HIGHMARK WHOLECARE

JANUARY 2022

Provider Newsletter

An Update for Highmark Wholecare Providers and Clinicians

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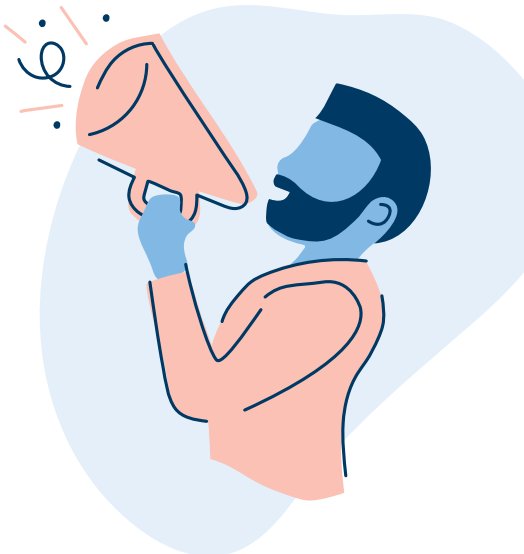
Special Announcement

Gateway Health Plans are now Highmark Wholecare!

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



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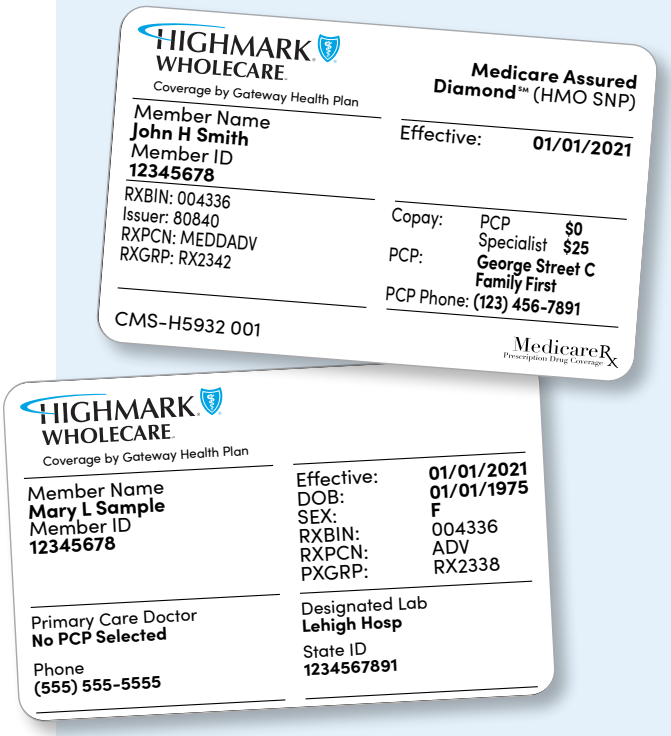
Our plans will continue to offer the same great benefits, just under new names. Members will continue to receive our same commitment to care and whole person approach to their health.

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 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.

The SOAP Note Campaign submission deadline for 2021 dates of service is January 31, 2022.

To be eligible for payment, the SOAP Note must include the following information:

- One office visit for a physical exam must occur by December 31, 2021.
- Documentation of the exam completed via submission of a SOAP Note in Inovalon's ePASS® portal.
- All mandatory fields on the SOAP Note must be completed.
- The provider signature date must be the actual date the SOAP note is signed.
- A claim must be submitted for the exam and the date of service on the claim must match the exam date on the completed SOAP note.

QUESTIONS?

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

Highmark Wholecare will be performing medical record reviews for HEDIS Measurement Data Year 2021.

The HEDIS medical record collection/reviews will begin in January 2022. We appreciate your cooperation with this matter and are happy to assist you with fulfilling this request in any way possible. Some options for submitting medical records include via secure fax, secure messaging through NaviNet or an on-site review. A member of our retrieval staff will be contacting you to discuss your preference.

Please recall that, as outlined in your Participating Provider Agreement with Highmark Wholecare, you are required to respond to requests for medical records in support of all state and regulatory-required activities, including the annual HEDIS medical record review project, within the requested timeframe and at no cost to Highmark Wholecare and its members.

If you have questions or concerns about any portion of this process, please email **ClinicalQualitySupportTeam@HighmarkWholecare.com** or call **412-420-6428**. We appreciate your assistance in this effort and thank you for collaborating with us to improve the health of individuals, families and communities.

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: National Correct Coding Initiative (NCCI) Edits

The Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B and Medicaid claims.

