HIGHMARK WHOLECARE

NOVEMBER 2022

Provider Newsletter

An Update for Highmark Wholecare Providers and Clinicians

IN THIS ISSUE

Accessibility to Care Standards

Highmark Wholecare maintains standards and processes for ongoing monitoring of access to health care. Practice sites are contractually required to conform to the standards to ensure that services are provided to members in a timely manner. Please take a few minutes to review the accessibility standards and share with your office staff that schedule member appointments, including off-site central scheduling and call center staff. These standards and additional resource information related to accessibility are available on the Highmark Wholecare provider website.

You can access the standards here.

Medicare Assured Members Individual Care Plans Through NaviNet

Highmark Wholecare sends our Medicare Assured providers a copy of every Medicare Assured members' Care Plan through the Highmark Wholecare provider portal (NaviNet) that is based on the member's individual goals identified while completing their annual Health Risk Assessment (HRA). The Plan has sent a copy of each member's care plan to the member as well. Please be sure to review and discuss the care plan with your Highmark Wholecare patients, so we can work together to help our members reach their health care goals. Providers also have the ability to review quarterly materials that are sent to members that address common chronic conditions. They can also be found by accessing the Highmark Wholecare provider portal.

Reminder: Highmark Wholecare is collaborating with Quest Analytics to ensure an accurate provider directory.

State and federal regulations mandate that health plans display an accurate directory of network providers and requires the reviewing and updating of provider information on a regular basis to avoid misdirecting members. As a result, Highmark Wholecare is working with Quest Analytics to perform outreach and data validation via their BetterDoctor Exchange platform.

All outreach efforts to Highmark Wholecare providers will be made under the BetterDoctor name and providers will be directed to BetterDoctor's online verification tool to review, update and attest to any changes. Provider outreach began in May 2022, and will occur every 90 days going forward. An FAQ document is available on the provider page of the Highmark Wholecare website: https://highmarkwholecare.com/Portals/8/provider_forms/BetterDoctorProviderFAQ.pdf. For more information about BetterDoctor, visit their website: questanalytics.com/solutions/betterdoctor/. You may also contact them at support@betterdoctor.com or by phone at 1-844-668-2543, Monday through Friday, 9 a.m. to 5 p.m. central time.

Claims Submission Timely Filing Guidelines

Medicaid

- Initial claim must be submitted within 180 calendar days from the date of service.
- Providers must bill within 60 calendar days from the date an EOB from the primary carrier when Highmark Wholecare is secondary. An original bill along with a copy of the EOB is required to process the claim.
- Corrected claims or requests for review must be received within 365 calendar days from the date of service on the claim.

Medicare

- Initial claim must be submitted within 365 calendar days from the date of service.
- Providers must bill within 365 calendar days from the date of an Explanation of Benefits (EOB) from the primary carrier when Highmark Wholecare is secondary. An original bill along with a copy of the EOB is required to process the claim.
- Corrected claims or requests for review must be received within 365 calendar days from the date of service on the claim.

Correction to Medicaid Provider Manual Regarding Provider Appeals

There is a typo regarding the timeframe listed under the Provider Appeals Section 1-b in the on-line version of the Medicaid Provider Manual. We are working to have this corrected as soon as possible. The correct timeframe is listed in bold below.

First Level Appeal

- To request a provider appeal, providers must make a written request for appeal which must be received by the plan within:

    a. Sixty (60) calendar days of the date of their denial notice denying an authorization unless otherwise negotiated by contract. In this instance, there is a denied authorization, however, services have already been provided.

    b. **One hundred eighty (180) calendar days from the claim denial, unless otherwise negotiated by contract.** When an authorization has been denied, the provider must adhere to the sixty (60) calendar day time frame above, the one hundred eighty (180) calendar days once the claim has denied does not apply.

November 12th–20th is National Hunger and Homelessness Awareness Week.

Organized every year by the National Coalition for the Homeless, this is a chance for health care providers to support and address social determinants of health (SDOH) issues related to homelessness and food insecurities.

Did you know:

- As of January 2020, Pennsylvania had an estimated **13,375** people experiencing homelessness on any given day.
- Pennsylvania is ranked in the top 10 states with the highest homeless population (8th).
- Of that total, **1,550** were family households, **977** were veterans, **716** were unaccompanied young adults (aged 18–24), and **1,772** were individuals experiencing chronic homelessness.
- Many cities in the U.S. are increasingly making homelessness a crime, which blocks the homeless from participating in normal activities.

