HIGHMARK WHOLECARE

OCTOBER 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.

Provider Billing Address Reported on Claims

Highmark Wholecare requires that the billing provider address submitted on claims must be a physical address. Paper claims as well as claims submitted via Change Healthcare or RelayHealth will be rejected if a P.O. Box number is submitted as the billing address. In order to prevent claims from being rejected, please be sure to submit a physical address as the billing address.

For additional information regarding Highmark Wholecare policies and procedures, please visit our website at HighmarkWholecare.com/.

October is National Depression Education and Awareness Month.

According to the Center for Disease Control (CDC), about 14.8 million adults in the U.S. are affected by Major Depressive Disorder. Because of this, suicide is the 12th leading cause of death in the United States. In 2020 45,979 Americas died by suicide, and there were an estimated 1.2 million suicide attempts.

This important month is focused on educating individuals about the signs, symptoms, and treatment options for depression. Highmark Wholecare recommends regular depression screenings of its members by health care providers in all settings, to ensure the highest quality of care.

Health care providers can support patients with depression by:

- Providing regular screenings for depression
  - Beck Depression Inventory (BDI), PHQ-9, Hamilton Depression rating scale (HAM-D), Geriatric Depression Scale, Children's Depression Inventory (CDI)
- Providing referrals to mental health treatment/psychiatry
- Ensuring close follow-up to make sure patients are improving
- Collaborating with mental health providers on a regular basis

October is Attention Deficit/Hyperactivity Disorder (ADHD) Awareness Month.

This is a time to celebrate the progress made in ADHD education and advocacy, understand the work that still needs to be done such as reducing stigma, and raise awareness about the importance of early diagnosis and treatment. Without ADHD awareness, children and adults may continue to struggle.

ADHD stigma often causes challenges in social, job, and school settings. It may also affect how a person with ADHD views themselves. Stigma can cause people with ADHD and their caregivers to avoid seeking care. **Help raise ADHD awareness and reduce stigma to avoid delayed diagnosis and treatment.**

For more information on ADHD visit Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) https://chadd.org.

Red Ribbon Week

The Red Ribbon Campaign® is the oldest and largest drug prevention program in the nation, reaching millions of young people during Red Ribbon Week®, October 23 – 31 each year.

This campaign is an ideal way for people and communities to unite and take a visible stand against the use of drugs. During the week of October 23 – 31 stand with Highmark Wholecare by encouraging those you serve to make a personal commitment to a drug-free lifestyle.

More information on Red Ribbon Week can be found at https://www.redribbon.org/.

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
- Claims

Please go to our website at https://highmarkwholecare.com/provider/Education-Webinars and select from one of the dates available.

Sign up for one of our scheduled webinars taking place every Wednesday from 12 - 12:45 p.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.

This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare serves a Medicaid plan to Blue Shield members in 13 counties in central Pennsylvania, as well as, to Blue Cross Blue Shield members in 27 counties in western Pennsylvania. Highmark Wholecare serves Medicare Dual Special Needs plans (D-SNP) to Blue Shield members in 14 counties in northeastern Pennsylvania, 12 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.

Mark your calendar!

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

Topic	Date/Time	Key Speaker
Rural Appalachia: Disparities and Barriers to Behavioral Health Services	Wednesday, November 2 noon–1 p.m.	**Shannen Lyons, MSW, LCSW, CAADC** Addiction Specialist Highmark Wholecare
Registration link for October webinar: https://bit.ly/LearningEarningFREECME_RuralAppalachiaDisparitiesandBarrierstoBHServices		
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: 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

continued >

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).

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.

Medicaid Administrative Bulletins (MABs) now available on our website!

In addition to the monthly provider newsletter, Highmark Wholecare shares communications regarding important Medicaid and Medicare provider updates, which can be found on our website under Medicaid and Medicare Provider Resources pages. We have recently created a new section on our Medicaid Provider Resources page for Medicaid Administrative Bulletins (MABs) that have been issued by the PA Department of Human Services (DHS). The MABs are posted to ensure you are aware of important Medicaid updates that may affect your practice.

