HIGHMARK WHOLECARE

MAY 2022

Provider Newsletter

An Update for Highmark Wholecare Providers and Clinicians

IN THIS ISSUE

2022 Medicaid Provider Policy and Procedure Manual – Spring Edition

The Spring Edition of the 2022 Medicaid Provider Policy and Procedure Manual is now available on the Highmark Wholecare website via the following link: MedicaidManual.pdf (highmarkwholecare.com). The manual may also be accessed via the NaviNet Plan Central landing page.

Thank you for the care you provide Highmark Wholecare members!

Mark Your Calendar!

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

Topic	Date/Time	Key Speaker
Making Sense of Modifiers 25 and 59: When and How to Use Them	Wednesday, June 1, 2022 noon–1 p.m.	**Belinda Wilson, CPC** **Robin Richards, CPC** Fraud Consultant **Jayme Patterson, CPC** Fraud Analyst Fraud Waste & Abuse, Highmark Wholecare
^^ Registration link for June webinar - https://bit.ly/JuneWebinar_MakingSenseofModifiers ^^		
Social Determinants of Health: Connecting the Dots to Effect Positive Change	Wednesday, July 6, 2022 noon–1 p.m.	**Elizabeth Dimpfl, LSW, CCM** Senior Product Consultant Strategy & Innovation Highmark Wholecare
^^ Registration link for July webinar - https://bit.ly/JulyWebinar SocialDeterminantsofHealthConnectingtheDotsto EffectPositiveChange ^^		
Youth Tobacco Cessation	Wednesday, August 3, 2022 noon–1 p.m.	**TBD**
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, free account at CME.AHN.org. After enrolling, you will receive WebEx login information for the webinar. You only need to enroll **ONCE** to be eligible to receive CME credit for attendance at live webinar activities. Instructions for claiming CME/CEU credit will be provided at each live webinar.

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

QUESTIONS?

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

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

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

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

HWPE Incentive Program Launch

2022 Highmark Wholecare Practitioner Excellence (HWPE) Incentive Program go-live date is 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 1-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 added. These will continue to be offered through mid-September.

1. Select a date and time.

Wednesday, May 18, 2022 at 1 p.m. Go to: https://bit.ly/HWPE2022Overview13
Thursday, June 9, 2022 at 9 a.m. Go to: https://bit.ly/HWPE2022Overview14
Tuesday, June 28, 2022 at 10 a.m. Go to: https://bit.ly/HWPE2022Overview15

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.

Provider Webinars: 2022 Annual Provider Education

Highmark Wholecare invites you to attend our Annual Provider Education Webinar.

This annual training will provide current information related to topics such as:

- EPSDT
- Access/Accessibility Surveys
- Fraud, Waste and Abuse
- Model of Care
- Self-service Tools
- Cultural Competency

Please go to our website at https://highmarkwholecare.com/provider/Education-Webinars and sign up for one of our scheduled webinars taking place every Wednesday from 8:00 a.m to 8:45 a.m.

We look forward to continue working with you to provide high quality, cost effective care for patients. If you have any questions please contact your designated Provider Account Liaison or Lead Provider Relations Representative.

This training is required by DHS and CMS, your participation is encouraged.

Payment Cycle Update

Since the implementation of our new claims processing platform on October 1, 2021, Highmark Wholecare has been issuing daily payment cycles. While these daily cycles were intially planned to occur for one month, we've continued them throughout our stabilization period.

Now that our claims processing platform is stabilized, we will be returning to normal payment cycles. Effective June 1, 2022, payment cycles will begin running twice a week.

Thank you for your continued support of Highmark Wholecare.

Care Gap Management Application Launch

2022 Novillus CGMA Go-Live Date: April 1, 2022

At Highmark Wholecare, we value the important role practitioners play in serving our members. Highmark Wholecare would like to welcome you to our Care Gap Management Application (CGMA), live as of April 1, 2022. This application supports Highmark Wholecare's mission to improve the health and wellness of the individuals and the communities we serve by offering providers access to important care gap information.

