioner Charges	$1,500.00
Primary Carrier Allowable Primary Payment (80% of Allowable)	$1,000.00 $800.00
Highmark Wholecare Allowable if Primary Highmark Wholecare compares the Primary Carrier Payment to the Highmark Wholecare Allowable	$600.00 $800.00 vs. $600.00
Highmark Wholecare does not issue payment	$0.00

Example of Patient Responsibility remaining after Primary Plan Payment:

Practitioner Charges Primary Care Allowable	$1,500.00 $1,000.00
Primary Payment (80% of Allowable)	$800.00
Patient Responsibility Under Primary Plan Highmark Wholecare Allowable if Primary	$200.00 $850.00
Highmark Wholecare compares the Primary Carrier Payment to the Highmark Wholecare	$800.00 vs. $850.00
Highmark Wholecare Issues Payment	$50.00

Medicare

Our members twenty-one (21) or younger may have Medicare fee-for-service. When Medicare is the other insurance, the following processing criteria applies:

- Referrals and authorizations are not required for services covered by Medicare. Once Medicare benefits have been exhausted, or if a service is not covered by Medicare, our referral and authorization criteria will apply.
- For Medicare Part A and Medicare Part B services, coverage is provided according to a benefits-less-benefits calculation.

Our company will determine the amount that would normally be paid under the plan using the allowable amount from the Medicare Plan as the billed amount. If the amount that we would pay is more than the amount Medicare pays, we may pay the difference up to the maximum allowable, contingent on the benefit-less-benefit calculation. If the amount that we would pay is equal to or less than the amount Medicare pays, we will not issue any additional payment.

For Medicare services that are not covered by MA or our company, we must pay cost sharing to the extent that the payment made under Medicare for the service and the payment made by our company does not exceed eighty percent (80%) of the Medicare approved amount.

Example A	
Practitioner Charges	$1,500.00
Deductible is Satisfied	-
Medicare Allowable	$1,000.00
Medicare Payment (80% of Allowable)	$800.00
Health Plan Allowable if Primary	$600.00
Health Plan compares the Medicare Payment to the Highmark Wholecare Allowable	$800.00 vs. $600.00
Health Plan does not issue payment	$0.00

Example B	
Practitioner Charges	$1,500.00
Deductible is Satisfied	-
Medicare Allowable	$1,000.00
Medicare Payment (80% of Allowable)	$800.00
Health Plan Allowable if Primary	$850.00
Health Plan compares the Medicare Payment to the Highmark Wholecare Allowable	$800.00 vs. $850.00
Health Plan issues Payment for the Difference	$50.00

Example C	
Practitioner Charges	$1,500.00
Medicare Allowable	$1,000.00
Medicare Applies $50.00 to Satisfy the Deductible	$50.00
Medicare Payment (80% of Allowable) Remaining After Deductible is Satisfied	$760.00
Health Plan Allowable if Primary	$850.00
Health Plan compares the Medicare Payment to the Highmark Wholecare Allowable	$760.00 vs. $850.00
Health Plan Issues Payment for the Difference	$90.00

Private Duty Nursing

We will coordinate benefits with a commercial plan using a benefits-less-benefits approach for limited nursing care services and for expanded services. However, for these specific services only, the total amount billed to the primary plan will be the basis for the benefit determination of our liability.

Example A	
Nursing Charges	$1,000.00
Primary Carrier Allowance	$600.00
Primary Carrier Payment	$500.00
Health Plan Allowable If Primary	$800.00
Health Plan compares the Primary Carrier Payment to	$500.00 vs. $800.00
Health Plan Issues Payment	$300.00

Our normal claims processing procedures for members with other primary insurance require that a primary carrier EOB be submitted for each date of service.

In an effort to improve provider cash flow and to facilitate administrative procedures, we provide an optional Explanation of Benefits (EOB) exception process for extended nursing services. When the primary carrier has denied all extended nursing services, providers can submit the primary carrier's denial letter to us. We will determine if the letter is accepted in lieu of EOBs for a defined period of time. This procedure eliminates the need to submit primary carrier EOBs with each claim submitted to us. Our company's exception procedure for nursing services is as follows:

- Submit medical records to the review committee of the primary insurance plan.
- Allow adequate time for the review to be completed prior to the onset of services that you want us to consider for primary coverage. Upon receipt of the letter from the primary plan, please forward to a Claims Reviewer at:

  Highmark Wholecare
  Attention: Claims Department Four Gateway Center
  444 Liberty Avenue, Suite 2100
  Pittsburgh, PA 15222-1222

  Faxed correspondence will not be accepted. Letters must be received within one month of the date on the denial letter. (See examples one (1) and two (2) following). Our review will be completed within three weeks of receipt.
- Following the review, we will send written documentation advising the provider if the letter was accepted. If the denial letter is now accepted, EOBs must be submitted with each claim.
- If we take a primary position, the time period for which the letter has been accepted will be specified in the letter sent to you. If we accept a denial letter and take a primary position, it will be valid for the balance of the calendar year.
- The provider would need to submit another denial letter the beginning of the next calendar year. When benefits are exhausted under the primary carrier or whenever there is a change of coverage during a calendar year, the process for EOBs/denial letters will need to be re-assessed (See example #3). If there are gaps in the allowable time period, any services rendered during the time period not covered by the allowable dates in the exception letter will require that EOBs be submitted from the primary plan, or we will not be able to coordinate benefits for those charges.
- In order for claims to be processed without delay, the services billed must align with the correct dates of services and procedure codes authorized and in accordance with our plan's Private Duty Nursing Billing Guidelines.
- For each patient, either EOBs or the EOB exception process must be consistently followed.

Example #1
Primary insurance review letter dated May tenth (10th). We receive a letter June fifth (5th).
Our Determination - We assume primary plan and EOB exemption begins April first (1st).

Examples #2
Primary insurance review letter dated March fifth (5th). We receive a letter June fifth (5th).
Our determination – We will require EOBs since nursing services exception letter was not received in thirty (30) days.

Example #3
EOBs received from primary insurance for January, February, and March. Benefits exhausted on March twenty-fifth (25th). Provider can continue to submit EOBs or revert to nursing services exception procedures for balance of calendar year.

Autism Act Claims Processing Procedures for physical therapy, speech therapy, and/or occupational therapy.

For members under age twenty-one and the following criteria applies:

- Precertification/Authorization through our UM Department is required.
- We will require a primary plan EOB.
  - If primary plan thirty-six thousand dollars ($36,000) annual payment limit has expired, EOB must include applicable denial.
  - If primary plan is a self-funded plan, EOB must include wording on the EOB.

- An alternate letter process rather than an EOB will be required annually to request exemption and will apply to this procedure as follows:
    - If we are notified that the other insurance company is a self-funded plan and is exempt from the Autism Act, we will require a letter from the insurance company. The letter will be evaluated for approval or denial. Letters should be sent directly to our Claims Review Department rather than the P.O. Box and should include the following wording:
        - Based on the Autism Insurance Act 62, the member is covered under XXXXX (name of company) and this is a self-funded plan.

Subrogation

In accordance with our agreement with DHS, if a member is injured or becomes ill through the act of a third party, medical expenses may be covered by casualty insurance, liability insurance, or litigation. Any correspondence or inquiry forwarded to our company by an attorney, practitioner of service, insurance carrier, etc. relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement, will be handled by our Legal Department and will be forwarded to DHS' Third Party Liability Department.

Claims submitted by a provider and without an EOB statement from auto insurance or casualty plans without any notation on the original bill of the primary payer, will be processed similar to any other claims. We may neither unreasonably delay payment nor deny payment of claims because they are involved in injury stemming from an accident, such as a motor vehicle accident, where the services are otherwise covered. Timely filing criteria for original claims are one hundred eighty (180) calendar days from the date of service to be eligible for payment. EOB or auto/workers compensation/casualty exhaustion letters qualify for consideration if they are received within sixty (60) calendar days of the date of the EOB/letter along with submission of the initial bill in order for us to coordinate benefits.

However, if the auto/casualty EOB is submitted after we paid as primary, claims cannot be adjusted, as we must comply with criteria set by DHS.

All requests from legal representatives, and/or insurers for information concerning copies of patient bills or medical records must be submitted to our legal department.

A cover letter identifying the date and description of the injury, requested dates of services for billing statements, and release of information signed by the member should be forwarded to the following address:

Highmark Wholecare
Attention: Payment Accuracy &
Coordination Department
Four Gateway Center
444 Liberty Avenue,
Suite 2100
Pittsburgh, PA 15222-
1222

Claim Coding Software

Our company uses a fully automated coding review product that programmatically evaluates claim payments to verify the clinical accuracy of professional claims in accordance with clinical editing criteria.

This coding program contains complete sets of rules that correspond to CPT-4, HCPCS, ICD-10, AMA, and CMS guidelines as well as industry standards, medical policy, and literature and academic affiliations. The program used is designed to assure data integrity for ongoing data analysis and reviews procedures across dates of service and across providers at the claim, practitioner, and practitioner-specialty level.

Billing

Billing Procedures

A "clean claim" as used in this section means a claim for payment for a healthcare service that has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. A claim from a healthcare provider who is under investigation for fraud or abuse regarding that claim will not be considered a "clean claim".