Please reach out to your Provider Relations contact, should you have any questions or need training on the resources available to your practice.

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.

Emergency Medicine and Opioid Use Disorder Series

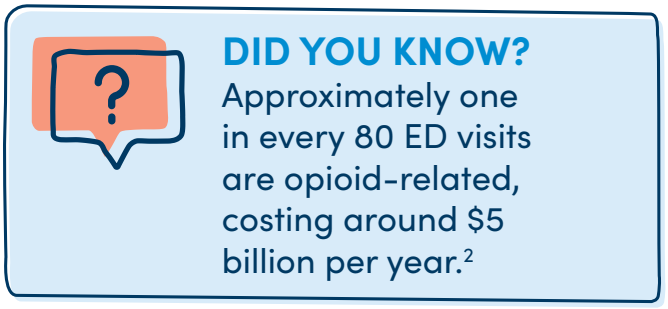
Screening for Opioid Use Disorder

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.[1]

So, where do we start?

When a patient's ED visit is directly related to their opioid use, it can be easier to identify an opportunity to provide further assessment and care than when a patient presents with an unrelated -- or seemingly unrelated -- complaint. Because of this, the use of brief, validated screening tools can help to identify individuals who require further assessment. Specific examples of evidence-based screening tools and assessment resources can be found at https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools.



When all patients are screened for substance use, 75-85% of patients screen negative and require no further assessment or intervention. For the 15-25% of patients who screen positive, further assessment can be conducted to assess for and diagnose OUD. Next month, we will address next steps for the subset of individuals who screen positive by reviewing information about assessing for and diagnosing OUD.

As always, 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

Co-Prescribing Naloxone with Opioids

In order to reduce the risk of overdose deaths, prescribers should strongly consider co-prescribing naloxone (brand name NARCAN®) with opioids and provide education about its use for the following patients who are at risk of opioid overdose:

- **Patients prescribed opioids who:**
  - Are receiving opioids at a dosage of 50 morphine milligram equivalents (MME) per day or greater (for long-term chronic pain as well as acute, short-term prescriptions).
  - Have respiratory conditions such as chronic obstructive pulmonary disease (COPD) or obstructive sleep apnea (regardless of opioid dose).
  - Have been prescribed benzodiazepines (regardless of opioid dose).
  - Have a non-opioid substance use disorder, report alcohol use, or have a mental health disorder (regardless of opioid dose).
- **Patients at high risk for experiencing or responding to an opioid overdose, including individuals:**
  - Using heroin, illicit synthetic opioids or misusing prescription opioids.
  - Using other illicit drugs such as stimulants, including methamphetamine and cocaine, which could potentially be contaminated with illicit synthetic opioids like fentanyl.
  - Receiving treatment for opioid use disorder, including medications for opioid use disorder (methadone, buprenorphine, or naltrexone).
  - With a history of opioid misuse that were recently released from incarceration or other controlled settings where tolerance to opioids has been lost.

Naloxone can reverse the life-threatening respiratory depression associated with opioid overdose. If your patient is hesitant to accept a prescription for naloxone, consider utilizing motivational interviewing to explore the resistance. Some patients may be more receptive to accepting a prescription for naloxone when different scenarios are discussed, such as encountering an unconscious individual out in public who may be experiencing an opioid overdose or an opioid overdose emergency in a child who ingested the patient's opioid prescription.

For additional information, visit https://www.hhs.gov/opioids/treatment/overdose-response/index.html or contact one of our Addiction Specialists at BHI2@HighmarkWholecare.com.

Highmark Home and Community Services' Enhanced Community Care Management (ECCM) Program

Starting the last week of October, this program will be expanding into select regions of Western PA.

Highmark Wholecare has partnered with Highmark Home and Community Services' Enhanced Community Care Management (ECCM) program for both Medicare and Medicaid members that helps them manage their health, obtain access to valuable health, and work with a care team to achieve their best health.

What is ECCM?

