Medicaid Provider Policy and Procedure Manual



HIGHMARK WHOLECARE

Please visit **highmark.com/wholecare**

For inquiries, please call Provider Services at **1-800-392-1147 (TTY: 711)**.

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Quick Reference

Important Phone Numbers for Highmark Wholecare

Contact Type	Contact Information	Hours of Operation
TTY/TDD (For all departments)	**711** or **1-800-232-5460**	8 a.m.–5 p.m. Monday–Friday
Provider Services (Claims Inquiries and Eligibility Verification)	**1-800-392-1147**	7 a.m.–5 p.m. Monday–Friday
Highmark Wholecare Interactive Voice Response System (IVR) **(Eligibility Check)**	**1-800-642-3515** **1-800-392-1147**	24 hours a day. Seven days a week.
Eligibility Verification System (EVS)	**1-800-766-5EVS** **1-800-766-5387**	
Member Services	**1-800-392-1147**	8 a.m.–8 p.m. Monday–Friday
Medical Management/ Utilization Management (UM)	**1-800-392-1147**	8:30 a.m.–4:30 p.m. Monday–Friday Voicemail during off hours. The call will be returned the next business day. Please do not leave multiple voicemails.
Authorizations for certain Sleep Studies and Radiation, Oncology for members eighteen (18) years and older.	**1-800-546-7092** or **www.healthhelp.com/ highmarkwholecare**	8 a.m.–6 p.m. Monday–Friday Website is available 24 hours a day. Seven days a week.

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Contact Type	Contact Information	Hours of Operation
Authorizations for Cardiology, Radiology Management, PT, OT, ST, Musculoskeletal Surgery Procedures (MSK), Trigger Point Injections, and Interventional Pain Management	**1-800-546-7092** or **www.healthhelp.com/highmarkwholecare**	8 a.m.–6 p.m. Monday–Friday Website is available 24 hours a day. Seven days a week.
Authorizations for Family Planning	**1-800-532-9465** Fax: **1-833-559-2857**	8:30 a.m.–4:30 p.m. Monday–Friday Voicemail during off hours. The call will be returned the next business day. Please do not leave multiple voicemails.
Pharmacy (Non-Formulary Requests and Prior Authorizations)	**1-800-392-1147** Fax: **1-888-245-2047** Electronic prior authorization (ePA) at **CoverMyMeds.com**	8:30 a.m.–5 p.m. Monday–Friday
Care Management	**1-800-392-1147**	8:30 a.m.–4:30 p.m. Monday–Friday
VSP Provider Servicing	**1-800-615-1883**	6 a.m.–5 p.m.
United Concordia Dental (Dental benefit provider)	**1-866-568-5467**	8 a.m.–8 p.m. Monday–Friday
MA Provider Compliance Hotline (Fraud and Abuse Reporting)	**1-866-379-8477**	8:30 a.m.–4 p.m. Monday–Friday
Fraud, Waste, and Abuse (FWA) Concerns/Inquiries	**1-844-718-6400**	24 hours a day. Seven days a week.
MA Provider Enrollment Applications	**1-800-537-8862**	8:30 a.m.–4:30 p.m. Monday–Friday
Regulatory Affairs	**1-800-392-1147**	8:30 a.m.–4:30 p.m. Monday–Friday
Practice Change Information	Fax: **1-855-451-6680**	24 hours a day. Seven days a week.

Important Addresses & Fax Numbers

Reason for Mailing:	Mailing Address:
Highmark Wholecare Medicaid Claims	Attention: Claims Processing Department PO Box 211713 Eagan, MN 55121
Administrative Claims Reviews	Attention: Claims Department Highmark Wholecare PO Box 890063 Camp Hill, PA 17089 Fax: **1-844-207-0334**
Clinical Provider Appeals	Attention: Appeals and Grievance Highmark Wholecare PO Box 890034 Camp Hill, PA 17089 Fax: **412-255-4503**
Credentialing	Attention: Credentialing Department Highmark Wholecare PO Box 535191 Pittsburgh, PA 15253-5191
Practice Change Information	Attention: Provider Information Management Highmark Wholecare PO Box 890039 Camp Hill, PA 17089-0039 Fax: **1-855-451-6680**
Dental Claims	Attention: Claims Department PO Box 2190 Milwaukee, WI 53201
High Dental Claims Corrected (Adjusted)	Attention: Corrected Claims PO Box 1613 Milwaukee, WI 53201
Dental Prior Authorizations	Attention: Pre-Authorizations PO Box 2170 Milwaukee, WI 53201

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Reason for Mailing:	Mailing Address:
Dental Orthodontic Prior Authorizations	Attention: Pre-Authorizations PO Box 2170 Milwaukee, WI 53201
Vision Claims	**In Network** Vision Service Plan Attention: Claim Services PO Box 495907 Cincinnati, OH 45249-5907 **Out of Network and Retail** Vision Service Plan Attention: Claim Services PO Box 495918 Cincinnati, OH 45249-5918

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.

To find the member's BH MCO visit: **https://www.pa.gov/agencies/dhs/resources/medicaid/bhc/bhc-mcos**.

To find the members County Drug and Alcohol office visit: **https://www.pa.gov/agencies/ddap/treatment-and-support/county-drug-and-alcohol-offices#sortCriteria=%40copapwptitle%20ascending%2C%40title%20ascending%2C%40copapwpeducatorname%20ascending**

County	BH-MCO	Contact Information	Single County Authority for Substance Abuse/Misuse
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

Continues on the next page

County	BH-MCO	Contact Information	Single County Authority for Substance Abuse/Misuse
Armstrong	Carelon	**1-877-688-5969**	Armstrong/Indiana/Clarion Drug and Alcohol Commission, Inc. **724-354-2746**
Beaver	Carelon	**1-877-688-5970**	Beaver County Behavioral Health Drug and Alcohol Program **724-847-6225**
Bedford	Magellan	**1-800-424-3711**	Personal Solutions, Inc. Bedford **814-381-0921**
Berks	Community Care Behavioral Health	**1-866-292-7886**	Berks County on Chemical Abuse **1-610-376-8669**
Blair	Community Care Behavioral Health	**1-855-520-9715**	Blair County Drug and Alcohol Program, Inc. **814-381-0921**
Butler	Carelon	**1-877-688-5971**	The Butler County Drug and Alcohol Program, Inc. **724-284-5114**
Cambria	Magellan	**1-800-424-0485**	Cambria County Drug and Alcohol Program **814-536-5338**
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, Inc. **814-371-9002**
Crawford	Carelon	**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**

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County	BH-MCO	Contact Information	Single County Authority for Substance Abuse/Misuse
Erie	Community Care Behavioral Health	**1-855-224-1777**	Erie County Office of Drug and Alcohol Abuse **814-451-6877**
Fayette	Carelon	**1-877-688-5972**	Fayette County Drug and Alcohol Commission, Inc. **724-438-3576**
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**
Huntington	Community Care Behavioral Health	**1-866-878-6046**	Juniata Valley Tri-County Drug and Alcohol Abuse Commission **717-242-1446**
Indiana	Carelon	**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, Inc. **814-370-9002**
Lancaster	Performcare	**1-888-722-8646**	Lancaster County Drug and Alcohol Commission **717-299-8023**
Lawrence	Carelon	**1-877-688-5975**	Lawrence County Drug and Alcohol Commission, Inc. **724-658-5580**
Lebanon	Performcare	**1-888-722-8646**	Lebanon County Commission Drug and Alcohol Abuse **717-274-0427**
Lehigh	Magellan	**1-866-238-2311**	Lehigh County Drug and 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**

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County	BH-MCO	Contact Information	Single County Authority for Substance Abuse/Misuse
Mercer	Carelon	**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	Magellan	**1-800-424-5860**	Somerset Drug and Alcohol **814-445-1530**
Venango	Carelon	**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	Carelon	**1-877-688-5976**	Washington D&A Commission, Inc. **724-223-1181**
Westmoreland	Carelon	**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**

Opioid Use Disorder Centers of Excellence (OUD-COEs)

OUD-COEs provide comprehensive care management services to individuals with OUD and are charged with identifying and addressing both treatment and non-treatment needs. These centers utilize Community-Based Care Management (CBCM) teams comprised of social workers, physicians, nurses, and Certified Recovery Specialists to outreach into communities, rapidly identify and engage individuals with OUD, and ensure they receive integrated physical health, behavioral health, and Medication for Opioid Use Disorder (MOUD) services to support long-term recovery. OUD-COEs aim to increase access to MOUD, improve care coordination, and integrate physical and behavioral health care to improve engagement and retention in treatment for individuals with OUD.

For a comprehensive listing of OUD-COEs please visit **https://www.pa.gov/agencies/dhs/resources/mental-health-substance-use-disorder/substance-usedisorder/centers-of-excellence.html**

Ophelia

Ophelia offers an all-virtual option for the treatment of opioid use disorder (OUD), including medications for opioid use disorder (MOUD), psuchosocial supports, and current treatment for nicotine dependency.

Patient referrals for Highmark Wholecare members can be made:

- Online via **my.ophelia.com/referrals/highmark-wholecare**
- By Phone/Text: **215-585-2144**
- By visiting the website at **https://ophelia.com/**

PathWAYS Maternal Health Homes

PathWAYS Maternal Health Homes is a program aimed at providing support and treatment to pregnant individuals with substance use disorders. Including pre and postnatal care, medications, counseling, and wrap-around services including childcare, transportation, and peer support services. The program also offers comprehensive case management, care coordination/navigation, family support, and transitional follow up care to make it easier to complete treatment plans and ensure the best possible outcomes for the individual and the baby.

More information about the program and enrolling can be found by calling Highmark Wholecare Maternity Case Management Department **1-800-392-1147 (TTY 711)** or by visiting **https://www.highmark.com/wholecare/medicaid/benefits-and-coverage/pregnancy-pediatrics/pathway**.

Allegheny Health Network's Center for Recovery Medicine

Through the AHN Center for Inclusion Health, the growing addiction medicine services and multidisciplinary team of recovery specialists are providing life-changing substance use treatment. Consisting of a highly trained care team including board-certified addiction medicine specialists, nurses, social workers, behavioral health specialists, and certified recovery specialists. The team helps people with opioid use and other substance use disorders get treatment when and where they need it.

Two locations:

1. West Penn Mellon Pavilion: 4815 Liberty Avenue, Suite M56, Pittsburgh, PA 15224
2. Federal North Medical Office Building: 1307 Federal Street, Suite 301, Pittsburgh, PA 15212

Request an appointment online at **www.ahn.org/services/medicine/center-for-inclusion-health/addiction-medicine#appointments** or call the Addiction Medicine team **412-359-4644**.

UPMC Medical Toxicology Telemedicine Bridge Program

UPMC Toxicology Telemedicine Bridge Clinic offers visits by phone or through video telemedicine to begin medication treatment for substance use disorder, particularly opioid use disorder. UPMC Toxicology Telemedicine Bridge Clinic services are available throughout Pennsylvania regardless of insurance. The goal is temporary treatment while working to establish patients in local long-term care.

- Call **412-432-1042** Monday–Friday, 8 a.m.–5 p.m. to schedule with a registration professional.
- Register and schedule 24/7 online at **UPMC.com/toxicologybridgeappt**.

Important Addresses

Highmark Wholecare Medicaid/Medicare Assured Mailing Address List

Important Note:

To ensure your correspondence reaches the intended department, all mailing addresses MUST include the appropriate Delivery Code and Attention Line.

Corporate Office:

Delivery Code
Attention: Highmark Wholecare
120 Fifth Ave.
Pittsburgh, PA 15222

FedEx & UPS Packages:

All FedEx & UPS packages must be sent to the Corporate Office address along with the appropriate Delivery Code and Attention Line.

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Reason for Mailing:	Mailing Address:
Medical Claims – Medicaid Medical Medicaid Payer ID – 25169	Attention: Claims Administrator PO Box 211713 Eagan, MN 55121 When submitting claims, please note the Pennsylvania Payer ID Number is 25169. Any claim submitted to the wrong address or with an incorrect Payer ID Number will reject.
Claims – Medicare Assured Medical and Behavioral Health Medicare Payer ID – 60550	Attention: Claims Administrator PO Box 211164 Eagan, MN 55121 When submitting claims, please note the Pennsylvania Payer ID Number is 60550. Any claim submitted to the wrong address or with an incorrect Payer ID Number will reject.
Administrative Claims Reviews Provider Portal via NaviNet – Preferred submission method Fax to **1-844-207-0334**	Delivery Code: WC-CLAIMS Attention: Claims Highmark Wholecare PO Box 890063 Camp Hill, PA 17089
Refund Payments Refund payments should be submitted to the following address. Refund forms can be submitted through the Provider Portal via NaviNet.	Attention: Checks and Refunds PO Box 890135 Camp Hill, PA 17089
Clinical Provider Appeals Provider Portal via NaviNet – Preferred submission method Fax to **412-255-4503**	Attention: Provider Appeals Highmark Wholecare PO Box 890034 Camp Hill, PA 17089
Credentialing	Delivery Code: WC-CRED Attention: Credentialing Highmark Wholecare PO Box 535191 Pittsburgh, PA 15253-5191

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Reason for Mailing:	Mailing Address:
Dental Claims	Attention: Claims United Concordia PO Box 2190 Milwaukee, WI 53201
High Dental Claims Corrected (Adjusted)	Attention: Corrected Claims PO 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
Member Appeals & Grievances	Attention: Appeals & Grievances Highmark Wholecare PO Box 890034 Camp Hill, PA 17089
Member Enrollment/Disenrollment	Delivery Code: WC-ENROLL Attention: Enrollment Highmark Wholecare PO Box 535191 Pittsburgh, PA 15253-5191
Member Transfers	Delivery Code: WC-ENROLL Attention: Enrollment Highmark Wholecare PO Box 535191 Pittsburgh, PA 15253-5191

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Reason for Mailing:	Mailing Address:
Overpayments Self-Audit/Overpayment Form can be submitted through the Provider Portal via NaviNet.	**For Claim Retraction, mail Overpayment Form to:** Delivery Code: FIPR Attention: FWA/SIU Unit Highmark Wholecare 120 Fifth Ave., PAP-4 Pittsburgh, PA 15222 **For Checks, mail checks with form to:** Highmark Wholecare Attention: FWA/SIU Unit PO Box 890135 Camp Hill, PA 17089
Pharmacy and Therapeutics (P&T) Committee	Delivery Code: WC-PHARM Attention: Pharmacy Services Highmark Wholecare PO Box 22158 Pittsburgh, PA 15222
Practice Change Information Fax to **1-855-451-6680** - Preferred submission method FQHC/RHC providers submit their changes to: **HWC_Roster_Updates@highmark.com** Web: **Practice Change Request Form**	Delivery Code: WC-PDM Attention: Provider Data Management Highmark Wholecare PO Box 890039 Camp Hill, PA 17089-0039
Prescription Drug Claims	Attention: Reimbursements Administrator Highmark Wholecare PO Box 22158 Pittsburgh, PA 15222
Quality of Care Correspondence Preferred method of communication: **Quality_of_Care@highmarkwholecare.com** Fax to **1-855-878-4168**	Delivery Code: WC-QCARE Attention: Quality of Care Highmark Wholecare 120 Fifth Ave. Pittsburgh, PA 15222

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Reason for Mailing:	Mailing Address:
Retrospective Authorization Reviews Provider Portal via NaviNet – Preferred submission method	Attention: Retrospective Reviews Highmark Wholecare PO Box 22278 Pittsburgh PA 15222
Subrogation (COB)	Delivery Code: WC-ENROLL Attention: Enrollment Highmark Wholecare PO Box 535191 Pittsburgh, PA 15253-5191
VSP Vision Claims	**In Network** Vision Service Plan Attention: Claim Services PO Box 495907 Cincinnati, OH 45249-5907 **Out of Network and Retail** Vision Service Plan Attention: Claim Services PO Box 495918 Cincinnati, OH 45249-5918



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 Providers section of our website at **providers.highmark.com/wholecare** under Medicaid.