In addition, a claim shall be considered "clean" if the appropriate corresponding referral has been submitted or the appropriate authorization has been obtained in compliance with our Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS-1500 claim forms (or their replacement with CMS designations, as applicable) or an acceptable electronic format through our contracted clearinghouse:

1. Patient name.
2. Patient medical plan identifier.
3. Date of service for each covered service.
4. Description of covered services rendered using valid coding and abbreviated description.
5. ICD-10 surgical diagnosis code (as applicable).
6. Name of practitioner/provider and applicable/required NPI numbers.
7. Provider tax identification number.
8. Valid CMS place of service code. Place of Service Code Set | CMS
9. Billed charge amount for each covered service.
10. Primary carrier EOB when patient has other insurance.
11. All applicable ICD-10-CM diagnosis codes—inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD-10-CM diagnosis code.
12. APR-DRG code for inpatient hospital claims.

Providers are encouraged to refer to the DHS Provider Quick Tips for Reporting Diagnosis Codes for Immunization Administration.

We process medical expenses upon receipt of a correctly completed CMS form and hospital expenses upon receipt of a correctly completed UB-04 claim form. Sample copies of a UB-04 and a CMS-1500 claim forms can be found in the Forms and Reference Material section of this manual. A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink.

A claim without valid, legible information in all mandatory categories is subject to rejection/denial. To assure reimbursement to the correct payee, our company practitioner number must be included on every claim.

Providers of medical or other items or services and suppliers that qualify for an NPI are required to include their NPI on all claims for payment submitted under the Medicare and Medicaid programs.

NPIs for billing, rendering, ordering and attending providers are required to be reported on paper claims in addition to electronic claims.

For imaging and clinical laboratory services and items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as well as home health services, the NPI of the ordering/referring provider is required in addition to the NPI of the billing provider on paper claims and EDI claims

Paper and EDI Claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form and just like rejected EDI claims will not be loaded in our claims system. Providers will be held to timely filing policies in regards to submission of the initial and corrected claims.

To comply with encounter data reporting, PCPs and specialty care practitioner must submit claims under the individual practitioner identification number rather than the practice or group identification number. CMS submissions for anesthesiology, pathology, radiology, and emergency room practitioner groups must also include the individual practitioner identification number. Any claim billed on a CMS-1500 form must include the individual practitioner identification number (box thirty-one (31) on the CMS form). Please note that it is extremely important to promptly notify Highmark Wholecare of any change that involves adding practitioners to any group practice, as failure to do so may result in a denial of service. Highmark Wholecare will process claims utilizing individual practitioner numbers even if the individual practitioner number is not included on the claim. The only exception to the individual practitioner number requirement applies to UB-04 claim form facility.

All claims must have complete and accurate ICD-10-CM diagnosis codes for claims consideration. If the diagnosis code requires, but does not include the fourth- (4th) or fifth- (5th) digit classification, the claim will be denied.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal at punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained in the claim is true, accurate, and complete.

Highmark Wholecare's Claim office address is:

Highmark Wholecare
Attention: Claims Processing Department
P.O. Box 173 Sidney, NE 69192

Any questions concerning billing procedures or claim payments can be directed to the Provider Services Department at 1-800-392-1147.

Federally Qualified Health Centers/Rural Health Centers

Overview

We will pay all Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) rate(s) that are not less than the Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by DHS. We will also make a payment separate from the PPS rate(s) to any FQHC that has opted–in to the Alternative Payment Methodology for inpatient deliveries. If a FQHC/RHC has opted-out of receiving the PPS rate from the PH-MCOs, upon notification from the Department of the date that the FQHC/RHC has opt-out, the PH-MCO is no longer required to make payment at the FFS PPS rate, as noted above. Effective with the FQHC/RHC opt- out, the PH-MCO must negotiate and pay the opted-out FQHC/RHC at rates that are no less than what the PH-MCO pays to other providers who provide comparable services within the PH-MCO's Provider Network. The information below is intended as a reference for **Medical Service Encounters only (Behavioral Health services must be billed to the BH-MCO in your county)** for Pennsylvania Medicaid members. Providers should refer to our dental benefit provider, United Concordia Dental (UCD), for instructions on submitting Dental Service Encounters.

EncounterDefinition

Rates are charged for each encounter. An eligible encounter is defined as:

Medical Service Encounter: An encounter between a medical provider and a patient during which medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Family planning encounters and obstetrical encounters are a subset of medical encounters.

Eligible Providers include:

- Physician (including Podiatrists)
- Mid-level Practitioners:
    - CRNP (midwife or a licensed nurse practitioner).
    - Licensed Physician Assistant.
    - Speech, physical, and occupational therapist.
    - Audiologist.
    - Case Manager.
    - Nutritionist.

FQHC/RHC Claim Submission

CMS-1500 Format / Electronic 837P Format

- FQHCs and RHCs may submit claims for medical encounters provided to our members on paper CMS-1500 claim forms, UB-04 claim forms or electronic 837P claim forms.
- Our company encourages our FQHC/RHC providers to submit physician charges on CMS 1500 forms.
- Include the Group Name and Group NPI # in the equivalent box 33 provider billing information field on the CMS-1500 claim form. Remember to include the rendering physician's name in box thirty-one (31) with the rendering NPI in box 24J.
- We will use the NPI of the ordering, referring or prescribing provider included on the rendering providers claim to validate the provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering provider will be denied if it is submitted without the ordering/prescribing/referring provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA provider.
- PA/CRNPs can bill alone under Medicaid LOB.
    - Remember: All practitioners MUST come over on the FQHC-RHC Provider Change Form or

FQHC/RHC Roster Template and be setup in our credentialing/claims system PRIOR to rendering services.
    - All FQHC/RHC must have a collaborative agreement on file between the physician and extender(s) on staff.
- **The encounter code T1015 must be listed in addition to the related fee-for-service procedure codes in order for the claim to process**. This is essential for services needed to measure the quality of care provided, such as immunization codes and in office labs like Hemoglobin A1c and urine protein tests for diabetics. Total charges for the encounter should be billed with code T1015. **Claims submitted with just the T1015 will not be paid.**
- For COB processing if the claim is billed with T1015 clinic code (or any other global clinic code) and the EOB has the same DOS, the billed amount does not need to match.
- A claim shall not be considered a clean claim unless and until it includes all information required including but not limited to, procedure codes for all services rendered during the visit, appropriate place of service codes, and complete diagnosis codes regardless of expected payment.

Timely filing criteria for original claims are one hundred eighty (180) calendar days from the date of service. Corrected claims or requests for review are considered if information is submitted within three hundred sixty-five (365) calendar days from the earliest date of service on the claim. If you bill on paper we will only accept paper claims on a CMS-1500 or a UB-04 claim form. No other billing forms will be accepted.

Providers must bill within one hundred and eighty (180) calendar days from the date of an Explanation of Benefits (EOB) from the primary carrier when Highmark Wholecare is secondary. An original bill along with a copy of the EOB is required to process the claim.

Claims submitted after these deadlines will be denied for untimely filing.

Any claim that has been submitted to our company but does not appear on a remittance advice within sixty (60) days following submission should be researched by calling the Provider Services Department to inquire whether the claim was received and/or processed.

FQHC/RHC Medicaid Billing ONLY:

Encounter code T1015 for FQHC/RHC Medicaid billing must be listed in addition to the related fee-for-service procedure codes in order for the claim to process. This is essential for services needed to measure the quality of care provided, such as immunization codes and in office labs like Hemoglobin A1c and urine protein tests for diabetics. Total charges for the encounter should be billed with code T1015.

Claims submitted with just the T1015 will not be paid.

ALL participating FQHC/RHC providers are required to bill with the following Place of Service Code.

50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

NOTE: For services rendered at an FQHC or RHC facility, please do not bill with POS 11.

Keeping your FQHC/RHC Roster current can help eliminate denials

- Rejected-No valid precertification on file.
- Provider ID or NPI number and Tax ID do not match.

Please refer to the FQHC/RHC Roster Template Instructions and FQHC/RHC Roster Template which is located on the Highmark Wholecare website at: FQHC/RHC Resources (highmarkwholecare.com).

EPSDT Billing Guidelines for FQHCs/RHCs:

- An Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screen is complete when codes from each service area required for that age, including the appropriate evaluation and management codes, and appropriate modifiers, are documented in the record and on the claim.
- Consult the current Pennsylvania EPSDT Program Periodicity Schedule and Coding Matrix as well as the Advisory Committee on Immunization Practices (ACIP) Recommended Childhood Immunization Schedule for screening eligibility information and the services required to bill for a complete EPSDT screen. These can be found on the Highmark Wholecare website under Provider Resources EPSDT.
- Highmark Wholecare uses fully automated coding review software. The software programmatically evaluates claim payments in accordance with CPT-4, HCPCS, ICD-10, AMA and CMS guidelines as well as industry standards, medical policy and literature and academic affiliations.
- The claim must include the T1015 in addition to the Visit Codes 99381/99391-99385/99395 and the EP modifier.
- The EPSDT Periodicity is considered compliant when all the services for the periodicity are completed and listed on the claim in addition to the T code and Visit code. The claim must include Procedure Code T1015 with modifier EP in addition to all of the individual age appropriate procedure codes from the Periodicity Schedule.
- Claims will be paid at the providers EPSDT rate only if the appropriate evaluation and management code and EP modifier are submitted.
- With the exception of the dental component for clinics that do not offer dental services,
- FQHCs/RHCs may not bill for partial screens. Therefore, all codes for the child's periodicity must be included on the claim.