- Supportive and palliative care for high risk populations, providing care coordination and specialty medical expertise that collaborates closely with the PCP and focuses on leading patients to live their best lives.
- ECCM's interdisciplinary care team includes physicians, advanced practice providers, registered nurses and licensed social workers, and care coordinators. It provides team-driven care directed by whole-person centered outcomes, such as self-management of patient's chronic conditions, improved quality of life, symptom burden alleviation, emotional well-being improvement, increased communication, stronger continuity of care and decreased caregiver burden.
- ECCM care is provided both virtually and in the community.
- The ECCM team ensures it is meeting patients where they are and matching them with the appropriate resources based on the patients' changing needs.
- The ECCM model is flexible, reducing disruption for the patient, family, and caregiver by providing care during the most complex parts of the care continuum. ECCM is the extra set of eyes and hands in the home to monitor patients more closely when they need it the most.

For questions or information regarding this program contact Highmark Wholecare provider services at: Medicaid 1-800-392-1147, Medicare Assured 1-800-685-5209.

Somatus

When it comes to your patients' kidney health, they have a whole team on their side! Highmark Wholecare has partnered with Somatus to offer personalized, in-home healthcare support to those with, or at risk of developing, kidney disease. Somatus serves as a one-on-one care team – all at no additional costs for eligible members.

With Somatus, members receive:

- Health care support when and where it's convenient for them
- A personal health coach
- A full care team consisting of a dietician, social worker, nurses and pharmacists who can review the patient's health in a 360˚ view.
- Help setting appointments and getting medication refills
- Immediate access to nurses 24/7
- Help finding support for transportation, food, and medicine

This no-cost benefit is a perfect way to help members stay on top of their health. Learn more at www.somatus.com. For questions, please email us at: ProviderEngagementTeam@HighmarkWholecare.com.

S9123/S9124 Provider Alert

Physical HealthChoices (PH) and Community Health Choices (CHC) Managed Care Organizations' (MCOs) Home Health Care Services (HHCS) will begin EVV visit verification beginning January 1, 2023. After the MCOs validate the visit information and adjudicate the claims, the subsequent encounters are sent to PROMISe (DHS) where an electronic EVV visit validation call is completed to ensure accuracy. In addition to procedure code, T1019, Highmark Wholecare will also require EVV validation for the following procedure codes:

S9123 – Registered nurse, providing care in the home; per hour.

S9124 – Licensed practical nurse, providing care in the home; per hour.

Due to DHS rounding rules, there has been MCO and provider abrasion with S9123/S9124 for services less than one hour. This necessitated the need for new procedure codes (T1002 and T1003) to be utilized for EVV HHCS services for 15-minute units. Beginning January 1, 2023, Highmark Wholecare will be transitioning to procedure code T1002.

T1003 – LPN 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.

T1002 – RN 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 procedure code T1002 beginning with dates of service for January 1, 2023 and forward. Providers do not need to request new authorizations. However, providers will be responsible to bill with procedure code T1002 based on the authorizations.

In addition to the T1002, Highmark Wholecare is providing the following updates to HHCS:

Shared Home Health Care Services (HHCS):

- Effective January 1, 2023, providers that are authorized for shared HHCS should use the TT modifier on all EVV encounters for members that have shared HHCS. 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 HHCS.

Rounding Rules:

- Effective January 1, 2023, 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.

Procedure Code	Unit Type	Unit Type
T1002/T1003	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
S9123/S9124	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 October 12, 2022 at 2PM CT and October 26, 2022 at 10 AM CT. NetSmart has sent the invites for the provider townhall meeting in a previous email. Questions related to the HHCS updates can be emailed to EVV@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**

continued >

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.

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

Bilateral Procedure Billing

Highmark Wholecare follows guidance from the Centers for Medicare and Medicaid Services (CMS), the Pennsylvania Department of Human Services (PA DHS), as well as industry standards such as the AMA CPT and ICD-10-CM Guidelines.

The ICD-10-CM Manual contains certain diagnosis codes to indicate laterality: right, left, or bilateral. Providers should report diagnosis codes that accurately reflect the laterality of the condition and/or services.

