HIGHMARK WHOLECARE

APRIL 2022

# Provider Newsletter

## An Update for Highmark Wholecare Providers and Clinicians

IN THIS ISSUE



## 2022 Provider Responsibilities and Compliance Program Training

### April 25, 2022
### Noon - 1 p.m.

### Meeting Information:

The Highmark Wholecare Fraud, Waste, and Abuse Unit (FWA) will be hosting a live Provider training webinar on April 25, 2022. Training topics include:

- Compliance Plan Requirements and Value
- Elements of an Effective Compliance Plan
- Highmark Wholecare's Checklist and Oversight
- Reviewing Licensure and Credentials
- Privacy

All are welcome to take advantage of this learning opportunity. Please use the registration link below to reserve your seat today!

**Click here to register.**

# Mark Your Calendar!

## Upcoming Learning and Earning with Highmark Wholecare Free Professional Education CME/CEU Webinars

| Topic | Date/Time | Key Speaker |
|---|---|---|
| **Introduction to Screening, Brief Intervention, and Referral to Treatment (SBIRT)**<br><br>**Behavioral Health Webinar** | Wednesday, May 4, 2022 noon–1 p.m. | **Alec Howard, MPH**<br>Research Specialist, Program Evaluation and Research Unit (PERU)<br>University of Pittsburgh<br><br>**Shannen Lyons, LCSW CAADC**<br>Addiction Specialist<br>Highmark Wholecare |
| **Making Sense of Modifiers 25 and 59: When and How to Use Them**<br><br>**Fraud Waste and Abuse** | Wednesday, June 1, 2022 noon–1 p.m. | **Belinda Wilson, CPC**<br><br>**Robin Richards, CPC**<br>Fraud Consultant<br><br>**Jayme Patterson, CPC**<br>Fraud Analyst<br><br>Fraud Waste & Abuse, Highmark Wholecare |
| **Additional webinars will be announced soon.** | | |

## Who qualifies for CME?

Webinars are free and open to all interested. CME/CEU Credits are available for: physicians, midlevel practitioners, nurses, psychologists and social workers.

Each webinar is eligible for one (1) CME/CEU credit. To receive credit, you must ***enroll*** at: https://www.surveymonkey.com/r/NZJYDF7 and create a free account at cme.ahn.org. After enrolling, you will receive WebEx login information for the webinar. You only need to enroll **ONCE** to be eligible to receive CME credit for attendance at live webinar activities. Instructions for claiming CME/CEU credit will be provided at each live webinar.

**You must also create a free account at CME.AHN.org to access your transcript.**

### QUESTIONS?

Questions? Contact the Highmark Wholecare Provider Engagement Team at:
ProviderEngagementTeam@HighmarkWholecare.com

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This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Allegheny General Hospital and Highmark Wholecare. Allegheny General Hospital is accredited by the ACCME to provide continuing medical education for physicians. Allegheny General Hospital designates this live webinar activity for a maximum of 1.0 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Allegheny Health Network is approved by the American Psychological Association to sponsor continuing education for psychologists. Allegheny General Hospital maintains responsibility for this program and its content. Social workers may claim credits for attending educational courses and programs delivered by pre-approved providers, such as the American Psychological Association. Approved for 1.0 APA credits.

In accordance with the Accreditation Council for Continuing Medical Education (ACCME) and the policy of Allegheny Health Network, presenters must disclose all relevant financial relationships, which in the context of their presentation(s), could be perceived as a real or apparent conflict of interest, (e.g., ownership of stock, honorarium, or consulting fees). Any identifiable conflicts will be resolved prior to the activity. Any such relationships will be disclosed to the learner prior to the presentation(s).

# Accessibility Standards

Highmark Wholecare maintains standards and processes for ongoing monitoring of access to health care. Practice sites are contractually required to conform to the standards to ensure that services are provided to members in a timely manner. Please take a few minutes to review the standards and share with your office staff that schedule member appointments. These standards and additional resource information related to accessibility are available on the Highmark Wholecare provider website.

**You can access the standards here.**

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# Behavioral Health Accessibility

Highmark Wholecare has established Medicare accessibility standards related to behavioral health services. Behavioral Health office sites are educated regarding the access standards quarterly in our provider newsletter, in our Medicare Provider Manual and on our provider website. Highmark Wholecare monitors behavioral health office compliance with the access standards by conducting an annual telephonic accessibility audit. The most recent annual audit results identified that improvement is needed to ensure that members have timely access to behavioral health services. In an effort to reduce accessibility standard interpretation barriers, we have provided detail to the standards including definitions, examples, and scenarios.

**Behavioral Health Access Standards Detail**

# EPSDT – Dyslipidemia

As part of the EPSDT Schedule, Dyslipidemia is a Universal Screening that occurs in 2 time frames and at other times if indicated by history and/or symptoms.

**Screenings for Dyslipidemia should occur between:**

- 9 years to 11 years
- 17 years to 20 years

Other ages should be screened based on history and or symptoms.

## Billing

The recommended coding by the Pennsylvania Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule and Coding Matrix:

All EPSDT screening services must be reported with age-appropriate evaluation and management code along with the EP modifier.

