2024

Federally Qualified Health Centers and Rural Health Clinics Provider Policy and Procedures References

HIGHMARK. WHOLECARE.

Credentialing Process

HIGHMARK. WHOLECARE.

Who is Credentialed?

- Highmark Wholecare credentials all Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Highmark Wholecare DOES NOT credential the individual provider.

- New Site Location with a different TIN, NPI, Medicaid or Medicare ID is required to go through the credentialing process.

- Contact your Sr. Provider Contract Consultant for a Highmark Wholecare Organizational Provider Application and the required documentation needed with the completed application.

Requirements for New FQHC/RHC Locations

All FQHC/RHCs must meet the following criteria for the facility to be successfully credentialed:

1. A completed and accurate **Highmark Wholecare Organizational Application** (including NPI, MAID/CARE, and TIN numbers, attached w9, accurate disclosure questions, and signed attestation).

2. If the Facility is contracted/set up for the Medicaid line of business, the Medicaid number and practice location must be verified via the **PROMISe website.**

3. Page 6 of the application must be completed with the provider's initials and provider licenses must be attached.

4. A copy of the professional and general liability policies.

5. FQHC are recredentialed at the Facility level every three years.

FQHC/RHC New Site Location

Documentation Required:

- Medicaid and/or Medicare PPS Rate Letter(s).
- State license(s) and other certifications:
  - Certificate of accreditation and the report from the most recent survey by the accrediting organization.
  - If your facility or organization is non-accredited, you must include your HCFA/Pennsylvania State survey report. Highmark Wholecare will review the results of your survey to determine your approval in the Highmark Wholecare network.
- Face sheets for professional and general insurance policies.
- W-9.

Health Resources and Services Administration (HRSA) Approval Reminder

- If the 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 Highmark Wholecare of the change in scope of services within 30 days of the issue date identified in block 1 of the HRSA's Notice of Grant Award.

- Additionally, any interim rate letter(s) received from PA DHS must be forwarded to Highmark Wholecare within 10 days of receipt.

FQHC/RHC Provider Roster Process

HIGHMARK WHOLECARE

FQHC/RHC Provider Change Process

The Highmark Wholecare physician agreement indicates that participating providers must submit written notice:

- Ninety (90) calendar days prior to the date the provider intends to terminate.
- Sixty (60) days prior if you plan to close your practice to new patients.
- Thirty (30) days prior for a practice location change.

Whenever an FQHC/RHC has New Adds (physician or group), Demographic changes, and/or Terminations occur within an FQHC/RHC practice location(s), an FQHC/RHC **Provider Change Form** must be completed and sent to Highmark Wholecare **within the timeframe indicate above.**

Provider Roster Requirements for New Locations

Individual Practitioners must meet the following criteria to be successfully onboarded:

1. The facility must provide a list of all Practitioners that will be practicing at their location.
2. Must have a valid PA Medicaid ID for the specific location being requested if participating with Highmark Wholecare Medicaid.
3. Must have a valid Medicare ID number if participating with Medicare Assured.
4. Valid License #.
5. Must not be on any Exclusion/Preclusion/Sanctioned list.

Once the providers are loaded from the initial Roster provided, they then fall into the ongoing monitoring that all Credentialed and Delegated Practitioners undergo. Examples include the PRV State File reconciliation, Exclusion and Sanction List compare, etc.

FQHC/RHC Provider Change Process

The FQHC/RHC Provider Change Form is an addition to the Roster Template (Excel) used in the past. **When updating multiple providers at two or more service locations, use the Roster Template for multiple updates.**

- All practice changes must be submitted using the **FQHC/RHC Provider Change Form**.
- All appropriate fields on the form must be completed.
- For any Tax ID or Payment Remittance Name or Address Change, a W-9 must be attached.
- Any time a new location is added, an **Organizational Provider Participation Application** must be completed and submitted with an updated change form.
- Completed change forms and required attachments are sent to **Roster_Updates@HighmarkWholecare.com**

Please note: It can take up to 30 days to complete roster updates. Also, incomplete change forms will be returned to the original sender.

FQHC/RHC Provider Change Process

In 2022, Highmark Wholecare rolled-out the new Highmark Wholecare FQHC/RHC Provider Change Form to be used when reporting: New Add(s), Termination(s) and Demographic Changes. This fillable form is designed to capture up to nine practitioners per **ONE** single practice location.

Your Enrollment/Credentialing staff will experience the benefits of using this new fillable form when reporting changes:

- Easy to fill in data
- Easy to read
- Faster processing
- A more **efficient** greener process for submitting provider changes.

The FQHC/RHC Provider Change Form is located on our website: Provider Resource Center (highmarkprc.com)

Physician Extenders (PA/CRNP) and Behavior Health Counselors Reminders

Physician Assistants (PA) & Certified Registered Nurse Practitioners (CRNP) can bill alone under the Medicare LOB.

