Welcome 2023 Federally Qualified Health Centers and Rural Health Clinics Provider Orientation

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Welcome!

Please read the participation tips below:

- ✓All participants phones have been muted
- ✓Please check your audio settings
- ✓If you experience audio issues during the presentation, please provide your contact information in the chat and a representative will contact you following the presentation
- ✓Please use the chat feature if you have any questions

2023

Annual Provider Training

FQHC/RHC Guidelines and Resource Center

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Required Annual Provider Training

The Pennsylvania Department of Human Services (DHS) and the Centers for Medicaid and Medicare Services (CMS) requires Managed Care Organizations (MCOs) to provide annual training to their participating providers. Providers are to attend at least one education training session.

Complete the attestation at the end of the training to certify that you received training and met this requirement.

About Highmark Wholecare

Health care plus more.

With Highmark Wholecare, members experience health care that goes beyond what they've previously experienced.

It's health care that sees the bigger picture.

It's more than a trip to the doctor or pharmacy.

It's all the things that keep you going—transportation, housing, healthy meals. It's the wellbeing of real people with real challenges. It's more choices.

Health care includes those not-so-little extra options that keep our members healthy while also helping them live fuller lives.

With Highmark Wholecare, health care is all this—**plus more.**

Medicaid Plan Overview

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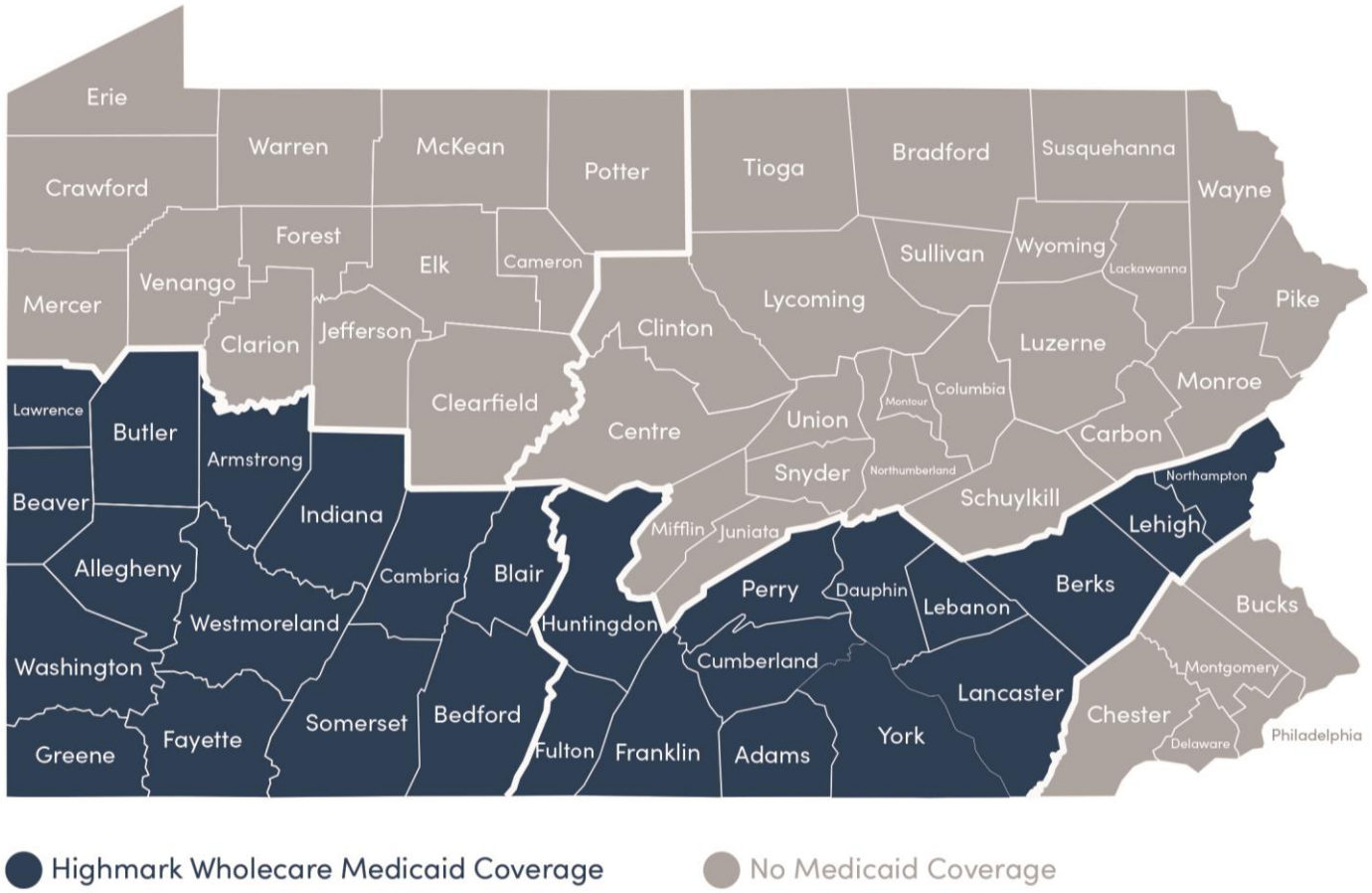
Medicaid Coverage Area



HealthChoices

HealthChoices is Pennsylvania's Medical Assistance managed care program

Physical health services are provided through the physical health managed care organizations (PH-MCOs). Behavioral health services are provided through behavioral health managed care organizations (BH-MCOs).

Here are four ways to enroll in or change coverage to Highmark Wholecare:

- Online: https:/www.enrollnow.net/enroll
- PA Enrollment Services Mobile App
- Phone: 1-800-440-3989
- Mail: PA Enrollment Services P.O. Box 61077 Harrisburg, PA 17106

Information can be found on:

https://highmarkwholecare.com/LegislativeResources

https://www.dhs.pa.gov/healthchoices/Pages/HealthChoices.aspx

Member Benefits

On top of regular Medicaid benefits, as a Highmark Wholecare member, member will get access to our team of master problem solvers who are always there to help our members get access to the benefits and services needed to get healthy and stay healthy. Some of the most popular are:

- A nurse line you can call 24/7
- Wellness coaching
- Counseling to help quit smoking
- Lifestyle and transition management
- Access to affordable housing
- Access to healthy food
- Online member portal
- Information & support for pregnant moms
- Access to free cell phone service
- Boys and Girls Club Teen Workforce Academy
- GED Testing Programs

United Concordia Dental

Davis Vision Network

Verifying Patient Eligibility

MEDICAID

- **NaviNet®**
- **Highmark Wholecare IVR (telephonic system)**
  - Available 24 hours/7 days a week
  - 800-642-3515
- **PROMISe** online at http://promise.dpw.state.pa.us
- **PA Medical Assistance Eligibility Verification System (EVS)** 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.
  - 800-392-1147
- **PCP Monthly Roster**

Medicare Assured Plan Overview

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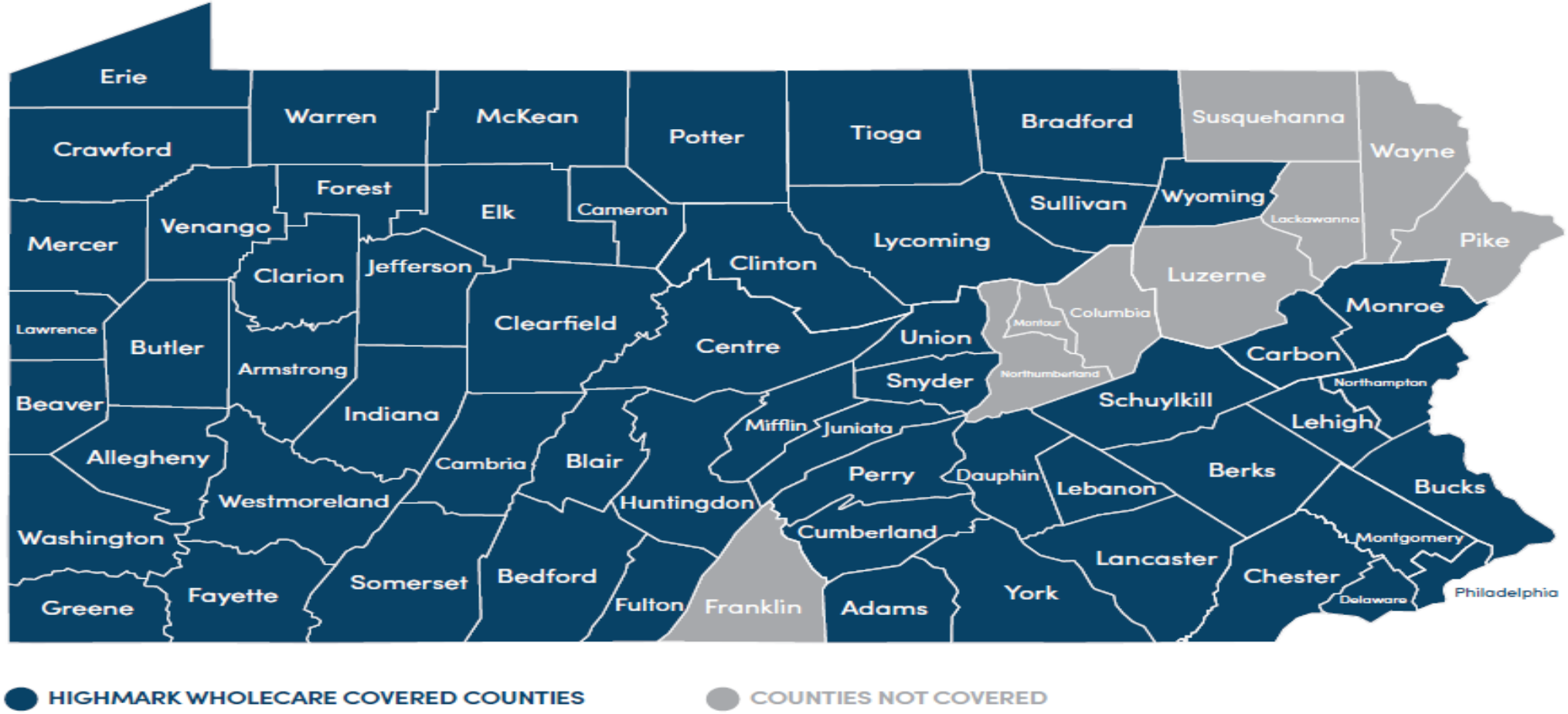
Medicare Assured Coverage Area



Medicare Plans

For individuals who qualify, there is no, or a low, monthly premium (depending on their level of Medicaid eligibility).