In addition, the AMA CPT Manual instructs the use of laterality modifiers. The laterality of the modifier must correspond to the ICD-10-CM diagnosis billed:

- **RT** – Right side
- **LT** – Left side
- **50** – Bilateral
- **E1** – Upper left, eyelid
- **E2** – Lower left, eyelid
- **E3** – Upper right, eyelid
- **E4** – Lower right, eyelid
- **FA** – Left hand, thumb
- **F1** – Left hand, second digit
- **F2** – Left hand, third digit
- **F3** – Left hand, fourth digit
- **F4** – Left hand, fifth digit
- **F5** – Right hand, thumb
- **F6** – Right hand, second digit
- **F7** – Right hand, third digit
- **F8** – Right hand, fourth digit
- **F9** – Right hand, fifth digit
- **TA** – Left foot, great toe
- **T1** – Left foot, second digit
- **T2** – Left foot, third digit
- **T3** – Left foot, fourth digit
- **T4** – Left foot, fifth digit
- **T5** – Right foot, great toe
- **T6** – Right foot, second digit
- **T7** – Right foot, third digit
- **T8** – Right foot, fourth digit
- **T9** – Right foot, fifth digit

CMS states modifiers RT, LT, or 50 should be applied to CPT codes that identify procedures performed on paired organs (e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries). Modifiers RT and LT should be used whenever a procedure is performed on only one side. These modifiers are required whenever they are appropriate.

continued >

Examples

- **H25.11** – Age-related nuclear cataract, **right eye**
- **H25.12** – Age-related nuclear cataract, **left eye**
- **H25.13** – Age-related nuclear cataract, **bilateral**
- **66983** – Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)
  - **66983 – RT** bill with diagnosis H25.11
  - **66983 – LT** bill with diagnosis H25.12
  - **66983 – 50** bill with diagnosis H25.13
- **N83.201** – Unspecified ovarian cyst, **right side**
- **N83.202** – Unspecified ovarian cyst, **left side**
- **58661** – Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
  - **58661 – RT** bill with diagnosis N83.201
  - **58661 – LT** bill with diagnosis N83.202
  - **58661 – 50** bill with diagnosis N83.201 and N83.202

References

- American Medical Association, Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage
- American Medical Association, Current Procedural Terminology (CPT)
- Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 4 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
- ICD-10-CM Official Guidelines for Coding and Reporting, FY 2023 https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines.pdf
- Novitas Solutions, Anatomical Modifiers https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00144519

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.

continued >

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 (Vyvgar)	**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.

continued >

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)

*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 (Vyvgar)	**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)
J3490*	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.

continued >

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)

*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

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.

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 Telephonic/ Telehealth Counseling program with 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/rehab/skilled nursing facility.

24-Hour Nurse Line: A toll-free 24-hour nurse line is available 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: Memberships 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 Diamond℠ (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.

Highmark Wholecare Transitions of Care (TRC) Provider Guide

At Highmark Wholecare, we value the important role our practitioners play in serving and providing quality care to our members. To that end, our quality team worked with providers throughout the second and third quarters of the year to gain a better understanding of their individual transition of care and follow up care processes, and gained feedback on industry-wide processes. As a result of these conversations, we are able to share the following best practices guide to transitions of care for our providers.

Measure Description: The percentage of discharges for Medicare members 18 years of age and older who had each of the following. Four rates are reported:

- **Notification of Inpatient Admission.** Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- **Receipt of Discharge Information.** Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- **Patient Engagement After Inpatient Discharge.** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- **Medication Reconciliation Post-Discharge.** Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Measure Importance: Medicare Stars measure

Transitions of Care Gap Closure At-a-Glance

Sub-measure	Time frame	Administrative	Medical Recored Review
Notification of Inpatient Admission	Day of admission through 2 days after the admission (3 total days).		Received notification from [ ] on XX/XX/20XX that patient was admitted inpatient to [facility name] on XX/XX/20XX.
Receipt of Discharge Information	Day of discharge through 2 days after the discharge (3 total days).		Received notification from [ ] on XX/XX/20XX that patient was discharged from an inpatient admission at [facility name] on XX/XX/20XX.
Patient Engagement After Inpatient Discharge	Within 30 days after discharge	**Online Assessments:** 98969-98972, 99421-99444, 99457 **Outpatient:** 99201-99205, 99211-99215,99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401- 99404, 99411-99412, 99429, 99455-99456, 99483 **Telephone Visits:** 98966-98968, 99441-99443 **Transitional Care Management Services:** 99495-99496	Evidence of engagement with the patient indicating that it was in follow up to a recent inpatient discharge.
Medication Reconciliation Post-Discharge	Date of discharge through 30 days after discharge (31 total days).	**Medication Reconciliation Encounter:** 99483 99495 99496 **Medication Reconciliation Intervention:** 1111F	Patient Name, Date of Birth Date of Service and Provider Acknowledgment of recent inpatient discharge. Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.

