2026 Provider Manual



HIGHMARK HEALTH OPTIONS

WV.HighmarkHealthOptions.com

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Quick Reference

Contact Type	Phone/Fax/Email/Website	Hours of Operation
TTY/TDD (For all departments)	**711**	8 a.m.–5 p.m., Monday–Friday
Provider Services (Claims Inquiries and Eligibility Verification)	**Phone: 1-833-957-0020**	8 a.m.–5 p.m., Monday–Friday
HHO WV Interactive Voice Response System (IVR) (Eligibility Check)	**1-833-957-0020**	24 hours a day, 7 days a week
West Virginia Medicaid/ CHIP Eligibility	**Phone: 1-888-483-0793** **www.wvmmis.com**	
Medical Management (Utilization Management [UM]) Per WV Bill SB267, all prior authorization requests must be submitted via our authorization portal, GuidingCare, via NaviNet. Should the provider portal be unavailable, use phone or fax numbers.	**Phone: 1-833-957-0020** **Please do not leave multiple voicemails.** **Fax:** UM BH: **1-833-547-2023** UM NICU: **1-833-547-2024** UM DME: **1-833-547-2025** UM Maternity: **1-833-547-2026** UM IP/OP/SPU: **1-833-547-2027** UM Chiropractic: **1-833-547-2028** UM Acute IP: **1-833-559-2848** Pharmacy: **1-833-547-2030**	8:30 a.m.–4:30 p.m., Monday–Friday (Voicemail during off hours. The call will be returned the next business day.)

HealthHelp Authorizations for: • **Outpatient Imaging** • **Physical Therapy** • **Occupational Therapy** • **Speech Therapy** • **Trigger Point Injections** • **Interventional Pain Management** • **Musculoskeletal Surgery (MSK)** • **Cardiology** • **Sleep Studies (ages 18 and older)** • **Radiation Oncology (ages 18 and older)**	Submit electronically to HealthHelp via NaviNet. Providers are not able to submit any authorization requests through the HealthHelp provider landing page. **Fax Expedited: 1-877-637-6935** **Phone: 1-888-209-2763**	8 a.m.–6 p.m., Monday–Friday
Care Management	**Phone: 1-833-957-0020**	8:30 a.m.–4:30 p.m., Monday–Friday
Fraud, Waste, and Abuse (FWA) Concerns/Inquiries	**Phone: 1-844-718-6400**	24 hours a day, 7 days a week
VSP Vision (Vision Benefit Provider)	**Phone: 1-800-615-1883**	9 a.m.–8 p.m., Monday–Saturday
United Concordia Dental (Dental Benefit Provider)	**Phone: 1-866-568-5467**	8 a.m.–8 p.m., Monday–Friday
Member Services	**Phone: 1-833-957-0020**	8 a.m.–8 p.m., Monday–Friday
Practice Change Information	**Fax: 1-855-451-6680**	24 hours a day, 7 days a week
WV Provider Enrollment Applications	**Phone: 1-888-483-0793 (Option 3)** **www.wvmmis.com/SitePages/Provider-Enrollment.aspx**	7 a.m.–7 p.m., Monday–Friday

Important Addresses and Fax Numbers

Reason for Mailing	Contact Information
Highmark Health Options WV Medicaid Paper Claims	Attention: Claims Processing Department Highmark Health Options WV PO Box 211349 Eagan, MN 55121
Administrative Claims Reviews	**NaviNet is preferred submission method or Fax: 1-833-623-2571.** Attention: Claims Department Highmark Health Options WV PO Box 1749 Parkersburg, WV 26102
Member Appeals and Grievances	Attention: Member Appeals and Grievances Highmark Health Options WV PO Box 1709 Parkersburg, WV 26102
Clinical Provider Appeals	**NaviNet is preferred submission method.** Attention: Clinical Provider Appeals Highmark Health Options WV PO Box 890416 Camp Hill, PA 17089-0416 **Fax: 1-833-547-2022**
Credentialing	Attention: Credentialing Department Highmark Health Options WV PO Box 2500 Parkersburg, WV 26102
Practice Change Information	**Fax is preferred submission method.** **Fax: 1-855-451-6680** Attention: Provider Information Management Highmark Health Options WV PO Box 2500 Parkersburg, WV 26102
Dental Claims	Attention: Claims Department Highmark Health Options WV PO Box 69455 Harrisburg, PA 17106
HighDental Claims Corrected (Adjusted)	Attention: Pre-Authorizations Highmark Health Options WV PO Box 69455 Harrisburg, PA 17106

Reason for Mailing	Contact Information
Overpayments	**For claim retraction, mail overpayment form to:** Delivery Code: FIPR Attention: FWA/SIU Unit Highmark Health Options 120 Fifth Avenue Pittsburgh, PA 15222 **For checks, mail checks with form to:** Highmark Health Options Attention: FWA/SIU Unit PO Box 890387 Camp Hill, PA 17089
Dental Prior Authorizations	Attention: Pre-Authorizations Highmark Health Options WV PO Box 69455 Harrisburg, PA 17106
Dental Orthodontic Prior Authorizations	Attention: Pre-Authorizations Highmark Health Options WV PO Box 69455 Harrisburg, PA 17106
Vision Claims	**In Network:** Attention: Claim Services Vision Service Plan PO Box 495907 Cincinnati, OH 45249-5907 **Out of Network and Retail:** Attention: Claim Services Vision Service Plan PO Box 495907 Cincinnati, OH 45249-5907
Member Disenrollment/ Enrollment/Transfer	Attention: Enrollment Highmark Health Options WV PO Box 2500 Parkersburg, WV 26102
Quality of Care Medical Records and/ or Correspondence	**Preferred method of delivery:** Secure Email: **Quality_of_Care@highmarkwholecare.com** Secure Fax: **855-878-4168** Delivery Code: WC-QCARE Attention: Quality of Care HHO WV 120 Fifth Ave. Pittsburgh, PA 15222

Introduction

About This Manual

This manual contains information about procedures and policies that apply to providers in the Highmark Health Options West Virginia (HHO WV) network. This manual, combined with other administrative requirements as defined or described in the applicable provider agreement, supplements, and is made part of their provider agreement. This manual offers access to information on processes such as filing claims, researching patient benefits, and joining the network. It also includes important contact information on how to communicate with HHO WV. This manual was designed to be a provider's primary reference guide to HHO WV. This manual and any updates are available in the Provider section of our website at **WV.HighmarkHealthOptions.com**.

Providers will be notified of any Bureau for Medical Services (BMS) policy or program change or HHO WV procedure change at least 30 days prior to the intended effective date.

Corporate Overview

HHO WV is a Highmark Blue Cross Blue Shield West Virginia affiliate and administered managed care organization. HHO WV is contracted with the state of West Virginia, Department of Health Services (DoHS), and the Bureau for Medical Services (BMS) to provide health services to eligible West Virginia Medicaid and WVCHIP managed care enrollees. HHO WV collaborates with providers and regulators to improve health outcomes, simplify the health care experience, and ensure affordability. HHO WV helps members receive the care and services they need to live healthier and more independent lives. HHO WV members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing or very little for their health coverage.

Social Determinants of Health

Social determinants of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

A number of Medicaid enrollees experience a disparate level of social needs such as transportation, housing, food access, unemployment, or education level. HHO WV encourages billing of ICD-10 Z-codes where appropriate to collect data so that HHO WV may assist these members in obtaining the necessary services.

SDoH can be grouped into five domains:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Social determinants of health (SDoH) have a major impact on people's health, well-being, and quality of life.

Examples of SDoH include:

- Safe housing, transportation, and neighborhoods.
- Racism, discrimination, and violence.
- Education, job opportunities, and income.
- Access to nutritious foods and physical activity opportunities.
- Polluted air and water.
- Language and literacy skills.

SDoH also contributes to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Health Care Disparities

HHO WV understands that to help improve our members' quality of life, we must consider racial, ethnic, cultural, and linguistic differences. For this reason, addressing disparities in health care is high on our leadership's agenda. We believe a strong patient-provider relationship is the key to reducing the gap in unequal health care access and health care outcomes due to cultural, language, and/or geographic barriers.

To develop a strong patient-provider relationship, HHO WV, via the HHO WV Cultural Competency Data Form, voluntarily collects all provider race, ethnicity, and language information to connect members to the appropriate practitioners, deliver better provider-patient communication, and improve patients' health, wellness, and safety. Disclosing this information is strictly voluntary and will not be used for credentialing, contracting, or for any discriminatory purposes. Additionally, HHO WV and BMS require all providers to take cultural competency training and to inform HHO WV about the various trainings taken by providers and their office staff throughout the year. Providers can access the Cultural Competency Data Form on the HHO WV website.

Another example of how we are working to close a quality gap can be seen in our diabetes disease management programs. To improve interventions at the point of care, HHO WV pays for Primary Care Providers (PCPs) to perform in-office HbA1c tests. Test results can be available in as little as five minutes. HHO WV also has cross-cultural education programs in place to increase awareness of racial and ethnic disparities in health care among our employees, members, and providers. A provider cultural toolkit is available at **WV.HighmarkHealthOptions.com**.

The cultural toolkit includes facts about health care disparities from the Institute of Medicine, tips on how to better communicate with patients, tools to evaluate how well the practice is delivering quality care to culturally diverse populations, information about communication regulations and resources from the Title VI of the Civil Rights Act of 1964, facts about various cultures to enable the advocacy of high-quality, culturally competent services to multi-ethnic populations, and web-based modules for physicians to practice responding to situations where culturally competent care is needed and more.

Lastly, HHO WV assesses our member populations' language profile at least every three years and makes the Population Assessment Language Profile Report available to practitioners through updates in provider newsletters.

Cultural Competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender identity, age, mental or physical disability, sexual orientation, genetic information or medical history, homelessness, ability to pay, or ability to speak English. HHO WV expects practitioners and providers to treat all enrollees with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid. Providers are prohibited from intentionally segregating Medicaid and WVCHIP enrollees in any way from other persons receiving services.

HHO WV has developed effective practitioner and provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on enrollees' diverse backgrounds, including the various cultural, racial, and linguistic challenges that enrollees encounter, and we develop and implement proven methods for responding to those challenges.

Practitioners and providers may receive education about important topics such as:

- The impact that an enrollee's religious and/or cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices).
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.).
- History of the disability rights movement and the progression of civil rights for people with disabilities.
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care.
- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage enrollees from such backgrounds to seek needed treatment.

Our Provider Relations and outreach representatives may conduct cultural competency training during practitioner and provider orientation meetings, which is designed to help practitioners and providers:

- Bridge cultures.
- Build stronger patient relationships.
- Provide more effective care to ethnic and minority patients.
- Work with patients to help obtain better health outcomes.

In addition to the above, Highmark Health Options West Virginia participating providers will have access to online training on topics such as Cultural Competency, SDoH, SDoH Codes for Providers, and Population Needs.

Continuing Quality Care

Health care is an ever-changing field and HHO WV strives to stay on top of its members' needs. HHO WV is committed to continually improving and providing high standards of quality in every aspect of service. This commitment is led by HHO WV's Quality Improvement/Utilization Management (QI/UM) Committee, comprised of experts from a wide variety of medical fields. The QI/UM Committee evaluates HHO WV's ongoing efforts as well as new protocols and quality initiatives to improve service and care for members.

Health Care Disparities, Cultural Competency, and Social Determinants of Health

To develop a strong patient-provider relationship, HHO WV will attempt to voluntarily collect all provider race, ethnicity, and language information to connect members to the appropriate practitioners, deliver better provider-patient communication, and improve patients' health, wellness, and safety. Disclosing this information is strictly voluntary and will not be used for credentialing, contracting, or for any discriminatory purposes. HHO WV assesses our member populations' language profile at least every three years and will make the Population Assessment Language Profile Report available to practitioners through updates in provider newsletters. Additionally, HHO WV is encouraging all providers to take cultural competency training and to inform HHO WV about the various trainings taken by providers and their office staff throughout the year.

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

HHO WV has developed effective practitioner and provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on enrollees' diverse backgrounds, including the various cultural, racial, and linguistic challenges that enrollees encounter, and we develop and implement proven methods for responding to those challenges. HHO WV has cross-cultural education programs in place to increase awareness of racial and ethnic disparities in health care among our employees, members, and providers. Provider culturally competent care toolkit is available at **providers.highmark.com/hho-wv/resources/provider-manual.html**.

The cultural toolkit includes facts about health care disparities from the Institute of Medicine, tips on how to better communicate with patients, tools to evaluate how well the practice is delivering quality care to culturally diverse populations, information about communication regulations and resources from the Title VI of the Civil Rights Act of 1964, facts about various cultures to enable the advocacy of high-quality, culturally competent services to multi-ethnic populations, and web-based modules for physicians to practice responding to situations where culturally competent care is needed and more. Additional online trainings will be available on topics such as Social Determinants of Health (SDoH), SDoH Codes for Providers, and Population Needs.

SDoH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Several Medicaid enrollees experience a disparate level of social needs such as transportation, housing, nutritional food access, unemployment, education level, language, racism, discrimination, violence and polluted air or water. HHO WV encourages billing of ICD-10 Z-codes where appropriate to collect data so that HHO WV may assist these members in obtaining the necessary services. SDoH also contributes to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Wellness

HHO WV is committed to improving the health and well-being of its members through a coordinated population health approach that promotes wellness, preventive care, disease management, and health education. These activities are supported across the organization through collaborative efforts led by the Quality Improvement and Utilization Management Departments, Care Management Programs, and other operational areas. Together, these teams support evidence-based preventive health services, chronic condition management, and continuous quality improvement initiatives designed to improve health outcomes and advance health equity.

Preventive health care:

- Annual flu vaccinations (ages 18 and older)
- Annual wellness visit (ages 18 and older)
- Breast cancer screening (women ages 40–74)
- Colorectal cancer screening (ages 45–75)
- Diabetes tests as needed, such as HbA1C, dilated retinal eye exam, and microalbumin (for members with diabetes)
- Tobacco cessation education and benefits
- Pediatric and adult immunization reminders

Benefits of HHO WV

Members receive improved access to primary medical care, health, and wellness programs. Providers receive timely payments, simplified administrative procedures, and dedicated provider servicing. HHO WV fulfills its mission and ensures the availability of high-quality medical care for the eligible population to positively affect the personal health of individuals.



How Does HHO WV Work?

The Plan contracts directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide care for our membership. The Plan's provider network includes hospitals, providers, ancillary locations, a network of home health care agencies, and other related health care providers. Practitioners and other health care providers are chosen in such a manner that existing patterns of care, including patterns of hospital admissions, can be maintained. Participating practitioners treat patients in their offices as they do their non-HHO WV patients and agree not to discriminate in the treatment of or in the quality of services delivered to HHO WV's members based on race, sex, age, religion, place of residence, or health status. Because of the cultural diversity of our membership, participating providers must be culturally sensitive to the needs of our members. Participation in the Plan in no way precludes participation in any other program with which the provider may be affiliated.

For information on becoming a participating provider go to the Provider Network Participation section of this manual.

Provider Self-Service

NaviNet is a web-based solution securely linking providers nationwide through a single website. This service is available at no cost to our participating providers. NaviNet is the preferred tool for inquiring about member information.

HHO WV encourages our participating providers to access the NaviNet secure Provider Portal to utilize the self-service tools available, including:

- Secure Messaging and Document Exchange for direct and secure bi-directional communication and submission of documentation.
- Claims search including remittance advice data search option that displays all claims that have been paid to a specific check number.
- Batch claims search which allows the user to view all claims for a specific provider office.
- Submit and review authorization requests.
- Submit provider post-service appeals.
- Submit claims and payment disputes.

Authorizations Portal

Providers must electronically submit authorizations and receive responses and real-time updates through the Authorization Portal. Should the provider portal be unavailable, use UM phone or fax numbers. Providers will access the Authorization Portal through NaviNet SSO (Single Sign-On) functionality. From health plan drop-down select Highmark Health Options West Virginia>GuidingCare>Authorization Portal from the Plan Workflows menu. Upon accessing the Authorization Portal, you will see the home page. From the home page, you will be able to start a new authorization, view authorizations in progress, and withdraw a pending authorization. There is a count of authorizations in progress by the authorization request type.

Provider Relations Role

HHO WV uses dedicated, highly trained Provider Account Liaisons (PALs) who are keenly aware that it is essential that our providers and their staff have a solid understanding of the members' needs, our contract requirements, protocols, and Federal and/or State regulations to provide exceptional access and quality health care to our members.

PALs give initial orientation training to providers and their office staff within 30 calendar days of successfully gaining approval to participate in our network. During that training the Provider Manual is reviewed. The training familiarizes new providers and their staff with our policies and procedures.

Provider training materials and HHO WV policies and procedures are located on the HHO WV website at **WV.HighmarkHealthOptions.com**.

Each participating primary care practice, specialty care practice, and hospital is assigned a PAL who is responsible for ongoing education. As a follow-up to the initial orientation, each assigned PAL regularly contacts providers and their staff to ensure full understanding of the responsibilities outlined in the Provider Agreements and Manual.

Educational topics include but are not limited to the following:

Plan Overview

- Cultural Competency, Culture of Disabilities and Chronic Conditions, and SDoH
- HealthCheck (EPSDT) Program
- Mental Health and Substance Use Disorder/Challenges
- OB/GYN and Family Planning Services
- Tobacco Cessation
- Resources and Self-Service Tools (Plan Contacts, Website, NaviNet, Provider Portal, Customer Service, Out-of-Network Referral Process)
- Provider Responsibilities
- Practice Updates and Changes, State Revalidation, Continuity and Coordination of Care, Coverage Arrangements, Appointment Standards and After-Hours Care, Provider Surveys, Member Rights and Responsibilities, Reporting Suspected Child Abuse and Neglect, Medical Records, Reportable Conditions
- Compliance (Fraud, Waste, and Abuse, False Claims Act)
- Claims Billing
- Motivational Interviewing
- ACEs
- Member Resources
- Carved-out Services (such as NEMT and Pharmacy)
- Encounter Data, Submission, Timely Filing, Payment, Balance Billing Members, COB, Cost Sharing, Payment Disputes
- Utilization Management (Authorization Process, GuidingCare Platform, Second Opinions)
- Case Management/Care Coordination (Case Management Overview, Specialist Treating as PCP, Preventative Health)
- Clinical Programs (Evidence Based Health Education & Preventative Care Programs) Each participating primary care practice, specialty care practice, and hospital is assigned a PAL who is responsible for ongoing education. As a follow-up to the initial orientation, each assigned PAL regularly contacts providers and their staff to ensure full understanding of the responsibilities outlined in the Provider Agreements and Manual.