To find out more information or to volunteer and donate to this great cause, please visit the Hunger & Homelessness Awareness Week website (hhweek.org).

Provider Webinar: 2023 Medicare Assured D-SNP

Join Highmark Wholecare to learn about the NEW 2023 benefits and programs we are offering to our Medicare Assured Dual Eligible Special Needs Plan (D-SNP) members.

This webinar will introduce the benefits and programs offered to assist members with their most basic needs like healthy food, utilities and more!

Please visit our website to register:
https://highmarkwholecare.com/Provider/Upcoming-Live-Webinars

If you have any questions regarding this webinar, please contact your designated Provider Account Liaison or Lead Provider Relations Representative.

Thank you for your continued support of Highmark Wholecare and our members.

Mark your calendar!

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

Topic	Date/Time	Key Speaker
Neonatal Abstinence Syndrome: Where We Started and Where We Are Now	Wednesday, January 4, noon–1 p.m.	**David Turkewitz, MD** Medical Director, Newborn Nurseries Allegheny Health Network
Registration link for January webinar: https://bit.ly/LearningEarningFREECME_NeonatalAbstinenceSyndrome		
Co-Occurring Disorders: Which Came First, the Chicken or the Egg?	Wednesday, February 1, noon–1 p.m.	**Shannen Lyons, MSW, LCSW, CAADC** Addiction Specialist Highmark Wholecare
Registration link for February webinar: Link coming soon!		

Who qualifies for CME?

Webinars are free and open to all interested. CME/CEU credits are available for physicians, midlevel practitioners, nurses, psychologists and social workers.

Each webinar is eligible for one (1) CME/CEU credit. To receive credit, you must create a free account at CME.AHN.org. After creating your account, you will need to register for the webinars you wish to attend, using the instructions above. You only need to create the account one time to be eligible to receive CME credit for attendance at all live Learning and Earning webinar activities as well as accessing your transcripts. Instructions for claiming CME/CEU credit will be provided at each live webinar.

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

QUESTIONS?

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

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

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

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

2022 Fraud, Waste, and Abuse (FWA) Community Education Opportunity

December 7, 11:00 AM – 12:30 PM

Speakers:

Jennifer Snerr
Supervisory Special Agent
Pennsylvania Office of Attorney General

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

Meeting Information:

In collaboration with the Pennsylvania Attorney General's Office, the Highmark Wholecare Fraud, Waste, and Abuse Unit (FWA) will be hosting a live community educational webinar on December 7, 2022. The topics of discussion will include an overview of Care-Dependent Exploitation and Phone/Internet Scams. 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

Provider Notification for Post Service Authorization Requests

Beginning December 15, 2022, authorization requests made after the care has been completed (post service/post discharge) must be submitted as an appeal once a claim denial has been received. Post service authorization requests will not be accepted by Utilization Management.

Post service claim denials based on lack of prior authorization must be appealed within 180 days of the denied claim. Medical necessity denials, must be appealed within 60 days of the denied authorization. Please submit the appeal request with all supporting documentation through the Highmark Wholecare provider portal, via NaviNet, by fax at 1-855-501-3904, or by mail at the following address:

Highmark Wholecare
Attn: Clinical Provider Appeals
PO Box 22278
Pittsburgh, PA 15222

Authorization requests, inpatient notifications, and continued stay clinical updates are encouraged to be submitted 24 hours a day, 7 days a week through the Highmark Wholecare provider portal, via NaviNet, or through fax to one of the numbers below. Telephonic requests may also be submitted by calling Utilization Management at 1-800-392-1147 for Medicaid members and 1-800-685-5209 for Medicare members, Monday – Friday from 8:30 a.m. – 4:30 p.m.

Utilization Management Fax Numbers:

1-888-245-2034 – Acute Inpatient Care

1-888-245-2063 – Chiropractic Care

1-888-245-2015 – Scheduled Inpatient/Outpatient/Special Procedure Unit Care

1-855-888-8252 – Inpatient Surgeries/Maternity Care

1-866-263-0324 – Durable Medical Equipment

As a reminder, please utilize NaviNet to check the status of your claims, verify benefits and submit pre-service authorization requests or clinical updates.