Childhood Nutrition and Weight Management Services for MA members under twenty-one (21) years of age.

Our company allows reimbursement for MA Childhood Nutritional and Weight Management Services when bill with the T1015 along with the specific modifiers for participating Medicaid FQHC/RHCs. The MA Childhood Nutrition and Weight Management Services Bulletin allows for reimbursement to FQHCs and RHCs enrolled in the MA Program when the services are medically necessary and rendered to MA beneficiaries under twenty-one (21) years of age who are experiencing weight management problems. Please refer to the most recent MA Bulletin regarding Childhood Nutrition and Weight Management Services from the link below: https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/MAB2020052603.pdf

A claim shall not be considered a clean claim unless and until it includes all information required including but not limited to, procedure codes for all services rendered during the visit, appropriate place of service code, and complete diagnosis codes regardless of expected payment.

Refer to Obstetrical Care Services for Maternity – Prenatal and Postpartum Care billing instructions.

Multiple Encounter Submission

Encounters with more than one (1) eligible practitioner and multiple encounters with the same eligible practitioner that take place on the same date, at a single location, and that have the same diagnosis constitute a single encounter. The following two (2) conditions are recognized for payment of more than one encounter rate on the same day:

1. After the first encounter, the member suffers a different illness or injury requiring additional diagnosis or treatment; and
2. The patient has a medical visit, a behavioral health visit, or a dental visit on the same day.

The medical necessity of multiple encounters must be clearly documented in the medical record. Providers must exercise caution when billing for multiple encounters on the same day, and such instances are subject to post-payment review to determine the validity and appropriateness of multiple encounters.

Providers may not inappropriately generate multiple encounters by unbundling services that are routinely provided together during a single visit or scheduling multiple patient visits for services that could be performed at a single visit.

Include only one encounter per claim. **Claims with more than one encounter listed will be denied. When billing for more than one encounter per day, submit one claim for each encounter**.

- On each claim, to indicate it is a separate encounter, enter "unrelated diagnosis" and the time of both visits in field nineteen (19) on the CMS-1500 Claim Form or in the Comments field when billing electronically.
- Documentation for all encounters must be kept in the member's file.

Obstetrical Care Services

The first visit with an obstetrical patient is considered the intake visit. If a patient becomes Highmark Wholecare plan member during the course of her pregnancy her first visit as a member is considered to be her intake visit, regardless of trimester. An ONAF must be completed in full at the intake visit, signed by the provider, and forwarded to Highmark Wholecare within two (2) to five (5) business days of the initial intake visit. The ONAF is not a claim, however, it must be received by Highmark Wholecare in order to process the claim for the intake visit. Submit claims on a CMS-1500 form within 180 calendar days from the date of service to receive payment for the intake package. The intake package code is T1001-U9.

Providers are able to submit the ONAF via the NaviNet online form submission tool and through online submission here. Providers still have the option to fax completed ONAFs. The fax number is 1-888-225-2360.

Obstetric practitioners are reimbursed on a per visit basis. All visits and dates of service must be included on the CMS-1500 form and identified with appropriate maternity codes for appropriate reimbursement. Delivery charges are to be coded with CPT codes. The date billed for a delivery code, in CPT code format, must be the actual date of service.

All charges for newborns that become enrolled in Highmark Wholecare, other than hospital bills covering the confinement for both mother and baby, are processed under the newborn name and newborns Highmark Wholecare identification number. For prompt payment, please submit claims with the newborn patient information or the claim will be pended for manual research. Inpatient hospital bills for newborns should be submitted separately from the Moms confinement. Per Diem payments for inpatient maternity services that cover the confinement for both Mom and baby will be issued under the mothers Highmark Wholecare identification number and the newborn's claim will be processed for informational purposes only.

Surgical Procedure Services

Highmark Wholecare reimburses surgical procedures billed by physicians in accordance with industry standard protocols and limits payment to a maximum of three (3) surgical procedures/operating sessions.

Highmark Wholecare determines reimbursement upon the clinical intensity of each procedure and reimburses at one hundred percent (100%) for the most clinically intensive surgery, and fifty percent (50%) for the second (2nd) and third (3rd) procedures. Pre-operative and post-operative visits will only be reimbursed to the extent that they qualify for payment according to the follow-up criteria, regardless of whether a referral is on file or not.

An assistant surgeon may bill for one procedure per date of service, and will be reimbursed at twenty (20) percent of Highmark Wholecare's maximum allowable fee, as long as the surgical procedure code allows an assistant surgeon to be present for the surgery. If the assistant surgeon charges are submitted under the supervising physicians name, the AS modifier indicating this was a physician's assistant must be included on the claim.

Anesthesia Services

Highmark Wholecare processes anesthesia services based on anesthesia procedure codes only.

Anesthesia services should be billed with the correct American Society of Anesthesiologists (ASA) code in the range of 00100-01999, which are included in the CPT manual and reimbursed as time-based anesthesia. All services must be billed in minutes. Fractions of a minute should be rounded to whole minutes (thirty (30) seconds or greater: round up; less than thirty (30) seconds: round down). For billing purposes, the number of minutes of anesthesia time will be placed in field 24G on the CMS-1500 claim form for providers who bill in paper format. All anesthesia services should be billed with the appropriate anesthesia modifier.

Hospital Services

Hospital claims are submitted on a UB-04 claim form. To assure that claims are processed for the correct member, the members eight (8) digit identification number must be used on all claims. Practitioners rendering services in an outpatient hospital clinic should include the group practice number of the practitioner's group on the claim when submitting on a UB-04, while individual practitioner number must be reported when submitting claims on a CMS-1500 form. To aid in the recording of payment, patient account numbers recorded on the claim form by the practitioner are indicated in the Patient ID field on the remittance advice.

UB-04 Data Elements for Submission of Claims for Paper Claims

EDI requirements must be followed for electronic claims submissions.

Field	Description	Requirements
1	ProviderName,Address,CityState, Zip, Telephone, Fax, CountryCode	Required
2	Payto Name, Address, City, State, Zip	Required If Different from Billing Provider in Field one (1)
3a	PatientControlNumber	Required
3b	MedicalRecordNumber	NotRequired
4	Type of Bill	Required – If four(4) Digits Submitted, the Lead zero(0) will be Ignored
5	Federal Tax Number	Required
6	StatementCoversPeriod	Required
7	UnlabeledField	NotUsed
8a	PatientName	Required
9	PatientAddress	Required
10	Birthdate	Required
11	PatientSex	Required
12	AdmissionDate	Requiredfor InpatientandHome Health
13	AdmissionHour	NotRequired
14	TypeofAdmission/Visit	Required,IfInpatient
15	SourceofAdmission	Required
16	DischargeHour	NotRequired
17	PatientStatus	Required
18-28	ConditionCodes	MaybeRequiredin SpecificCircumstances (ConsultCMSCriteria)
29	AccidentState	NotUsed
30	UnlabeledField	NotUsed
31-34	OccurrenceCodesand Dates	MaybeRequiredin SpecificCircumstances (ConsultCMSCriteria)
35-36	OccurrenceSpan Codes and Dates	Required,IfInpatient
37	UnlabeledField	NotUsed
38	ResponsibleParty Nameand Address	NotRequired
39-41	ValueCodes and Amounts	Required,IfInpatient
42	RevenueCodes	Required
Field	Description	Requirements
43	RevenueDescriptions	Required
44	HCPCS/Rates/HIPPS Codes	Required,IfOutpatient
45	ServiceDates	Required,IfOutpatient
46	ServiceUnits	Required
47	TotalCharges	Required
48	Non-coveredCharges	Required,IfApplicable
49	UnlabeledField	NotUsed
50	PayerIdentification	Required
51	Health Plan ID	Notrequired
52	ReleaseofInformationCertificationIndicator	Required
53	AssignmentofBenefits	NotUsed
54	PriorPayments	Required,IfApplicable
55	EstimatedAmountDuefrom Patient	NotRequired
56	NationalProviderID	Required– NPI Number
57	OtherProvider ID	Health Plan Member Identification Number should be entered on paper claims only- legacy number reported as secondary identifier to NPI on electronicclaims
58	Insured'sName	Required,IfApplicable
59	PatientRelationshiptoInsured	Required,IfApplicable
60	Certificate-Social Security Number-Health Insurance Claim-Identification Number	Health Plan Member IdentificationNumberRequired
61	InsuranceGroupName	Required,IfApplicable
62	InsuranceGroupNumber	Required,IfApplicable
63	TreatmentAuthorizationCode	Required,IfApplicable

64	DocumentControlNumber	NotRequired
65	EmployerName	Required,IfApplicable
66	DiagnosisandProcedureCodeQualifier	Required
67	PrincipalDiagnosisCode	Required(Coding for Present on Admission datarequired)
67A-67Q	OtherDiagnosisCodes	Required(Coding for Present on Admission datarequired)
68	UnlabeledField	NotUsed
69	AdmittingDiagnosisCode	Required
70A-70C	PatientReason for Visit	NotRequired
71	ProspectivePaymentSystem (PPS)Code	Required for DRG Code – If four(4) Digits Submitted, the Lead zero (0) will be Ignored
72	ExternalCause of InjuryCodes	NotUsed
73	UnlabeledField	NotUsed
74	PrincipalProcedureCode and Date	Required,IfApplicable
74A-74E	OtherProcedure Codes and Date	Required,IfApplicable
75	UnlabeledField	NotUsed
76	AttendingProviderNameand Identifiers(Including NPI)	MaybeRequired in Specific Circumstances (ConsultCMS Criteria) If Not Required, Do Not Send
77	OperatingProviderName and Identifiers (Including NPI)	MaybeRequired in Specific Circumstances (ConsultCMS Criteria) If Not Required, Do Not Send
78-79	OtherProviderName and Identifiers (IncludingNPI)	MaybeRequired in Specific Circumstances (ConsultCMS Criteria) If Not Required, Do Not Send
80	Remarks	MaybeRequiredin Specific Circumstances (ConsultCMS Criteria)
81	Code – Code Field	Optional(ConsultCMSCriteria)

CMS-1500 Data Elements for Submission of Claims for Paper Claims

EDI Requirements Must be followed for electronic claims submissions.