PCP's Role

The definition of a PCP is a physician, nurse practitioner, physician assistant, or other participating provider a member has chosen to be their personal doctor. The PCP works with our members to provide and coordinate their health care, such as performing checkups and shots, sending them to specialists if needed, or admitting them to the hospital.

To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member's designated PCP. By focusing all of a member's medical decisions through the PCP, members are given comprehensive and high-quality care in a cost-effective manner. One of HHO WV's goals is to work together with a dedicated group of practitioners to make a positive impact on the health of our membership and truly make a difference.

Enrollment with the State

All network providers that order, refer, or render Medicaid and WVCHIP covered services must enroll with BMS, through the fiscal agent, as a Medicaid/WVCHIP provider, as required by 42 CFR §438.602(b). Enrollment with BMS does not obligate the MCO provider to offer services under the FFS delivery system. The MCO is not required to contract with a provider enrolled with BMS that does not meet their credentialing or other requirements.

Contracts/No Gag Clause

HHO WV allows open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care for the patient. All of HHO WV contracts with practitioners and providers include an affirmative statement indicating that the practitioner can freely communicate with patients regarding the treatment options available to them, including medication treatment options regardless of benefit coverage limitations. There is no language in HHO WV contracts that prohibits open clinical dialogue between practitioner and patient.

Quality Improvement

Purpose of the QI Program

The purpose of the QI program is to ensure that members have access to and receive safe, appropriate, timely, and equitable quality medical and behavioral health care services. The QI program monitors and evaluates the quality and appropriateness of care provided by HHO WV's provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality improvement methodologies and industry-accepted quality measurement tools, HHO WV evaluates its performance outcomes to:

- Identify opportunities to improve the provision and delivery of health care and health plan services.
- Identify opportunities to improve member and provider satisfaction with care delivery and services.
- Achieve optimum member health outcomes.

The QI Program centers on these key areas: (a) quality of clinical care, (b) safety of clinical care, (c) quality of service, (d) members' experience and (e) health. The QI program strives to improve members' adherence to preventive care guidelines, disease management strategies, and therapies that are essential to the successful management of certain chronic conditions.

The program also strives to improve patient safety through:

- Educating members and providers regarding safe practices.
- The assessment and identification of opportunities to improve patient safety throughout the provider network.
- Communication to members and providers of safety activities and provisions that may be in place throughout the network.

To ensure that all these efforts impact all members equitably, the QI program endeavors to continually identify opportunities to impact racial and ethnic disparities and language barriers in health care. In addition, the QI department maintains a catalog of policies and procedures that guide the execution of the QI program. QI policies and procedures are reviewed and updated annually to reflect changes in requirements, government regulations, and the needs of the membership and provider network.

Goal of the QI Program

The QI Program utilizes a Plan, Do, Study and Act framework when setting goals. The goal of the QI program is to ensure the provision and delivery of high-quality medical and behavioral health care, pharmaceutical, and other covered health care services and quality health plan services (Plan). Additional goals for the QI program are to serve members with complex health needs and to serve a diverse membership in the most equitable way. The QI program focuses on monitoring and evaluating the quality and appropriateness of care provided by HHO's provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system (Do). HHO's performance is assessed through utilizing quality improvement concepts and appropriately recognized quality measurement tools and reports, such as qualitative, quantitative, and root/cause barrier analyses. HHO focuses on assessing its performance outcomes to identify opportunities for improvement in the provision and delivery of health care and health plan services, patient safety, satisfaction with care and services (Study). Continuous assessment is also imperative for achieving optimum member health outcomes (Act).



Of specific importance, the QI Program focuses on three key areas:

- Preventive health care.
- Prevalent chronic health care conditions.
- Service indicators.

The QI Program strives to:

- Improve members' compliance with preventive care guidelines, disease management strategies, and therapies that are essential to the successful management of certain chronic conditions.
- Identify opportunities which address disparities in health care.
- Improve patient safety by:
- Providing member and practitioner education about safe practices.
  - Assessing the identifying opportunities to improve patient safety throughout the practitioner/provider network.
  - Communicating to members and practitioners about the safety and provisions in place throughout the network.

By considering population demographics and health risks, utilization of health care resources, and financial analysis, HHO WV ensures that the major population groups are represented in QI activities and health management programs chosen for assessment and monitoring. This information, along with high-volume/high-cost medical and pharmaceutical reports, health risk appraisal data, disease and care management data, satisfaction survey information, and other utilization reports, will be used to identify members with special needs and/or chronic conditions and to develop programs and services to assist in managing their condition.

Objective of the QI Program

The objectives of the QI program are consistent with HHO WV's mission, as well as its commitment to the effective use of health care resources, and continuous quality improvement to positively affect the members' whole care and their social determinants of health. An annual QI work plan is developed to ensure that the current needs of the population are being evaluated, changes are tracked and trended, programs are enhanced or implemented to address the needs of members, and to ensure continuous quality improvement. The QI program is evaluated quarterly and annually to determine the status of all activities and identify opportunities which align with the QI program objectives.

Objectives of the QI Program are as follows:

- Development and implementation of an annual QI work plan to assure completion of planned activities. The current needs of the population are evaluated and demonstrated continuous quality improvement. The work plan is updated quarterly to track progress of goals and initiatives for each year.
- The provision of appropriate, timely, and quality health care services.
- Develop guidelines and studies which address the member population.
- Assess practitioner performance.

Scope of the QI Program

The scope of the QI program includes a comprehensive evaluation, quantitative, and qualitative barrier analysis of the utilization of health care services and programs, access and availability to those services, the needs of the members served, the quality of the care provided, and establishment of utilization guideline and review processes. Implementation and evaluation of the QI program is embedded into HHO WV's daily operations. The QI program leverages internal information, systems, practitioners, and community resources to monitor and evaluate use of health care services, continuous improvement, and to assure implementation of positive change. The responsibility of implementing the QI program is an HHO WV corporate responsibility, not only that of the QI department.

The scope of the QI Program focuses on the following areas:

- Quality of Clinical Care The QI program focuses on delivering to members clinical services that are safe, appropriate, and meet professional standards. This is ensured through the monitoring of key indicators including, but not limited to Healthcare Effectiveness Data and Information Set (HEDIS) measures, Preventive and Clinical Practice Guideline studies, and review of Quality-of-Care concerns such as Preventable Serious Adverse Events (PSAE), Never Events. Initiatives are designed and implemented to address any indicators that have not been achieved or are negatively deviating from goals.
- Quality of Service The QI program focuses on delivering customer service to members that is professional, accessible, available, and meaningful. This is ensured through the monitoring of key indicators including, but not limited to, the annual Consumer Assessment of Health care Providers and Systems (CAHPS), member satisfaction survey, member complaints, appeals and grievances, and member and provider call center statistics. Initiatives are designed and implemented to address any indicators that have not been achieved or are negatively deviating from goals.

- Safety of Clinical Care The QI program works to improve patient safety by monitoring for member and practitioner education regarding safe practices, by assessing and identifying opportunities to improve patient safety throughout the practitioner/provider network, and by ensuring that members and practitioners have been informed about safety activities and provisions which may be in place throughout the network. An additional method for monitoring safe practices and identifying opportunities involves collaboration with the Fraud Waste and Abuse department auditing providers prescribing patterns and reviewing clinical data related to safe prescribing methods and following clinical practice guidelines.
- Member Experience The QI program focuses on creating and maintaining a positive member experience through taking initiative based on the results of the annual CAHPS survey, and the trending of member inquires, complaints, appeals, and grievances to identify areas of opportunity. Health Equity programs and activities, various community programs and SDoH programs exist for members and their satisfaction with these programs is monitored annually. Experience is also monitored through the quality and availability of provider services.

Furthermore, the QI program utilizes appropriate internal resources, race/ethnicity data, information systems, practitioner data, and community resources. Data and resources are used to monitor and evaluate utilization of health care patterns, the continuous improvement process, and to ensure implementation of positive change. Additionally, the plan utilizes Member Advisory Committee which meets quarterly, to solicit feedback from the membership regarding programs, benefits, policies and procedures.

The scope of the program includes:

- Analysis and evaluation of the quality of clinical services provided to members.
- Monitoring of service quality.
- Delivery of a health equity program to improve and ensure services provided to member are culturally and linguistically appropriate.
- Monitoring and evaluation of network availability and accessibility.
- Monitoring and evaluation of practitioner activities.
- Review of activities falling within the scope of UM.
- Oversight to ensure proper credentialing of new practitioners, as well as the recredentialing of participating practitioners.
- Oversight to ensure the goals of the population health management activities are being met.
- Monitoring and evaluation of care management/complex care management activities.
- Ensuring appropriate oversight of those QI and UM functions which have been delegated by monitoring activities through the QI/UM Committee.
- An evaluation of risk management and patient safety.
- Monitoring the utilization of health care services and programs.
- Implementing at least two state mandated PIPs and one MCO selected.

Lastly, the scope of the QI Program comprises a comprehensive quantitative and qualitative evaluation and barrier analysis of:

- The utilization of health care services and programs.
- Access and availability to health care services.
- The needs of the members served.
- The quality of the care provided.
- Establishment of utilization guidelines and review processes.

To request a copy of the quality improvement program, work plan, or annual evaluation, please contact HHO WV's Provider Services Department at **1-833-957-0020**, Monday-Friday, 8 a.m.-5 p.m.

Clinical Practice Guidelines

The Clinical Practice Guidelines are designed as a resource to assist practitioners in caring for HHO WV's members. The clinical practice and preventive health guidelines will be developed using either evidence-based clinical guidelines from recognized sources, or through involvement of board-certified practitioners from appropriate specialties. Guidelines are evaluated on an ongoing basis and are developed based on the prevalent diseases or conditions of HHO WV's members, as well as applicable regulatory and accrediting body requirements. The use of guidelines permits HHO WV to measure the impact of the guidelines on outcomes of care and may reduce inter-practitioner variation in diagnosis and treatment.

Clinical guidelines are not meant to replace individual practitioner judgment based upon direct patient contact.

Some examples of clinical guidelines include but are not limited to:

- Pediatric Preventive/EPSDT/Lead Screening (birth to age 21)
- Adult Preventive
- Asthma
- ADHD
- Cardiac
- COPD
- Cystic Fibrosis
- Depression
- Diabetes
- Healthy Weight Management for Children and Adolescents
- Health Weight Management
- HIV
- Hypertension
- Opioids – Prescribing for Chronic Pain
- Palliative Care
- Prenatal Care – Routine and High Risk
- Preventive Dental Care – Pediatric
- Schizophrenia (Children and Adolescents)
- Sickle Cell Disease
- Substance Use Disorder

Service Quality

HHO WV conducts numerous activities throughout the year to measure the quality of services provided to patients.

Some of these activities include:

- Analysis of complaints and grievances.
- Availability and accessibility studies.
- Conducting the CAHPS® member experience survey.
- Review of disenrollment data.

Medical Record Requests and Standards

Each year a randomly selected number of PCPs, specialists, and BH providers participate in the HHO WV provider medical record audit to ensure records comply with medical record standards.

These have been adopted by the HHO WV QI/UM Committee. Medical record standards have been developed for PCPs, specialists, and BH providers.

Standards verify that providers are:

- Assured that medical records are being evaluated in a consistent manner.
- Aware of the expected level of care and associated documentation.
- Aware of the requirements for maintenance of confidential medical information and record keeping.

The QI/UM Committee has established the scoring standard of 80% of the elements pertaining to the medical record standards. If during a provider medical record audit, a score of 80% has not been met, a follow-up review will be scheduled to assess improvement. Providers are notified of their results and any areas of deficiency by letter within 45 days of the review.

To request and receive medical records, and to request that they be amended or corrected, for which the MCO will act 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.



Frequency of Reviews

A sample of medical records from a randomly selected group of providers are reviewed each year.

Medical Record Standards – PCPs and Specialists	
1. Member ID	Each page in the record contains member name or member ID number.
2. Signed entry	All entries are signed or initialed (electronically) by the provider.
3. Dated entry	All entries are dated.
4. Legibility	The record is legible to someone other than the provider or provider's staff.
5. Problem list (PCPs only)	Problem list is current and completed for each member, including significant illness, medical conditions, and health maintenance concerns.
6. Medication list	Prescribed medications and dosages are documented on a medication list.
7. Allergies	Presence or absence of allergies or adverse reactions to medications are prominently noted (ages 1 and older). An absence of allergies should be clearly documented in the record.
8. Medical history	Includes serious injuries, operations, and illnesses of member. For children and adolescents, this includes prenatal care, birth, and childhood illnesses.
9. Tobacco use	Use or non-use of tobacco products is documented on members ages 12 and older.
10. Alcohol use	Use or non-use of alcohol is documented on members ages 12 and older.
11. Drug use	Use or non-use of illicit drugs is documented on members ages 12 and older.
12. History and physical	A complete history and physical exam, including appropriate subjective and objective information for presenting complaints.
13. Lab, diagnostic tests, and other studies	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
14. Working diagnosis	There is a clearly documented diagnostic impression by the provider that is consistent with findings for each patient visit.
15. Plan of action, therapies, treatment, prescribed regimens	Each visit is finalized with a plan of action or treatment plan that are consistent with diagnosis. Treatment options (e.g., medical versus surgical, etc.), and risks of treatments are discussed as appropriate.
16. Follow-up visit	Notation concerning follow-up care included.
17. Continuity of care	Includes documentation on communication between PCP or specialist care (whichever is applicable), notes from consultations, follow-up plans for significantly abnormal lab or imaging results, emergency department discharge summaries, and records from transferred care or SNFs or home care agencies, as applicable.

18. Discharge summary	If the member was in the hospital, there is a discharge summary signed and dated within 30 days.
19. Care medically appropriate	Medical record describes medically appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk.
20. Confidentiality	Medical records contain confidentiality statements or a copy of signed consents to release information.

Medical Record Standards – BH Providers	
1. Member ID	Each page in the record contains member name or member ID number.
2. Signed entry	All entries are signed or initialed (electronically) by the provider.
3. Dated entry	All entries are dated.
4. Legibility	The record is legible to someone other than the provider or provider's staff.
5. Psychological assessment and presenting problem list	A mental status examination is documented in the medical record. Presenting problems and relevant psychological and social conditions affecting the member's medical and psychiatric status are documented. Imminent risk of harm or suicidal ideation are documented.
6. Medication list	Prescribed medications and dosages are documented on a medication list.
7. Allergies or adverse reactions	Presence or absence of allergies or adverse reactions to medications are prominently noted. An absence of allergies should be clearly documented in the record.
8. Tobacco use	Use or non-use of tobacco products is documented on members ages 12 and older.
9. Alcohol use	Use or non-use of alcohol is documented on members ages 12 and older.
10. Drug use	Use or non-use of illicit drugs is documented on members ages 12 and older.
11. Lab, diagnostic tests, and other studies	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
12. Working diagnosis	There is a clearly documented diagnostic impression by the provider that is consistent with findings for each member visit.
13. Plan of action, therapies, treatment	The provider initiating a treatment plan must describe the active target interventions with specific, measurable goals, and stated in behavioral terms, at the level of care proposed. Includes follow-up care.
14. Preventive services	There is documentation of preventive services, as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources.

Medical Record Standards – BH Providers (continued)	
15. Consultation, referrals, continuity, and coordination of care	The medical record reflects continuity and coordination of care between the PCP, specialists, consultants, ancillary providers, and health care institutions, as applicable. Discharge summaries are included, if applicable.
16. Discharge plan	If the member terminates treatment, documentation of a discharge plan is present.
17. Care medically appropriate	Medical record describes appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk. Record reflects that members who become homicidal or suicidal receive immediate and relevant interventions.
18. Confidentiality	Medical records contain confidentiality statements or a copy of signed consents to release information.

Maintaining Medical and Financial Records

Providers will develop and maintain a medical record for each patient in accordance with the requirements established by federal and state laws. Medical records will include reports from referring providers, discharge summaries, records of emergency care received by patients, prescriptions written by the provider, and other information as federal and state laws and regulations or accreditation standards require. Providers will maintain medical records for a minimum of 10 years from the date of patient discharge or 10 years from the patient's date of majority, whichever is later. Providers will maintain a master history of appointments for a minimum of one year from the date of service to allow for monitoring and investigation of grievances related to scheduling.

Medical Record Requests

From time to time, HHO WV will submit an ad-hoc request for medical records. It is imperative that providers in our participating network respond to these requests within fifteen business days, with the exception of Quality-of-Care cases which require a response within 3 business days, as dictated per contractual obligations. If HHO WV requests medical records, the provider must provide copies of those records at no cost. This includes notifying any 3rd party who may maintain medical records of this stipulation as well as the time constraints. These requests are made to comply with regulatory requirements, requests, audits, or for operational purposes (e.g., to investigate quality of care issues, complaints/grievances, or Serious Adverse Event cases).



Living Will Declaration

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a new law that has come to be known as the Patient Self-Determination Act. It became effective on December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, and health maintenance organizations that receive Medicare or Medicaid funds.

The primary purpose of the act is to make sure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute an advance directive if they so desire. The Act also prevents discrimination in health care if the member chooses not to execute an advance directive.

As a participating provider within the network, you are responsible for determining if the member has executed an advance directive and for providing education about advance directives when it is requested. While there is no specific governmentally mandated form, you can request a copy of a Living Will form from our Provider Services Department by calling **1-833-957-0020**.

A copy of the Living Will form should be maintained in the member's medical record. Medical Record Review Standards state that providers should ask members ages 21 and older whether they have executed an advance directive and document the member's response in their medical records. Providers will receive educational materials regarding a member's right to advance directives upon entering the practitioner network.

Participation in Decision-Making

HHO WV permits the enrollee's parent or representative to facilitate care or treatment decisions when the enrollee is unable to do so. HHO WV will provide for enrollee or representative involvement in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment, and comply with requirements of Federal and State law with respect to advance directives.

