

Provider Newsletter

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



FEATURED ARTICLES:

Highmark Health Options West Virginia Achieves NCQA Accreditation

Model of Care Training Summary

Improving Access to Care for People with Disabilities

Provider Update: Policies and HCPCS Codes

...And More

Table of Contents

- Highmark Health Options West Virginia
Achieves NCQA Accreditation..... 4**
- Model of Care Training Summary 5**
- Improving Access to Care for
People with Disabilities 6**
- Important Reminder: Provider Appeal Form
for Fax and Mail Submissions..... 7**
- Federal Reporting Requirements 8**
- Provider Self-Audits 9**
- Enhancing Children’s Oral Health: The Power of
Fluoride Varnish in Primary Care 10**
- Highmark Health Options Practitioner
Excellence Program.....12**
- Required Reportable Diseases and Conditions13**
- Provider Update: Policies and HCPCS Codes 14**
- Ensuring Quality Care and Service through
our Quality Improvement Program.....17**
- Provider Fraud, Waste, and Abuse (FWA) Training 18**
- Accessibility Standards: Timeliness of Access of Care 19**
- Member Rights and Responsibilities20**
- Policy Updates..... 22**
- Notice of Practice/Practitioner Changes.....24**
- Cultural Competency Data Form 25**
- Encounter Submissions 26**
- Plan Contact Information 27**



When you see this icon, click it to return to this content list.



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.



Highmark Health Options West Virginia Achieves NCQA Accreditation



Among the core accountabilities of the National Committee for Quality Assurance (NCQA) is the accreditation and certification of health plans. Health Plan Accreditation serves many purposes such as improving operational efficiency, meeting state requirements, providing a framework for member and patient care, and demonstrating an organizational commitment to quality.

Highmark Health Options West Virginia recently received NCQA Health Plan and Health Outcomes accreditations. Health Plan Accreditation evaluates how effectively a health plan manages quality and improvement, population health, network services, utilization, and member rights. It also assesses credentialing, member connections, and Medicaid benefits and services. Health Outcomes focuses on Highmark Health Options' data-driven understanding of our members' unique needs and experiences.

It highlights our commitment to identifying and addressing gaps and disparities in care. It also confirms our promise to actively provide services and resources that consider cultural, linguistic, disability-related, and other personal needs that can often be barriers to accessing appropriate and timely care.

Contractually required, this significant achievement demonstrates Highmark Health Options' emphasis on delivering high-quality, member-centric care and helps ensure that our plan effectively supports care that improves and maintains members' health and wellness while also managing costs and meeting governmental requirements.



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



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.

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



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[®] 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[®] (preferred method)
- Fax: 1-833-547-2022
- Mail: Highmark Health Options
Attention: WV 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.





Federal Reporting Requirements

Highmark Health Options West Virginia must comply with the following federal reporting and compliance requirements and must submit applicable reports to the Bureau for Medical Services (BMS) for the services listed below:

1. Abortions must comply with the requirements of 42 CFR §441. Subpart E – Abortions. This includes completion of the information form – Certification Regarding Abortion.
2. Hysterectomies and sterilizations must comply with 42 CFR §441. Subpart F – Sterilizations. This includes completion of the consent form.
3. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and reporting must comply with 42 CFR §441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

Additional information regarding the state requirements and procedures for these services can be found in the **2025 Provider Manual**.



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 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. Additional information on provider self-audits can be found in the **Medicaid** and **Medicare** Provider Manuals.



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**



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 HHOWVPET@highmarkhealth.org 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. 3 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 HHOWVPET@highmarkhealth.org.

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.



Required Reportable Diseases and Conditions

Accurate and timely reporting of communicable disease allows for critical disease surveillance, investigation, and public health follow-up.

Disease reporting allows for:

- **Disease Surveillance:** Tracking disease trends to identify outbreaks and potential public health threats.
- **Case Investigation:** Understanding the source and spread of infections to prevent further transmission.
- **Public Health Follow-up:** Providing education, treatment, and preventative measures to individuals and their contacts.