Notification of Inpatient Admission

Completed by Medical Record Review only

Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting. This must include:

- Time Frame: Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (3 total days).
- Documentation in the outpatient medical record must include **evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received.**

Any of the following examples meet criteria:

Communication:

- Between inpatient providers or staff and the member's PCP or ongoing care provider.
- About admission between emergency department and the member's PCP or ongoing care provider.
- About admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system.
- About admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria.
- About admission to the member's PCP or ongoing care provider from the member's health plan.

Indication that:

- The member's PCP or ongoing care provider admitted the member to the hospital.
- A specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.
- The PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay.

Documentation that the PCP or ongoing care provider performed a preadmission exam or **received communication about a planned inpatient admission.** The time frame that the planned inpatient admission must be communicated is not limited to the day of admission through 2 days after the admission (3 total days).

Suggested Workflow:

- Provider office receives notification of inpatient admission from Health Information Exchange, Electronic Medical Record, Facility or Health Plan.
- Provider documents and acknowledges receipt of notification of inpatient admission in the medical record.

Appropriate Documentation Verbiage example:

- Received notification on XX/XX/20XX that patient was admitted inpatient to [facility name] on XX/XX/20XX.

The following notations or examples of documentation DO NOT count as closing the care gap:

- Notification of Inpatient Admission Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge.
- Documentation of notification that does not include a time frame or date when the documentation was received.

Receipt of Discharge Information

Completed by Medical Record Review only

Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting with evidence of the date when the documentation was received.

Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following:

- The practitioner responsible for the member's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list.
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care post-discharge.

Appropriate Documentation Verbiage example:

Received notification on XX/XX/20XX that patient was discharged from an inpatient admission at [facility name] on XX/XX/20XX.

Include copy of notification if provided in writing.

Patient Engagement after Inpatient Discharge

Administrative or Medical Record Review

Administrative Gap Closure: Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement (captured via medical claims received by the health plan):

- An outpatient visit
- A telephone visit
- Transitional care management services
- An e-visit or virtual check-in

Medical Record Review Gap Closure: Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria:

- An outpatient visit, including office visits and home visits.
- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider).

CPT codes for Administrative Gap Closure – Preferred Method

- Online Assessments: 98969-98972, 99421-99444, 99457
- Outpatient: 99201-99205, 99211-99215,99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401- 99404, 99411-99412, 99429, 99455-99456, 99483
- Telephone Visits: 98966-98968, 99441-99443
- Transitional Care Management Services: 99495-99496

Medication Reconciliation Post-Discharge

Administrative or Medical Record Review

Administrative: Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days) identified through medical claims submitted to the health plan.

CPT Codes for Administrative Gap Closure (Preferred Method):

Medication Reconciliation Encounter:
99483
99495
99496

Medication Reconciliation Intervention:
1111F

Medical Record Review:

Include:

- Patient Name, Date of Birth
- Date of Service and Provider
- Acknowledgment of recent inpatient discharge
  - Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
  - Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
  - Documentation of the member's current medications with a notation that the discharge medications were reviewed.
  - Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
  - Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
  - Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
  - Notation that no medications were prescribed or ordered upon discharge.

Notes:

- Documentation of “post-op/surgery follow up” without a reference to “hospitalization,” “admission” or “inpatient stay” does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization.

- A medication reconciliation performed without the member present meets criteria. Can review in the EMR and document medication reconciliation as described above.

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.

HM Home and Community Services is a separate company that offers specialized care coordination and/or supportive care 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").