

Provider Newsletter

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

FEATURED ARTICLES:

New
Communications Hub

PCP Member Rosters
Now Available in the
Provider Portal

Highmark Health
Options West Virginia
Provider Workshop

West Virginia Service
Area Population
Language Data

...And More

Table of Contents

New Communications Hub.....4

PCP Member Rosters Now Available in the Provider Portal5

2026 Annual Provider Accessibility Audit Results6

Cotiviti Claims Pattern Review (CPR)7

Your Corrective Action Plans Support Compliance8

Highmark Health Options West Virginia Provider Workshop.....9

Final HHOPE Incentive Program Opt-In Deadline 10

Policy Updates..... 11

Updated Policies HCPCS Codes.....13

Join the Upcoming Podiatry Care Provider Webinar..... 15

West Virginia Service Area Population Language Data..... 16

Clinical Practice and Preventive Health Guidelines17

Interactive Care Management Programs..... 18

Best Practices for Documentation and Coding of Cancers20

**Invitation to Participate - Individualized Care Plan (ICP)
and Interdisciplinary Care Team..... 22**

Model of Care Training Summary 23

Notice of Practice/Practitioner Changes.....24

Cultural Competency Data Form25

Encounter Submissions26

Member Rights and Responsibilities 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**. Call Provider Services Monday–Friday, 8 a.m.–5 p.m. at one of the following numbers:

Highmark Health Options Medicaid: **1-833-957-0020**

Highmark Health Options Duals (HMO SNP): **1-833-957-0025**



New Communications Hub



Highmark Health Options will launch 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 **Provider Manual and Newsletters** section under **Resources** 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 HHOWVPR@highmarkhealth.org.

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 West Virginia conducted the 2026 Annual Accessibility Audit of Medicaid primary care providers, medical specialists, and behavioral health specialists during March and 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 practice sites see patients for emergent care immediately or direct patients to an emergency facility; see patients for urgent care within 48 hours and routine care within 21 calendar days.
- Ob-gyn specialist practice sites see patients for emergent care immediately or direct patients to an emergency facility and see patients for urgent care within 48 hours.
- Oncology specialist practice sites see patients for emergent care immediately or direct patients to an emergency facility, see patients for urgent care within 48 hours and routine care within 21 calendar days.
- Behavioral health practice sites see patients for urgent care within 48 hours.

To promote continued improvement in access to care, Highmark Health Options West Virginia is 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.



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 **844-718-6400**.



Highmark Health Options West Virginia Provider Workshop

Attend a Highmark Health Options West Virginia Provider Workshop!

Highmark Health Options is offering provider workshops as an opportunity to enhance your practice and stay ahead in the evolving healthcare landscape. Connect directly with Highmark Health Options team members, enjoy a complimentary breakfast and snacks, and gain essential insights on the following:

- Authorizations
- Care Coordination
- Case Management
- Compliance and Billing
- Essential Programs
- Practice Management
- Provider Responsibilities
- Tools and Resources
- Utilization Management

Register for a workshop here.

Registration will begin at 8 a.m., with the workshop held from 8:30 a.m.–12 p.m.

Date	City	Location
Sept. 29, 2026	Martinsburg, WV	Hilton Garden Inn
Oct. 6, 2026	Beckley, WV	Tamarack Marketplace
Oct. 13, 2026	Bridgeport, WV	Courtyard Marriott
Nov. 4, 2026	Charleston, WV	Holiday Inn & Suites
Dec. 8, 2026	Huntington, WV	Delta Hotel Downtown



Final HHOPE Incentive Program Opt-In Deadline Reminder: September 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 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 **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.

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 **HHOWVPET@highmarkhealth.org**.

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



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 **Provider Resource Center**.