This includes:

- Providing written information to clients concerning their rights under State law to accept or refuse medical or surgical treatment and to formulate advance directives and concerning the MCO's policies with respect to the implementation of such rights (this information must be included in the enrollee handbook).
- Documenting in the enrollee's medical record whether or not the enrollee has executed an advanced directive.
- Not conditioning the provision of care or otherwise discriminating against an enrollee based on whether the enrollee has executed an advance directive.
- Ensuring compliance with requirements of state law respecting advance directives.
- Providing education for staff and the community on issues concerning advance directives.

The MCO may not prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future decisions.

Important Provider Information and Responsibilities

Notice of Practice/Practitioner Changes

One of the many benefits to the HHO WV member is improved access to medical care through HHO WV's contracted provider network. HHO WV strives 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 up-to-date and accurate information about HHO WV's network providers, it is imperative that providers notify Highmark Health Options of any of the following:

- Address changes.
- Phone & Fax number changes.
- Changes of 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 HHO WV a written notice at least 30 days in advance of the change by completing the HHO WV Practice/Provider Change Request Form, or practices/practitioners may submit notice on your practice letterhead.

Please submit change requests via fax or mail.

Fax: 1-855-451-6680

Or Mail to:

Highmark Health Options WV
Attention: Provider Information Management
P.O. Box 535191
Pittsburgh, PA 15253-5191

Provider Self-Service

NaviNet

NaviNet is a web-based solution securely linking providers nationwide through a single website. This service is available at no cost to our participating providers. NaviNet is the preferred tool for inquiring about member information.

HHO WV encourages our participating providers to access the NaviNet secure Provider Portal to utilize the self-service tools available, including:

- Secure Messaging and Document Exchange for direct and secure bi-directional communication and submission of documentation.
- Claims search including remittance advice data search option that displays all claims that have been paid to a specific check number.
- Batch claims search which allows the user to view all claims for a specific provider office.
- Submit and review authorization requests.
- Submit provider post-service appeals.

Authorization Portal

Providers must electronically submit authorizations and will receive responses and real-time updates through the Authorization Portal. Should the provider portal be unavailable, use UM phone or fax numbers. Providers will access the Authorization Portal through NaviNet SSO (Single Sign-On) functionality. From health plan drop-down select HHO WV and then GuidingCare> Authorization Portal from the Plan Workflows menu. Upon accessing the Authorization Portal, you will see the home page. From the home page you will be able to start a new authorization, view authorizations in progress, and withdraw a pending authorization. There is a count of Authorizations in progress by the authorization request type.

Billing Responsibilities

Billing Patients for Covered Services

Providers may not bill or collect any payment from Medicaid or WVCHIP enrollees for care that was determined to not be medically necessary. Payment by Highmark Health Options is considered payment in full. Providers may not balance bill enrollees for covered services. Providers may directly bill patients when noncovered services are provided; however, before providing such services, the provider must notify the patient in writing that:

- The service(s) to be provided are not covered.
- Costs for non-covered services prior to rendering such services.
- They have the right to appeal an adverse coverage decision.
- They will be financially liable for services if the appeal is not successful.
- That Highmark Health Options will not pay for nor be liable for those services.
- The patient must then sign the agreement, thereby accepting responsibility.

Billing for Missed Scheduled Appointments

A participating provider's Highmark Health Options agreement and the BMS contract prohibits providers from collecting copays for missed appointments.

No-Show Policy

The following Member No-Show policy has been instituted to help providers manage HHO WV members who violate office policy in regard to scheduled appointments.

HHO WV will recognize the individual practitioner's written office policy regarding scheduled appointments. Practitioners are responsible for recording no-show appointments in the member's medical record. When a transfer is being conducted due to member no-show, the practitioner's notification should indicate that the practitioner wants to transfer the member to another PCP's practice.

Confidentiality and HIPAA Requirement

All network providers agree to abide by all HHO WV policies and procedures regarding member confidentiality. All personal health information (PHI) and personally identifiable information (PII) about HHO WV members is subject to state and federal statutory and regulatory privacy standards.

The provider must have an established program to:

- Effectuate full compliance with all applicable state and federal privacy and breach notification laws for the protection of PHI and PII.
- Notify individuals, appropriate official bodies, and the media in the event of a breach of PHI or PII. Providers will maintain a privacy compliance and breach notification program in accordance with industry best practices. Under these policies, the provider must:
  - Ensure that a patient's individually identifiable health information as defined by HIPAA (necessary for treatment, payment, or health care operations [TPO]) is released to HHO WV without seeking the consent of a patient. In addition, providers will assure that PHI for TPO will be made available to the Bureau for Medical Services, Department of Health Services, Department of Insurance,or HHO WV business associates for use without patient consent. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations. HHO WV follows HIPAA requirements and limits its requests to the amount of PHI that is minimally necessary to meet the TPO function.
  - **This information includes PHI used for:**
    - Accreditation surveys
    - Appeals
    - Case management
    - Claims payment
    - Continuity and coordination of care
    - Disease management
    - Medical management
    - Medical record audits
    - Quality assessment and measurement
    - Quality of care issues
    - Treatment
- Ensure that patient records are considered privileged information and, therefore, are protected by obligations of confidentiality.

- Conduct environmental security of confidential information and monitor practice and provider sites. Provider sites must comply with the Environmental Assessment standards that require patient records to be protected from public access.
- Make medical records available for all patient visits for established patients.
- Provide the highest level of protection and confidentiality of patients' medical and personal information used for any purposes in accordance with federal and state laws or regulations, including:
  - HIPAA, 45 CFR Parts 160, 162, and 164.
  - Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.
  - The HITECH Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb 17, 2009) and related regulations.
  - 42 U.S.C. § 1396a(a)(7) – State plan for medical assistance.
  - 42 C.F.R. § 431.300 et seq. – Medical Assistance – Safeguarding Information on Applicants and Recipients.
  - Provide the patient, or a patient's representative, including head of household, legal guardian, or durable power of attorney, access to view and receive copies of the medical record upon written request. Patients are entitled to one free copy of their medical records. The fee for additional copies should not exceed the costs of time and materials used to compile, copy, and furnish such records. Records should be available within 14 calendar days of the written request and follow the specific procedures of the provider.



Continuity and Coordination of Care Requirements

Specialists, hospitals, and skilled nursing facilities must ensure compliance with the continuity and coordination of care requirements. Providers can do this by ensuring that all discharge summaries and progress reports are reported back to the patient's PCP.

Potential Preventable Serious Adverse Events, Hospital Acquired Conditions, and Never Events

Quality of Care Concerns (including; potential preventable serious adverse events, hospital acquired conditions, and never events) are identified by several internal and external mechanisms such as case management review, credentialing/recredentialing activities, claims payment retrospective review, UM case review, complaint and grievance review, fraud, waste, and abuse (FWA) investigations, practitioner/providers, delegates, and state and/or federal agencies.

Once a potential event has been identified, an extensive review is conducted by the HHO WV Quality Initiatives and Medical Management Departments. The process includes, when necessary, a medical record review and possible phone or mail communication with the provider. Once it has been determined if an actual event has been discovered, HHO WV will, when necessary, verify if payment denial or retraction needs to take place, and notify the practitioner/provider by mail if that is required.

Reportable Diseases

By state mandate, providers must report communicable diseases and conditions to local health departments. HHO WV providers are to comply with all state laws in the reporting of communicable diseases and conditions. Timely reporting is vital to minimize outbreaks and prevalence. Reportable diseases include, but are not limited to, the following primary types of diseases: sexually transmitted infections (STIs), TB and communicable diseases (for example, HIV, AIDS, etc.). HHO WV attests annually that we have provided written notification to participating providers about your responsibility to report and procedures for reporting these primary types of diseases to the state. Division of Surveillance and Disease Control Reporting Health care practitioners and providers are required to report certain diseases by state law. This is to allow for disease surveillance and appropriate case investigation/public follow-up.

The three primary types of diseases that must be reported are:

- **Sexually Transmitted Disease Program:** Per WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, practitioners, and providers must report cases involving a sexually transmitted disease to the Division of Surveillance and Disease Control.
- **Tuberculosis Program:** Per WV Statute Chapter 26-5A-4 and WV Regulations 16-25-3, practitioners and providers must report individuals with diseases caused by M. tuberculosis to the WV Bureau for Public, DSDC, and TB Program.
- **Communicable Disease Program:** Per WV Legislative Rules Title 6-4, Series 7, practitioners, and providers must report cases of communicable disease noted as reportable in West Virginia to the local health departments in the appropriate time frame and method outlined in legislative rules. Per legislative rule, reports of category IV diseases, including HIV and AIDS, are to be submitted directly to the State Health Department, not to local jurisdictions.

Bureau for Public Health Laboratories

HHO WV network providers are required by law to use Bureau for Public Health Laboratories for certain cases (e.g., metabolic testing for newborns, rabies), and the Bureau for Public Health Laboratories is required to perform tests, including core services. In addition, all HHO WV contracted laboratories who have positive findings of certain reportable diseases under the Reportable Disease Rule in category I, II, and IV (the list of reportable diseases is available from BMS) must submit an isolate, serum specimen or other designated material to the Office of Laboratory Services (OLS) for confirmation or other testing needed for epidemiological surveillance. These services are usually funded by state or federal funds; however, whenever a service is not funded by other state or federal funds, HHO WV will reimburse OLS for these services.

Language Services

Providers are expected to comply with Title VI of the Civil Rights Act of 1964 that prohibits race, color, or national origin discrimination in programs receiving federal funds. Providers are obligated to take reasonable steps to provide meaningful access to services for patients with limited English proficiency, including provision of translator services. Provider offices are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA) in adherence to Section 504, the Rehabilitation Act of 1973, and related federal and state requirements. Providers are expected to arrange and coordinate interpreter services to assist patients who are hearing impaired.

Practitioners may obtain copies of documents that explain legal requirements for translation services by contacting Highmark Health Options WV Provider Services Department at **1-833-957-0020**. For interpreter services, please contact a qualified medical interpretation service such as Language Line Services. Practitioner offices can contact the Language Line at **1-800-874-9426** for assistance with Limited English Proficient (LEP) patients and the WV State Relay line at **1-866-430-1274** for patients with hearing impairments.

PCP's Role and Responsibilities

PCPs are responsible for 24/7 coordination of assigned and attributed patients' health care needs and access to services provided by hospitals, specialty care providers, ancillary services, and other health care services. HHO WV expects PCPs to play an active role in coordinating the health care services needed by patients, including scheduling annual visits.

HHO WV can provide comprehensive and high-quality care in a cost-effective manner by focusing all patient medical decisions through the PCP. HHO WV contracts with a mix of PCPs to ensure the primary care needs of adult and pediatric enrollees are met.

HHO WV designates the following providers as PCPs, as appropriate:

- Certified nurse midwives
  (Certified nurse midwives are required to practice in a collaborative relationship with a licensed physician (West Virginia Code §30-15-7). HHO WV will ensure compliance with all relevant federal and state regulations related to certified nurse midwives.)
- Advanced practice nurses (e.g., nurse practitioners (NP))
- Physician Assistants (PA)
- Physicians with the following specialties: General practice; Family practice; Internal medicine; Obstetrics/Gynecology; and Pediatrics.

The PCP's role is to:

- Maintain continuity of each enrollee's health care by serving as the enrollee's primary care provider.
- Provide primary behavioral health services within their scope of practice.
- Provide 24/7 access.
- Make referrals for specialty care and other Medically Necessary covered services, including behavioral health, both in-network and out-of-network, consistent with HHO WV's utilization management policies.
- Maintain a current medical record for the enrollee, including documentation of all services provided to the enrollee by the PCP, as well as any specialty or referral services.
- Adhere to the EPSDT Periodicity Schedule for enrollees age 20 and younger.
- Follow MCO-established procedures for coordination of in-network and out-of-network services for Medicaid enrollees.

HHO WV retains responsibility for monitoring PCP actions to ensure they comply with Plan and West Virginia Medicaid and WVCHIP managed care program policies. HHO WV will provide this information through its provider manual, continuing education agendas, informal visits by provider representatives, or any other means. HHO WV will ensure that PCPs are successfully identifying and referring patients to a behavioral health provider and provide education to PCPs who do not have training in this area.

PCP's Role in Verifying Eligibility and Panel Status

All providers, regardless of contract status, must verify an enrollee's enrollment status prior to the delivery of nonemergent, covered services. Providers are not reimbursed for services rendered to enrollees who lost eligibility. Enrollee eligibility can be verified online with the **WV Medicaid Management Information System, HHO WV's secure provider portal (NaviNet)** or Interactive Voice Response System **1-833-957-0020**.

PCPs can confirm a patient's panel status by consulting their panel list to verify that a particular patient is assigned to them. The panel list is distributed around the first of every month. PCPs should check the panel list each time a patient is seen in the office.

PCP Assignments

A PCP agrees to accept a minimum number of HHO WV members to their panel at each authorized office location without regard to their status as a new or existing patient to that practice or location. Each family member has the freedom to choose any in-network PCP. A PCP must regularly review the roster of patients assigned to the PCP's practice to ensure that appropriate care coordination activities are enforced.

PCP Assignment Changes

Patients may change PCPs if a satisfactory relationship does not develop. PCPs will not seek to transfer a patient from their practice based on the patient's health status. However, a patient whose behavior would preclude delivery of optimum medical care may be transferred from the provider's panel.

PCP changes are processed under the following guidelines:

- **If the request is received prior to the 25th of the current month, the new effective date will be the first of the following month.**
  - Example: A patient's request is received on Oct. 7; the member's effective date with the new PCP will be Nov. 1.
- **If the request is received on or after the 25th of the current month, the new effective date will be the first of the subsequent month.**
  - Example: A patent's request is received on Oct. 28; the member's effective date with the new PCP will be Dec. 1.

Immediate change requests:

- An exception to the above guidelines can be made if the situation warrants.

Patient Noncompliance

Written Transfer Requests

If inappropriate behavior or patient noncompliance with no-show policies should occur and the PCP desires to transfer a patient, the PCP must send a letter requesting that the patient be removed from their panel.

The PCP must send the letter to Enrollment. The letter must:

- Include the patient's name and HHO WV ID number.
- State the no-show policy and the patient who has violated the policy.

Send correspondence to:

Highmark Health Options WV
Attention Enrollment
614 Market St.
Parkersburg, WV 26101

Process and Determination

Enrollment notifies the original provider in writing when the transfer has been completed. If the patient requests not to be transferred, the PCP will have the final determination regarding continuation of primary care services.

Emergency Care during the Transfer Process

PCPs are required to provide emergency care for any patient who is dismissed from their practice until the patient's transfer is complete.

Second Opinions

HHO WV ensures patient access to second opinions. Second opinions may be requested by HHO WV, the patient, the patient's caregiver, or the PCP. HHO WV will provide for a second opinion from a qualified health care provider within the network or arrange for the patient to obtain one outside the network at no cost.

The second opinion specialist must not be in the same practice as the attending provider and must be an in-network provider, when there's one available within the network. Second opinions from out-of-network providers must be authorized when no in-network provider is accessible to the member or when no in-network provider can meet the patient's needs.

Second Surgical Opinions

Second surgical opinions may be requested by Highmark Heath Options, the patient, the patient's caregiver, or the PCP.

When requesting a second surgical opinion, providers issue a referral to a consulting provider who:

- Is in a practice other than that of the attending provider or the provider who rendered the first opinion.
- Possesses a different tax identification number than the attending provider.

Highmark Health Options Practitioner Excellence (HHOPE) Program

Highmark Health Options recognizes the valuable role practitioners play in serving our members and improving their health outcomes. The Highmark Health Options Practitioner Excellence (HHOPE) program rewards primary care and dental providers for delivering high-quality, accessible, and efficient care, with a focus on closing care gaps. The HHOPE program is open to primary care physicians (including internists, family medicine physicians, and pediatricians) and dentists.

Providers receive incentives for performance in these quality measure areas:

- Controlling high blood pressure
- Glycemic status assessment for patients with diabetes (HbA1c > 9.0%)
- Oral evaluations
- Well-child visits (from birth-15 months and 15-30 months)
- Lead screening for children
- Adolescent immunizations (Combo 2)
- Childhood immunizations (Combo 10)
- Timeliness of prenatal care

For complete program details, a full list of measures, and enrollment information, please visit our website.

Highmark Health Options Practitioner Excellence (HHOPE) Program Performance

Highmark Health Options Practitioner Excellence Provider Performance Reporting:

Provider Performance reports will be available monthly through the Highmark Health Options Care Gap Management Application (CGMA). Access to the CGMA is required to view this information. Providers, regardless of HHOPE program participation, can access their performance data within the CGMA. The CGMA reports detailed provider performance across all incentivized HHOPE program measures, as well as additional non-incentivized profiled measures. To gain access to the CGMA and the HHOPE performance reporting, please contact your dedicated Clinical Transformation Consultant or email us at **HHOWVPET@highmarkhealth.org**.

Specialty Care Providers

Specialty care providers must verify eligibility prior to rendering services to ensure reimbursement. Eligibility and benefits verifications are available 24/7.

Specialists Functioning as Primary Care Providers

A specialist may function as a PCP for a patient with complex illnesses or conditions. For a specialist to function as a PCP, the specialist must be approved based on regulatory standards.

Transportation

Emergent Transport

HHO WV considers emergent transportation as transportation that allows immediate access to medical or behavioral health (BH) care and lack of access could precipitate a medical or BH crisis for the patient. Either an in-network or out-of-network ambulance provider may render emergent transportation without an authorization.

Emergent situations are:

- Acute care to acute care
- Behavioral health to behavioral health
- Acute care to behavioral health
- Behavioral health to acute care
- Emergency department to acute care or behavioral health facility
- Emergency department to emergency department
- Hospital to hospital when a patient is being discharged from one hospital and being admitted to another

Nonemergent Transport

Nonemergent transport is covered by the State for transportation to health care visits. Authorization for nonemergent ambulance transportation is required. HHO WV considers nonemergent transportation as transportation for a patient who does not require immediate access to medical or BH care, and if care is not provided the result would not be a medical or BH crisis.

Nonemergent transportation scenarios are:

- Ambulance transport from home to a PCP office.
- Ambulance transport to home upon discharge from a hospital or an emergency room visit.

