

Welcome!

EVV Training with Highmark Wholecare

The program will begin at noon.

You will hear silence until we begin.

Please take this opportunity to check your connections.



*The Q&A box is available to type
any questions or issues.*



Provider Electronic Visit Verification Training

August 19, 2026



This information is issued on behalf of Gateway Health Plan, Inc. d/b/a Highmark Wholecare, an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare provides Medicaid coverage for Blue Shield in 13 counties in central PA and Blue Cross Blue Shield in 14 counties in western PA.

Disclaimer

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Today's Speakers



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Agenda



- ❖ Overview of FWA
- ❖ Provider Responsibilities
- ❖ Documentation Requirements
- ❖ HHAeXchange
- ❖ Appendix

Overview of FWA

FIPR Mission

Definitions of FWA

Examples of FWA

Fraud in Home
Health

21st Century Cures
Act



FIPR Mission and Strategy

- Highmark Wholecare's **Financial Investigation and Provider Review ("FIPR")** supports Highmark Wholecare by investigating fraud, waste and abuse ("FWA") and recovering overpayments for our customers.
- FIPR reviews and investigates potentially fraudulent and/or inappropriate billings submitted by providers and/or participants, using industry-leading data analytics and national third-party vendors.
- Within FIPR, Highmark Wholecare has **Electronic Visit Verification ("EVV")** Investigators who oversee EVV compliance requirements.



Highmark Wholecare's Mission:
Whole person care - that helps people achieve not just physical health, but whole life health.

FIPR Mission:
To protect our customers and lower the cost of healthcare by deploying comprehensive solutions that combat FWA

FIPR Strategy:
Utilize data analysis techniques to identify aberrant claims, perform claim coding reviews and conduct a variety of audits using investigative methods to assess the appropriateness of provider payments and pursue overpayment recoveries

Definitions of FWA



Fraud

- Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain, by means of false or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program.
- Fraud is intentional or actions that result in deliberate overpayments.



Waste

- Practices that, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program, such as overusing services.
- Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.



Abuse

- Actions that may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program.
- Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of FWA



Fraud

- Billing for services not provided (known as phantom billing)
- Upcoding (billing for a more expensive service than received)
- Unbundling (multiple bills for same service)
- Misrepresenting services (billing medically unnecessary services)
- Falsifying records (such as diagnosis)
- Kickbacks (paying/receiving money in exchange for business)



Waste

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory

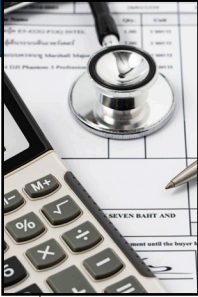


Abuse

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Fraud within Home Health

Red flags are patterns, practices or aberrant activities that indicate the possibility of fraud.



Billing for services that haven't been rendered



Receiving kickbacks for beneficiary referrals



Impossible days



Submitting multiple billings for the same service & usually high volume of the same services



Altering records, including timesheets



Pressure to pay claims quickly

21st Century Cures Act

The 21st Century Cures Act (The Cures Act) enacted changes to strengthen fraud and abuse measures in the Medicaid program; including requiring states to screen and enroll providers with the State Medicaid Agency and establishing a timeline for states to adopt electronic verification systems.

See [Public Law 114-255](#) for further information.



- The Cures Act passed in both the House and Senate with strong bipartisan support and was signed into law on December 13, 2016.
- The Cures Act provided the National Institutes of Health (NIH) with tools and resources needed to advance biomedical research, from foundational basic research studies to advanced clinical trials of new therapies.
 - Provisions included funding and administration, reducing opioid abuse, medical research and drug development.



Section 12006 of the 21st Century Cures Act requires states to implement an EVV system for Medicaid-funded Personal Care Services (PCS) and for Home Health Care Services (HHCS) that require an in-home visit by a provider.