- 9 year to 11 year EPSDT visit CPT code is 99383 or 99393
- 17 year to 20 year EPSDT visit CPT code is 99384 or 99394

The CPT code suggested for **Dyslipidemia Screening is 80061.**

Modifier:

- 90 when applicable
  - When laboratory procedures are performed by a party other than the treating or reporting physician, use CPT code plus modifier 90 Reference Outside Lab. This modifier is used to indicate that although the physician is reporting the performance of a laboratory test, the actual testing component was a service from laboratory.
- 52 when applicable
  - When screenings are not completed, the 52 modifier should be applied. If a screening service/component is reported with modifier 52, the provider must complete the screening service/component during the next screening opportunity according to the Periodicity Schedule.

**For questions regarding the EPSDT program, feel free to contact EPSDTinfo@HighmarkWholecare.com.**

**Thank you for partnering with Highmark Wholecare to keep children healthy.**

### References:

https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/Physicians-Recommend-all-Children,-Ages-9-11,-Be-Screened-for-Cholesterol.aspx

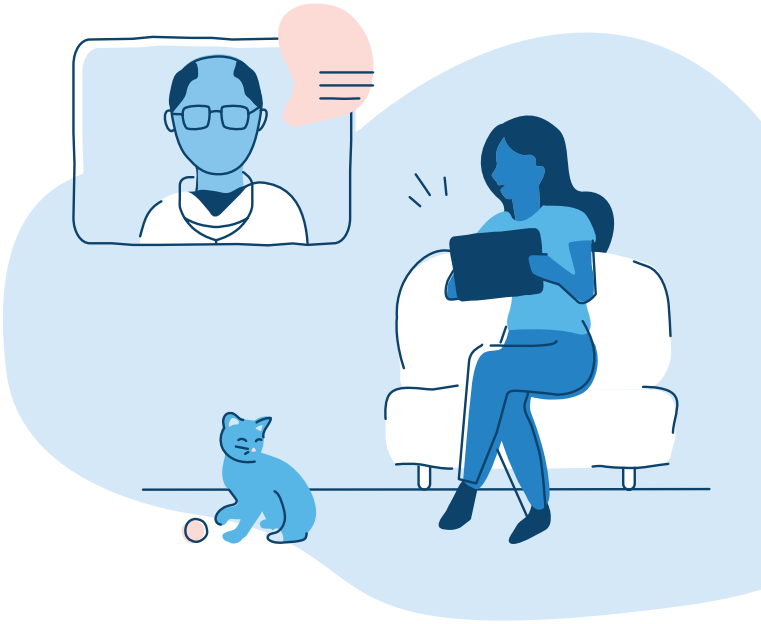
https://www.aafp.org/afp/2009/0415/p703.html

*These codes are not all encompassing and use does not guarantee payment. They are intended as a guide to provide education around appropriate screenings and coding as part of the EPSDT program.*

# Highmark Wholecare partners with Allegheny Health Network to address SBIRT referral to treatment for individuals struggling with Substance Use Disorders.

**Providers will have access to an AHN licensed clinician to assist in linking patients to treatment immediately upon a positive SBIRT screening, via a telehealth session.**

- Patients evaluated to be appropriate for Allegheny Health Network's Center for Recovery Medicine; Opioid Use Disorder Center of Excellence will have an initial appointment scheduled within 24 hours.
- Please call AHN at **412-400-0707** to reach a licensed clinician.



**For questions and more information, please contact Shannen Lyons (SLyons@HighmarkWholecare.com) at Highmark Wholecare.**

# Change in Blood Lead Reference Value

## Blood Lead Level is Now Elevated at 3.5µg/dL per CDC and PA DOH Guidelines

Effective January 1, 2022, Pennsylvania Department of Health has adopted the CDC's lower blood lead reference value of 3.5µg/dL. Highmark Wholecare is following the 3.5µg/dL per the CDC and PA DOH recommendations.

**The recommendations have been updated to the following:**

- County municipal health departments and health care providers should use the updated lower blood lead reference value of 3.5µg/dL in case management and promote the new blood lead reference value of 3.5µg/dL as a way to identify children with blood lead levels that are higher than levels of most children in the United States.
- A capillary test at 3.5µg/dL or above should be followed up with a confirmation test within the appropriate time frame based on the CDC's recommendation. A child with two capillary tests at 3.5µg/dL and above and tested within 84 days is considered as having a confirmed elevated blood lead level (EBLL). A child with a venous test at 3.5µg/dL or above is considered as having an EBLL.

