HIGHMARK WHOLECARE

FEBRUARY 2022

# Provider Newsletter

## An Update for Highmark Wholecare Providers and Clinicians

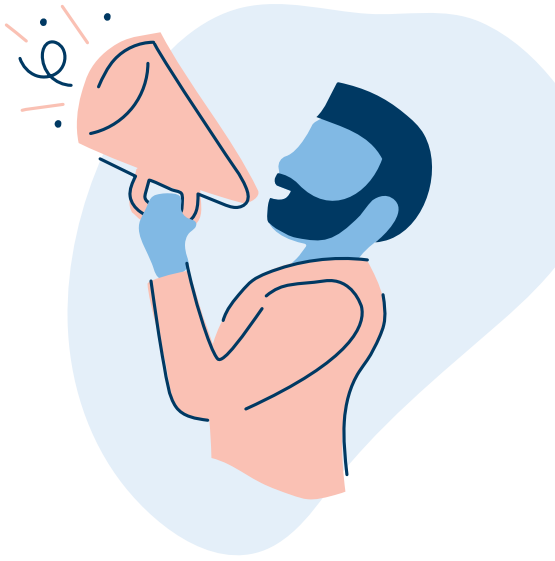
IN THIS ISSUE



# Special Announcement

## Gateway Health Plans are now Highmark Wholecare!

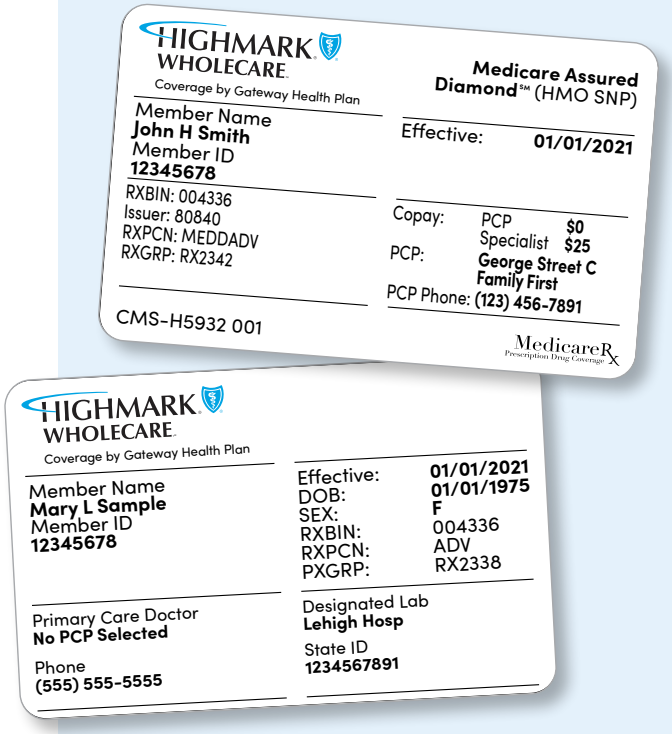
As of January 1, 2022, our Medicaid and D-SNP plans have a new name – Highmark Wholecare.



Our plans will continue to offer the same great benefits, just under new names. Members will continue to receive our same commitment to care and whole person approach to their health.

## What does this mean for your patients?

- The only change that has occurred is the plan name – the new health plans are called Highmark Wholecare.
- Member benefits will be provided according to their plan and will continue to be among the strongest in the industry.
- Members will still have access to the same doctors and specialists who are part of our network.
- Members received their new ID card in late December. See sample ID cards to the right.