West Virginia law requires the reporting of three primary categories of diseases. The MCO may be responsible for further screening, diagnosis, and treatment of identified cases enrolled in the MCO, or screening, diagnosis, and treatment of case contacts enrolled in the MCO, as necessary to protect the public's health.

- **Sexually Transmitted Diseases (STDs):** Division of Surveillance and Disease Control, which has an established program for notifying partners, including follow-up of contacts to individuals with HIV and AIDS. MCOs may be contacted to provide appropriate screening and treatment for contacts who are enrollees.

- **Tuberculosis (TB):** Office of Prevention and Epidemiology Services (OEPS): Report individuals with diseases caused by M. tuberculosis to the WV OEPS, TB Program.
- **Communicable Diseases:** Division of Surveillance and Disease Control, Communicable Disease Program.

Disease surveillance allows appropriate public health action to be undertaken—patient education and instruction to prevent further spread, contact identification and treatment, environmental investigation, outbreak identification and investigation, etc.

Report cases of communicable diseases noted as reportable in West Virginia to the local health departments in the appropriate time frame and method outlined in legislative rules. Detailed infectious disease reporting requirements can be obtained from the Bureau for Public Health. Please familiarize yourself with these requirements to ensure compliance.

Adhering to these reporting requirements is essential for maintaining public health and ensuring the well-being of our community.

For further information, please contact Provider Services at the following:

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



Provider Update: Policies and HCPCS Codes



The policies and HCPCS codes below have been updated: Effective Aug. 1, 2026

Prior authorization is required for all of the HCPCS codes listed in the appropriate table on pages 16 and 17. Failure to obtain authorization will result in a claim denial. The prior authorization process will apply to all Highmark Health Options members.

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Highmark Health Options WV Medicaid Procedure Codes Requiring Authorization:

HCPCS	Drug Name
J3590*	Qivigy (immune globuline (Human) – Kthm)
Q5161	Aukelso, Bosaya (denosumab-kyqq)
J3590*	Loargys (pegzilarginase-nbln)
J8499*	Orladeyo (berotralstat HCl)
J3490*	Vykoura (leucovorin calcium)
J3490*	Yuviwel (navepegritide)
J3590*	Lerochol (Lerodalcibep-liga)
J8499*	Kygevvi (doxecitine-doxribtimine)
J8999*	Lifyorli (relacorilant)
J3590*	Avlayah (tildenafilusp alfa-eknm)
Q4160	NuShield (amniotic membrane allograft (human))
J3111	Evenity (romosozumab-aqqg)
J3300	Triesence (triamcinolone acetone ophth)
J3299	Xipere (triamcinolone acetone suprachoroidal)
Q5162	Bildyos, Bilprevda (denosumab-nxxp)
Q5158	Bomynta, Connexence (denosumab-bnht)
J3590*	Xtrenbo, Enoby (denosumab-qbde)
J0897	Prolia, Xgeva (denosumab)
Q5136	Jubbonti, Wyost (denosumab-bbdz)
Q5157	Osenvelt, Stobolco (denosumab-bmwo)
Q5159	Ospomyv, Xbryk (denosumab-dssb)