Providers should contact in-network ambulance providers to render nonemergent transportation when possible. Ambulance transportation from one facility to another for diagnostic testing or services not available at the current facility, with the expectation of the patient returning to the original facility upon completion of service, is the responsibility of the originating facility and does not require an authorization. The originating facility should assume the cost for this type of transport even if, for unforeseen circumstances, the patient remains at the receiving facility. The originating facility may contact an ambulance service of their choosing to provide transport in this scenario only.

Behavioral Health Services

HHO WV members have access to high-quality behavioral health (BH) services for treatment of mental health (MH) and substance use disorders (SUD) at a level of care within the least restrictive environment. In-network providers offer services and support for HHO WV members' BH, MH, and SUD needs across a continuum of care. The HHO WV BH program adheres to the Mental Health Parity Act and all West Virginia laws related to coverage for BH, MH, and SUD.

BH Crisis Intervention Services (CIS)

The goal of CIS is the prevention of unnecessary or inappropriate hospitalization of a person experiencing severe symptoms of a mental illness or substance-related problem. CIS staff can better assess the patient's environment, support systems, and current level of functioning by providing services in the community and gaining a clear understanding of the type of treatment and support services that will be needed.

Substance Use Disorder (SUD) Services

SUD services are behavioral health treatment services provided to members with a known or suspected substance use disorder when medically necessary. Benefits include targeted case management, behavioral health assessment, drug screening, inpatient and/or outpatient services, residential adult services, Naloxone administration services, methadone and non-methadone medication assisted treatment, and peer recovery support services. Some services require prior authorization or have benefit limits.

HealthCheck (EPSDT)

HealthCheck is the name for West Virginia's EPSDT Program. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a child preventive health component of Medicaid. Federal law requires that state Medicaid programs provide medically necessary health care services to Medicaid-eligible children.

Providers are referred to the BMS Medicaid Physician Provider Manual for state requirements and procedures related to EPSDT services and reporting. EPSDT services and reporting must comply with 42 CFR §441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

The HealthCheck Program works to equip West Virginia's Medicaid providers with the necessary tools and knowledge to carry out EPSDT services appropriate to the American Academy of Pediatrics' standard for pediatric preventive health care, **Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents**. Providers should perform the screening for all eligible members using the BMS HealthCheck screening form at **www.dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx**.

HHO WV will educate providers to ensure they answer the questions contained on the HealthCheck forms regardless of how their actual materials are formatted, so that such information can be recorded and reported to BMS with any other information required for the purposes of tracking EPSDT participation goals.

Providers must adhere to the EPSDT Periodicity Schedule for enrollees ages 20 and younger. The provider should perform the screening (periodic, comprehensive child health assessments) for all eligible members. EPSDT services should be regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. HHO WV will also outreach to parents to encourage consistent participation in the EPSDT screenings and benefits.

As part of HealthCheck, screening services are provided by primary medical providers at regular intervals (**periodic screens**) and whenever a problem is suspected.

Screening services include all the following:

- **Comprehensive Health and Developmental History**: Includes an assessment of both physical and mental health development.
- **Comprehensive Unclothed Physical Exam**: Should be supervised.
- **Immunizations:** In accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices (ACIP).

- **Laboratory Tests**
- **Lead Toxicity Screening**: All children must receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning.
- **Vision Screening**
- **Hearing Screening**
- **Behavioral Health Screening**
- **Developmental Screening**: Includes developmental screening using a standardized screening tool at 9, 18, and 30 months and an autism-specific screening at 18 and 24 months of age.
- **Oral Health Screening**
- **Health Education**: Health education and counseling to both parents (or guardians) and children is designed to assist in understanding what to expect in terms of the child's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

When a physical or mental health condition is suspected or identified during a HealthCheck screen, diagnostic and treatment services are provided.

- **Vision Services**: Includes diagnosis and treatment for defects in vision, including eyeglasses.
- **Dental Services**: Includes relief of pain and infections, restoration of teeth and maintenance of dental health. Although an oral health screening is a part of a well child exam, it does not substitute for referral to and examination by a dentist.
- **Hearing Services**: Includes diagnosis and treatment for defects in hearing, including hearing aids.
- **Other Necessary Health Care**: States must provide other necessary health care, diagnosis services, treatment, and other measures described in section 1905(a) of the Social Security Act to correct or improve defects, and physical and mental illnesses and conditions discovered by the screening services.

It is important to document all the above on the member's chart or electronic health record (EHR) as well as referrals. The provider should submit an 837P or 1500 claim form with the appropriate diagnosis codes, and procedure codes and modifiers. The EP modifier must be billed on all EPSDT services. EPSDT claims are paid without any coordination of benefits. If the provider performs a well-child exam at the same time as a sick visit, please use the appropriate diagnosis, procedure, and modifier codes.

HHO WV verifies that PCPs and special needs providers can provide EPSDT services. PCPs treating patients ages 20 and younger who are unable to comply with the requirements of the EPSDT program must plan for EPSDT screenings to be performed elsewhere by an in-network provider. Alternative PCPs and specialists should forward a copy of the completed progress report to the PCP so it can be placed in the patient's chart.

Vaccines for Children (VFC) Program

The vaccines for children (VFC) program is a federally funded program administered by the State Bureau's Public Health Immunization Program, that helps provide immunizations to WV children age 18 and younger and is one of the following: Medicaid-eligible, Uninsured, Under-insured, American Indian, or Alaska Native. Vaccines available through the VFC program are those recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC).



Standard Immunizations for Children and Adolescents

All age-appropriate vaccines through age 18 are covered as recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunizations. WVCHIP covers immunizations as part of an associated office visit to a doctor enrolled in the Vaccines for Children (VFC) program. See the "Immunization Schedules" located at **www.chip.wv.gov** for more details.

WVCHIP purchases vaccines from the State's VFC program. This program allows physicians to provide free vaccines to children. Members should receive vaccinations from providers that participate in this program. For more information about the VFC program, visit **www.cdc.gov/vaccines/programs/vfc/index.html**.

Oral Health Fluoride Varnish Program

Dental screening in this context shall mean, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. Primary care providers may receive a reimbursement for fluoride varnish application. Providers are encouraged to complete the Smiles for Life Curriculum course prior to administering this service, but are not required. A referral to a dentist at or after age 1 is recommended. A referral to a dentist shall be mandatory at age 3 and annually thereafter through age 18 for WV CHIP members and age 20 for Medicaid members. The application of the fluoride varnish should be covered for children ages six months to three years. Providers should include education and counseling with the child's caregiver. WVCHIP allows coverage for two fluoride varnish applications per year (one every six months). Application must be provided and billed in conjunction with a comprehensive well-child exam and an oral health risk assessment should be conducted prior to application. For more information, please refer to the **Medical Infant/Child Health Program Fluoride Varnish by Primary Care Practioners WVCHIP Coverage Policy** found at **www.chip.wv.gov**.

Obstetrics and Gynecology (OB/GYN)

General Information

To eliminate any perceived barrier to accessing OB/GYN services, HHO WV allows all members to self-refer to any participating OB/GYN for any OB/GYN related condition, not just for an annual exam or suspected pregnancy. When a member self-refers to the OB/GYN, the OB/GYN's office is required to verify eligibility of the member. HHO WV members may also self-refer for family planning services.

HHO WV permits its PCPs to perform routine gynecological exams and pap tests and provide care during pregnancy if they are so trained and equipped in their office. PCPs who provide obstetrical services must bill in accordance with HHO WV guidelines and may only provide obstetrical services to those patients assigned to their panel.

As you are caring for our members, and you feel additional support or assistance is needed, please refer members back to the Care Coordination Team for ongoing care management and support.

To refer a Maternity Care Coordinator, please call **1-833-957-0020**.

West Virginia Prenatal Risk Screening Instrument (PRSI)

Providers are required to submit the completed PRSI to the state portal via this link: **PRSI - WV**.

HHO WV recognizes the need for multiple services on one date of service for a pregnant member. Please follow CPT guidelines and usage of modifier 25 for reimbursement of multiple distinct services. For example, a member can receive a prenatal office visit and a fetal non-stress test on the same day. In this instance, the appropriate fetal NST CPT can be submitted and a modifier of 25 should be applied to the distinct E&M service provided on the same day.

Additionally, all applicable encounter diagnosis codes should be submitted to capture all services rendered.

OB/GYN Referrals

Referrals are not required for services rendered by participating providers. The OB/GYN is responsible for the coordination of a pregnant member's health care needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care services. To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member's designated PCP.

HHO WV members can self-refer to any participating OB/GYN for any OB/GYN related condition, not just for an annual exam or suspected pregnancy. When a member self-refers to the OB/GYN, the OB/GYN's office is required to verify eligibility of the member. HHO WV members may also self-refer for family planning services without an authorization to in-network and out of network providers.

The OB/GYN practitioner is responsible for providing written correspondence to the members PCP for coordination and continuity of care.

Effective January 1, 2026, elective termination of pregnancies will be managed via HHO WV. These services will require prior authorization.

All HHO WV UM prior-authorization requirements remain in place.

Examples include but are not limited to:

- Advanced imaging services.
- Therapies.
- Chiropractic visits.
- Out of network requests.
- Interventional spine pain management procedures and MSK surgeries.
- Physician administered chemotherapy drugs, symptom management drugs and supportive agents, and radiation therapy.

Please be sure to check the prior-authorization procedure code search tool, available on the provider page of our website, to confirm if the service requires prior authorization. If you are still unsure which services require an authorization, contact Provider Services at **1-833-957-0020**.

HHO WV Medicaid members can obtain outpatient laboratory work at any participating laboratory or hospital. No referral is needed; only a lab order form or prescription from the ordering provider is needed.

Diagnostic Testing

Fetal non-stress tests and obstetrical ultrasounds can be performed in the OB/GYNs office or at a participating hospital without an authorization from the Plan.

Newborns

HHO WV has written policies and procedures for enrolling newborn children of Medicaid and WVCHIP enrollees retroactively effective to the time of birth. These enrollment procedures include:

- Transfer of newborn information to the DoHS customer service center.
- Processing completion within 30 calendar days of the date of birth. Newborns of program-eligible mothers who are enrolled at the time of the child's birth will be enrolled in the mother's MCO.
- Submission of the newborn enrollment forms to the DoHS customer service center within 60 calendar days of the date of delivery or as soon thereafter as the MCO becomes aware of the delivery. HHO WV will exhaust all possible avenues to research, locate, and include on the forms the names for newborns, which will in turn help to decrease issues with missing capitation payments.

HHO WV is responsible for all Medically Necessary covered services provided under the standard benefit package to the newborn child or an enrolled mother for the first 60 to 90 calendar days of life based upon the cut-off date for MCO enrollment with the enrollment broker. The child's date of birth will be counted as day one. BMS will pay a full month's capitation for all newborns. The MCO will receive capitation payments for all subsequent months that the child remains enrolled with HHO WV.

Family Planning Services

Our members have direct access for family planning services without a referral or authorization and may also seek family planning services at the practitioner or provider of their choice (in or out of network). Participating providers should educate members about the release of necessary medical data to HHO WV.

The following services are included:

- Annual gynecological exam
- Annual pap smear
- Lab services
- Contraceptive supplies, devices, and medications for specific treatment
- Contraceptive counseling



A comprehensive family planning exam includes the following:

- Assessing a member's risk for unintended pregnancy, poor pregnancy outcome, or need for family support services.
- Age-appropriateness of information provided to members and the need for confidentiality of information.

Pregnancy diagnosis and counseling, including:

- Referral to a participating obstetrical practitioner/provider for early entry into prenatal care, for members diagnosed as pregnant who wish to continue the pregnancy.
- Information on all legal options available for members diagnosed with unintended pregnancies and, if they desire, referral for appropriate obstetrical and gynecological service.
- Information about the availability of contraceptive methods for non-pregnant member.

Education, including, but not limited to:

- Reasons why family planning is important to maintain individual and family health.
- Basic information regarding reproductive anatomy.
- Risk factors and complications of various contraceptive methods.
- Information on the transmission, diagnosis, and treatment of sexually transmitted diseases.
- Education about acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV).
- Procedures of self-breast examination.

For members ages 15–44, the medical record should include documentation of a discussion regarding family planning which may include assessments of sexual activity, contraception, STD screening, and/or counseling OR documentation that the member saw a family planning practitioner.

Treatment for STDs

HHO WV members can access any participating practitioner or provider or State enrolled practitioner or provider for treatment of a sexually transmitted disease without prior approval from HHO WV.

Transportation Service

Emergency transportation is covered for all HHO WV members.

Non-emergent medical transportation is covered for Medicaid members under West Virginia Medicaid's Fee-For-Service program. Members must contact Modivcare, the BMS contracted statewide transportation vendor, at **844-549-8353** to arrange services.

Non-emergent medical transportation is covered under the WVCHIP program.



Sterilization/Hysterectomy

In accordance with WV Medicaid and WVCHIP we will cover a sterilization or hysterectomy determined to be medically necessary by the attending physician in consultation with the patient.

All federal and state laws regarding this benefit must be adhered to, ensuring the completion of the required forms, and shall comply with the requirements of 42 CFR 441. Subpart F. 45.

The required forms are located on the Bureau for Medical Services website. The consent form must be submitted with the claim.

Forms can be found here:

www.wvmmis.com/SharepointDownload?parent=forms&docname=Sterilization%20Consent%20Form.pdf

www.wvmmis.com/SharepointDownload?parent=forms&docname=Hysterectomy%20Acknowledgement%20Form.pdf

Access/Availability and Appointment Standards

Each year HHO WV evaluates the number and geographic distribution of network providers in relationship to the location of its members. HHO WV takes into consideration the special and cultural needs of members and its network providers.

We utilize accessibility/availability standards based on State and Federal regulations. Federal law requires that participating practitioners and providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to members not enrolled in Medicaid or WVCHIP. If the practitioner or provider serves only Medicaid and/or WVCHIP recipients, hours offered to HHO WV managed care members must be comparable to those for Medicaid and WVCHIP fee-for-service members. The Access Standards are communicated to practitioners, providers, and members through the HHO WV website, and as part of the Provider Manual. Practitioners and providers that do not meet HHO WV's access standards are provided recommendations for improvements in order to meet the set standard.

Provider Appointment Access Standards (Timeliness of Access to Care)

HHO WV members are expected to receive an appointment with a qualified primary care or specialty provider based on the following standards:

Type of Care	Time Frame Requirement
PCPs and Specialists (Medical)	
Emergency Services	Immediately seen or referred to an emergency facility
Urgent Care	Within 24 hours
Routine Care	PCP, OB/GYN, or Certified Nurse Midwife within 15 business days Specialists (non-OB/GYN) within 30 business days

Type of Care	Time Frame Requirement
Specialists (Behavioral Health)	
Emergency Services	Immediately seen or referred to an emergency facility
Non-Life-Threatening Emergency	Within 6 hours, or direct to emergency facility or crisis center
Urgent Care	Within 24 hours
Initial Routine Care	Within 10 business days
Follow-up Routine Care	Within 15 business days

Other Timeliness of Access to Care Standards	
After-Hours Access (PCP, Behavioral Health Specialists)	After hours calls from members with an emergent or urgent medical condition will be handled within one hour of the member contacting the practice site—through immediate instruction or member receives call back from practice site with instruction, within one hour. **Instructions provided by the practice will include one or more of the following options:** • Call 911/988 or go to nearest emergency room. • Direct patient to behavioral health crisis unit, crisis intervention, or mobile response team. • Direct patient to go to an urgent care center. • See patient same day. • See patient at another location same day. **Important reminders:** • Practice sites must be accessible to members 24 hours a day/7 days a week. • Our members must be instructed to call 911/988 or go directly to the emergency room in the case of a true emergency. • Answering services or machines must instruct members on how to reach an on call physician. The member must receive a phone call within one hour with instructions.
Initial Prenatal Care (PCPs and Specialists that provide prenatal care)	Must be provided within 14 calendar days of pregnancy confirmation.
Supplemental Security Income (SSI) (PCPs and Specialists who manage enrollee's care)	SSI enrollees must be encouraged to schedule an appointment with a PCP or Specialist who manages the enrollee's care within 45 calendar days of initial enrollment.
EPSDT Services (For enrollees under the age of 21)	Must be scheduled in accordance with EPSDT guidelines and the EPSDT Periodicity Schedule.

Behavioral Health Provider Coordination of Care with Members PCP

All HHO WV BH/SUD treatment providers are encouraged to identify a patient's PCP to coordinate care planning. In addition, providers are encouraged to determine if a patient is receiving BH/SUD treatment services. In the event the provider does not have access to appropriate release of information form(s) that are needed for information sharing and collaboration, the Highmark Heath Options release of information form may be used. If assistance is needed to coordinate care between BH and physical health, the provider may call Care Management for assistance.

Hours of Operation

In accordance with 42 CFR §438.206(c)(1)(ii), HHO WV will ensure that the hours of operation of its providers are convenient, do not discriminate against enrollees, and are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS. MCOs must ensure that waiting times at sites of care are kept to a minimum and ensure that the waiting time standard for Medicaid and WVCHIP enrollees is the same standard used for commercial enrollees. Providers cannot discriminate against Medicaid and WVCHIP enrollees in the order that patients are seen or in the order that appointments are given (providers are not permitted to schedule Medicaid/WVCHIP-only days).

The definition of a PCP is a specific practitioner, practitioner group, or a certified registered nurse practitioner (CRNP) operating under the scope of his/her licensure, who is responsible for supervising, prescribing, and providing primary care services, locating, coordinating, and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of a member. The PCP is responsible for the coordination of a member's health care needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care services.

To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the members designated PCP. By focusing all a member's medical decisions through the PCP, members are given comprehensive and high-quality care in a cost-effective manner.

One of HHO WV's goals is to work together with a dedicated group of practitioners to make a positive impact on the health of our membership and truly make a difference.

Measure and Monitoring Adherence

All network providers are contractually required to adhere to the Accessibility Standards per their Highmark Health Options West Virginia (HHO WV) Medicaid Agreement. HHO WV measures and monitors practitioner compliance with its established accessibility standards by conducting an annual practitioner appointment access and an after-hours access audit; through ongoing and quarterly review of member complaints related to practitioner access; by conducting Environmental Assessments; and through review of Consumer Assessment of Healthcare Providers and Systems (CAHPS) results related to member experience. The results of these measurement tools along with Corrective Action Plan (CAP) documents submitted by practitioner office locations are utilized to detect opportunities to drive provider education and increase compliance with the accessibility standards to ensure members have timely access to care.