- Physician (PA) extenders CAN NOW bill alone under the Medicaid LOB and NO LONGER need to bill under a supervising physician.
- Highmark Wholecare will set up Licensed Social Workers (LSWs) under the Medicare LOB provided they have a valid Medicare ID.
- **Licensed Professional Counselors (LPC)** and **Marriage & Family Therapist and Mental Health Counselors:**
  - As of January 1, 2024, are recognized by Medicare & BH services. LPCs and Marriage & Family Therapist and Mental Health Counselors are eligible for Medicare enrollment and reimbursement for their services.

Claims & Billing

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Claims Payment Policy

- Highmark Wholecare is required to cover all services that are covered under Medicaid and Medicare; however, we follow our own claims processing policies and procedures.

- Highmark Wholecare follows claims payment policies which are national in scope, simple to understand and aligned with current industry and medical society standards.

- Claims payment policies are made available to all providers via the Highmark Wholecare website: https://highmarkwholecare.com/Provider/Provider-Resources/Payment-Policies

Claims Coding Software

Highmark Wholecare utilizes a fully automated coding review product that programmatically evaluates claim payments to verify the clinical accuracy of professional claims in accordance with clinical editing criteria. This coding program contains complete sets of rules that correspond to CPT, HCPCS, ICD-10, AMA and CMS guidelines as well as industry standards, medical policy and literature and academic affiliations.

The program used at Highmark Wholecare 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.

Encounter Data

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

FQHC/RHC Encounters with more than one eligible practitioner and multiple encounters

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:

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

The medical necessity of multiple encounters must be clearly documented in the medical record.

FQHC/RHC Medicaid Billing

- Encounter code for FQHC/RHC Medicaid billing requires the T1015 code for medical services. Total charges for the encounter should be billed with code T1015.
- In addition, FQHC/RHC must bill the appropriate approved Evaluation and Management (E&M) Current Procedural Terminology (CPT) code from the current Medicaid Fee Schedule
- The T1015 code is limited to one medical encounter per day.
- Claims submitted with just the T1015 will not be paid.

FQHC/RHC Medicaid Encounter Codes Reminder

FQHC/RHC Medicaid

- T1015
- T1015-EP: Visit Codes 99381/99391-99385/99395 and the EP modifier – **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) billing only**
- T1001-U9: (Initial Obstetrical Needs Assessment Form (ONAF)) – **OB Billing Only**
- T1015-U9: E&M (99202-99205, 99211-99215) & U9 Modifier – **OB Billing Only**
- T1015 -U3: E&M 92002, 92004, 92012 and 92014 & U3 Modifier – **Routine Vision Billing– Ophthalmologist or Optometrist ONLY**

EPSDT Billing

- All EPSDT screening services, including vaccine administration fees, are to be submitted to Highmark Wholecare on a CMS-1500 or the corresponding 837P format for EDI claims within 60 days from the date of service.
- An EPSDT screen is complete when codes from each service area required for that age, including the appropriate evaluation and management codes, are documented.
- EPSDT claims will pay only if the appropriate evaluation and management code along with the EP modifier are submitted.
- As a reminder, FQHCs/RHCs are “not permitted” to do incomplete screenings per EPSDT regulations. An ENTIRE EPSDT screening is required.

FQHC/RHC OB/GYN Coding

- All prenatal visits and dates of service must be included on the **CMS-1500 form** and identified with **T1015,** along with the appropriate **E&M codes** (99201 - 99205 and 99211 - 99215).
- The U9 pricing modifier must follow the code in the first position on the claim form.
- Delivery charges must be identified with CPT codes.
- 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.
- Highmark Wholecare will reimburse providers a payment of $200 plus the contracted percentage increase for initial prenatal visits rendered within the first trimester.
- Providers must report the following: **99429-HD** (First Trimester Outreach), **T1015-U9** (Initial Risk Assessment), and an **E&M codes** (99201 - 99205 and 99211-99215) with a U9 modifier. All three codes must be reported together on the same claim with a diagnosis of pregnancy, to allow for the bonus payment.

FQHC Medicare Billing

Refer to Medicare Learning Network (MLN) Matters® Article titled Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) for Approved Preventive Health Services, Medical Health Services and Codes provided in that article.

Article Title:	**MLN Matters® Number:**
MLN Matters Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)	MM8743

- FQHC qualified encounter code for Medicare.
- Total charges for the encounter should be billed with the appropriate approved E&M CPT code from the current Medicare Fee Schedule.
- Claims submitted with just the encounter code will not be paid.