Qualifying members receive healthcare coverage, plus prescription drug coverage, dental, transportation, vision, hearing services, fitness center membership and much more – all from ONE plan!

- **Medicare Assured Diamond** (HMO SNP) - for those with **full medical assistance** such as Full Benefit Dual Eligible (FBDE), Qualified Medicare Beneficiary (QMB), Qualified Medicare Beneficiary Plus (QMB+) or Specified Low-Income Medicare Beneficiary Plus (SLMB+)

- **Medicare Assured Ruby** (HMO SNP) - for those with **some level of medical assistance** from the state such as Specified Low-Income Medicare Beneficiary (SLMB) or Qualifying Individual (QI)

Medicare Assured Benefits

Our Medicare plans are designed to provide more than healthcare for those who qualify. Highmark Wholecare offers medical and prescription drug coverage, and all the benefits of Original Medicare, PLUS more and programs such as:

- ✓ Preventative Health, Disease and Case Management
- ✓ Highmark Wholecare Lifestyle Management Programs
- ✓ SDOH Programs.
- ✓ Highmark Wholecare offers a Goodness Rewards[SM] program

More information including benefit exclusions and limitations are outlined in the Medicare Provider Manual and Medicare Benefit Guide which is available on our website.

DSNP Member Benefits (highmarkwholecare.com)

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2023 Highmark Wholecare Benefits

Premiums and Benefits	Highmark Wholecare Medicare Assured Diamond (HMO SNP)	Highmark Wholecare Medicare Assured Ruby (HMO SNP)
Monthly Plan Premium	You pay $0.	You pay $0.
Deductible	No deductible.	No deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than $8,300 annually for in-network Medicare-covered services.	You pay no more than $6,700 annually for in-network Medicare-covered services.
Inpatient Hospital*	You pay per benefit period a: $0 copay each day for days 1-90. $0 copay each day for lifetime reserve days 91-150.	You pay per benefit period a: $250 copay each day for days 1-6. $0 copay each day for days 7-90. $0 copay each day for lifetime reserve days 91-150.
Outpatient Hospital*	You pay $0 copay for each Medicare-covered outpatient service.	Depending on the service provided, you pay between $0 copay and 20% coinsurance.
Ambulatory Surgery Center	You pay $0 copay per day for each Medicare-covered surgery performed in an ambulatory surgical center.	You pay $200 copay per day for each Medicare-covered surgery performed in an ambulatory surgical center.
Doctor Visits		
• Primary Care	You pay $0 copay for each primary care physician visit.	You pay $0 copay for each primary care physician visit.
• Specialists	You pay $0 copay for each specialist physician visit.	You pay $25 copay for each specialist physician visit.
Preventive Care (e.g., flu vaccine, cancer screenings)	You pay $0.	You pay $0.
Emergency Care	You pay $0 copay for each emergency care service.	You pay $95 copay for each emergency care service. Copay is waived if admitted to hospital within 24 hours.
Urgently Needed Services	You pay $0 copay for each urgently needed service.	You pay $25 copay for each urgently needed service.

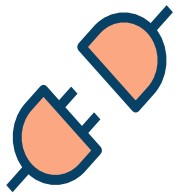
*Prior authorization may be required

New Benefits to the DSNP Plan 2023

In 2023 the Highmark Wholecare Diamond plan will be helping members address some of the most basic needs like food and living supports!

Healthy Food Benefit: Monthly (Diamond Members Only)

- Includes access to a monthly food card to be used at participating retailers across PA, via pre-paid card
- Retailers include Walmart, Giant Eagle, Get-Go, Dollar General
- In store, online or catalog options available
- Additional online capabilities for other services like Mom's Meals (prepared meals and or food box)
- Mobile application to keep track of it all



Utilities: Quarterly (Diamond Members Only)

- Members have the ability to use their quarterly allowance to pay any of the following utilities:
  - Electric, gas, water, sewage, waste, internet, cell phone, or cable

2023 DSNP Benefits for Diamond and Ruby Members

Dental: Members are covered for preventive dental services including a yearly plan allowance for comprehensive dental services.

Vision: (Davis Vision Network) Members receive an annual routine eye exam and free glasses or contact lenses.

Hearing: Members receive an annual routine hearing exam and a hearing aid/ per ear. Includes rechargeable aids.

Meals Post Discharge: Members are eligible for meals up to 30 days after being discharged from inpatient stay at a hospital/rehab/skilled nursing facility.

OTC: Members receive a quarterly allowance to purchase plan approved over-the-counter items such as vitamins, topical ointments and tobacco cessation items.

Part D: $0 copay for all formulary drugs (tiers 1-5) during all stages of the drug benefit.

2023 DSNP Benefits for Diamond and Ruby Members

Home and Bathroom Safety: To help our members prevent the slips and falls that can lead to greater medical issues, we cover plan approved safety devices that best suit their needs.

Nutritional Counseling: Members are eligible to enroll in a Telephonic/Telehealth Counseling program with a Registered Dietitian (RD) to help prevent, treat and reverse illness.

Transportation: All members receive a yearly allowance of one-way transportation trips for non-emergency medically-related appointments. Diamond members have the option to use a portion of their allowance towards non-health related transportation, such as the grocery store.

Personal Emergency Response System (PERS): Members are eligible to receive one personal emergency response unit per member lifetime.

Fitness: Memberships at participating network fitness centers at no cost. Includes at-home fitness packs and access to virtual fitness classes.

24/ Nurse Line: A toll-free 24-hour nurse line is available at no cost to the member. Members can receive coaching and advice from our trained clinicians.

DSNP Reminder for Providers

Highmark Wholecare Medicare Assured D-SNP Members Will Maintain Access to Care.

Our Medicare Assured Dual Eligible Special Needs (D-SNP) members **will not lose** coverage when enrolled in the CHC Medicaid program.

Members **are eligible** to receive D-SNP benefits if they receive both Medicaid and Medicare. **Medicare is the primary payer**, and Medicaid is always the payer of last resort.

The CHC Medicaid program does not, in any way, change or impact how members enrolled in Medicare D-SNP plans access care.

Providers **can submit** claims to the CHC plan regardless of your status with the CHC plan.

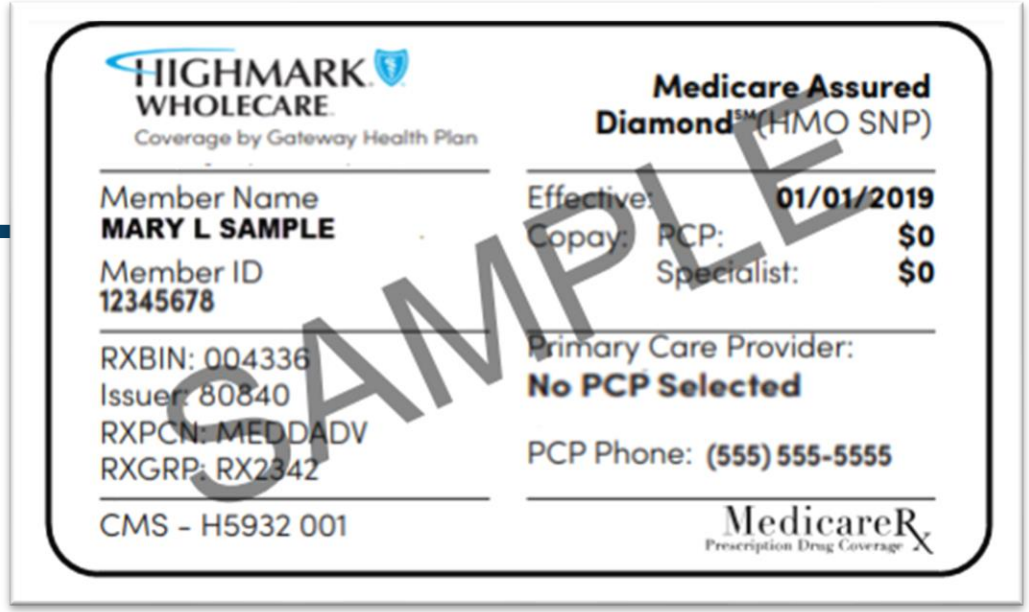
Resources

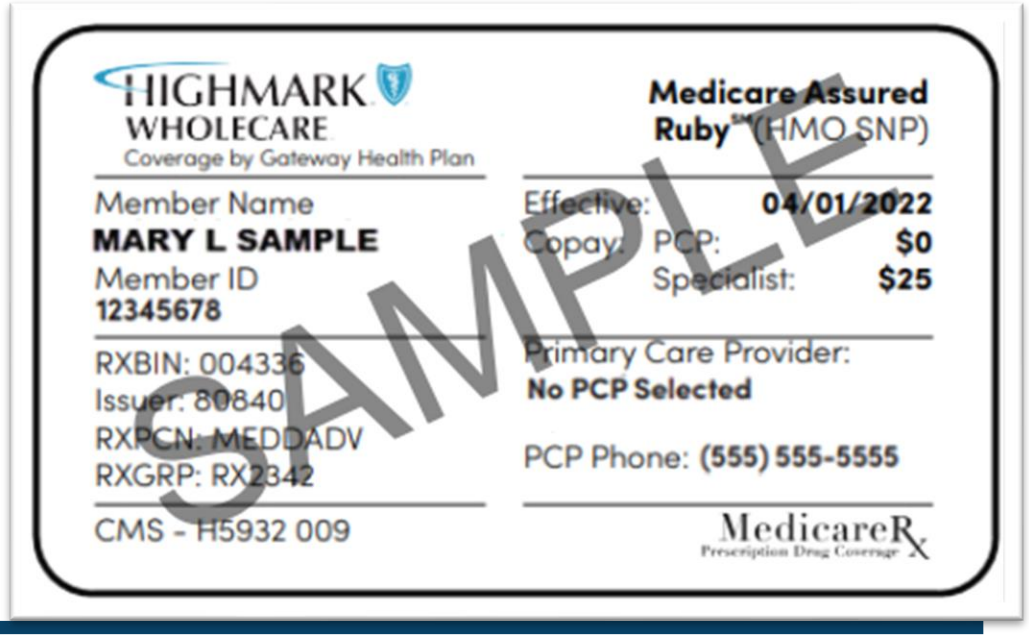
- CHC Fact Sheet
- Adult Benefit Package
- Long-Term Services and Support Benefits Guide
- Coordination with Medicare
- Populations Services by CHC
- Eligibility Verification System (EVS)

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.
  - 800-685-5209
- **PCP Monthly Roster**





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

Laboratory Services

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- Members are required to have all their outpatient laboratory work completed through the appropriate PCP designated lab. The PCP is required to select a designated laboratory based upon the office's location and the lab used most frequently.