Policy Updates

Notification date: 09/28/2026

Effective date: 12/01/2026

Medicaid Policies:

Annual Review

- HHO-WV-MP-2257 Bioengineered Skin and Skin Replacement Therapy in the Outpatient Setting:** Changes include Organizing Procedure Codes.
- HHO-WV-MP-2190-003 Hearing Loss and Implants:** Changes to policy include: Name change of policy from External Hearing Aids, Auditory Brainstem Implant, Bone-anchored Hearing Devices and audiological testing to Hearing Loss and Implants, Updated Hearing Aid Coverage, Added Repair/Replacement and Billing and Reimbursement of Hearing Aids, Updated Bone Conduction Implants Section, Added Cochlear Implants Coverage, Added Documentation Requirements Section and updated Procedure Code Section.
- HHO-WV-RP-2204 Out of Network Services:** No changes.
- HHO-WV-MP-2216 Gender Affirmation:** Changes to policy include: Updated eligible criteria from Female to Male services, Updated criteria of what needs to be put in letters, updated non-covered services, added criteria about Surgical Revisions and added Covered Procedure Codes.

Continues on the next page



5. **HHO-WV-MP-2261 Obstetrical Ultrasound:** No changes.
6. **HHO-WV-RP-2235 Mental Health Parity:** Changes include: Added criteria under Mental Health Parity Regulations.
7. **HHO-WV-RP-2120 Chiropractic Services:** No changes to policy.
8. **HHO-WV-RP-2003-003 Vaccines:** Changes to policy include Updating Reimbursement Guidelines and deleting procedure codes 90460, 90461, 90477, 90644 & 90690 as codes are no longer on fee schedule.
9. **HHO-WV-RP-2264 Lab Panel Testing:** No changes to policy.
10. **HHO-WV-MP-2011 Genetic Testing for Congenital Abnormalities:** Changes to policy include Adding When HHO will not cover genetic testing and deleting procedure codes 81422, 81508-81512.
11. **HHO-WV-MP-2207-002 Genetic Testing for Colorectal Cancer Susceptibility:** Changes to policy include Deleting Procedure Codes G0121& G0328 as codes are no longer on fee schedule.
12. **HHO-WV- RP-2263-002 Physician Office Lab Testing:** Changes to policy include Taking off Codes 80324 & 80325 off of policy as codes not on fee schedule.
13. **HHO-WV-RP-2266 Critical Care with Home Discharge:** No changes to policy.
14. **HHO-WV-RP-2005 Facility Based Behavioral Health Services:** No changes to policy.

New

1. **HHO-WV-MP-2115-001:** Labiaplasty
2. **HHO-WV-RP-2150-001:** Convenience Kits, Drug and Biological Waste



Updated Policies HCPCS Codes

Effective 11/1/2026:

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
Q5166	Jubereq, Osvyrti (denosumab-desu)
J3590*	Otarmeni (Lunsotogene Parvec-cwha)
Q5168	Nufymco (Ranibizumab-leyk Intravitreal)
J3590*	Lumvoa (Veligrotug-vvze)
J3590*	Skyrizi (Risankizumab-rzaa Soln Prefilled Syringe 55 MG/0.37ML)
J3590*	Tregzi (Tregs & HSPC & Tcons-vldq Susp for IV Infusion Pack)

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

Continues on the next page



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

HCPCS	Drug Name
J8999*	Jakafi XR (Ruxolitinib Phosphate Tab ER)
Q5166	Jubreq, Osvyrti (denosumab-desu)
J3590*	Otarmoni (Lunsotogene Parvec-cwha)
Q5168	Nufymco (Ranibizumab-leyk Intravitrea)
J7172	Hympavzi (Marstacimab-hncq Subcutaneous Soln Auto-inj)
J3590*	Lumvoa (Veligrotug-vvze)
J3590*	Skyrizi (Risankizumab-rzaa Soln Prefilled Syringe 55 MG/0.37ML)
J3590*	Tregzi (Tregs & HSPC & Tcons-vldq Suspension for IV Infusion Pack)

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



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.