The CGMA has been designed to help providers by simplifying the flow of members' care gap information between you and us. With this powerful, yet easy-to-use web application, you will be able to:

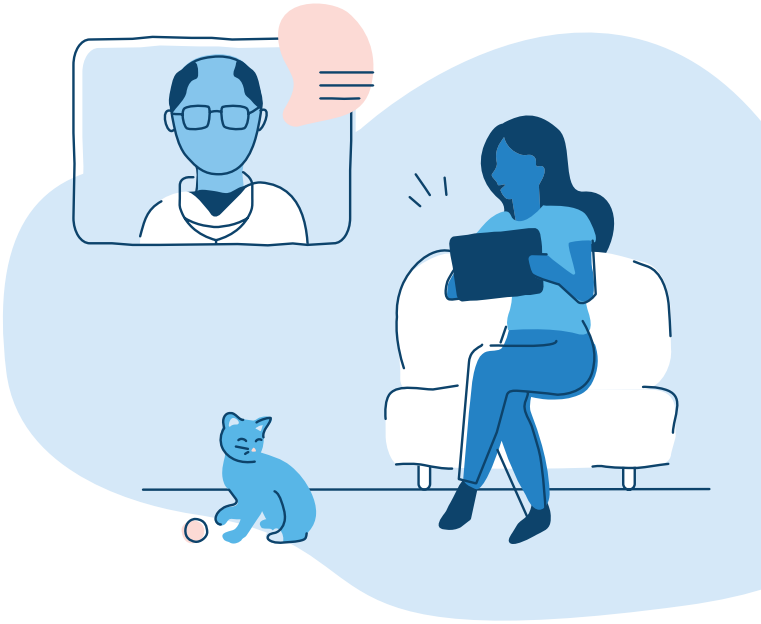
- View member care gaps
- Submit evidence for care gap closure
- View your progress toward closing member care gaps
- View your Highmark Wholecare Health member roster
- ...and much more

If you did not utilize the CGMA last year, please contact your Clinical Transformation Consultant directly or email us at: ProviderEngagementTeam@HighmarkWholecare.com for information on accessing the CGMA.

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.

May is Mental Health Awareness Month

Mental Health Awareness Month has been observed each May in the United States since 1949 and was started by the Mental Health America organization.

Did you know that one in five individuals live with a mental health disorder? However, 55% of U.S. counties do not have a single practicing psychiatrist, and 148 million people live in a designated Mental Health Professional Shortage Area. When access to mental health care is not the issue, the stigma of behavioral health challenges can make it difficult for people to disclose their struggles or to seek help.

To support mental health awareness and competency, Highmark Wholecare is proud to offer Mental Health First Aid trainings to our colleagues and provider partners to ensure the best services for our members' behavioral health needs. Mental Health First Aid is a skills-based training course that teaches participants about and how to respond to new or worsening behavioral health challenges, including mental health crises. Our clinically trained, Certified Mental Health First Aid instructors are passionate about supporting mental health within our community and would be glad to share this knowledge.

For more information or to request a training, please contact the Highmark Wholecare Behavioral Health team at BH12@HighmarkWholecare.com

For more information on Mental Health Awareness Month, please visit the National Alliance on Mental Illness (NAMI) at https://nami.org/Home

If you or someone you know is experiencing a mental health crisis, please call the NAMI Helpline at 1-800-950-NAMI (6264). Individuals can also text "NAMI" to 741741 for immediate assistance.

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**

continued >

Program	Asthma	Cardiac	COPD	Diabetes	Hypertension	Healthy Weight Management	MOM Matters* (Maternal Outreach and Management)
Enrollement	• Members are identified through claims, member self-referral, or Highmark Wholecare utilization management • 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						

Physician Portfolio Reports

The Physician Portfolio report is an opportunity for Highmark Wholecare to provide data and facilitate ongoing conversations in partnership with you, our providers, to continually improve the quality of care that is delivered to our members, your patients. The Physician Portfolio will be distributed twice yearly, in January and in July, to Highmark Wholecare's PA Medicaid PCP practices with panel sizes of 50 or more members.

The Physician Portfolio provides actionable data for multiple measures, including utilization and pharmacy, as well as preventive measures. This report compares you to your peers and identifies areas of opportunity where Highmark Wholecare and your practice can work together to ensure the delivery of the best care possible for your patients. The report will be available to PCPs with panel sizes of 50 or more via NaviNet, in Highmark Wholecare's Provider Portal.