## What does this mean for you and your office team?

- Same claim submission process electronically or via mail
- Same authorization process
- Same user-friendly Navinet experience
- Same Provider Services phone numbers

### Medicaid Claims Processing

P.O. Box 173
Sidney, NE 69162

### Medicare Claims Processing

P.O. Box 93
Sidney, NE 69162

## For more information, contact Provider Services using the below numbers:

### Medicare D-SNP

**1-800-685-5209**
Monday through Friday,
8:00 a.m. to 5:00 p.m.

### Medicaid

**1-800-392-1147**
Monday through Friday,
8:00 a.m. to 5:00 p.m.

# Medicare Provider Manual Notification of Availability

The January Edition of the 2022 Medicare Provider Manual is now available on the Highmark Wholecare provider website.

**You can access the manual here.**

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# 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.**

## Provider Relations Claims Education Webinars Coming Soon!

**Provider Claims Education Webinars will be held monthly.**

**Topics to include:**

- SDOH Coding
- Top Denials
- NCCI Edits
- Modifiers
- And more

The webinars will provide opportunities to learn and stay current with billing and coding regulations.

# New Provider Reimbursement Policy

We are excited to announce that Highmark Wholecare has implemented the new H0049 prescreen billing code for SBIRT screenings effective January 1, 2022. This ensures that providers are reimbursed for individuals who screen negative for substance use disorders.

Highmark Wholecare's medical claims payment and prior-authorization policy is a reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern and/or otherwise influence medical necessity decisions.

| Reimbursement Policy | |
|---|---|
| **Policy Name:** | Screening, Brief Intervention, and Referral to Treatment (SBIRT) Reimbursement |
| Policy number: | PI-011 |
| Original Effective Date: | January 1, 2022 |
| Annual Approval Date: | |
| Products: | Pennsylvania HealthChoices Medical Assistance/All Medicare Products |

Highmark Wholecare provides coverage for medically necessary Screening, Brief Intervention, and Referral to Treatment (SBIRT) treatment in a physical health care setting. Providers are asked to perform this evaluation in order to determine if a potential Substance Use Disorder exists and then as appropriate, referral to treatment.

**Highmark Wholecare is paying the Screening for Alcohol and/or Drug Screening in addition to the office visit as outlined in this policy.**

**Procedure Codes**

The screening for SBIRT shall be billed using procedural code H0049 for a reimbursement of $3.00 per screening up to twice per year. This would be paid in addition to the office visit and will be reimbursed. If another SBIRT code is used, it will not be reimbursed.

# Mark Your Calendar!

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

| Topic | Date/Time | Key Speaker |
|---|---|---|
| 2022 Highmark Wholecare Practitioner Excellence (HWPE) Program Overview | Wednesday, April 6, 2022 12-1 p.m. | **Kerri Bentz**<br>Director, Provider Quality<br>Highmark Wholecare |
| Introduction to Screening, Brief Intervention, and Referral to Treatment (SBIRT)<br><br>**Behavioral Health Webinar** | Wednesday, May 4, 2022 12-1 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 |
| **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.

To receive CME/CEU credit you must ***enroll*** at: https://www.surveymonkey.com/r/NZJYDF7. You only need to enroll **ONCE** through SurveyMonkey to be eligible to receive CME credit for attendance at live webinar activities and to receive quarterly WebEx login information. Further instructions for claiming CME 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).

# 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 above changes 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: Modifier KX Usage

Modifier KX is a multipurpose, informational modifier that can be used for several purposes. This modifier is used to specify documentation requirements are met for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS items). Additionally, the modifier can be used to indicate the service supports a gender/procedure conflict.

### DMEPOS

Modifier KX is required on all DMEPOS claims. This modifier indicates that the supplier has ensured coverage criteria for the DMEPOS billed is met and the documentation does exist to support the medical necessity of the item. Documentation must be available upon request.

### GENDER

Modifier KX should be used to identify services for members with transgender, ambiguous genitalia, and hermaphrodite members. Providers should use this modifier to bill for procedures codes that are gender specific. The modifier will act as an alert that there is no billing error and will allow the claim to continue with normal processing. Institutional providers should bill along with condition code 45 (Ambiguous Gender Category).

