HIGHMARK WHOLECARE

MARCH 2022

Provider Newsletter

An Update for Highmark Wholecare Providers and Clinicians

IN THIS ISSUE

Gateway Health Plans are now Highmark Wholecare!

Same great benefits for your patients who are members. Same dedicated team to support your needs.

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 noon–1 p.m.	**Kerri Bentz** Director, Provider Quality Highmark Wholecare
Introduction to Screening, Brief Intervention, and Referral to Treatment (SBIRT) **Behavioral Health Webinar**	Wednesday, May 4, 2022 noon–1 p.m.	**Alec Howard, MPH** Research Specialist, Program Evaluation and Research Unit (PERU) University of Pittsburgh **Shannen Lyons, LCSW CAADC** Addiction Specialist 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).

HWPE Incentive Program Launch!

2022 Highmark Wholecare Practitioner Excellence (HWPE) Incentive Program Go-Live Date: March 1, 2022

At Highmark Wholecare, we value the important role practitioners play in serving our members. Highmark Wholecare would like to welcome you to the Highmark Wholecare Practitioner Excellence Program. This program supports Highmark Wholecare's mission to improve the health and wellness of the individuals and the communities we serve by providing access to integrated, superior healthcare.

Highmark Wholecare has developed a Highmark Wholecare Practitioner Excellence (HWPE) Incentive Program Guide. Visit the website to review the guide: Practitioner Excellence Program **(HighmarkWholecare.com).**

The provider must acknowledge that they are opting-in to the program. Please contact your Clinical Transformation Consultant directly or email us at: **ProviderEngagementTeam@HighmarkWholecare.com** for information on the opt-in process. By opting-in, the provider also acknowledges the intent to participate in the program. Providers will be enrolled in the Medicaid Maternity Quality program, Medicaid and Medicare HWPE program based on provider specialty, eligibility criteria outlined in the HWPE manual and network participation.

Mark Your Calendar: 2022 HWPE Overview Webinar Series

Register Today!

Highmark Wholecare's Provider Engagement Team has set up multiple one-hour webinars to provide an overview of the 2022 Highmark Wholecare Practitioner Excellence Program. You can register today for one or multiple of the online events by following the steps below. If none of the dates/times work, there will be additional sessions. These will continue to be offered through mid-September.

1. Select a date and time

Thursday, March 17, 2022 9 a.m. Go to: https://bit.ly/HWPE2022Overview5	Tuesday, March 29, 2022 9 a.m. Go to: https://bit.ly/HWPE2022Overview8
Tuesday, March 22, 2022 1 p.m. Go to: https://bit.ly/HWPE2022Overview6	Wednesday, April 6, 2022 12 p.m. Go to: https://bit.ly/LearningEarningHWPE2022 **Earn CME/CEUs**
Thursday, March 24, 2022 9 a.m. Go to: https://bit.ly/HWPE2022Overview7	Tuesday, April 12, 2022 1 p.m. Go to: https://bit.ly/HWPE2022Overview9a

2. Click "Register"

3. On the registration form, enter your information and then click "Submit." Once the host approves your registration, you will receive a confirmation email message with instructions on how to join the event.

Please contact your dedicated Provider Engagement representative or email us at: ProviderEngagementTeam@Highmarkwholecare.com.

Register Now!

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Billing & Reimbursement Webinar

Come learn about the benefits of billing for substance use screening and the newly-approved code.

Tuesday March 15th, 2022, noon-1 p.m.
https://pitt.zoom.us/j/99601396746

For registration questions, please contact:
Shannen Lyons, SLyons@HighmarkWholecare.com or Alec Howard, AJH178@Pitt.edu

Why should you become trained in SBIRT?

"SBIRT saves lives. The goal is to identify and effectively intervene with those who are at moderate or high risk for psychosocial or health related problems related to their substance use. It can be performed in a variety of settings and supports the emphasis on health and wellness. SBIRT is endorsed by SAMHSA, CMS, and locally, the PA Perinatal Quality Collaborative. As providers, we want to create safe spaces and opportunities for open discussions. SBIRT can be the key to starting those conversations."

