HIGHMARK WHOLECARE

JULY 2022

Provider Newsletter

An Update for Highmark Wholecare Providers and Clinicians

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Important Reminder

You are receiving this notice because one or more of your providers are still showing as not yet revalidated per the Department of Human Services (DHS) May revalidation file. If you have already received confirmation from DHS that your revalidation application has been received, please disregard this notice.

If you have a provider within your practice or a practice location that is no longer valid, please notify Highmark Wholecare as soon as possible by submitting a Practice/Provider Change Form.

The Practice/Provider Change Form is located on our website under Provider Medicaid Forms and Reference Materials. (www.highmarkwholecare.com)

Please submit change requests via fax or mail.

Fax: 1-855-451-6680

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

As a reminder, failure to revalidate will result in the following: Providers rendering services to Medicaid Members will NOT get paid if they are not enrolled/revalidated.
Payments cannot be made retroactively.

Please visit https://provider.enrollment.dpw.state.pa.us/Home to check the status of your application or apply online today.

Mark your calendar!

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

Topic	Date/Time	Key Speaker
Youth Tobacco Cessation	Wednesday, August 3 noon–1 p.m.	**Hannah Cristofano** Youth Services Coordinator Adagio Health
To Register for the August Learning & Earning webinar, please send a word or excel document to ProviderEngagementTeam@HighmarkWholecare.com and provide the following information: Credential options- MD/DO; CRNP/PA; MSN/BSN/RN/LPN; Behavioral Health Provider; Certified Coder; Other		
Opioid Overdose Reversal: Naloxone (NARCAN®)	Wednesday, October 5 noon–1 p.m.	**Rachel Shuster, BSN, RN, CARN, CAAP** Addiction Specialist Highmark Wholecare
Registration link for October webinar will be available soon.		
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 create a free account at CME.AHN.org. After creating your account, you will need to register for the webinars you wish to attend, using the using the instructions above. You only need to create the account one time to be eligible to receive CME credit for attendance at all live Learning and Earning webinar activities as well as accessing your transcripts. 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 General Hospital is approved by the American Psychological Association to offer continuing education for psychologists. Allegheny General Hospital maintains responsibility for the 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).

Reimbursement Policy

Policy Name: Screening, Brief Intervention, and Referral to Treatment (SBIRT) Reimbursement

Policy Number: PI-011

Original Effective Date: January 1, 2022

Products: Pennsylvania HealthChoices Medical Assistance
All Medicare Products

Disclaimer

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.

Policy Scope

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

Highmark Wholecare will pay for 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 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.

Policy History

Date	Activity
01/01/2022	Initial effective date Policy Sources updated

July is Black, Indigenous, Persons of Color (BIPOC) Mental Health Month!

In June of 2008, named after American author, journalist, teacher, and mental health advocate, Bebe Moore Campbell, who championed mental health accessibility for the Black community, July has come to be a month for reflecting on the needs of underserved groups in BIPOC communities.

BIPOC Barriers to Receiving Treatment

Racism and discrimination – Systemic racism and discrimination practices have had a long and profound history within our country and the mental health care industry is not exempt.

Stigma against mental health – BIPOC communities tend to view mental illness as a personal failing or weakness rather than a real, diagnosable and treatable condition.

Limited access to care – Lack of insurance or access to funds for mental wellness is a huge barrier for many people in the BIPOC community. According to the American Psychiatric Association, only one-third of Black adults who need mental health treatment actually receive it, despite being more likely to report symptoms of emotional distress like hopelessness than White Americans.

Providers don't reflect the communities they serve – The vast majority of mental health treatment providers in the United States are White.

Lack of culturally competent treatment – Cultural competency is a core component of the "whole person" approach to behavioral health care. By implementing some type of cultural competency training, which aims to helps providers understand the importance of culture, cultural identity, and intersectionality they can provide the best level of care possible.

Highmark Wholecare remains committed to recognizing the racioethnic disparities that affect our communities while working towards innovative solutions. For resources to support our members in the BIPOC communities please visit BIPOC Mental Health Month | Mental Health America (mhanational.org).

