

Provider Newsletter

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

FEATURED ARTICLES:

New
Communication Hub

PCP Member Rosters
Now Available in the
Provider Portal

Final HHOPE
Incentive Program
Opt-In Deadline
Reminder: Sept. 30

2026 Clinical
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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**



New Communications Hub



Highmark Health Options and Highmark Health Options Duals (HMO SNP) is launching a new Communications Hub on the **Provider Resource Center** at the end of the year. This enhancement is designed to streamline access to critical information and improve the overall communication experience for our provider partners.

The new Communications Hub will become your main source of Highmark information, serving as a single, easily navigable destination.

Key features and benefits include:

- **Improved Navigation:** The hub will feature an intuitive design and improved search functionality, making it easier and faster for providers to find the specific information they need.
- **Enhanced Organization:** New filters will allow providers to refine content by topic.

The Communications Hub will replace the **Latest Updates** section in the main website menu.

We encourage you to explore the new Communications Hub upon its launch and provide feedback through our website survey, which can be found by clicking on the light blue **Give Feedback** tab on the right side of the screen. We read all feedback and use it when considering future enhancements.





PCP Member Rosters Now Available in the Provider Portal

Highmark Health Options Medicaid and Highmark Health Options Duals (Medicare) PCPs can now access their member rosters within our provider portal, accessed via NaviNet. The member rosters display real-time member data and can be downloaded into Excel. Effective November 1, 2026, we will no longer be mailing rosters via US Mail.

Please reach out to our Provider Relations team with any questions at hproviderrelations@highmark.com.

Accessing member rosters:

- Once logged into the portal, select **Enhanced Provider Features** from the Workflow list.
- Go to **Reporting** and select **Member Roster Report** from the drop-down menu.
- Select **Change Provider to select the providers you have access to** and click on **Get Results**. Click **Export Data** to export to Excel.



2026 Annual Provider Accessibility Audit Results

Highmark Health Options and Highmark Health Options Duals (HMO SNP) conducted the 2026 Annual Accessibility Audit of Medicaid and Medicare D-SNP primary care providers, medical specialists, and behavioral health specialists January through April of this year. The audit determined if participating practice sites were adhering to established access standards related to the timeliness of member care. Practice sites that failed one or more standards have received a letter indicating required next steps.

The Audit Identified the Following Achievements:

Medicaid

- **Primary Care:** Over 90% of primary care practice sites see patients for urgent care within 48 hours, routine care within 21 calendar days, and provide timely access to after-hours care.
- **High Volume Specialty Care:** Over 90% of high-volume specialty care practice sites see patients for emergency care immediately or direct patients to an emergency facility, and see patients for urgent care within 48 hours.

- **Behavioral Health:** Over 90% of behavioral health practice sites see patients for non-life-threatening emergency within six hours or direct the patient to the emergency room or a behavioral health crisis center, see patients for urgent care within 48 hours, non-emergency outpatient within 21 calendar days, follow-up routine care within 15 business days, and provide timely access to after-hours care.

Medicare

- **Primary care:** Over 90% of primary care practice sites see patients for emergent care immediately or direct patients to an emergency facility.
- **Behavioral Health:** 100% of behavioral health practice sites see patients for emergent care immediately or direct patients to an emergency facility, and over 90% see patients for routine care within 30 business days.

To promote continued improvement in access to care, we are focusing on the continuous education of our provider network through the Accessibility Standards. Please use the resources found on our **Provider Resource Center** to supply continued education for your office staff that schedule member appointments, including central scheduling and call center staff.

Thank you for your participation in the audit and ensuring patients have timely access to care.



Cotiviti Claims Pattern Review (CPR)

Highmark is enhancing its existing claim editing program to broaden the overall accuracy and integrity of our claims processing. To enhance the accuracy and timeliness of claims processing, Highmark is implementing Cotiviti Claims Pattern Review (CPR).

CPR will enable efficient Payment Policy Management and review of claims while utilizing “real time” analytics. CPR will have the ability to pause claims processing and enable Cotiviti CPR experts to review claims for proper validation prior to payment. As part of this process, registered nurses with coding certifications will review claim data in conjunction with patient claim history to validate appropriate claims processing.

Where to Send Appeals for CPR

Providers have the right to submit for review any claim they feel was denied or paid incorrectly.

Providers have three options to send in Cotiviti CPR Appeals:

1. Direct upload to the **Secure Portal**. Simply click on the “Submit Records” button and enter your password: high90CCVC.
2. Secure faxing to **800-409-0499**.

3. Mailing the records directly to Cotiviti. Please mark the envelope “Confidential” and send to:

C/O Cotiviti-6150
10701 S Riverfront Pkwy,
Box 12017
South Jordan, Utah 84095

Information regarding Cotiviti CPR can be found in the **Medicaid** and the **Medicare** Provider Manuals, located on the **Provider Resource Center**.