Lakshmi Reddy, M.D.
Highmark Wholecare, Medical Director, Medical Management

"My name is Rebekah Hughey, MD, and I am a family medicine physician who has used SBIRT as a screening tool in my practice for many years. SBIRT is highly effective as a screening tool, and is an evidence-based approach for intervening at all stages of substance use disorders. SBIRT can be used in a variety of healthcare settings and can screen for multiple types of substance use disorders, making it extremely useful. I highly recommend this tool for use in the primary care health setting."

Rebekah Hughey, M.D.
Highmark Wholecare, Medical Director, Medical Management

2022 Provider Responsibilities and Compliance Program Training

April 25, 2022

Noon – 1 p.m.

Meeting Information:

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

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

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

Click here to register.

EPSDT – Anemia Screening

The American Academy of Pediatrics and the American Family Physician identify Anemia Screening as a Universal Screening. Iron deficiency and iron-deficiency anemia continue to be of concern.

The anemia screenings are required:

- Between nine and 12 months of age.
- The AAP also recommends risk assessment for anemia at four months of age, 15 months of age and then each periodicity thereafter.
- For females beginning at 12 years of age, do once after onset of menses.

For CDC Guidelines please refer to Morbidity and Mortality Weekly Report (MMWR) at https://www.cdc.gov/mmwr/preview/ind1998_rr.html April 3, 1998 / Vol. 47 / No. RR-04 / Pg 1-29.

Billing

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

- One month to 11 month EPSDT visit CPT Code is 99381 or 99391
- 12 month to four year EPSDT visit CPT Code is 99382 or 99392

Provider should choose most appropriate test:

- The CPT code for spun Hematocrit is 85013
- The CPT code for Hemoglobin is 85018

Modifier:

- 90 when applicable
- When laboratory procedures are performed by a party other than the treating or reporting physician, use CPT code plus modifier 90 Reference Outside Lab. This modifier is used to indicate that although the physician is reporting the performance of a laboratory test, the actual testing component was a service from laboratory.

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

References:

https://www.aafp.org/afp/2011/0301/p624.html

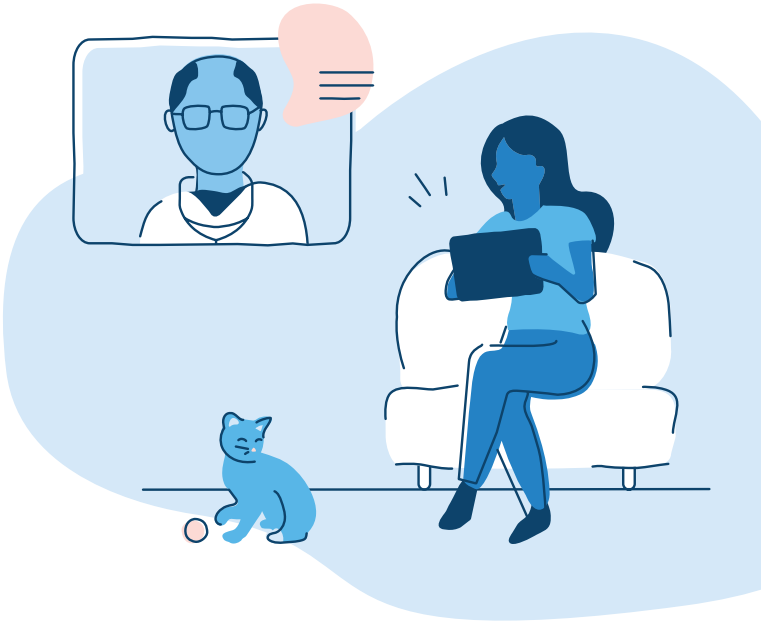
https://pediatrics.aappublications.org/content/126/5/1040.full

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

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

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

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



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

Change in Blood Lead Reference Value

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

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

The recommendations have been updated to the following:

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

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

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

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

Highmark Wholecare Lifestyle Management Programs

Balancing Lifestyle for Maximum Health and Wellness

Program	Asthma	Cardiac	COPD	Diabetes	Hypertension	Healthy Weight Management	MOM Matters* (Maternal Outreach and Management)
Eligibility	Any member with a diagnosis of asthma	Any adult member with the following diagnosis: AMI, atrial fibrillation, CHF, heart failure diagnosis, IVD, MI or stroke	Any adult member with a diagnosis of COPD	Any adult member with a diagnosis of Type 1 or Type 2 diabetes	Any adult member with a diagnosis of hypertension	Any member with a diagnosis of overweight or obesity	All pregnant or postpartum females
Contact for Referrals	**Medicaid: 1-800-392-1147** **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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Program	Asthma	Cardiac	COPD	Diabetes	Hypertension	Healthy Weight Management	MOM Matters* (Maternal Outreach and Management)
Enrollment	• Members are identified through claims, member self-referral, or Highmark Wholecare utilization management • Provider referrals are also welcome!						**Provider submission of the Obstetrical Needs Assessment Form (ONAF) helps identify high-risk women for proactive interventions**
Coordination of Care	• Case managers assist you and your patients with coordination of care for specialists visits • Home health, behavioral health, DME and community referral needs are coordinated through the Highmark Wholecare Case Management department						
Provider Benefits and Support	• The management of members in programs aimed at: - 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						

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. **Please note the revised effective dates for this new authorization program are listed below.**

- **March 21, 2022 –** Health system open for providers to submit requests
- **April 1, 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. 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 above, 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.

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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 sent to the fax number provided on the request submission form.
- **Phone:** If an ordering provider chooses to submit their request via phone, a HealthHelp client service representative will provide a verbal authorization 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-hour 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 that urgent request. If you choose to fax the request, 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. to 4:30 p.m., Monday - Friday. TTY users call 711.

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

“Incident To” Services in the Office Setting

“Incident to” services are defined as those services that are furnished incident to physician professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home.

Qualifying "Incident To" Services

In your office, qualifying “Incident To” services must meet the following guidelines:

- Employed by the same entity
- Person supervising and person performing the service must be employed by the same entity. They may be an employee, leased employee or independent contractor
- Only performed in place of service 11 (physician's office)
- Service must be integral, although incidental
- Patient must be an established patient with an established diagnosis. The follow-up services rendered must be connected to the course of treatment the physician planned at the initial service

Note: *(1)* "Incident to" billing does not apply to a new patient or a new problem for an established patient; *(2)* "Incident to” services furnished by staff of a substitute physician or regular physician are covered if furnished under the supervision of each.

Active Participation and Direct Supervision

It is expected that the physician performs subsequent services of a frequency that reflects active participation for the course of treatment of the specific problem. The physician must be present in the office suite and immediately available and able to aid and provide direction throughout the time the service is performed. The supervising physician does not have to be in the same room, but must be in the office or clinic. When a patient is seen in a group practice by a Nonphysician Practitioner (“NPP”), it is acceptable to have an NPP perform an incident to service when another physician of the group is in the suite and available for oversight as needed. Group members may provide cross coverage for each other and incident to guidelines can be met in this circumstance.

Example: A patient with chronic sinusitis will probably not have to be seen by the physician as often as a patient with congestive heart failure.

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Non-covered "Incident To" Services

- An NPP cannot see a new patient and bill the services as "incident to" the physician
- "Incident to" does not apply in the following place of service:
  - Inpatient
  - Outpatient
  - Nursing facilities
- A Clinical Social Worker can't bill for incident to services under their NPI
- Medical Nutrition Therapy and Diabetes Self-Management Training services are performed
- Immediate relatives or household members reimbursement for charges imposed by a physician or his immediate relatives or members of his household are not made. It applies to items and services furnished incident to a physician's professional services (for example, by the physician's nurse or technician) only if the physician who ordered or supervised the services has an excluded relationship to the beneficiary. The only exception is items furnished by an incorporated non-physician supplier
- Diagnostic tests benefit set forth in §1861(s)(3) of the Act is separate and distinct from the "incident to" benefit set forth in §1861(s)(2) of the Act, diagnostic tests need not meet the "incident to" requirements
- Neither ambulance services nor emergency medical technician services performed under a provider's telephone supervision
- Services which have their own statutory benefit categories

Documentation

The patient's medical records must clearly indicate the following:

- Identify the individual who rendered the service
- Document physician's presence in the office at the time of the service
- Show physician's initiation and continued involvement in treatment
- The service must be within the scope of practice of the non-physician practitioner as defined by state law
- Prove service as reasonable and necessary

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When an NPP acts as a scribe for the physician by writing notes into the medical record while the physician is personally performing the service, the medical records should clearly indicate this situation and be signed by both the scribe and the physician.