Field #	Description	Requirements
1	Insurance Type	Required
1a	Insured Identification Number	Health Plan Member Identification Number Required (Ten (10) digit MA Recipient Number acceptable for Electronic Claims)
2	Patient's Name	Required
3	Patient's Birth Date	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient Relationship to Insured	Required
7	Insured's Address	Required
8	Patient Status	Required
9	Other Insured's Name	Required, If Applicable
9a	Other Insured's Policy or Group Number	Required, If Applicable
9b	Other Insured's Date of Birth, Sex	Required, If Applicable
9c	Employer's Name or School Name	Required, If Applicable
9d	Insurance Plan Name or Program Name	Required, If Applicable
10	Is Patient Condition Related to: a. Employment b. Auto accident c. Other accident	Required, If Applicable
10d	Reserved for Local Use	Not Required (see instructions for EPSDT claims instructions)
11	Insured's Policy Group or FECA Number	Required
11a	Insured's Date of Birth, Sex	Required, If Applicable
11b	Employer's Name or School Name	Required, If Applicable
11c	Insurance Plan Name or Program Name	Required, If Applicable
11d	Is There Another Health Benefit Plan?	Required, If Applicable
12	Patient or Authorized Person's Signature	Required
13	Insured's or Authorized Person's Signature	Required
14	Date of Current: Illness OR Injury OR Pregnancy	Required, If Applicable
15	If Patient has had Same or Similar Illness, Give First Date	Not Required
16	Dates Patient Unable to Work in Current Occupation	Required, If Applicable
17	Name of Referring Practitioner or Other Source	Required
17a	Identification Number of Referring Practitioner	Not Required
18	Hospitalization Dates Related to Current Services	Required, If Applicable
19	Reserved for Local Use	Not Required
20	Outside Lab	Not Required
21	Diagnosis or Nature of Illness or Injury	Required
22	Medical Resubmission Code	Not Required
23	Prior Authorization Number	Not Required
24a	Date(s) of Service	Required
24b	Place of Service	Required
24c	Type of Service	Not Required
24d	Procedures, Services, or Supplies CPT/HCPCS/Modifier	Required
24e	Diagnosis Code	Required
24f	Charges	Required
24g	Days or Units	Required
24h	EPSDT Family Plan	Not Required (see instructions for EPST claims submissions)
24i	EMG	Not Required
24j	COB	Not Required for Highmark Wholecare Primary Claims
24k	Reserved for Local Use	Not Required
25	Federal Tax Identification Number	Required
26	Patient Account Number	Not Required, but includes payment information when present to assist with reconciliation in provider records
27	Accept Assignment	Not Required
28	Total Charge	Required
29	Amount Paid	Not Required

Field #	Description	Requirements
30	Balance Due	Not Required
31	Signature of Practitioner or Supplier including degrees or credentials	Health Plan Individual Practitioner Name and Date Required
32	Name and Address of Facility Where Services were Rendered	Name and Address Required
33	Practitioner's, Supplier's Billing Name, Address, Zip Code and Phone Number	Health Plan Vendor Name, Address, and Number Required

Complaints, Grievances, and Fair Hearings – For Our Providers

If you are a provider and wish to file a grievance (appeal) on the member's behalf, we ask that you complete the Consent for Provider to File a Grievance for Member form in addition to your appeal request submission. The form must be filled out in its entirety, including signatures from the member and a witness. This form is available in the Medicaid Provider Forms and Reference Material section on the Highmark Wholecare website.

This will allow for a faster turnaround time to the grievance (appeal) process. This form does not need to be completed if your request for appeal should need to be expedited. Expedited grievances (appeals) should only be filed if the members life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular grievance process.

Complaints, Grievances, and Fair Hearings

If a provider or Highmark Wholecare does something that you are unhappy about or do not agree with, you can tell Highmark Wholecare or the Department of Human Services what you are unhappy about or that you disagree with what the provider or Highmark Wholecare has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell Highmark Wholecare you are unhappy with Highmark Wholecare or your provider or do not agree with a decision by Highmark Wholecare.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that Highmark Wholecare has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

First Level Complaint

What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call Highmark Wholecare at 1-800-392-1147/TTY 711 (1-800-654-5984) and tell Highmark Wholecare your Complaint, or
- Write down your Complaint and send it to Highmark Wholecare by mail or fax, or:
- If you received a notice from Highmark Wholecare telling you Highmark Wholecare's decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to Highmark Wholecare by mail or fax.

Highmark Wholecare's address and fax number for Complaints:

Highmark Wholecare
Attn: Appeals & Grievances
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within 60 days of getting **a notice** telling you that

- Highmark Wholecare has decided that you cannot get a service or item you want because it is not a covered service or item.
- Highmark Wholecare will not pay a provider for a service or item you got.
- Highmark Wholecare did not tell you it's decision about a Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.
- Highmark Wholecare has denied your request to disagree with Highmark Wholecare's decision that you have to pay your provider.

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

New member appointment for your first Examination:	**We will make an appointment for you…**
members with HIV/AIDS	with PCP or specialist no later than seven (7) days after you become a Highmark Wholecare member unless you are already being treated by a PCP or specialist.
members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than forty-five (45)days after you become a Highmark Wholecare member, unless you are already being treated by a PCP or specialist.
members under the age of twenty-one (21)	with PCP for an EPSDT screen no later than forty-five (45) days after you become a Highmark Wholecare member, unless you are already being treated by a PCP or specialist.
all other members	with PCP no later than three (3) weeks after you become a member of Highmark Wholecare Member.
Members who are pregnant:	**We will make an appointment for you…**
pregnant women in their first trimester	with Ob-gyn provider within ten (10) business days of Highmark Wholecare learning you are pregnant.
pregnant women in their second trimester	with Ob-gyn provider within five (5) business days of Highmark Wholecare learning you are pregnant.
pregnant women in their third trimester	with Ob-gyn provider within four (4) business days of Highmark Wholecare learning you are pregnant.
pregnant women with high-risk pregnancies	with Ob-gyn provider within twenty-four (24) hours of Highmark Wholecare learning you are pregnant or immediately if an emergency.

Appointment with:	An appointment must be scheduled…
PCP	
urgent medical condition	within twenty-four (24) hours.
routine appointment	within ten (10) business days.
health assessment/general physical examination	within three (3) weeks.
Specialists (when referred by PCP):	
urgent medical condition	within twenty-four (24) hours of referral.
routine appointment with one of the following specialists: ● Dentist. ● Dermatology. ● Orthopedic Surgery. ● Otolaryngology. ● Pediatric Allergy & Immunology. ● Pediatric Dentistry ● Pediatric Endocrinology. ● Pediatric Gastroenterology. ● Pediatric General Surgery. ● Pediatric Hematology. ● Pediatric Infectious Disease. ● Pediatric Nephrology. ● Pediatric Neurology. ● Pediatric Oncology. ● Pediatric Pulmonology. ● Pediatric Rehab Medicine. ● Pediatric Rheumatology. ● Pediatric Urology.	within fifteen (15) business days of referral.
routine appointment with all other specialists:	within ten (10) business days of referral.

You may file all other complaints at any time.

What Happens After I File a First Level Complaint?

After you file your Complaint, you will get a letter from Highmark Wholecare telling you that Highmark Wholecare has received your Complaint, and about the First Level Complaint review process.

You may ask Highmark Wholecare to see any information Highmark Wholecare has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to Highmark Wholecare.

You may attend the Complaint review if you want to attend it. Highmark Wholecare will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more Highmark Wholecare staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. Highmark Wholecare will mail you a notice within 30 days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 151.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What If I Do Not Like Highmark Wholecare's Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- Highmark Wholecare's decision that you cannot get a service or item you want because it is not a covered service or item.
- Highmark Wholecare's decision not to pay a provider for a service or item you got.
- Highmark Wholecare's failure to decide a Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.
- You did not get a service or item within the time by which you should have received it.
- Highmark Wholecare's decision to deny your request to disagree with Highmark Wholecare's decision that you have to pay your provider.