Medical Records: Provider Signature Requirement

Highmark Wholecare may request copies of medical records from a provider in connection with claims overpayment or for cases involving alleged Fraud, Waste, and Abuse ("FWA"). We require providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations, and Medicare manuals as well as other applicable professional associations and advisory agencies.

Medical records MUST contain timely provider signatures as outlined in the Highmark Wholecare Provider Manuals. Providers should follow these guidelines for basic medical record signature requirements:

- Providers should follow the medical record standards as defined in Medicaid contracts, Medicare manuals, provider contracts, provider manuals, and all Federal and State regulations.
- Providers must have medical records that include all Medicaid and/or Medicare requirements; records should be individual and kept secure.
- All amendments or changes to documentation must be signed and dated by the clinician amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.
- Medical Record documentation must have enough information to show the date a provider ordered or performed the service(s). If entries are dated immediately above or below an undated entry, a medical review may reasonably assume the entry date in question.

Resources:

MedicareManual.pdf (highmarkwholecare.com)

MedicaidManual.pdf (highmarkwholecare.com)

MLN905364 – Complying with Medicare Signature Requirements (cms.gov)

28 Pa. Code Chapter 563. Medical Records (pacodeandbulletin.gov)

Medicare Program Integrity Manual (cms.gov)

2022 Annual Accessibility Audit

Your practice site may soon receive a call from Highmark Wholecare's contracted NCQA certified vendor, SPH Analytics. SPH is conducting an appointment access audit and an after-hours access audit to assess your site's compliance with Highmark Wholecare's standards related to timely access to care for our members. In preparation for the upcoming audit, please review the "Accessibility to Care Standards" on our provider website at https://highmarkwholecare.com/Provider/Provider-Resources/Accessibility-to-Care-Standards

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T1019 – Electronic Visit Verification - Personal Care Services

On May 1, 2022, Highmark Wholecare transitioned personal care services (PCS) to procedure code T1019. Highmark Wholecare received notification from the Pennsylvania Department of Human Services (DHS) that there was an issue with the implementation of the T1019 PCS procedure code for electronic visit verification (EVV). Subsequently, DHS requested that all Physical Health Managed Care Organizations (including Highmark Wholecare) pay the T1019 PCS procedure code in good faith.

As a result, Highmark Wholecare will pay providers for the T1019 PCS procedure code by claims submitted directly to Highmark Wholecare. Providers are reminded that claims for the T1019 PCS procedure code must still meet the EVV requirements which include:

1. Supporting authorizations must be approved by Highmark Wholecare for T1019 PCS procedure code and be available in Netsmart
2. Services must be recorded with EVV in Netsmart
3. Claims must be submitted by encounter to match the EVV in Netsmart

Information related to the T1019 is available in the May 2022 Highmark Wholecare Provider Newsletter on pages 18-19, available at https://highmarkwholecare.com/Portals/8/provider_newsletter/May22.pdf

General claim submission information is available on the Highmark Wholecare Medicaid Provider Website, available at https://highmarkwholecare.com/Provider/Medicaid-Resources/Medicaid-Provider-Forms-and-Reference-Materials

Maternal Depression Screening

Maternal Depression Screening has been included in the Pennsylvania EPSDT Periodicity Schedule since August 2017. The screening should be completed as part of the 1-, 2, 4, and 6-month visits. Postpartum depression occurs in up to 20% of women who have recently given birth and it is estimated that fewer than half of the cases are recognized. Additionally, studies have found that PPD is more common among women who are disadvantaged and is highly prevalent in low-income black mothers. Since as many as 40% of women do not attend their postpartum care visit, this screening is particularly important for screening new mothers for postpartum depression.

Children with mothers who have postpartum depression are more likely to have:

- Poor infant self-regulation
- Insecure attachment
- Developmental Delays
- ADHD
- Anxiety disorder
- Conduct Disorder

Screening for postpartum depression increases opportunities for identification and intervention for both mother and baby. Physicians are encouraged to be familiar with their community resources available for mothers who may test positive on a maternal depression screening.

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Billing:

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

- **1 month to 11 month EPSDT visit CPT Code is 99381 or 99391**

The CPT code for Maternal Depression Screening is **96161.**

Modifier 52 should be appended when someone other than the child's mother brings the child to the visit and the screening is unable to be completed.