- Ways to verify the PCP's designated laboratory:
  - Member ID Card
  - Online Provider Directory
  - NaviNet Eligibility and Benefit screen
  - Calling Provider Services at 1-800-392-1147.

- Should you wish to change your laboratory, please complete the Provider Change Request form located on our website: https://highmarkwholecare.com/Portals/8/provider_forms/Practice%20Change%20Request%20Form.pdf.

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.

Provider Responsibilities

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Provider Updates and Practice Changes

- If your practice is already contracted with Highmark Wholecare but need to make a change, please complete FQHC-RHC Provider Change Form FQHC/RHC Guidelines and Resource Center

- Quarterly outreach will be made under the BetterDoctor name and providers will be directed to BetterDoctor's online verification tool to review, update and attest to any changes. Provider outreach will occur every 90 days.

- For more information about BetterDoctor, visit their website https://questanalytics.com/how-we-help/betterdoctor/. You may also contact them at support@betterdoctor.com or by phone at 844-668-2543, Monday through Friday, 9 a.m. to 5 p.m. central time.

State Provider Revalidation

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- Department of Human Services (DHS) **requires all Medicaid providers to revalidate their enrollment at least every five (5) years**.
- All providers 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.
- Please take the appropriate precautions to ensure revalidation is completed timely to ensure claims payment and participation in the Highmark Wholecare PA Medicaid provider network is not interrupted.
- **Failure to revalidate will result in the following:**
    1. Providers rendering services to Medicaid Members will NOT get paid if they are not enrolled/revalidated.
    2. Payments cannot be made retroactively.
- Please visit https://provider.enrollment.dpw.state.pa.us/Home to check the status of your application or apply online today.

Continuity and Coordination of Care

Specialists, Hospitals and Skilled Nursing Facilities must ensure compliance with the Continuity and Coordination of Care requirements, by ensuring that all discharge summaries, consultation and progress reports are reported back to the member's PCP.

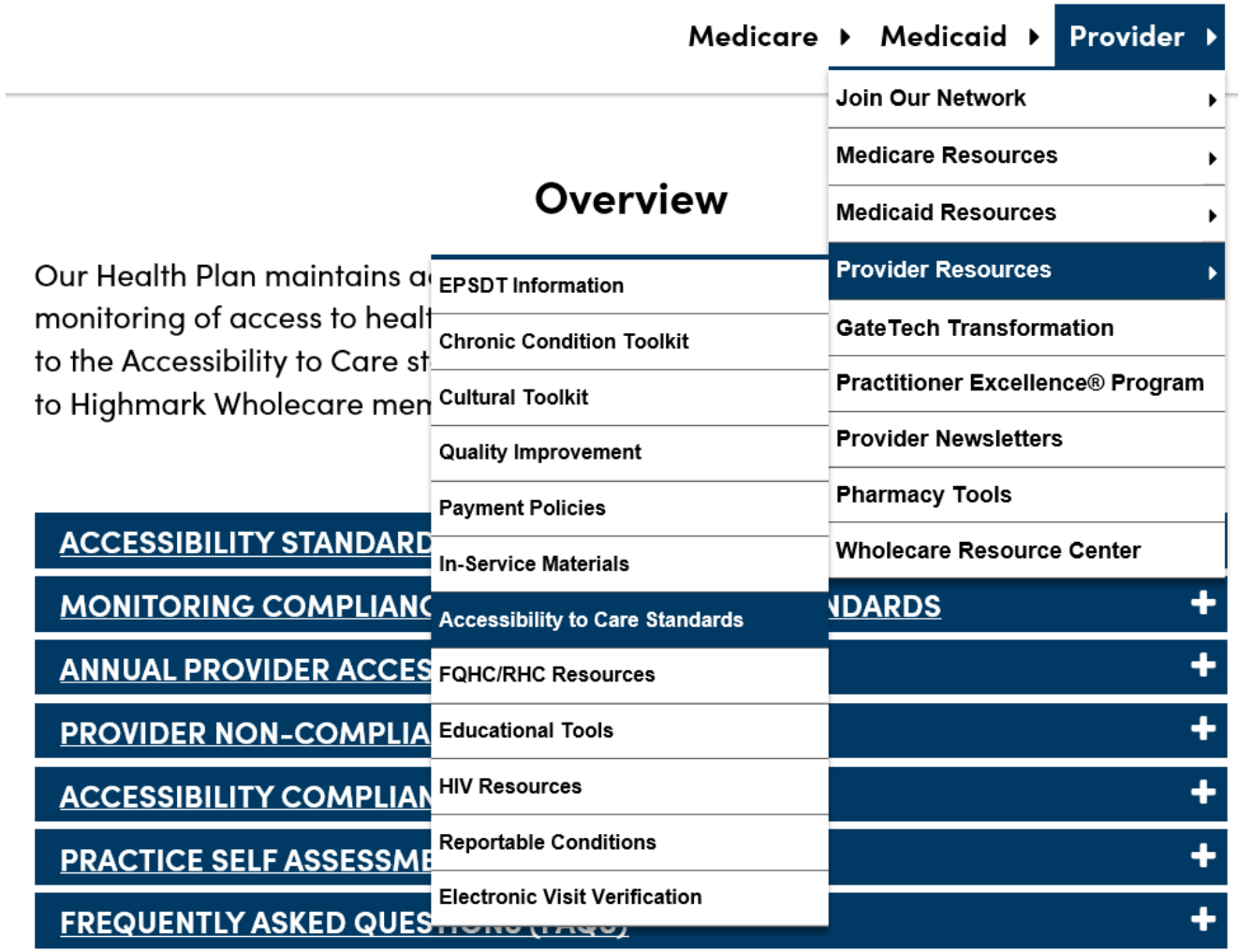
Accessibility to Care Standards

Highmark Wholecare maintains standards and processes for ongoing monitoring of access to health care in accordance with DHS and CMS requirements. Providers are contractually required to conform to these standards to ensure that health care services are provided to our members in a timely manner.

The appointment standards and other accessibility resources are located on our provider website at https://www.highmarkwholecare.com/provider/provider-resources/accessibility-to-care-standard. Please see the screenshots on the following slide.

Highmark Wholecare has a requirement that our Provider's hours of operations for their Medicaid patients are expected to be no less than what your practice offers to commercial members. Please see Highmark Wholecare's procedure manual regarding provider availability and accessibility.

Accessibility Standards



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ANNUAL ACCESSIBILITY AUDIT

Our company contracts with a NCQA certified survey vendor to conduct an annual appointment and after-hours accessibility audit of primary care and specialist practices to determine if practices are adhering to established access standards related to the timeliness of our members to receive care.

- Appointment Access Audit: Includes phone interviews with your office's scheduling staff, during business hours, to assess the wait time for members to schedule appointments with your practice site.
- After-hours Access Audit: Includes phone calls to your office, during non-business hours, to assess if your practice site's after-hours protocol provides members with appropriate instruction on receiving care for an emergent or urgent medical condition in a timely manner.

Please take a few minutes to review the below Medicaid and Medicare standards and share with your staff that schedule member appointments. The standards and other Accessibility resource information can also be found on our provider website at Accessibility to Care Standards (highmarkwholecare.com).

Medicaid Accessibility Standards

Your practice site has contractually agreed to provide timely access to care for our members. Please review the below access standards related to appointment wait times/protocol:

PROVIDER TYPE	APPOINTMENT TYPE /PROTOCOL	ACCESS STANDARD
PCP, Specialist	Emergent Care	Immediately seen or referred to an emergency facility Practice sites will be able to schedule an appointment immediately or refer the member to an emergency facility.
PCP, Specialist	Urgent Care	Within 24 hours Practice sites will be able to schedule an appointment within 24 hours of being contacted by member.
PCPs and Specialists who provide prenatal care	High-risk pregnancies	Within twenty-four (24) hours of being identified as high risk or immediately if an emergency.

Provider Survey

Highmark Wholecare uses a NCQA certified vendor to conduct an annual, telephonic accessibility audit and a separate provider satisfaction survey. We use the audit and survey responses to identify initiatives to improve access and improve both member and provider satisfaction.

- **After- Hours and Appointment Availability Survey**
  - Highmark Wholecare Providers are expected to follow certain accessibility standards which are outlined in the Policy and Procedure Manual and are referred to in your contract. All providers are expected to be available for timely appointments and to be accessible when needed after-hours. In addition, Highmark Wholecare is expected to monitor your compliance with these standards.
- **Provider Satisfaction Survey**
  - The Provider Satisfaction survey is typically conducted sometime around the last quarter of the year. It is first sent out via mail. If a completed survey is not returned, SPH Analytics will follow-up with a phone call to the practice. We do print the results of the survey in our Newsletter, now available at our website.

Your participation in these surveys is mandatory.

Coverage Arrangements

- All participating practitioners must **ensure 24-hour, 7 days-a-week coverage** for members.
- Coverage arrangements should be made with another **Plan participating** practitioner or practitioners who have otherwise been approved by the Plan.
- All encounters must be billed under the name of the **rendering practitioner**.
- Primary care practitioners agree that, in their absence, **timely scheduling** of appointments for members shall be maintained.
- Offices should **follow CMS regulations** with regards to **locum tenens** – they are recognized for services up to a sixty (60) calendar day time frame.
- **Claims are to be billed** under the participating supervising/lead physician

Member Rights and Responsibilities

- Highmark Wholecare regularly monitors compliance related to members' rights and responsibilities, including those rights defined by Section 1557 of the Affordable Care Act of 2010.
- Information of Member Rights and Responsibilities is in our:
  - **Medicare Provider Manual**

    https://highmarkwholecare.com/Portals/8/MedicareManual.pdf
  - **Medicaid Provider Manual**

    https://highmarkwholecare.com/Portals/8/MedicaidManual.pdf

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.

To Report:

- **Call ChildLine at 1-800-932-0313.** The toll-free intake line is available 24 hours/7 days a week to receive reports of suspected child abuse. As a mandated reporter, you must provide your name and contact information when making the call.
- Electronic reports may be submitted directly to ChildLine via the **Child Welfare Information Solution portal.** This option is only available to Mandated Reporters.

To learn more about Child Protective Services Law, 23 Pa.C.S. §§ 6301—6385 go to: https://www.dhs.pa.gov/KeepKidsSafe/Pages/Report-Abuse.aspx.

Transfer of Medical Records

Practitioners are required to transfer member medical records or copies of records to newly designated PCPs within:

MEDICAID: 7 business days from the receipt of the request from DHS, its agent, the member or the members' new PCP, without charging the member.