- The documentation submitted to support billing "incident to" services must clearly link the services of the NPP auxiliary staff to the services of the supervision physician.
- Evidence of the link may include:
  - Co-signature or legibly identify and credentials (i.e., MD, DO, NP, PA, etc.) of the practitioner who provided the service and the supervising physician on documentation entries
  - Documentation from other dates of service. For example the initial visit establishing the link between the two providers
  - Make sure the name and professional designation of the person rendering the service is legible in the documentation of each service

Resources:

(IOM) Publication 100-02, Chapter 15, Section 60.

https://www.novitas-solutions.com/webcenter/portal/MedicareJL/IncidentTool

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00150920

https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00004947

Medicare Parts A and B Cost Sharing

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

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

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

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

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

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

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

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

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

Medicare Assured
1-800-685-5209

Medicaid
1-800-392-1147

Notice of Practice/Practitioner Changes

Medicaid and Medicare

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

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

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

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

Please submit change requests via fax or mail.

Fax: 1-855-451-6680

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

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

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

Encounters Submissions

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

Please help us improve the Highmark Wholecare member experience by completing the Cultural Competency Data Form.

By providing your race, ethnicity, language and cultural competency training data, you allow Highmark Wholecare to better connect members to the appropriate practitioners, deliver more effective provider-patient communication and improve a patient's health, wellness and safety. The information requested is strictly voluntary and the information you provide will not be used for any adverse contracting, credentialing actions or discriminatory purposes.

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

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

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

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

Coding Corner: Correct Modifier Usage

Highmark Wholecare follows standard coding guidance when processing claims. Sources include AMA CPT Manual, CMS, Novitas Solutions, Noridian and Pennsylvania Department of Human Services. As stated in the guidance, proper modifiers must be utilized.

Some of the modifier categories required for billing include:

Anesthesia:

The following anesthesia pricing modifiers should be placed in the first modifier position:

- **AA** – Anesthesia services personally performed by the anesthesiologist
- **AD** – Supervision, more than four procedures
- **QK** – Medical direction of two, three or four concurrent anesthesia procedures
- **QX** – Qualified non-physician anesthetist with medical direction by a physician
- **QY** – Medical direction of one CRNA/AA by an anesthesiologist
- **QZ** – Certified registered nurse anesthetist (CRNA) without medical direction by a physician

Bilateral procedures:

The Centers for Medicare and Medicaid Services physician fee schedule assigns status indicators that determine if a procedure is considered bilateral. Status indicators 1 & 3 are assigned to these procedures and one of the following modifiers should be used:

- **LT** – Left side
- **RT** – Right side
- **50** – Bilateral procedure, both sides

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Chiropractic Services:

Modifier **AT** (Active Treatment) shall be used when chiropractors bill for active/corrective treatment on the following CPTs.

- **98940** - Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
- **98941** - Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
- **98942** - Chiropractic manipulative treatment (CMT); spinal, 5 regions
- **98943** - Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions

Percutaneous Coronary Interventions (PCI)

Claims for PCI must include the appropriate modifiers to identify which vessel is undergoing a specific procedure:

- **LC** - Left circumflex coronary artery
- **LD** - Left anterior descending coronary artery
- **LM** - Left main coronary artery
- **RC** - Right coronary artery
- **RI** - Ramus intermedius

Outpatient Therapies:

The following modifiers should be appended to Outpatient Therapy services:

- **GN** - Service delivered personally by a **speech-language pathologist** or under an outpatient speech-language pathology plan of care
- **GO** - Service delivered personally by an **occupational therapist** or under an outpatient occupational therapy plan of care
- **GP** - Service delivered personally by a **physical therapist** or under an outpatient physical therapy plan of care