To get more information about the Physician Portfolio Report, or the NaviNet portal, please contact your Highmark Wholecare Clinical Transformation Consultant at ProviderEngagementTeam@HighmarkWholecare.com.

Be sure to share this important information with all the physicians in your practice.

Blood Pressure Cuffs for Members

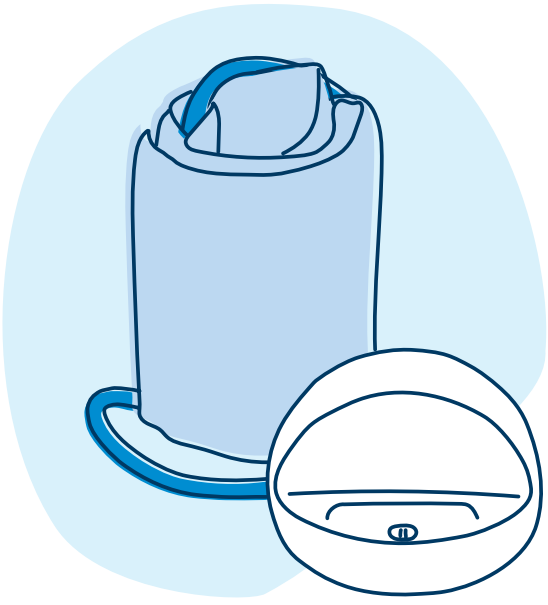
Here at Highmark Wholecare, we are committed to providing the highest quality of care and experience to our members. We also understand that addressing hypertension within your patients is a priority for every doctor, and this is why we are offering free Blood Pressure Cuffs to our members.

A doctor must write Medicaid members a script for an automated digital BP cuff monitor. Then, this script must be sent to an in-network DME Company with Highmark Wholecare, along with the diagnosis of hypertension. The DME Company will then start the process of the prior authorization. Once Highmark Wholecare approved, then the DME Company will reach out to the patient for shipping address, and sizing of the BP Cuff (A4670 Automatic Digital BP Cuff). This process will take roughly 2-3 weeks.

Medicare members will have to use their over-the-counter benefits. The BP units in the catalog will be fully covered in either Diamond or Ruby plan allowance. Please see chart below for pricing.

Blood Pressure Monitors			
Advocate Blood Pressure Monitor XL, Cuff Circumference 12.6 in. - 20.5 in.	00112	Automatic Arm Blood Pressure Monitoring System provides accurate and precise measurement giving you the reassurance you need while testing.	$36.50
Healthcare Cuff Digital Blood Pressure Monitor, Cuff Circumference, 9 in. - 17 in.	90327	Enjoy comfortable self-adjusting cuff inflation. Measurement algorithm clinically validated. Easy to read display window.	$43.50
Omron Upper Arm Blood Monitor Cuff Circumference, 9 in. - 17 in.	00358	Quick and easy home blood pressure monitor helps ensure consistent, precise readings and utilizes a simple one touch mode.	$60.00

Limit: 1 unit per this category per year.



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: Drug Administration Codes

Non-Chemotherapy vs. Chemotherapy

Highmark Wholecare follows standard coding guidance when processing claims. Sources include AMA CPT Manual, CMS, Novitas Solutions, Noridian, and Pennsylvania Department of Human Services.

When billing subcutaneous/intramuscular injections and intravenous infusions, it is important to remember that there are separate CPT codes for non-chemotherapy and chemotherapy services.

Per the AMA CPT Manual, "chemotherapy administration codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also, to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as certain monoclonal antibody agents, and other biologic response modifiers."

Infusion of chemotherapy or other drug or biologic agents is highly complex. It is considered more complex than therapeutic drug agents because of the advanced training required, special considerations for preparation, significant chance of adverse reaction, and frequent monitoring.

When coding infusions that do not require this level of complexity, please refer to the non-chemotherapy CPT codes listed below.