MEDICARE: 14 business days from the receipt of the request from CMS or its agent, the member or the members' new PCP, without charging the member.

Reportable Conditions

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. Our 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.

The regulations, which include the complete list of reportable conditions can be found via the Pennsylvania Department of Health website: https://www.health.pa.gov/topics/Reporting-Registries/Pages/Reportable-Diseases.aspx

Pharmacy

- Highmark Wholecare covers pharmacy benefits that include prescription medicines and over- the-counter medicines and vitamins with a doctor’s prescription
- Highmark Wholecare covers medicines listed on the Statewide Preferred Drug List (PDL) and the Highmark Wholecare Supplemental Formulary
- Any medicine prescribed that is not on the Statewide PDL 42 and Highmark Wholecare’s Supplemental Formulary needs prior authorization.
- The Statewide PDL and Highmark Wholecare’s Supplemental Formulary can change from time to time.

Compliance

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Compliance

MEDICARE

Highmark Wholecare Medicare Assured Medicare Compliance Program is designed to prevent, detect and correct Medicare Part C and Part D program non-compliance as well as Fraud, Waste and Abuse (FWA).

All parties, including Highmark Wholecare employees, governing body, first tier entities, downstream entities, related entities, and members involved with Highmark Wholecare Medicare Assured must comply with all applicable federal and state laws and regulations.

Compliance Glossary of Terms

Compliance Resources

Reporting Issues

Fraud, Waste and Abuse

Our policies and procedures follow the guidelines set forth by CMS, where applicable.

https://www.cms.gov/About-CMS/Components/CPI/CPIReportingFraud

Providers can find FWA trainings created by the Plan's Fraud, Waste and Abuse Unit on our website:

https://highmarkwholecare.com/fraud-and-abuse

It is a requirement to review the Provider FWA Training upon contracting and annually thereafter.

Reporting FWA – Special Investigation Unit (SIU)

If you suspect FWA, it is your responsibility to report the issue to us. You can report FWA in the following ways:

Phone	• Fraud Hotline: 1-844-718-6400
Email	• SIU@HighmarkWholecare.com
Online	• https://www.HighmarkWholecare.com/fraud-and-abuse
Mail	• Highmark Wholecare Attention: Payment integrity Department, Four Gateway Center, Suite 2100, 444 Liberty Avenue, Pittsburgh, PA 15222

Reporting FWA – Medicaid

Reporting to the Pennsylvania Department of Human Services (DHS) at:

Phone	• 1-844-DHS-TIPS or 1-844-347-8477
Fax	• 1-717-772-4655 Attn: MA Provider
Online	• www.dhs.pa.gov
Mail	• Bureau of Program Integrity, MA Provider Compliance Hotline, PO Box 2675, Harrisburg, PA 17105-2675

Provider Self-Audit: Required by DHS & OIG

- Providers can submit overpayments to Highmark Wholecare by using the Provider Self-Audit Overpayment form found on our website. https://highmarkwholecare.com/Provider/Medicaid-Resources/medicaid-provider-forms-and-reference-materials
- Both DHS & OIG require providers to conduct self-audits to identify documentation errors & potential overpayments.
- Federal & State laws and regulations require overpayments to be returned within ***60*** days of identification.

Resources for Self-Audits:
DHS Guidance
OIG Guidance
CMS Guidance

Recipient Restriction Program

Highmark Wholecare maintains a Recipient Restriction Program in cooperation with the Department of Human Services, which restricts members who miss-utilize medical services or pharmacy benefits. Those members who are in the program are restricted to certain practitioners. Highmark Wholecare enforces and monitors these restrictions.

To learn more about these programs please call 1-800-392-1147.

Model of Care

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As a Special Needs Plan, Highmark Wholecare is required by CMS to administer a Model of Care Plan. In accordance with CMS guidelines, Highmark Wholecare's SNP MOC Plan is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization to provide coordinated care for special needs individuals. An MAO must design separate MOCs to meet the special needs of the target population for each Special Needs Plan it offers, meaning that Highmark Wholecare has multiple MOCs.

Annual review of the MOC is required by all providers. Upon reviewing the annual MOC document, please go to https://www.HighmarkWholecare.com/provider/moc-response and attest your review of the document. The MOC Document can be found on in the Provider section of our website.

Complaints, Grievances, and Appeals

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Provider Complaint Process

If a provider wants to raise issues with Highmark Wholecare policies, procedures and administrative functions, concerns can be forwarded via the Provider Complaint Messaging Center located within the NaviNet® secure Provider Portal

Providers can expect a response within 30 days of receipt. If additional time is needed, status updates to the provider will be sent as applicable.

Member Complaints, Grievances, and Appeals

Members have the right to tell Highmark Wholecare or the Department of Human Services, if they are unhappy about or do not agree with something that a provider or Highmark Wholecare has done.

- A “grievance” is the type of complaint that can be made if a member has any other type of problem with Highmark Wholecare or one of our plan providers
- An “appeal” can be filed if a member asks Highmark Wholecare to reconsider and change a decision we have made about what services or benefits are covered or what we will pay for a service or benefit.

An Environmental Assessment will be conducted in response to a complaint which is related to non-compliance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

Detailed information on Member Complaints, Grievances, and Fair Hearing Process can be found in the Provider Manual:

Medicaid Manual : starting on page 137 Medicare Manual : starting on page 111

Complaints, Grievances, and Fair Hearings

In order to act as a representative, the member and representative must complete the Appointment of Representative Form (AOR) which is located on the Highmark Wholecare website. Appointment of Representative Form

Exception: form does not need to be completed if request for appeal should need to be expedited.

- Expedited grievances (appeals) should only be filed if the member's 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.

Provider Appeals

Any provider may file a provider appeal to request the review of any post-service denial. Appeals for services that have not yet been provided must follow the Member Grievance or Complaint Process. The Provider Appeal Process must be initiated by the provider through a written request for an appeal.

Failure to follow the prior authorization process may result in the administrative denial of your claim, regardless of medical necessity.

It is the responsibility of the provider to submit a request for a retrospective authorization when outside of their control and provide justification as to why an authorization was not requested within the timeframe.

Provider Appeals

Provider Appeal Requests can be submitted via:

NaviNet	• https://connect.NaviNet.net
Fax	• 1-855-501-3904

Select Highmark Wholecare from the NaviNet home page, choose Enhanced Provider Features and select ‘Submit Appeals and Claims Disputes’. Please include all documentation to support you request. Documents can be uploaded through the portal.

Credentialing Process

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Credentialing - Who is Credentialed?

- Highmark Wholecare credentials all Federally Qualified Health Centers and Rural Health Clinics, and NOT 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.

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
- FQHC/RHC Guidelines and Resource Center

Health Resources and Services Administration (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 Highmark Wholecare of the change in scope of services within 30 days of the issue date identified in block 1 of 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

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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.**

FQHC/RHC Provider Change Process

The FQHC/RHC Provider Change Form is an added 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.
- **FQHC/RHC Guidelines and Resource Center**
- 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 9 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: FQHC/RHC Guidelines and Resource Center

Claims & Billing

HIGHMARK WHOLECARE

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 – **EPSDT billing only**
- T1001-U9: (Initial 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 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 Matter Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)	MLN Matters® Number: 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:	Required Billing Updates for Rural Health Clinics	MLN Matters® Number: 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 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***

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 (PA)

Medicaid

1-800-392-1147 (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 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

MEDICAID

Payment by Highmark Wholecare is considered payment in full

Provider 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).

Claims and Billing Reminders

- Payment for CPT and HCPCS codes are covered to the extent they are recognized by Medical Assistance.
- All encounters, regardless of expected payment must be submitted via CMS1500 or 837 format.
- Correct coding must be submitted for each service rendered using valid CPT & HCPCS codes, appropriate modifiers and place of service locations.
- Always bill with the highest level of diagnosis code that is valid at the time of service.
- Handwritten claims are not accepted.
- Billing provider address must be a physical location, claims will be rejected if a PO box number is submitted.
- Claims status inquiries can be researched via NaviNet for a claim which does not appear on a remittance advice within 60 days following submission.

Utilization Management

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Second Opinions and Out of Plan Referrals

Out of Plan Referrals

- 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.

Referrals for Second Opinions

- Second opinions may be requested by Highmark Wholecare, the member or the PCP.
- Referral to an in-network qualified health care professional that is not in practice with the practitioner who rendered the first opinion.
- Out of network referrals may be authorized when no in-network practitioner or provider is accessible or able to meet the member’s needs.

Direct Access

Our members are permitted to “self-refer” for specialist care.

- Referrals are not required for services rendered by participating providers.
- The PCP is responsible for the coordination of a member’s healthcare needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other healthcare services.
- To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member’s designated PCP.
- All Highmark Wholecare UM prior-authorization requirements remain in place.

Prior Authorization

Highmark Wholecare ensures that utilization management criteria are available to practitioners and providers who make a request via telephone, email, fax or letter. Medical policies are available to practitioners and providers on the Highmark Wholecare website. Additionally, information about how to request this information is included on all denial notices.

The UM department assesses the medical appropriateness of services using McKesson's Interqual Procedure Criteria, approval criteria based on a Medical Director's review of the latest medical literature and citations, and CMS and DHS/HealthChoices definition of medical necessity when authorizing the delivery of healthcare services to plan members. A comprehensive list of items requiring authorization can be found on our website under the provider section for Medicare Provider Updates.

If a request for a covered service does not meet the criteria requirements, a Highmark Wholecare Medical Director will review for a medical necessity determination. An opportunity to discuss the request with the Medical Director will also be provided to the ordering physician.

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.

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.

Prior Authorization

- Authorizations allow us to verify eligibility, assess medical necessity, establish appropriate location for services and identify members who would benefit from Case Management.
- It is important for prior authorizations to be accompanied by complete clinical information supporting the specific services being requested.
- The ordering Provider is responsible for obtaining authorization.
- Refer to the Provider Portal within NaviNet for a listing of services which require precertification.
- Prior authorization is required for potentially experimental, investigational or cosmetic services.
- Non-covered benefits will not be paid unless special circumstances exist. A medical director's review of a request may determine that the item requested is non-covered. All services not on the Medicaid or CMS fee schedule or any service provided by a non-participating provider requires prior authorization.
- Refer to the Utilization Management Guide or the Provider Manual for detailed information on guidelines and procedures for submitting requests and obtaining authorization.