Overview of Highmark Wholecare

About Us

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 team members are helping to drive this new kind of health care in collaboration with a network of 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 based on race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age. 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 organization.

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 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 Resource Center

The **Wholecare Resource Center** is a new, free support resource tool supported by the "find help" 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 more than 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 (D-SNP) plans, serving those with Medicare Parts A and B, among other qualifying factors.

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 eye wear), and dental benefits (including dentures)*.
- Health and wellness education, such as heart disease, diabetes, and smoking/tobacco cessation.
- Bathroom and home safety 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 health care option on our website at **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 we strive to stay on top of the members' needs. We are committed to continually improving and providing high standards of quality in every aspect of service. This commitment is led by the Highmark Wholecare's Quality Improvement/Utilization Management Committee, made up of experts in a wide variety of medical fields. The QI/UM Committee evaluates our ongoing efforts as well as new protocols and quality initiatives in order to improve service and care for members.

Wellness & Disease Management

Highmark Wholecare is committed to improving the life of its membership 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 18 and older)
  - Breast Cancer Screening (Women ages 50 to 74 years)
  - Colorectal Cancer Screening (Ages 50 to 75 years)
  - Diabetes tests as needed, such as HbA1C, dilated retinal eye exam, and microalbumin (Members with diabetes)
- Tobacco cessation education and benefits
- Pediatric and adult immunization reminders
- Mom Matters Maternity
- Wellness coaches
  - Registered Dietitian
  - Certified Diabetes Educator
  - Certified Rehab Counselor



Health Care Disparities

Highmark Wholecare understands that 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. Highmark Wholecare is a NCQA accredited organization in Health Outcomes and Community-Focused Care.

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 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. 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 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 years and makes the Population Assessment Language Profile report available to practitioners through updates in **Highmark Wholecare Provider Newsletter**.

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 them 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 it serves. The goal of this initiative is to help people better understand and navigate the health care system.

Benefits of Highmark Wholecare

Members receive improved access to primary medical care and 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 150 hospitals, over 20,000 providers, over 5,000 ancillary locations, a network of pharmacies, home health care agencies, and other related health care providers. Practitioners and other health care 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 based on race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age. 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.

Provider Self-Service

NaviNet is a web-based solution that securely links 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.

We encourage 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 a 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.
- Submit Provider Post-Service Appeals.
- Submit Claims and Payment Disputes.
- Code Authorization Look-Up Tool.
- Substance Use Disorder Resource Page.

Highmark Wholecare Providers are able to initiate authorization requests online by accessing the Authorization Portal through NaviNet Single Sign-On (SSO) functionality. From the Health Plans dropdown on the NaviNet Plan Central page, select Highmark Wholecare then GuidingCare>Authorization Portal from the Plan Workflows menu. For additional information regarding GuidingCare, please refer to the **GuidingCare User Guide** on our website.

Provider Relations Role

Highmark Wholecare uses dedicated, highly trained Provider Account Liaisons (PALs), Strategic Provider Account Liaisons and Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Contracting and Servicing Consultants. We are keenly aware that it is essential 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 will provide an initial training orientation to providers and their office staff within 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 company policies and procedures.

All Provider In-Service training materials are located on the Highmark Wholecare website at **providers.highmark.com/wholecare/provider-resources/in-service-materials**.

FQHC/RHC In-Service resources are located on the Highmark Wholecare website at **providers.highmark.com/wholecare/provider-resources/fqhc-rhc-resources**.

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

Primary Care Practitioner's Role

The definition of a primary care practitioner (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 health care needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care 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. 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 our 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 **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 **Department of Human Service**s.

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 years.

Per our HealthChoices Agreement (HCA) we are required to ensure that all providers operating within the PHMCO'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 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 21, 22, 23, 24, 31, or 32 and the service line Date of Service is greater than/equal to July 1, 2019.
- The claim Service Facility National Provider Identifier (NPI) (2301C NM109) equals the Billing Provider NPI (2010A A NM109), and the service Line Date of Service is greater than/equal to July 1, 2019, on all professional claims.

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:

1. 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.
2. 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 our 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 our contracts that prohibits open clinical dialogue between practitioner and patient.

Quality Improvement

Purpose of the Quality Improvement Program

The purpose of the Quality Improvement (QI) 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 the Highmark Wholecare 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:

- Preventive health care.
- Prevalent chronic health care conditions.
- Service indicators.
- Quality of clinical care.
- Safety of clinical care.
- Quality of service.
- Member experience.
- Health equity.

The QI Program strives to improve member adherence to preventive care guidelines, disease management strategies, and therapies that are essential to the successful management of certain chronic conditions.

The QI Program also strives to improve patient safety through:

- Education of members and providers regarding safe practices.
- 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 these efforts impact all members equally, the QI Program aspires to continually identify opportunities to positively impact health outcomes and address any health care disparities as well as language barriers.

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.

Goals of the Quality Improvement Program

The QI Program utilizes a Plan, Do, Study, and Act framework when setting goals. The goal of the QI program is to ensure the provision and delivery of high-quality medical and behavioral health care, pharmacy services, and other covered health care services and quality health plan services (Plan). Additional goals for the QI program are to serve members with complex health needs and to serve a diverse membership in the most equitable way. The QI 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 health care delivery system (Do).

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 (Study). Continuous assessment is also imperative for achieving optimum member health outcomes (Act).

By considering population demographics and health risks, utilization of health care resources, and financial analysis, Highmark Wholecare ensures that the major population groups are represented in QI activities and health management programs chosen for assessment and monitoring. This information, along with high volume/high-cost medical and pharmacy 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.

Objectives of the Quality Improvement Program

The objectives of the QI program are consistent with Highmark Wholecare mission, which is a commitment to the effective use of health care resources and to continuous quality improvement to provide their members with a remarkable health experience, therefore positively affecting the members' whole care and their 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 program is evaluated quarterly and annually to determine the status of all activities and identify opportunities which align with the QI program objectives.

The objectives of the QI Program are outlined below:

1. 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.
2. The provision of appropriate, timely, and quality health care services.
3. Develop guidelines which address the member population.
4. Assess practitioner performance.

Scope of the Quality Improvement Program

The scope of the QI 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 guideline and review processes. Implementation and evaluation of the QI program is embedded into Highmark Wholecare's daily operations. The QI program leverages internal information, systems, practitioners, and community resources to monitor and evaluate use of health care services, continuous improvement, and to assure implementation of positive change. The responsibility of implementing the QI program is a Highmark Wholecare corporate responsibility, not only that of the QI and UM departments. The scope of the QI Program focuses on the following areas:

Quality of Clinical Care

The QI 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, Healthcare Effectiveness Data and Information Set (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 identification of the most prevalent chronic disease/conditions with management to achieve established goals with positive health outcomes. 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 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 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. An additional method for monitoring safe practices and identifying opportunities involves collaboration with the Fraud Waste and Abuse department auditing providers prescribing patterns and reviewing clinical data related to safe prescribing methods and following clinical practice guidelines.

Member Experience

The QI Program focuses on creating and maintaining a positive member experience through initiatives based on the results of the annual CAHPS survey, and the trending of member inquires, complaints, appeals, and grievances to identify areas of opportunity. Health Equity programs and activities, various community programs, Community Partnership programs and care coordination programs exist for members and their satisfaction with these programs is monitored annually.

Member experience is also monitored through the quality and availability of provider services. This is ensured through the monitoring of network primary care physician (PCP) and specialist availability and accessibility, medical record reviews, including documentation standards, the assessment of continuity and coordination of care, and the conducting of an annual Member and Provider Satisfaction Survey. Additionally, the plan utilizes the Health Education Advisory Committee (HEAC), which meets quarterly, to solicit feedback from the membership regarding programs, benefits, policies, and procedures.

Health Outcomes

The QI Program, which oversees the Health Outcomes Program, works to address health care disparities for its minority members and ensure that services are accessible and provided to all enrollees in a culturally competent and inclusive manner. The QI Health Outcomes Program, outlines goals, including ongoing cultural competency awareness training for staff and providers, program partnerships, social risks and social needs, collection of race, ethnicity, and language (R/E/L), disability, sexual orientation and gender identity (SOGI), and preferred pronouns data from members, and targeted member outreach interventions that are inclusive as well as culturally, ethnically, and linguistically sensitive.

Furthermore, the QI 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 Health Outcomes 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 proper credentialing of new practitioners, as well as the recredentialing of participating practitioners.

- 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 through the QI/UM 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.
- Monitoring the utilization of health care services and programs.
- Implementing at least one rapid-cycle improvement pilot per year.

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 our members. The clinical practice and preventive guidelines have been developed using either evidence-based clinical guidelines from recognized sources, or through the involvement of board-certified practitioners from appropriate specialties. The guidelines are evaluated on an ongoing basis and are developed based on the prevalent diseases, conditions or relevance to our 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 practice and preventive 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 **providers.highmark.com**, including:

- Pediatric Preventive/EPSDT/Lead Screening (Birth to age 21)
- Adult Preventive
- Asthma
- ADHD
- Cardiac
- Chronic obstructive pulmonary disease (COPD)
- Cystic Fibrosis
- Depression
- Diabetes
- Healthy weight management for children and adolescents
- Healthy 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 Wholecare will submit an ad-hoc request for medical records. It is imperative that providers in our participating network respond to these requests within 15 business days, with the exception of Quality-of-Care cases which require a response within three business days, as dictated per contractual obligations. If Highmark Wholecare requests 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. 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 **https://providers.highmark.com/wholecare/provider-resources/quality-improvement**.

A score of 80% 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

Quality of Care concerns (including 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, utilization Management 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 questions, please contact Highmark Wholecare's Provider Services Department at **1-800-392-1147**.

Patient Safety

Patient safety is the responsibility of every health care professional. Health care errors can occur at any point in the health care delivery system; they can be costly in terms of human life, function, and health care dollars. Then there are the indirect costs of health care 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 in 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 facility's risk management department. Offer to participate in multidisciplinary work groups dedicated to error reduction. Ask our Quality Improvement Department how you can support compliance with our safety initiatives.

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

If you would like to learn more about patient safety, visit these websites:

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

Reportable Conditions

Highmark Wholecare practitioners are contractually required to follow our 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 our Provider Services Department at **1-800-685-5209**. The regulations, which include the complete list of reportable conditions, can be found via the Pennsylvania Code website at **pacodeandbulletin.gov**.

Living Will Declaration Advance Directives

The Patient Self-Determination Act is a federal law that 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**.

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 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 health care benefits and to appropriately access services within a managed health care 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 members being referred because they are not able to be reached or are not showing for appointments, providers must complete three outreach attempts prior to sending the Member Outreach form.

For more information, or to request member outreach, please call our Care 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)

The Provider Engagement Team 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 Practitioner Excellence pay-for-performance program. PET is a strategic partner with our providers in achieving their quality goals.

Contact the Highmark Wholecare Provider Engagement Team at **ProviderEngagementTeam@HighmarkWholecare.com**.



Member

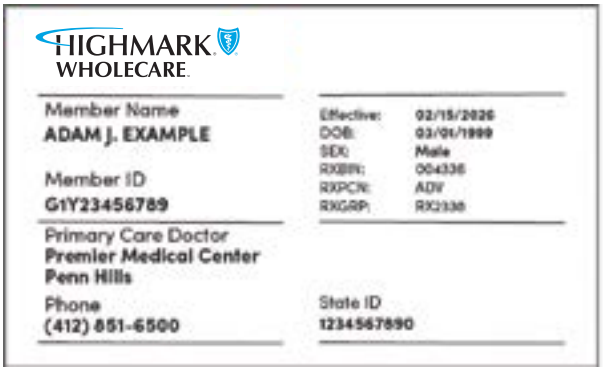
Enrollment Process

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 to six 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 to use the EVS.

To access DHS' EVS, call **1-800-766-5EVS (5387)**. Please have your 13-digit Master Provider Index (MPI) Number and the member's State ID (also known as Recipient Number) from the member's 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 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:

- **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.
- **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.
- **Highmark Wholecare Interactive Voice Response System (IVR):** Available 24 hours a day, seven days a week at **1-800-642-3515**.

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 telecopier 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 Address 1:	123 Main Street
Member City:	Anywhere, PA 12345
Member Telephone:	0000000000
PCP Code:	7654321
PCP Name:	Pediatric Practice
PCP Telephone:	1234567891
PCP Address 1:	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
TPL:	
TPL Address 1:	
TPL City:	
TPL Enrollment Date:	
TPL Contract Num:	

For additional information call **1-800-392-1147**.