For more detailed information from the Health Alert please refer to the following link: https://www.health.pa.gov/topics/Documents/HAN/2022-623-01-27-ADV-Lead%20Blood%20Level.pdf

Recommended actions based on blood lead level: https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm

Highmark Wholecare EPSDT reference materials for links on Environmental Lead Investigation and Care Management for children with elevated blood lead levels: https://highmarkwholecare.com/Provider/Provider-Resources/EPSDT-Information

# Highmark Wholecare Lifestyle Management Programs

## Balancing Lifestyle for Maximum Health and Wellness

| Program | Asthma | Cardiac | COPD | Diabetes | Hypertension | Healthy Weight Management | MOM Matters* (Maternal Outreach and Management) |
|---|---|---|---|---|---|---|---|
| **Eligibility** | Any member with a diagnosis of asthma | Any adult member with the following diagnosis: AMI, atrial fibrillation, CHF, heart failure diagnosis, IVD, MI or stroke | Any adult member with a diagnosis of COPD | Any adult member with a diagnosis of Type 1 or Type 2 diabetes | Any adult member with a diagnosis of hypertension | Any member with a diagnosis of overweight or obesity | All pregnant or postpartum females |
| **Contact for Referrals** | **Medicaid: 1-800-392-1147**<br>**Medicare Assured: 1-800-685-5209** | | | | | | |
| **Description** | • The programs provide patient education for medication, diet and lab testing adherence, as well as other tools to reduce inpatient and emergency room utilization<br>• The programs emphasize prevention and exacerbation of complications by using evidence-based guidelines and member empowerment strategies<br>• The programs support the physician's plan of care and supports the provider-member relationship | | | | | | **This program offers care coordination and SDoH resources to reduce low birth weight, pre-term deliveries and NICU** |

*continued >*

| Program | Asthma | Cardiac | COPD | Diabetes | Hypertension | Healthy Weight Management | MOM Matters* (Maternal Outreach and Management) |
|---|---|---|---|---|---|---|---|
| **Enrollement** | • Members are identified through claims, member self-referral, or Highmark Wholecare utilization management<br>• Provider referrals are also welcome! | | | | | | **Provider submission of the Obstetrical Needs Assessment Form (ONAF) helps identify high-risk women for proactive interventions** |
| **Coordination of Care** | • Case managers assist you and your patients with coordination of care for specialists visits<br>• Home health, behavioral health, DME and community referral needs are coordinated through the Highmark Wholecare Case Management department | | | | | | |
| **Provider Benefits and Support** | • The management of members in programs aimed at:<br>- Decreasing inpatient and ED utilization<br>- Increasing appropriate lab testing and medication adherence<br>• Encouraging adherence to obtain flu and pneumonia immunizations as well as other preventative testing and procedures | | | | | | |

# Annual Wellness Visits

Annual Wellness Visits (AWVs) are an important yet underutilized vehicle for ensuring our members get the vital care they need. Here at Highmark Wholecare, we recognize the importance of AWVs and want to ensure that every member in our health plan gets one annually. AWVs are free to Medicare members and, in many instances, can be conducted remotely via telehealth. With the ever-increasing emphasis on value-based care that focuses on shared savings, it is urgent for providers to complete AWVs for each of their assigned members. Doing so keeps members healthy, reduces healthcare costs, and can increase practice revenues. **It's a common misconception that you have to wait 365 days prior to completing another AWV for your patient, but that is a myth. These AWVs can be billed to Highmark Wholecare on a calendar basis, and you do not have to wait 365 days between AWVs.** Our member incentive program, Goodness Rewards, incentivizes our members with $100 for completing an AWV in 2022. The member must be enrolled in Goodness Rewards either by going to www.Goodnessrewards.com or calling 1-800-539-5722 (TTY: 711), and the provider must bill an appropriate billing code for this visit.

Please use the following coding guidance to document the Annual Wellness Visit. These are the only codes that will result in the member receiving a Goodness Reward gift card:

99381, 99382, 99383, 99384, 99385 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, G0402, G0438, G0439, G0466, G0467, G0468

# Continuity of Care Across Settings

The seamless sharing of information between healthcare providers, such as between primary care physicians (PCPs) and specialists, presents many challenges to the continuity of care and treatment of our members. Highmark Wholecare's membership includes some of the most vulnerable individuals who may suffer from severe or chronic illnesses. Enhanced communication among and between all those who participate in providing care to a patient is imperative in ensuring that all decisions about the patient's care are informed and contribute to the patient's overall well-being. Continuity of care issues can result in sub-optimal outcomes, increased costs, and medical errors.

It is to the benefit of both the patient and healthcare professional to communicate any reports, therapies, medications, and concerns identified by providers across treatment settings. Please contact your Provider Relations Representative with questions about how you can help improve patient care between settings.

# Medical Record Review Standards

Every year Highmark Wholecare conducts a review of medical records from a sample of providers to ensure consistent documentation of medical care delivered to members. This review assesses compliance with multiple standards and critical elements developed and approved by the Highmark Wholecare Quality Improvement & Utilization Management Committee to meet State, Federal and regulatory requirements. Examples of these standards include: documentation of continuity and coordination of care, execution of an advanced directive, legibility of written documentation, follow-up visits, and signing and dating of notes.

Should you or your practice be selected for medical record review, your cooperation with providing access to the requested records is required as a participating provider in the Highmark Wholecare network. Please note that Highmark Wholecare may not be held responsible for any costs that may be incurred with providing the requested medical records. Results of the review will be provided by letter within forty-five (45) calendar days. It is our goal to ensure an efficient, informative, and meaningful review as we assist you in fulfilling this important requirement.

The Medical Record Review Standards are available upon request, or can be found online:
MRR_Explanation.pdf (highmarkwholecare.com)

# Non-Suicidal Self-Injury Awareness

Highmark Wholecare is working to help end the stigma surrounding self-harm through awareness and education.