The AMA CPT Manual instructs to report both the specific service as well as the codes for the specific substances or drugs provided.

continued >

Subcutaneous or Intramuscular Injections	
Non-Chemotherapy	**Chemotherapy**
96372 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	**96401** - Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
** Report **96372** for non-antineoplastic, non-hormonal or hormonal therapy injections	**96402** - Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic
Intravenous Infusion	
Non-Chemotherapy	**Chemotherapy**
96365 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	**96413** - Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
96366 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	**96415** - Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)
96367 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)	**96416** - Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump
96368 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)	**96417** - Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)

Sources

American Medical Association, Current Procedural Terminology (CPT)

Prior authorization requirements for Sleep, Radiation Oncology and Cardiology began on April 1, 2022

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) for outpatient services. A list of procedure codes requiring authorization can be found at www.healthhelp.com/highmarkwholecare.

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

Web: www.healthhelp.com/highmarkwholecare

Fax: 877-637-6934

Phone: 888-265-0072

Fax Expedited: 877-637-6935

Please have the following information ready when you login or call

- Member ID and Date of Birth
- Insurance Plan
- Ordering Physician and Practice
- Procedure Code(s)
- Patient Height and Weight
- Indication
- Diagnosis Code - only 1 primary Dx
- Related Clinical Information
- Facility where the service will be performed
- Appointment Date

HealthHelp representatives are available from 8:00 a.m. to 6:00 p.m. EST, Monday through Friday. The website is available seven (7) days a week, 24 hours a day.

To check the status of a request, please go to www.healthhelp.com/webstatus. Login access to WebStatus can be requested at www.healthhelp.com/highmarkwholecare

The fastest and easiest way to submit your authorization request is online. To learn more about WebConsult, attend one of our webinars. More information at: www.healthhelp.com/highmarkwholecare

T1090 Provider Alert

Physical HealthChoices (PH) Managed Care Organizations' (MCOs) Personal Care Service (PCS) encounters have been subject to EVV visit verification since January 1, 2021. After the MCOs validate the visit information and adjudicate the claims, the subsequent encounters are sent to the PROMISe (DHS) where an electronic EVV visit validation call is completed to ensure accuracy. Currently, Highmark Wholecare requires EVV validation with the following procedure code:

S9122 – Home health aide or certified nurse assistant, providing care in the home; per hour.

Due to DHS rounding rules, there has been MCO and provider abrasion with S9122 for services less than one hour. This necessitated the need for a new procedure code (T1019) to be utilized for EVV PCS services for 15-minute units. Beginning May 1, 2022, Highmark Wholecare will be transitioning to procedure code T1019.

T1019 – Personal Care Services, per 15 Minutes, not for an inpatient or resident of a Hospital, Nursing Facility, ICF/MR or IMD, part of the individualized plan of treatment.

To accommodate for this change, Highmark Wholecare will authorize PCS with procedure code T1019 beginning with dates of service for May 1, 2022 and forward. Providers do not need to request new authorizations. However, providers will be responsible to bill with procedure code T1019 based on the authorizations.

In addition to the T1019, Highmark Wholecare is providing the following updates to PCS:

Shared Personal Care Services (PCS):

- Effective May 1, 2022, providers that are authorized for shared PCS should use the TT modifier on all EVV encounters for members that have shared PCS. Modifier TT is for individualized care provided to more than one patient in the same setting. Modifier TT must be appended to the procedure code for all members that participated in the shared PCS.

Rounding Rules:

- Effective May 1, 2022, the following rounding rules will be applied by encounter. The DHS Aggregator uses the below rounding rules to indicate a unit based on the Clock-in and Clock-out times. In addition to the below rounding rules, the Add Unit Rule is used to calculate units.

continued >

Procedure Code	Unit Type	Unit Type
T1019	15 Minutes	0 mins. – 7 mins. = 0 units 8 mins. – 22 mins. = 1 unit 23 mins. – 37 mins. = 2 units 38 mins. – 52 mins. = 3 units 53 mins. – 67 mins. = 4 units 68 mins. – 82 mins. = 5 units
S9122	Hour	0 mins. – 52 mins. = 0 units 53 mins. – 112 mins. = 1 unit 113 mins. – 172 mins. = 2 units 173 mins. – 232 mins. = 3 units 233 mins. – 292 mins. = 4 units 293 mins. – 352 mins. = 5 units

To support the updates, Highmark Wholecare and NetSmart will be hosting a provider townhall meeting on April 20, 2022. NetSmart will send the invite to provider townhall meeting in a subsequent email. Questions related to the PCS updates can be emailed to EVV@HighmarkWholecare.com.

