Q1 2026

Provider Newsletter

for Highmark Health Options | Highmark Health Options Duals | WEST VIRGINIA

FEATURED ARTICLES:

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Contact Us

We're here to help. Provider Relations can answer any questions you may have about working with Highmark Health Options West Virginia and can be reached at **HHOWVPR@highmarkhealth.org**. You can also call Provider Services with administrative questions at **1-833-957-0020 (TTY: 711)**, Monday–Friday, 8 a.m.–5 p.m.

West Virginia HHOPE Incentive Program Opt-In, Webinar, and CGMA Launch

We value the important role practitioners play in serving our members and welcome you to the 2026 Highmark Health Options Practitioner Excellence (HHOPE) Program, which launched on March 2, 2026.

The program 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.

2026 HHOPE Program Opt-In

Please contact your Clinical Transformation Consultant directly or email us at **HHOWVPET@highmarkhealth.org** for information on the opt-in process.

By opting-in, the provider also acknowledges the intent to participate in the program. Providers will be enrolled in their chosen programs based on provider specialty and eligibility criteria, as outlined in the West Virginia HHOPE Guide found on the **Provider Resource Center (PRC).**

2026 HHOPE Overview Webinar Series

The HHOPE PET team is offering multiple, hour-long webinars to provide an overview of the 2026 HHOPE program. If you missed our March sessions, you still have four more opportunities to join us.

Please register following the steps below:

1. Use the links below for the session(s) you would like to attend and click "Register."
   - **Wednesday, April 8 at 12 p.m.**
   - **Tuesday, April 14 at 11 a.m.**
   - **Tuesday, June 9 at 1 p.m.**
   - **Thursday, Sept. 3 at 12 p.m.**
2. On the registration form, enter your information and 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 **HHOWVPET@highmarkhealth.org**.

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

The Care Gap Management Application (CGMA), launching April 1, offers providers access to critical care gap information. This application streamlines the flow of member care gap data, supporting our mission to improve health and wellness.

The D-SNP launch date will be announced at a later time.

With this powerful, yet easy-to-use web application, you will be able to:

- View member care gaps.
- Submit evidence for care gap closure.
- View your progress towards closing member care gaps.
- View your Highmark Health Options' health member roster.
- View your HHOPE Performance and Opportunity Reporting
- Generate bulk member-level gap PDF reports.
- Generating multi-provider gap reports.
- Enhance measure due dates (now available for applicable measures like, W30, OMW).
- Display a measure badge with remaining days to act for event-based measures.

Model of Care Training Summary

Model of Care Overview

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 SNP MOC is divided into four sections:

1. Description of the 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 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 website**. Once you have completed this training, please submit an **attestation** indicating that you have completed and comprehend the Model of Care training.

Pharmacy Codes Update

The policies and HCPCS codes below have been updated, effective May 1, 2026. Prior authorization is required for all of the HCPCS codes listed in the appropriate table below. Failure to obtain authorization will result in a claim denial. The prior authorization process will apply to all Highmark Health Options members.

Highmark Health Options WV Medicaid Procedure Codes Requiring Authorization:

HCPCS	Drug Name
J3490*	Repemplo (plozasiran sodium)
J3590*	Voyxact (sibeprenlimab-szsi)
J3590*	Itvisma (onasemnogene abeparvovec-brve)
J3590*	Exdensur (depemokimub-ulaa)
J8499*	Daybue (trofinetide)

*These medications will be reviewed under the applicable miscellaneous procedure code (NOC) until a permanent HCPCS code is assigned.

Highmark Health Options WV Medicare D-SNP Procedure Codes Requiring Authorization:

HCPCS	Drug Name
J3490*	Repemplo (plozasiran sodium)
J3590*	Voyxact (sibeprenlimab-szsi)
J3590*	Itvisma (onasemnogene abeparvovec-brve)
J3590*	Exdensur (depemokimub-ulaa)
J8499*	Daybue (trofinetide)
J3590*	Xtrenbo (denosumab-qbde)
J3590*	Enoby (denosumab-qbde)

*These medications will be reviewed under the applicable miscellaneous procedure code (NOC) until a permanent HCPCS code is assigned.