Additional information regarding Highmark Wholecare policies and procedures can be found in our provider manuals located on the provider page of our website at www.highmarkwholecare.com.

Emergency Medicine and Opioid Use Disorder Series

Diagnosing Opioid Use Disorder

In August, we announced that we would be providing information monthly to our Emergency Medicine providers regarding treating Opioid Use Disorder (OUD) in the Emergency Department, specifically regarding Medications for Opioid Use Disorder (MOUD).

Emergency Department (ED) adoption of evidence-based practices for patients with substance use disorder is essential to addressing the nation's substance use and overdose epidemic. Those that are reluctant to adopt these practices miss a key opportunity to improve health outcomes, save lives, and reduce racial disparities. Approximately one of every 80 ED visits are opioid-related, costing around $5 billion per year.[2]

Last month, we reviewed evidence-based screening tools practitioners and clinicians can use as part of their routine when assessing patients. For the 15-25% of patients who screen positive, further assessment can be conducted to assess for and diagnose OUD.

An assessment should include:

- A medical and psychiatric history, a substance use history, and an evaluation of family and psychosocial supports
- Frequency of opioid use and route of administration (e.g., oral, intravenous, intranasal) can help gauge likelihood of severe withdrawal or possible infections, which will influence further testing and the need for counseling
- Prescription drug use history accessed through the state's PDMP, where available, to detect unreported use of other controlled medications, such as benzodiazepines or other opioid medications, that may interact adversely with the treatment medications
- Previous attempts to stop using opioids, type of treatment used, and response to treatment

By utilizing this information, the practitioner can identify if the patient, in the last 12 months, meets any of the eleven different criteria that are used to not only diagnose OUD but also to categorize the severity of the diagnosis as mild (2-3 criteria), moderate (4-5 criteria), or severe (6+ criteria).[3]

We encourage you to outreach to our Behavioral Health team should you be interested in one-on-one collaboration and technical assistance regarding launching or strengthening addictions services in these settings. A member of our team can be reached via email at BHI2@HighmarkWholecare.com.

References

1. Yeboah-Sampong, S., Weber, E., & Friedman, S. (2021). Emergency: Hospitals are violating federal law by denying required care for substance use disorders in emergency departments [PDF]. Legal Action Center. Retrieved July 11, 2022 from https://www.lac.org/assets/files/LAC-Report-Final-7.19.21.pdf

2. Langabeer, J. R., Stotts, A. L., Bobrow, B. J., Wang, H. E., Chambers, K. A., Yatsco, A. J., Cardenas-Turanzas, M., & Champagne-Langabeer, T. (2021). Prevalence and charges of opioid-related visits to U. S. emergency departments. Drug and Alcohol Dependence, 221, 108568. https://doi.org/10.1016/j.drugalcdep.2021.108568

3. Substance Abuse and Mental Health Services Administration. (2021). Use of Medication-Assisted Treatment in Emergency Departments [PDF]. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep21-pl-guide-5.pdf

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

Important Update Regarding Maximum Out of Pocket (MOOP)

Beginning January 1, 2023, per the CY 2023 Medicare Advantage Final Rule, Medicare Advantage Plans must calculate Maximum Out-of-Pocket based on the accrual of all cost-sharing in the plan benefit, regardless of whether that cost-sharing is paid by the beneficiary, Medicaid, other secondary insurance, or remains unpaid.

MOOP is a cost-sharing limit that once reached, triggers a Medicare Advantage plan to pay 100% of the allowed costs for covered Part A and Part B services. MOOP is accumulated as claims for Part A and Part B services are received, and finalized by, a health plan.

Historically, MOOP accumulations have primarily been tracked for Highmark Wholecare Medicare Assured Ruby members, as only actual member out of pocket costs were required to be tracked. In order to be compliant with the CY2023 MA Final Rule, we will begin tracking MOOP accumulations for Highmark Wholecare Medicare Assured Diamond members, as well.

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 or Community HealthChoices Plan (CHC) is liable for the cost-sharing. Providers further agree that upon payment from Highmark Wholecare Medicare Assured, 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.