Medical Record Requests – Provider Reminder

We may request copies of medical records from the provider in connection with claims overpayment or for cases involving alleged FWA. If we request medical records, the provider must provide copies of those records at no cost to the Plan. This includes notifying any third party who may maintain medical records of this stipulation.

In addition, the provider must provide access to any medical, financial or administrative records related to the services provided to our members within thirty (30) calendar days of our request or sooner. All required documentation must be submitted at the time of the original medical record request. Additional documentation will not be accepted after the review is complete.

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.

EPSDT Vision Screening

Vision screenings in children are important to identify structural abnormalities as well as visual acuity. Children who have ocular abnormalities or those who fail vision assessment should be referred to a pediatric ophthalmologist or appropriately trained eye care specialist.

Vision Screenings by age 4 can be completed in the primary care office by testing of visual acuity with age-appropriate eye charts. If by age 4 a child cannot be fully screened, they should be referred for further assessment by an optometrist or ophthalmologist for a full vision screening.

Vision screenings should be completed at the following ages:

- 3 years old
- 4 years old
- 5 years old
- 6 years old
- 8 years old
- 10 years old
- 12 years old
- 15 years old

Instrument-based screening may be completed to detect amblyopia, strabismus, and/or high refractive error in children who are unable or unwilling to cooperate with traditional visual acuity screening.

Billing

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

- **12 month to 4 year EPSDT visit CPT Code is 99382 or 99392**
- **5 year to 11 year EPSDT visit CPT Code is 99383 or 99393**
- **12 year to 17 year EPSDT visit CPT Code is 99384 or 99394**

Provider should choose most appropriate test:

- The CPT code for **Visual Acuity Screen 99173**
  - This would include eye charts
- The CPT code for **Instrument-based screening 99174**
  - Instrument-based ocular screening, bilateral; with remote analysis and report
- The CPT code for **Instrument-based screening is 99177**
  - Instrument-based ocular screening; with on-site analysis

Modifier 52 should be applied for a Vision Screening that may not be completed. If a screening service/component is reported with modifier 52, the provider must complete the screening service/component during the next screening opportunity according to the Periodicity Schedule.

https://www.aappublications.org/news/2015/12/07/Vision120715

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

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

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.

Hearing Screening

Hearing loss is the most common congenital condition in the United States. The Joint Committee on Infant Hearing recommends universal newborn and periodic hearing throughout childhood as an important means of detecting acquired hearing loss as well as congenital cases missed by inadequate or inaccurate newborn screening. A study conducted in 2005 showed that 10 percent of children failed hearing screenings, and yet pediatricians neither rechecked nor referred more than half of these children.[1]

The goal of hearing screening is early detection of hearing loss to improve developmental and language outcomes. Hearing impairment in childhood has a detrimental impact on effective communication development. It can also impact educational performance.

All newborns should receive an initial hearing screening before being discharged from the hospital as part of the universal newborn hearing screening. If the hearing screening was not completed in the hospital or was inconclusive, a hearing screening should be completed by 3 months of age.

Hearing screenings should be completed at the following ages:

- 4 years old
- 5 years old
- 6 years old
- 8 years old
- 10 years old
- Between 11 years old and 14 years old
- Between 15 years old and 17 years old
- Between 18 years old and 20 years old

Billing

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

- **12 month to 4 year EPSDT visit CPT Code is 99382 or 99392**
- **5 year to 11 year EPSDT visit CPT Code is 99383 or 99393**
- **12 year to 17 year EPSDT visit CPT Code is 99384 or 99394**

Provider should choose most appropriate test:

- The CPT code for **Audio Screen 92551**
  - Screening Test, pure tone, air only. Basically a pass fail test. If the patient fails they should be scheduled for the Threshold test or referred to an audiologist to determine the problem.
- The CPT code for **Pure tone-air only 92552**
  - Threshold test is used to define more specific diagnosis of the patient's hearing problem. This test identifies the softest level a patient can hear.
- The CPT code for **Tympanometry 92567**
  - Tests how well the eardrum moves.
- The CPT for **Acoustic reflex texting, threshold 92568**
  - Sounds move through a device in the ear to measure a reflex.