## What is Self-Harm?

Self-harm or non-suicidal self-injury (NSSI) is defined as deliberate, non-suicidal actions intended to cause physical injury to the body. We don't define self-harm as suicidal behavior, but continued self-harm over a period of time can lead to suicidal thoughts.

**Most common methods of NSSI include:**

- Burning
- Cutting
- Headbanging
- Hair pulling
- Excessive scratching
- Punching oneself or other objects to inflict injury
- Purposefully breaking bones

**Warning signs of NSSI Include:**

- Decreased academic or occupational peformance
- Increased isolation
- Low self-esteem
- Relationship problems
- Unexplained injuries

**For more information, or if you have a patient who is struggling with self-harm or suicidal thoughts please visit the National Suicide Prevention Lifeline at https://suicidepreventionlifeline.org/ or call 1-800-273-8255.**

# Medications to Require Medical Prior Authorization

## Medicare Assured

A subset of medications require a pre-service authorization for medications obtained through the medical benefit. This prior authorization process applies to **all Highmark Wholecare Medicare Assured members**. Failure to obtain authorization will result in a claim denial.

### Procedure Codes Requiring Authorization

| Authorization Required as of 02/21/2022 | | | |
|---|---|---|---|
| **Procedure Code** | **Description** | **Procedure Code** | **Description** |
| **J0257** | alpha 1 proteinase inhibitor (Glassia) | **J3590*** | lonapegsomatropin-tcgd (Skytrofa) |
| **J3590*** | efgartigimod alfa-fcab (Vyvgar) | **J3490*** | vosoritide (Voxzogo) |
| **J1931** | laronidase (Aldurazyme) | | |
| **Authorization Required as of 04/01/2022** | | | |
| **Procedure Code** | **Description** | **Procedure Code** | **Description** |
| **J3590*** | alirocumab (Praluent) | **J3590*** | tezepelumba-ekko (Tezpire) |
| **J3590*** | evolocumab (Repatha) | **J3590*** | tralokinumab-ldrm (Adbry) |
| **J3490*** | inclisiran (Leqvio) | | |

*This medications will be reviewed under the miscellaneous/not otherwise specified procedure codes until a permanent code is assigned.

#### What if the medication is not on this list?

This list is intended to function as a notification and is subject to change. Please refer to the Provider Portal Lookup Tool (accessed via Navinet: https://navinet.navimedix.com) to determine if a drug/HCPCS code requires authorization and to submit authorization requests.

#### Would you prefer to get the medication through pharmacy?

This change only applies to the medical benefit. If the medication is to be billed at the pharmacy/specialty pharmacy, you will continue to submit requests to the Highmark Wholecare pharmacy department. They can be reached at **1-800-685-5209.**

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## Submitting a Request

The most efficient path of submitting a request (for one of the medications on the list above) is via Navinet. A form has been added to Navinet with autofill functionality to make completing and submitting your online request easier and faster.

If you have questions regarding the authorization process and how to submit authorizations electronically, please contact your Highmark Wholecare Provider Relations Representative directly or Highmark Wholecare Pharmacy Services using the phone number **1-800-685-5209.**

## Additional Information

- Any decision to deny a prior authorization is made by a licensed pharmacist based on individual member needs, characteristics of the local delivery system, and established clinical criteria.
- Authorization does not guarantee payment of claims. Medications listed above will be reimbursed by Highmark Wholecare only if it is medically necessary, a covered service, and provided to an eligible member.
- Non-covered benefits will not be paid unless special circumstances exists. Always review member benefits to determine covered and non-covered services.
- Current provider notifications can be viewed at: https://highmarkwholecare.com/Provider/Medicare-Resources/Medicare-Provider-Updates

# Medications to Require Medical Prior Authorization

## Medicaid

A subset of medications require a pre-service authorization for medications obtained through the medical benefit. This prior authorization process applies to all Highmark Wholecare Medicaid members. Medical necessity criteria for each medication listed below is outlined in the specific medication policies available online. To access Highmark Wholecare medical policies, please visit: https://www.highmarkwholecare.com/provider/medicaid-resources/medication-policies. Failure to obtain authorization will result in a claim denial.

### Procedure Codes Requiring Authorization

| Authorization Required as of 02/21/2022 | | | |
|---|---|---|---|
| **Procedure Code** | **Description** | **Procedure Code** | **Description** |
| **J0257** | alpha 1 proteinase inhibitor (Glassia) | **J3590*** | lonapegsomatropin-tcgd (Skytrofa) |
| **J3590*** | efgartigimod alfa-fcab (Vyvgar) | **J2840** | sebelipase alfa (Kanuma) |
| **J1931** | laronidase (Aldurazyme) | **J3490*** | vosoritide (Voxzogo) |
| **Authorization Required as of 04/01/2022** | | | |
| **Procedure Code** | **Description** | **Procedure Code** | **Description** |
| **J3590*** | alirocumab (Praluent) | **J3590*** | tezepelumba-ekko (Tezpire) |
| **J3590*** | evolocumab (Repatha) | **J3590*** | tralokinumab-ldrm (Adbry) |
| **J3490*** | inclisiran (Leqvio) | | |

*This medications will be reviewed under the miscellaneous/not otherwise specified procedure codes until a permanent code is assigned.