Fraud, Waste, and Abuse in Durable Medical Equipment

DME Fraud Schemes

Durable Medical Equipment (DME) is equipment that is used to serve a medical purpose with repeated use, which is generally not useful to a person in the absence of illness and injury. When medically necessary, DME can be covered by insurance. DME suppliers are often identified as prominent perpetrators of fraud, waste, and abuse. Common schemes include:

- Billing for medically unnecessary equipment or services that were never provided
- Billing for periodic services (rentals or maintenance) that was never performed
- Billing for equipment for patients who do not qualify for the equipment
- Billing for more costly equipment than that which was provided
- Knowingly providing defective equipment
- Forging or falsifying signatures and medical records
- Paying kickbacks to physicians for referrals

What you can do:

Report potential fraud to Highmark Wholecare's Fraud Waste and Abuse team if you suspect something is not right by calling 412-255-4340 or 1-844-718-6400 or visiting https://highmarkwholecare.com/fraud-and-abuse. Red flags to look out for include:

- Your patient receives DME equipment or supplies that is not requested
- A patient receives an Explanation of Benefits (EOB) for equipment is not needed, was not received, or was previously returned
- A patient is offered "free" equipment or supplies but your insurance is billed
- EOB is issued for services for someone who has passed away
- Someone requests a patient's Medicare Insurance Number or other personal health information in exchange for money or other gifts
- A website that asks for a patient's personal health information
- You receive a form for DME from a company that you are unfamiliar with

References:

https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?&&NCDId=190&ncdver=1&NCDSect=280.1&bc=BEAAAAAAAQAAAA%3D%3D#:~:text=The%20term%20DME%20is%20defined,of%20illness%20or%20injury%3B%20and

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

https://www.usfraudattorneys.com/healthcare-fraud/durable-medical-equipment-fraud#:~:text=Durable%20Medical%20Equipment%20suppliers%20can,equipment%2C%20that%20never%20was%20performed

Provider Guidance in Supporting Patients with Screening, Brief Intervention and Referral to Treatment (SBIRT)

CPT Code H0049: Brief Substance Use screening less than 5 minutes.

Highmark Wholecare will now be reimbursing providers for SBIRT pre-screenings done within a patient visit.

- Approved to be billed up to two pre-screens for alcohol and/or substances (other than tobacco) per 12-month period
- SBIRT pre-screening approved as an assessment tool
- Approved by the Center for Medicare & Medicaid Services (CMS)
- Approved for Telehealth reimbursement
- May be used to report substance use assessments in adolescents 12 years and older

SBIRT pre-screenings should be administered to all adult/adolescent patients. It rules out patients who are at low or no-risk using one pre-screening question for alcohol and one pre-screening question for drugs.

Providers interested in more information, please contact Shannen Lyons, Addiction Specialist at SLyons@HighmarkWholecare.com

Highmark Wholecare Lifestyle Management Programs

Balancing Lifestyle for Maximum Health and Wellness

Program	Asthma	Cardiac	COPD	Diabetes	Hypertension	Healthy Weight Management	MOM Matters* (Maternal Outreach and Management)
Eligibility	Any member with a diagnosis of asthma	Any adult member with the following diagnosis: AMI, atrial fibrillation, CHF, heart failure diagnosis, IVD, MI or stroke	Any adult member with a diagnosis of COPD	Any adult member with a diagnosis of Type 1 or Type 2 diabetes	Any adult member with a diagnosis of hypertension	Any member with a diagnosis of overweight or obesity	All pregnant or postpartum females
Contact for Referrals	**Medicaid: 1-800-392-1147** **Medicare Assured: 1-800-685-5209**						
Description	• The programs provide patient education for medication, diet and lab testing adherence, as well as other tools to reduce inpatient and emergency room utilization • The programs emphasize prevention and exacerbation of complications by using evidence-based guidelines and member empowerment strategies • The programs support the physician's plan of care and supports the provider-member relationship						**This program offers care coordination and SDOH resources to reduce low birth weight, pre-term deliveries and NICU**

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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						

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.

2023 Highmark Wholecare Benefits

Highmark Wholecare is pleased to announce several new and exciting benefit enhancements for Medicare plan members beginning January 2023.

Healthy Food Benefit: *(Diamond Members only)*
$135 monthly allowance to purchase healthy foods and produce at participating grocery stores, from a catalog, online or through the mobile app.

Utility Support Benefit: *(Diamond Members only)*
$100 quarterly allowance to be used for plan approved utility expenses.

