

# Provider Newsletter

for Highmark Health Options | Highmark Health Options Duals (HMO SNP) | DELAWARE



## FEATURED ARTICLES:

Improving Access to Care for People with Disabilities

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Model of Care Training Summary

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Enhancing Children's Oral Health: The Power of Fluoride Varnish in Primary Care

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Highmark Health Options Practitioner Excellence Program

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...And More

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## Contact Us

Highmark Health Options and Highmark Health Options Duals (HMO SNP) Provider Services is the first line of communication for providers' questions and inquiries. Provider Services is available Monday–Friday, 8 a.m.–5 p.m., and can be reached by calling the following numbers:

HHO Provider Services: **1-844-325-6251**   HHO Duals Provider Services: **1-855-401-8251**



# Improving Access to Care for People with Disabilities

We encourage providers to advocate for accessible health care and to achieve health equity for individuals with disabilities.

Improved physical accessibility to these services is a fundamental component of this effort. The Centers for Medicare and Medicaid Services (CMS) created a guide, developed for health care providers, staff, and administrators in outpatient environments. The guide explores various physical challenges that individuals may encounter, provides guidance regarding assessing your facility's accessibility, and describes effective approaches to designing and executing patient-centered care programs and policies.

It's important to note that the steps outlined herein are intended as a starting point for assessment and do not supersede federal, state, or local regulations. For a deeper understanding of unique practice requirements and additional barriers, engaging with experts and individuals with disabilities is highly recommended.

**Access the guide today at [cms.gov](https://www.cms.gov) and other resources related to:**

- Modernizing Health Care to Improve Physical Accessibility
- Modernizing Health Care to Improve Communication Accessibility
- Navigating Health Care with a Disability

**Additionally, Disability Help provides information on 10 best practices for accessibility in health care facilities, which include:**

- Ensuring wheelchair-friendly pathways and ADA-compliant restrooms for physical accessibility.
- Providing sign language interpreters and telecommunication relay services for deaf patients. Implementing digital accessibility standards like Web Content Accessibility Guidelines (WCAG) for all health care websites and electronic records.
- Offering disability sensitivity training for staff to improve communication and care.
- Making reasonable modifications like early appointments and allowing companions to accommodate patient needs.

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For additional information please visit Disability Help's **10 Best Practices for Accessibility in Healthcare Facilities - Resources on Disability Assistance: Your Rights and Benefits.**

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# Model of Care Training Summary



## Provider Training Requirement

As a Dual Eligible Special Needs Plan (D-SNP), Highmark is required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC). In accordance with CMS guidelines, Highmark's D-SNP MOC 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 network providers are expected to complete and attest to MOC training on an annual basis.

### The D-SNP MOC is divided into four sections:

1. Description of the D-SNP Population
2. Care Coordination
3. Provider Network
4. Quality Measurement & Performance Improvement

The annual provider training focuses on the D-SNP Provider Network section and outlines what Highmark expects from our providers in maintaining an effective MOC.

The MOC ensures that the D-SNP Provider Network is comprehensive and able to care for the unique and specific needs of the population by implementing the following elements throughout the D-SNP Provider Network.

1. Specialized Expertise
2. Use of Clinical Practice Guidelines (CPGs) and Care Transition Protocols (CTPs)
3. Annual Model of Care Training for the Provider Network

The training also includes common MOC terms and definitions, as well as Highmark contact information.

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### Action Required

Review the Model of Care Provider Training found on our **Provider Resource Center**. Once you have completed this training, please **submit an attestation** indicating that you have completed and comprehend the Model of Care training.

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# Enhancing Children's Oral Health: The Power of Fluoride Varnish in Primary Care



To address the impact of Early Childhood Caries (ECC), which affects nearly one in four children ages 2-5 in the U.S., as reported by the **American Academy of Pediatric Dentistry (AAPD)**, primary care providers are encouraged to integrate fluoride varnish application into well-child visits.

## Fluoride Varnish: A Proven Solution

Fluoride varnish is a highly effective, evidence-based intervention that significantly reduces caries incidence in primary teeth by 30-50% according to the **AAPD**. It works by strengthening tooth enamel and can even reverse early signs of decay, offering a powerful protective shield against cavities.