Practitioners can also call 1-800-392-1147 and press two 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/Enhanced Member Support 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 24 hours a day, seven 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/Enhanced Member Supports Unit.
- **Press 6:** If you are calling regarding credentialing status.

ACCESS Cards

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

PCPs Role in Determining Eligibility

PCPs verify eligibility by consulting their panel listing to confirm that the member is a part of the practitioner's panel. The panel list is distributed on or about the first 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 or the fifteenth 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 new born was added to the member's grant.

Member Benefit

Highmark Wholecare members are eligible for all the benefits covered under the Pennsylvania DHS Medicaid program. Members obtain most of their health care 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 health care needs and access to services provided by hospitals, specialty care practitioners, ancillary providers, and other health care providers as needed.

Benefits and Special Services

Highmark Wholecare members that are age 21 or older may have copayments and applicable service limits. Service limits do not apply for members under age 21 or if member is pregnant.

Copayments do not apply to:

- Members under age 21.
- Any member who is pregnant (through the post-partum period beginning on the last day of the pregnancy and extending through the last day of the 12th month in which the post-partum period ends).
- Residents in a long-term care facility or other medical institution.
- Individuals receiving hospice care.
- Women in the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program.
- Individuals in the Title IV-B Foster Care and IV-E Foster Care and Adoption Assistance Programs regardless of age.

Members cannot be denied a service if they are unable to pay their copayment.

The provider is required to submit in field 29 of the CMS-1500 form and field 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 age 16.
- Braces for teeth for members under age 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 21 when prescribed by a doctor.
- Orthopedic shoes and hearing aids for members under age 21, if medically necessary.
- Emergency care 24 hours a day, seven days a week.
- Twenty-four-hour toll-free member telephone service for non-emergency and urgent needs, through Member Service.
- EPSDT expanded services for members under age 21.
- Extended home nursing services for members under age 21, if medically necessary.
- Nursing facility care (limited to 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 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 copayment include: See page 48 and 49.

Medical Assistance		
Benefit	**Copay*/Limits**	**Comment**
Brand Name RX	$3.00	Applicable to age 21 and older.
Generic Drug RX	$1.00	Applicable to age 21 and older.

Continues on the next page

Benefit	Copay*/Limits	Comment
Inpatient Hospital (General or Rehab)	$3.00/per day, up to $21.00/per admission	Applicable to age 21 and older.
Surgical Procedures Any Setting	$3.00/per covered service	Applicable to age 21 and older.
Office Visits (Not applicable to PCPs, OBs, GYNs or OB/GYNs)	$2.00/per visit	Applicable to age 21 and older.
Radiology Services	$1.00/per covered service	Applicable to age 21 and older at hospital or physician office.
Chiropractor Outpatient Visits	$2.00/per visit	Applicable to age 21 and older.
Podiatrist Outpatient Visits	$2.00/per visit	Applicable to age 21 and older.
Tobacco Cessation	Seventy visits per calendar year	
Home Health Care including Nursing, Aide, and Therapy Services	28 days unlimited/15 days per month thereafter	Applicable to age 21 and older.
Dental	Highmark Wholecare covers all medically necessary dental services for children. Children may go to a participating provider.	Applicable to members under age 21.
Dental	Two exams, two cleanings (one every six months), and X-rays. Limited lifetime benefits for: One partial upper denture or one full upper denture; and one partial lower denture or one full lower denture. Benefit Limit Exception (BLE) is required for the below services: Crowns and related services; Periodontal services. Additional evaluations, cleanings, and dentures. Note: Root canals do not require prior authorization or BLE authorization if submitted by an Endodontist. If submitted by a general dentist, only a preauthorization is required.	Applicable to age 21 and older.

Continues on the next page

Benefit	Copay*/Limits	Comment
Vision	Highmark Wholecare covers all medically necessary vision services for children under age 21. Children may go to any participating vision provider within the Highmark Wholecare network. • Standard frames and eyeglass lenses*, or • Standard contact lenses and fittings, or • Standard frames and eyeglass lenses* and standard contact lenses. *Lens options include basic single, bi-focal, trifocal, and/or polyvcarbonate lenses. High index lenses are also available and do have a co-pay. Contact Member Services for more information. Replacement of eyeglasses or contact lenses if lost, broken, stolen or if the prescription changes. You must get all eyeglasses and contact lenses from a Highmark Wholecare participating optical supplier. If you need help locating a participating eye doctor or optical supplier, call VSP Member Services at **1-866-412-5825 (TTY: 711)**. If medically necessary, exception to limits can be made with written documentation.	Applicable to members under age 21.
Vision	Highmark Wholecare covers some vision services for adults. Members must go to a participating provider. Members are given a $100 credit for each calendar year to be used towards standard frames, eyeglass lenses and contact lenses combined. If medically necessary, members aged 21 and older who are diagnosed with Aphakia are covered for the following each calendar year. • Two pairs of standard frames and eyeglass lenses, or • Two pairs of standard contact lenses, or • One pair of standard frames and eyeglass lenses and one set of standard contact lenses.	Applicable to age 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 $2.00.
- Medical exams requested by the department.
- More than one of a series of a specific allergy test provided in a 24-hour period.
- Targeted case management services.
- Members under 21.
- Members who are pregnant (through the post-partum period beginning when pregnancy ends and extending through the last day of the 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 identity, 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 record 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 for Provider and press four 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 member's health.
- The exception is a cost-effective alternative to the MA program.
- Granting the exception is necessary to comply with Federal law.

Any exception request received prior to the service being rendered will get a response within 21 days of the date Highmark Wholecare received the request. Prospective urgent exception requests will be responded to within 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 30 days of the date that Highmark Wholecare received the request.

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

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 **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 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.

For the mailing address, please refer to the **Important Addresses** section on page 10.

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's 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 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-day supply for new medications or a 15-day supply for an ongoing medication (the pharmacist must contact Highmark Wholecare to obtain a manual override for a 15-day supply).

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

- Medication is prescribed for a Federal Food and Drug Administration (FDA) 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 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 **highmarkwholecare.com**.

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

Specialty Pharmacy Network

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 in our network. Prescribers can call the Pharmacy Services Department to confirm whether a pharmacy is contracted with Highmark Wholecare as a specialty pharmacy provider. Prescribers can also find a listing of our specialty pharmacy network on our website under the Provider Tab, Pharmacy Tools section or 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 Drugs

All drugs that are indicated as specialty are available through the specialty pharmacy network. The indication for specialty drugs is found within the searchable formulary of our website at **client.formularynavigator.com/Search.aspx?siteCode=9766213130**.

If you have questions about how members obtain a specialty medication, please call Pharmacy Services at **1-800-392-1147**.

Drugs Covered Under the Pharmacy 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

Highmark Wholecare excludes coverage of any drug marketed by a drug company (or labeler) who does not participate in the Medicaid Drug Rebate Program and drug products, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide rebates to the Medicaid agency except for vaccines, compounding materials, certain vitamins and minerals or diabetic supplies. Additionally, Highmark Wholecare excludes coverage for Drug Efficacy Study Implementation (DESI) drugs as well as any non-compensable drugs in accordance with 55 PA Code §1121.54 as found on the Pennsylvania Code and Bulletin website at **www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1121/s1121.54.html&d=reduce**.

Days' Supply Dispensing Limitations

Members may receive up to a 34-day drug supply per prescription or refill. A 34-day supply shall be interpreted to mean consecutive 34-day supply, (i.e., if a physician prescribes a medication b.i.d. (two times a day), a 34-day supply corresponds to a quantity of 68). The dispensing pharmacist must accurately calculate the days' supply. A 90-day supply is available for select maintenance medications. This list is available by accessing the MA 90-Day Generic Medication Supply tab on our website **providers.highmark.com/wholecare/pharmacy-tools**.

Drug Recalls and Drug Safety Monitoring

Highmark Wholecare is dedicated to providing prescribers with access to the most up to date medication safety information. Drug recall and drug safety updates can occur daily due to newly published research or to the FDA's Adverse Event Reporting Program. 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 **www.highmark.com/wholecare/legislative-resources/drug-safety-recalls**.

Pharmacists as Providers

Highmark Wholecare recognizes licensed pharmacists with an NPI as participating providers when enrolled with Pennsylvania Medical Assistance and credentialed with Highmark Wholecare. Pharmacists may render medically necessary services within their scope of practice and are considered part of the multidisciplinary care team in supporting member outcomes.

Covered pharmacist services, when performed within scope of practice and consistent with Highmark Wholecare policy, may include:

- Medication therapy management (MTM) and medication reviews
- Immunizations and medication administration
- Chronic disease management under collaborative practice agreements or protocols
- Preventive services, including authorized screenings and tobacco cessation
- Medication adherence support and care coordination

Additional pharmacist-provided services may be reimbursed at the discretion of Highmark Wholecare, consistent with Pennsylvania Medical Assistance Bulletin 31-24-02.

Coverage Arrangements

All participating practitioners must ensure 24-hour, seven days-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. All encounters must be billed under the name of the rendering practitioner, not the member's assigned primary care practitioner. Any services paid per the member's assigned primary care practitioner contract will be paid directly to the participating covering primary care practitioner.

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 primary care practitioner. 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 and all reimbursements will be paid directly to the covering practitioner. Participating practitioners will be held responsible for the actions of their non-participating coverage practitioners. Primary care practitioners 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 60 calendar daytime 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 60 calendar daytime frame has elapsed, if the locum provider's services are still needed, the provider should become an employee of the group and would be required to be credentialed.

Laboratory Services

Highmark Wholecare Medicaid members can obtain outpatient laboratory work at any participating laboratory or hospital. No referral is needed; only a lab order form or prescription from the ordering provider is needed. All other authorization 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 or lab form and can be performed at any participating laboratory or hospital. Specialists and OB/GYN practitioners can order laboratory testing directly. 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 a participating laboratory or hospital.

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 allows for preadmission laboratory testing to be completed by any participating laboratory or hospital. No referral is needed; only a lab order form or prescription from the ordering provider is needed.

Blood Lead Screening

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

The PCP can use either Kirby Health Center Laboratory or any other participating laboratory or hospital 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's 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. **Recommended Actions Based on Blood Lead Level | Childhood Lead Poisoning Prevention | CDC**.

Environmental Lead Investigation (ELI)

A provider should submit an order to an enrolled ELI provider for a comprehensive environmental lead investigation for a Highmar kWholecare member under 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 the Highmark Wholecare website, Provider Resources, or EPSDT page for a current list of ELI providers and instructions on how to make referrals.

Highmark Wholecare will cover ELI for members under 21 years of age who are enrolled in 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 **HWC_EPSDTinfo@Highmark.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 for UM for assistance.

Primary Care Practitioner

Primary Care Practitioner (PCP) Selection

Each member in a family has the freedom to choose any participating primary care practitioner, and a member may change to another primary care practitioner should a satisfactory patient-practitioner relationship not develop. A primary care practitioner 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 health care needs of such members and without regard to their status as a new or existing patient to that practice or location. The primary care practitioner must maintain at least 20 weekly appointment hours per marketed location.

After reaching their contracted patient panel minimum, the primary care practitioner may, upon 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 primary care practitioner's 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 Practitioner Excellence Program

Highmark Wholecare values the role practitioners play in servicing our members and improving their total health outcomes. Through the Highmark Wholecare Practitioner Excellence (HWPE) program, we reward provider performance that demonstrates high-quality, accessible, and efficient health care.

Provider Incentive Program Objectives:

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

Who is eligible?

- PCP practices.
- Obstetricians/Gynecologists.
- Dentists (Medicaid).

Providers must meet minimum eligibility requirements which can be found on our website at **wholecare.highmarkprc.com/Join-Our-Network/Join-Our-Network**.

Performance Measures

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

- Child & Adolescent Well-Care Visits (age three–21).
- Oral Evaluation, Dental Services (age six months–20 years).
- Controlling High Blood Pressure.
- Glycemic Status Assessment for Patients with Diabetes - Glycemic Status >9%.
- Asthma Medication Ratio.
- Maternity: Prenatal Care in the First Trimester and Postpartum Care.
- Plan All-Cause Readmissions.
- Lead Screening for Children.
- Developmental Screening in the first three Years of Life.
- Well-Child Visits in the First 15 Months of Life, six or more.
- Electronic Quality Measures.
- Health Equity Measures.

For a complete listing of the measures and program details, please visit our website at **providers.highmark.com/wholecare/practitioner-excellence-program**.

Scorecards and HWPE Quality Reports

Scorecards

The provider incentive scorecard provides a summary of the services and payments the practitioner received, broken down by measure. Scorecards and their associated payments are made annually.

HWPE Quality Reports

The dashboard report provides primary care practices with member specific care gaps on provider incentive measures. The purpose of the HWPE Quality 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 Work groups and practice visits by Provider Relations, Medical Directors, Quality Program Managers, and Provider Engagement. 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

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

Accurate Submission of Encounter/Claim Data

Encounter/claim data provides the basis for many key medical management 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 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 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 member's 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: **www.cdc.gov/nchs/icd/icd-10-cm/**.
- 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: **www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf**.

There are two volumes which consist of:

- **The Disease Tabular (Numeric)**: 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):** 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 through age 18 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 PCP's 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, PAs, and CRNPs can help prevent tooth decay by providing topical fluoride varnish (TFV) in the office for their Highmark Wholecare patients through age 20.

Highmark Wholecare reimburses PCPs, PAs, and CRNPs for the application of topical fluoride varnish with a fee-for services payment of $18 for rendering this service, up to six per calendar year under procedure code 99188.

Addition of Newborns

When a member selects Highmark Wholecare, the member's effective date is usually the first or the 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 PCP's monthly panel listing. Newborns will be effective on their date of birth or the date the new born 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 25th of the current month, the new effective date will be the first of the following month. For example, if a member's request is received on October 7, the member will be effective November 1 with the new PCP.
- When the request is received on or after the 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 28, the member will be effective December 1 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 90 calendar days prior to the date the provider intends to terminate. There is also 60 days' notice required if you plan to close your practice to new patients and 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 time frames 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 **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 30 days of the issue date identified in block one of HRSA's Notice of Grant Award. Additionally, any interim rate letter(s) received from PA DHS must be forwarded to the Plan within 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

Primary care practitioners 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, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age; and to observe, protect and promote the rights of members as patients.