Transportation for Non-Medical Needs: *(Diamond Members only)*
All members receive a yearly allowance of one-way transportation trips for non-emergency medically-related appointments. Diamond members have the option to use a portion of their allowance toward non-health related transportation, such as trips to the grocery store to use their Healthy Food card.

$0 RX Copays: *(Diamond and Ruby Members)*
$0 for covered drugs in all tiers and in all phases of the Part D drug benefit.

Dental:
Members are covered for preventive dental services including a yearly plan allowance for comprehensive dental services.

- **Diamond** – $8,000 comprehensive allowance per year, includes preventive services.
- **Ruby** – $3,500 comprehensive allowance per year.

Vision: *(Davis Vision Network)*
Members receive an annual routine eye exam and free glasses or contact lenses.
– Or –

- **Diamond –** $600 allowance toward the purchase of non-vendor frames or contact lenses.
- **Ruby** – $200 allowance toward the purchase of non-vendor frames or contact lenses.

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Hearing:

Members receive an annual routine hearing exam and a hearing aid per ear. Includes rechargeable aids.

- **Diamond** - one hearing aid per ear every year.
- **Ruby** - one hearing aid per ear every three years.

OTC:

Members receive a quarterly allowance to purchase plan approved over-the-counter items such as vitamins, topical ointments and tobacco cessation items.

- **Diamond** - $320 per quarter
- **Ruby** - $140 per quarter

Home and Bathroom Safety: To help our members prevent the slips and falls that can lead to greater medical issues, we cover plan approved safety devices that best suit their needs.

Nutritional Counseling: Members are eligible to enroll in a Telphonic/Telehealth Counseling program wiht a Registered Dietitian (RD) to help prevent, treat and reverse illness.

Meals Post Discharge: Members are eligible for meals up to 30 days after being discharged from inpatient stay at a hospital/skilled nursing facility.

24-Hour Nurse Line: A toll-free 24-hour nurse line is availble at no cost to the member. Members can receive coaching and advice from our trained clinicians.

Personal Emergency Response System (PERS): Members are eligible to receive one personal emergency response unit per member lifetime.

Fitness: Membership at participating network fitness centers at no cost. Includes at-home fitness packs and access to virtual fitness classes.

	Highmark Wholecare Medicare Assured Diamond℠ (HMO SNP)	**Highmark Wholecare Medicare Assured Ruby℠** (HMO SNP)
Monthly Plan Premium	$0	$0
Deductible	No deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include dental)	$8,300 annually for in-network Medicare-covered services	$6,700 annually for in-network Medicare-covered services

Please visit HighmarkWholecare.com for a full listing of our 2023 Medicare benefits.

Model of Care

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

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

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

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

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

There are 3 sections in this MOC section:

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

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

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

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

Common MOC Terms and Definitions:

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

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

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

continued >

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

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

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

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

Other Important Information About Our MOC

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

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

Providers: 1-800-685-5209

Member Self Referral: 1-800-685-5209

Highmark Wholecare employees may refer via the established internal process.

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

Action Required:

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

Medications to Require Medical Prior Authorization

Medicare Assured

A subset of medications require a pre-service authorization for medications obtained through the medical benefit. This prior authorization process applies to **all Highmark Wholecare Medicare Assured members**. Failure to obtain authorization will result in a claim denial.

Procedure Codes Requiring Authorization

Authorization Required as of 02/21/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
J0257	alpha 1 proteinase inhibitor (Glassia)	**J9332**	lonapegsomatropin-tcgd (Skytrofa)
J9332	efgartigimod alfa-fcab (Vyvgart)	**J3490***	vosoritide (Voxzogo)
J1931	laronidase (Aldurazyme)		

Authorization Required as of 04/01/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
J3590*	alirocumab (Praluent)	**J2356**	tezepelumba-ekko (Tezpire)
J3590*	evolocumab (Repatha)	**J3590***	tralokinumab-ldrm (Adbry)
J1306	inclisiran (Leqvio)		

Authorization Required as of 07/01/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
Q2056	ciltacabtagene autoleucel (Carvykti)	**Q5125**	filgrastim-ayow (Releuko)
J2777	faricimab-svoa (Vabysmo)	**J8499***	mitapivat (Pyrukynd)
J1437	ferric derisomaltose (Monoferric)	**J2779**	ranibizumab (Susvimo)
J1443	ferric pyrophosphate citrate solution (Triferic)	**Q5124**	ranibizumab-nuna (Byooviz)
J1444	ferric pyrophosphate citrate powder (Triferic)	**J1302**	sutimlimab-jome (Enjaymo)
J1445	ferric pyrophosphate citrate (Triferic AVNU)		

*This medication will be reviewed under the miscellaneous/not otherwise specified procedure codes until a permanent code is assigned.