Telehealth

HHO WV will require its provider network to comply with BMS requirements to implement and use technology including, but not limited to, telemedicine, telehealth, and telemonitoring services to improve quality and access to care. Use of such technology must be in accordance with BMS policy.

The MCO must:

- Promote and employ broad-based utilization of statewide access to HIPAA-compliant telemedicine service systems including, but not limited to, access to TTYs and 711 telecommunication relay services.
- Follow state guidelines for Telemedicine equipment or connectivity.

- Follow accepted HIPAA and 42 C.F.R. § 2 regulations that affect telemedicine transmission, including, but not limited to, staff and contract provider training, room setup, and security of transmission lines. The MCO must have and implement policies and procedures that follow all federal and state security and procedure guidelines.
- Identify, develop, and implement training for accepted telemedicine practices.

Services should be provided face-to-face with HHO WV members whenever possible. HHO WV recognizes there are instances when face-to-face consultations are not feasible. Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio, and video equipment. An exception will be made for audio-only telecommunication when the member does not have access to video capability or for an urgent medical situation, provided that the use of audio-only telecommunication technology is consistent with state and federal requirements, including guidance by CMS with respect to Medicaid payment and OCR with respect to compliance with Health Insurance Portability and Accountability Act (HIPAA).

Telemedicine is viewed as a cost effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations) between provider and patient. This definition is modeled on CMS definition of telehealth services. The Plan does not restrict the performance of telehealth/telemedicine services to rural locations only and allows for both PCPs and Specialists to provide this service. Any eligible member can receive telemedicine/telehealth primary care services regardless of where they are located. PCPs can render services using interactive telecommunication technology to their Highmark Health Options West Virginia assigned members. Providers much obtain consent from members, or their legal guardian, prior to performing any services via telemedicine.

The claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

Place of Service 02: The location where health services and health-related services are provided or received through a telecommunication system.

The claim must include the appropriate modifier when billing for audio and video:

- **Modifier GT**: Via Interactive Audio and Video Telecommunications systems.
- **Modifier 95**: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

Providers should fully document the services rendered and the telecommunication technology used to render the service, in the HHO WV member's medical record. If the service was rendered using audio only technology, providers are to document that the services were rendered using audio-only technology and the reason audio/video technology could not be used.

Provider Network Participation

Introduction to Network Participation

Eligible providers must sign an agreement to participate in the HHO WV provider network. Providers agree to provide services to HHO WV members according to the terms of their agreement, the regulations that outline their obligations, and any relevant administrative requirements while in the network, including this Provider Manual. No provider acting within the scope of his or her license or certification under applicable state law, shall face discrimination with respect to participation, reimbursement, or indemnification.

Mutual obligations are contained in the agreements and regulations that professional providers execute when joining the network. HHO WV encourages members to obtain health care services from in-network providers, which could increase the provider's patient base.

Key contractual provisions include that network providers will:

- Accept the network allowance as payment in full for covered services.
- Handle basic claim-filing paperwork for the patient.
- Provide or arrange for the provision of medically necessary covered services for HHO WV members on the same basis as that of all other patients.
- Recommend patients see other in-network providers when necessary. In-network providers are eligible to become actively involved with HHO WV as corporate professional members and as members of the company's various professional committees and advisory councils. All providers who submit claims must obtain an individual National Provider Identifier (NPI) number. The NPI is a 10-digit numerical identifier for providers of health care services. HHO WV makes payments only for eligible services rendered by a provider with a valid NPI.

Providers (e.g., physicians and any applicable health professionals) must be credentialed to participate in the HHO WV network. Professional providers can begin the application process through the online CAQH ProView credentialing database developed by the Council for Affordable Quality Healthcare (CAQH). Providers complete one standard application that meets the needs of HHO WV and other in-network health plans and health care organizations. Once CAQH registration is finished, the provider will receive additional information for completing the application process.

Who is Credentialed?

Practitioners: Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Medicine (DMD), Doctor of Dental Surgery (DDS), Doctor of Optometry (OD), Doctorate of Psychology (Ph.D.), and Doctorate of Philosophy (Ph.D.). This listing is subject to change.

Extenders: Physician Assistant (PA), Certified Nurse Practitioner (CRNP), Certified Nurse Midwife (CNM), a Clinical Nurse Specialist (CNS) and a Certified Nurse Practitioner (CNP). (This listing is subject to change.)

Facility and Ancillary Service Providers: Hospitals, Nursing Homes, Skilled Nursing Facilities, Home Health,

Hospice, Rehabilitation Facilities, Ambulatory Surgical Centers, Portable X-ray Suppliers, End Stage Renal Disease Facilities, Outpatient Physical Therapy, and Speech Therapy providers, Rural Health Clinics, and Federally Qualified Health Centers. (This listing is subject to change.)

Practitioners/Providers Excluded From Participation in Federal Health Care Programs

We are prohibited from participating with or entering into any agreement with any individual or entity that has been excluded from participation in Federal Health Care Programs, including Medicare, Medicaid, or the Children's Health Insurance Program.

The Federal Health and Human Services – Office of Inspector General (HHS-OIG) has an online exclusions database available at **www.exclusions.oig.hhs.gov**. It is a comprehensive listing of individuals and firms that are excluded from participation in federal health care programs. This database allows practitioners and providers to screen their practice, managing employees, contractors, etc., to determine whether any has been excluded from participating in federal health care programs.

Practitioners and providers are encouraged to check their information in the exclusions database monthly. Practitioners and providers must immediately report to us any exclusion information discovered.

Board Certification

PCPs and specialists, including podiatrists, are required to be board certified in the specialty in which they practice or meet one of the exceptions to board certification to be credentialed in the HHO WV network.

HHO WV recognizes the following boards for certification:

- America Board of Medical Specialties (ABMS)
- American Academy of Oral and Maxillofacial Radiology (AAOMR)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Multiple Specialties in Podiatry (ABMSP) (Applies if ABPM or ABFAS boards are not available to provider.)
- American Board of Oral and Maxillofacial Surgery (ABOMS)
- American Board of Podiatric Medicine (ABPM)
- American Osteopathic Association Board (AOA)
- American Board of Facial Plastic and Reconstructive Surgery (for Otolaryngology/Facial Plastic Surgery)

All applicable providers who are not board certified and are applying to participate in a Highmark credentialed network must meet one of the following exception criteria to be considered eligible:

- **Exception 1**: Completed training prior to Dec. 31, 1987:
  - Providers must have graduated from an accredited medical osteopathic, podiatric medical, or dental school; completed an applicable accredited residency or fellowship acceptable to the Highmark Network Quality and Credentials Committee in the specialty in which they practice; and completed training prior to Dec. 31, 1987.

- **Exception 2**: Board eligibility period:
  - Providers must have completed an approved, applicable residency or fellowship in the specialty in which they practice and complete board certification by Dec. 31st of the sixth year of completing approved, applicable residency training or contiguous subsequent fellowship training in the specialty in which they practice.
- **Exception 3**: Rural exception:
  - The ZIP code of the practice location is determined by Quest analytics software as a rural location, and providers have completed an ACGME/AOA-approved, applicable residency or fellowship in the specialty of practice.

Network Malpractice Insurance Criteria

Providers must carry and always maintain liability and professional liability (malpractice) insurance to insure the group provider and each individual provider against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance or omission of any provider service. The amount of coverage carried should not be less than the amounts required by any applicable state laws or less than coverage levels required by HHO WV. Providers must provide evidence of coverage to the network upon request. Providers must also notify HHO WV at least 30 days in advance of any reduction or termination of malpractice coverage.

Medicaid Providers

All participating providers must be enrolled with the Bureau for Medical Services and notify HHO WV within 30 days of any changes in location, licensure, certification, or status.

All eligible providers receive one standard NPI number that they are required to use when submitting health care transactions. The NPI is a result of the CMS mandate that supports HIPAA simplification standards intended to improve the efficiency of the health care system and help reduce fraud and abuse.

The National Plan and Provider Enumeration System (NPPES) is the central electronic enumerating system used for assigning NPIs.

Providers can apply for NPIs three ways:

- Call NPPES for a paper application at **1-800-465-3203 (TTY: 1-800-692-2326)**.
- Complete the web-based application process.
- Download and complete a paper application from the NPPES website and mail to NPPES.

Provider Tax Identification Numbers

In addition to claims processing, HHO WV uses a provider's tax identification number to accurately identify providers for other business functions and with outside vendors or partners during the normal course of business operations.

The use of Social Security numbers (SSN) is discouraged in lieu of business tax identification numbers whenever the provider's tax identification number is asked for. Providers who choose to submit a SSN as a tax identification number acknowledge, understand, and agree that HHO WV will treat the SSN in the same way it handles other providers' business tax identification numbers and will not be liable to a provider for any intentional or unintentional disclosures of the SSN. To avoid using SSNs as the provider tax identification number, providers should obtain and use a federal EIN issued by the IRS.

Out-of-Network Provider Payment Guidelines

Although they do not sign an agreement with HHO WV, out-of-network providers are required to accurately report services performed and fees charged. Services must be covered as adequately and timely as if such services were provided within the network, and for as long as the MCO is unable to provide them through in-network providers.

Clinical Laboratory Improvement Amendment (CLIA) Certificate

The CLIA certificate is required for each location performing lab services for West Virginia Medicaid. The CLIA question is in section 4 of the CAQH application.

Directing Care to Network Providers

HHO WV network providers must refer members who need additional, nonemergent services to in-network providers when there is an in-network provider with the required specialty. If a treating provider cannot identify a physician or facility (in- or out-of-network) to refer a patient (e.g., for highly specialized, unusual, or infrequently performed services), then the provider may contact HHO WV UM department for assistance.

Termination from the Network

The decision to terminate a provider may be made by the Medical Director(s) of Quality Management in urgent situations. A provider may also be terminated by the Director of Provider Experience and the Chief Operating Officer for any legitimate business reason.

A provider will be given a written decision to terminate with the specific reason for the decision and any reconsideration and appeal rights. Final termination decisions will negatively affect the provider's reimbursement for services provided to patients.

Valid Reasons for Termination

Network providers will be terminated in accordance with the relevant terms of their provider agreement for failure to satisfy the following criteria:

- Maintain acceptable professional liability claims history.
- Maintain an active DEA certificate, where applicable.
- Maintain an active license to practice.
- Maintain coverage for malpractice insurance in the minimum amounts required.
- Meet appropriate recredentialing requirements.
- Participate in recredentialing, which requires providing all requested recredentialing information, and be recredentialed for network participation.
- Provide acceptable clinical quality of care to patients.

Network providers will also be terminated if, in HHO WV sole discretion, should any of the following occur or are in imminent danger of occurring:

- Acts or omissions that cause HHO WV to violate any law or regulation or which negatively affect HHO WV under any regulatory or certification requirements.
- Acts or omissions that jeopardize the health or welfare of a patient.
- Acts or omissions that negatively affect the operation of the network.
- Failure to provide an acceptable level of care.

A provider may not be terminated for any of the following reasons or actions:

- Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill possessed by a reputable health care provider practicing according to the applicable legal standard of care.

Discussing:

- HHO WV decision to deny payment for a health care service.
- Medically necessary and appropriate care with or on behalf of a patient, including information regarding the nature of treatment, risks of treatment, alternative treatment, or the availability of alternate therapies, consultations, or tests.
- The process that HHO WV uses or proposes to use to deny payment for a health care service.
- Filing a grievance against HHO WV in response to a disapproval of payment for requested service, an approval of the requested service at a lower scope or duration, or a disapproval of the requested service but an approval of payment of an alternative service.
- Having a practice that includes a substantial number of patients with expensive medical conditions.
- Objecting to the provision of or refusal to provide health care service on moral or religious grounds.
- Protesting a decision, policy, or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the provider's ability to provide medically necessary and appropriate health care.
- Refusing to refer a patient for health care services when the provider's refusal is based on moral or religious grounds, and the provider has made adequate information available to the patients in their practice.



Leaving the Network

To resign from the HHO WV network, providers must fax or mail a Practice/Provider Change Request Form, or written notice on your practice letterhead to Provider Information Management (PIM). A resignation may be submitted at any time and is effective in accordance with the termination provision in the agreement the provider has executed.

Continuation of Care throughout a Contract Termination

In the event of an agreement termination by either party, the provider will continue to render necessary care to HHO WV member(s) consistent with contractual or legal obligations. Continuation of care (COC) is a process followed to permit a patient to continue an ongoing course of treatment with a PCP, specialist, or facility whose contract has been terminated for reasons other than for cause, and to be provided and paid in accordance with the terms and conditions of the agreement. COC also covers a patient in the second or third trimester of pregnancy; the transition period will last through postpartum care related to the delivery.

The provider must notify HHO WV that the patient is in a COC situation. If HHO WV does not take actions to make alternative care available to the member within 90 days after receipt of the provider notice, then for COC services provided after termination, HHO WV will pay the provider the standard rates paid to out-of-network providers for that geographical area.

Notwithstanding the foregoing obligations, HHO WV's obligations under this provision do not apply to the extent that other in-network providers are not available to replace the terminating in-network provider due to:

- Contractual provisions between the terminating provider and a facility where HHO WV members receive care that limits or precludes other in-network providers from rendering replacement services to HHO WV members (e.g., an exclusive services agreement between the terminating in-network provider and a facility where a HHO WV members receives services).
- Geographic or travel-time barriers.

Provider Credentialing

Introduction to Credentialing

Providers are initially credentialed prior to network admission and recredentialed every three years unless otherwise required by specialty type or regulation. HHO WV must credential providers and utilize procedures that comply with National Committee for Quality Assurance (NCQA), CMS, and State of West Virginia MCO standards. The credentialing and recredentialing processes are performed by HHO WV staff who work cooperatively with network providers to ensure patients have access only to providers who meet the HHO WV standards of professional qualifications.

All network professional providers must use the Council for Affordable Quality Healthcare (CAQH) system for credentialing and recredentialing. Organizational providers (ancillary and facility) will need to access the Organizational Initial Credentialing Setup form. HHO WV has delegated credentialing responsibilities to Highmark Inc., its parent company. Highmark credentialing staff follow an established process to credential providers for the HHO WV network.

The initial credentialing process includes:

- Completion of a CAQH online application.
- Completion of the initial credentialing application.
- Inquiry to National Practitioner Data Bank for sanction history.
- Signed attestation verifying all information on the application and stating any reasons for inability to perform essential duties, lack of illegal drug use, loss of license or privileges, felony, and disciplinary action.
- Verification of disclosure form on file with the State of West Virginia.
- Verification of primary source.
- Other verification as needed.

All new providers must:

- Be approved by HHO WV through a routine assessment process or by the Highmark Network Quality and Credentialing Committee, as applicable.
- Sign an agreement.

The provider's network participation and ability to treat HHO WV members does not begin until the provider's signed contract is returned, and the contract is counter executed.

Providers Who Already Have a CAQH ID

Providers who already have a CAQH ID should log into CAQH ProView and re-attest to the CAQH application. Providers must add Highmark as an authorized plan or grant global authorization (HHO WV has delegated credentialing responsibilities to its parent company, Highmark Inc.).

In approximately 10 business days, an email with additional information and instructions will be sent to the credentialing contact email address supplied by the provider. In certain instances, the communication may be sent via postal mail to the credentialing mailing address supplied by the provider.

Providers Without a Registered CAQH ID

CAQH is used for credentialing purposes as well as to update certain Highmark provider data. Visit CAQH ProView to obtain a CAQH ID and complete the application. The online solution will guide you through the process, which will take several hours to complete the first time (however, the application does not need to be completed all at one time). Helpful resources are available through links on the login page to help you initially navigate the system. Be sure to select Highmark as a plan authorized to receive your information.

Providers Without Internet Access

Providers without internet access will need to contact CAQH by calling the toll-free CAQH help desk at **1-888-599-1771** for other options to complete the CAQH credentialing application.

Electronic Transactions Required

HHO WV has taken steps to eliminate paper transactions with providers in support of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. As part of this initiative, all providers are strongly encouraged to enroll.

The Credentialing Process

The provider's participation in the credentialed network is effective upon completion of a HHO WV-executed agreement. The effective date is stated within the welcome letter after the credentialing letter is sent.

During initial credentialing, providers in West Virginia participate in the process of contracting with HHO WV in the following steps:

- The provider must submit all information requested through CAQH. HHO WV will then provide additional information and instructions.
- Upon approval of the Highmark Quality and Credentialing committee, or medical director, the provider will receive written notification regarding their credentialing decision within 60 days.

Highmark Health Options staff reviews the application. If the application is incomplete, Highmark Health Options will contact the practice to request the missing information. Practitioners have the right to correct erroneous information submitted by another party or correct his or her own information submitted incorrectly. Applicants have 10 calendar days from the date of Highmark Health Options notification to submit written corrections and supporting documentation to Highmark Health Option's Credentialing Department. A credentialing decision will not be rendered until the 10 calendar days have expired.

Practitioners, upon request, have the right to be informed of the status of their credentialing or recredentialing application. Practitioners also have the right to review any information submitted in support of their credentialing applications except for National Practitioner Data Bank (NPDB) and/or Healthcare Integrity Practitioner Data Bank (HIPDB) reports, letters of recommendation, and information that is peer review protected. A practitioner must submit a written request to review their credentialing information. All appropriate credentialing information will be sent by certified mail, overnight mail, or carrier to the practitioner within 10 business days from the date that the Credentialing Department received the request.