Your Corrective Action Plans Support Compliance



Highmark's Financial Investigations and Provider Reviews (FIPR) team conducts audits regarding fraud waste and abuse (FWA). An audit that identifies errors will require corrective actions, including a Corrective Action Plan (CAP) to address and resolve the deficiencies.

Providers are responsible for correcting areas of noncompliance. An effective CAP will:

- Specify steps to remediate the underlying problem, including identifying time frames of implementation and staff members who are responsible for changes
- Improve processes so that outcomes are more effective and efficient
- Include methods to monitor the effectiveness of the changes

Providers are expected to submit a CAP when requested within 30 days. Subsequent FWA audits may be performed to measure CAP adherence.

Resources:

- **Corrective Action Plan (CAP) Guidelines**
 - **Medicaid Provider Manual**
 - **Medicare Provider Manual**
-

Questions:

Contact the Special Investigations Unit (SIU) at SIU_HHO@highmark.com or call the FWA hotline at **1-844-325-6256**.



Final HHOPE Incentive Program Opt-In Deadline

Reminder: Sept. 30

Act now to participate and opt-in to the 2026 Highmark Health Options Practitioner Excellence (HHOPE) Program! The deadline to opt-in is September 30, 2026.

The program supports Highmark Health Options/Highmark Blue Cross Blue Shield (hereafter “Highmark”) mission to improve the health and wellness of the individuals and the communities we serve by providing access to integrated, superior healthcare.

Please contact your Clinical Transformation Consultant directly or email us at **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.

More information can be found in the HHOPE Program Guide, located on the **Provider Resource Center**.

If you have been unable to attend any of the webinars, the training presentation is also available for review. If you have questions, feel free to reach out to our Clinical Transformation Consultant directly team directly at **DePET@Highmark.com**.

2026 Highmark Care Gap Management Application & Provider Reporting

We encourage you to utilize our Care Gap Management Application (CGMA). CGMA supports Highmark’s mission to improve the health and wellness of the individuals and the communities we serve by offering providers actionable care gap data.

With the CGMA, you can:

- View member care gaps
- Submit evidence for care gap closure
- View your progress towards closing member care gaps
- See your member roster
- Review your HHOPE performance and opportunity reporting
- Complete bulk evidence submissions for a member
- Generate member-level gap reports in bulk
- Generate multi-provider gap reports
- See due dates for applicable measures (e.g., W30, OMW)
- Use the measure badge to see event-based due dates; remaining to take action are displayed on the measure banner



Best Practices for Documentation & Coding of Cancers

ICD-10 codes from categories C00-D49 should be used when coding for Cancers. Characterizing with specificity (type/site/laterality) and documenting current status and treatment, allows for an accurate reflection of disease burden.

To view the full coding course, a video presentation and the Coding and Documentation Resource, visit the **Coding Education HCC University**.

Importance of Clinical Documentation for Cancer

Specify Active/Current

Record should clearly state:

- Recent diagnosis awaiting treatment
- Undergoing active treatment
 - Directed at the site
 - Palliative purposes
- Present, but unresponsive
- Watchful waiting
- Refusal of treatment or unable to continue with treatment plan

Metastatic

Record should clearly identify:

- Primary site
- Secondary site

Use terms such as “to” and “from” or “primary” and “secondary”

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In Remission

Specific to Lymphoma, Leukemia, and Multiple Myeloma. Record should clearly state:

- Not having achieved remission
- In remission
- In relapse

History of (Do not use with active/current cancer)

Record should include the following:

- Eradicated and/or all treatment has been completed
- No evidence/recurrence of disease (NED)
- Undergoing treatment for prophylactic purposes
- Ongoing surveillance post cure

Other Best Practices Include



Monitoring

How is the patient doing?

Document signs, symptoms, disease progression/regression or ongoing surveillance.



Address/Assess

How will the condition be evaluated?

Document discussion, review of records, counseling, or ordering further tests.



Evaluate

What is the current state of the condition? Document current state, test results, medication effectiveness or response to treatment.



Treatment Documentation

What is being done to help the condition? Document care, prescribed medications, referral to specialist, or other modalities.



Interactive Care Management Programs



Refer eligible patients today to Interactive Care Management Programs and access care plans through the Provider Portal to support coordinated care.

Highmark Health Options and Highmark Health Options Duals (HMO SNP) offer Interactive Care Management Programs at no cost to eligible members, to support your patients' health. Programs address varying levels of clinical complexity, chronic disease burden, and preventive needs across the continuum of care. Services are implemented in accordance with applicable evidence-based clinical guidelines.

Program Highlights

- **Complex Case Management:** Individualized, person-centered support for members with high-acuity medical, behavioral health, substance use conditions, as well as those experiencing significant social determinants of health/health-related social needs.
- **Disease Management:** Targeted support for cardiovascular, metabolic, respiratory, gastrointestinal, and renal conditions, with focus areas evolving based on population health analysis and emerging clinical priorities.