Types of NCCI Edits

The NCCI contains two types of edits:

1. NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect coding combinations are reported.
2. Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

NCCI PTP Edits

PTP Edits consist of Column I and Column II codes. Column II codes are often the component of a more comprehensive Column I code. These codes are typically considered to be mutually exclusive and should not be

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reported together. However, there are some instances when codes may be billed together when an appropriate modifier is used. The NCCI PTP table will have the following indicators:

Modifier Indicator	Definition
0 (Not Allowed)	There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider.
1 (Allowed)	The modifiers associated with NCCI are allowed with this PTP code pair when appropriate.
9 (Not Applicable)	This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.

Modifiers that will bypass a Column I/Column II edit – "1 Allowed"

When clinically appropriate, the following modifiers may be used with PTP pairs with status indicator "1 – Allowed". Documentation in the medical record must support use of the following modifiers:

Anatomic Modifiers:

- E1 –E4 – Anatomic modifiers of the eyelid
- FA, F1 – F9 – Anatomic modifiers of the fingers
- TA, T1-T9 – Anatomic modifiers of the toes
- LT – Left side of the body
- RT – Right side of the body
- LC, LD, LM, RC, RI – Anatomic modifiers of the coronary arteries

Global Surgery Modifiers:

- 24 – Unrelated E&M service by the same physician during a postoperative period
- 25 – Significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service
- 57 – Decision for surgery
- 58 – Staged or related procedure or service by the same physician during the postoperative period
- 78 – Unplanned return to the operating/ procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
- 79 – Unrelated procedure or service by the same physician during the postoperative period

Other Modifiers:

- 27 – Multiple outpatient E&M encounters on the same date
- 59 – Distinct procedural service
- 91 – Repeat clinical diagnostic laboratory test

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- **XE*** – Separate encounter, a service that is distinct because it occurred during a separate encounter
- **XS*** – Separate structure, a service that is distinct because it was performed on a separate organ/structure
- **XP*** – Separate practitioner, a service that is distinct because it was performed by a different practitioner
- **XU*** – Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

** XE, XS, XP, XU are to be used for Medicare claims in place of the 59 modifier*

Further instructions on the NCCI PTP tables are found in CMS' "How to Use the Medicare National Correct Coding Initiative (NCCI) Tools" (ICN 901346, June 2020): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf

The NCCI PTP tables for Medicare include PTP for Practitioner and Outpatient claims and can be found at this link: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/PTP-Coding-Edits

The NCCI PTP tables for Medicaid include PTP for Practitioner, Outpatient, and Durable Medical Equipment (DME) claims and can be found at this link: https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative/medicaid-ncci-edit-files/index.html

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.

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 Availability 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.

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.*

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Specialist (Specialties): **Dermatology** **Orthopedic Surgery** **Otolaryngology** **Ped Allergy & Immunology** **Ped Endocrinology** **Ped Gastroenterology** **Ped General Surgery** **Ped Hematology** **Ped Infectious Disease** **Ped Nephrology** **Ped Neurology** **Ped Oncology** **Ped Pulmonology** **Ped Rehab Medicine** **Ped Rheumatology** **Ped Urology**	**Routine Care**	**Within 15 business days from the date of referral** *Practice sites will be able to schedule an appointment within 15 business days from the date of referral.*
PCP, Specialist **For all other specialist types not listed above.**	**Routine Care**	**Within 10 business days** *Practice sites will be able to schedule an appointment within 10 business day of being contacted by member.*
PCP	**Health Assessment/ General Physical Examinations and First Examinations**	**Within 3 weeks of enrollment** *Practice sites will be able to schedule an appointment within 3 weeks.*
PCP	**After-hours Care** *Practice sites will be accessible to members 24 hours a day/7 days a week.*	**After hours calls from members with an emergent or urgent medical condition will be handled within one hour of the member contacting the practice site.** *Instructions provided by the practice will include one or more of the following options:* **Call 911 or go to nearest emergency room* **Direct patient to go to an urgent care center* **See patient same day* **See patient at another location same day* **Important reminders:** *Our members must be instructed to call 911 or go directly to the emergency room in the case of a true emergency.* *Answering services or machines must instruct members on how to reach an on call physician. The member must receive a phone call within one hour with instructions.*