Primary care practitioners 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, to assist our practitioners in the management of members who violate office policy regarding scheduled appointments, the Plan has instituted the following Member No-Show Policy: **The Plan will recognize the individual practitioners written office policy regarding 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 PCP's 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 member's name and Highmark Wholecare ID Number, and, when applicable, state their no-show policy, and the member(s) who has (have) violated the policy. Letters can be attached and emailed to **MedicaidEnrollmentPCPReleases@highmark.com**.

All written requests are forwarded to the Enrollment Department within 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 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 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

Primary care practitioners are required to transfer member medical records or copies of records to newly designated primary care practitioners within seven business days from receipt of the request from DHS, its agent, the member, or the member's new primary care practitioner, 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, contracted Opioid Use Disorder Centers of Excellence and Maternal Health Homes for the treatment of substance use disorders, physical health provider claims for office visits related to the prescribing of medications used as part of treatment for substance use disorders and screenings related to mental health and substance use disorder, home health care, 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.

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 and post-stabilization services in accordance with 42 C.F.R. §438.114 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 health care 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-MCOs 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. Highmark Wholecare collaborates with the member's 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.

Highmark Wholecare requests the support and input from the provider into the development of the integrated care plan that is being developed with your patient. Highmark Wholecare is contractually required to share the integrated care plan with the member's provider during the care plan development.

The first step that a provider can take to support 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 there are any concerns about the patient's behavioral health, their behavioral health treatment, or would like to relay information about the patient or make a referral for treatment. If the provider has any questions, needs a copy of the member's integrated care plan or release of information, or refer a patient to have an integrated care plan developed with us, please call **1-800-392-1147**.

Telehealth

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. Historically, telemedicine seeks to improve a patient's health by permitting two-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).

The term "telehealth" has emerged as the umbrella term that encompasses the full range of services furnished remotely. Telehealth 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 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 can render services using interactive telecommunication technology to their Highmark Wholecare assigned members. Providers must obtain consent from members, or their legal guardian, prior to performing any services via telehealth.

The claim should reflect the designated Place of Service (POS) code 02 when telehealth is delivered in a setting other than the individual's home and code 10 when telehealth is delivered in the individual's home in accordance with MA Bulletin 99-23-08.

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 24 hours.
Routine Appointments	Within 10 business days.
Health Assessment/General Physical Examinations and First Examinations	Within three 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 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 30 minutes, or at any time, no more than up to one hour when the physician encounters an unanticipated urgent medical condition visit or is treating a member with a difficult medical condition need.

Continues on the next page

New member EPSDT Screens (Applies to PCPs who treat members under age 21)	Within 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 days from the effective date of enrollment unless the 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 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 10 business days of the member being identified as being pregnant.
Second trimester visit (Applies to PCPs who provide prenatal care)	Within five business days of the member being identified as being pregnant.
Third trimester visit (Applies to PCPs who provide prenatal care)	Within four business days of the member being identified as being pregnant.
High-risk pregnancies (Applies to PCPs who provide prenatal care)	Within 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 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 age 21. 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 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 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 member's 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 health care. 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 PCPs and specialists for special needs can 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 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 age three months.
- 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 timeframes and at other times if indicated by history and/or symptoms. This should be completed between ages nine and 11 and again between ages 17 and 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 eyeglasses. 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 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 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-, two-, four-, and six-month visits. Postpartum Depression (PPD) occurs in up to 20% 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 40% 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:

- 9–11 month visit.
- 18 month visit.
- 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:

- 18 month visit.
- 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 Enhanced Member Supports Unit (EMSU), formerly 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 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 9–11 month screening and the second test for lead should be conducted during the 24 month 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 Kirby Health Center Laboratory or any other participating laboratory or hospital 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's 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. **Recommended Actions Based on Blood Lead Level | Childhood Lead Poisoning Prevention | CDC**

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 21 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 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 2025 Immunization Schedules. The immunization schedules are broken out into three separate tables to include by age, a catch-up schedule, and by medical indications.

Highmark Wholecare follows recommended childhood immunization schedules approved by 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 12-month, 18-month through six-year well-child visits. Fluoride varnish assessment is also recommended at this age. The child should be referred to a dental provider when the first tooth erupts, but no later than age 12 months and the child should see the dentist every six months there after.

The dentist must check for the following and initiate treatment or refer as necessary:

- Cavities.
- 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 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 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 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 the provider cannot complete one of the screenings, modifier 52 should be added to the individual screening code and a $0.00 amount should be billed.
- If a screening code is reported with modifier 52, the provider must complete the screening during the next opportunity according to the Periodicity Schedule.
- Modifier 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 90 Reference Outside Lab and a $0.00 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 for ages 11 and 14) add the CPT code and 52 modifier with $0.00 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, medical 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) 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 52 or 90 plus CPT code when applicable.
- Appropriate ICD-10 diagnosis codes must be noted in box 21.
- Report visit code ‘03’ in box 24 (h) of the CMS-1500 form when providing EPSDT screening service.
- Report the applicable two-character EPSDT referral code for referrals made or needed as a result of the screen in box 10 (d) on the CMS-1500. Codes for referrals made or needed as a result of the screen are:
  - YO – Other
  - YB – Behavioral
  - YV – Vision
  - YM – Medical
  - YH – Hearing
  - 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) 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 52 or 90 plus CPT code when applicable.
- Appropriate ICD-10 diagnosis codes must be noted in box 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 the applicable two character referral code:
  - YO – Other
  - YB – Behavioral
  - YV – Vision
  - YM – Medical
  - YH – Hearing
  - YD – Dental

EPSDT Authorization for Specialty Care

If a member needs to be referred for specialty care because 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 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. Member eligibility can be verified by accessing NaviNet. In addition, providers can utilize The Plan's telephonic eligibility verification system (IVR). IVR can be reached by calling **1-800-642-3515** and is available 24 hours a day, seven days a week. The Pennsylvania MA Member EVS can be reached at **1-800-766-5EVS (5387)** 24 hours a day, seven days a week.

Referrals

Referrals are not required for the Medicaid product. The PCP is responsible for the coordination of a member's health care needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care 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 HealthHelp prior authorization).
- Therapies (requires HealthHelp prior authorization).
- Chiropractic visits.
- Out of network requests.
- Interventional spine pain management procedures and MSK surgeries (requires HealthHelp prior-authorization).
- Chemotherapeutic drugs, symptom management drugs and supportive agents, and radiation therapy drugs (requires OncoHealth 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.

Highmark Wholecare Medicaid members can obtain outpatient laboratory work at any participating laboratory or hospital. No referral is needed; only a lab order form or prescription from the ordering provider is needed. All other authorization 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, nonpayment 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 $90.00 for adult MA and $180.00 for adult General Assistance (GA) every six months. Highmark Wholecare will reimburse the member for any applicable copays based upon claims submission that exceed the maximum from January–June and again from July–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 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.

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 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 PCPs

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. 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	Standard
All Specialists	Emergent Care	Immediately seen or referred to an emergency facility.
All Specialists	Urgent Care	Within 24 hours.

Continues on the next page

Provider Type	Appointment Type	Standard
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	Routine Care	Within 15 business days from the date of referral.
Specialties not listed above	Routine Care	Within 10 business days.
All Specialists	Wait time in the waiting room and exam room for a routine care appointment.	Average office wait time no more than 30 minutes, or at any time, than up to one hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a member with a difficult medical condition need.
All Specialists	First time appointment with persons known to be HIV positive or diagnosed with AIDS.	Within seven days from the effective date of enrollment unless member is already in active care with a PCP or specialist.
All Specialists	First time appointment with member who is a Supplemental Security Income (SSI) or SSI related consumer.	Within 45 days of enrollment unless the member is already in active care with a PCP or specialist.
All Specialists	Missed Appointment	Conduct outreach whenever a member misses an appointment and document in the medical record. Three 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 contact Highmark Wholecare to verify eligibility of the member. Highmark Wholecare members may also self-refer for family planning services.

Highmark Wholecare permits its primary care practitioners to perform routine gynecological exams and pap tests and provide care during pregnancy if they are so trained and equipped in their office. Primary care practitioners 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 Enhanced Member Supports Unit (EMSU), formerly Special Needs Unit, for ongoing case management and support. To refer to the EMSU, 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, at **www.dhs.pa.gov** and under the Medicaid Forms & Reference Materials section at **providers.highmark.com/content/dam/highmark/en/providerresourcecenter/wholecare/documents/forms/PAMA_ONAFForm.pdf**.

Providers can submit the ONAF via the NaviNet online form submission tool and through the online submission process by logging in **here**. Providers still 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 28–32-week visits and at the post-partum visit. These two updates should also be submitted to the Plan immediately following completion. These two updates should also be faxed or sent through the online submission tool to Highmark Wholecare immediately following completion as noted above.

The purpose of the Obstetrical Needs Assessment Form is to help identify risk factors early in the pregnancy and engage the woman in case management. For that reason, the Obstetrical Needs Assessment Form must be faxed to Highmark Wholecare's MOM Matters® Department within two to five business days of the intake visit and at least 30 days prior to delivery. The ONAF is not a claim.

However, the ONAF must be received by the Plan to process the claim for the intake visit. Please submit claims on a CMS-1500 form within 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 $200.00 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 to five 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), and an E&M code (99202–99205 and 99211–99215) with a 25 modifier needs to be billed on the E&M (99202–99205 and 99211–99215) in addition to the U9 pregnancy modifier. All three 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.
   - 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.
   - If the member's first prenatal visit doesn't occur within the first trimester, then code 99429-HD should not be billed. However, the first visit with an obstetrical patient is the intake visit. If a patient becomes a Highmark Wholecare member during her pregnancy, her first visit as a Highmark Wholecare member is her intake visit and should be completed within the first 42 days of 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 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 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	Nutritional Counseling	S9470
Smoking Cessation Counseling	G9016	Substance Abuse Problem Identification and Referral	H0004
Genetic Risk Assessment	99205 TF or HD (as modifiers)	Parenting Program	S9444
Outreach Visit (maximum of three)	H1002	Urgent Transport (car)	A0425
In-depth Psychosocial 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 health care needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care 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 can 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 member's 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 HealthHelp prior authorization).
- Therapies (requires HealthHelp prior authorization).
- Chiropractic visits.
- Out of network requests.
- Interventional spine pain management procedures and MSK surgeries (requires HealthHelp prior authorization).
- Chemotherapeutic drugs, symptom management drugs and supportive agents, and radiation therapy drugs (requires OncoHealth 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**.

Highmark Wholecare Medicaid members can obtain outpatient laboratory work at any participating laboratory or hospital. No referral is needed; only a lab order form or prescription from the ordering provider is needed. All other authorization 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/GYN office or at a participating hospital without an authorization from the Plan. Please follow above mentioned CPT billing guidelines and use modifier 25 when billing two 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 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.

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
Suspected Pregnancy	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

Item	OB Referral	Authorization	Type of PCP Follow Up
OUT OF OFFICE SERVICES			
SPU/Ambulatory Surgery Services*	No	Yes	Summary Report
Inpatient Hospitalization	No	Yes	Summary Report
Home Healthcare/Hospice Services/IV Infusion	No	Yes	None
Mammogram	No	No	Summary Report
OB Ultrasounds	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.

**Highmark Wholecare will cover four (99501) postpartum home visits in 365 days.

*Highmark Wholecare Medicaid members can obtain outpatient laboratory work at any participating laboratory or hospital. No referral is needed; only a lab order form or prescription from the ordering provider is needed. All other authorization requirements remain the same.

Note: Genetic testing requires prior authorization.

Family Planning Guidelines

If a Highmark Wholecare patient presents for family planning benefits, practitioners need to be aware of the following:

- The patient's Highmark Wholecare eligibility can be verified by utilizing NaviNet or 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 30 days prior to the procedure.
- The appropriate documentation must be obtained for abortion services.
- The appropriate documentation must be preauthorized at least five business days prior to the procedure by contacting Highmark Wholecare Utilization Management Department at **1-800-392-1147**.

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 Highmark Wholecare, which will issue an approval for payment once the appropriate forms are received and reviewed. Highmark Wholecare may be contacted at **1-800-532-9465**. The appropriate forms may be faxed to **412-201-4701**.

Postpartum tubal ligations must be preauthorized by Highmark Wholecare. All outpatient laboratory testing should be ordered with a prescription through the member's PCP or OB/GYN practitioner. Highmark Wholecare Medicaid members can obtain outpatient laboratory work at any participating laboratory or hospital. No referral is needed; only a lab order form or prescription from the ordering provider is needed.

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.

Appointment Standards

Appointment standards for OB/GYN practitioners are as follows:

First Trimester	Within 10 business days of the member being identified as being pregnant.
Second Trimester	Within five business days of the member being identified as being pregnant.
Third Trimester	Within four business days of the member being identified as being pregnant.
High-Risk Pregnancies	Within 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 24 hours.
Routine Care	Within 10 business days.
Waiting time in the waiting room and exam room for a routine care appointment	Average office wait time is no more than 30 minutes, or at any time, no more than up to one 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 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 four days of enrollment unless the member is already in active care with a PCP or specialist.
Missed Appointment	Conduct outreach whenever a member misses an appointment and document in the medical record. Three attempts with at least one attempt to include a telephone call.

Policies and Procedures

Highmark Wholecare 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 Utilization Management Standards and Quality Improvement Guidelines.

Please know the Plan makes decisions concerning coverage of health care 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 underutilization 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 to encourage decisions on the coverage of health care 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 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 visit **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 24 day, seven 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 at **www.pafsa.org/child-abuse-facts-and-prevention-in-pennsylvania/**.