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice**.

You must ask for a Fair Hearing within **120 days from the mail date on the notice** telling you the Complaint decision.

For all other complaints, you may file a Second Level Complaint within **45 days of the date you got the complaint decision notice.**

For information about Fair Hearings, see page 158.
For information about external Complaint review, see page 154.
If you need more information about help during the Complaint process, see page 151.

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call Highmark Wholecare at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) and tell Highmark Wholecare your Second Level Complaint, or
- Write down your Second Level Complaint and send it to Highmark Wholecare by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to Highmark Wholecare by mail or fax.

Highmark Wholecare's address and fax number for Second Level Complaints:

Highmark Wholecare
Attn: Appeals & Grievances
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from Highmark Wholecare telling you that Highmark Wholecare has received your Complaint, and about the Second Level Complaint review process.

You may ask Highmark Wholecare to see any information Highmark Wholecare has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about Complaint to Highmark Wholecare.

You may attend the Complaint review if you want to attend it. Highmark Wholecare will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee made up of 3 or more people, including at 1 person who does not work for Highmark Wholecare, will meet to decide your Second Level Complaint. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. Highmark Wholecare will mail you a notice within 45 days from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 155.

What If I Do Not Like Highmark Wholecare's Decision on My Second Level Complaint?

You may ask for an external review from the Pennsylvania Insurance Department's Bureau of Managed Care. You must ask for anexternal review within **15 days of the date you got the Second Level Complaint decision notice.**

External Complaint Review

How Do I Ask for an External Complaint Review?

Send your request for external review of your Complaint to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, Pennsylvania 17120
Telephone Number: 1-877-881-6388

You can also go to the File a Complaint Page at: https://www.insurance.pa.gov/Consumers/insurance-complaint/Pages/default.aspx

If you need help filing your request for external review, call the Bureau of Consumer Services at 1-877-881-6388.

If you ask, the Bureau of Consumer Services will help you put your Complaint in writing.

What Happens After I Ask for an External Complaint Review?

The Insurance Department will get your file from Highmark Wholecare. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you want to continue getting services, you must ask for an external Complaint review or a Fair Hearing within 10 days of the date on the notice telling you Highmark Wholecare's First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you for the services or items to continue until a decision is made. If you will be asking for both an external Complaint review and a Fair Hearing, you must request both the external Complaint review and the Fair Hearing within 10 days of the date on the notice telling you Highmark Wholecare's First Level Complaint decision. If you wait to request a Fair Hearing until after receiving a decision on your external Complaint, services will not continue.

GRIEVANCES

What is a Grievance?

When Highmark Wholecare denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you Highmark Wholecare's decision.

A Grievance is when you tell Highmark Wholecare you disagree with Highmark Wholecare's decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call Highmark Wholecare at (800)392-1147/TTY 711 ((800)-654-5984) and tell Highmark Wholecare your grievance, or
- Write down your Grievance and send it to Highmark Wholecare by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from Highmark Wholecare and send it to Highmark Wholecare by mail or fax.

Highmark Wholecare's address and fax number for Grievances:

Highmark Wholecare
Attn: Appeals & Grievances
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** that telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from Highmark Wholecare telling you that Highmark Wholecare has received your Grievance, and about the Grievance review process.

You may ask Highmark Wholecare to see any information that Highmark Wholecare used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to Highmark Wholecare.

You may attend the Grievance review if you want to attend it. Highmark Wholecare will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. If the Grievance is about dental services, the Grievance review committee will include a dentist. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. Highmark Wholecare will mail you a notice within 30 days from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page 158.

What to do to continue getting services:
If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I Do Not Like Highmark Wholecare's Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for Highmark Wholecare.

You must ask for an external Grievance review within 15 days of the date you got the **Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services within **120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see page 157
For information about external Grievance reviews, see below.
If you need more information about help during the Grievance process, see page 158.

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call Highmark Wholecare at 1-800-392-1147/TTY 711 (1-800-654-5984) and tell Highmark Wholecare your Grievance, or
- Write down your Grievance and sent it to Highmark Wholecare by mail to: **Highmark Wholecare Attn: Appeals & Grievances P.O. Box 22278 Pittsburgh, PA 15222**

Highmark Wholecare will send your request for external Grievance review to the Insurance Department.

What Happens After I Ask for an External Grievance Review?

Highmark Wholecare will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

Highmark Wholecare will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within 15 days of filing the request for an external Grievance review.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you want to continue getting services, you must ask for an external Grievance review within 10 days of the date on the notice telling you Highmark Wholecare's Grievance decision for the services or items to continue until a decision is made. If you will be asking for both an external Grievance review and a Fair Hearing, you must request both the external Grievance review and the Fair Hearing within 10 days of the date on the notice telling you Highmark Wholecare's Grievance decision. If you wait to request a Fair Hearing until after receiving a decision on your external Grievance, services will not continue.

Expedited Complaints and Grievances

What Can I Do if My Health is at Immediate Risk?

If your doctor or dentist believes that waiting 30 days to get a decision about your Complaint or Grievance could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask Highmark Wholecare for an early decision by calling Highmark Wholecare at 1 (800)392-1147/TTY 711 (1(800)654-5984), faxing a letter or the Complaint/Grievance Request Form to (412)255-4503, or sending an email to MedicaidCommitteeReviews@highmarkwholecare.com.
- Your doctor or dentist should fax a signed letter to (412)255-4503 within 72 hours of your request for an early decision that explains why Highmark Wholecare taking 30 days to tell you the decision about your Complaint or Grievance could harm your health.

If Highmark Wholecare does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, Highmark Wholecare will decide your Complaint or Grievance in the usual time frame of 30 days from when Highmark Wholecare first got your Complaint or Grievance.

Expedited Complaint and Expedited External Complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the complaint review in person, but may have to appear by phone or by video conference because Highmark Wholecare has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

Highmark Wholecare will tell you the decision about your Complaint within 48 hours of when Highmark Wholecare gets your doctor's or dentist's letter explaining why the usual time frame for deciding your complaint will harm your health or within 72 hours from when Highmark Wholecare gets your request for an early decision, whichever is sooner, unless you ask Highmark Wholecare to take more time to decide your Complaint. You can ask Highmark Wholecare to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Insurance Department within **2 business days from the date you get the expedited Complaint decision notice**. To ask for expedited external review of a Complaint:

- Call Highmark Wholecare at 1-800-392-1147 (TTY user's call 711 or 1-800-654-5984) and tell us your Complaint, or
- Send an email to Highmark Wholecare at MedicaidCommitteeReviews@highmarkwholecare.com, or
- Write down your Complaint and send it to Highmark Wholecare by mail or fax: **Highmark Wholecare Attn: Appeals & Grievances P.O. Box 22278 Pittsburgh, PA 15222 Fax: 412-255-4503**

Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. If the Grievance is about dental services, the expedited Grievance review committee will include a dentist. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference because Highmark Wholecare has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the grievance review, it will not affect our decision.

We will tell you the decision about your Grievance within 48 hours of when Highmark Wholecare gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when Highmark Wholecare gets your request for an early decision, whicheveris sooner, unless you ask Highmark Wholecare to take more time to decide your Grievance. You can ask us to take up to 14 more days to decide your grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing. An expedited external Grievance is a review by a doctor who does not work for Highmark Wholecare.

You must ask for expedited external Grievance review within **2 business days from the date you get the expedited Grievance decision notice.** To ask for expedited external review of a Grievance:

- Call Highmark Wholecare at 1-800-392-1147 (TTY user's call 711 or 1-800-654-5984) and tell Highmark Wholecare your grievance, or
- Send an email to Highmark Wholecare at MedicaidCommitteeReviews@highmarkwholecare.com, or
- Write down your Grievance and send it to us by mail or fax: **Highmark Wholecare Attn: Appeals & Grievances P.O. Box 22278 Pittsburgh, PA 15222 Fax: 412-255-4503**

Highmark Wholecare will send your request to the Insurance Department within 24 hours after receiving it.

You must ask for a Fair Hearing within 120 days from the date on the notice telling you the expedited Grievance decision.

What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of Highmark Wholecare will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer, or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell Highmark Wholecare, in writing, the name of that person and how Highmark Wholecare can reach him or her.

You or the person you choose to represent you may ask Highmark Wholecare to see any information Highmark Wholecare has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call Highmark Wholecare's toll-free telephone number at 1-800-392-1147 (TTY user's call 711 or 1-800-654-5984) if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

Persons Whose Primary Language is Not English

If you ask for language interpreter services, Highmark Wholecare will provide the services at no cost to you.

Persons with Disabilities

Highmark Wholecare will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by Highmark Wholecare at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something Highmark Wholecare did or did not do. These hearings are called "Fair Hearings". You can ask for a Fair Hearing after Highmark Wholecare decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked within 120 days from the date on the notice telling you Highmark Wholecare's decision on your First Level Complaint or Grievance about the following:

- ✓ The denial of a service or item you want because it is not a covered service or item.
- ✓ The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- ✓ Highmark Wholecare's failure to decide a First Level Complaint or Grievance you advised Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.