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PCPs who treat members under the age of twenty-one (21)	**New Member EPSDT screens**	**Within forty-five (45) days from the effective date of enrollment,** *unless the child is already under the care of a PCP and is current with screen and immunizations*
PCP, Specialist	**First time appointment with Persons known to be HIV positive or diagnosed with AIDS**	**Within seven (7) days from the effective date of enrollment,** *unless a member is already in active care with a PCP or Specialist*
PCP, Specialist	**First time appointment with member who is a Supplemental Security Income (SSI) or SSI related consumer**	**Within forty-five (45) days from the effective date of enrollment,** *unless a member is already in active care with a PCP or Specialist*
PCPs and Specialists who provide prenatal care	**First (1st) trimester visit**	**Within ten (10) business days of the member being identified as being pregnant**
PCPs and Specialists who provide prenatal care	**Second (2nd) trimester visit**	**Within five (5) business days of the member being identified as being pregnant**
PCPs and Specialists who provide prenatal care	**Third (3rd) trimester visit**	**Within four (4) business days of the member being identified as being pregnant**
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**
PCP, Specialist	**Missed Appointment**	**Conduct outreach whenever a member misses an appointment and document in the medical record.** *Practice sites must make three (3) attempts to reach the member with at least one attempt to include a phone call.*
PCP, Specialist	**Wait Time in the Waiting Room and exam room for routine care appointment**	**Average office wait time is no more than thirty (30) minutes or at any time no more than up to (1) hour** *when the physician encounters an unanticipated urgent medical condition visit or is treating a member with a difficult medical condition need.*

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Medicare 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, Behavioral Health (BH)	**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.*
Behavioral Health (BH)	**Non-Life Threatening Emergency Care**	**Within 6 hours** *Practice sites will be able to schedule an appointment within 6 hours of being contacted by member or will direct member to go to the emergency room or a behavioral health crisis unit.*
PCP, Specialist	**Urgent Care**	**Within 24 hours** *Practice sites will be able to schedule an appointment within 24 hours of being contacted by member.*
Behavioral Health (BH)		**Within 48 hours** *Behavioral health practice sites will be able to schedule an appointment within 48 hours of being contacted by member.*
PCP	**Non-Urgent, but in need of medical attention**	**Within 1 week** *Practice sites will be able to schedule an appointment within 1 week of being contacted by member.*
PCP, Specialist	**Routine or Preventative Care**	**Within 30 days** *Practice sites will be able to schedule an appointment within 30 days of being contacted by member.*
Behavioral Health (BH)	**Initial Routine Care (BH)**	**Within 10 business days (BH)**
	Follow up Routine Care (BH)	**Within 15 business days (BH)**

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PCP, Specialist	**Wait Time in the Waiting Room and exam room for routine care appointment**	**Average office wait time is no more than thirty (30) minutes or at any time no more than up to (1) hour** *when the physician encounters an unanticipated urgent medical condition visit or is treating a member with a difficult medical condition need.*
PCP	**After-Hours Care** *Practice sites will be accessible to members 24 hours a day/ 7 days a week.*	**After hours calls from members with an emergent or urgent medical condition will be handled within one hour of the member contacting the practice site.** *Instructions provided by the practice will include one or more of the following options:* **Call 911 or go to nearest emergency room* **Direct patient to go to an urgent care center* **See patient same day* **See patient at another location same day* **Important reminders:** *Our members must be instructed to call 911 or go directly to the emergency room in the case of a true emergency.* *Answering services or machines must instruct members on how to reach an on call physician. The member must receive a phone call within one hour with instructions.*

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. An MAO must design separate MOCs to meet the special needs of the target population for each SNP it offers, meaning that we have multiple MOCs.

We have an MOC that has goals and objectives for the targeted populations, a specialized provider network, uses 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, have disabilities 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 healthcare 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 reponsiblities.

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 practioners to execute treatment plans based on a member's medical needs and wishes. When appropriate, behavioral health guidelines are followed using government guidelines.

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3. During a care transition, it is expected that the transfering 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.
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 given out during annual trainings. The manuals are also availabe on the provider section of our website.
7. We expect provider directories to be continuously updated regarding taking new members, how long waiting lists are for 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 assesment of risk that can generate automatic referrals for complex case management and then at least annually with continous enrollment. Newly enrolled members identified for the Centers for Medicare and Medicaid Services (CMS) monthly enrollment file are requested to complete an intital HRA within 90 days of their effective date of enrollment as required by CMS MOC standards. Each member with a year of continous 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, when possible

- Member personal health care preferences, when possible

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- Member self-management goals and objectives, determined via participation with the member and/or caregiver, when possible
- Identification of:
  - -Goals and measureable 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, and an individiualized care plan (ICP) is developed and 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 ICP analyzes, modifies, upates, and discusses new ICP information with the members and providers, as appropriate.

Highmark Wholecare's Provider Portal should be utilized frequently for any communication regardinng members, or their 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 complete the provider acknowledgement of MOC training. Click agree to acknowledge you have reviewed and understand the MOC information and submit your attestation.