Visit their website 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, subcontractors, individuals, and entities against the exclusion databases as required by 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 DHSs 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: **exclusions.oig.hhs.gov/**
2. Federal General Services Administration, System for Award Management: **www.sam.gov/SAM/pages/public/searchRecords/search.jsf**
3. PADHS – Medicheck System: **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 $5,000,000.00 (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 provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

Compliance with State and Federal Requirements

Per the provider agreement:

- 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 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 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 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 60 days advance written notice in Highmark Wholecare's sole and absolute discretion. Within 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 provider's 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

For the Plan to meet the standards set forth by 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 months of the effective date of the change(s), or within six 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 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 and Sanctioning

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 Provider Engagement staff, Provider Account Liaisons (PALs) and our Medical Directors. The company follows a tiered approach to education and sanctioning prior to implementing termination procedures. Network practitioners who do not improve through the provider education process will be referred to the Quality Improvement/Utilization Management 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.
- Utilization management trends exceeding the peer group.
- Quality indicator outcomes below the peer group.
- Identification of Severe Quality of Care concerns.
- Failure to cooperate with administrative aspects of the QI 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 in 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

We have 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 Health Care 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 the Civil Rights Act of 1964 that prohibits race, color, and national origin 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

Practitioners 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 practitioners in locating resources upon request. Highmark Wholecare offers the Member Handbook and other information in large print, Braille, on cassette tape, or computer diskette at no cost to the member. Please instruct members to call Member Services at **1-800-392-1147** to ask for these other formats. Practitioner offices are required to adhere to the 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 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 Highmark Wholecare 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.
   - State plan for MA: 42 U.S.C. § 1396a (a) (7).
   - MA — Safeguarding Information on Applicants and Recipients: 42 C.F.R. § 431.300 et seq.
   - Mental Health Procedures General Provisions: 55 Pa. Code Chapter 5100.
   - Confidentiality of Alcohol and Drug Abuse Patient Records: 42 C.F.R. Part 2.
   - Pennsylvania Breach of Personal Information Notification Act: 73 P.S. § 2301 et seq.
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 health care operations (TPO) is released to Highmark Wholecare 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 Highmark Wholecare 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. Highmark Wholecare 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 authorized 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)

We have a comprehensive policy for handling the prevention, detection, and reporting of fraud, waste, and abuse (FWA). It is our policy to investigate any actions by members, employees, or practitioners that affects the integrity of Highmark Wholecare and/or the MA Program. We enforce all industry standard claim coding requirements including those from NCCI, AMA, CPT, ICD-10-CM, NCDs, LCDs, and HCPCS.

Providers are responsible for knowing 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:** Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs.
  - Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- **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 or federal regulations) for health care in a managed care setting.
  - Abuse can be committed by the health plan, 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.
- **Compliance Program:** To ensure compliance with FWA requirements of Medicaid contracts Highmark Wholecare and providers will have:
  - Written policies, procedures, and standards of conduct readily available for all employees which outlines our commitment to an 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, and
  - 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 $5,000 to $10,000 plus three 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.
- **Financial Investigations and Provider Review (FIPR):** A multi-faceted unit within Highmark Wholecare that is involved in detecting and investigating FWA. In addition, the team works to ensure that claims are paid correctly by both pre-pay and post-pay auditing methods and in accordance with 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, but not limited to:

- Referral of information regarding suspected or confirmed FWA to us.
- Submission of statistical and narrative reports regarding FWA detection activities.
- Submission of medical record requests for pre-payment and post-payment review.
- Participation in interviews and audits.
- Completion of provider compliance assessment.

Providers can find FWA trainings created by the Plan's FIPR Team on our website at **providers.highmark.com/wholecare/provider-resources/education-webinars**.

All providers are required to have a representative review the Provider FWA Training upon contracting with us 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 the Plan. Further information and updates concerning the Provider FWA Training can be found on the Highmark Wholecare website.

Our policies and procedures follow the guidelines set forth by CMS, where applicable.
For further information on Fraud, Waste, and Abuse, Providers should refer to the CMS website **Reporting Fraud | CMS**.

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 by calling the Fraud, Waste, and Abuse Hotline at **1-844-718-6400**.

Some common examples of provider 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.

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

Highmark Wholecare 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 and medical record reviews.
- Retrospective claims edits and medical record reviews.
- Provider education.
- FWA investigations and audits.
- Provider compliance assessments.
- Provider overpayment determinations and extrapolations.

Our FWA recovery functions rely on reimbursement policies, medical record standards, and coding requirements that are outlined in the following: Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), National Correct Coding Initiative (NCCI), National Committee for Quality Assurance (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.

Highmark Wholecare 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 FWA recovery efforts identify overpayments, the following activities will occur:

- We will comply with all federal and state guidelines to identify overpayments,
- We may determine provider recoveries based on audit results and extrapolation methodologies,
- We will pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within 60 days,
- We will refer suspected FWA to appropriate agencies, such as Medicaid oversight and CMS Medics, and
- We may recommend corrective actions that may include pre-payment review, payment suspension, and potential termination from Highmark Wholecare's provider network.

We may deny payment or pursue overpayments for the following reasons (but 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.
Potential fraudulent activities.
Excessive services.
Altered/forged records.
Inpatient readmissions (up to 30 days).

Fraud, Waste, and Abuse Audits

At times, FIPR 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 the Plan, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond. Overpayment letters issued through administrative reviews will be sent at the discretion of FIPR management.

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

- Retrospective data mining reviews.
- Subrogation.
- Inpatient and outpatient chart reviews.
- Pre-payment clinical validation and claims pattern reviews.

Vendor specific questions should be directed to the Plan's Provider Services by calling **1-800-392-1147**.

Overpayments

Highmark Wholecare, 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.

TRENDSubmit: Provider Self-Reporting Process

Providers can electronically submit overpayments via TRENDSubmit. This secure, online process allows providers to be notified of claim retractions in real-time and eliminates the manual paper process. The TRENDSubmit team provides user training resources and ongoing support.

Please see below for more information on TRENDSubmit. Providers can contact Jennifer Baron via email at **jbaron@trendhealthpartners.com** in order to initiate TRENDSubmit access.

Providers must notify us in writing of the reason for the self-identified overpayment and should provide payment within 60 calendar days in accordance with 42 U.S.C. §1320a7k(d) (2). If the claim is over two years old, a check is preferred. If the claim is less than two 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** which is 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. FIPR 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.

For the mailing address, please refer to the **Important Addresses** section on page 10.

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

- Self-Audit e-bulletin posted by CMS: **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.pa.gov/agencies/dhs/report-fraud/medicaid-provider-self-audit-protocol**.

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 years old, please provide a check.
  - For claims less than two 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 the Plan. 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 30 calendar days of our 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. Failure to provide requested medical records within the specified time frame will result in claims being denied.

We require 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, Medicare manuals, provider contracts, provider manuals, and all regulations.
- Providers are responsible for having compliance programs that prevent and detect FWA and report and return overpayments within 60 days of identification.
- Providers must have member records that include all Medicaid and/or Medicare 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, 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 misuse, 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 author's identification)
	Documents that member or guardian reviewed or participated in 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 treatment
	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.–4:00 p.m., Monday–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 Format: **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 misusing 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 years (restrictions may be lifted after a period of five 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 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). The County Assistance Office (CAO) receives notification of a member's restriction through flags in DHS's eCIS, as eCIS receives information from HealthChoices.
- 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 30 days from the date of the request, with notification within five 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 member's 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. Members must send their request for a Fair Hearing.

Department of Human Services
Office of Medical Assistance Programs — Division of Program and Provider Compliance
Recipient Restriction Section
PO Box 2675
Harrisburg, PA 17105-2675

Environmental Assessment (EA) Standards

We have established specific guidelines for conducting Environmental Assessment Site Visits, including medical record-keeping standards for all practitioner types, including primary care practitioners, specialty care practitioners, and dental providers. An Environmental Assessment will be conducted on an ongoing basis through monitoring of complaints. Our subcontracted vendor conducts all site visits for contracted dental providers. The purpose of the site visit is to ensure that practitioners are in compliance with our Environmental Assessment Standards.

When an environmental assessment is required, a Provider Account Liaison will schedule an on-site or virtual site visit with the office site to conduct an Environmental Assessment. The Environmental Assessment must be conducted with the Office Manager or with a practitioner of the practice. The Provider Account Liaison will complete the Environmental Assessment Form and physically or virtually 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 Environmental Assessment Standards.

Upon completion of the review, the Provider Account Liaison will conduct an exit interview with the Office Manager and/or practitioner. The results of the Environmental Assessment will be reviewed. Non-compliance issues must be addressed with a corrective action plan within 30 days of receipt for non-compliant standards.

The Provider Account Liaison will conduct a follow-up visit within 90 days or until the office site is compliant. 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 not acceptable, the Medical Director may suggest a different corrective action plan. If the office is not agreeable to correcting the identified problem, the information will be presented to the Quality Improvement/Utilization Management Committee for review. Special circumstances may be granted based upon size, geographic location of the practice, and potential harm to members. The Provider Account Liaison 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.

Provider Account Liaisons 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

Physical Accessibility/ADA Standards:

1. Is there adequate parking available near the physician office?
2. Is handicapped parking available? (One accessible space per every 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 36 inch) ramp leading to the office?
6. Does the ramp have railings (if longer than six feet)?
7. Are the patient entrance and exit clearly marked and unobstructed?
8. Are the hallways entrance and 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?

Accessibility Standards:

1. Is the waiting time to schedule a routine appointment less than or equal to 10 business days for Medicaid?
2. Is the waiting time to schedule a routine appointment less than or equal to 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 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 24 hours?
5. Is the waiting time for an EPSDT screen for a new member less than or equal to 45 days?
6. Wait time in the waiting room is no longer than 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 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 days?
12. Is the waiting time for an appointment for SSI patients less than or equal to 45 days from date of enrollment?
13. Is the office able to perform EPSDT screens? (Offices whose panel limit is age 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 24 hours a day, seven 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 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 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 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 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 do 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 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, all pediatric shift care services, 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 three 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 practitioner's request for an authorization of non-emergency hospital care; however, no party should assume the other has obtained authorization. Highmark Wholecare will also accept notification from the hospital's Admissions and/or 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. The peer review opportunity is available until the appeal process is initiated.

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 nonparticipating hospital, the member will be transferred within 24 hours of stabilization, when appropriate.

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 of the procedure date. Please submit authorization requests electronically via NaviNet (refer to Online Authorization section) or call Highmark Wholecare's UM department.

Emergency Room

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:

- 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.
- Serious impairment to bodily functions.
- 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).
- 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.
- Earache.
- 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 health care 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 health care 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 Skilled Nursing Facility (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 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 **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 drugs, it is imperative that providers abide by the following claim and invoice submission guidelines when submitting their claims for reimbursement.

Outlined below are 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 service 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’s name circled should also be included.

Highmark Wholecare would like to take this opportunity to provide 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 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 touchpoints 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 health care professional to communicate any reports, therapies, medications, and concerns identified by providers across treatment settings.

DRG Post-Payment Audits

Highmark Wholecare 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 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 the subcontractor describing the outcome of the medical records and claim review.
- You will have 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 subcontractor's 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 Fraud, Waste, and Abuse Hotline 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 us 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 at Highmark Wholecare's Financial Investigations and Provider Review Division by calling our Fraud, Waste, and Abuse Hotline at **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 health care needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care 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 HealthHelp prior authorization).
- Therapies (requires HealthHelp prior authorization).
- Chiropractic visits.
- Out of network requests.
- Interventional spine pain management procedures and MSK surgeries (requires HealthHelp prior authorization).
- Chemotherapeutic drugs, symptom management drugs and supportive agents, and radiation therapy drugs (requires OncoHealth 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.

Highmark Wholecare Medicaid members can obtain outpatient laboratory work at any participating laboratory or hospital. No referral is needed; only a lab order form or prescription from the ordering provider is needed. All other authorization 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 health care professional 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 health care 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

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

Audiology

Highmark Wholecare members under age 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 hearing 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 VSP 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/GYN's office is required to verify eligibility of the member.

Authorizations

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 InterQual Procedure Criteria, approval criteria based on a Medical Director's review of the latest medical literature and citations, and DHS/HealthChoices definition of medical necessity when authorizing the delivery of health care services to plan members.

A 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 health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a health care service under this agreement.

Requesting Precertification

The UM department is committed to assuring prompt, efficient delivery of health care services and to monitor quality of care provided to Highmark Wholecare members. Authorization is the responsibility of the admitting practitioner or ordering provider and must be obtained by submitting requests electronically (refer to Online Authorizations below). If for some reason NaviNet and GuidingCare are not available, call Highmark Wholecare's UM Department.

If a service requires authorization and is being requested by a participating specialist, the specialist's office must initiate the authorization process with Highmark Wholecare. 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 health care, 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. The ordering practitioner is offered a peer review opportunity with the Highmark Wholecare Medical Director for all potential denial determinations. The peer review opportunity is available until the appeal process is initiated. If the request is denied, a practitioner may appeal the decision. Please refer to the **Complaints, Grievances, and Fair Hearings** section of this manual for the process to appeal a decision.

The following services, not all inclusive, 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).
  - Interventional spine pain management procedures and MSK surgeries (HealthHelp).
- Outpatient Services
  - Experimental, investigational, or cosmetic services.
  - DME and any non-standard (i.e., deluxe) DME.
  - Outpatient therapies (physical, occupational, speech - HealthHelp) excluding evaluations.
  - Chiropractic.
  - Non-participating home health care.
  - Prosthetics.
  - Hospice.
  - Transplant services.
  - Radiology management (HealthHelp).
  - Cardiology (HealthHelp).
  - Sleep and Radiation Oncology for members over 18 (HealthHelp).
  - Interventional spine pain management procedures and MSK surgeries (HealthHelp).
  - Trigger Point Injections and Interventional Pain Management (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.

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 HealthHelp 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. Providers should request prior authorization through the HealthHelp website at **healthhelp.com/highmarkwholecare**. Providers can also contact the HealthHelp dedicated toll-free phone number, Monday–Friday, 8 a.m.–6 p.m. at **1-888-265-0072**.

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.

Program Exceptions

The Program Exception (PE) process is in place to address provider requests for Utilization Management review for those services that have limits, or if the member needs more services than the Medicaid fee schedule limit allows. This process also applies to requests for Utilization Management review of a service which is included in the member's benefit package but not currently listed on the Medicaid fee schedule so it can be reviewed for medical necessity based on the HealthChoices program for members less than age 21 or to determine special circumstances for members aged 21 and older.