Accreditation Statement: Allegheny General Hospital is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Allegheny General Hospital designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™

Disclosure Statement: In accordance with the Accreditation Council for Continuing Medical Education (ACCME) and the policy of Allegheny General Hospital, presenters must disclose all relevant financial relationships, which in the context of their presentation(s), could be perceived as a real or apparent conflict of interest, (e.g., ownership of stock, honoraria or consulting fees). Any identifiable conflicts will be resolved prior to the activity. Any such relationships will be disclosed to the learner prior to the presentation(s). Highmark Presenters have no relevant financial relationships with commercial interests to disclose.



West Virginia Service Area Population Language Data



Learn more about the language profile of your service area!

The Highmark Health Options Government Quality Department and the Data Analytics team collect and reviews data from several sources to assist in determining the language characteristics and patterns of our service area and membership to determine the cultural adequacy of services provided. This information is also used to anticipate and plan for changes in the language services Highmark Health Options provides to our population. We assess the population's language profile at least annually, using direct reporting from Bureau for Medical Services (BMS), health risk assessments, and West Virginia state census/community-level data. The language profile of Highmark Health Options West Virginia service area and their membership is very similar when comparing the data included.

Language Profile of Highmark Health Options West Virginia Members as of July 2025

Enrollment Data

- 100% of Highmark Health Options members report speaking English
- No other languages were reported by the membership

Language Profile for the Population of West Virginia

2024 American Community Survey, U.S. Census Bureau:

- 96.10% of West Virginia households speak English
- 1.8% of West Virginia households speak Spanish
- All other languages reported make up 2.1% of the service area population

For more information, please contact the Government Quality Department.



Clinical Practice and Preventive Health Guidelines



Highmark Health Options West Virginia believes in providing the best possible health care to our members, and providers are encouraged to review clinical practice and preventive health guidelines.

These guidelines are based on the latest clinical practice guidelines from professionally and industry-recognized sources or through the experience of board-certified practitioners from appropriate specialties when guidelines are not available. They help guide our providers in administering consistent, high-quality health care for specific conditions relevant to our members. They are not meant to replace the clinical judgement of our providers, but instead to support you in making informed decisions about the best care for our members.

Before guidelines are put into practice, they are reviewed and approved by Highmark Health Options' Quality Improvement and Utilization Management Committee.

Examples of some of the guidelines include:

- Pediatric Preventive/EPSTD/Lead Screening (Birth to 21 Years)
- Adult Preventive Care
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)

- Bipolar
- Cardiac Medical Management
- Chronic Obstructive Pulmonary Disease (COPD)
- Cystic Fibrosis
- Depression
- Diabetes
- Human Immunodeficiency Virus (HIV)
- Hypertension
- Major Depression in Adults in Primary Care
- Opioid Prescribing for Chronic Pain
- Healthy Weight Management
- Healthy Weight Management in Children and Adolescents
- Palliative Care
- Routine and High Risk Prenatal Care
- Preventive Dental Care
- Schizophrenia
- Sickle Cell Disease
- Substance Use Disorder

A complete listing of the **Clinical Practice Guidelines** are available on our Provider Resource Center. Guidelines can be printed from the website or to receive a paper copy, call Provider Services at **833-957-0020**.



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:** 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.

Continues on the next page



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 Provider Services, Monday-Friday 8 a.m.-5 p.m.

- Highmark Health Options West Virginia Provider Services at **1-833-957-0020**
- Highmark Health Options Duals Provider Services at **1-833-957-0025**



Best Practices for Documentation and 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”