In addition to these codes, it is expected that the statewide preferred drug list (PDL) will be referenced to ensure a preferred drug is prescribed and administered when possible. Effective January 1, 2020, all MA covered drugs designated as non-preferred are covered and available to MA beneficiaries when found to be medically necessary through the prior authorization process. This requirement applies to both the medical benefit and pharmacy benefit. You may access the complete statewide PDL now through the Department of Human Services website at: https://papdl.com/preferred-drug-list. The searchable PDL and prior authorization guidelines are also located on the Highmark Wholecare, Medicaid website at https://highmarkwholecare.com/Medicaid.

**What if the medication is not on this list?**

This list is intended to function as a notification and is subject to change. Please refer to the Provider Portal Lookup Tool (accessed via Navinet: https://navinet.navimedix.com) to determine if a drug/HCPCS code requires authorization and to submit authorization requests.

*continued >*

### Would you prefer to get the medication through pharmacy?

This change only applies to the medical benefit. If the medication is to be billed at the pharmacy/specialty pharmacy, you will continue to submit requests to the Highmark Wholecare pharmacy department. They can be reached at **1-800-392-1147.**

### Submitting a Request

The most efficient path of submitting a request (for one of the medications on the list above) is via Navinet. A form has been added to Navinet with autofill functionality to make completing and submitting your online request easier and faster.

If you have questions regarding the authorization process and how to submit authorizations electronically, please contact your Highmark Wholecare Provider Relations Representative directly or Highmark Wholecare Pharmacy Services using the phone number **1-800-392-1147.**

### Additional Information

- Any decision to deny a prior authorization is made by a Medical Director based on individual member needs, characteristics of the local delivery system, and established clinical criteria.
- Authorization does not guarantee payment of claims. Medications listed above will be reimbursed by Highmark Wholecare only if it is medically necessary, a covered service, and provided to an eligible member.
- Non-covered benefits will not be paid unless special circumstances exists. Always review member benefits to determine covered and non-covered services.
- Current and previous provider notifications can be viewed at: https://highmarkwholecare.com/Provider/Medicaid-Resources/Medicaid-Provider-Updates

# Medicare Parts A and B Cost Sharing

All members enrolled in Highmark Wholecare Medicare Assured® Diamond and Highmark Wholecare Medicare Assured Ruby also have Medicaid (Medical Assistance) or receive some assistance from the State.

Some members will be eligible for Medicaid coverage to pay for cost sharing (deductibles, copayments and coinsurance). They may also have coverage for Medicaid covered services, depending on their level of Medicaid eligibility.

As a reminder, Highmark Wholecare's dually eligible Medicare Assured members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for the costsharing.

Providers further agree that upon payment from Highmark Wholecare under Highmark Wholecare's Medicare Assured line of business, providers will accept Highmark Wholecare's Medicare Assured plan payment as payment in full; or bill the appropriate State source. Please make sure to follow Medicaid coverage and claims processing guidelines. Balance billing a dual eligible for deductible, coinsurance and copayments is prohibited by federal law.

Highmark Wholecare and its practitioner network are also prohibited from excluding or denying benefits to or otherwise discriminating against any eligible and qualified individual regardless of race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency or age.

Highmark Wholecare Medicaid and Medicare Assured members have certain rights and responsibilities as members of Highmark Wholecare. To detail those rights and responsibilities in full, Highmark Wholecare maintains a Members' Rights and Responsibilities Statement which is reviewed and revised annually.

The Member Rights and Responsibilities Statement can be located in either the Member Handbook for Medicaid members, or the Evidence of Coverage for Medicare Assured members. The Member Rights and Responsibilities Statement is also available for review online at **HighmarkWholecare.com**.

Providers are also encouraged to contact Highmark Wholecare if you have questions about this Provider Update or need additional Highmark Wholecare Medicare Assured member specific information.

Highmark Wholecare's Medicare Assured Provider Services Department can be reached at one of the following numbers:

**Medicare Assured**
**1-800-685-5209**

**Medicaid**
**1-800-392-1147**

# Notice of Practice/Practitioner Changes

## Medicaid and Medicare

One of the many benefits to the Highmark Wholecare member is improved access to medical care through Highmark Wholecare's contracted provider network. Highmark Wholecare strives to provide the most accurate and up-to-date information in our provider directory to allow our members unhindered access to network providers.

To ensure our members have up-to-date and accurate information about Highmark Wholecare's network providers, it is imperative that providers notify Highmark Wholecare of any of the following:

- Address changes;
- Phone & fax number changes;
- Changes of hours of operation;
- Primary Care Practice (PCP) panel status changes (Open, Closed & Existing Only);
- Practitioner participation status (additions & terminations) and;
- Mergers and acquisitions.

Providers who experience such changes must provide Highmark Wholecare a written notice at least 60 days in advance of the change by completing the Highmark Wholecare Practice/ Provider Change Request Form, or practices/ practitioners may submit notice on your practice letterhead.

### Please submit change requests via fax or mail.

**Fax:** 1-855-451-6680

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

As a friendly reminder for Federally Qualified Health Centers and Rural Health Clinics, please report any of the changes listed on this page using the Roster Template which is located on the Highmark Wholecare website under: Provider-Provider Resources- FQHC/RHC Resources.