FQHC Medicare Encounter Codes Reminder

FQHC – Medicare

- G0466 – FQHC visit, new patient
- G0467 – FQHC visit, established patient
- G0468 – FQHC visit, IPPE or AWV
- G0469 – FQHC visit, mental health, new patient
- G0470 – FQHC visit, mental health, established patient

RHC Medicare Billing

Refer to MLN Matters® Article titled Required Billing Updates for Rural Health Clinics for the Approved Preventive Health Services, Medical Health Services and Codes are provided in that article.

Article Title:	**MLN Matters® Number:**
Required Billing Updates for Rural Health Clinics	MM9269 Revised

- RHC qualified encounter code for Medicare.
- Total charges for the encounter should be billed with the appropriate approved E&M CPT code from the current Medicare Fee Schedule.
- Claims submitted with just the encounter code will not be paid.

RHC Medicare Encounter Codes Reminder

RHC Medicare - Medical Health Services (68) 9 series & G-HCPCS Codes

RHC Qualifying Visits

Medical Services

HCPCS Code	Short Descriptor
92002	Eye exam new patient
92004	Eye exam new patient
92012	Eye exam establish patient
92014	Eye exam&tx estab pt 1/>vst
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99318	Annual nursing fac assessmnt
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99334	Domicil/r-home visit est pat
99335	Domicil/r-home visit est pat
99336	Domicil/r-home visit est pat
99337	Domicil/r-home visit est pat
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
99497	Advncd care plan 30 min

Approved Preventive Health Services

HCPCS Code	Short Descriptor
G0101	Ca screen; pelvic/breast exam
G0102*	Prostate ca screening; dre
G0117*	Glaucoma scrn hgh risk direc
G0118*	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

Coinsurance and deductible are not waived

Mental Health Services

HCPCS Code	Short Descriptor
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

FQHC/RHC Medicaid & Medicare Billing Place of Service

In accordance with the Centers for Medicare and Medicaid Services (CMS) – Highmark Wholecare Medicaid and Medicare plans require FQHCs and RHCs to submit qualified visits using established specific payment codes. The FQHC/RHC Medicaid and Medicare Billing Guide is ONLY applicable to those practices who are contracted under a Highmark Wholecare Ancillary Services Agreement.

Medicaid: FQHCs/RHCs contracted under an Ancillary Services Agreement are paid their DHS PPS rate.

Medicare:

- **FQHCs** contracted under an Ancillary Services Agreement are reimbursed at the **CMS Prospective Payment System** (PPS) rate.
- **RHCs** contracted under an Ancillary Services Agreement are reimbursed at the **CMS All Inclusive Rate** (AIR).

  FQHC Place of Service (POS): **50**

  RHC Place of Service (POS): **72**

More information can be found on the Highmark Wholecare website in the Highmark Wholecare Medicaid/Medicare Provider Manuals.

Coordination of Benefits and Third-Party Liability (TPL) Inquiry

- Highmark Wholecare will be the payer of last resort on Medicaid claims for services provided to members with other insurance coverage. With exception of preventative pediatric care, EPSDT claims.

- Upon receipt of the primary carrier's EOB, the practitioner should submit a claim to Highmark Wholecare along with the EOB from the primary insurance. Secondary claims may be filed electronically following HIPPAA Compliant transaction guidelines.

- It is the member's responsibility to contact DHS to have other insurance information updated.

- ***Members cannot be billed for any primary insurance co-payments and/or co-insurance, as regulated by DHS.***

Contact Customer Service to initiate a TPL Inquiry

Medicare Assured

1-800-685-5209 (TTY 711)

Medicaid

1-800-392-1147 (TTY 711)

FQHC/RHC EOB Billing Reminder

When billing electronically or on paper, please submit the claim over to Highmark Wholecare with the appropriate encounter code associated with the PPS rate payment, along with the appropriate Evaluation & Management codes. Make sure the primary EOB is attached. Highmark Wholecare will coordinate the benefits.

- **For example:**
  FQHC & RHC T1015 for Medicaid
  FQHC appropriate G-Code for Medicare
  RHC appropriate 99XXX for Medicare

Copayments and Cost Sharing

MEDICAID

- Highmark Wholecare members that are age twenty-one (21) or older may have copayments.
- Copayments do not apply to the following members:
  - Members under twenty-one (21).
  - Any member who is pregnant (through the post-partum period beginning on the last day of the pregnancy and extending through the end of the month in which the 365-day period following termination of the pregnancy ends).
  - Members who reside in a nursing home.
- When processing claims, Highmark Wholecare's system automatically deducts the copayment from the provider's reimbursement and the copayment is reflected on the provider's remittance advice.

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

Medicare Parts A and B Cost Sharing

As a reminder, our dually eligible Medicare Assured members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency or Community HealthChoices Plan (CHC) is liable for the cost-sharing.