The credentialing process includes verification or confirmation of:

- Board certification (if applicable)
- DoHS Provider Disclosure List
- Drug Enforcement Agency (DEA) certificate issued by each state where practicing
- History of liability claims
- Malpractice coverage amounts
- Medical education and training (as applicable)
- National Practitioner Data Bank (NPDB)
- Unrestricted licensing in the state(s) where practicing
- Work history
- Hospital privileges or coverage arrangements

Credentialing reviews the application for:

- 24/7 coverage (if applicable).
- HHO WV staff verifies that all information required for NCQA, and state and federal regulatory agencies is complete. If verification cannot be completed within the required 180 days, the provider will be asked to re-sign and re-date the attestation page of the application and provide valid, current information. Electronic signatures are accepted on the application.
- If the credentials file elements meet all the credentialing criteria, the Medical Director will review the application and render a decision. If the application does not meet the credentialing criteria, the Highmark Network Quality and Credentialing Committee reviews the application. In some instances, the committee may request additional information before rendering a decision.
- Upon approval of the Highmark Network Quality and Credentialing Committee or the Medical Director, the provider will receive written notification. If denied initial credentialing status, the provider will receive written notification within 60 days.
- A copy of the agreement will be sent to the provider for a signature. The provider will send the agreement back and HHO WV will counter-execute it. The provider will then receive a fully executed contract and a welcome letter with the effective date of the new provider or group.

*These are verified through primary sources.

Confidentiality and Antibias Statements

All provider information obtained in the credentialing process, except as otherwise provided by law, is kept confidential. Credentialing and recredentialing decisions will not be based on a provider's race, religion, ethnic or national identity, gender, age, sexual orientation, or the type of procedures or patients in which the provider specializes.

Credentialing Time Frame

Upon receipt of an individual provider's initial credentialing or re-credentialing application, HHO WV will make a determination on that application within 60 calendar days for credentialing and 60 calendar days for recredentialing. HHO WV will make a determination on a provider's clean application within this timeframe unless we identify a substantive quality or safety concern in the course of provider credentialing or recredentialing that requires further investigation. Upon notice to the individual provider, clinic, or facility, BMS allows MCO 30 additional calendar days to investigate the quality or safety concern(s), after which, notice of the application determination must be made to the individual provider, clinic, or facility. For each institutional provider or supplier, HHO WV will determine, and redetermine at specified intervals, that the provider or supplier is licensed to operate in the state, is in compliance with any other applicable state or federal requirements and is reviewed and approved by an appropriate accrediting body or is determined by the HHO WV to meet established standards.

Credentialing Committee

The Credentialing Committee is responsible for reviewing and approving all initial credentialing and recredentialing requests.

- The committee reviews any findings or deficiencies along with an evaluation of the provider's corrective actions identified during the credentialing or recredentialing process to aid in the decision-making process.
- The committee considers all information obtained during the credentialing or recredentialing process to make a final decision.

Final decisions and outcomes are determined by committee member vote and documented in the meeting minutes. HHO WV furnishes written notification to providers regarding the status of the credentialing or recredentialing process.

Provider Credentialing Scenarios

Returning Providers

A provider who wishes to return to the network will be required to undergo initial credentialing if the provider:

- Submitted a signed, explicit document stating that they no longer wish to be a network provider, and there has been a break in service or contract of greater than 30 days.
- Was terminated during the recredentialing process, and there has been a break in service or contract of greater than 30 days.

A provider returning to the network may also be required to execute a new agreement. If a network-credentialed provider moves from one network practice to another, no further credentialing is required if notification from the provider is received within 30 days and 90 days prior to the recredentialing due date. If the provider's notification is received more than 30 days after the move to another network practice or is not within 90 days of the recredentialing date, the provider will not be terminated; however, initial credentialing will be required.



Scenarios When Credentialing is Not Required

An established provider who has already been credentialed by HHO WV is not required to be credentialed again when:

- Joining another established network practice of the same specialty in a different or the same geographic area within six months.
- Leaving a group practice to begin a solo practice.

HHO WV must be notified within 30 days if a credentialed provider joins an existing network provider of the same specialty.

Failure to Complete or Supply Required Information

Providers who fail to complete the credentialing or recredentialing process, or fail to supply all required information, will be deemed as voluntarily withdrawing from the network. The process for initial applicants will be discontinued. For recredentialing providers, patients may receive notification that the provider no longer participates in the network. Credentialing representatives may ask detailed questions regarding malpractice cases. Providers not submitting the requested information could be denied or terminated from the network.

Credentialing Requirements

24/7 Coverage

HHO WV requires all credentialed network providers to provide coverage for appropriate treatment and referrals to patients 24 hours a day, 7 days a week. For this requirement to be met, patients must be able to speak to a provider after regular hours. This can be accomplished either directly or through an on-call arrangement with another HHO WV-credentialed provider of the same or similar specialty. All hospital-based providers are exempt from answering the 24-hour coverage question at that location.

An answering service, pager, or direct telephone access where the provider or their designee can be contacted is acceptable. A referral to a crisis line is **not** acceptable unless a prior arrangement has been made with the crisis line where the provider or their designee can be contacted directly, if needed.

The following specialties are exempt from 24/7 coverage requirements:

- Audiologists
- Certified diabetic educator
- Dermatopathologists
- Dietitians and nutritionists
- Massage therapists
- Occupational therapists
- Oral and maxillofacial pathologists
- Pathologists
- Physical therapists
- Read-only practitioners
- Speech and language pathologists

Admitting and Clinical Privileges

PCPs (family practitioners, pediatricians, internists, general practitioners, geriatricians, adolescent medicine, obstetrics/gynecologists, and CRNPs) and Primary Care Physician Assistants are required to have admitting privileges in good standing at an in-network hospital.

Clinical privilege requirements, including admitting, will be waived for all providers and CRNP PCPs who, on the application, document arrangements that are acceptable to HHO WV for adequate coverage through another credentialed in-network provider. The provider must have privileges at an in-network hospital or belong to a credentialed in-network group of the same specialty. The names of the covering providers must be provided on the application. A co-signed document from the covering providers is not required. Providers are required to use in-network providers for all coverage arrangements, including ambulance.

Covering practitioners, whether participating or not, must adhere to all of HHO WV's administrative requirements. Additionally, covering practitioners must agree not to bill the member for any covered services. The covering practitioner should report all calls and services provided to the member's PCP. To request approval of a non-participating covering practitioner, a non-participating authorization would need to be requested by the PCP through the UM Department. All encounters must be billed under the name of the rendering practitioner. Reimbursements will be paid directly to the covering practitioner. Participating practitioners will be held responsible for the actions of their non-participating coverage practitioners. PCPs agree that, in their absence, timely scheduling of appointments for members shall be maintained.

Applicable provider specialists are not required to have clinical privileges in good standing at an in-network hospital, including:

- Addiction psychiatry
- Anatomic pathology
- Anesthesiology
- Audiology
- Certified behavioral analyst
- Certified diabetic educator
- Certified midwife
- Child and adolescent psychiatry
- Chiropractic
- CRN anesthetist
- CRN mental health
- CRNP specialist
- Cytopathology
- Dental anesthesiology
- Emergency medicine
- General dentistry
- Nonsurgical podiatry
- Nuclear medicine
- Oral maxillofacial pathology
- Oral maxillofacial radiology
- Pathology
- Physiatry or physical medicine
- Provider specialists that work in a Highmark credentialed urgent care or MAU setting only: Psychiatry, Radiology, and read-only providers.

Additional Requirements for Allied Health Providers

In addition, criteria for allied health providers include:

- Evidence of appropriate education and training, such as licensure which often verifies education.
- Physician assistants are required to practice within the state of West Virginia, have a Physician Assistant license issued by the State board, and have a collaborative agreement with a provider who is credentialed and contracted in the same network.
- Registered nurses (RNs) must have an active advanced practice certification by an entity approved by the state licensing board.

Provider Office Site Quality Evaluation Standards

HHO WV has established specific guidelines for conducting site visits, including medical record-keeping standards for PCPs, obstetricians/gynecologists (OB/GYNs), behavioral health providers, and other high-volume specialists during the initial credentialing process. A HHO WV representative will schedule an on-site or virtual visit at each office site to document a structured review of the site and medical record keeping practices to ensure conformance with Plan standards. Environmental assessments will be conducted as needed if a member complaint warrants an additional site visit. Site visits are not required at the time of recredentialing. The Office Manager or a provider in the practice must be present during the assessment.

The HHO WV representative will:

- Assess the office for evidence of environmental assessment standards compliance.
- Complete the environmental assessment form.
- Examine the appointment schedule.
- Interview staff.
- Tour the office.
- Upon completion of the review, the PAL will conduct an exit interview with the office manager or provider.

Office Site Reviews

An on-site office site survey will be completed on the following provider types (unless the provider has joined an office that has previously completed a site survey):

- Primary Care Providers (PCP)
- Obstetrics/Gynecology (OB/GYN)
- Behavioral health providers
- High volume specialties

Each specialty provider shall ensure his or her respective service delivery site meets all applicable requirements of the law and has the necessary and current license, certification, accreditation, or designation approval per state requirements.

Noncompliant Follow-Up

Noncompliance issues must be addressed with a corrective action plan (CAP) within 30 days of receipt for noncompliant standards. The representative will conduct a follow-up visit within 90 days or until the office site is compliant.

The Medical Director will:

- Assess the potential impact of the discrepancy to patient care and evaluate the CAP if any of the standards are not met.
- Present the information to the QI/UM Committee for review if the office is not agreeable to correcting the identified problem.
- Suggest a different CAP if the plan is not acceptable.

Special circumstances may be granted based on size, geographic location of the practice, and potential harm to patients. The representative will communicate the results to providers. HHO WV staff conduct site visits that include compliance with the ADA and Section 504.

Environmental Assessment Standards	Met	Not Met	N/A	Comments
Physical Accessibility/ADA Standards *(Informational purposes only - do not score)*				
1. Is there adequate parking available near the physician office?				
2. Is handicapped parking available (1 accessible space per every 25 parking spaces)?				
3. Are the accessible parking spaces clearly marked for people with disabilities?				
4. Can person using a mobility aid (e.g., walker, scooter, or wheelchair) get from the accessible parking space to the office door?				
5. Is there a wide enough (at least 36") ramp leading to the office?				
6. Does the ramp have railings (if longer than 6 ft.)?				
7. Are the patient entrance and exit clearly marked and unobstructed?				
8. Are the hallways entrance/exits handicapped accessible?				
9. If the office is not on the first or ground floor is there an elevator?				
10. Is there a pathway through the provider's office wide enough for a person to maneuver a wheelchair?				
11. Are the office, waiting room, restroom, and at least one exam room wheel-chair accessible? (If not, are accommodations made for patients with mobility aids (e.g., walker, scooter, or wheelchair)?				

12. Are there grab bars in the restroom?				
13. Are the office hours displayed?				
14. Are patient areas clearly marked as non-smoking?				

Accessibility Standards	Met	Not Met	N/A	Comments
1. Is the waiting time to schedule a routine appointment less than or equal to 21 calendar days? (Exceptions are permitted at specific times when PCP capacity is temporarily limited)				
2. Is the waiting time to schedule an urgent care appointment less than or equal to 48 hours?				
3. Is the waiting time for an EPSDT screen in accordance with EPSDT guidelines and the EPSDT Periodicity Schedule?				
4. Does the practice have at least 20 hours of patient scheduling per week per office? (N/A for Specialists)				
5. Are there appointments on the schedule for emergencies?				
6. Are emergent patients seen immediately or referred to an emergency facility?				
7. The practice has physician coverage arrangements for vacations, etc.?				
8. Is the waiting time for an appointment for SSI patients less than or equal to 45 calendar days from date of initial enrollment?				
9. Is the office able to perform EPSDT screens? (Offices whose panel limit is 21 and under) Should the PCP be unable to conduct the necessary EPSDT screen, the PCP is responsible and willing to arrange to have the necessary EPSDT Screens conducted by another network practitioner and ensure that all relevant medical information, including the results of the EPSDT Screens, are incorporated into the member's PCP medical record.				
10. For PCPs: A physician is available 24 hours a day/7 days per week. A live person, recording or auto attendant will direct patients in the case of a true emergency to call 911 or go to the nearest Emergency Room. An on-call physician is available after-hours.				

Applicable for PCP's or Specialists Providing Prenatal Care	Met	Not Met	N/A	Comments
1. PCPs or Specialists providing Prenatal Care must be able to schedule a first trimester visit within 14 calendar days of pregnancy confirmation.				
2. PCPs providing vaccinations must have a working refrigerator with accurate and up to date temperature log. The refrigerator must not contain lab specimens, other medications, or staff food/drinks.				

Medical Record Keeping	Met	Not Met	N/A	Comments
1. Are medical records maintained in a current and comprehensive fashion and do they conform to standard medical practices?				
2. Are medical records protected from public access?				
3. Does the office have a written confidentiality policy that applies to all staff?				
4. Are records documented legibly?				
5. Does the office have an organized filing system for prompt retrieval of patient medical records?				
6. Is there a single medical record for each patient? (Family charts must clearly delineate individual records.)				
7. Do records identify the member on each page?				
8. Are all medically related patient phone calls documented in the medical record?				
9. Does the office recall missed appointments and make documentation in the medical record?				
10. Is the allergy notation or NKA visible in the same place on every record?				
11. Is the patient's history kept in the medical record? Is there a medical history in each patient record?				
12. Are there treatment/progress notes in each patient's record?				
13. Is there a problem list in the medical record?				
14. Is there a standard place in the medical record for preventive care/immunization information?				

Recredentialing Process

Recredentialing is completed at least once every three years with any applicable providers and allied health professionals in-network. HHO WV policies require recredentialing to protect HHO WV members. The three-year credentialing cycle is consistent with NCQA, CMS, and State of West Virginia standards.

A quality review is conducted at the time of recredentialing and includes:

- Information regarding clinical quality actions or sanction activity.
- Member:
  - Complaints related to both administrative and quality-of-care issues.
  - Grievances and appeals issues, malpractice history, medical record reviews.
  - Satisfaction.
- Office site information.

Notification to Complete Online Process

All in-network providers must use CAQH's Universal Provider Datasource® for recredentialing.

Six months prior to the end of the three-year credentialing cycle, the provider will receive notification that the recredentialing application is due:

- **For providers registered with CAQH**: Highmark will send a letter to notify the practitioner that it is time for recredentialing. The provider will then log into CAQH ProView to review and re-attest to their CAQH application.
- **For providers not yet registered with CAQH**: Use CAQH ProView to obtain a CAQH ID and complete the application. Providers must add Highmark as an authorized plan or grant global authorization.

Assessment of Clinical Quality

During recredentialing, providers are evaluated on their performance, judgment, and clinical competence.

Criteria used may include:

- Data completeness.
- Malpractice history.
- Member complaints.
- Member grievances and appeals.
- Overutilization.
- Participation in quality improvement activities and condition management programs.
- Quality-of-care concerns.
- Sanctioning history.
- Underutilization.

Assessment of Data Completeness

HHO WV must include an evaluation of a provider's data completeness in the recredentialing process to comply with the standards of various accrediting and regulatory entities, such as CMS. The data completeness evaluation occurs in concert with the HEDIS® and risk adjustment data validation (RADV) chart audits.

Data completeness evaluations are incorporated into the recredentialing process as follows:

- **Year one**: If a data completeness deficiency or deficiencies are noted by one of the clinical quality staff during a HEDIS or RADV chart audit, feedback sheet(s) will be left in each patient's medical record detailing the deficiencies found. If the individual provider receives five or more unique feedback sheets in the first year, the provider will be flagged in the database.
- **Year two**: If five or more feedback sheets are left with the same provider in the subsequent year, the provider will receive a letter that explains that the credentialing decisions for all providers in the practice could be affected if five or more feedback sheets are given to the provider for a third consecutive year.
- **Year three**: If a provider receives five or more feedback sheets for three consecutive years, the providers at that office will be evaluated as exceptions at the time of their next recredentialing review, which could potentially lead to termination from the network.

Dual Credentialing and Recredentialing as Both PCP and Specialist

All dual-credentialed providers will appear in the provider directories as both PCP and specialist.

Provider Categories

An individual provider may participate as both PCP and specialist if the provider meets network credentialing standards for each category. HHO WV contracts with network providers as either:

- **PCPs**: Adolescent medicine, family practitioners, general practitioners, geriatricians, internists, obstetrics/gynecologists, and pediatricians.
- **Specialists**: All other MDs or DOs.

Dual Credentialing Criteria

Providers who want to be credentialed as both a PCP and a specialist must:

- Be board certified or meet one of the board certification exceptions for each specialty requested. Each specialty not boarded or not meeting exception will be process discontinued.
- Demonstrate that the practice adequately provides primary care services to patients.
- Meet the standards for PCPs.

Recredentialing as Both PCP and Specialist

Dual-credentialed providers will undergo full recredentialing for PCP and specialist participation every three years.

Reconsiderations and Appeals

Reconsideration hearings are available to network providers in the event of a denial or termination action, or a limited or modified decision made by the Highmark Network Quality and Credentialing Committee.

This could be due to:

- Any reason reportable to the National Practitioner Data Bank (NPDB).
- The lack of required qualifications at the time of recredentialing. This includes:
  - Failure to obtain or keep appropriate board certification.
  - Insufficient malpractice insurance coverage.
  - Lack of adequate clinical hospital privileges.
  - Loss of an unrestricted state license.
  - Loss of DEA license.

The provider must request the reconsideration in writing within 30 days of receiving the notice of the termination.

The provider will be given the opportunity to present information to the Highmark Network Quality and Credentialing Committee by the following options:

- Participating in a committee meeting via telephone conference call at a Credentials Committee meeting.
- Writing to the Credentials Committee for consideration, which will take place during a Credentials Committee meeting.
- After the meeting, the provider will receive a written notice of the final decision, which includes the:
  - Basis for the decision.
  - Appeal process.
  - Provider's right to an appeal to the Appeals Review Committee for West Virginia providers within 30 days if the decision is upheld.



The provider will remain in the network until the Highmark Network Quality and Credentialing Committee's or Appeal Review Committee makes a final decision to terminate, and an effective date of termination is established.

Appeals of a Credentials Committee Decision

An appeal of a decision is available to a network provider if the Credentials Committee upholds a denial or termination action following a reconsideration hearing. The written notice issued following the reconsideration hearing advises the provider of the right to appeal as well as the appeal process.

It states the following:

- Providers are allowed at least 30 days after receipt of the notification to request a hearing.
- Providers may be represented by an attorney or another person of their choice.
- The appointment of a hearing officer or a panel of individuals to review the appeal.
- The specific time period for submitting the request.
- Written notification of the appeal decision will be provided that contains the specific reasons for the decision.