- ✓ The denial of your request to disagree with Highmark Wholecare's decision that you have to pay your provider.
- ✓ The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- ✓ You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling that Highmark Wholecare failed to decide a First Level Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter, it needs to include the following information:

- ✓ Your (the member's) name and date of birth;
- ✓ A telephone number where you can be reached during the day;
- ✓ Whether you want to have the Fair Hearing in person or by telephone;
- ✓ The reason(s) you are asking for a Fair Hearing; and
- ✓ A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program Complaint, Grievance and Fair Hearings
PO Box 2675
Harrisburg, PA 17105-2675

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer, or other person may help you during the Fair Hearing. You MUST participate in the Fair Hearing.

Highmark Wholecare will also go to your Fair Hearing to explain why Highmark Wholecare made the decision or explain what happened.

You may ask Highmark Wholecare to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Highmark Wholecare, not including the number of days between the date on the written notice of the Highmark Wholecare's First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because Highmark Wholecare did not tell you its decision about a Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Highmark Wholecare, not including the number of days between the date on the notice telling you that Highmark Wholecare failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 10 days of the date on the notice telling you Highmark Wholecare's First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339 or by faxing a letter or the Fair Hearing Request Form to 717-772-6328. Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call Highmark Wholecare at 1-800-392-1147/TTY 711 (1-800-654-5984) if you need help or have questions about Fair Hearings, you can contact your local legal aid office, Pennsylvania Legal Aid Network at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

Provider Appeals

Any provider may file a provider appeal to request the review of any post-service denial. This process is intended to afford providers with the opportunity to address issues regarding payment only. Appeals for services that have not yet been provided must follow the member grievance or complaint processes. The Provider Appeal Process must be initiated by the provider through a written request for an appeal. The written request for an appeal, along with all supporting documentation, must be sent to:

Highmark Wholecare
Attention: Provider Appeals & Grievance
P.O. Box 22278 Pittsburgh, PA 15222, or Fax: 1-855-501-3904

First Level Appeal

1. To request a provider appeal, providers must make a written request for appeal which must be received by the plan within:
   a. Sixty (60) calendar days of the date of their denial notice denying an authorization unless otherwise negotiated by contract. In this instance, there is a denied authorization, however, services have already been provided.
   b. One hundred eighty (180) calendar days from the claim denial, unless otherwise negotiated by contract. When an authorization has been denied, the provider must adhere to the sixty (60) calendar day time frame above, the one hundred eighty (180) calendar days once the claim has denied does not apply.
2. When submitting a written request for an appeal, the provider is required to submit any and all supporting documentation including, but not limited to, a copy of the denied claim, the reason for the appeal, and the member's medical records containing all pertinent information regarding the services rendered by the provider.
3. The Appeal Committee will be comprised of one or more Highmark Wholecare staff members who were not involved in the initial review ensuring providers receive an equitable, unbiased decision based on evidence. All first level provider appeal reviews will be completed within sixty (60) calendar days of the date the written request was received.
4. The provider will be informed of the decision in writing by mail notification within sixty (60) calendar days from receipt. This notification will include additional appeal rights as applicable (i.e. Second (2nd) Level Provider Appeal) (see below). If the appeal is approved, payment will be issued within sixty (60) calendar days of notification.

Second Level Appeal

1. If the provider is not in agreement with the first level provider appeal committee's decision, the provider may seek a second level provider appeal. A request for a second level provider appeal must be submitted to the plan in writing within sixty (60) calendar days of the date on the first (1st) level provider appeal decision letter, or as otherwise indicated by contract. All second level provider appeal requests must include rationale and or additional supporting information as to why the provider does not agree with the plans' first (1st) level provider appeal committee's decision.
2. The appeal committee will be comprised of member(s) who were not involved in any previous level of review ensuring providers receive an equitable, unbiased decision based on evidence. At least one-fourth (1/4) of the committee will include a healthcare professional.
   - The committee will have authority, training, and expertise to address/resolve the issue. All data available will be available to the committee to make a documented decision. All second (2nd) level provider appeal reviews will be completed within sixty (60) calendar days of the date the second level provider appeal request was received.

3. The second level appeal committee will inform the provider of its decision in a written decision notice within sixty (60) calendar days. This is the final level of appeal and the decision is binding, unless otherwise governed per contract.

Care Management

Telephonic Management

1. Case Managers proactively reach out to higher-risk members to:
2. Assess overall well-being, including SDoH needs.
3. Determine the member's understanding of their condition(s).
4. Assess behavioral, economic, environmental, social, spiritual, and medical needs.
5. Discuss lifestyle management issues including but not limited to diet, nutrition, meal planning, weight management, exercise, and smoking cessation.
6. Refer members to a health educator, home health visits, behavioral health, or any other discipline if indicated.
7. Communicate with members care team as needed.
8. Perform medication reconciliation to assess compliance and understanding; assess for polypharmacy and multiple prescribers.
9. Review claims for laboratory testing and follow up with member for results.
10. Provide pillboxes if needed.

The program helps providers by:

- Decrease inpatient and emergency room utilization.
- Increase appropriate lab testing and medication adherence.
- Emphasize the importance of making and keeping appointments and provide coaching on how to make the best use of the time with the provider.
- Encourage adherence to obtain flu and pneumonia immunizations.
- Provide education to assist your patients in understanding their condition and life style implications, and motivating them to take a proactive role in managing their health.

We would like to work with you to make a positive impact on your patient's health! For more information or to refer a patient to any of the Lifestyle Management programs call 1-800-392-1147.

Highmark Wholecare Lifestyle Management Program SM

Highmark Wholecare Lifestyle Management programs provides support to members with chronic conditions to promote improved health and self-management. These programs are also designed to support the provider/patient relationship and plan of care.

The Lifestyle Management programs include Asthma, Cardiac, COPD, Diabetes, Hypertension, MOM Matters and Healthy Weight Management.

The program provides the following member benefits and support:

- Welcome letter and brochure provide members with information about the Lifestyle Management program and how to reach a case manager or opt out.
- Member newsletters provide members with educational information about their chronic conditions.
- Website provides Lifestyle Management program material and has links to the Pennsylvania Quit Line to assist members with smoking cessation.
- Educational materials may be mailed to members.
- IVR campaigns provide members with tips to help manage their condition.

- Text message programs may be offered to certain member populations.
- Linkage to community resources to address Social Determinants of Health that impact the members' health.

Asthma Program

The Highmark Wholecare Lifestyle Management Asthma Program emphasizes patient education self-management, and medication adherence. The program aims to reduce the necessity of asthma related emergency room visits and reduce inpatient utilization in our asthma population.

Members age two (2) years and older are eligible for the program. The program encourages an active lifestyle while minimizing or preventing asthma exacerbations and improving quality of life. Members are automatically enrolled once they are identified with asthma, but are able to opt-out if they choose.

By participating in the Asthma Program, your patients can receive:

- Education about asthma, self-management tools and medication adherence.
- Support to identify and minimize their asthma triggers
- Information to recognize early symptoms requiring medical attention
- Ability to understand the difference between a rescue inhaler and a controller medication and how to use both properly
- Program includes pediatric specific learning materials.

For more information or to refer a patient to the Asthma Program call 1-800-392-1147.

Diabetes Program

The Highmark Wholecare Lifestyle Management Diabetes Program emphasizes education and personal responsibility for diabetes management to reduce the need for hospitalizations, ER visits, and to prevent complications related to diabetes.

All adult and pediatric members with Type 1 or Type 2 diabetes are eligible for this program. Members are automatically enrolled once they are identified with diabetes but are able to opt-out if they choose.

By participating in the Diabetes Program, your patients can receive:

- Education regarding co-existing conditions, smoking cessation, medication adherence, and blood glucose monitoring.
- Reinforcement of your plan of care.
- Targeted telephonic and/or mailed reminders to patients who are due for diabetes-related lab/tests.
- Member newsletters with diabetes related articles.

For more information or to refer a patient to the Diabetes program call 1-800-392-1147.

Cardiac Program

The Highmark Wholecare Lifestyle Management Cardiac Program emphasizes patient education, and support to help members with cardiac conditions take an active role in their well-being by adopting a heart healthy lifestyle by taking medications as prescribed and by understanding how to avoid sudden flare ups of their condition.

Adult members with a diagnosis of AMI, Atrial Fibrillation, Chronic Heart Failure, Heart Failure Diagnosis, IVD, or MI are eligible for this program. Members are automatically enrolled once they are identified with one of

these cardiac conditions but are able to opt out if they choose.

By participating in the Cardiac Program, your patients can receive:

- Patient education and self-management tools.
- Telephonic case management to high-risk cardiac patients.
- Reinforcement of your plan of care including assistance with smoking cessation, medication compliance, and appropriate lab testing.

For more information or to refer a patient to the Cardiac Program, call 1-800-392-1147.

COPD Program

The Highmark Wholecare Lifestyle Management COPD Program emphasizes patient education self-management, and medication adherence. The program promotes lifestyle modification and safety to reduce inpatient utilization, emergency room visits, and preventable flare-ups.

Members twenty-one years of age and older with a diagnosis of COPD are eligible for this program. Members are automatically enrolled once they are identified with COPD but are able to opt-out if they choose.