Letters of Medical Necessity

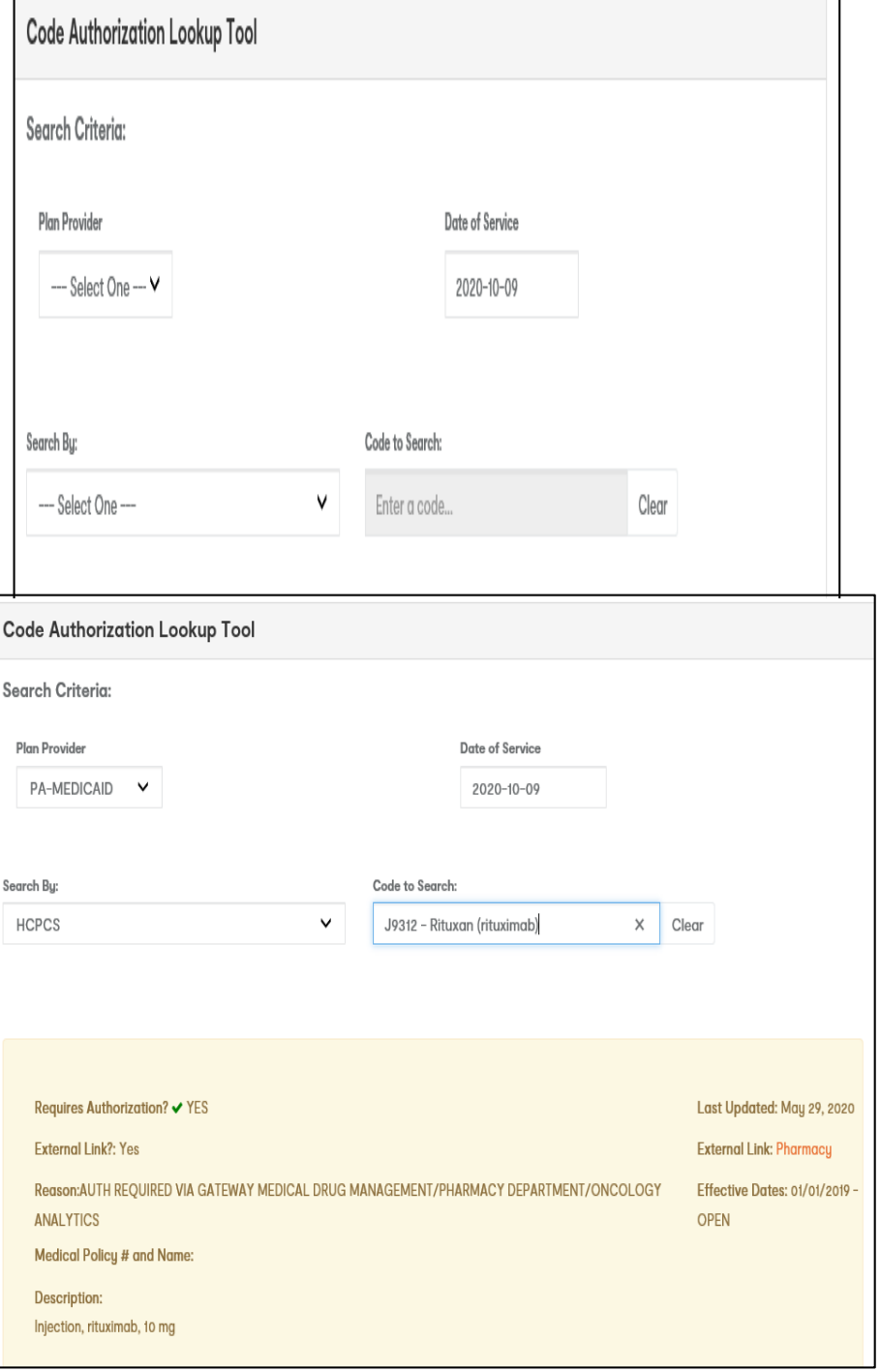
In cases where Letters of Medical Necessity are needed, it is important to:

- Discuss the need for a Letter of Medical Necessity (LOMN) with the UM representative
- Fax the LOMN along with any other supporting documentation such as progress notes, testing results or consultations by specialists
- Should be submitted by the appropriate licensed healthcare professional such as MD, DO, CRNP, NP or PA (not all inclusive)
- Submit the LOMN for new and ongoing requests for services
- Outline within the LOMN the service requested, the setting, quantity and duration of the service or item requested
- Also, include the member's overall condition and needs as well as any recent or expected changes to the member's overall condition

Prior Authorization via NaviNet®

Participating providers should submit authorizations electronically to the provider portal via NaviNet® .

Providers can utilize the Code Authorization Lookup Tool within NaviNet® to determine if a code requires prior authorization. The Authorization Tool is updated regularly.



Prior Authorization Contacts and Resources

	Services	Phone/Website
Medical Management (Utilization Management(UM))	Medicaid Medicare	1-800-392-1147 Monday-Friday 8:30AM to 4:30PM 1-800-685-5209 Monday-Friday 8:30AM to 4:30PM
Pharmacy (Non-Formulary Requests and Prior Authorization)		1-800-392-1147 Monday-Friday 8:30AM to 5:00PM
National Imaging Associates (NIA)	Outpatient Imaging services, Physical Therapy, Occupational Therapy, Speech Therapy, Trigger Point Injections, Interventional Pain Management services and Musculoskeletal Surgery (MSK) services	1-800-424-4890 Monday through Friday 8:00AM to 8:00PM or through the www.RadMD.com
OncoHealth	Chemotherapeutic drugs, symptom management drugs and supportive agents, and radiation therapy drugs	OneUM web portal or by fax to 1-800-264-6128 or phone at 1-888-916-2616 from 8:30AM to 6:00PM, Monday-Friday
HealthHelp	Sleep Studies, Radiation Oncology and Cardiology Note: a complete list of procedure codes requiring authorization can be found at: www.healthhelp.com/HighmarkWholecare.	1-888-265-0072

The Special Needs Unit

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Special Needs Unit (SNU)

- A member with Special Needs is based upon a non-categorical or generic definition of Special Needs. This definition will include but not be limited to key attributes of ongoing physical, developmental, emotional or behavioral conditions, or life circumstance which may serve as a barrier to the member's access to care or services.

- The goal of the SNU Case Management is to intervene in medically or socially complex cases that may benefit from increased coordination of services to optimize health and prevent disease. The SNU is staffed by individuals with medical or social service backgrounds in the following areas: oncology, medically complex children, HIV/AIDS, substance abuse, mental health, physical rehabilitation, and intellectual disability.

- A SNU Case Manager is available at 1-800-392-1147, Monday through Friday from 8:30 AM to 4:30 PM to assist with coordination of the member's healthcare needs.

Case Management

Case Management

- Highmark Wholecare understands that many factors impact the ability and desire for members to focus on their health. Case Managers intervene with members who have complex medical or social issues.
- Our Case Management Dept. has expertise in the following areas: Oncology, Medically Fragile Children, Medical/Surgical, HIV/AIDS, Obstetrics and MH/MR. Case Management services are available to assist in the care of any member, regardless of diagnosis.

Coordination of Care

- Communication with the PCP is critical for overseeing patients' care. Hospitals and specialists must send all records and test results to the member's PCP.

Specialists Functioning as PCP's

As a result of the Commonwealth of Pennsylvania's HealthChoices Program, specialists in the HealthChoices counties may function as a PCP for members with special needs, complex illnesses, or conditions.

In order for a specialist to function as a PCP, the specialist must be approved by the Highmark Wholecare Medical Director and agree to act as a PCP.

Preventative Health, Disease and Case Management

MEDICAID & MEDICARE

Preventive Health Program

The Highmark Wholecare Preventive Health Program focuses on the importance of health screening and early detection of diseases. Key interventions of the program include:

- Reminders for Preventive Health screenings
- Telephonic outreach to assist members in scheduling mammograms when indicated
- Physician notification of members overdue for mammograms and/or pap smears
- Annual mailing of in-home colorectal test kit
- Member newsletters with articles focusing on the importance of Preventive Health
- Health screening Information on the Highmark Wholecare website
- Highmark Wholecare to Lifestyle Management Programs include:
    - Asthma Program, Cardiac Program, COPD Program, Diabetes Program, MOM Matters Program

Program Enrollment: 1-800-392-1147

Clinical Programs

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Highmark Wholecare Lifestyle Management Programs

- Asthma
- Cardiac
- COPD
- Diabetes
- Hypertension
- Healthy Weight
- MOM Matters

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- Highmark Wholecare to Lifestyle Management Programs include:
  - Asthma Program, Cardiac Program, COPD Program, Diabetes Program, MOM Matters Program

Program Enrollment: 1-800-392-1147

Maternity Home Visitation Program

DHS has required all MCOs establish an evidence-informed, outcomes-based Maternal, Infant and Early Childhood Visitation Program for all first-time parents and parents of infants with additional risk factors.

Highmark Wholecare will provide at least two home visits (these are in addition to clinical home health visits you may order).

The visits cover:

- Parent education on infant development
- Assessment of social determinates of health
- Assist the parents with resources to address the identified needs

The Customer Service Department is available to assist with any questions and can be reached at 1-800-392-1147.

MOMS Matters® Program

MEDICAID & MEDICARE

We have a special program for pregnant women called MOM Matters®. This program gives members the education and support needed to help the member have a healthy pregnancy. Highmark Wholecare's Maternity Team members are available to assist members in the following ways:

- Find a doctor and set up appointments for prenatal care
- Answer questions and direct members to community services
- Arrange a home visit by a nurse when needed
- Provide resources for transportation to and from doctor appointments
- Connect to the smoking quit line at 1-800-784-8669
- Earn rewards for going to all prenatal and post-partum care visits

Quality Improvement/Utilization Program

As a participating provider, Highmark Wholecare asks that you cooperate with QI activities to improve the quality of care and services members receive. This may include the collection and evaluation of data, participation in various QI initiatives and programs and allowing the plan to use and share your performance data.

To request a copy of the Quality Improvement Program, Work Plan or Annual Evaluation please contact Highmark Wholecare's Provider Services Department.

- 1-800-392-1147 (PA Medicaid)
- 1-800-685-5209 (PA Medicare)

Provider Education and Sanctioning

Highmark Wholecare practitioners will be monitored for compliance with administrative procedures, trends of inappropriate resource utilization, potential quality of care concerns, and compliance with medical record review standards.

Network practitioners who do not improve through the provider education process will be referred to the Highmark Wholecare QI/UM Committee for evaluation and recommendations.