Medicare Assured

1-800-685-5209 (TTY 711) (PA)

Medicaid

1-800-392-1147 (TTY 711) (PA)

Timely Filing Guidelines

Medicaid

- Initial submission – 180 calendar days from the date of service.
- 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.
- Corrected claims or requests for review must be received within 365 calendar days from the date of service on the claim.

Medicare

- Initial claims – 365 calendar days from the date of service.
- Providers must bill within 365 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.
- Corrected claims or requests for review must be received within 365 calendar days from the date of service on the claim.

Claims Submission

Electronic Claims accepted through Change Healthcare or Relay Health.

For submission of professional or institutional electronic claims for Highmark Wholecare, please refer to the following grid:

MEDICAID:

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

MEDICARE:

CPID	PAYER NAME	PAYER ID	CLAIM TYPE
2298	Highmark Wholecare Medicare Assured	60550	Professional
2912	Highmark Wholecare Medicare Assured	60550	Institutional

Medicaid Mailing Addresses: **Claims Processing Department P.O. Box 211713, Eagan, MN 55121**

Medicare Mailing Addresses: **Claims Administrator P.O. Box 211164, Eagan, MN 55121**

Claims Payment – ERA & EFT

- PNC Healthcare issues the payment on behalf of Highmark Wholecare via the Claim Payments & Remittances (CPR) service, powered by Echo Health.

- 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.

Payment Options:

- Virtual Card Payments
- Electronic Funds Transfer (EFT) Payments
- Medical Payment Exchange (MPX)
- Paper Checks

If you need assistance, contact ECHO Health at allpayer@echohealthinc.com or 888-834-3511, to sign up to receive EFT payments only or 835 and EFT.

Payment Disputes

Highmark Wholecare will review any claim that a practitioner feels was denied or paid incorrectly. These are administrative and billing denials. Please forward all the appropriate documentation, (i.e. the actual claim information and reason for the denial dispute) in order to expedite the review process.

- Payment disputes can be submitted for review via the NaviNet® portal under Enhanced Provider Features then select Submit Appeals and Claims Disputes.

- Providers can also fax payment disputes to 1-844-207-0334.

Balance Billing

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Payment by Highmark Wholecare is considered payment in full.

Providers may not bill, charge, or seek compensation from members for normally covered services or for completion of requests for medical records unless:

- The member is informed in advance that the proposed service is not a covered benefit and of the member's rights to appeal an adverse coverage decision.
- The member accepts financial liability in a signed document that includes the services provided.
- The document must include the service(s) provided, that Highmark Wholecare will not pay or be liable for said services, the cost of the non-covered service and notification that the member will be financially liable for the listed services.

Per DHS policy #99-10-14, providers may not bill MA recipients for missed appointments.

This provision does not prohibit collection of copayments (Refer to the Member Benefit and Copayments Section of the Provider Manual for information on copayments).

Overpayments

- For all overpayments, please complete and submit a Refund Form or a letter that contains all of the information requested on this form.

- The Refund Form is located on the Highmark Wholecare website at: **https://content.highmarkprc.com/Files/Wholecare/Forms/RefundForm.pdf**

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

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

Claims & Billing Reminders

Claims Exception Requests- claims that fall outside of the 180 days (Medicaid) or 365 days (Medicare) timely filing period require an explanation as to why the claims are being addressed outside the corrected filing period (365 calendar days from the date of service on the claim). All Claims Exception Requests require the Director/Sr. Leadership approval. Claims status inquiries can be researched via NaviNet or on the ECHO Claim Payments and Remittance Payer Resource Center.