Online Authorization

Highmark Wholecare providers have the capability to submit authorization requests electronically via GuidingCare, which is accessible through 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 (LOMN) – 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 health care 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 21 should explain why the needed care cannot be provided in the home setting.

Note: Highmark Wholecare Providers will access the Authorization Portal through NaviNet Single Sign-On (SSO) functionality. From the Health Plans dropdown on the NaviNet Plan Central page, select Highmark Wholecare then GuidingCare>Authorization Portal from the Plan Workflows menu. For additional information regarding GuidingCare, please refer to the **GuidingCare User Guide**.

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. Providers can go to the Provider Resource Center on our website and 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 8:30 a.m.–4:30 p.m., Monday–Friday at **1-800-392-1147**. 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 three business days.

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

1. Member name.
2. Member's eight-digit Highmark Wholecare ID number.
3. Diagnosis (ICD Code or precise terminology).
4. Procedure code (CPT, 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, past and present treatment.
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 three 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 or 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.

For the mailing address, please refer to the **Important Addresses** section on page 10.

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 HealthHelp website at **healthhelp.com/highmarkwholecare** or by calling into the dedicated toll-free phone number, Monday–Friday, 8 a.m.–6 p.m. at **1-888-265-0072**. A separate authorization number is required for each procedure ordered.

Chiropractic Services

Any participating practitioner must request prior authorization for chiropractic services by submitting the request online through GuidingCare, via NaviNet. If NaviNet and GuidingCare are not available, contact Highmark Wholecare's UM Department. 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 is subject to medical necessity determination based on Highmark Wholecare's criteria guidelines. All chiropractic services requested for children under age 13 are referred to Highmark Wholecare's Medical Director for review. Only one 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 nonparticipating DME vendor, or when a miscellaneous code is requested.
  - The use of HCPC code E1399 — DME, miscellaneous is only intended for use when a more appropriate code is not available. When an appropriate code does exist, that code must be used regardless of your contracted rate. It is not appropriate to use E1399 for payment increases.
- 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 ICD Code or precise terminology.
- Name of requested equipment or HIPAA compliant HCPC code 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 submit the request through GuidingCare, via NaviNet. If NaviNet and GuidingCare are not available, contact Highmark Wholecare's UM Department.



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 submit the authorization request through our GuidingCare authorization system, via NaviNet. If NaviNet and GuidingCare are not available, contact Highmark Wholecare's UM Department. Highmark Wholecare will coordinate the necessary arrangements between the PCP and the nursing facility to provide the member with continuity and coordination of care.

Outpatient Therapy Services

All Outpatient Therapy treatment services including physical therapy, occupational therapy, and speech therapy, cardiac and pulmonary rehab require prior authorization. Outpatient therapy services (physical therapy, occupational therapy, speech therapy) require prior authorization through the HealthHelp website at **healthhelp.com/highmarkwholecare** or by calling the dedicated toll-free phone number at **1-888-265-0072**, Monday–Friday, 8 a.m.–6 p.m. Outpatient cardiac and pulmonary rehab services require prior authorization by calling Highmark Wholecare's UM Department at **1-800-392-1147**. 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.

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 age 21 with the ordering practitioner and the home health care 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 online at **providers.highmark.com/content/dam/highmark/en/providerresourcecenter/wholecare/documents/pdfs/provider-newsletters/newsfeed/GuidingCareUserGuide.pdf**, fax at **1-888-245-2071**, or email at **CMDeptDocs@HighmarkWholecare.com**.

The following information will aid 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 EMSU Team. Case Managers can be contacted Monday–Friday, 8:30 a.m.–4:30 p.m.

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 of 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 $90.00 for adult Medical Assistance (MA) and $180.00 for adult General Assistance (GA) every six months. The Plan will reimburse the member for any applicable copays based upon claims submission that exceed the maximum from January–June and again from July–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

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.
- Highmark Wholecare 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 30 days 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 in the claims system. Providers will be held to timely filing policies regarding submission of the initial and corrected claims.
- The billing provider address submitted on claims (paper and electronic) must be a physical address. Claims will be rejected if a P.O. Box number is submitted as the billing address.
- Correct/current practitioner information, including Highmark Wholecare provider ID number, must be entered on all claims.
- Correct/current member information, including the eight-digit member ID number, must be entered on all claims.
- Outpatient/Inpatient drug claims: Once required prior authorization has been obtained, these drugs billed by dispensing prescribers must include correct and applicable National Drug Codes (NDCs), the corresponding J codes, and units on the claims.
- When submitting a claim for a drug purchased through the 340B program, the UD modifier must be included in the claim to prevent duplicate discounts by excluding the claim from Medicaid rebates.

- Please allow four to six weeks for a remittance advice. It is the practitioner's responsibility to research the status of a claim.
- Handwritten claims are not accepted.
- Payment by the plan is considered payment in full. In no circumstance, including but not limited to nonpayment 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.
- Highmark Wholecare 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.
- Highmark Wholecare Medicaid members can obtain outpatient laboratory work at any participating laboratory or hospital. No referral is needed; only a lab order form or prescription from the ordering provider is needed.

Timely filing criteria for original claims are 180 calendar days from the date of service. Corrected claims or requests for review are considered if information is submitted within 365 calendar days from the date of service on the claim. Practitioners must bill within 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.

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 call **1-800-392-1147**.

Timely Filing

Practitioners must submit a complete original, initial CMS-1500 or UB-04 claims form within 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 60 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.

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

Any claim that has been submitted to Highmark Wholecare but does not appear on a remittance advice within 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.

Highmark Wholecare accepts claims electronically through any clearinghouse. Practitioners are encouraged 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 Payer IDs:

Payer Name	Payer ID	Claim Type
Highmark Wholecare	25169	Professional
Highmark Wholecare	25169	Institutional

Requirements for Submitting Claims to Highmark Wholecare through a Clearinghouse

When submitting claims please note the Pennsylvania Payer ID Number is 25169. Any claim submitted with an incorrect Payer ID Number will be denied.

The billing provider address submitted on claims must be a physical address (paper and electronic). Claims will be rejected if a P.O. Box number is submitted as the billing address. The assigned eight-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.

Claims can be submitted with or without the Alpha character prefix appearing on the member's ID card.

The NPI (National Provider Identifier) 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 ensure that claims have been accepted via EDI, practitioners should receive and review acceptance/rejection reports from their clearinghouse.

If you are not submitting claims electronically, please contact your EDI vendor for information on how you can submit claims electronically.

Highmark Wholecare will accept electronic claims for services that would be submitted on a standard CMS-1500 or a UB-04 claims 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.

Claim Payments Electronic Remittance Advice

Highmark Wholecare uses PNC Healthcare 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 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 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 **enrollments.echohealthinc.com/EFTERAInvitation.aspx?tp=MDAyNzA=**
   - To sign up to receive EFT payments only or 835 and EFT from our company and from all Echo payers, visit **enrollments.echohealthinc.com/EFTERAInvitation.aspx?ReturnUrl=%2f**
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

Highmark Wholecare will review for reconsideration any claim that a provider 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. A plan participating 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 180 calendar days, will not qualify for review. All follow-up review requests must be received within 365 calendar days from the date of service on the claim. Claims inquiries for administrative reviews should be sent directly to Highmark Wholecare.

For the mailing address, please refer to Administrative Claims Reviews under the **Important Addresses** section on page 10 or fax to **1-844-207-0334**.

We cannot accept verbal requests to retract claim(s) 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 provider website at **providers.highmark.com**. The form, together with all supporting materials relevant to the claim(s) reversal request being made including but not limited to an Explanation of Benefits (EOB) from other insurance carriers and your refund check should be mailed to the PNC Bank, C/o Highmark Wholecare.

For the mailing address, please refer to the **Important Addresses** section on page 10.

Cotiviti Claims Pattern Review (CPR)

Highmark Wholecare utilizes Cotiviti Claims Pattern Review (CPR) to enhance the accuracy, integrity and timeliness of our claims processing. CPR has enabled efficient Payment Policy Management and allows for the review of claims using "real time" analytics, including the ability to pause claims processing and enabling Cotiviti CPR experts to review claims for proper validation prior to payment.

Cotiviti Claims Pattern Review Appeals Process

Providers have the right to submit for review any claim they feel was denied or paid incorrectly. Providers have three options to send in Cotiviti CPR Appeals:

1. Direct upload to the **Secure Portal**. Simply click on the "Submit Records" button and enter your password high90CCVC.
2. Secure faxing to **800-409-0499**.
3. Mailing the records directly to Cotiviti. Please mark the envelope "Confidential" and send to:

   C/O Cotiviti-6150
   10701 S Riverfront Pkwy,
   PO Box 12017
   South Jordan, Utah 84095

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 Highmark Wholecare.

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**.

Coordination of Benefits (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. Highmark Wholecare, like the Pennsylvania Medical Assistance (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.

The Plan may not deny or delay approval of otherwise covered treatments or services based on TPL considerations. 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. If a claim is denied due to the existence of TPL, the Plan will alert the provider at time of denial of the basis of such a denial and will allow the provider 180 days to request a waiver of timely filing requirements so that the provider may resubmit claims after adjudication of the claim by the TPL source.

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 process and pay a claim as primary when billed with procedure code T1001 along with the required Obstetrical Needs Assessment Form (ONAF) regardless of any primary carrier the member may have on file, or if an EOB from a primary carrier is attached to a claim.

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 authorization and billing procedures.
- File all claims within timely filing limits as required by the primary insurance carrier.
- Submit a copy of the primary carrier's EOB with the claim to our company within 365 days of the date of the service.
- 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.

For those individuals with Third Party Resources, including Medicare and commercial insurance, the plan may not require Prior Authorization or Program Exception approval of services prior to the service being performed if the service is covered by the Third-Party Resource. For MA compensable services, if the member's Third-Party Resource requires prior authorization and/or specialist referral in order to cover the service, the plan must accept the Third-Party Resource's prior authorization and/or specialist referral. If the Third-Party Resource does not require prior authorization and/or specialist referral in order to cover the service, the plan cannot require its own. In order to cover the service, the plan must accept the Third-Party Resource's prior authorization and/or specialist referral. If the Third-Party Resource does not require prior authorization and/or specialist referral in order to cover the service, the plan cannot require its own.

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 180 calendar days from the date of service. Claims submitted after this deadline will be denied for untimely filing. The 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 to comply with state regulations as necessary.

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 Highmark Wholecare receives a 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 canceled 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 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 Highmark Wholecare. 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 60 days from the date of service but will be accepted up to 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 $0.00. 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 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 age 19 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 (SFL) online training curriculum or through Healthy Teeth Health Children (HTHC) may administer and bill for fluoride varnish treatments for children less than five 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 years old) is painted with a fluoride solution to prevent tooth decay.

Once the certificate has been obtained, it must be submitted to PA DHS. PA DHS will then update the PCP's or CRNP's enrollment file and forward the information to Highmark Wholecare so our claims system can be updated. Refer to MA Bulletin MA Bulletin 09-16-10, 31- 16-10 for additional information on this process. Please note that Highmark Wholecare is not able to accept a certificate if it has not been submitted to PA DHS or if it is not appearing on the provider's DHS enrollment file.

Specialty/Fee-For-Service Providers

All specialists are required to submit encounters for all services performed, regardless of expected payment. 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 60 days of the date of the EOB. If required, our authorization 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
Primary Carrier Allowable	$1,000
Primary Payment (80% of Allowable)	$800
Highmark Wholecare Allowable if Primary	$600
Highmark Wholecare compares the Primary Carrier Payment to the Highmark Wholecare Allowable	$800 vs. $600
Highmark Wholecare Does Not Issue Payment	$0

Example of Patient Responsibility Remaining after Primary Plan Payment:

Practitioner Charges	$1,500
Primary Carrier Allowable	$1,000
Primary Payment (80% of Allowable)	$800
Patient Responsibility Under Primary Plan	$200
Highmark Wholecare Allowable if Primary	$850
Highmark Wholecare Compares the Primary Carrier Payment to the Highmark Wholecare	$800 vs. $850
Highmark Wholecare Issues Payment	$50



Medicare

Highmark Wholecare members age 21 or younger may have Medicare fee-for-service. When Medicare is the other insurance, the following processing criteria applies:

- 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 authorization criteria will apply.
- For Medicare Part A and Medicare Part B services, coverage is provided according to a benefits-less benefits calculation.

We 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 Medical Assistance or Highmark Wholecare, we must pay cost sharing to the extent that the payment made under Medicare for the service and the payment made by Highmark Wholecare does not exceed 80% of the Medicare approved amount.

Example A	
Practitioner Charges	$1,500
Deductible Satisfied	–
Medicare Allowable	$1,000
Medicare Payment (80% of Allowable)	$800
Health Plan Allowable if Primary	$600
Health Plan compares the Medicare Payment to the Highmark Wholecare Allowable	$800 vs. $600
Health Plan Does Not Issue Payment	$0

Example B	
Practitioner Charges	$1,500
Deductible Satisfied	–
Medicare Allowable	$1,000
Medicare Payment (80% of Allowable)	$800
Health Plan Allowable if Primary	$850
Health Plan compares the Medicare Payment to the Highmark Wholecare Allowable	$800 vs. $850
Health Plan Issues Payment for Difference	$50

Example C	
Practitioner Charges	$1,500
Medicare Allowable	$1,000
Medicare Applies $50 to Satisfy the Deductible	$50
Medicare Payment (80% of Allowable) Remaining After Deductible is Satisfied	$760
Health Plan Allowable if Primary	$850
Health Plan compares the Medicare Payment to the Highmark Wholecare Allowable	$760 vs. $850
Health Plan Issues Payment for Difference	$90

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	
Nurse Charges	$1,000
Primary Carrier Allowance	$600
Primary Carrier Payment	$500
Health Plan Allowable if Primary	$800
Health Plan compares the Primary Carrier Payment to the Health Plan Allowable	$500 vs. $800
Health Plan Issues Payment	$300

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

Pennsylvania Autism Insurance Act (Act 62)

Highmark Wholecare will pay for medically necessary autism-related services under the Medical Assistance (MA) program under Pennsylvania's Autism Insurance Act (ACT 62). ACT 62 is a statewide insurance mandate specific to services provided to children and adolescents with ASD.