> Six Elements of a Cures Compliant Visit



Who

Patient



Who

Caregiver



What

Type of
Service



Where

Location
of Service



When

Date of
Service



When

Time of
Service

Provider Responsibilities

Provider Self-Audit

Medical Record
Requests



Provider Self-Audits: Required by DHS and OIG

- Providers can submit overpayments to Highmark Wholecare by using the Provider Self-Audit Overpayment form found on our website
- Both the Department of Human Services (DHS) and the Office of the Inspector General (OIG) require providers to conduct self-audits to identify documentation errors and potential overpayments
- Federal and state laws and regulations require overpayments to be returned within **60 days** of identification

Resources for Self-Audits:
[DHS Guidance](#)
[OIG Guidance](#)



Provider Self-Audits/Overpayments Form

Instructions for Providers: Highmark Wholecare cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit this form for any self-identified overpayments to the Highmark Wholecare Financial Investigations and Provider Review Department. *Required fields are outlined in Red*

I. Self-Audit / Overpayment Information

A. Reason for Refund:

B. Type of Refund: (please check one)

Retraction Requested
(Claims less than 2 years old) ☒

Check Provided
(Claims more than 2 years old) ☐

RETRACTION

II. Provider Information

Date: Practice Name: Provider Number:
Practitioner Name: Phone Number:
Tax Identification Number: NPI Number:
Contact Person at Provider's Office:
Contact Phone Number: Contact E-mail Address:

III. Member/Claim Information: (Please use a separate sheet for additional Member/Claim Information)

Member Name	Member ID	Date of Service	Claim Number	Refund Amount

Other Information:

Period of Claims (based on dates of service):

Mail checks with a copy of this form to:
Highmark Wholecare
Attn: FIPR
PO Box 890135
Camp Hill, PA 17089

For Claim Retraction **ONLY**, mail this form to:

Delivery Code: FIPR
Attn: FWA/SIU Unit
Highmark Wholecare
120 Fifth Ave.
PAP-4
Pittsburgh, PA 15222

Email: FIPR-ProviderSelfAudits@highmark.com

For more information on Provider Self-Audits, check out these resources:

Provider
Resource
Center
(PSAs)

Medicaid
Provider
Manual

Online Overpayment Form: [Provider Self-Audits/Overpayments Form](#)

Trend Process:

Providers can now electronically submit overpayments via TRENDSubmit.

Secure, online process that allows providers to be notified of claim retractions in real-time.

TRENDSubmit team provides user training resources and ongoing support.

Contact [Jennifer Baron](#) to initiate access.

Medical Record Requests

Highmark Wholecare's FIPR Team will conduct retrospective reviews of claims and medical records to ensure claims accuracy and documentation standards.

- Providers must provide requested records at no cost to Highmark Wholecare. This includes notifying any third-party vendor who may maintain medical records of this stipulation.
- All requested documentation must be submitted at the time of the medical record request within 30 days from the letter date.
- Failure to provide requested medical records within the specified time frame will result in claims being denied



Documentation Requirements

Minimum Documentation

Consent to Treatment

Progress Notes





Minimum Documentation: Highmark Wholecare Provider Manual

Highmark Wholecare requires providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations as well as other applicable professional associations and advisory agencies. Providers should follow these 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 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.



Minimum Documentation: Highmark Wholecare Provider Manual

Additionally, the medical records must have the following:

- 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.,)
- Continuity of care is documented
- Immunizations and dates
- Must be easy to read and legible
- 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
- Laboratory and other studies ordered

Minimum Documentation: CMS – Documentation Matters Toolkit

- Providers are responsible for documenting each patient encounter completely, accurately and on time.
- Because providers rely on documentation to communicate important patient information, incomplete and inaccurate documentation can result in unintended and even dangerous patient outcomes.
- Accurate documentation supports compliance with federal and state laws and reduces fraud, waste and abuse.

CMS Resources



Documentation Matters Fact Sheet for Medical Professionals:

- <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-medicalprof-factsheet.pdf>

Documentation Matters Fact Sheet for Behavioral Health Practitioners:

- <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf>

Documentation Matters Fact Sheet for Medical Office Staff:

- <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-officestaff-factsheet.pdf>

Medical Records Resource Guide:

- <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-recorddoc-resourceguide.pdf>

Electronic Health Records Fact Sheet:

- <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf>

Consent to Treatment Guidance – Provider Manuals

- Valid for dates of service (update yearly)
- Identifies the patient
- Signed and dated by the patient
- Signed, dated and credentialed by the clinician
- List types of services and/or treatments
- Includes the benefits and potential risks
- Includes alternative services and/or treatments
- Must be easy to read and legible