By participating in the COPD Program, your patients can receive:

- Education on the importance of medication adherence as well as proper use of their inhalers.
- Tips to identify and avoid COPD triggers to help prevent an exacerbation and recognize when they should call their physician.
- Education to understand the role of supplemental oxygen and/or the benefits of a pulmonary rehabilitation program.
- Lifestyle modifications education including smoking cessation.
- Telephonic case management support to high-risk members.

For more information or to refer a patient to the COPD Program, call 1-800-392-1147.

Hypertension Program

The Highmark Wholecare Lifestyle Management Hypertension Program includes services and interventions that emphasize patient empowerment, self-management, provider education and support to promote wellness, and to reduce acute care utilization.

Members with a diagnosis of hypertension are eligible for this program. Members are automatically enrolled once they are identified with hypertension but are able to opt-out if they choose.

By participating in the Hypertension Program, your patients can receive:

- Patient education and self-management tools.
- Telephonic case management for high-risk members.
- Information on smoking cessation with referral to the state Quitline.
- Member newsletters with hypertension related articles.

For more information or to refer a patient to the Hypertension Program, call 1-800-392-1147.

MOM Matters Program

The MOM Matters Perinatal Program offers maternity care coordination to improve the frequency and timeliness of prenatal and postpartum care, to reduce the incidence of low birth weight and pre-term deliveries, and to decrease the need for NICU admissions with the goal of improving outcomes for all pregnant members. Specific interventions are designed to identify and engage members at high risk for adverse pregnancy outcomes. The MOM Matters Program supports the practitioner-patient relationship and plan of care and emphasizes the prevention of complications by using evidence-based guidelines and patient-empowerment strategies.

All members identified as pregnant or postpartum are eligible for this program. Pregnant or postpartum members are automatically enrolled but are able to opt-out if they choose.

The program will help your patient:

- Identify signs and symptoms of preterm labor or complications with the pregnancy.
- Understand lifestyle modifications to maintain a healthy pregnancy.
- Recognize how co-existing medical conditions can impact the pregnancy.
- Understand the importance of post-partum follow-up and assist with scheduling post-partum visit.
- Patient education and self-management tools.
- Information on smoking cessation with a referral to state Quitline.
- Member newsletters with pregnancy related articles.
- Home care coordinated through the members Highmark Wholecare case manager.

MOM Matters Program is now offering a home visiting program to provide ongoing support to pregnant and postpartum members, up to twenty-four (24) months postpartum. The goal of the home visiting program is to provide ongoing health education for women and children, provide referrals to community agencies to address identified SDoH needs and refer to evidence-informed home visiting programs as appropriate.

For more information or to refer a patient to the MOM Matters Prenatal Program call 1-800-392- 1147.

Healthy Weight Management

The Highmark Wholecare Healthy Weight Management Program emphasizes education and supports members on their journey of weight loss.

Adult and pediatric members diagnosed with overweight or obesity are eligible for this program. Members are automatically enrolled once they are identified, but are able to opt-out if they choose.

By participating in the Healthy Weight Management Program, your patients can receive:

- Education regarding co-existing conditions.
- How to eat healthy on a budget.
- How simple changes to your daily routine can lead to weight loss.
- Why weight is important for good health.

For more information or to refer a patient to the Healthy Weight Management Program call 1-800-392-1147.

Special Needs Unit Case Management

General Information

A member with Special Needs is based upon a non-categorical or generic definition of Special Needs. This definition will include but not be limited to key attributes of ongoing physical, developmental, emotional or behavioral conditions, or life circumstance which may serve as a barrier to the member's access to care or services.

The goal of the SNU Case Management is to intervene in medically or socially complex cases that may benefit from increased coordination of services to optimize health and prevent disease. The SNU is staffed by individuals with medical or social service backgrounds in the following areas: oncology, medically complex children, HIV/AIDS, substance abuse, mental health, physical rehabilitation, and intellectual disability.

A SNU Case Manager is available at 1-800-392-1147, Monday through Friday from 8:30 AM to 4:30 PM to assist with coordination of the member's healthcare needs.

The responsibilities of the SNU include:

- Liaison with various healthcare practitioners, community social service agencies, advocacy groups, and other agencies that the MA population may interface with.
- Case management of children with medically complex special needs.
- Coordination of services between primary care, specialty, ancillary, and behavioral health practitioners within and outside the network.
- Facilitation of dispute resolution including informing members of the complaint, grievance, and appeal mechanism that is available to the member. Facilitation of members' access to city, county, and commonwealth social agencies for those members with complicated ongoing social service needs that affect their ability to access and use medical services.

The PH-MCO Special Needs Unit case manager must function as the single point of contact to coordinate all health care needs including social determinates of health needs for vulnerable populations.

Examples of Member Referrals to the Special Needs Unit Case Management Team

Member with the following conditions and/or diagnoses are examples of appropriate referrals to the SNU:

- Children with special healthcare needs (i.e., Cerebral Palsy).
- HIV/AIDS.
- Mental health and substance abuse issues.
- Intellectual disabilities/developmental disabilities.
- High risk pregnancy.
- Social issues (i.e., domestic violence, substitute care, food, or housing insecurities).

Behavioral Health Coordinator

A BH Coordinator who is a behavioral health professional and is located in Pennsylvania shall monitor Highmark Wholecare for adherence to BH requirements in the HealthChoices Agreement. The primary functions of the BH Coordinator are:

- Coordinate Member care needs with BH Providers.
- Develop processes to coordinate behavioral healthcare between PCPs and BH Providers.
- Participate in the identification of best practices for BH in a primary care setting.
- Coordinate behavioral care with medically necessary services.
- Be knowledgeable of the BH Managed Care Agreement requirements and coordinate with the BH-MCO to effectuate the requirements.

To speak with Highmark Wholecare's BH Coordinator dial 1-800-685-5209 extension 8874.

Complex Case Management

Highmark Wholecare's SNU provides a Complex Case Management program for eligible members. A Case Manager can help members better understand their health condition and benefits and can also help to coordinate health care services. A Case Manager can tell members about community organizations and resources that may meet their needs.
Eligible members may include:

- Members with multiple medical conditions.
- Members with a complex medical history.
- Members that need assistance to become more self-reliant in managing their health care.
- Members that are at risk of a hospital admission.

Please contact the SNU Case Management to make a referral to the Complex Case Management program at 1-800-392-1147. TTY users call (711) or 1-800-654-5984.

Highmark Wholecare will review the request for enrollment and make the final decision for inclusion in the program.

Chronic Case Management

Highmark Wholecare's Special Needs Unit provides case management services for members with chronic illnesses not noted above. Case Managers focus on active condition monitoring, lifestyle management, preventive health, care coordination, and community resource referrals. To refer a member or discuss care coordination issues, contact SNU Case Management at 1-800-392-1147.

School Based-School Linked Services

Highmark Wholecare's Special Needs Team actively coordinates with the school based and school linked services throughout the State. Our Case Managers provide support and assistance as needed, to ensure that our members receive all required medically necessary services to allow for them to attend school. The CMs work closely with the members parent/guardian, the School based special needs staff, as well as the members physicians and specialists ensure that all required services are available for the member in the school setting. Call the Special needs team at 1-800-392-1147 asked to speak to a Special Needs Case Manager if you require assistance with school based/linked services.

Credentialing

Purpose of Credentialing

Credentialing is the process of performing a background investigation, as well as validation of a practitioner and providers credentials and qualifications. The credentialing and recredentialing processes also encompass a complete review of, to include but not limited to, malpractice histories, quality of care concerns, and licensure status. Highmark Wholecare prides itself on the integrity and quality of the composition of the practitioner and provider networks.

Who is Credentialed?

Practitioners: Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Medicine (DMD), Doctor of Dental Surgery (DDS), Doctor of Optometry (OD), Doctorate of Psychology (Ph.D.), and Doctorate of Philosophy (Ph.D.). This listing is subject to change.

Extenders: Physician Assistant (PA), Certified Nurse Practitioner (CRNP), Certified Nurse Midwife (CNM), a Clinical Nurse Specialist (CNS) and a Certified Nurse Practitioner (CNP). (This listing is subject to change.)

Facility and Ancillary Service Providers: Hospitals, Nursing Homes, Skilled Nursing Facilities, Home Health, Hospice, Rehabilitation Facilities, Ambulatory Surgical Centers, Portable X-ray Suppliers, End Stage Renal Disease Facilities, Outpatient Physical Therapy, and Speech Therapy providers, Rural Health Clinics, and Federally Qualified Health Centers. (This listing is subject to change.)

Credentialing Standards

Highmark Wholecare has established credentialing and recredentialing policies and procedures that meet CMS, DOH, DHS, and NCQA standards. Highmark Wholecare adherences to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach.

All information must be current and up-to-date to begin the credentialing process. Therefore, it is important to provide Highmark Wholecare with your CAQH ID on a completed Highmark Wholecare Provider Data Form and submit all attachments in a timely manner with the most current information available. Highmark Wholecare will obtain your most current application through the CAQH database.

In addition, extenders are required to submit a copy of their collaborative/written agreement with a Highmark Wholecare participating supervising practitioner/written agreement with a Highmark Wholecare participating supervising practitioner. This agreement must adhere by state specific regulations for collaborative/written agreements for extenders. Any time there is a change in the extender's supervising physician, the extender will be required to submit to Highmark Wholecare, a current copy of his/her new collaborative/written agreement as indicated in his/her approval letter. Where applicable, the submittal of the collaborative/written agreement to Highmark Wholecare must include a copy of the letter of approval from the State and if applicable, a DEA is required.