- **Maternity:** Education, risk screening, care coordination, and monitoring for pregnant, high-risk maternal-fetal, postpartum, and pediatric populations (as applicable by line of business).
- **Preventive Health:** Outreach supporting recommended screenings, immunizations, laboratory monitoring, and risk reduction strategies, including pre-diabetes and recommended screenings to promote early detection and prevention.

Member Identification and Participation

Members may be identified through systematic population health analytics, clinical review, health assessments, claims data, or direct member or provider referral. Participation is voluntary; members may enroll, decline, or opt out at any time unless otherwise specified by program requirements.

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Working With You

Care Management clinicians collaborate with treating providers to reinforce the plan of care, support medication adherence, coordinate specialty referrals, address care gaps, and connect members to community-based resources.

Access to Care Management Plans

Care Management plans for participating members are made available to practitioners through established communication channels, including the Provider Portal, to support timely engagement, coordination, member management, and continuity of care.

Referrals and Assistance

For referrals, questions, or assistance with Provider Portal access, please contact Provider Services, Monday-Friday 8 a.m.-5 p.m.

- Highmark Health Options Provider Services at **1-844-325-6251 (TTY: 711)**
- Highmark Health Options Duals Provider Services at **1-855-401-8251 (TTY: 711)**





2026 Clinical Practice Guidelines

Highmark Health Options and Highmark Health Options Duals (HMO SNP) compiles clinical practice and preventive health guidelines to assist providers in delivering appropriate care relevant to our members. These guidelines are developed using clinical practice guidelines (CPGs) from recognized sources. The guidelines also serve as a guide for our wellness programs.

Coverage decisions are based on member eligibility, contractual benefits, and determination of medical necessity.

A complete listing of guidelines are viewable online at **HHO Clinical Practice Guidelines**. Physical copies are available upon request by contacting the Quality Improvement Department at **1-844-325-6251**.

General CPG Limitations

Guidelines may not apply to every patient or clinical situation; some variation from guidelines is expected. Provider judgment and knowledge of an individual patient replaces CPGs. In addition, guidelines do not determine insurance coverage of health care services or products.



Join the Upcoming Podiatry Care Provider Webinar

The Complete Footprint: Navigating Coverage, Compliance, and Care in Podiatry

Tuesday, Nov. 17, 2026

12 p.m. – 1 p.m.

CME/CEU credits available

Register for this upcoming Lunch and Learn Webinar, exploring podiatry care and billing requirements for these services.

The session will cover the following objectives:

- Identify what constitutes podiatry
- Outline proper compliance with documentation, coding and modifier guidelines
- Identify common areas of potential Fraud, Waste, and Abuse within podiatry

Speakers from Financial Investigations and Provider Review (FIPR)

- Anne Lacienski, CPMA; Manager
- Cynthia Scott, CPC; Senior Investigator
- Jayme Patterson, CPC; Senior Investigator
- Sherry Roedersheimer, COC, CPC, CPMA; Lead Investigator

Qualifying for CME

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

This webinar is eligible for one CME/CEU credit. To receive credit, **create a free account**. You only need to enroll once to be eligible to receive CME credit for attendance at live webinar activities. Instructions for claiming CME/CEU credit will be provided during the live webinar. You must also **create a free account** to access your transcript.

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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.





Participating Providers Should Not Balance Bill Patients

Highmark Health Options (HHO) and Highmark Health Options Duals (HMO SNP) continues to receive numerous complaints about participating providers who have inappropriately balance billed 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 for covered services.

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





Reportable Conditions

Highmark Health Options and Highmark Health Options Duals (HMO SNP) providers must report certain diseases, infections, or conditions as determined by Delaware Code Title 16, Health and Safety § 1012 REPORTING OF DISEASES, INFECTIONS AND CONDITIONS. The Reportable Conditions Policy explains this contractual requirement as well as the methods by which providers will be notified of its necessity.

If you are looking for additional information or to obtain a copy of the Reportable Conditions policy, please contact the Provider Services Department at **1-855-401-8251**. Additionally, these regulations, including the complete list of reportable conditions and timeframes for reporting, can be found at **The Delaware Code Online**.



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.

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 by **submitting your attestation**.



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 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, their providers, or the State.
4. Get easy-to-understand information about Highmark. 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 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.

Continues on the next page



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 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 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 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 decides if new technology, tests, or treatments will be a covered benefit.
30. Leave (disenroll) from Highmark.
31. Give ideas about the rights and responsibilities of Highmark members.

Member Responsibilities

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

1. Tell Highmark 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.
4. Follow their provider's care plans and instructions as best as they can. Make sure they agree on them with their provider.

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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 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 staff.
11. Read and follow what is in the Member Handbook.
12. Learn what Highmark 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 follows.
17. Report fraud and abuse.
18. Tell Highmark 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 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 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.

Cotiviti is a separate company that administers pre-pay claim editing, retrospective data mining activities, readmissions, and chart reviews for Highmark Health Options.

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. Highmark Health Options Duals is offered by Highmark Blue Cross Blue Shield. Highmark Health Options Duals offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.

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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.