These requirements are included in:

[2025 Medicaid Provider Manual](#)



Progress Notes



Pennsylvania Regulations

The Pennsylvania Code establishes standards for medical records, including the entry of progress notes

55 Pa. Code 1101.51(e)(1): A provider, with the exception of pharmacies, laboratories, ambulance services and suppliers of medical goods and equipment shall keep patient records that meet all of the following standards:

- (vi) the record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment

Highmark Wholecare Provider Manual

- 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

HH AeXchange

EVV Compliance

State Aggregation
Report

Caregiver Report

Corrective Action Plans
(CAPs)



EVV Compliance for Home Health Providers

Highmark Wholecare is monitoring your agency's EVV compliance. Providers must achieve an 85% compliance rate.

- Effective January 1, 2025, DHS requires PCS and HHCS to maintain a minimum of 85% compliance rate for verified visits **without manual edits**. This means 85% of submitted visits must be complete and accurate, requiring no manual correction or data entry after the visit.



This is a mandatory change to adhere to both federal and state regulatory requirements, including The Cures Act.

- Providers who exceed the 15% manual edit threshold, and therefore fall below 85% compliance, for two consecutive quarters will receive a formal letter of non-compliance.
 - This letter will require your agency to complete a CAP to articulate the changes made to ensure ongoing compliance.
 - Continued non-compliance may lead to further actions, including overpayment notifications or termination from the Highmark Wholecare network.



Check out Highmark Wholecare's [Provider Resource Center](#) for newsletter articles regarding EVV Compliance.

EVV Compliance for Home Health Providers

Take Steps to Ensure Compliance Requirements are Met!

- HHAeXchange generates comprehensive monthly compliance reports.
 - Reports are sent to providers on the 21st of each month and provide a summary of your agency's EVV compliance with in-scope contracts and services billed to each Managed Care Organization (MCO).
 - Reports outline visit data for the previous month with both month and year-to-date snapshots.
 - Numbers can be validated through your agency's HHAeXchange exception reports.
 - Reports are automatically emailed to each user with an ADMIN role in your HHAeXchange Portal.
 - Open a support ticket with the [HHAeXchange support team](#) if your agency is not receiving this report.

Directions to use the HHAeXchange Reporting Module

- Navigate to the Report module -> EVV Compliance Reports
- Select the desired report
- Input any filters
- Select View Report

HHAeXchange is a separate company that provides the Electronic Visit Verification platform for home health services for Highmark Wholecare.

➤ What Makes a Visit Non-Compliant?



WHAT IT MEANS

A visit is non-compliant when required EVV data is missing, incorrect, or does not align with the scheduled visit.



HOW IT'S IDENTIFIED

In HHAeXchange, non-compliant visits are flagged as **EVV Exceptions** for review and correction.



WHY IT MATTERS

- Non-compliant visits can:
- Delay billing
- Trigger additional review
- Require manual corrections
- Increase audit risk



COMMON EVV EXCEPTIONS:

✗ No EVV captured 📍 Location mismatch ⌚ Missing clock-in/out 🔗 Not linked to schedule ➡ Manual confirmation used

> PA DHS EVV Compliance

Providers below 85% or with unresolved aggregation rejections face increased compliance risk

COMPLIANCE THRESHOLD

85%

DHS compliance monitoring threshold

Activity below this level may be flagged for follow-up.

1

Monitor

Review EVV compliance

2

Aggregate

Confirm visits transmit

3

Resolve

Fix rejections quickly

MCOs mirrors DHS monitoring with additional emphasis on aggregated visits.

> State Aggregation Report

Daily review confirms which EVV records reached the PA aggregator, and which failures must be resolved before billing

PURPOSE

Your daily EVV receipt

Shows whether confirmed EVV data was accepted, still processing, or failed.

Only bill after a Success response.

RECORD STATUS



Success

Accepted by the aggregator

Ready to move forward with billing workflow



Pending

Still processing

Monitor until it updates to Success or Failed



Failed

Action required

Use the error message as your fix-it list

DAILY REVIEW

- 1 Run all 3 sections
- 2 Filter to Failed first
- 3 Read Error Message
- 4 Fix or contact Support

Best practice: assign one staff owner for this daily check.