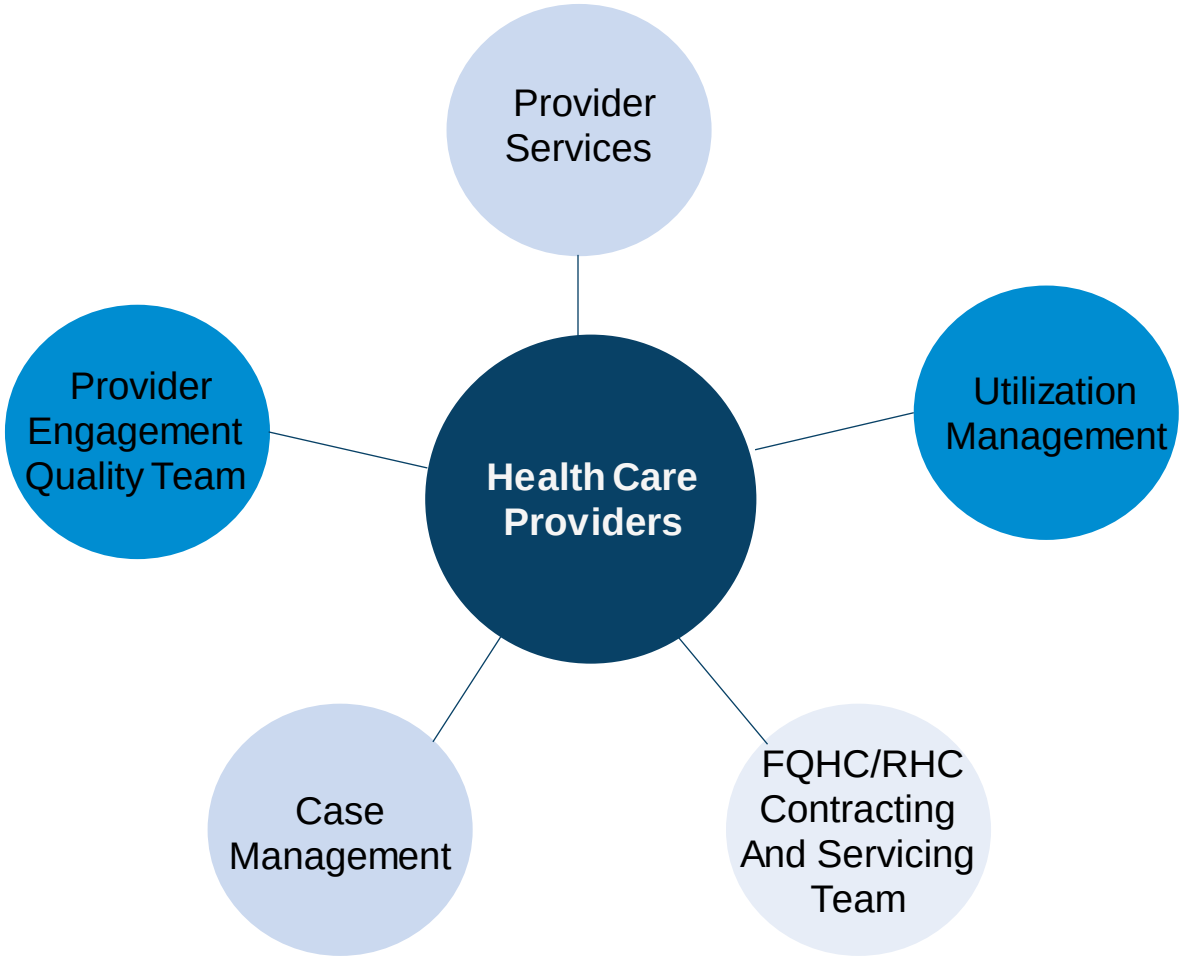
Claims Disputes can be submitted via the Highmark Wholecare Provider Portal via NaviNet through the Submit Appeals & Claims Disputes Portal Enhancements.

- **We eliminated Highmark Wholecare Referrals for the Medicaid Line of Business eff 1.1.2020.**
- A referral is only required for non-capitated lab services
- Referrals are NOT required for Medicare Assured.

FQHC/RHC Resources and Self-Service Tools

HIGHMARK WHOLECARE

Points of Contact



Helpful Plan Contacts

Provider Services department is available Monday through Friday between 7am and 5pm by calling:

PA Medicaid: 1-800-392-1147 (TTY 711)

PA Medicare: 1-800-685-5209 (TTY 711)