## Why Primary Care? The Benefits of Integration.

**Integrating fluoride varnish application into well-child visits offers multiple advantages:**

- **Increased Access:** Many young children see their primary care provider regularly but may not visit a dentist.

- **Early Intervention:** Allows for timely prevention before caries become extensive.
- **Trusted Relationships:** Parents often have established trust with their pediatrician, making them receptive to preventive advice.
- **Cost-Effectiveness:** Prevention is far more economical than treating established dental disease.

## Core Knowledge for Providers

- **Indications:** All children ages 1-4 at risk for caries. Consider risk factors such as high sugar intake, poor oral hygiene, or a family history of caries.
- **Contraindications:** Few, mainly known allergy to fluoride or colophony, or acute ulcerative gingivitis/stomatitis.
- **Frequency:** Typically every three to six months, aligning with well-child visit schedules.

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## Reimbursement

Providers who complete fluoride varnish application can be reimbursed for application of fluoride varnish during a visit using the CPT code 99188 following standard billing guidelines.

### Resources:

- **American Academy of Pediatric Dentistry (AAPD)**
- **American Academy of Pediatrics: Oral Health Practice Tools**
- **American Academy of Pediatrics: Oral Health Toolkit**



# Important Reminder: Provider Appeal Form for Fax and Mail Submissions

When submitting a post-service appeal by fax or mail, the **Provider Appeal Form** must be completed. **Effective August 1, 2026, failure to complete and submit this form will result in the cancellation of your appeal due to insufficient information.**

When you submit a post-service appeal through the NaviNet<sup>®</sup> Provider Portal, you will be prompted to complete this form within the portal. Please note, this form is only for post-service appeals, including reconsiderations of claim denials, retrospective reviews, and denied services. This form should not be used for member appeals, pre-service appeals, payment disputes, or resubmissions of corrected claims, which must be submitted to the Member Appeals Department or Claims Department, respectively.

**As a reminder, if you disagree with a denial and wish to formally dispute the decision, you have several options for submitting a post-service appeal:**

- Our Provider Portal, via NaviNet<sup>®</sup> (preferred method)
- HHO DE Medicaid Fax: **1-833-841-8074**
- HHO Duals (Medicare)  
Fax: **1-833-560-1828**
- Mail: Highmark Health Options  
Attention: DE Provider Appeals  
PO Box 890416  
Camp Hill, PA 17089-0416

**To ensure timely processing and review, your appeal request must include:**

- A Provider Appeal Form. All sections of the form must be completed.
- A written explanation of the appeal. Ensure you clearly state the reason for the appeal.
- Claim number(s) being appealed.
- Date of service being appealed.
- Code(s) being appealed.
- Complete and relevant supporting clinical documentation.
- Return mailing address. Provide a complete and accurate address for the appeal decision letter.
- Timely filing limits apply.



# Prescriber Notice: Diagnosis Code Requirement for Certain Medications



As part of ongoing efforts to ensure compliance with regulatory requirements, Highmark has identified a billing documentation gap related to certain high-cost and/or potentially abused maintenance medications.

During Medicaid drug claim reviews, auditors require documentation of a corresponding diagnosis that aligns with the FDA-approved indication for the prescribed medication. To ensure compliance and maintain the integrity of clinical records, providers must include the corresponding ICD-10 diagnosis code with all billed medical encounters involving prescribed maintenance medications on an annual basis, at a minimum.

**This requirement is especially important for the following therapeutic drug classes, which are flagged for review:**

- Stimulants (e.g., Adderall, Ritalin)
- Inflammatory Conditions (e.g., Entyvio, Cosentyx, Taltz, Humira, Rinvoq)
- Bowel Conditions (e.g., Trulance, Pentasa, Linzess, Sulfasalazine)
- Movement Disorders (e.g., Austedo, Ingrezza, Tetrabenazine)

Accurate and complete documentation, including diagnosis codes, not only supports appropriate clinical review and regulatory compliance, but also facilitates timely claims processing and continuity of care.



# New Name for Enhanced Community Care Management



Effective July 20, 2026, the Enhanced Community Care Management (ECCM) program will be renamed to Well in Place.

It's crucial to emphasize that this change is solely a name change. The core components of the program, services offered, and the dedicated interdisciplinary team remain unchanged.