Sources

American Medical Association, Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage

American Medical Association, Current Procedural Terminology (CPT)

Centers for Medicare and Medicaid Services, Local Coverage Article, Billing and Coding: Percutaneous Coronary Interventions (A57479) https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57479&ver=8&bc=0

Centers for Medicare and Medicaid Services, MLN Booklet: How to Use the MPFS Look-Up Tool, MLN901344, March 2021 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How_to_MPFS_Booklet_ICN901344.pdf

Centers for Medicare and Medicaid Services, Therapy Services https://www.cms.gov/Medicare/Billing/TherapyServices

Noridian, DME Jurisdiction A https://med.noridianmedicare.com/web/jadme

Novitas Solutions, Modifiers https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00003604

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

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

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

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

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

Other Important Information About Our MOC

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

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

Providers: 1-800-685-5209

Member Self Referral: 1-800-685-5209

Highmark Wholecare employees may refer via the established internal process.

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

Action Required:

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

The Highmark Wholecare Connection Centers bring Wholecare to the community.

We care for the whole person with a compassionate approach to health care that goes beyond doctors, hospitals and medicine.

We believe that everyone should have the opportunity to achieve their best health. As a result, we strive to meet our members where they are by fully engaging in the communities in which they live. That's why we created the Highmark Wholecare Connection Centers.

What are the Highmark Wholecare Connection Centers?

The Highmark Wholecare Connection Centers link our Medicaid and Medicare members to community resources through our partnerships with local community-based organizations and providers. Our centers provide personalized support services to address questions about membership and other health needs. These one-on-one consultations help simplify the often complex health care environment.

What services do the centers offer?

- Face-to-face, holistic care management and care coordination
- Member service support
- Wellness and nutrition education
- Various events and workshops
- Self-service member kiosks for basic internet searches, membership information, access to the Wholecare Resource Center and more
- Other programs are also offered, such as understanding your medication

Have your patients visit one of our two convenient locations.

EAST LIBERTY
6033 Broad Street
Pittsburgh, PA 15206
412-690-7400

PittsburghConnectionCenter
@HighmarkWholecare.com

MIDTOWN
1426 N. Third Street
Harrisburg, PA 17102
717-510-7600

HarrisburgConnectionCenter
@HighmarkWholecare.com

HighmarkWholecarePlans

HighmarkWholecare

ItsWholecare

HighmarkWholecare.com

PA Unites Against Covid

Motivational Interviewing

Have patients who are unsure about getting the Covid-19 vaccine or booster? Using this 3-step technique can help.

Sample Questions

How do you feel about getting the vaccine?

What is your understanding of the vaccine?

Would it be alright if I shared some information?

What are your thoughts about what I shared?

What might be the next step for you?

Step 1: Practice a guiding style

- Use neutral, open-ended questions to develop rapport
- Work to understand your patient's position
- Emphasize the patient's autonomy

Step 2: Listen with empathy

- Begin by asking what the patient already knows or is interested in knowing
- Ask targeted, open-ended questions to learn more
- After receiving permission, share concise bits of information
- Ask for feedback
- Stay as neutral as possible and weigh the pros and cons

Step 3: Respond mindfully and skillfully

- Summarize the discussion
- Highlight aspects that favor behavioral change
- Collaboratively decide on the patient's next step

Resources:

Boness, C.L., Nelson, M., & Douaihy, A.B. (in press). Motivational interviewing strategies for addressing COVID-19 vaccine hesitancy. Journal of the American Board of Family Medicine. Retrieved from https://osf.io/wqf6h/.

In order to assist our Primary Care Physician (PCP) offices with the management of Covid-19 vaccinations for their patients and engagement efforts with those who remain unvaccinated, Highmark Wholecare has created a monthly Covid-19 Vaccination Report that will identify the following statuses:

- Fully Vaccinated (with booster)
- Fully Vaccinated (without booster)
- Completed at least 1 dose
- Unvaccinated

This report is available through Highmark Wholecare's provider portal under "provider reports."

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.