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Authorization Required as of 11/01/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
J3590*	betibeglogene autotemcel (Zynteglo)	**J3590***	spesolimab-sbzo (Spevigo)
J9999*	bevacizumab-maly (Alymsys)	**J3490***	vutrisiran (Amvuttra)
Authorization Required as of 12/01/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
J3590*	eflapegastrim-xnst (Rolvedon)	**J3590***	pegfilgrastim-pbbk (Fylnetra)
J3590*	elivaldogene autotemcel (Skysona)	**J3590***	ranibizumab-eqrn (Cimerli)
J3590*	olipudase alfa-rpcp (Xenpozyme)		

*This medication will be reviewed under the miscellaneous/not otherwise specified procedure codes until a permanent code is assigned.

What if the medication is not on this list?

This list is intended to function as a notification and is subject to change. Please refer to the Provider Portal Lookup Tool (accessed via NaviNet: https://navinet.navimedix.com) to determine if a drug/HCPCS code requires authorization and to submit authorization requests.

Would you prefer to get the medication through a pharmacy?

This change only applies to the medical benefit. If the medication is to be billed at the pharmacy/specialty pharmacy, you will continue to submit requests to the Highmark Wholecare pharmacy department. They can be reached at **1-800-685-5209.**

Submitting a Request

The most efficient path of submitting a request (for one of the medications on the list above) is via NaviNet. A form has been added to NaviNet with autofill functionality to make completing and submitting your online request easier and faster.

If you have questions regarding the authorization process and how to submit authorizations electronically, please contact your Highmark Wholecare Provider Relations Representative directly or Highmark Wholecare Pharmacy Services using the phone number **1-800-685-5209.**

Additional Information

- Any decision to deny a prior authorization is made by a licensed pharmacist based on individual member needs, characteristics of the local delivery system, and established clinical criteria.
- Authorization does not guarantee payment of claims. Medications listed above will be reimbursed by Highmark Wholecare only if it is medically necessary, a covered service, and provided to an eligible member.
- Non-covered benefits will not be paid unless special circumstances exist. Always review member benefits to determine covered and non-covered services.
- Current provider notifications can be viewed at: https://highmarkwholecare.com/Provider/Medicare-Resources/Medicare-Provider-Updates

Medications to Require Medical Prior Authorization

Medicaid

A subset of medications require a pre-service authorization for medications obtained through the medical benefit. This prior authorization process applies to all Highmark Wholecare Medicaid members. Medical necessity criteria for each medication listed below is outlined in the specific medication policies available online. To access Highmark Wholecare medical policies, please visit: https://www.highmarkwholecare.com/provider/medicaid-resources/medication-policies. Failure to obtain authorization will result in a claim denial.

Procedure Codes Requiring Authorization

Authorization Required as of 02/21/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
J0257	alpha 1 proteinase inhibitor (Glassia)	**J9332**	lonapegsomatropin-tcgd (Skytrofa)
J9332	efgartigimod alfa-fcab (Vyvgart)	**J2840**	sebelipase alfa (Kanuma)
J1931	laronidase (Aldurazyme)	**J3490***	vosoritide (Voxzogo)
Authorization Required as of 04/01/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
J3590*	alirocumab (Praluent)	**J3590***	tezepelumba-ekko (Tezpire)
J3590*	evolocumab (Repatha)	**J3590***	tralokinumab-ldrm (Adbry)
J1306	inclisiran (Leqvio)		
Authorization Required as of 07/01/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
Q2056	ciltacabtagene autoleucel (Carvykti)	**Q5125**	filgrastim-ayow (Releuko)
J2777	faricimab-svoa (Vabysmo)	**J8499***	mitapivat (Pyrukynd)
J1437	ferric derisomaltose (Monoferric)	**J2779**	ranibizumab (Susvimo)
J1443	ferric pyrophosphate citrate solution (Triferic)	**Q5124**	ranibizumab-nuna (Byooviz)
J1444	ferric pyrophosphate citrate powder (Triferic)	**J1302**	sutimlimab-jome (Enjaymo)
J1445	ferric pyrophosphate citrate (Triferic AVNU)		

*This medication will be reviewed under the miscellaneous/not otherwise specified procedure codes until a permanent code is assigned.