Fraud, Waste and Abuse Audits and Medical Record Request Standards

The Financial Investigations and Provider Review (FIPR) Team is responsible for conducting audits regarding Fraud, Waste and Abuse (FWA). If selected for an audit, you will receive a letter from the primary investigator, or delegates that have been contracted by the Plan, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond.

If Highmark requests medical records, you must provide copies of the records at no cost to the Plan. This includes notifying any third party who may maintain medical records of this stipulation. In addition, you must provide access to any medical, financial, or administrative records related to the services provided to our members within 30 calendar days of our request or sooner. All required documentation must be submitted at the time of the original medical record request. Additional documentation will not be accepted after the review is complete.

Failure to provide requested medical records within the specified timeframe will result in claims being denied.

We require medical records to comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations, and Medicare manuals as well as other applicable professional associations and advisory agencies. For more information on medical record requests and standards, please refer to the Medicaid and Medicare Provider Manuals, located on the **Provider Resource Center (PRC)**.

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 West Virginia 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, Maternal-Fetal, and Pediatric:** Education, risk screening, care coordination, and monitoring for pregnant, high-risk maternal-fetal, postpartum, and pediatric populations.
- **Preventive Health:** Outreach supporting recommended screenings, immunizations, laboratory monitoring, and risk reduction strategies, including pre-diabetes and recommended cancer screenings to promote early detection and prevention.
- **Health Promotion:** Education and lifestyle strategies supporting healthy aging, brain health, nutrition, physical activity, and overall wellness.

For more information, you can access the **Provider Portal** or visit our **Provider Resource Center (PRC)**.

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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.

Partnering 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 Highmark Health Options West Virginia Provider Services at **1-833-957-0020** or Highmark Health Options Duals Provider Services at **1-833-957-0025 (TTY: 711)**, Monday–Friday, 8 a.m.–5 p.m.

We value your partnership and remain committed to coordinated, high-quality, member-centered care.

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.

2026 Annual Provider Orientation and Annual Education

The 2026 Annual Provider Orientation and Annual Education on demand webinar is now available on our **Provider Resource Center (PRC)**.

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, Cotiviti Claims Pattern Review (CPR) will be implemented.

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.

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

Upcoming Medical Record Review Standards

Highmark Health Options West Virginia is required to perform medical record audits in order to continue providing medical coverage for the Medical Assistance/Medicare population. 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 the West Virginia Highmark Health Options 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. For your reference, the Medical Record Review Standards are available upon request, or can be found on our **Provider Resource Center (PRC)**.

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.

Annual HEDIS Medical Record Review

Highmark Health Options is conducting its annual HEDIS medical record review for Measurement Data Year 2025, which started in January and continues through April 2026. The National Committee for Quality Assurance (NCQA) requires this review to assess provider compliance with standardized performance measurements.

We appreciate your assistance with medical record collection and review and are happy to assist you in fulfilling this request in any way we can. To best meet your needs, there are multiple options for submitting medical records including secure fax, UPS, or an on-site review. Highmark Health Options retrieval staff will contact providers to discuss their preferred submission method.

It is important to remember that, as per the Participating Provider Agreement, providers are obligated to respond to these medical record requests within the requested timeframe and at no cost to Highmark Health Options or its members.

The HEDIS measurements are being collected to cover various areas that include:

- Weight Assessment and Counseling for Children/Adolescents
- Care for Older Adults
- Controlling High Blood Pressure
- Diabetes-related Assessments (Glycemic Status and Blood Pressure Control)
- Transitions of Care
- Prenatal and Postpartum Care

For any questions or concerns about this process, providers can contact Leslie Riding at **leslie.riding@highmark.com** or by calling **412-918-8981**.

HHO Duals (HMO SNP) Important Update Regarding Medicare Telehealth Coverage

As of Oct. 1, 2025, changes to Original Medicare telehealth coverage are in effect due to Congress not extending pandemic-era telehealth policies. Now, Original Medicare will only cover most telehealth services for beneficiaries located in a rural office or medical facility.