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 cooperate with administrative aspects of the QI/UM Program
- Failure to provide adequate practitioner coverage

Highmark Wholecare Practitioner Excellence (HWPE) Program

- At Highmark Wholecare, we value the important role practitioners play in serving our members. This program supports Highmark Wholecare's mission to improve the health and wellness of the individuals and the communities we serve.
- The intent of the provider program is to encourage improvement in the process of care for Highmark Wholecare members. We support recognizing and rewarding performance for those practices committed to providing quality healthcare that is accessible and efficient.
- In order for providers to participate in the current HWPE® program, they must acknowledge that they are opting-in to the program.

2023 Medicaid Goodness Rewards Overview

The 2023 Goodness Rewards Incentive Program offers members incentives for completing specific health activities. Members will be rewarded via gift cards, that can be used at any merchant location that accepts. Please note: These gift cards cannot be used for the purchase of tobacco, alcohol, firearms, at an ATM, and certain OTC products.

Rewards can be saved up and redeemed at a later time.

Rewards redeemed online and sent via email the same day of redemption.

2023 Medicare Goodness Rewards Overview

The 2023 Goodness Rewards Incentive Program offers members incentives for completing specific health activities. Members will receive a gift just for activating into the program. Members can choose one gift between the following gifts: Cozy Throw Blanket, Portable Chair, or Umbrella with Carrying Case & Pocket Planner (bundle). Additional rewards can be earned for completing the yearly health survey (HRA) and Annual Wellness Visits.

Rewards can be saved up and redeemed at a later time.

Rewards redeemed online and sent via email the same day of redemption.

Members now receive a reward just for signing up!

MEDICAID ONLY

Tobacco Cessation Resources

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Tobacco Cessation

Highmark Wholecare realizes that our providers can have the biggest impact in helping our members quit. To assist our providers in working with Highmark Wholecare members to quit using tobacco, Highmark Wholecare has information readily available on the website to assist with:

- Effective ways to discuss tobacco cessation
- Tobacco Cessation benefits available to Highmark Wholecare members
- Provider information related to tobacco cessation counseling certification
- Information regarding the PA Free Quitline
- Additional Tobacco Cessation Resources

Mental Health & Substance Use Disorder

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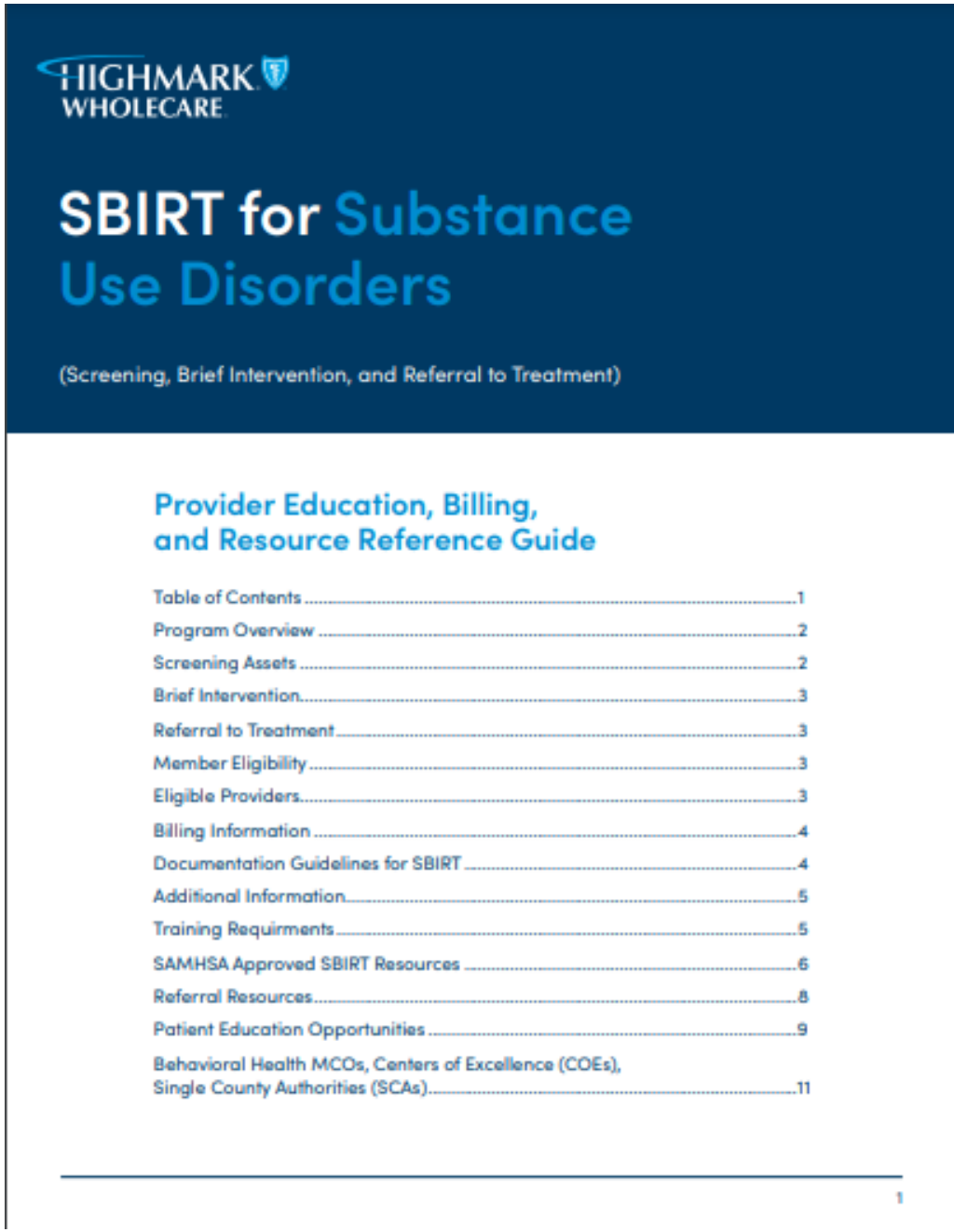
Screening, Brief Intervention, & Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is designed to prevent members from developing substance use disorders, for early detection of suspected substance use disorder, or to refer members for treatment.

These services are not intended to treat members already diagnosed with substance use disorder or those members already receiving substance use disorder treatment services.


HIGHMARK WHOLECARE

SBIRT for Substance Use Disorders

(Screening, Brief Intervention, and Referral to Treatment)

Provider Education, Billing, and Resource Reference Guide

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1

Screening, Brief Intervention, & Referral to Treatment (SBIRT) for Substance Use Disorders

- There are several evidence-based screening/assessment tools including:
  - The Alcohol Use Disorders Inventory Test (AUDIT)
  - The Drug Abuse Screening Test (DAST)
  - The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
  - The Car, Relax, Alone, Forget, Friends, Trouble Screening Test (CRAFFT), for adolescents
  - The Problem Oriented Screening Instrument for Teenagers (POSIT)

- Links to these screening/assessment tools, as well as others, can be located at: http://www.integration.samhsa.gov/clinical-practice/sbirt/screening

Mental Health and Substance Use

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- PCPs and all non-behavioral health providers are encouraged to recommend behavioral health services when appropriate.

- **Telephonic Psychiatric Consultation Service Program (TIPS)**
  - ***FREE*** program that provides real time resources to the PCPs and other providers who desire immediate consultative advice for children with behavioral health concerns, covered by Medical Assistance, up to age 21. More information is on our website under Medicaid Resources.

- **Integrated Care Program at Highmark Wholecare**
  - Providers can refer members for care management. Referrals received will be screened for program appropriateness. To make a member referral or for more information call: 800-392-1147

Behavioral Health and Substance Use Services for Medicaid Members

The Department of Human Services (DHS) has carved out the Behavioral Health and Substance Abuse Services for members, by County of residence.

Visit https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/BehavioralHealth-MCOs.aspx for a current listing of BH-MCOs.

Opioid Intervention

Highmark Wholecare is committed to working with providers to ensure safe, quality healthcare for our members. As you are aware, prescription medications are an important part of improving the quality of life for millions of Americans living with acute or chronic pain. However, one of the most serious public health problems in our country is the risky or harmful use of these substances, particularly prescription opioid pain medications.

Pennsylvania is among the top 10 states with the highest opioid use and overdose rates nationally.

Opioid Treatment Programs (OTPs)
MEDICARE

- Since 2020, Medicare members have been able to receive treatment for opioid use disorder at Opioid Treatment Programs (OTPs)
- OTPs sometimes known as “methadone clinics” but also utilize other medications to treat opioid use disorder like buprenorphine and naltrexone
- Dispense and administer opioid agonist and antagonists including naloxone, toxicology testing, individual and group therapy, counseling, intake activities, and periodic assessments
- Covered through bundled Part B codes for dually eligible individuals where Medicare is the primary payer and Medicaid is the payer of last resort.

Note: Medicaid members should be able to access care at OTPs and can call their behavioral health managed care organization (BH-MCO) for more information.

Centers of Excellence

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- For PA Medicaid members with opioid use disorder
- Helps patient navigate the healthcare system and community resources
- Focus on holistic recovery, addressing both treatment and non-treatment needs
- Certified Recovery Specialists, who themselves are in recovery may offer support services
- A referral is not necessary, but a member is only able to work with one COE at a time.

Additional information and resources regarding Opioid and Substance Use Disorders are available on the Highmark Wholecare website Provider Resource Center.

A complete list of Pennsylvania Opioid Use Disorder Centers of Excellence (OUD-COEs) can be found at Centers of Excellence (pa.gov).

Cultural Competence

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Healthcare Disparities

Highmark Wholecare believes a strong patient-provider relationship is the key to reducing the gap in unequal healthcare access and healthcare outcomes due to cultural and language barriers. Highmark Wholecare is continuously working to close the gap in health outcomes by focusing on education and prevention.

Highmark Wholecare has cross-cultural education programs in place to increase awareness of racial and ethnic disparities in healthcare among our employees, members and providers. Highmark Wholecare is an active partner in the community through many outreach and community-based activities.

Provider Cultural Toolkit

Highmark Wholecare has assembled a list of resources and web-based tools to assist you and your office staff in providing care that is sensitive to the cultural and linguistic differences of your patients.

The toolkit is located on our website:
https://www.HighmarkWholecare.com/provider/provider-resources/cultural-toolkit

Cultural Competency forms can be obtained on our website:
https://www.HighmarkWholecare.com/Portals/8/provider_forms/CulturalCompetencyDataForm.pdf

Cultural Competency Data Form

By providing your race, ethnicity, language and cultural competency training data, you allow Highmark Wholecare to better connect members to the appropriate practitioners, deliver more effective provider-patient communication and improve a patient's health, wellness and safety.

The information is strictly voluntary and the information you provide will not be used for any adverse contracting, credentialing actions or discriminatory purposes.