Continues on the next page



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

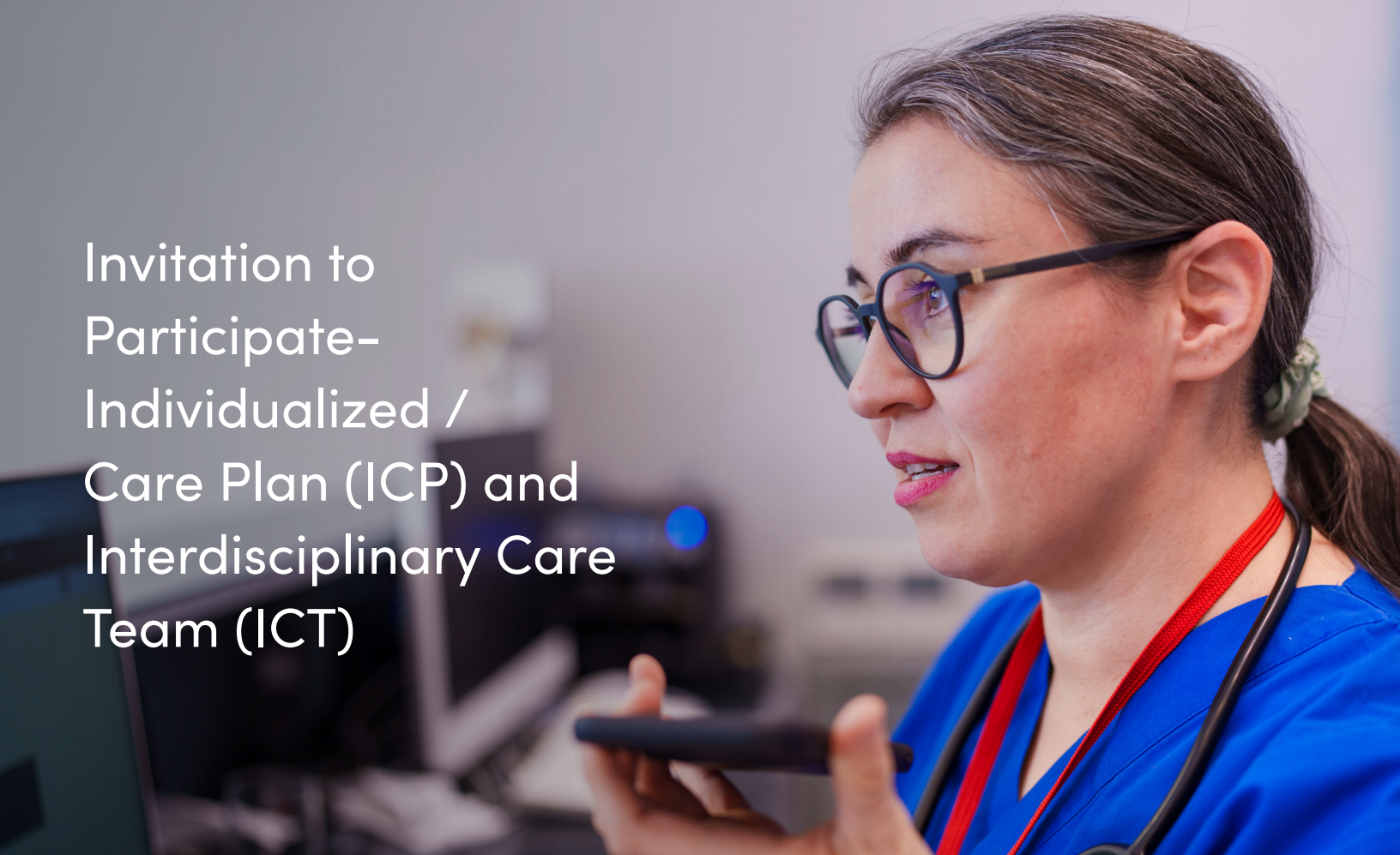
What is the current state of the condition? Document current state, test results, medication effectiveness or response to treatment.



Treatment Documentation

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





Invitation to Participate– Individualized / Care Plan (ICP) and Interdisciplinary Care Team (ICT)

At Highmark Health Options (HHO) Duals West Virginia, 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)**.



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 the **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**.



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.



A woman with dark hair, wearing glasses and a white lab coat over a grey shirt, is seated at a desk. She is holding a tablet computer with both hands and looking down at the screen. On the desk in front of her are some papers and a stethoscope. A laptop is partially visible on the right side of the desk. The background is a blurred office or clinical setting.

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.



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;

Continues on the next page



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)





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.

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.