ACT 62 requires Highmark Wholecare to cover medically necessary services that are for assessment and treatment of ASD for children and adolescents under twenty-one years of age. Like the Pennsylvania Medical Assistance (MA) program, Highmark Wholecare is the payer of last resort, providers must identify third party resources.

Claims Processing Procedures for physical therapy, speech therapy, and/or occupational therapy. For members under age twenty-one, the following criteria applies:

- Precertification/Authorization through our UM Department is required.
- We will require a primary plan EOB.
  - If primary plan $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.

For the mailing address, please refer to Administrative Claims Reviews under the **Important Addresses** section on page 10 or fax to **1-844-207-0334**.

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 Highmark Wholecare 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 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 60 calendar days of the date of the EOB/letter along with submission of the initial bill 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.

For the mailing address, please refer to the **Important Addresses** section on page 10.

Claim Coding Software

Highmark Wholecare uses HIPAA compliant automated coding software to improve accuracy and efficiency in claims processing, payment and reporting and to verify the clinical accuracy of professional and outpatient claims in accordance with clinical editing criteria.

This coding software contains complete sets of rules that correspond to Current Procedural Terminology (CPT-4), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases-version 10 (ICD-10), American Medical Association (AMA), as well as industry standards, medical policy, and literature and academic affiliations. These requirements may be amended to comply with federal and state regulations as necessary. The software 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 health care service that can be processed without obtaining additional information from the Provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in the Claims system. Claims under investigation for Fraud or Abuse or under review to determine if they are Medically Necessary are not Clean Claims. 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 health care provider who is under investigation for fraud or abuse or under review to determine if they are Medically Necessary are not Clean Claims.

In addition, a claim shall be considered "clean" if the appropriate authorization has been obtained in compliance with our company's 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.

We may pend or deny a claim if you do not list:

- Patient name.
- Patient medical plan identifier.
- Date of service for each covered service.
- Description of covered services rendered using valid coding and abbreviated description.
- ICD-10 surgical diagnosis code (as applicable).

- Name of practitioners/providers and applicable/required National Provider Identifier (NPI) numbers.
- The billing provider address submitted on claims be a physical address.
- Provider Tax Identification Number (TIN).
- Valid CMS place of service code(s). **Place of Service Code Set | CMS**
- Billed charge amount for each covered service.
- Primary carrier Explanation of Benefits (EOB) when patient has other insurance.
- 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.
- 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, Highmark Wholecare 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 regard 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. The Center for Medicare and Medicaid Services (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 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 or fifth 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.

For the mailing address, please refer to the **Important Addresses** section on page 10.

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 (FQHC)/ Rural Health Clinics (RHC)

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–into 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.

Encounter Definition

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 & Occupational Therapist
  - Audiologist
  - Case Manager
  - Nutritionists

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 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.**

Keeping your FQHC/RHC Roster Current can Help Eliminate Denials

All practitioners must come over on the FQHC/RHC Provider Change Form or Roster Template and be setup with the plan's credentialing/claims system prior to rendering services. All FQHCs/RHCs must have a collaborative agreement on file between the physicians, and extender(s) on staff. For more information visit the FQHC-RHC Resources webpage and review the FQHC/RHC 2025 Annual Provider Education and Orientation Training PowerPoint at **highmarkwholecare.com/Provider/Provider-Resources/FQHC-RHCResources**

Timely filing criteria for original claims are 180 calendar days from the date of service. Corrected claims or requests for review are considered if information is submitted within 365 calendar days from the 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 60 calendar 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. Claims submitted after these deadlines will be denied for untimely filing.

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 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 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

Highmark Wholecare allows reimbursement for MA Childhood Nutritional and Weight Management Services when billed 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 age 21 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: **www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/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** on page 166 for billing instructions.

Multiple Encounter Submission

Encounters with more than one 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 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 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 her pregnancy her first visit as a member is 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 to five business days of the initial intake visit. The ONAF is not a claim, however, it must be received by Highmark Wholecare 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 can 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.

For more information visit the FQHC-RHC Resources webpage and review the FQHC/RHC 2024 Annual Training Provider Orientation PowerPoint: **highmarkwholecare.com/Provider/Provider- Resources/FQHC-RHC-Resources**.

All participating FQHCs/RHCs 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 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.

For more Claims and Billing information, refer to the Claims and Billing sections:

- General Information
- Electronic Claims Submission
- Claim Payments (Electronic Remittance Advice/Electronic Funds Transfer)
- Claims Review Process
- Coordination of Benefits
- Claim Coding Software
- Billing Procedures
- ...and more.

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

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 mom's 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 surgical procedures/ operating sessions.

Highmark Wholecare determines reimbursement upon the clinical intensity of each procedure and reimburses at 100% for the most clinically intensive surgery, and 50% for the second and third 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.

An assistant surgeon may bill for one procedure per date of service and will be reimbursed at 20% 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 (30 seconds or more: round up; less than 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 all providers who bill in paper format. All anesthesia services should be billed with the appropriate anesthesia modifier.

Hospital Services

Hospital claims are submitted on UB-04 claim forms. To assure that claims are processed for the correct member, the member's eight-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 Paper Claim Forms

EDI requirements must be followed for electronic claims submissions.

Field #	Description	Requirements
1	Provider name, address, city, state, ZIP, telephone, fax, country code	Required – Facility name and physical address where services were rendered (P.O. Box # is not acceptable here)
2	Pay to name, address, city, state, ZIP	Required – If different from billing provider in Field 1
3a	Patient control number	Required
3b	Medical record number	Not required
4	Type of bill	Required – If four digits are submitted, the lead 0 will be ignored
5	Federal tax number	Required
6	Statement covers period	Required
7	Unlabeled field	Not used
8a	Patient name	Required
9	Patient address	Required
10	Birthdate	Required
11	Patient sex	Required
12	Admission date	Required for inpatient and home health
13	Admission hour	Not required
14	Type of admission/visit	Required, if inpatient
15	Source of admission	Required
16	Discharge hour	Not required
17	Patient status	Required
18-28	Condition codes	Maybe required in specific circumstances (Consult CMS criteria)
29	Accident state	Not used
30	Unlabeled field	Not used

Continues on the next page

Field #	Description	Requirements
31-34	Occurrence codes and dates	Maybe required in specific circumstances (Consult CMS criteria)
35-36	Occurrence span codes and dates	Required, if inpatient
37	Unlabeled field	Not used
38	Responsible party name and address	Not required
39-41	Value codes and amounts	Required, if inpatient
42	Revenue codes	Required
43	Revenue descriptions	Required
44	HCPCS/Rates/HIPPS codes	Required, if outpatient
45	Service dates	Required, if outpatient
46	Service units	Required
47	Total charges	Required
48	Non-covered charges	Required, if applicable
49	Unlabeled field	Not used
50	Payer identification	Required
51	Health plan ID	Not required
52	Release of Information Certification Indicator	Required
53	Assignment of benefits	Not used
54	Prior payments	Required, if applicable
55	Estimated amount due from patient	Not required
56	National Provider ID	Required – NPI Number
57	Other Provider ID	Health Plan Practitioner Identification Number should be entered on paper claims only (legacy number reported as secondary identifier to NPI on electronic claims).
58	Insured's name	Required, if applicable

Continues on the next page

Field #	Description	Requirements
59	Patient relationship to insured	Required, if applicable
60	Certificate-Social Security Number-Health insurance Claim-Identification Number	Health Plan Member Identification Number Required
61	Insurance group name	Required, if applicable
62	Insurance group number	Required, if applicable
63	Treatment authorization code	Required, if applicable
64	Document control number	Not required
65	Employer name	Required, if applicable
66	Diagnosis and procedure code qualifier	Required
67	Principal diagnosis code	Required (Coding for present on admission data required)
67A-67Q	Other diagnosis codes	Required (Coding for present on admission data required)
68	Unlabeled field	Not used
69	Admitting diagnosis code	Required
70A-70C	Patient reason for visit	Not required
71	Prospective Payment System (PPS) code	Required for DRG Code – If four digits submitted, the Lead 0 will be ignored
72	External cause of injury codes	Not used
73	Unlabeled field	Not used
74	Principal Procedure Code and date	Required, if applicable
74A-74E	Other procedure codes and date	Required, if applicable
75	Unlabeled field	Not used
76	Attending Provider Name and identifiers (Including NPI)	Maybe required in specific circumstances (Consult CMS criteria) If not required, do not send

Continues on the next page

Field #	Description	Requirements
77	Operating Provider Name and identifiers (Including NPI)	Maybe required in specific circumstances (Consult CMS criteria) If not required, do not send
78-79	Other Provider Name and identifiers (Including NPI)	Maybe required in specific circumstances (Consult CMS criteria) If not required, do not send
80	Remarks	Maybe required in specific circumstances (Consult CMS criteria)
81	Code – Code field	Optional (Consult CMS criteria)

CMS-1500 Data Elements for Submission of Paper Claim Forms

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
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	Reserved for NUCC use	Not required
9	Other insured's name	Required, if applicable
9a	Other insured's policy or group number	Required, if applicable
9b	Reserved for NUCC use	Not required
9c	Reserved for NUCC	Not required

Continues on the next page

Field #	Description	Requirements
9d	Insurance plan name or program name	Required, if applicable
10a,b,c	Is patient condition related to: a) Employment b) Auto accident c) Other accident	Required, if applicable
10d	Claim Codes (Designated by NUCC)	Not required
11	Insured's Policy Group or FECA Number	Required
11a	Insured's date of birth, sex	Required, if applicable
11b	Other Claim ID	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 or Authorized Person's signature	Required
14	Date of current: Illness OR injury OR pregnancy	Required, if applicable
15	Other date	Not required
16	Dates patient unable to work in current occupation	Required, if applicable
17	Name of referring practitioner or other source	Required, if applicable
17a	Other identification number of referring practitioner	Required, if applicable
17b	National Provider Identifier (NPI)	Required
18	Hospitalization dates related to current services	Required, if applicable

Continues on the next page

Field #	Description	Requirements
19	Additional claim information (Designated by NUCC)	May be required in specific circumstances (Consult CMS criteria)
20	Outside lab	Required, if applicable
21	Diagnosis or nature of illness or injury (Relate to 24E)	Required
22	Resubmission code and/or original ref. no	Required, if applicable
23	Prior authorization number	Required, if applicable
24A	Date(s) of service	Required
24B	Place of service	Required
24C	EMG	Required, if applicable
24D	Procedures, services, or supplies CPT/HCPCS/Modifier	Required
24E	Diagnosis code pointer	Required
24F	Charges	Required
24G	Days or units	Required
24H	EPSDT Family Plan	Required, if applicable
24I	ID qualifier	Required, if applicable
24J	Rendering Provider ID	Required
25	Federal Tax Identification Number, SSN/EIN	Required
26	Patient account number	Required
27	Accept assignment	Required
28	Total charge	Required
29	Amount paid (Required when another carrier is primary payer)	Required, if applicable
30	Reserved for NUCC use	Not required

Continues on the next page

Field #	Description	Requirements
31	Signature of Physician or Supplier including degrees or credentials/date	Required Health Plan individual practitioner name and date required
32	Service facility location information	Required. Facility name and physical address where services were rendered required (P.O. Box #s are not acceptable here.
32a	Name and address of facility where services were rendered (If other than home or office)	Required
32b	Other ID#	Required, if applicable
33	Billing provider info and phone #	Required Facility name and physical address where services were rendered (P.O. Box # is not acceptable here)
33a	NPI number	Required
33b	Other ID#	Required. If applicable



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.

Introduction

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 or 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
  Attention: 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 its 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 first exam:	We will make an appointment for you:
Members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a member in Highmark Wholecare 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 45 days after you become a member in Highmark Wholecare unless you are already being treated by a PCP or specialist.
Members under age 21	with PCP for an EPSDT exam no later than 45 days after you become a member in Highmark Wholecare unless you are already being treated by a PCP or specialist.
All other members	with PCP no later than 3 weeks after you become a member in Highmark Wholecare.

Members who are pregnant:	We will make an appointment for you:
Pregnant women in their first trimester	with OB/GYN provider within 10 business days of Highmark Wholecare learning you are pregnant.
Pregnant women in their second trimester	with OB/GYN provider within 5 business days of Highmark Wholecare learning you are pregnant.
Pregnant women in their third trimester	with OB/GYN provider within 4 business days of Highmark Wholecare learning you are pregnant.
Pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of Highmark Wholecare learning you are pregnant.

Appointment with:	An appointment must be scheduled:
PCP	
urgent medical condition	within 24 hours
routine appointment	within 10 business days
health assessment/general physical exam	within 3 weeks

Appointment with:	An appointment must be scheduled:
Specialists (when referred by PCP)	
urgent medical condition	within 24 hours of referral
routine appointment with one of the following Specialists: • Dentist • Dermatology • Orthopedic Surgery • Otolaryngology • Pediatric Allergy and 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 15 business days of referral
Routine appointment with all other specialists	within 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 video conference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of one 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 or licensed dentist will be on the committee. Highmark Wholecare will mail you a notice within 30 days from the date Highmark Wholecare received the Complaint unless you have requested that Highmark Wholecare take an additional 14 days to decide the Complaint. The notice will tell you Highmark Wholecare's decision on your First Level Complaint 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 file a Complaint that is postmarked or received by Highmark Wholecare within 15 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 to not 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 not getting 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 by submitting your request in writing to the Pennsylvania Insurance Department's Bureau of Consumer Services within **15 days of the date you got the First Level Complaint decision notice**.

To ask for an external review of your Complaint, send your request to the following:

Pennsylvania Insurance Department
Bureau of Heath Coverage Access, Administration, and Appeals
Room 1311, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or

Go to the "File a Complaint Page" at **hwc.fyi/consumer-help**.

If you need help filing your request for external review, call the Bureau of Consumer Services at **1-877-881-6388**. 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**.

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: 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
  Attention: 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 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 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by video conference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of three or more people, including at least one 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 or licensed dentist 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 176.