In the event of an appeal, the panel of individuals to review the appeal will be the Appeals Review Committee for West Virginia providers. The Appeals Review Committee decisions are final and not subject to further appeal. When the final determination has been made concerning a proposed corrective action that adversely affects a provider's clinical privileges or network status for a period longer than 30 days, or a final decision notification of termination has been rendered, the Director of Quality Management or their designee will report such corrective action to the appropriate parties, including the state licensing agency or the NPDB, pursuant to the requirements of HIPAA.

Member Eligibility, Benefits, and Rights

Member Eligibility

All members, except newborns, become effective on the first of each month and become terminated on the last day of the month. To verify member eligibility please visit HHO WV's secure provider portal (NaviNet) or HHO WV Interactive Voice Response System (IVR) (Eligibility Check) at **1-833-957-0020**. Providers may also use the State's MMIS Portal to validate eligibility.

Newborns

Newborn children of eligible members will be automatically enrolled with the mother's health plan, unless mothers choose a different health plan for their child. Newborns will be enrolled in the plan on birth month for a minimum of 60 days starting with the day of birth.

To maintain Medicaid eligibility, newborns must have their own Medicaid numbers before the end of the birth month, plus two-month time frame. To ensure that you will continue being paid for services, you should remind mothers to contact their local DoHS office to obtain a Medicaid number for their child.

Member Rights and Responsibilities

All HHO WV members have the following rights and responsibilities. The Members' Rights and Responsibilities statement is reviewed and revised annually, or as needed, and is distributed to new members and practitioners, and existing members and practitioners upon request. HHO WV does not and is 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 identify, disability, English proficiency, or age. HHO WV regularly monitors compliance related to members' rights and responsibilities, including those rights defined by Section 1557 of the ACA of 2010.

Provider training materials and HHO WV policies and procedures are located on the HHO WV website at **WV.HighmarkHealthOptions.com**.

Member Rights

As a HHO WV Member, you have the right to:

- Be treated with respect, recognizing your dignity and need for privacy, by HHO WV staff and network providers.
- Get information in a way that you can easily understand and find help when you need it.
- Get information that you can easily understand about HHO WV, its services, and the doctors and other providers that treat you.
- Pick the network health care providers that you want to treat you.
- Get emergency services when you need them from any provider without Highmark Health Option's approval.
- Get information that you can easily understand and talk to your providers about your treatment options, risks of treatment, and tests that may be self-administered without any interference from HHO WV.

- Make all decisions about your health care, including the right to refuse treatment, and to express preferences about future treatment decisions. If you cannot make treatment decisions by yourself, you have the right to have someone else help you make decisions or make decisions for you.
- Talk with providers in confidence and to have your health care information and records kept confidential.
- See and get a copy of your medical records and to ask for changes or corrections to your records.
- Ask for a second opinion.
- File a grievance if you disagree with Highmark Health Option's decision that a service is not medically necessary for you.
- File a complaint if you are unhappy about the care or treatment you have received.
- Ask for a BMS Fair Hearing.
- Be free from any form of restraint or seclusion used to force you to do something, to discipline you, to make it easier for the provider, or to punish you.
- Get information about services that HHO WV or a provider does not cover because of moral or religious objections and about how to get those services.
- Exercise your rights without it negatively affecting the way BMS, HHO WV, and network providers treat you.
- Create an advance directive.
- Make recommendations about the rights and responsibilities of Highmark Health Option's members.

Member Responsibilities

As a HHO WV member you have a responsibility to:

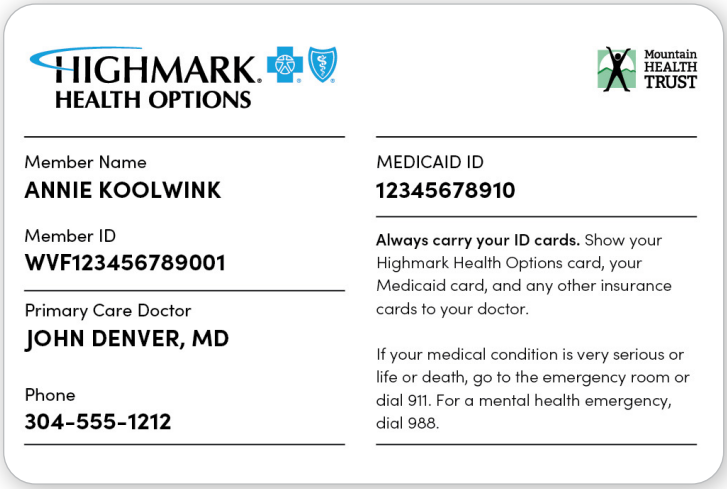
- Provide, to the extent you can, information needed by your providers.
- Follow instructions and guidelines given by your providers.
- Be involved in decisions about your health care and treatment.
- Work with your providers to create and carry out your treatment plans.
- Tell your providers what you want and need.
- Learn about Highmark Health Option's coverage, including all covered and non-covered benefits and limits.
- Use only network providers unless HHO WV approves an out-of-network provider, or you have Medicare.
- Get a referral from your PCP to see a certain specialist, if applicable.
- Respect other patients, provider staff, and provider workers.
- Make a good-faith effort to pay your copayments.
- Report fraud and abuse to the West Virginia BMS Fraud and Abuse Reporting Hotline.

Member Identification Cards

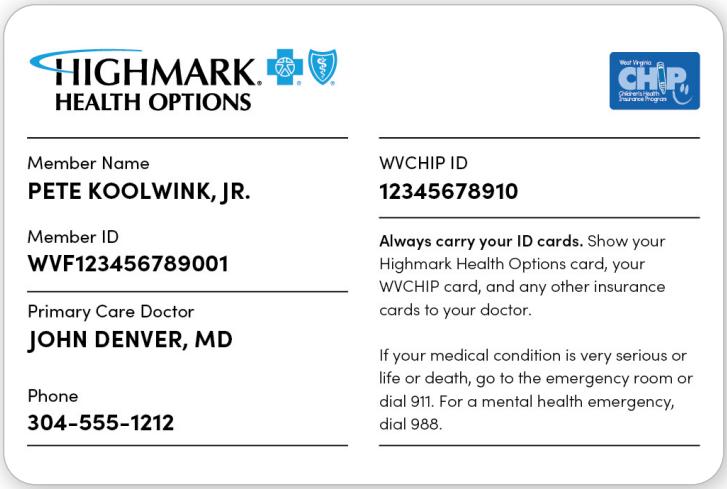
Recipients approved by the Bureau for Medical Services are added to HHO WV information system with the effective date assigned by the Bureau for Medical Services. Newly enrolled members receive a welcome

letter and ID card. All providers are responsible for reviewing both the Medicaid card and HHO WV's card to verify an enrollee's eligibility and enrollment.

Sample ID Cards



HHO WV Medicaid ID Card



HHO WV/CHIP ID Card

Covered Benefits and Services

HHO WV is responsible for all covered medical conditions within the basic benefit package for each member. The package includes inpatient; outpatient and ambulatory medical and surgical services; gynecological, obstetric, and family planning services; limited behavioral health services; and a variety of other services.

These covered services are for participating providers:

- MCO Covered Services for Mountain Health Trust
- MCO Covered Dental Services for Mountain Health Trust
- MCO Covered Behavioral Services for Mountain Health Trust

The charts in the Appendix section of this manual present an explanation of the medical, behavioral, and dental services which the MCO is required to provide; however, the Medicaid and WV Transplant State Plans and policy is the final source for defining these services.

Refer to the FFS Medicaid provider manuals available on the WV DoHS at **bms.wv.gov/providers/west-virginia-medicaid-fee-schedules** for an explanation of service limitations. The MCO must promptly provide or arrange to make available for enrollees all Medically Necessary services listed below and assume financial responsibility for the provision of these services.

Please note that these charts, which list the definitions of services provided under the FFS Medicaid program, are provided as a reference for the MCO. The MCO is responsible for determining whether services are Medically Necessary and whether the MCO will require prior approval for services.

Benefit packages differ depending on whether the beneficiary is covered under MHT, WVCHIP or FFS programs. WVCHIP enrollees receive the same benefits as comparable MHT Medicaid populations.

Non-Emergent Medical Transportation

Non-emergent medical transportation is covered for Medicaid and WV CHIP program members. Routine medical transportation to and from WV CHIP covered services may be covered under FFS. Members must contact Modivcare, the BMS contracted statewide transportation vendor, at **844-549-8353** to arrange services.

Direct Access

The MCO must provide or arrange for necessary specialty care, including women's health services. In accordance with 42 CFR §438.206(b)(2), the MCO must allow women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within the network for women's routine and preventive health care services, in addition to direct access to a PCP for routine services, if the PCP is not a women's health specialist. The MCO must have a policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan.

Emergent Services and Urgent Care

An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child).
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

The following conditions are examples that most likely require emergency treatment:

- Blackouts
- Breathing problems
- Car accidents
- Chest pain
- Choking
- Criminal attack (mugging or rape)
- Danger of losing life or limb
- Heavy bleeding
- Loss of speech
- Drug overdose
- Paralysis
- Poisoning
- Possible broken bones
- Seizures

Abortion Services

Effective January 1, 2026, termination of pregnancies will be managed via HHO WV. These services will require prior authorization and must comply with requirements of 42 CFR §441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.

Pharmacy Coverage

The pharmacy benefit for outpatient prescriptions is carved out to the State. Simple or compound substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance (e.g., prescription drugs, family planning supplies, vitamins for children to age 21, and prenatal vitamins) are covered by FFS Medicaid/WVCHIP. Hemophilia-related clotting factor drugs, Spinraza, other drugs deemed by BMS as appropriate for FFS coverage, and Hepatitis-C virus-related drugs will be covered by FFS Medicaid/WVCHIP. Drugs and supplies dispensed by a physician, acquired by the physician at no cost, are not covered by Medicaid and WVCHIP.

HHO WV remains responsible for all outpatient physician administered drugs. When submitting claims for physician administered drugs purchased through the 340B program, providers must include a "UD" modifier on the claim for proper reporting, in addition to the appropriate billing units, Healthcare Common Procedure Coding System (HCPCS) code and corresponding National Drug Code (NDC).

		Phone Number
Pharmacy - Member Pharmacy Benefit Claims	WV Medicaid WVCHIP	**1-888-483-0801** **1-855-230-7778**
Pharmacy and Prescriber - Member Pharmacy Benefit Claim Prior Authorization – Rational Drug Therapy Program	WV Medicaid WVCHIP	**1-800-847-3859** **1-800-847-3859**
Physician administered drug covered under a member's medical benefit	WV Medicaid WVCHIP	**1-833-957-0020** **1-833-957-0020**

Medicaid/WVCHIP Copays

Medicaid Copayments: Medical Services	Up to 50.00% FPL	50.01 – 100.00% FPL	100.01% FPL and Above
Inpatient Hospital (Acute Care)	$0	$35	$75
Office Visits (Physicians and Nurse Practitioners)	$0	$2	$4
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (excluding emergency rooms)	$0	$2	$4
Non-Emergency Use of Emergency Room	$8	$8	$8

CHIP Copayments: Medical Services	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
Physician Visit (nonmedical home)	$5	$15	$20
Inpatient Hospital Admissions	No copay	$25	$25
Outpatient Surgical Services	No copay	$25	$25
Emergency Department (waived if admitted)	No copay	$35	$35
Dental Benefit	No copay	No copay	$25 copay for some non-preventative services

CHIP Out of Pocket Maximums: # of Children Copay Maximum	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
1 Child Medical Maximum	$150	$150	$200
2 Children Medical Maximum	$300	$300	$400
3 or more Children Medical Maximum	$450	$450	$600
Dental Services	Does not apply	Does not apply	$150 per family

The member copayment amount will be reflected on the remittance advice if it is applicable. Members and providers can access copay and member eligibility information through the WV Medicaid Fiscal Agents AVRS system by calling **1-888-483-0793**.

Telephonic Management

High-risk patients receive proactive telephonic outreach from Care Coordinators to assess well-being (including social determinants of health), health literacy, and lifestyle management needs. Care Coordinators address behavioral, economic, environmental, social, spiritual, and medical needs, providing referrals and communicating with the care team as needed. They also perform medication reconciliation, review lab results, and provide support (i.e., pillboxes). Telephonic management helps providers improve patient outcomes by increasing adherence to testing and medication, improving appointment keeping, and promoting preventative measures (i.e., immunizations) and self-management of health conditions.

Providers can refer patients to any HHO WV Care Coordination Program by calling **1-844-325-6251**. Patients may opt out at any time.

Care Management Program Overview

Highmark Health Options West Virginia offers comprehensive Care Management services designed to support coordination across the continuum of care, improve health outcomes, and promote equitable access to services. These services are provided at no cost to members and include service coordination support, clinician-led Care Management Programs, and vendor-supported Wellness Programs. Services are individualized based on member needs and program eligibility.

All Care Management services are delivered in alignment with evidence-based clinical guidelines to ensure consistent, high-quality, and appropriate care.

Care Management Programs

Highmark Health Options West Virginia Care Management Programs provide interactive, clinician-led support for members who may benefit from individualized clinical engagement.

Program categories include:

- **Complex Case Management:** Supports members with complex or catastrophic conditions, significant behavioral health needs, substance use disorders, or medical or psychosocial instability through intensive care coordination, ongoing clinical assessment, and Care Management team collaboration.

- **Disease Management:** Focuses on members with chronic diseases, including diabetes, digestive disorders, cardiovascular conditions, hyperlipidemia, hypertension, pulmonary disease, and renal disease, through condition-specific education, self-management support, and ongoing engagement.
- **Maternity:** Provides support for members with pregnancy-related needs, including high-risk pregnancies, to promote appropriate prenatal and postpartum care and improve birth outcomes.
- **Preventive Health:** Targets members with identified risk factors, such as pre-diabetes or tobacco use, to help reduce progression to chronic disease.

Based on assessed needs, services include comprehensive assessment, individualized care plan development, condition-specific education, medication adherence support, coordination with treating providers, care transitions support, referrals to community-based resources, and ongoing clinical monitoring.

Wellness Programs (Vendor Supported)

Highmark Health Options West Virginia partners with a vendor to offer Wellness Programs focused on prevention and healthy behavior change. Programs include Weight Management, Diabetes Support, and Diabetes Prevention. Members engage directly with the vendor for coaching, education, and self-management tools.

Member Identification and Eligibility

Members may be identified for Care Management or Wellness Programs through multiple sources, including:

- Claims and encounter data
- Data-driven methods (i.e., predictive analytics and risk stratification models)
- Direct interaction with Care Management staff
- Practitioner/Provider referrals
- Self-referrals or caregiver referrals
- Utilization Management referrals (i.e., discharge planning)

Care Management Team and Roles

Care Management services are delivered by a multidisciplinary team that includes both non-licensed and licensed staff:

- **Service Coordinators (Non-Licensed Staff):** Support members with healthcare navigation and access needs, including appointment scheduling, transportation coordination, preventive care reminders, benefits navigation, language assistance, post-discharge outreach, and referrals to community-based and social determinants of health/health-related social needs (SDoH/HRSNs), such as food insecurity or lack of transportation. Clinical concerns are escalated to licensed staff, as appropriate.
- **Care Coordinators (Licensed Clinical Staff):** Licensed clinicians conduct assessments, develop individualized care plans, provide condition-specific education, support medication management, coordinate care across providers and settings, and monitor clinical progress. For maternity populations, Care Coordinators provide prenatal risk assessment, education, coordination with obstetric providers, and postpartum follow-up. Licensed staff practice within their scope and partner with treating providers to support coordinated care.

Member Participation

Participation in Care Management Programs is voluntary. Members may choose to participate, decline services, or discontinue participation at any time.

Provider Collaboration and Access to Services

Highmark Health Options West Virginia Care Management coordinates with treating providers to support whole person care and address care gaps.

Providers have access to Care Management services and may refer members who may benefit from these services. Providers can also access care plans for members participating in Care Management through Highmark Health Options West Virginia Provider Portal to support shared care planning and coordination of care.

Referrals may be submitted through the provider portal or by contacting Provider Services for assistance. For additional information, visit **providers.highmark.com/hho-wv** or call **1-833-957-0020**.

Behavioral Health Coordinator

A BH Coordinator who is a behavioral health professional and located inWest Virginia shall monitor HHO WV for adherence to BH requirements in the Agreement.

The primary functions of the BH Coordinator are:

- Coordinate Member care needs with BH Providers.
- Develop processes to coordinate behavioral health care between PCPs and BH Providers.
- Participate in the identification of best practices for BH in a primary care setting.
- Coordinate behavioral care with medically necessary services.
- Be knowledgeable of the BH Managed Care Agreement requirements and coordinate with the BH-MCO to effectuate the requirements.

School Based-School Linked Services

HHO WV Special Needs Team actively coordinates with the school based and school linked services throughout the State. Our Case Managers provide support and assistance as needed, to ensure that our members receive all required medically necessary services to allow for them to attend school. The CMs work closely with the member's parent/guardian, the school based special needs staff, as well as the member's physicians and specialists ensure that all required services are available for the member in the school setting. Call the Special Needs Team at **1-833-957-0020** asked to speak to a Special Needs Case Manager if you require assistance with school based/linked services.

Member Communications

Social Media Prohibitions

The following prohibitions are applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. Posting or sending any protected private information on social media source;
2. Advertising on social media platforms that entail direct communication with potential enrollees. This list includes, but is not limited to Instagram, Twitter, Teams, Zoom, Snapchat, Skype, WhatsApp, Facebook Messenger, MeetUp, Viber, and any other personal communication services;
3. Responding to any comments on social media posts from potential enrollees except when to provide general response, such as MCO phone number, links to the MCO web site or the enrollment broker phone number;
4. Partaking in individual communication on social media outlets;
5. Requesting followers or adding individuals as friends (i.e., friends on Facebook, followers on Instagram or Twitter); and
6. Tagging individuals on social media source.

Events and In-Person Marketing

If the MCO, its agents, Subcontractors, MCO providers, or any individual, organization, or entity connected to the MCO, whether paid or unpaid (i.e. volunteers), engages in or participates in-person at an event, either physically or by digital communication technologies (i.e. Zoom or other video conferencing methods) on behalf of the MCO, the MCO must ensure that the participant's conduct is not solicitous of enrollment and that any MCO materials distributed by or through the participant at such an event comply with the Marketing and Member Materials Policies contained in the MCO Contract

Marketing Representative Training

The MCO is required to inform any agents, subcontractors, providers, and/or any individual, organization, or entity connected to the MCO, whether paid or unpaid, of these Marketing and Member Material Policies prior to such person's participation in any event or in-person marketing activity on behalf of the MCO.