Note: There are exceptions for the following services and they will continue to be covered by Original Medicare:

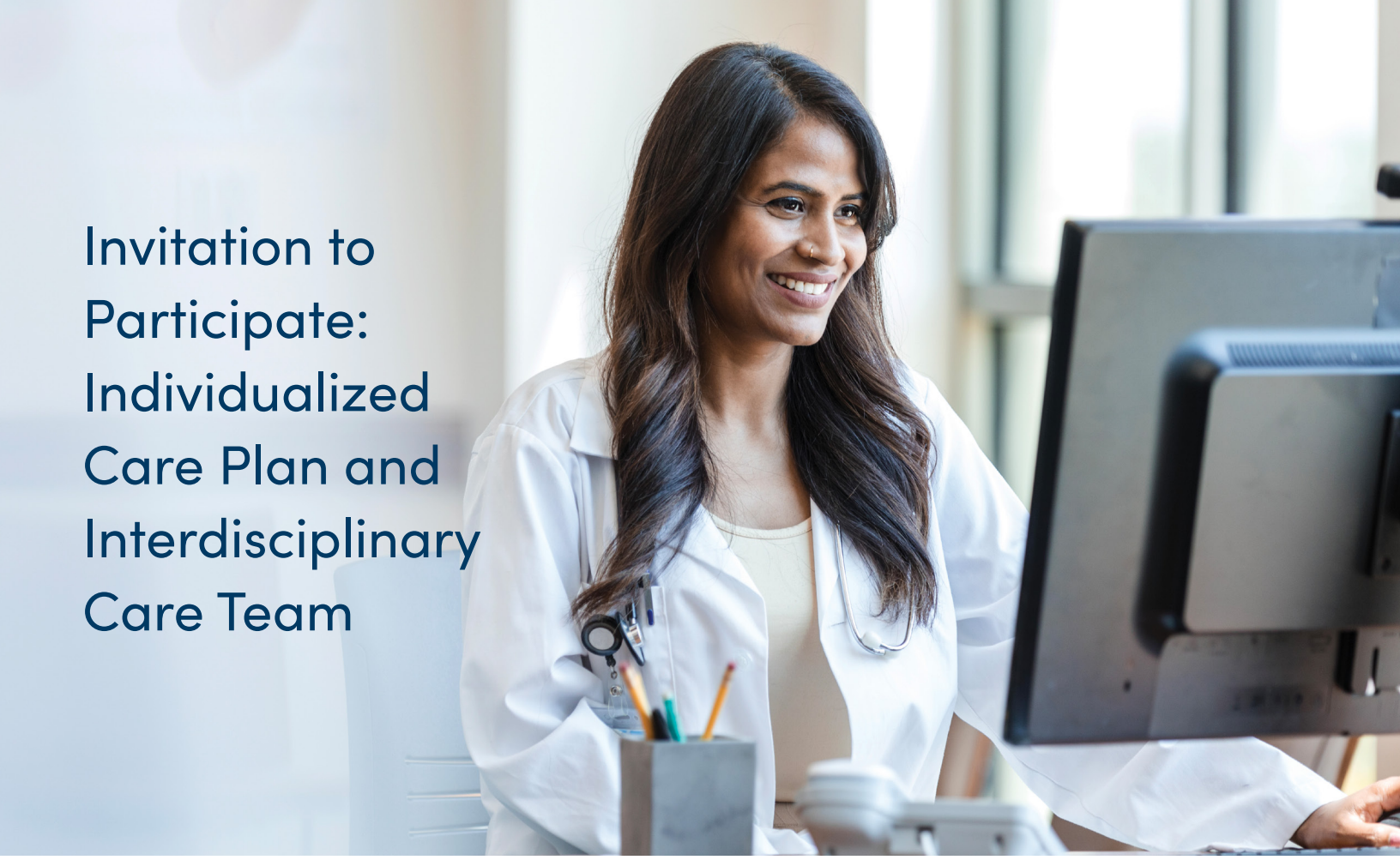
- Monthly End Stage Renal Disease (ESRD) visits.
- Services for the diagnosis, evaluation, or treatment of symptoms of an accute stroke.
- Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder, including a substance use disorder.

How This Affects Highmark D-SNP Plans

While these changes impact Original Medicare, Highmark Medicare D-SNP plans will provide coverage of expanded telehealth benefits for your D-SNP patients in 2026.