As a reminder, the PA Department of Human Services (DHS) requires all providers to have current NPI information. It is critical that providers revalidate their information on a regular basis. If providers do not enroll/revalidate their information with DHS, no payments will be made.

## Encounters Submissions

In order to effectively and efficiently manage a member's health services, encounter submissions must be comprehensive and accurately coded. As a reminder, all Highmark Wholecare providers are contractually required to submit encounters for all member visits regardless of expected payment.

## Please help us improve the Highmark Wholecare member experience by completing the 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 requested is strictly voluntary and the information you provide will not be used for any adverse contracting, credentialing actions or discriminatory purposes.

**The Cultural Competency Data e-form is located on the Highmark Wholecare website in the Cultural Toolkit Resource Guide at the link below:**

https://www.HighmarkWholecare.com/provider/provider-resources/cultural-toolkit

**You can also download a copy of the Cultural Competency Data Form from the link below:**

https://www.HighmarkWholecare.com/Portals/8/provider_forms/CulturalCompetencyDataForm.pdf

# Coding Corner: Pregnancy Coding – Normal vs Complicated

Diagnoses related to pregnancy can be found in Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00 – O09A) of the ICD-10-CM Manual. These codes should be reported on the maternal claim only. Codes for the newborn claim may be found in Chapter 16: Certain Originating in the Perinatal Period (P00 – P96).

Codes from Chapter 15 should always be sequenced in the principal or first-listed position on the claim. Supervision of High-Risk Pregnancy (Category O09) should always be first listed. It is not appropriate to use "routine" diagnoses with these codes. Secondary codes may be listed, however, the principal diagnosis should correspond to the principal complication that necessitated the encounter. Multiple complications may be listed in any sequence.

**Code examples:**

- **O09.02** – Supervision of pregnancy with history of infertility, second trimester
- **O09.521** – Supervision of elderly multigravida, first trimester
- **O09.72** – Supervision of high-risk pregnancy due to social problems, second trimester

The majority of the codes in Chapter 15 have a final character indicating the trimester of pregnancy. Exceptions to this would be if a condition only occurs in a certain trimester. "Unspecified trimester" should rarely be used, and only in circumstances when documentation is insufficient and it is not possible to obtain clarification.

**Code examples**

- **O26.851** – Spotting complicating pregnancy, **first trimester**
- **O26.852** – Spotting complicating pregnancy, **second trimester**
- **O26.853** – Spotting complicating pregnancy, **third trimester**
- **O26.859** – Spotting complicating pregnancy, **unspecified**

*continued >*

Visits for routine pregnancies, with no complications present, should be coded from Category Z34. This category has an Excludes 1 notation stating these codes should never be reported with diagnoses from Chapter 15. Likewise, Chapter 15 has an Excludes 1 notation for normal pregnancy diagnoses from Category Z34.

**Code examples:**

- **Z34.01** – Encounter for supervision of normal first pregnancy, first trimester
- **Z34.82** – Encounter for supervision of other normal pregnancy, second trimester
- **Z34.93** – Encounter for supervision of normal pregnancy, unspecified, third trimester

Use a code from Category Z3A to indicate the weeks of gestation of the pregnancy. These codes should be used on the maternal claim only and should never be coded as the primary diagnosis. This category has a "Code First" notation in the ICD Manual that instructs to list complications of pregnancy first.

**Code examples**

- **Z3A.13** – 13 weeks gestation of pregnancy
- **Z3A.20** – 20 weeks gestation of pregnancy
- **Z3A.41** – 41 weeks gestation of pregnancy

**References**

ICD-10-CM Official Guidelines for Coding and Reporting, FY 2022, Section I.C.15, Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00 – O9A) 2022 ICD-10-CM Guidelines (cdc.gov)

World Health Organization (WHO), International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

# Model of Care

## As a Special Needs Plan (SNP), Highmark Wholecare is required by the Centers for Medicare and Medicaid services (CMS) to administer a Model of Care (MOC) 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 (MAO) to provide coordinated care for special needs individuals.

Our MOC has goals and objectives for targeted populations, a specialized provider network, utilizes nationally-recognized clinical practice guidelines, conducts health risk assessments to identify the special needs of beneficiaries, and adds services for the most vulnerable beneficiaries including, but not limited to those beneficiaries who are frail, disabled, or near the end-of-life.

The SNP MOC includes 4 main sections: Description of the SNP population, Care Coordination, SNP Provider Network, and MOC Quality Measurement and Performance. This training will focus on the SNP Provider Network section and what Highmark Wholecare expects from its providers.

**Provider Network** - The SNP Provider Network is a network of health care providers who are contracted to provide health care services to SNP beneficiaries. SNPs must ensure that their MOC identifies, fully describes, and implements the following elements for their SNP Provider Networks.

**There are 3 sections in this MOC section:**

1. Specialized Expertise
2. Use of Clinical Practice Guidelines and Care Transition Protocols
3. Model of Care Training

Within the above elements, Highmark Wholecare's expectations of providers are explained in detail. The below is a summary of our provider network composition and responsibilities.