RUN ALL THREE REPORT SECTIONS

A visit may fail because of caregiver, patient, or visit data: review each section before billing.

Caregiver

Patient

Visits

> EVV Compliance by Caregiver Report

Use this weekly to identify caregivers who may need coaching, follow-up, or additional EVV support.

PURPOSE

Caregiver-level visibility

Shows compliance percentages and exception counts by caregiver, making it easier to spot repeat EVV capture issues.

% Compliance

Red flag for coaching

Counts

How many visits are impacted

**Recommended cadence:
Weekly**

WHAT TO REVIEW

1 High exception rates
Start with caregivers who have the highest % Exceptions.

2 Exception volume
Validate whether the issue is isolated or affecting many visits.

3 Repeat patterns
Look for missed clock-ins, missed clock-outs, or manual adjustments.

4 Progress over time
Rerun weekly to see if coaching is improving EVV adoption.

HOW TO USE IT

Best use case

Focus training where it is needed most instead of waiting for billing issues or repeated exceptions.

IDENTIFY

Find caregivers with high exceptions

COACH

Review EVV expectations and barriers

MONITOR

Track progress week over week

Corrective Action Plans (“CAPs”)

The FIPR Team may recommend a CAP for providers.

- An investigation of a provider for aberrant behavior that results in overpayments may require a CAP. There may be other circumstances in which a CAP is needed, such as actions that may cause potential harm to patients, quality of care issues and inappropriate behaviors.
- The Investigator will consult with Highmark FIPR Management to determine if a CAP is needed. Other internal departments may be requested to provide feedback on corrective actions for a provider or member if additional opinions are needed to bring resolution to a case.

CAP Elements

1. Date

2. Findings

3. Timeframe of CAP

4. Type of Actions

5. Duration of CAP



If at any time the provider fails to fulfill the requirements of their CAP, the Investigator will discuss next steps with Highmark FIPR Management.

Thank you!

- Questions?
 - Email us at EVV@highmark.com
- This presentation along with a recording of the live audio will be made available on the [Highmark Wholecare website](https://www.highmark.com/wholecare) (<https://www.highmark.com/wholecare>).