Highmark Wholecare's standards include, but are not limited to, the following:

- A current, unrestricted license.
- Fully completed and attested CAQH application.
- Active individual Master Provider Index (MPI) number.
- NPI number.
- Curriculum Vitae and/or Work History to include month and year.
- Copy of current, unencumbered DEA certificate, if applicable.
- Current hospital admitting privileges for PCPs or appropriate coverage arrangement.
- Acceptable malpractice history as subject to decision by Highmark Wholecare Medical Directors.
- Practitioners must maintain professional liability coverage as required by the state in which he/she practices or as outlined in the practitioner contractual agreement. For those self- insured a statement on letterhead indicating the providers are insured by a self- indemnification policy needs submitted.
- Active participation in the Medicare and/or Medicaid programs; free of sanctions.
- Foreign graduates must submit an ECFMG certificate.
- Other items as deemed appropriate.

The credentialing/recredentialing process involves primary sourced verification of practitioner credentials.

Highmark Wholecare's Credentialing Department will notify practitioners, in writing, within forty-five (45) calendar days of receiving any information obtained during the credentialing or recredentialing process that varies substantially from the information provided by the practitioner. Practitioners have the right to correct erroneous information submitted by another party or to correct his or her own information submitted incorrectly. Applicants have ten (10) calendar days from the date of Highmark Wholecare's notification to submit written corrections and supporting documentation to Highmark Wholecare's Credentialing Department. A credentialing decision will not be rendered until the ten (10) calendar days have expired.

Practitioners, upon request, have the right to be informed of the status of their credentialing or recredentialing application. Practitioners also have the right to review any information submitted in support of their credentialing applications except for National Practitioner Data Bank (NPDB) and/or Healthcare Integrity Practitioner Data Bank (HIPDB) reports, letters of recommendation, and information that is peer review protected. A practitioner must submit a written request to review their credentialing information. All appropriate credentialing information will be sent by certified mail, overnight mail or carrier to the practitioner within ten (10) business days from the date that the Credentialing Department received the request.

All practitioners must be recredentialed at least every three years in order to continue participation with Highmark Wholecare. This helps to assure Highmark Wholecare's continued compliance with NCQA, DHS, CMS, and DOH regulations, as well as to uphold the integrity and quality of the networks. Extensions of this timeframe will only be considered in the event the practitioner is on maternity leave, military leave or sabbatical. Otherwise, extensions cannot be granted.

Highmark Wholecare is committed to protecting the confidentiality of all practitioner information obtained by the Credentialing Department as outlined in Highmark Wholecare PlusSM Confidentiality of Practitioner/Provider Credentialing Information Policy and Procedure.

Ongoing Performance Monitoring

Highmark Wholecare's Credentialing Department conducts ongoing monitoring of sanctions, licensure disciplinary actions, and member complaints.

Sanction information is reviewed by utilizing the Office of Inspector General's (OIG) report, the Medicare Opt-Out Listing (CMS), the System for Award Management (SAM), CMS Preclusion Listing and MediCheck in Pennsylvania. Information can also be obtained from the American Medical Association (AMA) and the National Provider Data Bank (NPDB)/Healthcare Integrity Practitioner Data Bank (HIPDB) as needed.

Monitoring of limitations on licensure is conducted on a monthly basis. If a Highmark Wholecare participating practitioner is found on the OIG, Medicare Opt-Out List, Medicare/Medicaid sanction/exclusion listing or State Board of Medicine disciplinary action report, the practitioners file is immediately pulled for further investigation.

Depending on severity level of the sanction, the practitioner may be sent to the Medical Director for review and recommendation, sent to QI/UM committee for review and decision and/or terminated. In all instances, the information is reported to the QI/UM committee.

Monitoring of member complaints is conducted on a quarterly basis. In coordination with the Highmark Wholecare Provider Relations team, the Highmark Wholecare credentialing department reviews trends of compliant reports, which reveals member complaints filed against practitioners. The Credentialing Department will review and investigate all trends of complaints regarding: attitude of provider, provider treatment, quality issues of physician, and any complaints regarding adverse events. If after investigation the complaint is considered viable, it is documented. Depending upon the severity level of the complaint(s), the practitioner may be sent to the Medical Director for review and recommendation, sent to QI/UM Committee for review and decision and/or terminated and outcome presented to QI/UM Committee.

Highmark Wholecare's recredentialing process includes a comprehensive review of a practitioner's credentials, as well as a review of any issues that may have been identified through a member complaint report and/or quality of care database.

Practitioner Absences

Highmark Wholecare continues to follow NCQA guidelines for practitioners called to active military service, on maternity leave or on an approved sabbatical. However, it is the practitioner or their offices responsibility to notify Highmark Wholecare in writing that the practitioner has been called to active duty or beginning the said leave, as well as provide an expected return date. The letter should also include the practitioner who will be covering during his or her leave. The Highmark Wholecare Credentialing Department will not terminate the practitioner if they are called to active duty, on maternity leave or on an approved sabbatical if appropriate coverage is in place. Practitioner(s) office should notify Highmark Wholecare of practitioners return, as soon as possible, but not exceeding ten (10) business days from the practitioners return to the office. The Highmark Wholecare Credentialing Department will determine, based upon the length of time, if the practitioner will have to complete a recredentialing application. If the practitioner requires recredentialing, the application must be completed within sixty (60) calendar days of the practitioner resuming practice.

Denial and Termination

In accordance with Highmark Wholecare's business practices, the inclusion of a practitioner in the Highmark Wholecare Practitioner/Provider Network is within the sole discretion of Highmark Wholecare.

Highmark Wholecare conducts credentialing in a non-discriminating manner and does not make credentialing decisions based on an applicant's type of procedures performed, type of patients, or a practitioner's specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation, or disability. Highmark Wholecare understands and abides by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall on the sole basis of the disability be excluded from participation.

If a practitioner meets Highmark Wholecare's credentialing criteria, a Highmark Wholecare Medical Director may approve the credentialing applicant. If a practitioner does not meet Highmark Wholecare's baseline credentialing criteria, the QI/UM committee will make a final determination on participation or continued participation. If a practitioner fails to submit information and/or documentation within requested time frames, processing of the practitioner application may be discontinued or terminated. All requests for recredentialing updates must be completed and returned in a timely manner. Failure to do so could result in denial or termination of participation.

Denial and termination decisions that are made based on quality concerns can be appealed and are handled according to Highmark Wholecare's Due Process Policy and Procedure. If necessary, the information is reported to the National Practitioner Data Bank and Bureau of Quality Management and Provider Integrity in compliance with the current 45 CFR Part 60 and the Health Care Quality Improvement Act, as well as State licensing boards.

Practitioners who want to request a review of a termination, other than for quality of care concerns, must submit a written request for the review along with any supporting documentation to Highmark Wholecare within thirty (30) calendar days of the date of the certified notification.

Delegated Credentialing

Delegation is the formal process by which Highmark Wholecare has given other entities the authority to perform credentialing functions on the behalf of Highmark Wholecare. Highmark Wholecare may delegate certain activities to a credentialing verification organization (CVO), Independent Practitioner Association (IPA), hospital, medical group, or other organizations that employ and/or contract with practitioners. Organizations must demonstrate that there is a credentialing program in place and the ability to maintain a program that continuously meets Highmark Wholecare's program requirements. The delegated entity has authority to conduct specific activities on behalf of Highmark Wholecare. Highmark Wholecare has ultimate accountability for the quality of work performed and retains the right to approve, suspend, or terminate the practitioners and site. Any further sub delegation shall occur only with the approval of Highmark Wholecare and shall be monitored and reported back to Highmark Wholecare.

FORMS AND REFERENCE MATERIALS

https://www.Highmark Wholecarehealthplan.com/provider/medicaid-resources

EPSDT FORMS AND REFERENCE MATERIALS

https://www.Highmark Wholecarehealthplan.com/provider/medicaid-resources

Change Healthcare is a separate company that administers E&M audits, education and probe audit expansion for Highmark Wholecare.

NaviNet is a separate company that provides an internet-based application for providers to streamline data exchanges between their offices and Highmark Wholecare such as routine eligibility, benefits, and claims status inquiries.

HealthHelp is a separate company that offers education and guidance from specialists in sleep, cardiology, and radiation oncology from Highmark Wholecare

Adagio Health is a separate company that provides women's health services for Highmark Wholecare.

Davis Vision is a separate company that administers vision benefit(s) for Highmark Wholecare.

NIA/Magellan is a separate company that administers prior authorization for certain services for Highmark Wholecare.

United Concordia Dental is a separate company that administers dental benefit(s) for Highmark Wholecare.

This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Wholecare serves a Medicaid plan to Blue Shield member in 13 counties in central Pennsylvania, as well as, to Blue Cross Blue Shield members in 27 counties in western Pennsylvania. Highmark Wholecare serves Medicare Dual Special Needs plans (D-SNP) to Blue Shield members in 14 counties in northeastern Pennsylvania, 12 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.

Relay Health is a separate company that administers claim reporting for Highmark Wholecare