[1]https://jamanetwork.com/journals/jamapediatrics/fullarticle/486135

https://www.cdc.gov/ncbddd/hearingloss/recommendations.html

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

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.

Model of Care

As a Special Needs Plan (SNP), Highmark Wholecare is required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC) Plan.

In accordance with CMS guidelines, Highmark Wholecare's SNP MOC Plan is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization (MAO) to provide coordinated care for special needs individuals.

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

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

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

There are 3 sections in this MOC section:

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

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

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

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

Common MOC Terms and Definitions:

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

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

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

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

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

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

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

Other Important Information About Our MOC

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

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

Providers: 1-800-685-5209

Member Self Referral: 1-800-685-5209

Highmark Wholecare employees may refer via the established internal process.

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

Action Required:

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

Clinical Practice and Preventive Health Guidelines

Highmark Wholecare adopts clinical practice and preventive health guidelines to assist practitioners in providing appropriate healthcare for specific clinical conditions relevant to our members. These guidelines are developed using evidence-based clinical practice guidelines from professionally and industry-recognized sources, or through the experience of board-certified practitioners from appropriate specialties when guidelines from recognized sources are not available. The use of guidelines is intended to increase practitioner consistency with current standards in diagnosis and treatment. Clinical practice guidelines are not intended to supersede the clinical judgement of the practitioner providing care.

Before distribution, the guidelines are reviewed and approved by Highmark Wholecare's Quality Improvement and Utilization Management Committee.

Examples of some of the guidelines include:

- Pediatric Preventive/EPSDT/Lead Screening (Birth to 21 Years)
- Adult Preventive Care
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar
- Cardiac Medical Management
- COPD
- Cystic Fibrosis
- Depression
- Diabetes
- HIV
- Hypertension
- Major Depression in Adults in Primary Care
- Opioid Prescribing for Chronic Pain
- Healthy Weight Management
- Healthy Weight Management in Children and Adolescents
- Palliative Care
- Routine and High Risk Prenatal Care
- Preventive Dental Care
- Schizophrenia
- Sickle Cell Disease
- Substance Use Disorder

A complete listing of the guidelines are available online at Frequently Asked Questions (highmarkwholecare.com). Under the Provider Tab, click Medicare or Medicaid Resources, then Clinical Guidelines. Guidelines can be printed from the website. To obtain a paper copy, call Provider Services at 1-800-392-1147 (Medicaid) or 1-800-685-5209 (Medicare).

Ensuring Quality Care and Service

Ensuring the excellent provision of healthcare and services for our members is the primary goal of the Highmark Wholecare Quality Improvement/Utilization Management (QI/UM) Program. Highmark Wholecare continuously monitors how well we're helping our members:

- Get preventive care
- Get care for long-standing health problems
- Understand the medicines they take
- Stay out of the hospital
- Have appropriate access to practitioners
- Make and keep doctor appointments
- Share health information with their doctors
- Receive care in a culturally competent manner

The Quality Program leverages results from member surveys, medical record reviews, the Healthcare Effectiveness Data Information Set (HEDIS®), and other tools to measure how we are doing and to help set goals for future quality activities. We also work closely with doctors within our network to monitor the care and services our members receive, as well as to determine what we can do to better serve our members. Highmark Wholecare maintains a QI/UM Work Plan to analyze activities conducted as part of its QI/UM Program. This Work Plan is evaluated every three months to identify issues and ensure that actions have been taken to address them.

Highmark Wholecare also conducts an annual review of its QI/UM Program to see how well we've met the healthcare and service needs of our members. The annual evaluation of the 2021 QI/UM Program is complete. We accomplished the majority of the QI/UM Program goals, implemented new and innovative programs, identified areas for improvement, and are developing plans to address improvement opportunities in 2022.

Please call Provider Services if you would like to request more information about our Quality Program, QI/UM Work Plan, or summary evaluation of the 2021 QI/UM Program.

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

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.

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").