For details on a specific plan's telehealth coverage, please refer to the Evidence of Coverage documents for a given benefit year.

Invitation to Participate: Individualized Care Plan and Interdisciplinary Care Team



At Highmark Health Options (HHO) Duals West Virgina, we're dedicated to the complete health and well-being of our members. Our goal is to empower care providers in keeping Highmark Medicare D-SNP members as healthy as possible. As a valued member of the Interdisciplinary Care Team (ICT), you are the first step to the success of our members' care. Each Medicare member has an Individualized Care Plan (ICP), which they have access to on the member portal or by mail upon request. You have access to the ICPs for your panel, available on the provider portal. We encourage you to review the member's care plan with them during their next visit.

We also invite you to participate in ICT meetings regarding your patients. The purpose of ICT meetings is to focus on our members and their specific needs to help achieve their overall health care goals. Each ICT meeting results in an updated Individualized Care Plan, so your input is critically important.

Please call the Case Management Department to schedule an ICT meeting for any of your Highmark patients at **1-833-957-0025 (TTY: 711)**.

Medicare Parts A and B Cost-Sharing

All members enrolled in Highmark Health Options Duals 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 the Highmark Health Options Duals Medicare Assured Plan, 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 a deductible, coinsurance, or copayment is prohibited by federal law.

Our organization and provider 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 Health Options Duals 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 **highmark.com/health-options-wv**.

Providers are encouraged to contact us if you have questions about this Provider Update or need additional member-specific information.

Medicare Assured: 1-833-957-0025

Medicaid: 1-833-957-0020

Call Provider Services with administrative questions at **1-833-957-0020**, Monday–Friday, 8 a.m.–5 p.m.

Policy Updates

Highmark regularly reviews and updates our policies and procedures. Advanced notification will be provided via our newsletter or by fax, and posted on our website 60 days prior to the effective date.

Medicaid Provider Updates

Policy Updates:

Notification date: March 30, 2026
Effective date: June 1, 2026

Medicaid Policies:

1. **HHO-WV-RP-2121-002 Transportation Ambulance:** Changes include updating procedure codes.
2. **HHO-WV-RP-2013-002 Therapy Services:** No changes.
3. **HHO-WV-RP-2002-002 Federally Qualified Health Centers (FQHC):** Changes include updating procedure codes and adding provider requirements.
4. **HHO-WV-RP-2200-003 Provider Preventable Conditions, Hospital Aquired Conditions, or Other Preventable/ Adverse Events:** No changes.
5. **HHO-WV-RP-2203-003 Noncovered or Non-Reimbursable Services:** No changes.

New Policy

1. **HHO-WV-MP-2262-001 Microdisectomy, Lumbar**
2. **HHO-WV-MP-2263-001 Vitamin D Testing**
3. **HHO-WV-MP-2264-001 Single Photon Emission Computed Tomography (SPECT)**

Accessibility Standards: Timeliness of Access to Care

Highmark Health Options (HHO) West Virginia 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.

The accessibility standards and additional resource information related to accessibility are available on our **Provider Resource Center (PRC)**.

Member Rights and Responsibilities

Highmark Health Options West Virginia 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 Health Options West Virginia maintains a Members Rights and Responsibilities statement, which is reviewed and revised annually.

Highmark Health Options West Virginia and its practitioner 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:

Members have the right to:

- To receive information in accordance with the standards set forth in this contract;
- To be treated with respect and due consideration of his or her dignity and privacy;
- To accessible services;
- To choose providers from among those affiliated with the MCO;
- To participate in decision-making regarding his or her health care, including the right to refuse treatment;
- To receive information on available treatment options or alternative courses of care, presented in a manner appropriate to the enrollee's condition and ability to understand;
- To request and receive his or her medical records, and to request that they be amended or corrected, for which the MCO will take action in a timely manner of no later than 30 calendar days from receipt of a request for records, and no later than 60 calendar days from the receipt of a request for amendments, in accordance with the privacy rule as set forth in 45 CFR parts §164.524 and §164.526, upon their effective dates, to the extent they apply;
- To obtain a prompt resolution of issues raised by the enrollee, including complaints, grievances, or appeals and issues relating to authorization, coverage, or payment of services;
- To access their health information through the use of APIs in accordance with the requirements set forth by 42 CFR §431.60 and §438.242;
- To offer suggestions for changes in policies and procedures;

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- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- To be provided informed consent; and
- To be furnished healthcare services as set forth in this contract.
- Receive a written explanation in the event a medical service or Part D drug is not covered, or if their coverage is restricted in some way. Ask for a state fair hearing after a decision has been made about their appeal.
- Contact the Department of Health and Human Services' Office for Civil Rights if they believe their rights have not been respected due to their race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age.