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

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

HCPCS	Drug Name
J3590*	Qivigy (immune globuline (Human) – Kthm)
Q5161	Aukelso, Bosaya (denosumab-kyqq)
J3590*	Loargys (pegzilarginase-nbln)
Q5156	Avtozma (tocilizumab-anoh)
J8499*	Orladeyo (berotralstat HCl)
J3490*	Vykoura (leucovorin calcium)
J3490*	Yuviwel (navepegritide)
J3590*	Lerochol (Lerodalcibep-liga)
J8499*	Kygevvi (doxycitine-doxribtimine)
J8999*	Lifyorli (relacorilant)
J3590*	Avlayah (tvidenofusp alfa-eknm)
Q4160	NuShield (amniotic membrane allograft (human))
J3111	Evenity (romosozumab-aqqg)
J3300	Triesence (triamcinolone acetonide ophth)
J3299	Xipere (triamcinolone acetonide suprachoroidal)
Q5162	Bildyos, Bilprevda (denosumab-nxxp)
Q5157	Osenvelt, Stobolco (denosumab-bmwo)
Q5158	Bomynta, Connexence (denosumab-bnht)
J0174	Leqembi (lecanemab-irmb)
J0175	Kisunla (donanemab-azbt)
J0225	Amvuttra (vutrisiran)
J2329	Briumvi (ublituximab-xiiy)

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



Ensuring Quality Care and Service through our Quality Improvement Program



The Highmark Health Options West Virginia Quality Improvement (QI) Program strives to ensure our members receive excellent health care and services.

To help achieve this, Highmark continuously monitors how well we are helping our members:

- Get preventive care.
- Get care for long-standing health problems.
- Understand the medicines they take.
- Stay out of the hospital.
- Have appropriate access to practitioners.
- Make and keep doctor appointments.
- Share health information with their doctors.
- Receive care in a culturally competent manner.

The program uses results from member surveys, medical record reviews, the Healthcare Effectiveness Data Information Set (HEDIS®), and other tools to measure how we are doing and to help set goals for future quality activities. We also work closely with you, our network providers, to monitor the care and services our members receive and determine what we can do to better serve them.

Highmark maintains a QI Work Plan to analyze activities conducted as part of its QI Program. This Work Plan is evaluated every three months to identify issues and ensure that actions have been taken to address them.

We also conduct an annual review of our QI Program to see how well we've met the health care and service needs of our members. The annual evaluation of the 2025 QI Program is complete, and we accomplished the majority of the program's goals, implemented new and innovative programs, identified areas for improvement, and are developing plans to address improvement opportunities in 2026.

Please call Provider Services if you would like to request more information about our 2026 QI Program, QI Work Plan, or summary evaluation of the 2025 QI Program.

- Medicaid: **1-833-957-0020 (TTY: 711)**
- Medicare Assured: **1-800-957-0025 (TTY: 711)**



Provider Fraud, Waste, and Abuse (FWA) Training

Meeting Information:

The Financial Investigations and Provider Review (FIPR) Division will be hosting a live provider FWA training webinar on Tuesday, June 30, 2026, from 12 p.m.-1 p.m. Providers or provider representatives are strongly encouraged to take advantage of this live opportunity.

Speakers:

- Mara Elliott, RHIA Senior Business Solutions Consultant
- Kylie Wilson, MS Business Analyst Consultant

Objectives Include:

1. Provide an overview of FWA.
2. Review FWA Laws and Regulations.
3. Identify provider responsibilities as they relate to FWA.
4. Discuss provider documentation requirements.
5. Identify the various types of FWA Investigations.
6. Discuss outcomes for non-compliance with State, Federal, and contractual obligations.

Registration:

After **registering**, you will receive a confirmation email containing information about joining the webinar. If you have questions, please contact your designated Provider Account Liaison.

To help increase accessibility to training, previous FWA trainings have been placed on our **Provider Resource Center**. As a reminder, all providers must have a representative review the Provider FWA Training upon contracting with Highmark and annually each year after. The provider representative will be responsible for communicating the information obtained from the Provider FWA Training to the entire staff of the provider. Providers must either attend the annual Provider FWA Training or independently review the required materials.





Accessibility Standards: Timeliness of Access to Care

Highmark Health Options 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**.