Limited English Proficiency (LEP)

- Participating providers are required, by law, to provide translation and interpreter services (including American sign language services) at their practice location.
- For interpreter services, please contact a qualified medical interpretation service such as Language Line Services. Practitioner offices can contact the AT&T Language Line at 1-800-874-9426 for assistance with Limited English Proficient (LEP) patients and the PA State Relay line at 711 for patients with hearing impairments.
- ***Providers are responsible for the coordination and cost of interpreter services for members who are hearing impaired.***

Social Determinants of Health (SDOH)

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The Impact of Social Determinants of Health

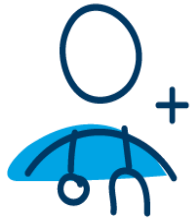
The condition in which people are born, grow, live, work, and age – impacts a wide range of health, functioning and quality of life outcomes, which can lead to inequities and risks

Economic Stability	Neighborhood & Physical Environment	Education	Food	Community & Social Context	Health Care System
• Employment • Income • Expenses • Debt • Medical Bills • Support	• Housing • Transportation • Safety • Parks • Playgrounds • Walkability	• Literacy • Language • Early Childhood Education • Vocational Training • Higher Education	• Hunger • Access to healthy options	• Social Integration • Support Systems • Community Engagement • Discrimination	• Health Coverage • Provider Availability • Provider linguistic and cultural competency • Quality of care
Health Outcomes **Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations**					

The Wholecare Approach

Connect with:

- ✓Care Management
- ✓Non-Medical Transport
- ✓Wholecare Resource Center
- ✓Housing Coordinators



Through community partnerships, Highmark Wholecare provides qualified members:

- ✓ Meals to support members who are food insecure and links to long term food resources
- ✓Partnerships with local libraries and food banks to promote a greater understanding of healthy choices
- ✓Highmark Wholecare to Lifestyle Management programs to help you understand and manage your health condition
- ✓Transportation Resources

Creating Stronger, Healthier Futures

Our communities and our members are filled with potential. Financial independence is important. It leads to self-worth, pride, less stress and a much healthier, happier life. As part of our Highmark Wholecare to Success program, we help prepare our members for their future by providing support for:

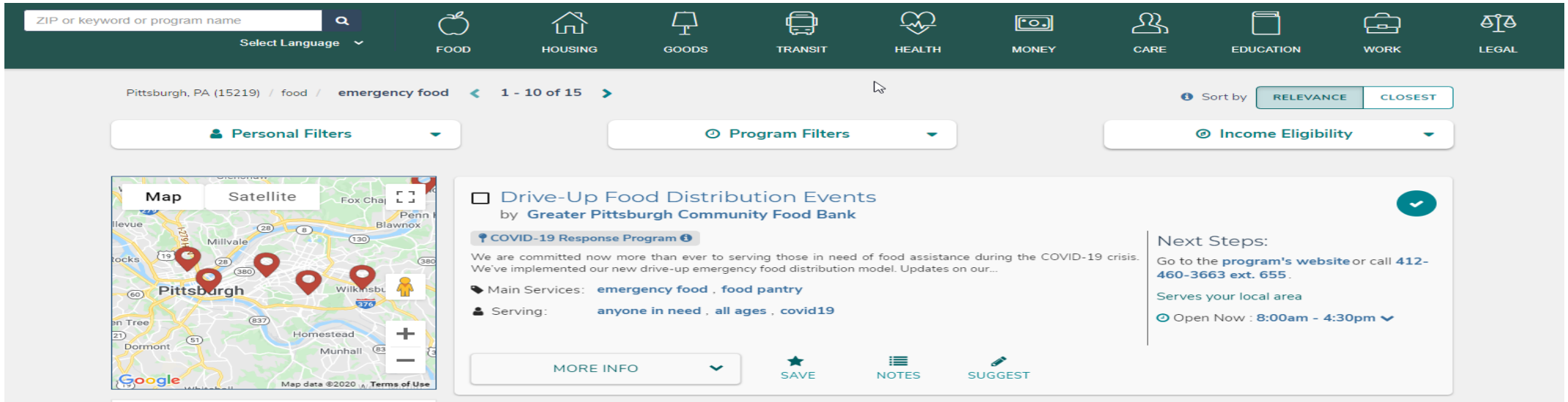
- ✓ Education and employment counseling and connecting members to resources to help them succeed through our success champions
- ✓ Payment for GED testing
- ✓ Assistance finding work through **FlexJobs.com** which specializes in providing part-time and work-from-home jobs

Highmark Wholecare Resource Center

Highmark Wholecare Resource Center
The purpose of the Highmark Wholecare Resource Center is to be an all-encompassing database of free or reduced cost social care programs throughout the community for staff, providers, and members. The platform allows “seekers” (those looking for programs) the ability to easily view program specific requirements, contact information, and even make direct online referrals.

The Highmark Wholecare Resource Center can be accessed in the following ways:

- Highmark Wholecare website: https://highmarkwholecare.com/
- Provider Portal: https://navinet.navimedix.com/



Providers and Z codes

Providers are encouraged to screen for SDOH

PCMHs and FQHCs may have additional requirements not imposed by Highmark Wholecare.

G9919 and G9920 are most commonly used as evidence of the screener

G9920 is used when the screener is negative for related needs.

G9919 is when the individual screens positive.

- Z codes should be submitted with G9919 to designate in which areas the member screened positive.

Z Codes could also be submitted on other claims outside of G9919; it should not be the primary diagnosis code

OB/GYN Services

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OB/GYN Services

- Members may self-direct to any participating OB/GYN for any OB/GYN related condition, not just for an annual exam or suspected pregnancy.
- OB/GYN's office is required to verify eligibility of the member.
- PCPs may perform routine gynecological exams and pap tests and provide care during pregnancy if they are so trained and equipped in their office.
- Highmark Wholecare members may also self-direct for family planning services.

Care Management Department, 1-800-685-5209

Obstetrical Needs Assessment Form (ONAF)

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.

ONAF should be updated at the 28-32 week visits and at the post-partum visit.

Download a Copy of the ONAF:

ONAF Form

Submitting the ONAF

Submit 2-5 business days after the initial intake visit and at least 30 days prior to delivery.

- ✓ Fax: 1-888-225-2360
- ✓ Online submission process by logging in here.

For instructions on using the online submission tool, view the "OB User Guide"

Family Planning

- All family planning benefits provided under Highmark Wholecare are administered through Adagio Health, Inc.
- Eligibility can be verified by calling 1-800-642-3515.
- Family planning patients DO NOT need a referral from their PCP under federal mandate.
- If a family planning patient becomes pregnant, she may self-refer to her OB/GYN for prenatal care. DHS permits members to see any participating or non-participating practitioner for family planning services only.
- The Sterilization Consent Form (MA-31) must be obtained from the patient thirty (30) days prior to the procedure.
- For additional information, please view the Family Planning Guidelines found in our Provider Manual.

LARC and Oral Contraceptives

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Long Acting Reversible Contraceptives (LARC) and Oral Contraceptives

Highmark Wholecare covers all family planning services, including oral contraceptives and long acting reversible contraceptives (LARC), according to the PA Medicaid fee schedule and preferred drug list. LARC placement is covered in both the inpatient and outpatient settings.

Please see the LARC scenario table below for further instruction. Covered contraceptives can be found on the PA Preferred Drug List: https://papdl.com/preferred-drug-list

Devices and medications designated as non-preferred will require clinical review to determine medical necessity. The CPT codes below include covered procedures and are not all-inclusive.

CPT Code:	Device Description
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant

LARC Scenario Examples	CPT	Place of service for CPT	HCPCS	Place of service for HCPCS	Diagnosis code	Comment
LARC placement in the inpatient setting	58300	21	J7296	22	Z30.430	Bill HCPCS with place of service 22
LARC placement in the outpatient setting	58300	22	J7296	22	Z30.430	Bill CPT and HCPCS on same claim with place of service 22

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EPSDT Program

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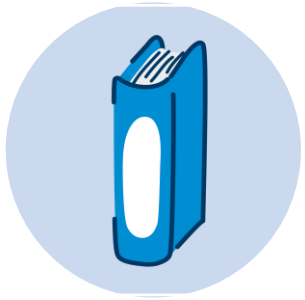
Growing Up With Highmark Wholecare

- Program based upon the federally mandated EPSDT Program for MA eligible children under the age of 21 years.
- Required screens, tests, and immunizations are outlined by the Pennsylvania EPSDT Program Periodicity Schedule. The most current version of these schedules, as well as validated screening tools, can be found on Highmark Wholecare's website under Provider Resources/EPSDT.
- 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.
- New members must be seen within forty-five (45) days from the effective date of enrollment.

Highmark Wholecare Care Coordination:

- Coordinates medically necessary services for members
- Outreach via telephone and mail, to members to provide education and assistance with scheduling appointments, transportation, and other issues that prevent access to healthcare
- Outreaches to members identified by the PCP offices who are delayed with screens and/or immunizations or who are non-adherent with appointments Member Outreach Form
- Quarterly dashboard report available via the provider portal (Enhanced Provider Features) to assist providers in identifying members who are due or overdue for their screenings

EPSDT Reminders



An EPSDT visit is considered complete when **ALL of the age-appropriate screens** are completed (including immunizations) and then properly billed to the MCO.

Missing screenings will show that the member/provider is non-compliant with EPSDT.

EPSDT preventive visit codes overlap with HWPE® incentive codes.

For questions, please contact the EPSDT Coordinator at EPSDTInfo@HighmarkWholecare.com.

Required Screens, Tests, and Immunizations

Maternal Depression Screening – 1, 2, 4, and 6 month visit

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.

Developmental Surveillance – completed at all EPSDT visits

Surveillance is the observation of a child to identify whether the child may be at risk of developmental delay. 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 for developmental delays and ASDs

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.

Developmental Screening – 9-11,18, and 30 month visit

Children with Elevated Blood Lead Levels (EBLL) should receive additional developmental screens.

Required Screens, Tests, and Immunizations

continued…

Autism Screening –18- and 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. CONNECT Helpline at 1-800-692-7288.

Blood Lead Level Screening –9-11 months and 24 months

- Requires all children under the age of 7 receive a minimum of 2 blood lead screenings.
- The CDC requires the use of a blood lead test when screening children for lead poisoning.
- The PCP can use either their designated laboratory or Kirby Health Center Laboratory to process blood lead samples. A supply kit from our preferred laboratory can be requested by calling 1-888-841-6699 and identifying yourself as a participating Highmark Wholecare practitioner.