The change in name is intended to help members better understand and engage with the program, while also supporting increased referrals from providers for appropriate care. The referral process will also remain the same.

The new name, Well in Place, which may appear with the tagline, "The right care. Right where you are," more accurately conveys the dedication in providing personalized health support conveniently where members live or receive care, often right in their homes or communities.

Through programs, such as Well in Place, Highmark is committed to transforming health care and creating a more holistic experience for members with serious illness or complex conditions.

All relevant member and provider materials will be updated to reflect the Well in Place name change and will be distributed closer to the launch date.

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For additional questions, access the **Provider Service Center** or reach out to **[GetSPS@highmark.com](mailto:GetSPS@highmark.com)**.

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# Upcoming Medical Record Review Standards



As part of our contract to provide medical coverage for the Medical Assistance/Medicare population, Highmark Health Options Delaware is required to perform medical record audits. These reviews are conducted on a periodic basis to ensure that our providers are keeping accurate and sufficient record documentation on our members.

This review assesses compliance with multiple standards and critical elements developed and approved by Highmark Health Options Delaware Quality Improvement & Utilization Management Committee. Some examples of these standards include documentation of continuity and coordination of care, execution of an advanced directive, legibility of written documentation, follow-up visits, and signing and dating of notes.

Records readily available from various projects may be reviewed and some formal requests for records will be made. If your practice is selected for a formal review, you will be contacted by the Quality Improvement Team for support and guidance. We kindly ask for your assistance with providing copies of the supporting documentation relating to the medical record review standards.

Our intention is to provide feedback and work collaboratively to address areas needing improvement. Our goal is to ensure that our members' medical records meet the required regulatory standards as outlined by contractual agreement. For your reference, the Medical Record Review Standards are available upon request, or can be found on the **Provider Resource Center**.



# Provider Self-Audits

Federal and state regulations require providers to routinely audit claims for overpayments. To meet this requirement, providers must notify Highmark in writing of the reason for the overpayment and return the full amount of the overpayment within 60 days of the date they identified the overpayment.

Providers can submit the **Medicaid** and **Medicare** Provider Self-Audit forms that are located on our website under the Provider Resource Center.

## Information to Submit for Self-Identified Overpayment

**When submitting information for an identified overpayment, please include the following:**

- Provider information (i.e., name, NPI, TIN, contact information).
- Self-audit/overpayment information.
- Period of claims:
  - For claims more than two years old, please provide a check.
  - For claims less than two years old, retraction of claims is preferred.
- List of affected claims and/or extrapolation calculation used to determine overpayment amount.

## TRENDSSubmit: Provider Self-Reporting Process

Providers can electronically submit overpayments via TRENDSSubmit. This secure, online process allows providers to be notified of claim retractions in real-time and eliminates the lengthy manual paper process. The TRENDSSubmit team provides user training resources and ongoing support.

Providers can contact Jennifer Baron at [jbaron@trendhealthpartners.com](mailto:jbaron@trendhealthpartners.com) in order to initiate TRENDSSubmit access.

If you have any questions regarding Provider Self-Audits, you can contact the Special Investigation Unit (SIU) at [ProviderSelfAudits@highmark.com](mailto:ProviderSelfAudits@highmark.com). Additional information on provider self-audits can be found in the Medicaid and Medicare Provider Manuals.



# Risk Adjustment: Importance of HCC Gap Closures

As a provider, you play an important role in managing care for your patients. Documenting and reporting patient complexity paints a picture of the patient's overall health (i.e., disease burden capture). Accurate reporting is critical to support Highmark's most vulnerable members.

As a reminder, providers should report and document all chronic conditions annually, and if possible, earlier in the year for each of their patients to promote quality of care and appropriate resource allocation. Each year, chronic conditions must be re-documented for CMS because the disease burden information for all patients is reset at the start of the calendar year. Although conditions are chronic, they require annual evaluation and documentation.

## **To ensure compliant and accurate disease burden capture, consider these tips and best practices:**

- Schedule annual wellness visits early in the year to ensure members are seen in a timely manner. The additional time frequently provided for these appointments allows for a more thorough and accurate assessment of disease burden.
- To ensure comprehensive documentation, we recommend reviewing and submitting claims for all chronic conditions during the patient's first visit of the year, as future visits may not occur.