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Mark Your Calendar!

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

Topic	Date/Time	Key Speaker
Cultural Competency for Behavioral Health and Substance Use Professionals **Behavioral Health Webinar**	Wednesday, February 2, 2022 12–1 p.m.	**Jennifer Conti, LSW** Senior Clinical Quality Manager **Shamly Austin PhD, MHA** Data Scientist 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).

2022 Fraud, Waste, and Abuse (FWA) Community Training

January 19, 2022 | 10:30 a.m. – 12:00 p.m.

Speakers:

Jennifer Sneer
Supervisory Special Agent
Pennsylvania Office of
Attorney General

David P. Shallcross
Director of Senior Protection Unit
Education and Outreach Specialist
Office of Public Engagement
Pennsylvania Office of
Attorney General

Meeting Information:

In collaboration with the Pennsylvania Attorney General's Office, the Highmark Wholecare Fraud, Waste, and Abuse Unit (FWA) will be hosting a live community training webinar on **January 19, 2022**. The topics of discussion will be an overview of Care-Dependent Abuse & Neglect and Elder Scams & Exploitation. All are welcome to take advantage of this learning opportunity. Please use the registration link below to reserve your seat today.

Registration Link:
https://hmkcares.com/fraudeducation.

New Authorization Requirements for Sleep, Radiation Oncology and Cardiology

Highmark Wholecare has partnered with specialty benefit management company HealthHelp to provide collaborative authorization programs for Medicaid and Medicare adult members (18 years and older) that improve quality and reduce the cost of care by providing expert peer consultation and the latest evidence-based medical criteria for outpatient Sleep, Radiation Oncology and Cardiology procedures. Effective dates for this new authorization program are listed below.

- **1/31/2022** HealthHelp system open for providers to submit requests
- **2/14/2022** Start of claims processing requiring a prior authorization

Highmark Wholecare is committed to ensuring that you receive information about process changes that may affect your office operations. You are receiving this notification because you have members in your practice who may be affected by this change. This new program is designed to improve health care, patient safety, utilization, and cost through the application of clinical criteria.

The HealthHelp authorization process for this program will involve collecting relevant clinical information from the ordering/treating physician's office, reviewing this information alongside current evidence-based guidelines, and if necessary, providing physician-to-physician consultation on treatment and/or test appropriateness and patient safety. If the requested service does not meet evidence-based guidelines, a HealthHelp specialist will have a provider-to-provider conversation with the requesting physician to consider alternatives.

Implementation of this collaborative and educational authorization program will ensure that Highmark Wholecare members receive clinically appropriate and medically necessary services.

For the effective dates listed on the left, all requests for the following tests and procedures will go through HealthHelp, except services rendered for emergency level of care:

- **Sleep:** Sleep Testing, PAP Therapy, Oral Appliances
- **Radiation Oncology:** 2D3D, Brachytherapy, Stereotactic, Proton Beam, IMRT, IGRT
- **Cardiology:** Peripheral Revascularization, Cardiac Devices, Ablation/EPS

A list of procedure codes requiring authorization can be found at **www.healthhelp.com/HighmarkWholecare**.

continued >

How to request and obtain an authorization:

Step 1: Requesting Authorization

Ordering providers can request an authorization using one of the following methods:

- **Web**: www.healthhelp.com/HighmarkWholecare
- **Fax**: 877-637-6934
- **Fax Expedited**: 877-637-6935
- **Phone**: 888-265-0072

*The most efficient method for obtaining an authorization number is through the web. Please contact HealthHelp program support at **1-800-546-7092** if you need assistance with setting up web access.*

Step 2: Receiving Authorization

- **Web**: If the ordering provider chooses to submit the request through the web, authorization will be available online to print.
- **Fax**: If the ordering provider chooses to submit the request via fax, a faxed copy of the authorization will be submitted to the ordering provider's office at the fax number provided by the provider's office on the form.
- **Phone**: If an ordering provider chooses to submit their request via the phone, a HealthHelp client service representative will provide a verbal authorization over the phone for an approved request. A faxed confirmation will also be faxed to the ordering provider's office.

HealthHelp representatives are available Monday–Friday, from 8 a.m. to 6 p.m. Eastern Standard Time. After-hours requests may be submitted by fax or via web portal.

For a medically necessary request that requires **immediate handling** due to an unforeseen illness, injury, or condition affecting the patient, a **phone call** to **888-265-0072 is the fastest way to process your urgent request**. If you choose to fax it, please ensure that legible contact information is included for the ordering provider/designee. It should also state how the provider may be reached within the next 24 hours, in case additional clinical information is needed to complete the review.