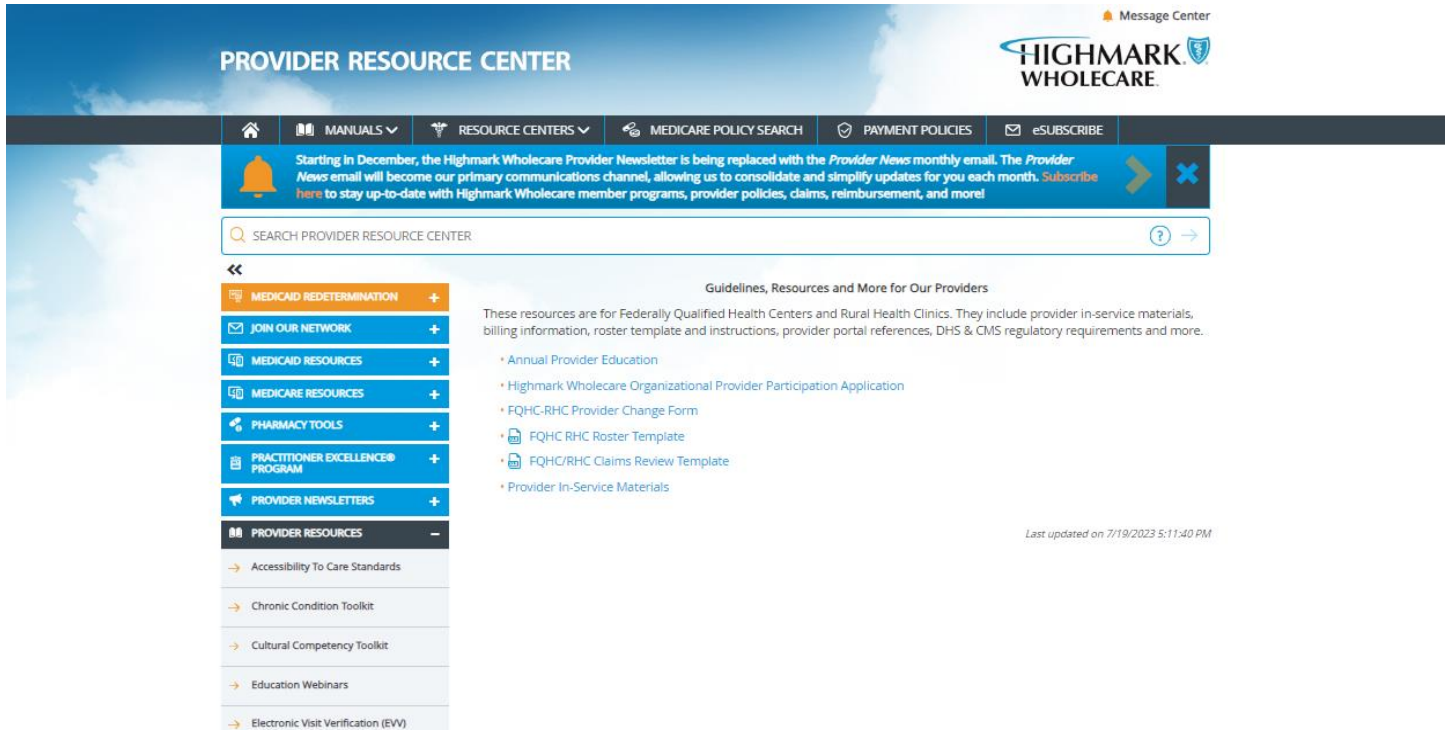
Provider Network Sr. Provider Contract Consultant - FQHC/RHC can assist with:

- Liaising between Highmark Wholecare and FQHC/RHC participating providers.
- Serving as your primary contact for both new and existing contracts
- High level or global issues
- Education and training
- Highmark Wholecare policies and procedures
- Webinars
- Engagement with key health centers regarding value-based programs.
- Fax Blasts
- Provider Newsletters
- Provider Updates

It’s as Simple as Clicking “Providers”

FQHC/RHC Resources: Guidelines, Resources and More for Our Providers

https://wholecare.highmarkprc.com/Provider-Resources/FQHC/RHC-Resources



Verifying Eligibility in NaviNet®

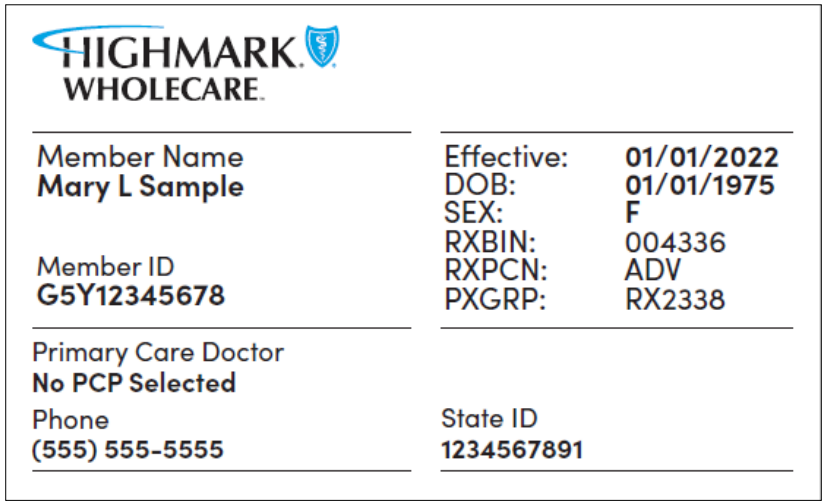
MEDICARE

Region	Product Names	NaviNet Display
Blue Cross Blue Shield	Diamond	MAPA
Blue Cross Blue Shield	Ruby	MABS
Blue Shield	Diamond	MAPA
Blue Shield	Ruby	MABS
Blue Shield – Southeast	Diamond	SPHS
Blue Shield – Southeast	Ruby	SPBS

Verifying Patient Eligibility

MEDICAID

- **NaviNet®.**
- **Highmark Wholecare IVR (telephonic system):**
  - Available 24 hours/7 days a week.
  - 1-800-642-3515.
- **PROMISe** online at http://promise.dpw.state.pa.us.
- **PA Medical Assistance Eligibility Verification System (EVS)**


HIGHMARK. WHOLECARE.