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 an external 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 written request for an external review of your Complaint to the following:

Pennsylvania Insurance Department
Bureau of Heath Coverage Access, Administration, and Appeals
Room 1311, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or

Go to the "File a Complaint Page" at **hwc.fyi/consumer-help**.

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 Pennsylvania 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 your request for an external Complaint review is postmarked or received by the Pennsylvania Insurance Department within 15 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, the services or items will 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 15 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 **1-800-392-1147 (TTY: 711 or 1-800-654-5984)** 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:

  Attention: Appeals & Grievances
  Highmark Wholecare
  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 video conference. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of three or more people, including a licensed doctor or licensed dentist, will meet to decide your Grievance. 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 183.

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 that is postmarked or received by Highmark Wholecare within 15 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.

If you need more information about help during the Complaint process, see page 176.

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 or 1-800-654-5984)** and tell Highmark Wholecare your Grievance, or
- Write down your Grievance and send it to Highmark Wholecare.

  Attention: Appeals & Grievances
  Highmark Wholecare
  P.O. Box 22278
  Pittsburgh, PA 15222
  Fax: 412-255-4503

Highmark Wholecare will send your request for external Grievance review to the Pennsylvania Insurance Department.

What Happens After I Ask for an External Grievance Review?

The Pennsylvania Insurance Department 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 20 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 15 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 15 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 or 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.

Note: Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

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

A committee of one or more people, including a licensed doctor or licensed dentist, will review your expedited Complaint. Other providers may participate in the review but, the licensed doctor or licensed dentist will decide your 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.

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 Pennsylvania Insurance Department **within two business days from the date you get the expedited Complaint decision notice**.

To ask for an expedited external review of a Complaint, send your request to the following:

Pennsylvania Insurance Department
Bureau of Heath Coverage Access, Administration and Appeals
Room 1311, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or

Go to the "File a Complaint Page" at **hwc.fyi/consumer-help**.

If you need help filing your request for external review, call the Bureau of Consumer Services at **1-877-881-6388**.

Expedited Grievance and Expedited External Grievance

A committee of three or more people, including a licensed doctor or licensed dentist, will meet to decide your Grievance. 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 video conference 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.

Highmark Wholecare 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, whichever is sooner, unless you ask Highmark Wholecare to take more time to decide your Grievance. You can ask Highmark Wholecare 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.

You must ask for expedited external Grievance review **within two 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: 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 Highmark Wholecare by mail or fax:

  Highmark Wholecare
  Attention: Appeals & Grievances
  P.O. Box 22278
  Pittsburgh, PA 15222
  Fax: 412-255-4503

Note: Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

Highmark Wholecare will send your request to the Pennsylvania 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: 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**. You can also find self-help forms and other information at **PHLP.org**.

Persons Whose Primary Language Is Not English

If you ask for language 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.
- 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, faxed, or submitted via email 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 told 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 you 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.

Note: Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

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 or email, 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.
- 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:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675
Fax: 717-772-6328
Email: **RA-PWCGFHteam@pa.gov**

Note: Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

You may send a request for a Fair Hearing through email and provide your personal identifying information in a letter mailed to the above address.

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 15 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**, by faxing a letter or the Fair Hearing Request Form to **717-772-6328** or submitting a request via email to **RA-PWCGFHteam@pa.gov**.

Note: Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

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, the Fair Hearing will not be expedited. The Fair Hearing will be scheduled and decided using the usual time frame.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within three 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's toll-free telephone number at **1-800-392-1147 (TTY: 711 or 1-800-654-5984)** if you need help or have questions about Fair Hearings, 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**.

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. Please send the written request for an appeal, along with all supporting documentation.

Attention: Appeals & Grievances
Highmark Wholecare
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

First Level Provider Appeal

1. To request a provider appeal, providers must make a written request for appeal which must be received by the plan within:
   a. 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. 180 calendar days of the date of their denial notice denying a post-service claim unless otherwise negotiated by contract. When an authorization has been denied, provider must adhere to the 60 calendar-day time frame, the 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 60 calendar days of the date the written request was received.
4. The provider will be informed of the decision in writing by mailing/faxing notification within 60 calendar days from receipt. This notification will include additional appeal rights as applicable (i.e., Second Level Provider Appeal-see below). If the appeal is approved, payment will be issued within 60 calendar days of notification.

Second Level Provider 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 60 calendar days of the date on the first 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 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 of the committee will include a health care 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 Level provider appeal reviews will be completed within 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 60 calendar days. This is the final level of appeal, and the decision is binding, unless otherwise governed per contract.

Care Management

Telephonic Management

Case Managers proactively reach out to higher-risk members to:

- Assess overall well-being, including SDoH needs.
- Determine the member's understanding of their condition(s).
- Assess behavioral, economic, environmental, social, spiritual, and medical needs.
- Discuss lifestyle management issues including but not limited to diet, nutrition, meal planning, weight management, exercise, and smoking cessation.
- Refer members to a health educator, home health visits, behavioral health, or any other discipline if indicated.
- Communicate with members care team as needed.
- Perform medication reconciliation to assess compliance and understanding; assess for polypharmacy and multiple prescribers.
- Review claims for laboratory testing and follow up with member for results.
- Provide pillboxes if needed.
- Educate about the Enhanced Member Supports Unit and offer case management services.

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 lifestyle implications and motivating them to take a proactive role in managing their health.

Disease Management Programs

Highmark Wholecare's Disease Management Programs use a multidisciplinary approach that identifies health conditions within our population. These programs focus on identifying the needs of the population within these chronic conditions and perform scheduled outreach activities to provide education, resources, and care coordination to members.

The program focuses on providing disease management for the following:

- Cardiometabolic conditions.
- Pulmonary disease.
- Renal disease.
- Digestive disorders.

Condition management for members supports the provider-member relationship and plan of care to emphasize the prevention of exacerbations and complications that require emergency room and inpatient health care services. Providers can refer patients by calling us. For more information or to refer a patient to Disease Management call **1-800-392-1147**. Participation is voluntary. To stop participating members only need to call.

MOM Matters

MOM Matters is multi-faceted and designed to optimize maternal and child health care and management, and address barriers to self-care, including non-clinical barriers related to social determinants of health. It addresses timeliness of prenatal care to reduce the incidence of low birth weight, preterm deliveries and NICU admissions. It also addresses timeliness of postpartum care to support connecting moms and families to services and resources.

Through participation, patients can work with a member of the MOM Matters Case Management team, comprised of nurses, social workers, and non-clinical staff, who provide telephonic and face to face support to assess and develop interventions based on the needs of pregnant members including SDOH, pregnancy risk factors, and comorbid health conditions. Collaboration with OB providers, community-based agencies and referrals to social service and community-based resources occurs as needed.

MOM Matters also partners with various evidence-informed Maternal Home Visiting programs to provide ongoing support to pregnant and postpartum members and their children. The Maternal Home Visiting program involves regularly scheduled home visits with trained community health workers, or other health professionals and focus on encouraging the use of preventative services, health promotion and education, healthy family, and child development, identifying, and resolving barriers to care and mitigating social determinants. Maternal Home Visiting programs collaborate with the MOM Matters Case Management Team to support moms and their children and can provide ongoing support through the child's 18 months of age.

MOM Matters can 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.
- Obtain patient education and self-management tools.
- Receive information on smoking cessation with a referral to state Quitline.
- Have access to member newsletters with pregnancy related articles.
- Get home care coordinated through the members Highmark Wholecare case manager.

All members identified as pregnant or postpartum are eligible. Pregnant or postpartum members are automatically enrolled. Participation is voluntary. To stop participating members only need to call. Providers can refer patients by calling us. For more information or to refer a patient to MOM Matters call **1-800-392-1147**.

Enhanced Member Supports Unit (EMSU), formerly Special Needs Unit, Case Management

General Information

The Enhanced Member Support Unit is responsible to provide support and Case Management Services to Members with special health care needs and/or HRSN that request or agree to receive Case Management Services. This unit serves members of all ages.

The goal of the EMSU 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 EMSU 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.

An EMSU Case Manager is available to assist with coordination of the member's health care needs Monday–Friday, 8:30 a.m.–4:30 p.m. at **1-800-392-1147**.

The responsibilities of the EMSU include:

- Liaison with various health care practitioners, community social service agencies, advocacy groups and other agencies that the MA population may interface with.
- Case management of members with serious and complex 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 EMSU 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.

Member with the following conditions and/or diagnoses are examples of appropriate referrals to the EMSU:

- Children with special health care 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 Behavioral Health Coordinator, who is a behavioral health professional and is located in Pennsylvania, shall monitor Highmark Wholecare for adherence to behavioral health requirements in the HealthChoices Agreement.

The primary functions of the Behavioral Health Coordinator are:

- Coordinate Member care needs with Behavioral Health Providers.
- Develop processes to coordinate behavioral health care between PCPs and Behavioral Health Providers.
- Participate in the identification of best practices for behavioral health in a primary care setting.
- Coordinate behavioral care with medically necessary services.
- Be knowledgeable of the Behavioral Health Managed Care Agreement requirements and coordinate with the BH-MCO to effectuate the requirements.

To speak with Highmark Wholecare's Medicaid Behavioral Health Coordinator call **1-800-392-1147**.

Complex Case Management

Highmark Wholecare's EMSU 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.

Contact the EMSU Case Management to make a referral to the Complex Case Management program at **1-800-392-1147 (TTY: 711 or 1-800-654-5984**).

Highmark Wholecare will review the request for enrollment and make the final decision for inclusion in the program. Participation is voluntary. To stop participating, members only need to call.

Chronic Case Management

Highmark Wholecare's EMSU 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 EMSU Case Management at **1-800-392-1147**. Participation is voluntary. To stop participating, members only need to call.

School Based and School Linked Services

Highmark Wholecare's EMSU 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 staff, as well as the members physicians and specialists ensure that all required services are available for the member in the school setting. Call EMSU at **1-800-392-1147** asked to speak to a Case Manager if you require assistance with school based and school linked services.

Introduction to Credentialing

Purpose of Credentialing

Credentialing is the process of performing a background investigation, as well as validation of a practitioner and provider's credentials and qualifications. The credentialing and recredentialing processes also encompass a complete review of, but not limited to, malpractice histories, quality of care concerns and licensure status. Our company 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), and Doctorate of Psychology (Ph.D.), Doctorate of Philosophy (Ph.D.) (This listing is subject to change.)

Extenders: Physician Assistant (PA), Certified Registered Nurse Practitioner (CRNP), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), and 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 (RHC), and Federally Qualified Health Centers (FQHC). (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 us 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. 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 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 must include a copy of the letter of approval from the State and if applicable per the collaborative/written agreement, a DEA is required.

Highmark Wholecare 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.
- National Provider Identifier (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 our company's Medical Directors and Legal Counsel.
- 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 need submitted.
- Active participation in the Medicare and/or Medical Assistance 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.

The Credentialing Department will notify practitioners, in writing, within 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 10 calendar days from the date of our company's notification to submit written corrections and supporting documentation to the Credentialing Department. A credentialing decision will not be rendered until the 10 calendar days have expired.

Practitioners, upon request, have the right to be informed of the status of their credentialing or recredentialing application, or a copy of the credentialing criteria. 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 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 within our company. This helps to ensure continued compliance with National Committee for Quality Assurance (NCQA), Department of Human Services (DHS), Center for Medicare and Medicaid Services (CMS) and the Department of Health (DOH), as well as to uphold the integrity and quality of the networks. 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 Plus℠ Confidentiality of Practitioner/Provider Credentialing Information Policy and Procedure.

Ongoing and Performance Monitoring

Our company'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), CMS Preclusion Listing, and applicable state disciplinary reports. 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 participating practitioner is found on the OIG, Medicare Opt-Out List, Medicare/Medicaid sanction/exclusion listing or applicable state disciplinary action report, the practitioner's 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 Quality Improvement/Utilization Management Committee for review and decision and/or immediately terminated. In all instances, the information is reported to the QI/UM Committee.

The credentialing department monitors member complaints as part of the recredentialing process on a monthly basis. The credentialing department receives complaint reports, which reveals member complaints filed against practitioners as well as trends in those complaints. If the complaint is deemed viable by the reporting area, it is documented in the reports.

Depending upon the severity level of the complaint(s), the practitioner may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or terminated and outcome presented to Quality Improvement/Utilization Management Committee.

Our 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 an approved sabbatical. However, it is the practitioner's or his/her office's responsibility to notify us in writing that the practitioner is called to active duty or beginning the leave, as well as an expected return date. The letter should also include the practitioner who will be covering during his or her leave. The Credentialing Department will not terminate the practitioner called to active duty, on maternity leave or on an approved sabbatical if appropriate coverage is in place. Practitioner/practitioner's office should notify us of the practitioners return, as soon as possible, but not exceeding 10 business days from the practitioners return to the office. The 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, it must be completed within 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 our Provider Network is within the sole discretion of our company.

We conduct credentialing in a non-discriminating manner and do 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. We understand and abide 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 does not meet our 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 us within 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 our behalf. We 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 our program requirements. The delegated entity has authority to conduct specific activities on behalf of our company. We have the ultimate accountability for the quality of work performed and retain the right to approve, suspend, or terminate the practitioners and site. Any further sub-delegation shall occur only with our approval and shall be monitored and reported back to us.



Forms and Reference Materials

https://providers.highmark.com/wholecare/resource-centers/medicaid-resources/forms-reference-materials

Change Healthcare is a separate company that administers E&M audits, education, and probe audit expansion for Highmark Wholecare.

Cotiviti is a separate company that administers pre-pay claim editing, retrospective data mining activities, readmissions, and chart reviews for Highmark Wholecare.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

HealthEdge Software, Inc. is a separate company that provides the GuidingCare® authorization software and portal.

VSP is a separate company that administers the vision benefit(s) for Highmark Wholecare.

United Concordia is a separate company that administers dental benefits.

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.

HIGHMARK WHOLECARE

120 Fifth Avenue
Pittsburgh, PA 15222

How to Contact Highmark Wholecare
1-800-392-1147 (TTY: 711)

Hours of Operation
Monday–Friday, 8 a.m.–8 p.m.

How to Find Participating Providers or Pharmacies
highmark.com/wholecare

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