**Sources**

Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, 240 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf

Noridian, Modifier KX https://med.noridianmedicare.com/web/jadme/topics/modifiers/kx

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# 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, a 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

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- Identification of:
  - Goals and measurable objectives
  - Whether they have been "met" or "not met"
  - Appropriate alternative actions if "not met"

- **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.

# 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) | | |

*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.**

### 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) |

*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.

**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.**

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

## 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

# Fraud, Waste, and Abuse

## Beware of COVID-19 Fraud Schemes

Ongoing alerts are being issued from Federal agencies that highlight COVID-19 schemes which increase the exposure for potential Fraud, Waste, and Abuse (FWA). This includes adapting previously known FWA schemes into COVID-19 modified operations, as well as the creation of new FWA schemes. Federal agencies have provided warnings using the following examples:

- Be mindful of how COVID-19 materials are being disposed of such as syringes, vials, vial container boxes, and vaccination record cards. Improper disposal of these items could be used by bad actors to commit fraud.
- Testing and treatment for COVID-19 may create opportunities to conduct and bill services that are not medically necessary. Do not bill for potentially unnecessary services. For example, billing for non-evidence-based treatments.
- Use correct coding and billing practices. Do not bill for services that have not been rendered, such as adding billing for an e-visit check-in call and then elevating that service to a regular E&M visit.
- Do not provide personal or patient information such as Social Security Numbers or credit card information to a Pop-Up COVID-19 testing site and/or tester who states they are able to offer free testing.

**More information can be found at the following OIG and HFPP resources:**

Fraud Alert: COVID-19 Scams | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services (hhs.gov)

https://www.cms.gov/files/document/hfpp-white-paper-healthcare-fraud-waste-and-abuse-context-covid-19.pdf

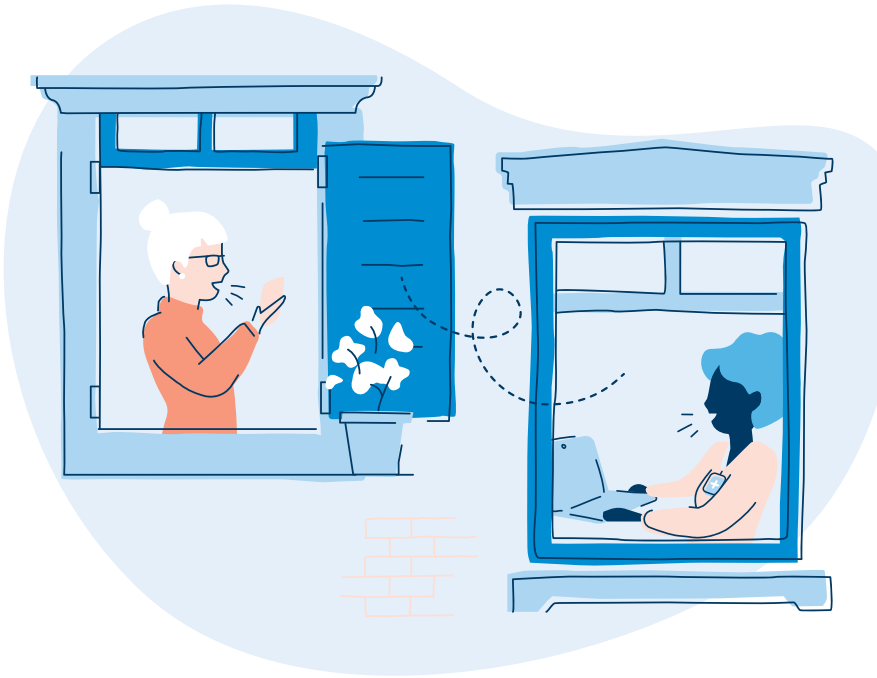
Officials Struggle to Regulate Pop-Up Covid Testing Sites — And Warn Patients to Beware | Kaiser Health News (khn.org)

# 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

**1-800-685-5235**

**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.