Member Name
Mary L Sample

Member ID
G5Y12345678

Primary Care Doctor
No PCP Selected

Phone
(555) 555-5555

Effective: 01/01/2022
DOB: 01/01/1975
SEX: F
RXBIN: 004336
RXPCN: ADV
PXGRP: RX2338

State ID
1234567891

Telephone Line:

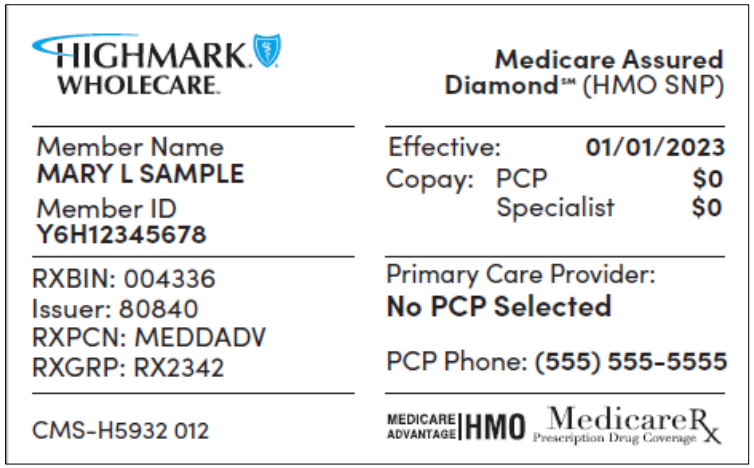
- 800-766-5387 using Member's ID card and PA Access Card information.

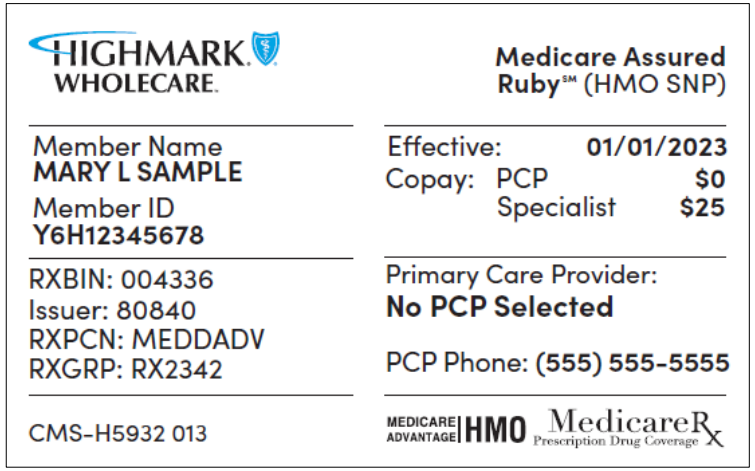
- **Provider Service**:
  - Monday through Friday, 7:00 a.m.- 5:00 p.m.
  - 1-800-392-1147.
- **PCP Monthly Roster.**

Verifying Patient Eligibility

MEDICARE

- **NaviNet**
- **Highmark Wholecare IVR (telephonic system):**
  - Available 24 hours/7 days a week.
  - 1-800-642-3515.
- **Provider Service:**
  - Monday through Friday, 7:00 a.m. – 5:00 p.m.
  - 1-800-685-5209.
- **PCP Monthly Roster**





Medicaid Member Lab Requirements

- As of June 1, 2023, Highmark Wholecare Medicaid members are no longer required to obtain laboratory services at a designated lab.
- Providers can send their Highmark Wholecare Medicaid patients to any in network lab with an order. Referrals are not required.
- Members may continue to utilize the lab they were previously visiting; however, this change offers them additional flexibility. This change not only helps improve member access, but it also makes lab requests easier for our providers.
- The member-specific lab designation was removed from Medicaid member ID cards.

NaviNet®

- Easy-to-use, free, internet-based solution for providers to streamline data exchanges between their offices and Highmark Wholecare. NaviNet provides information around the following:
    - Eligibility information.
    - Benefits information.
    - Claims Search Inquiry.

https://connect.NaviNet.net

Not a NaviNet user?