Appendix

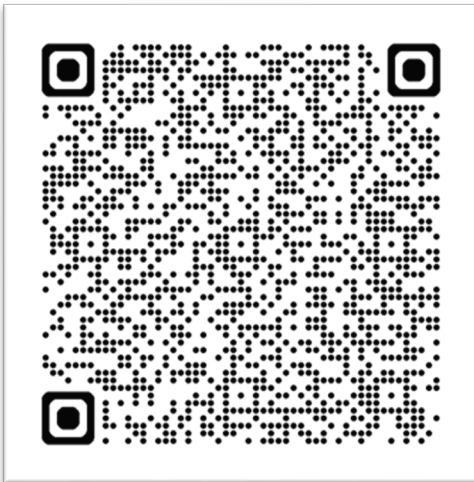


» HHAeXchange University

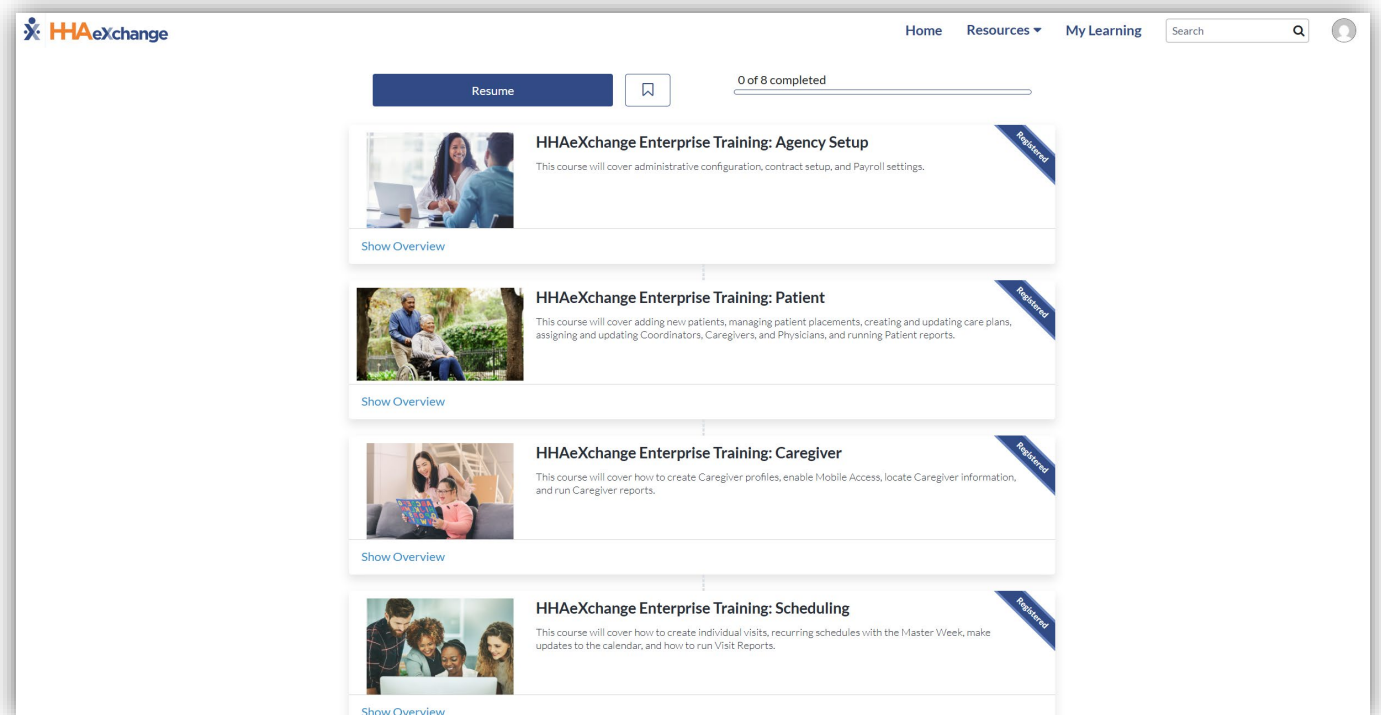
Onboarding Program Available

- HHAeXchange University is now available for providers to have a foundational overview of key topics such as:

- Patient & Caregiver Management
- Agency Setup
- Visit Maintenance
- Billing



<https://university.hhaexchange.com>



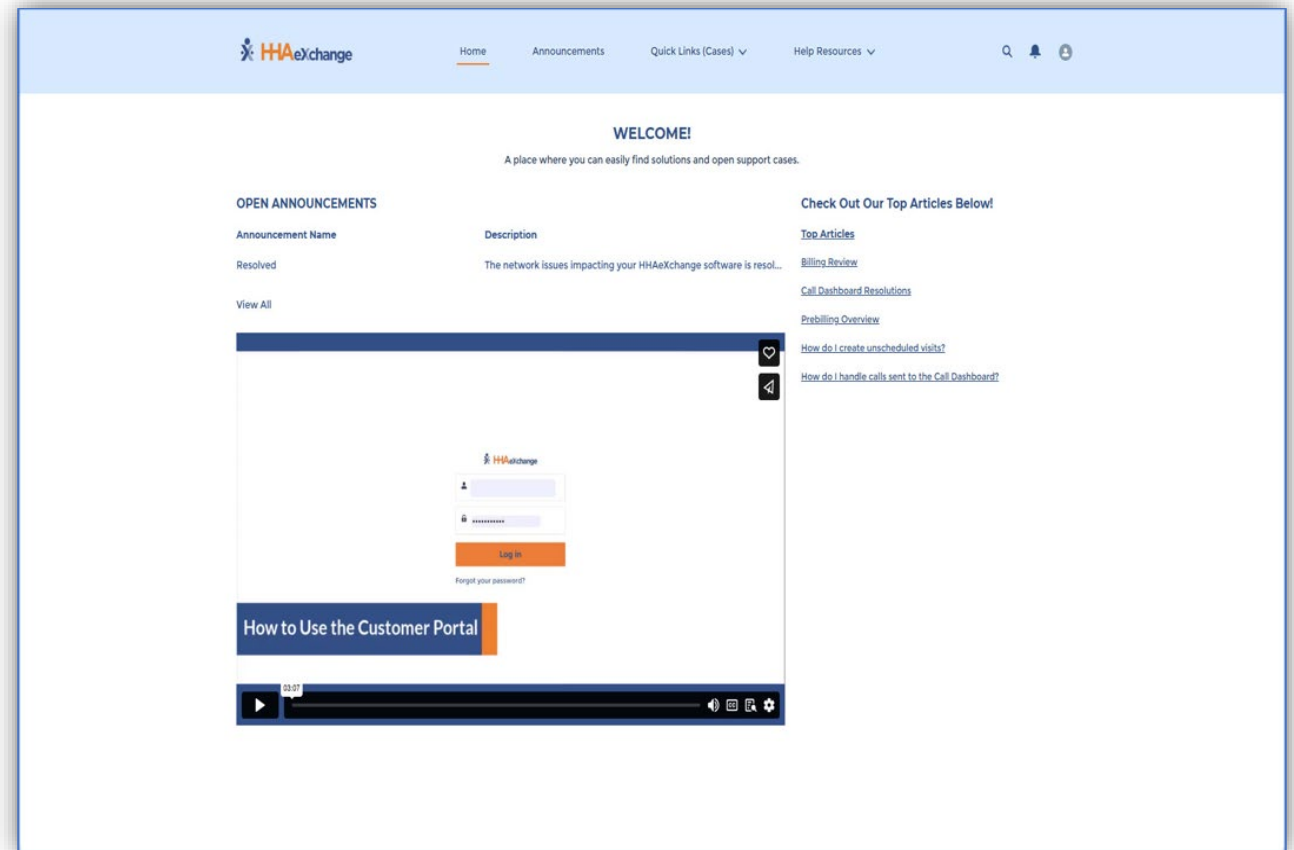
» Client Support Portal

Program Provider Support

- If you require additional support, use our brand-new client support portal to request help.



<https://hhaexchange.my.site.com/s/login/>



➤ Provider Resources: HHAeXchange Provider Knowledge Bases



**Provider Knowledge
Base**

<https://knowledge.hhaexchange.com/enterprise/Content/Home/Home-N.htm>



**Caregiver Knowledge
Base**

<https://knowledge.hhaexchange.com/caregiver/Content/Home/Home-CG.htm>



**Third-Party EVV (EDI)
Knowledge Base**

<https://knowledge.hhaexchange.com/edi/Content/Home/Home-C.htm>

Mark Your Calendars!

Visit the HHAeXchange Customer Events Page

- Register for upcoming live trainings and webinars tailored to your agency
- Find sessions on EVV, mobile app, scheduling, billing, reporting, and more
- Get expert tips, real-time answers, and practical takeaways to boost efficiency





Upcoming HHAeXchange Customer Events

We look forward to seeing you at one of our customer training webinars or in-person training events.

Filter by Event Type 



TUESDAY, JANUARY 13 AT 1PM ET
EVV Made Simple: How to Stay Compliant Every Day



JANUARY 27TH OR 28TH 2026
Minnesota EVV Readiness Bootcamp



LIVE TRAINING: FEBRUARY 2ND AT 2PM ET |
OFFICE HOURS: FEBRUARY 4TH AT 2PM ET
Post Go-Live Training + Office Hours: Admin Setup

Customer Training Events:
Elevate Your Skills | HHAeXchange



Resources

[Medicaid Resource Center](#)

- PA Medicaid Guidelines
- Forms and Reference Materials
- Provider Updates
- Provider Manual

[Highmark Wholecare Fraud and Abuse Website](#)

[Office of Inspector General – Consumer Fraud](#)

[Healthcare Fraud and Scams](#)

[Pennsylvania Department of Human Services Website](#)

[Provider Responsibilities](#)

[DHS Self-Audit Protocol](#)

[CMS Fraud and Abuse Website](#)

[CMS Self-Audit Snapshot](#)

[OIG Provider Self-Disclosure Protocol](#)

[Electronic Visit Verification \(EVV\)](#)