- Even if the primary reason for a visit is an acute problem, consider also addressing chronic conditions if your schedule allows, especially given the potential for acute issues (like a URI) to negatively impact a chronic condition (such as COPD).
- If addressing chronic conditions requires multiple visits, schedule follow-up appointments as early in the year as possible.
- Utilize pre-visit evaluation and pre-charting resources through Advanced Practice Clinicians to assist with the evaluation and documentation of chronic conditions.
- Proactive annual disease burden capture offers mutual benefits for patients and providers. By documenting conditions earlier in the year, we achieve:
  - More timely interventions, improved care coordination across multiple providers, and access to disease management programs that can mitigate disease progression.
  - Lower need for a concentrated effort on disease burden capture appointments at year-end, freeing up capacity for other essential patient care activities.

This documentation within the patient's chart is critical as it directly informs CMS and their health plan about the necessary healthcare resources required to support the patient's well-being.



# Highmark Health Options Practitioner Excellence Program



Opt-in to the 2026 Highmark Health Options Practitioner Excellence (HHOPE) Program by reaching out to your Clinical Transformation Consultant.

We value the important role practitioners play in serving our members, and welcome you to the program, which supports Highmark Health Options' mission to improve the health and wellness of the individuals and the communities we serve by providing access to integrated, superior health care.

Please contact your Clinical Transformation Consultant directly or email us at [DePET@Highmark.com](mailto:DePET@Highmark.com) for information on the opt-in process. By opting in, you are confirming your intent to participate in the program. Providers will be enrolled in their chosen programs based on provider specialty and eligibility criteria. This and more is outlined in the **HHOPE Program Guide**.

## 2026 HHOPE Webinar Series

There is one more live webinar providing an overview of the 2026 HHOPE Program.

**Use the link below and click "Register":**

- **Tuesday, Sept. 1 at 12 p.m.**

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

If you have questions, feel free to reach out to our Clinical Transformation Consultant directly team directly at [DePET@Highmark.com](mailto:DePET@Highmark.com).

## 2026 Highmark Health Options Care Gap Management Application (CGMA) & Provider Reporting

We value the important role practitioners play in serving our members. Remember that the Care Gap Management Application (CGMA) offers access to important information needed to view members' care gaps, submit evidence for gap closure, and perform many other functions that enable you to more easily manage member care gaps.





## Accessibility Standards: Timeliness of Access to Care

Highmark Health Options Delaware maintains standards and processes for ongoing monitoring of access to health care.

To help ensure our members receive services in a timely manner, practice sites are contractually required to follow these standards. 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.

Accessibility standards and additional resource information related to accessibility are available on our **Provider Resource Center**.





## Participating Providers Should Not Balance Bill Patients

Highmark Health Options (HHO) continues to receive numerous complaints about participating providers who have inappropriately balance billed HHO patients for services.

As a reminder, reference the following language from page 19 of the Highmark Health Options Provider Manual Billing Responsibilities section.

### **Billing patients for covered services**

Under no circumstance may a provider bill; charge, collect a deposit from, seek compensation, remuneration, or reimbursement from; or have any recourse against a patient for nonpayment by Highmark Health Options for covered services.

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Contact Provider Services at **1-844-325-6251** to learn more about balance billing.

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# Member Rights and Responsibilities

Highmark Health Options Medicaid and Medicare Dual Special Needs Plan (D-SNP) members have certain rights and responsibilities as members of Highmark. To detail those rights and responsibilities in full, Highmark maintains a Member Rights and Responsibilities statement, which is reviewed and revised annually.

Highmark and its provider network do not and are 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. Some additional rights and responsibilities include:

## Member Rights

**As a Highmark Health Options member, they have the right to:**

1. Be treated with respect, dignity, and privacy.
2. Know about their rights and what they need to do.
3. Use their rights without fear of punishment from Highmark Health Options, their providers, or the State.
4. Get easy-to-understand information about Highmark Health Options. This includes our services, our providers, and their rights and responsibilities.
5. Ask for the Member Handbook and other health care materials in ways they can understand. This means in other languages, large print, audio CD, or Braille—at no cost to them.
6. Ask for a free interpreter or help to translate information—at no cost to them.
7. Use interpreters who are not their family members or friends.
8. Get all Highmark Health Options benefits and services. This is true no matter their background, if they speak English well, if they have a disability, or if they are homeless.
9. Not be treated unfairly because of their age, sex, race, where they were born, language needs, or how sick they are.
10. Choose their primary care provider and other health care providers.
11. Talk with their providers about their care choices. They can make decisions about their health, even if it means saying no to treatment. This is true no matter the cost or if it's covered.
12. Make their own health care decisions. If they cannot make health care decisions by themselves, they have the right to have someone else help them make decisions. Or they can make decisions for them.