1. Highmark Wholecare expects all network practicing providers to utilize established clinical practice guidelines when providing care to members to ensure the right care is being provided at the right time, as well as to reduce interpractitioner variation in diagnosis and treatment.
2. We encourage providers to follow the adopted clinical practice guidelines, but allow the practitioners to execute treatment plans based on a member's medical needs and wishes. When appropriate, behavioral health guidelines are followed using government clinical criteria.
3. During a care transition, it is expected that the transferring facility will provide, within one business day, discharge summary and care plan information to the receiving facility or if returning home, to the PCP and member.

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4. We expect all network practicing providers to receive MOC training annually. If there is a trend of contiued non-attestation, those providers found to be non-compliant with the MOC may be targeted for potential clinical interventions. For those non-compliant providers, individual results such as, but not limited, utilization patterns, hospital admissions, readmissions and HEDIS performance outcomes may be reviewed.
5. We conduct medical record reviews at least annually. Reviews are conducted on PCPs, Speciality Care Practitioners, Behavioral Health Practitioners and ancillary providers. Results from the review are communicated to providers and include opportunities for improvement and education.
6. We provide multiple ways for providers to receive information about updates. Provider manuals and newsletters are located on the provider portal and website. Newsletters are updated quarterly and provide information regarding any new clinical programs or updates that would affect the provider's communication with their direct pod or ICT. Provider manuals are updated annually, and reviewed during annual trainings. Current manuals are always available on the provider section of our website.
7. Our provider directories are continuously updated regarding taking new members, how long waiting lists are to see specialists, and other barriers that may affect the member.

**Common MOC Terms and Definitions:**

Members may ask you about the following information that is routinely discussed with their case manager.

- **Health Risk Assessment (HRA) Survey:** We use the HRA to provide each Medicare member a means to assess their heath status and interest in making changes to improve their health promoting behaviors. The HRA is also used by the case managers to provide an initial assessment of risk that can generate automatic referrals for complex case management and then at least annually with continuous enrollment. Newly enrolled members identified for the Centers for Medicare and Medicaid Services (CMS) monthly enrollment file are requested to complete an initial HRA within 90 days of their effective date of enrollment as required by CMS MOC standards. Each member with a year of continuous enrollment is requested to complete a reassessment HRA within 12 months of the last documented HRA or the member's enrollment date, if there is no completed HRA.

- **Individualized Care Plan (ICP):** Highmark Wholecare's goal is to have Care Plans be as individualized as possible to include:
  - Services specifically tailored to the member's needs, including but not limited to specific interventions designed to meet needs as identified by the member or caregiver in the HRA
  - Member personal health care preferences
  - Member self-management goals and objectives, determined via participation with the member and/or caregiver
    - Identification of:
      - Goals and measurable objectives
      - Whether they have been "met" or "not met"
      - Appropriate alternative actions if "not met"

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- **Interdisciplinary Care Team (ICT):** Member care routinely demands a combination of efforts from physicians of various disciplines, registered nurses and licensed social workers, as well as other pertinent skilled health care professionals and paraprofessionals. Comprehensive patient care planning involves coordination, collaboration, and communication between this ICT and the member.

As a provider, you are an important part of the member's ICT. The ICT team members come together to conduct a clinical analysis of the member's identified level of risk, needs, and barriers to care. Once an Individualized Care Plan (ICP) is developed, it is then reviewed with the member. The member's agreement to work in partnership with his/her care manager, towards achievement of established goals, is obtained.

The ICT analyzes, modifies, updates, and discusses new ICP information with the member and providers, as appropriate.

Highmark Wholecare's Provider Portal should be utilized frequently for any communication regarding members, their individual ICP or ICT. Additionally, please watch for the Provider Dashboard, which is sent to providers on a quarterly basis. This dashboard identifies members' current care gaps and chronic disease conditions.

### Other Important Information About Our MOC

We recognize that a member's care needs are varied and are subject to change. Policies and procedures have been put in place to allow members to review the level of care management needed for their particular circumstance.

Members may be referred for Care Management in a variety of ways, including referral by Provider, Highmark Wholecare employee, or self-referral by member.

**Providers: 1-800-685-5209**

**Member Self Referral: 1-800-685-5209**

Highmark Wholecare employees may refer via the established internal process.

Oversight of the Model of Care Plan is managed by the Quality Improvement, Regulatory and Accreditation departments. Specific questions with regard to the MOC should be addressed with your Highmark Wholecare Provider Representative.

**Action Required:**

Please go to **https://www.HighmarkWholecare.com/provider/moc-response** to submit an attestation indicating that you have completed and comprehend this Model of Care training.

# Member Rights and Responsibilities

Highmark Wholecare Medicaid and Medicare Assured members have certain rights and responsibilities as members of Highmark Wholecare. To detail those rights and responsibilities in full, Highmark Wholecare maintains a Members' Rights and Responsibilities statement, which is reviewed and revised annually.