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:

1. To receive information in accordance with the standards set forth in this contract;
2. To be treated with respect and due consideration of his or her dignity and privacy;
3. To accessible services;
4. To choose providers from among those affiliated with the MCO;
5. To participate in decision-making regarding his or her health care, including the right to refuse treatment;
6. 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;
7. 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 thirty (30) calendar days from receipt of a request for records, and no later than sixty (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;
8. 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;
9. 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;
10. To offer suggestions for changes in policies and procedures;
11. 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;



12. To be provided informed consent;
13. To be furnished healthcare services as set forth in this contract;
14. To 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; and
15. To 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 responsibility:

1. To read through and follow the instructions in the Member Handbook or Evidence of Coverage;
2. 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.
3. To follow plans and instructions for care that they have agreed to with their practitioners;
4. To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible;
5. To treat health care staff and others with respect, which helps with the smooth running of their doctor's office, hospitals, and other offices;
6. To pay Medicare premiums and any applicable copayments or late enrollment penalties; and
7. To 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)



Prior Authorization and Medical Policy Updates



Please be sure to regularly check our Highmark Health Options West Virginia Provider Resource Center (PRC) for a list of procedure codes added to the Highmark Health Options West Virginia Medicaid and Medicare Prior Authorization List (PAL) that require prior authorization.

To find these codes, visit the PRC and click on the “Resources” tab. Then, select “Prior Authorization Code Lookup.” You may also search CPT codes in the Main Search Bar at the top of any page on the PRC to check prior authorization requirements.

Additionally, Highmark Health Options regularly reviews and updates our policies and procedures. To help you know when policies have been amended, an advanced notification will be provided via our newsletter or fax and posted on our website 60 days prior to the effective date. You can find the medical policy updates on the **PRC**.

Policy Updates

Notification date: 06/29/2026

Effective date: 09/01/2026

Medicaid Policies:

Annual Review

- HHO-WV-RP-2205-003 Claims Reprocessing after Rate Changes:**
No changes.
- HHO-WV-MP-2228 Vision Therapy:**
No changes.
- HHO-WV-MP-2128 Multiple Imaging Reduction:** No changes.
- HHO-WV-RP-2122 Ambulatory Surgical Center:** Changes include adding non-covered services section and removing Coordination of Benefits Section of policy.
- HHO-WV-RP-2129 Assistant Surgery:** Changes include taking out verbiage regarding Balance Billing.
- HHO-WV-RP-2201 Readmissions:** Changes include updating when readmissions will be denied.
- HHO-WV-MP-2003-Abdominoplasty:** Changes include updating Procedure Codes.
- HHO-WV-RP-2262 Long Term Acute Care (LTAC):** Changes include adding qualifications for LTAC.

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Archive

1. HHO-WV-RP-2236 Prior Authorization:
Archived 03/13/2026

New

1. **HHO-WV-MP-2267-001 Respiratory Infection Pathogen Panel (RIPP) Molecular Testing**
2. **HHO-WV-MP-2268-001 Thyroid Disorder Laboratory Testing**
3. **HHO-WV-MP-2269-001 Somatic Mutation Testing**
4. **HHO-WV-MP-2270-001 Pathology Testing with Mohs Micrographic Surgery**
5. **HHO-WV-MP-2271 Nail Disorder Infectious Disease Testing**
6. **HHO-WV-MP-2265 Prostate Cancer Screening**
7. **HHO-WV-MP-2266 Tc-99m PYP Scintigraphy**
8. **HHO-WV-RP-2269 Always Therapy**
9. **HHO-WV-RP-2270 Newborn Nursery Prior Auth**
10. **HHO-WV-RP-2267 DME**
11. **HHO-WV-MP-2075-001 Dental Sedation and Anesthesia**

Changes to Policy

1. **HHO-WV-RP-2138 Private Duty Nursing Made:** Changes include updating Procedure Codes.
2. **HHO-WV-RP-2263 Physician Office Lab Testing:** Changes include adding “If collected in office and billed as a stand alone collection” under Policy Position.



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.



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.





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 **HHOVContracting@highmark.com**.

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

As a reminder, our **Prior Authorization Code Lookup Tool** can help you identify 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.





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