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13. Be told about other treatment options or plans for care.
14. Ask another provider for their opinion about their health. This is called a second opinion.
15. Make a plan for their future medical care by creating an Advance Directive (living will).
16. Know how their health care providers are paid.
17. Get emergency care from any doctor, at any hospital, or in any place when they need it.
18. Keep their medical records and health information private. We will only share them if they tell us in writing that it is okay.
19. Get copies of their medical records and care plans. They can ask us to change or fix their medical records.
20. Choose any family planning doctor, whether they are in or out of our network.
21. Get care from a certified nurse midwife, or a certified children's or family nurse practitioner.
22. Know that Highmark Health Options can change benefits. We will mail them a letter when this happens.
23. Get information about services we don't cover because of moral or religious reasons. We will also tell them how to get those services.
24. Ask about Highmark Health Options programs to make care better (Quality Improvement). Also ask how we check that services are used correctly.
25. Get problems solved quickly about complaints, appeals, approvals, what is covered, and payment.
26. File a complaint (grievance) or an appeal if unhappy with their care, treatment, or decisions Highmark Health Options makes.
27. Ask for a State Fair Hearing if they don't agree with the decision about their appeal.
28. Not be held back or kept alone as punishment, to make things easier for staff, or to get back at them.
29. Find out how Highmark Health Options decides if new technology, tests, or treatments will be a covered benefit.
30. Leave (disenroll) from Highmark Health Options.
31. Give ideas about the rights and responsibilities of Highmark Health Options members.

## Member Responsibilities

**As a Highmark Health Options member, it's their responsibility to:**

1. Tell Highmark Health Options and their providers what they need to know to care for them. Also, tell them what they want or need.
2. Learn about their health problems. Work with their provider to make treatment goals that they both agree on.
3. Ask questions about their health, especially if they don't understand what their provider says.

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4. Follow their provider's care plans and instructions as best as they can. Make sure they agree on them with their provider.
5. Be part of decisions about their health care and treatment.
6. Make and keep medical appointments and tell their provider if they can't make it.
7. Use doctors in the Highmark Health Options network. They can see other doctors if it's an emergency or if we approve it.
8. Get a referral from their primary care provider to see certain specialists.
9. Use the emergency room only for real emergencies. Or use it if their doctor tells them to.
10. Respect other patients, clinic staff, and Highmark Health Options staff.
11. Read and follow what is in the Member Handbook.
12. Learn what Highmark Health Options covers. This includes benefits that are covered and those that are not, and any limits.
13. Always show their Member ID card and Medicaid card.
14. Try their best to pay their copays. If they owe a copay at the pharmacy, pay when they get their medicine.
15. Tell us right away if they get a bill they should not have. Also tell us if they have a complaint.
16. Know what laws Highmark Health Options follows.
17. Report fraud and abuse.
18. Tell Highmark Health Options and other groups (like the State, USPS, DMV) of changes in their life. This includes their address, phone number, family status, or other insurance.
19. Know that Highmark Health Options is not workers' compensation insurance.

\*If a minor becomes emancipated or legally freed from control by his or her parents (over the age of sixteen), or marries, he or she shall be responsible for following all Highmark Health Options member guidelines set forth above.

The Member Rights and Responsibilities Statement can be found in the Medicaid Member Handbook, the Evidence of Coverage, or on our website at **Medicaid Member Resources** and **Medicare Member Resources**.

**For more information, please call Provider Services at:**

- Medicaid: 1-844-325-6251
- Medicare: 1-855-401-8251





NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

Endorsed is a separate company that provides care management services.

Trend Health Partners is a separate company that provides post-payment accuracy & integrity solutions.

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All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.