For resources on Validated Screening Tools for Maternal Depression Screening, please refer to the Highmark Wholecare Website under Provider Resources: EPSDT.

https://www.postpartum.net/professionals/

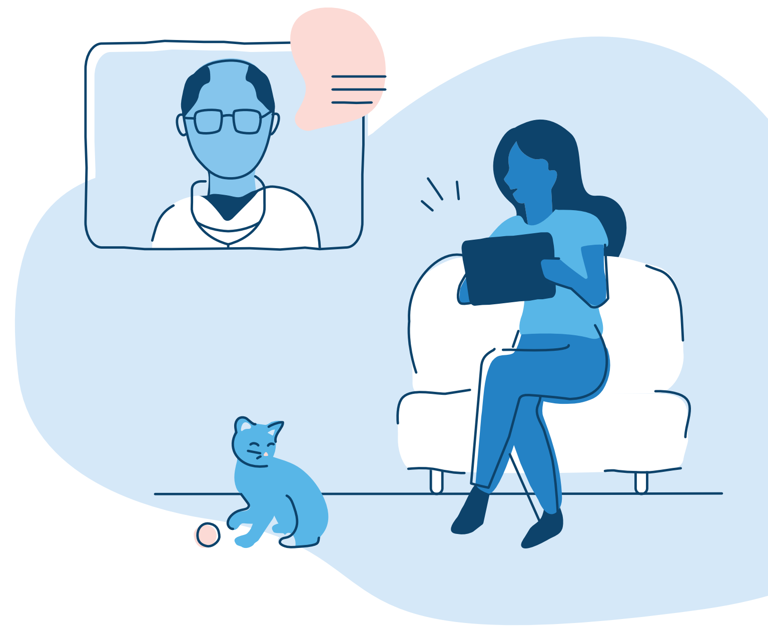
In Allegheny County, a child with a primary care giver who is at risk for depression or other mental health diagnosis, can receive At Risk Tracking Services through Early Intervention. This referral can be made by calling the Alliance at 412-885-6000.

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.

COVID-19 Therapeutic Agents Resource

The Pennsylvania Department of Health has developed a provider friendly "COVID-19 Therapeutics Handbook" (https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/PA%20DOH%20COVID-19%20Therapeutics%20Handbook.pdf) to assist providers with key information on the availability of COVID-19 therapeutic agents, accessing these therapies, and operationalizing the distribution. The handbook can also be found within the DOH website titled "COVID-19 Treatment & Preventive Options" (https://www.health.pa.gov/topics/disease/coronavirus/Pages/Prevention-Treatment.aspx).

The handbook includes the following sections:

1. Overview of therapeutic products
2. Enrolling in DOH therapeutics network
3. Setting up an account on the Health Partner Ordering Portal (HPOP)
4. Using Direct Ordering Request (DOR) to request therapeutics
5. Reporting therapeutics
6. Stocking therapeutics
7. Additional resources

Please use this tool at your convenience to assist you with your continued efforts in combatting COVID-19 in your patients.

Blood Lead Level Screening

On October 28, 2021, the CDC changed the Blood Lead Level Reference Value from 5 µg/dL to 3.5 µg/dL.

This means that providers should provide interventions to members at the new level of 3.5 µg/dL immediately.

The Pennsylvania EPSDT Periodicity Schedule requires that all children under age seven (7) receive a minimum of two blood lead tests as part of EPSDT well child screenings, regardless of the individual child's risk factors. The tests for lead should be conducted during the nine (9) to eleven (11) month periodicity and the second test for lead should be conducted during the twenty-four (24) months periodicity. Please refer to the Pennsylvania EPSDT Periodicity Schedule for further testing clarification.

Additionally, any child aged 24 months and above who are either new to Medicaid or with no previous documented lead testing, should receive a blood lead test.

The CDC requires the use of a blood lead test when screening children for lead poisoning. The CDC recommends that a provider use venous blood samples for the blood lead screening, when feasible as elevated initial blood lead results obtained on capillary screening specimens are presumptive and should be confirmed using a venous specimen.