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

Environmental Lead Investigation (ELI)

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

- Services must be provided by a participating Highmark Wholecare ELI provider
- Member must have a venous BLL result of at least 3.5 mcg/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

The process to refer for an Environmental Lead Investigation is quick and easy:

- Complete the appropriate referral form.
- Form can be found on the Highmark Wholecare website: https://highmarkwholecare.com/Provider/Provider-Resources/EPSDT-Information

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.
- Highmark Wholecare follows recommended childhood immunization schedules approved by the CDC Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics, and the American Academy of Family Physicians. You can find the most up to date immunization schedule here: https://www.cdc.gov/vaccines/schedules/hcp/index.html

- Children under 19 years of age receiving MA are eligible for 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.

Oral Health Risk Assessment

- Follows the American Academy of Pediatric Dentistry.
- A dental assessment at every well-child visit, through observation, should be conducted.
- Oral health risk assessment is recommended at the twelve (12) month, eighteen month through six (6) year well-child visits. Fluoride varnish assessment recommended at this age.
- Physicians and CRNPs with appropriate training and certification through Smiles for Life online training curriculum may administer and bill for fluoride varnish treatments for children less than five (5) years old.
- Submit a copy of the training certificate to:
- Highmark Wholecare Attention: Provider Information Management,
  - Mail: 444 Liberty Avenue, Suite 2100 Pittsburgh, Pa 15222-1222
  - Fax to **1-855-451-6680**
- At the top of the certificate, please include your thirteen (13) digit MA provider identification number and/or the health plan's Individual Provider Number.

Resources and Self-Service Tools

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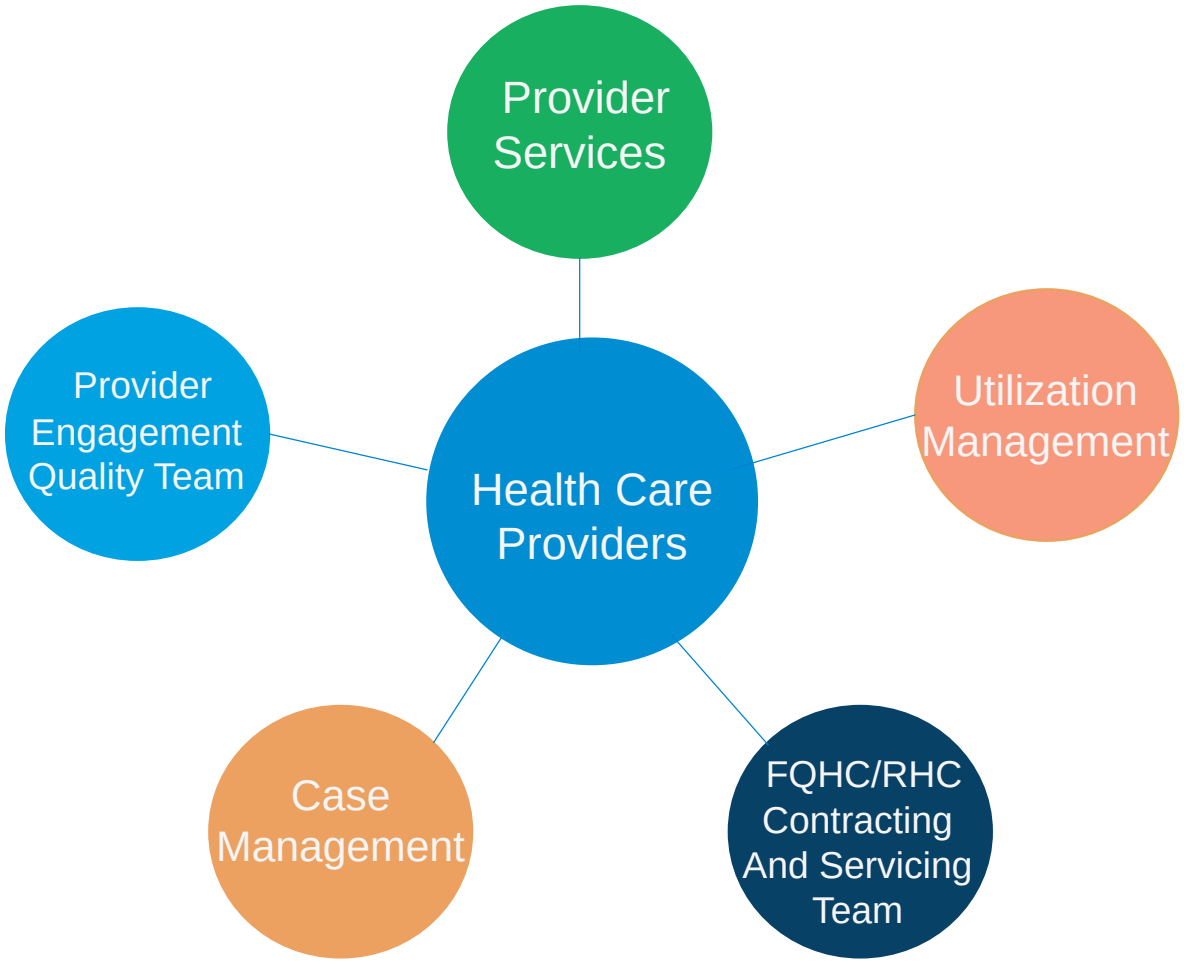
Points of Contact



Helpful Plan Contacts

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

PA Medicaid: 1-800-392-1147

PA Medicare: 800-685-5209

Provider Relations Provider Account Liaisons (PALs) and Lead Provider Relations Representatives can assist with:

- High level or global issues
- Education and training
- Highmark Wholecare policies and procedures
- Webinars

- Fax Blasts
- Provider Newsletters
- Provider Updates

Sr. Provider Contract Consultant - FQHC/RHC

The Sr. Provider Contract Consultant - FQHC/RHC:

- Acts as the liaison between Highmark Wholecare and FQHC/RHC participating providers.
- Serves as your primary contact for both new and existing contracts
- Conducts new provider orientations and outreach.
- Provides education/training on Highmark Wholecare policies, procedures and processes.
- Targets FQHC/RHC practices regarding EPSDT and Lead Screening initiatives.
- Engages with key health centers regarding value-based programs.

Website

- Provider Manuals
- Pharmacy Tools
- Online Provider Directory

- Provider Newsletters & Updates
- Medical and Payment Policies
- Medical Assistance Bulletins

https://highmarkwholecare.com

NaviNet®

- Easy-to-use, free, internet-based solution for providers to streamline data exchanges between their offices and Highmark Wholecare
  - Eligibility information
  - Benefits information
  - Claims Search Inquiry

https://connect.NaviNet.net

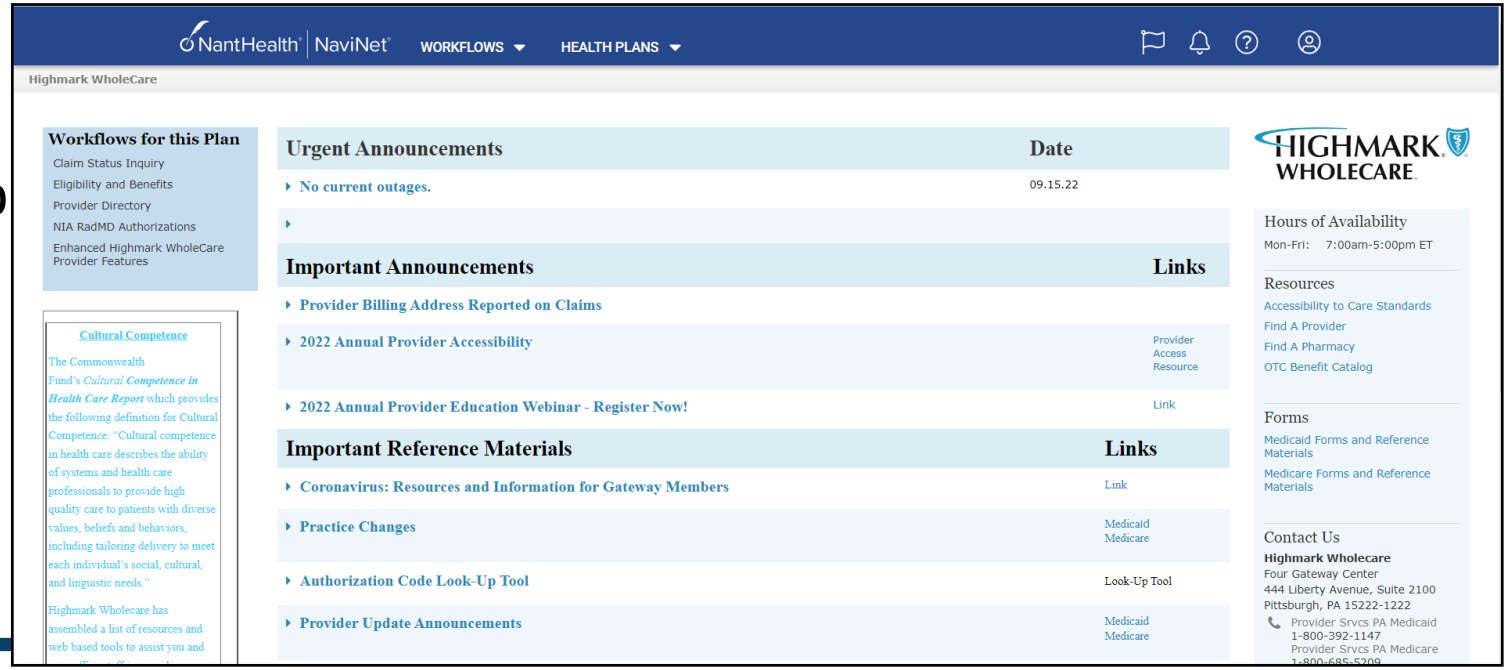
Not a NaviNet user?
Register for a new account

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.



Adagio Health is a separate company that provides women's health services for Highmark Wholecare.

Boys & Girls Clubs of Western Pennsylvania is a separate nonprofit organization that provides life-enhancing programing to all youth, including Highmark Wholecare members.

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

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

HealthHelp is a separate company that offers education and guidance from specialists in sleep, cardiology, and radiation oncology for Highmark Wholecare.

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

NIA/Magellan is a separate company that administers prior authorization for certain services for Highmark Wholecare.

Olivet Boys & Girls Club is a separate, nonprofit organization that provides high quality, holistic programming for youth in Reading and Berks County, including Highmark Wholecare members.

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

United Concordia Dental is a separate company that administers the dental benefit(s) for Highmark Wholecare.

This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross 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 14 counties in northeastern Pennsylvania, 12 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.

Thank you!

Remember to Complete Your Attestation

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