All urgent requests will be handled within the appropriate state-specific or federal program–mandated expedited time frames. HealthHelp strives to complete all expedited requests for review within 24 hours of the request's receipt, unless a more stringent time frame is mandated by specific state regulations.

Educational materials and program implementation information will be posted in the coming weeks.

For questions or information regarding general policy and procedures, contact a Highmark Wholecare provider representative at: Medicaid **1-800-392-1147**, Medicare Assured **1-800-685-5209**. Representatives are available 8 a.m. – 4:30 p.m., Monday - Friday. TTY users call 711.

Thank you.

continued >

HealthHelp Webinars

Cardiology, Radiation Oncology and Sleep Studies

Learn more about HealthHelp's authorization process by signing up for a system demo hosted by HealthHelp.

The webinar will give a system demonstration with user experience insight on how to appropriately enter procedure requests, along with additional program information such as the Highmark Wholecare procedure code list, support tools and HealthHelp contact information.

Register for your preferred session using the link shown below. For additional questions contact HealthHelp Program Support: **RCSupport@HealthHelp.com**, **1-800-546-7092**.

Highmark Wholecare – Getting Started with Cardiology Authorizations (LIVE sessions)
https://attendee.gotowebinar.com/register/1190641766263019020
Tuesday | January 18, 2022 | 12 p.m. - 1 p.m. EST

https://attendee.gotowebinar.com/register/7771608087477358606
Thursday | January 20, 2022 | 8 a.m. - 9 a.m. EST

Highmark Wholecare – Getting Started with Radiation Oncology Authorizations (LIVE sessions)
https://attendee.gotowebinar.com/register/5018434270815576846
Thursday | January 20, 2022 | 12 p.m. - 1 p.m. EST

https://attendee.gotowebinar.com/register/4558235878033202446
Friday | January 28, 2022 | 8 a.m. - 9 a.m. EST

Highmark Wholecare – Getting Started with Sleep Authorizations (LIVE sessions)
https://attendee.gotowebinar.com/register/983255181567177743
Friday | January 21, 2022 | 12 p.m. - 1 p.m. EST

https://attendee.gotowebinar.com/register/1290411451367768591
Thursday | January 27, 2022 | 8 a.m. - 9 a.m. EST

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

Important Phone Numbers

Provider Services

Monday – Friday, 8 a.m.– 4:30 p.m.

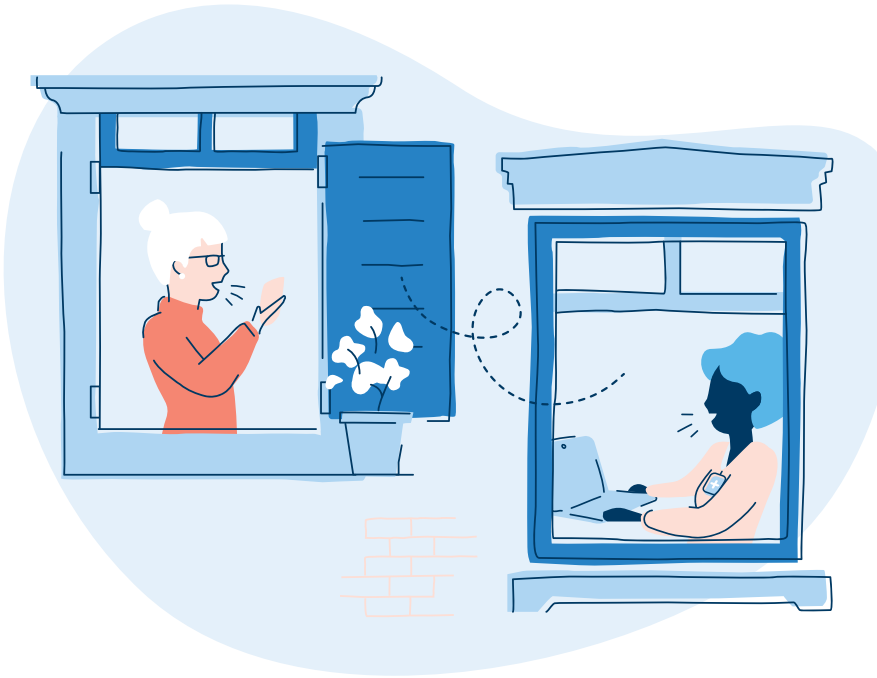
Medicare: 1-800-685-5209/TTY 711
Medicaid: 1-800-392-1147/TTY 711

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.