Highmark Wholecare and its practitioner network do not and are prohibited from excluding or denying benefits to, or otherwise discriminating against, any eligible and qualified individual regardless of race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency or age. Some additional rights and responsibilities include:

**Members have the right to:**

- Receive information from Highmark Wholecare in a way that works for them (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
- Be treated with fairness and respect at all times.
- Receive timely access to covered services and drugs.
- Have personal health information kept private and confidential.
- Receive information from Highmark Wholecare about the Plan, its network of providers, covered services, and rights.
- Have Highmark Wholecare support their right to make decisions about their care.
- Issue a complaint and/or to ask Highmark Wholecare to reconsider decisions the Plan has made by filing an appeal.
- Receive a written explanation in the event a medical service or Part D drug is not covered, or if their coverage is restricted in some way.
- Know their treatment options and risks in a way they can understand.
- Participate in decisions about their healthcare, including the right to refuse any recommended treatment.
- Be given instructions about what is to be done if they are not able to make decisions for themselves. This includes maintaining an advance directive, such as a living will or a power of attorney for healthcare.
- Contact the Department of Health and Human Services' Office for Civil Rights if they believe their rights have not been respected due to their race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency or age.

**Members are responsible for:**

- Getting familiar with their covered services and the rules they must follow to get these covered services.
- Informing Highmark Wholecare if they have any other health insurance coverage or prescription drug coverage in addition to our plan.
- Telling their doctor and other healthcare providers that they are enrolled in our plan.
- Helping their doctors and other practitioners care for them by providing needed information, asking questions, and following through on their care.
- Respecting the rights of other patients and to act in a way that helps the smooth running of their doctor's office, hospitals, and other offices.
- Paying Medicare premiums, and any applicable copayments or late enrollment penalties.
- Notifying Highmark Wholecare if they move, regardless of whether it is outside or inside of Highmark Wholecare's service area.

The Member Rights and Responsibilities statement can be located in either the Member Handbook for Medicaid members, or the Evidence of Coverage for Medicare Assured members. The Member Rights and Responsibilities Statement is also available for review online at HighmarkWholecare.com. For more information, please call Provider Services at:

Medicaid: 1-800-392-1147
Medicare Assured: 1-800-685-5209

# Reportable Conditions

Highmark Wholecare providers are contractually required to adhere to policies that are a part of the Highmark Wholecare Quality Improvement Program. This includes, but is not limited to, reporting certain diseases, infections, or conditions as determined by 28 Pa. Code §27.21 et seq. of the Pennsylvania Code, Subchapter B. REPORTING OF DISEASES, INFECTIONS AND CONDITIONS.

Highmark Wholecare Reportable Conditions policy has been established to detail this requirement as well as the methods by which practitioners will be notified of its necessity.

To request additional information or to obtain a copy of the Reportable Conditions policy, please contact Highmark Wholecare's Provider Services Department at either 1-800-685-5209 (Medicare Providers) or 1-800-392-1147 (Medicaid Providers). The regulations, which include the complete list of reportable conditions and timeframes for reporting, can be found via the State of Pennsylvania Code website at www.pacode.com.

# Fraud, Waste, and Abuse

## Beware of Fraudulent Impersonators

Ongoing alerts are being issued from Federal agencies that highlight current extortion schemes. Fraudsters are impersonating Medical Licensing Boards and other Regulatory agencies and have been contacting provider offices, soliciting providers for personal and financial information. At times these bad actors will advise the provider that they are part of a criminal investigation and may request the provider pay a "fee" in thousands of dollars relating to the investigation. The "fee" that is paid is then sent overseas.

### Be Prepared and Protect Your Information by Following These Tips:

- Verify the individual alleging to be from law enforcement or a medical board. Find contact information on the official website or physical office location of the agency requesting your information. Always confirm the requesting individual is employed by the agency they are representing.
- Be cautious with all payment requests relating to criminal investigations from any alleged law enforcement officer, especially any law enforcement officer located within the United States that is requesting that money be sent overseas.
- Do not provide personal identifying information (PII) such as Social Security Numbers, dates of birth, financial information, etc. in response to any suspicious email, text message, or call.
- Share this alert information with colleagues to help prevent others from becoming victims of fraud.

**More information can be found at the following resources:**

Scams and Safety — FBI

Submit a Hotline Complaint | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services (hhs.gov)

Scams Complaint – PA Office of Attorney General

# Important Phone Numbers

## Provider Services

Monday – Friday, 8 a.m.– 4:30 p.m.

Medicare: **1-800-685-5209/TTY 711**
Medicaid: **1-800-392-1147/TTY 711**

## Member Programs Services

Monday - Friday, 8:30 a.m.- 4:30 p.m.

- Care Management
- Maternity/MOM Matters®
- Asthma/ Cardiac/ COPD/ Diabetes
- Preventive Health Services/ EPSDT/Outreach

Medicare: **1-800-685-5209/TTY 711**
Medicaid: **1-800-392-1147/TTY 711**

## ALC (Transportation Services)

Monday – Friday, 8 a.m.– 5 p.m.
Saturday 9 a.m.– 1 p.m.

**1-877-797-0339/TTY 711**

*For Medicare Assured member only*

## Fraud and Abuse and Compliance Hotline

**1-844-718-6400**

**Voicemail during off hours:** The call will be returned the next business day. Please do not leave multiple voicemail messages or call for the same authorization request on the same day.

## Hours of Operation:

Please remember – 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. Highmark Wholecare's procedure manual regarding provider availability and accessibility.