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Authorization Required as of 11/01/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
J3590*	betibeglogene autotemcel (Zynteglo)	**J3590***	spesolimab-sbzo (Spevigo)
J9999*	bevacizumab-maly (Alymsys)	**J3490***	vutrisiran (Amvuttra)
Authorization Required as of 12/01/2022			
Procedure Code	**Description**	**Procedure Code**	**Description**
J3590*	eflapegastrim-xnst (Rolvedon)	**J3590***	pegfilgrastim-pbbk (Fylnetra)
J3590*	elivaldogene autotemcel (Skysona)	**J3590***	ranibizumab-eqrn (Cimerli)
J3590*	olipudase alfa-rpcp (Xenpozyme)		

*This medication will be reviewed under the miscellaneous/not otherwise specified procedure codes until a permanent code is assigned.

In addition to these codes, it is expected that the statewide preferred drug list (PDL) will be referenced to ensure a preferred drug is prescribed and administered when possible. **Effective January 1, 2023, all MA covered drugs designated as non-preferred are covered and available to MA beneficiaries when found to be medically necessary through the prior authorization process.** This requirement applies to both the medical benefit and pharmacy benefit. You may access the complete statewide PDL now through the Department of Human Services website at: https://papdl.com/preferred-drug-list. The searchable PDL and prior authorization guidelines are also located on the Highmark Wholecare, Medicaid website at https://highmarkwholecare.com/Medicaid.

What if the medication is not on this list?

This list is intended to function as a notification and is subject to change. Please refer to the Provider Portal Lookup Tool (accessed via NaviNet: https://navinet.navimedix.com) to determine if a drug/HCPCS code requires authorization and to submit authorization requests.

Would you prefer to get the medication through a pharmacy?

This change only applies to the medical benefit. If the medication is to be billed at the pharmacy/specialty pharmacy, you will continue to submit requests to the Highmark Wholecare pharmacy department. They can be reached at **1-800-392-1147.**

Submitting a Request

The most efficient path of submitting a request (for one of the medications on the list above) is via NaviNet. A form has been added to NaviNet with autofill functionality to make completing and submitting your online request easier and faster.

If you have questions regarding the authorization process and how to submit authorizations electronically, please contact your Highmark Wholecare Provider Relations Representative directly or Highmark Wholecare Pharmacy Services using the phone number **1-800-392-1147.**

Additional Information

- Any decision to deny a prior authorization is made by a Medical Director based on individual member needs, characteristics of the local delivery system, and established clinical criteria.
- Authorization does not guarantee payment of claims. Medications listed above will be reimbursed by Highmark Wholecare only if it is medically necessary, a covered service, and provided to an eligible member.
- Non-covered benefits will not be paid unless special circumstances exists. Always review member benefits to determine covered and non-covered services.
- Current and previous provider notifications can be viewed at: https://highmarkwholecare.com/Provider/Medicaid-Resources/Medicaid-Provider-Updates

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. Please reference your provider contract and Highmark Wholecare's procedure manual regarding provider availability and accessibility.

Affirmative Statement About Incentives

Highmark Wholecare's UM decisions are based only on the appropriateness of care and services and existence of coverage. Highmark Wholecare does not specifically reward practitioners or other individuals for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Highmark Wholecare monitors for both over- and under-utilization of care to prevent inappropriate decision making, to identify causes and corrective action, and to indicate inadequate coordination of care or inappropriate use of services. Highmark Wholecare is particularly concerned about under-utilization and monitors utilization activities to assure members receive all appropriate and necessary care.

Out of Network Cost to Members

Highmark Wholecare will approve a member to go out of network if it is unable to provide a necessary and covered service via an in-network practitioner or provider of care. When an out-of-network request is approved, Highmark Wholecare will coordinate payment with the out-of-network practitioner or provider to ensure that the cost to the member is no greater than it would be if the service was furnished in network.

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.