A blood lead screening should be done by a blood lead measurement of either a venous or capillary (finger stick) blood specimen. If screening is collected via capillary and is ≥3.5 µg/dL, a second venous blood lead measurement should be taken to confirm the results.

The PCP can use either their designated laboratory or Kirby Health Center Laboratory to process blood lead samples. If you choose to send blood lead samples to Kirby Health Center, you must use the sample Lead Analysis ID form. The form is only for Highmark Wholecare members, and when completing the form please verify the member's eligibility. All demographic information, including the practitioner name, member name, member address, member date of birth, Highmark Wholecare member identification number, and the date of service must be completed for the sample to be processed.

Blood Lead Levels of ≥3.5 µg/dL Require Retesting

Children should be retested when lead levels are ≥3.5 µg/dL. CDC guidelines should be followed for retesting when children have elevated blood lead levels. This calls for confirmatory testing as well as retesting any time a child has a blood lead level of ≥3.5 µg/dL.

https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm

Environmental Lead Investigation (ELI)

In accordance with guidance from the CDC, a provider should manage the condition of a child who is found to have an elevated blood lead level that is greater than or equal to 3.5 µg/dL.

Management should include follow-up blood tests and consideration of possible sources of contamination including housing, food, and toys. Locating the source of lead contamination is an integral part of the management and treatment of lead toxicity.

A provider should submit an order to an enrolled ELI provider for a comprehensive ELI for a Highmark Wholecare member under twenty-one years of age with a blood lead screening result of at least 3.5 µg /dL and where there is suspicion of environmental influences for lead contamination. The order for a comprehensive ELI must include a primary diagnosis code of toxic effect of lead and its components.

Highmark Wholecare will cover ELI for members under twenty-one (21) years of age who are enrolled with Highmark Wholecare within the following parameters:

- Services must be provided by a participating Highmark Wholecare ELI provider.
- Member must have a venous BLL result of at least 3.5 µg /dl based on venous draw.
- Limited to one ELI per household.
- A provider order is required. No prior authorization from Highmark Wholecare is needed.

For questions regarding the EPSDT program, please contact EPSDTinfo@HighmarkWholecare.com.

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** **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 • The programs emphasize prevention and exacerbation of complications by using evidence-based guidelines and member empowerment strategies • 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**

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<table>
<tr><th>Program</th><th>Asthma</th><th>Cardiac</th><th>COPD</th><th>Diabetes</th><th>Hypertension</th><th>Healthy Weight Management</th><th>MOM Matters* (Maternal Outreach and Management)</th></tr>
<tr><td>Enrollement</td><td colspan="6">Members are identified through claims, member self-referral, or Highmark Wholecare utilization management
Provider referrals are also welcome!</td><td>Provider submission of the Obstetrical Needs Assessment Form (ONAF) helps identify high-risk women for proactive interventions</td></tr>
<tr><td>Coordination of Care</td><td colspan="7">Case managers assist you and your patients with coordination of care for specialists visits
Home health, behavioral health, DME and community referral needs are coordinated through the Highmark Wholecare Case Management department</td></tr>
<tr><td>Provider Benefits and Support</td><td colspan="7">The management of members in programs aimed at:
Decreasing inpatient and ED utilization
Increasing appropriate lab testing and medication adherence
Encouraging adherence to obtain flu and pneumonia immunizations as well as other preventative testing and procedures</td></tr>
</table>

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, our dually eligible Medicare Assured members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for the cost-sharing.

Providers further agree that upon payment from Highmark Wholecare's Medicare Assured Plans, providers will accept the 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.

Our organization 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 plan members have certain rights and responsibilities as members of our plans. To detail those rights and responsibilities in full, we maintain a Member 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 us if you have questions about this Provider Update or need additional member specific information.