Register for a new account

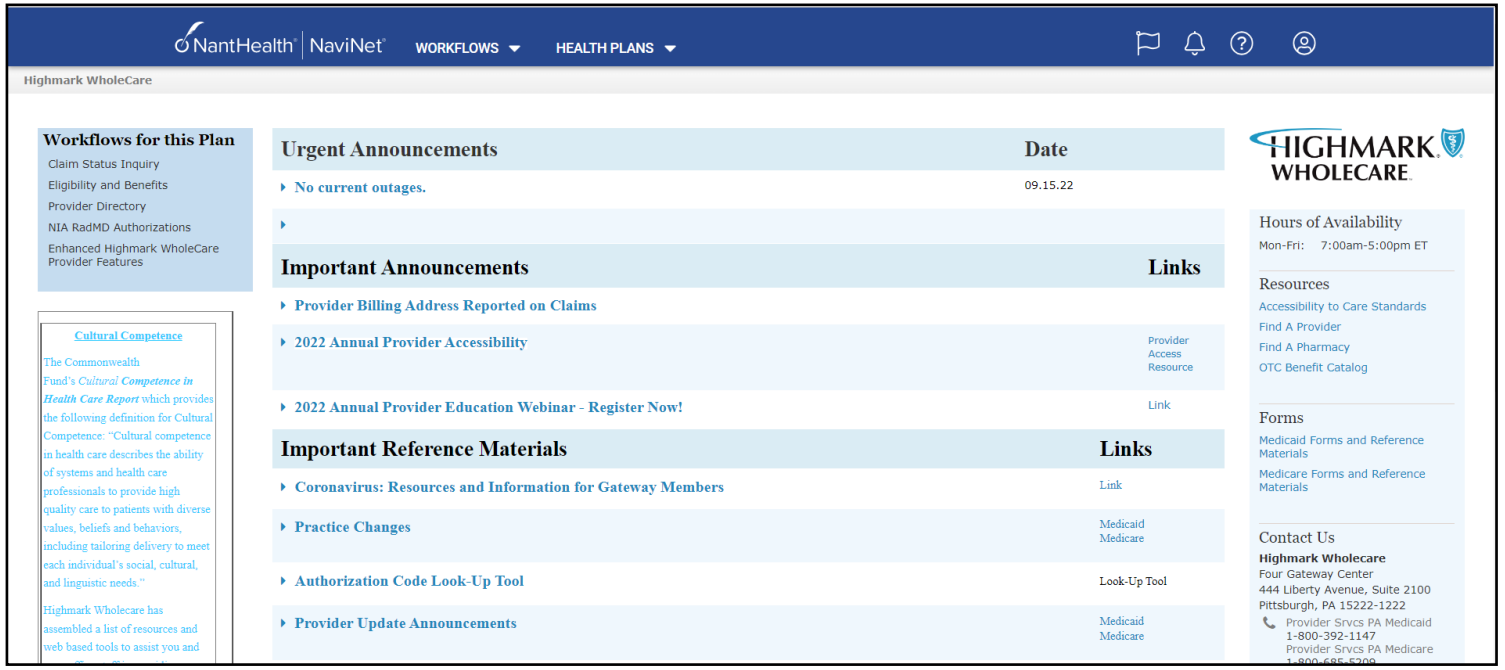
Already a NaviNet user?

Sign In

Provider Portal via NaviNet®

Enhanced Provider Features via the portal include submission of prior-authorization requests, appeals and claims disputes, code authorization look-up Tool, remittance advice inquiry, claims batch look-up and secure messaging.

If you have questions about how to utilize any of the Enhanced Provider Features or are interested in a demo, please contact your Provider Account Liaison.



Highmark Wholecare Medicaid/Medicare Provider Manuals & Provider Updates

Provider Manuals:

- Medicaid Provider Manual: https://content.highmarkprc.com/Files/Wholecare/Manuals/**MedicaidManua**l.pdf?preview=true
- Medicare Provider Manual: https://content.highmarkprc.com/Files/Wholecare/Manuals/**MedicareManual.**pdf

Provider Updates:

- Medicaid Provider Updates: https://wholecare.highmarkprc.com/**Medicaid-Resources/Provider-Updates**
- Medicare Provider Updates: https://wholecare.highmarkprc.com/Medicare-Resources/**Medicare-Updates**

Change Healthcare InterQual is a separate company that is used by Highmark Wholecare to determine medical criteria is met for certain services.

NaviNet® is a separate company that provides an internet-based application for providers to streamline data exchanges between their offices and Highmark Wholecare such as, routine eligibility, benefits and claims status inquiries.

Relay Health is a separate company that administers claim reporting for Highmark Wholecare.

This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare serves a Medicaid plan to Blue Shield members in 13 counties in central Pennsylvania, as well as, to Blue Cross Blue Shield members in 14 counties in western Pennsylvania. Highmark Wholecare serves Medicare Dual Special Needs plans (D-SNP) to Blue Shield members in 17 counties in northeastern Pennsylvania, 13 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.

Questions?

Contact:
Selene Richardson I Highmark Inc. I Sr. Provider Contract Consultant I FQHC/RHC Network
412-255-4321 (Office/Fax) 412-722-8413 (Mobile) I
Selene.Richardson@highmark.com

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