Each Enrollee has the following responsibilities:

- Reading through and follow the instructions in the Member Handbook or Evidence of Coverage.
- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care, including if they have any other health insurance coverage or prescription drug coverage in addition to our plan.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Treating health care staff and others with respect, which helps with the smooth running of their doctor's office, hospitals, and other offices.
- Paying Medicare premiums and any applicable copayments or late enrollment penalties.
- Get information about Highmark Health Options, our services, our providers, and member rights in a way that works for them (in languages other than English, in Braille, in large print, or other alternate formats, etc.).

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

For more information, please call Provider Services at:

- **Medicaid: 1-833-957-0020 (TTY: 711)**
- **Medicare Assured: 1-833-957-0025 (TTY: 711)**

Cultural Competency Data Form

Please help us improve the Highmark Health Options member experience by completing the **Cultural Competency Data Form**.

By providing your race, ethnicity, language, and cultural competency training data, you allow Highmark Health Options to better connect members to the appropriate practitioners, deliver more effective provider-patient communication, and improve patient 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 Form is located on the Highmark Health Options website in the **Cultural Competency Toolkit**.

Notice of Practice/ Practitioner Changes

One of the many benefits available to Highmark Health Options members is improved access to medical care through the Highmark Health Options contracted provider network. We strive 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 correct information about our network providers, it is imperative that providers notify Highmark Health Options of any of the following:

- Address changes
- Phone and fax number changes
- Changes in hours of operation
- Primary Care Practice (PCP) panel status changes (Open, Closed, and Existing Only)
- Practitioner participation status (additions and terminations)
- Mergers and acquisitions

Providers who experience such changes must provide Highmark Health Options a written notice at least 60 days in advance of the change by completing the Highmark Health Options Practice/Provider Change Request Form, or providers may submit notice on your practice letterhead.

Please submit change requests via fax or mail.

Fax: 1-855-451-6680

Note: FQHC/RHC providers should submit their changes to **FQHC_RHC_RosterUpdates@highmark.com**.

Mail:

Attention: Credentialing Department
Highmark Health Options WV
PO Box 2500
Parkersburg, WV 26102

PCPs and specialty care providers must submit claims under the individual national provider identification number (NPI) and tax identification number (TIN) to comply with encounter data reporting. Claims will be rejected up front if the individual provider number is not included. The only exception to this requirement applies to UB-04 charges for providers services when a remittance advice is issued to a hospital facility.

BMS billing guidelines state all providers must submit a taxonomy code on every claim. The submitted taxonomy must be associated with the specialty with which the provider has been credentialed. In instances where the provider's NPI is associated with more than one Highmark contracted specialty, the provider taxonomy code correlating to the services rendered should be submitted on the claim.

Encounter Submissions

In order to effectively and efficiently manage a member's health care services, encounter submissions must be comprehensive and accurately coded.

As a reminder, all Highmark Health Options providers are contractually required to submit encounters for all member visits regardless of expected payment.

Plan Contact Information

For questions related to contracting, connect with Provider Contracting at **304-424-0365** or **HHOWVContracting@highmark.com**.

For questions about working with HHO, contact Provider Relations at **HHOWVPR@highmarkhealth.org**.

As a reminder, our **Prior Authorization Code Lookup Tool** can help you identity if prior authorization is required for medical procedures and services.

Call Provider Services with administrative questions at **1-833-957-0020**, Monday–Friday, 8 a.m.–5 pm.

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

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.

Highmark Health Options West Virginia Inc. d/b/a Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association.

Highmark Health Options West Virginia 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.

MON-26-0030 (03/19/2026)