Our Provider Services Department can be reached at one of the following numbers,

Monday – Friday, 8 a.m.– 4:30 p.m.:

Medicare Assured
1-800-685-5209 (TTY 711)

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

Notice of Practice/Practitioner Changes

Medicaid and Medicare

One of the many benefits available to Highmark Wholecare members 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 e-Form from the link below:

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

Coding Corner: Ambulance Transportation Services Billing Tips

Highmark Wholecare follows guidance from the Centers for Medicare and Medicaid Services and the Pennsylvania Department of Human Services in regards to modifier usage for ambulance services. Therefore, the following destination modifiers are required:

- RH – Residence to Hospital
- HR – Hospital to Residence
- HE – Hospital to Residential. Domiciliary, custodial facility (nursing home, not skilled nursing facility)
- RE – Residence to Residential. Domiciliary, custodial facility (nursing home, not skilled nursing facility)
- HN – Hospital to Skilled Nursing Facility (SNF)
- PH – Residence to Non-Hospital based dialysis facility
- JH – Non-Hospital based dialysis facility to Hospital
- JR – Non-Hospital based dialysis facility to Residence
- RG – Residence to Hospital based dialysis facility (hospital or hospital-related)
- GR – Hospital based dialysis facility (hospital or hospital-related) to Residence
- SD – Scene of accident or acute event to Diagnostic or therapeutic site other than “P” (physician) or “H” Hospital
- SH – Scene of accident or acute event to Hospital
- SI – Scene of accident or acute event to Site of transfer (for example, airport or helicopter) between types of ambulance
- IH – Site of transfer (for example, airport or helicopter) between types of ambulance to Hospital
- HH – Hospital to Hospital
- HI – Hospital to Site of transfer (for example, airport or helicopter) between types of ambulance
- NH – Skilled Nursing Facility to Hospital

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- EH – Residential, Domiciliary, custodial facility (nursing home, not skilled nursing facility) to Hospital
- RD – Residence to Diagnostic or therapeutic site other than "P" (physician) or "H" Hospital
- II – Site of transfer (for example, airport or helicopter) between types of ambulance to Site of transfer (for example, airport or helicopter) between types of ambulance
- RN – Residence to Skilled Nursing Facility (SNF)
- HD – Hospital to Diagnostic or therapeutic site other than "P" (physician) or "H" Hospital

Please note the following billing circumstances are unique to **Medicaid** claims:

- For Medicaid claims, in addition to the destination modifiers, ambulance pricing modifier **U8** must be appended to ambulance procedure codes **A0425** (Ground mileage, per statue mile) and **A0430** (Ambulance service, conventional air services, transport, fixed wing) unless A0425 is appended with pricing modifier U9.
- While place of service 41 (Ambulance – Land) and 42 (Ambulance – Air or Water) are valid for Medicare, they are not currently valid with Pennsylvania Medicaid. PA DHS instructs to bill Ambulance Transportation Services with one of the following Place of Service:
- 12 – Patient's Home
- 21 – Inpatient Hospital
- 22 – Outpatient Hospital
- 23 – Emergency Room
- 24 – Ambulatory Surgical Center (ASC)/ Hospital Short Procedure Unit (SPU)
- 32 – Nursing Facility
- 49 – Independent Clinic
- 50 – Federally Qualified Health Center
- 54 – Intermediate Care Facility/Mentally Retarded
- 55 – Residential Substance Abuse Treatment Facility
- 65 – End Stage Renal Disease Treatment Facility
- 72 – Rural Health Clinic
- 99 – Other Unlisted Facility

Additional information may be found at the following sources:

Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 15 – Ambulance: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf

Pennsylvania Department of Human Services, CMS-1500 Claim Form Completion for PROMISe™ Ambulance Providers: https://www.dhs.pa.gov/providers/PROMISe_Guides/Documents/CMS%201500%20Billing%20Guide%20for%20PROMISe%20Ambulance%20Providers.pdf

Pennsylvania Department of Human Services, Provider Quick Tips #125, Reporting Ambulance Pick-Up/Drop-Off Point of Service: https://www.dhs.pa.gov/providers/Quick-Tips/Documents/125%20-%20Reporting%20Ambulance%20Pick-up%20Drop-Off%20Point%20of%20Service.pdf

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 to, 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"

continued >

- **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.

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.

Novillus, Inc. is a separate company which administers their Care Gap Management Application for Highmark Wholecare.

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

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

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association ("Highmark Wholecare").