Marketing Guidelines

HHO WV may conduct general advertising that does not specifically solicit the West Virginia Medicaid and WVCHIP managed care enrollees. HHO WV must submit marketing plans to BMS/WVCHIP for prior written approval.

Prohibited Marketing Practices

The following prohibitions are applicable to HHO WV, its agents, subcontractors, and participating providers:

1. Distributing Marketing materials without prior BMS approval.
2. Distributing Marketing materials written above the sixth (6th) grade reading level (Grade 6.9 or below), unless approved by BMS.
3. Making any assertion or statement (orally or in writing) that the MCO is endorsed by CMS, a federal or state government agency, or similar entity.
4. Making any written or oral statements containing material misrepresentations of fact or law relating to the MCO's plan or the Medicaid and WVCHIP program, services, or benefits.
5. Making false, misleading, or inaccurate statements relating to services or benefits of the MCO or Medicaid and WVCHIP program, or relating to the providers or potential providers contracting with the MCO.
6. Using the word, "Mountain," or phrase, "Mountain Health," except when referring to Mountain Health Trust or other State programs.
7. Marketing in or around public assistance offices, including eligibility offices.
8. Direct Mail Marketing to potential enrollees.
9. Directly or indirectly, engaging in door-to-door, email, text, telephone, and other Cold Call Marketing activities.
10. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email).
11. Inducing or accepting an enrollee's MCO enrollment or MCO disenrollment.
12. Using terms that would influence, mislead, or cause potential enrollees to contact the MCO, rather than the Enrollment Broker, for enrollment.
13. Using absolute superlatives (e.g., "the best," "highest ranked," "rated number 1") unless they are substantiated with supporting data provided to BMS.
14. Portraying competitors in a negative manner.
15. Referencing the commercial component of the MCO in any Marketing materials.
16. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone, or electronic means of communication.
17. Influencing enrollment in conjunction with the sale or offering of any private insurance.
18. Tying enrollment in the Medicaid/WVCHIP MCO with purchasing (or the provision of) other types of private insurance.
19. Charging enrollees for goods or services distributed at MCO or Medicaid/WVCHIP events.
20. Charging enrollees a fee for accessing the MCO's website.
21. Using marketing agents who are paid solely by commission.
22. Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying BMS' contractors or Subcontractors to send plan specific materials to potential enrollees.
23. Assisting with Medicaid/WVCHIP MCO enrollment form.
24. Conducting potential enrollee orientation in common areas of providers' offices.

25. Posting MCO-specific, non-health related materials or banners in provider offices.
26. Allowing providers to solicit enrollment or disenrollment in an MCO or distribute MCO-specific materials at a Marketing activity (This does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.).
27. Providing gifts to providers for the purpose of distributing them directly to the MCO's potential or current enrollees.
28. Offering gifts valued over $15 or $75 annually to potential enrollees.
29. Making potential enrollee gifts conditional based on enrollment with the MCO.
30. Discriminating against an enrollee or potential enrollee because of race, age, color, religion, natural origin,ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to enrollees with certain diagnoses.
31. Failing to provide an opt-out option in SMS/text message materials.

Social Media Marketing Guidelines

HHO WV must comply with the following social media marketing guidelines.

The following list is applicable to HHO WV, its agents, subcontractors, and providers:

1. Upon BMS/WVCHIP approval, HHO WV may engage in forms of social media advertising (i.e. Twitter, Facebook, Instagram).
2. Upon BMS/WVCHIP approval, HHO WV may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by BMS prior to distribution.
3. HHO WV may post Medicaid/WVCHIP events on social media sources. The content of such posts must be approved by BMS/WVCHIP approval prior to posting.
4. HHO WV may post general non-advertising information regarding health plan activities. The content of such posts does not require BMS/WVCHIP prior approval, and
5. Any member complaints received through social media sources must be processed and resolved through the general complaint intake system.
6. The following prohibitions are applicable to HHO WV, its agents, subcontractors, and providers. Posting or sending personal or protected private health information on social media.
7. Advertising on social media platforms that entail direct communication with potential members.
8. This list includes, but is not limited to: Snapchat, Skype, WhatsApp, Facebook Messenger, MeetUp, Viber, and any other personal communication services.
9. Responding to any comments on social media posts from potential members except when to provide a general response, such as giving a phone number or link to a website or the enrollment broker phone number.
10. Partaking in individual communication on social media outlets.
11. Requesting followers or adding individuals as friends or tagging individuals on social media sources (i.e., Facebook, Instagram, Twitter).
12. Tagging individuals on social media.

Reporting and Investigating MCO Marketing Violations

HHO WV' process to ensure fair and consistent investigation of alleged violations of BMS/WVCHIP marketing policies is:

Upon written receipt of any alleged violation(s) from BMS/WVCHIP, HHO WV must:

1. Acknowledge receipt, in writing, within one business day from the date of the receipt of the alleged violation.
2. Begin investigation of the alleged violation and complete investigation within 14 calendar days from the date of the receipt of the alleged violation.
3. Analyze the findings of the investigation and report findings to BMS/WVCHIP.



Medical Management

Medical Necessity Defined

HHO WV defines medical necessity as:

Items or services furnished or to be furnished to a patient for diagnosing, evaluating, treating, or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies that are reasonable and necessary for the diagnosis or treatment of illness or injury; to improve the functioning of a malformed body member; to attain, maintain, or regain functional capacity; for the prevention of illness; or to achieve age-appropriate growth and development. Determination of medical necessity is based on specific criteria.

Medical necessity, when prescribed and delivered by or through authorized and qualified providers, will be:

- Appropriate and effective to the comprehensive profile of the patient and the patient's family.
- Directly related to the patient's diagnosed medical condition or the effects of the condition and be provided to the patient only.
- Least costly, appropriate, and available health service alternative that represent an effective and appropriate use of program funds.
- Most appropriate care or service that can be safely and effectively provided to the patient and will not duplicate other services provided to the patient.
- Primarily directed to treat the patient's diagnosed medical condition or the effects of the condition in all settings for normal activities of daily living but will not be solely for the convenience of the patient, the patient's family, or the patient's provider.
- Recognized as either the treatment of choice (i.e., prevailing community or statewide standard) or common medical practice by the provider's peer group, or the functional equivalent of the other care and services that are commonly provided.

Rendered in response to a life-threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has and will be reasonably determined to:

- Diagnose, cure, correct, or ameliorate defects, physical and mental illnesses, and diagnosed conditions or the effects of such conditions.
- Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program.
- Prevent the worsening of conditions or effects of conditions that endanger life, cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay.

- Provide assistance in gaining access to needed medical, social, educational, and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition, in order that the patient might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into family, community, and facility.
- Restore or improve physical or mental functionality, including developmental functioning lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury, or condition.
- Sufficient in amount, scope, and duration to reasonably achieve its purpose.
- Timely, considering the nature and current state of the patient's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time.

Medical Necessity Criteria

HHO WV Utilization Management assesses the medical appropriateness of services using:

- American Society of Addiction Medicine (ASAM) criteria.
- InterQual® criteria.
- Medical policy approval criteria based on a medical director's review of the latest medical literature and citations, and the Bureau for Medical Services definition of medical necessity when authorizing the delivery of health care services to its members.

Authorizations are used to:

- Assess the medical necessity and appropriateness of care.
- Confirm the member's eligibility and covered benefits for services requested.
- Establish the appropriate site for care.
- Identify HHO WV members who would benefit from care management or disease management.

Determination of medical necessity for covered care and services must be documented in writing. The determination is based on medical information provided by the patient, the patient's family or caretaker, the PCP, and any other providers, programs, or agencies that have evaluated the patient. All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a health care service under the provider agreement.

Hospital and Facility Services

Inpatient Admissions

For HHO WV to monitor the quality of care and utilization of services by our members, all HHO WV practitioners are required to obtain an authorization number for all hospital admissions and certain outpatient surgical procedures by submitting authorization requests electronically through our authorization portal, GudingCare, via NaviNet. Should the provider portal be unavailable, use UM phone or fax numbers in advance of services being rendered, except in urgent or emergent situations. In the event services are needed urgently and/or emergently, authorization must be requested no later than four business days from arrival. Failure to obtain a timely authorization may result in the administrative denial of your claim without regard to medical necessity.

HHO WV will accept the PCP, ordering practitioner, or the attending practitioners request for an authorization of non-emergency hospital care; however, no party should assume the other has obtained authorization. HHO WV will also accept notification from the hospitals Admissions and/or Utilization Review Department.

The UM representative refers to the HHO WV Medical Director if criteria or established guidelines are not met for medical necessity. The ordering practitioner is offered a peer review opportunity with the HHO WV Medical Director for all potential denial determinations.

Emergency Admission at an Out-of-Network Hospital

When a patient requires hospitalization, the HHO WV policy is to have the service rendered in an in-network hospital. However, at times it may not be possible to follow this policy when a patient presents to the closest medical facility due to a medical emergency. When the patient's medical condition requires an admission to an out-of-network hospital, the patient will be transferred within 24 hours of stabilization or when appropriate. Utilization Management staff will concurrently monitor the patient's condition by communicating with the hospital's Utilization Review staff and the attending provider to determine when the patient is medically stable for transfer. HHO WV will coordinate all necessary transportation.

Hospital Guidelines for Triage

In all instances, when a patient presents to an emergency department for diagnosis and treatment of an illness or injury, the hospital's preestablished guidelines allow for the triage of illness and injury.

Urgent Care

The definition of urgent care is medically necessary treatment that is needed within 48 hours to prevent deterioration to the patient's health.

Examples are, but not limited to:

- Fever, sudden onset and recurring
- Nonspecific pain, i.e., abdominal, chest, etc.
- Persistent rash, vomiting
- Shortness of breath

Follow-Up Care After an Emergency Department Visit

All follow-up care after an emergency department visit must be coordinated through the PCP.



Home Health Care

HHO WV encourages the use of home-based services as an alternative to hospitalization when medically appropriate to:

- Allow for timely and appropriate discharge from the hospital.
- Avoid unnecessary admissions of members who could effectively be treated at home.
- Permit members to receive care in greater comfort due to familiar surroundings.
- Home-based services may include, but are not limited to:
  - High-risk pregnancy nurse visit
  - Hospice
  - Infant care (after initial postpartum visits)
  - Occupational, Physical, and Speech therapy
  - Skilled nursing for wound care, diabetic teaching, IV medication administration
  - Social services

Hospital Transfer Policy

When a HHO WV member requires hospitalization, HHO WV policy is to have the service rendered in a HHO WV participating hospital. However, HHO WV recognizes that it may not be possible to follow this general policy when a member presents to the closest medical facility due to a medical emergency. When the medical condition of the member requires an admission to a non- participating hospital, the member will be transferred within 24 hours of stabilization, when appropriate.

To determine that the member is medically stable for transfer the HHO WV UM staff will concurrently monitor the condition of the patient by communicating with the hospital's Utilization Review staff and the attending practitioner. HHO WV will coordinate all necessary transportation for the timely transfer of the member.

Outpatient Surgery Procedures

HHO WV practitioners may utilize a hospital's Short Procedure Unit (SPU) or Ambulatory Surgery Unit (ASU) for any authorized medically necessary procedure. Medical necessity reviews may be required for certain procedures. To verify if authorization is required refer to the Procedure Code Lookup feature available on the provider page of our website in advance of services being rendered, except in urgent or emergent situations.

In the event services are needed urgently and/or emergently, authorization must be requested within three business days of the procedure date. Authorization requests must be submitted electronically through our authorization portal, GuidingCare, via NaviNet. Should the provider portal be unavailable, use UM phone or fax numbers.

Emergency Room

The HHO WV definition of an emergency is inpatient and outpatient services needed immediately and provided by a qualified provider for emergency medical, behavioral health, or dental conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing their health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; and that are needed to evaluate or stabilize an emergency medical condition. These include accidental injury and poison related problems and complaints that may be indicative of serious, life-threatening medical problems, such as chest or abdominal pain, difficulty breathing or swallowing, or loss of consciousness.

The following conditions are examples to likely require emergency treatment:

- Danger of losing life or limb
- Poisoning
- Chest pain
- Drug overdose
- Choking
- Heavy bleeding
- Possible broken bones
- Sudden loss of or slurred speech
- Paralysis
- Breathing problems
- Seizures
- Criminal attack (mugging or rape)
- Blackouts

HHO WV members have been informed, through the Member Handbook, of general instances when emergency care is typically not needed. These are as follows:

- Cold
- Sore throat
- Small cuts
- Earache
- Swelling
- Cramps
- Cough
- Rash
- Bruises

In all instances, when a member presents to an emergency room for diagnosis and treatment of an illness or injury, the hospital's pre-established guidelines allow for the triage of illness and injury.

All follow-up care after an emergency room visit must be coordinated through the PCP. Members are informed via the Member Handbook to contact their PCP for a referral for follow-up care in instances such as, but not limited to:

- Removal of stitches
- Further diagnostic testing
- Wound check

Ambulance Services

Emergent transportation (302 or 911), including air ambulance, does not require authorization by HHO WV. HHO WV considers emergent transportation as transportation that allows immediate access to medical or behavioral health care and without such access could precipitate a medical or a behavioral health crisis for the patient. Either a participating or non-participating ambulance provider may render 302 or 911 transportation without an authorization from HHO WV.

HHO WV also considers the following situations emergent, and thus does not require authorization:

- Acute care to acute care
- Behavioral health to behavioral health
- Acute care to behavioral health
- Behavioral health to acute care
- Emergency department to acute care or behavioral health facility
- Emergency department to emergency department
- Hospital to hospital when a patient is being discharged from one hospital and being admitted to another

Providers should bill the above types of transports with the appropriate non-emergent, basic life support code and the modifier HH.

Authorization for non-emergent ambulance transportation is not required by the HHO WV UM department in advance of services being rendered. HHO WV considers non-emergent transportation as transportation for a patient that does not require immediate access to medical or behavioral health care and/or if not provided would not result in a medical or a behavioral health crisis as non-emergent. Non-emergent transportation may include the following scenarios:

Ambulance transports from one facility to another when the member is expected to remain at the receiving facility, which may include the following:

- Hospital to skilled nursing facility
- Skilled nursing facility to hospital (non-emergent)
- Hospital to rehabilitation facility
- Rehabilitation facility to hospital (non-emergent)
- Ambulance transport to home upon discharge
- Ambulance transport from home to a PCP office

A HHO WV participating ambulance provider should be contacted to render non-emergent transportation when possible. Non-participating non-emergent ambulance trips would require authorization. Ambulance transportation from one facility to another for diagnostic testing or services not available at the current facility, with the expectation of the member returning to the original facility upon completion of service, is the responsibility of the originating facility and does not require an authorization from HHO WV. The originating facility should assume the cost for this type of transport even if for unforeseen circumstances, the member remains at the receiving facility. The originating facility may contact any ambulance service of their choosing to provide transport in this scenario only.

Members who need non-emergency medical transportation services to secure medical care provided under the MA program should contact the WV MA Transportation Program (MATP) in their county to see if they qualify. Login - TripCare (modivcare.com). After 5 p.m., call **1-844-549-8353**. Questions/concerns about a client's ride request? Call the Ride Assist Line at **1-844-549-8354**.

Acute Inpatient Rehabilitation Facility

If a patient needs admission to an acute inpatient rehabilitation facility, the attending provider, hospital Utilization Review department, or rehabilitation facility must enter their authorization requests through our authorization portal, GuidingCare, via NaviNet. Should the provider portal be unavailable, use UM phone or fax numbers.

Home Infusion

Nursing visits and non-drug supplies related to home infusion services do not require an authorization. Providers should refer to the Highmark Health Options website under **Medication Information** regarding authorization requirements for infusion drugs.

Hospice Services

If a patient needs hospice services, including home hospice, inpatient hospice, continuous care, and respite, the PCP, attending provider, or hospice agency can enter their authorization requests through our authorization portal, GuidingCare, via NaviNet. Should the provider portal be unavailable, use UM phone or fax numbers. Case Managers will coordinate the necessary arrangements between the PCP and the hospice provider to ensure continuity and coordination of care. Due to interruptions of Medicaid coverage, HHO WV strongly recommends that providers verify eligibility if the patient's need for an item or service extends beyond the calendar month in which the authorization was given.

Outpatient Therapy Services

Outpatient therapy services (physical therapy, occupational therapy, speech therapy and cardiac rehab) will require prior authorization through HealthHelp via NaviNet. Providers are not able to submit any authorization requests through the HealthHelp provider landing page. HealthHelp can be reached by phone Monday–Friday, 8 a.m.–6 p.m. at **1-888-209-2763**. Pulmonary rehab services require prior authorization through HHO WV Utilization Management and must be submitted through our authorization portal, GuidingCare, via NaviNet. Should the provider portal be unavailable, use UM phone or fax numbers. The ordering provider of pulmonary rehab must contact Utilization Management to request a precertification. The provider will be asked to provide the prescription, fax the current progress notes, plan of treatment, and goals that support the medical necessity request.



Skilled Nursing Facility (SNF)

If a patient needs admission to an SNF, the PCP, attending provider, hospital Utilization Review department, or nursing facility should contact the Bureau for Medical Services. Once the member is admitted to the SNF, they are voluntarily disenrolled from the HHO WV. HHO WV will assist with coordinating the necessary arrangements between the acute care facility and SNF to provide medically necessary care.

Transmission of Laboratory Data

Hospitals will electronically provide HHO WV with all laboratory values relevant to HEDIS, accreditation, or regulatory requirements no less than four times per year or upon written request. All such laboratory values will be provided no later than the last business day of the calendar months of April, July, October, and January. In the event HHO WV asks for additional clinical laboratory values, hospitals will receive advance notice of at least 90 calendar days.

Private Duty Nursing (PDN) Services

Care Management coordinates medically necessary PDN services with the ordering provider and the home health care provider. Providers must enter prior authorizations through our authorization portal, GuidingCare, via NaviNet. Should the provider portal be unavailable, use UM phone or fax numbers.

Ordering Private Duty Nursing Services

If a patient needs private duty nursing (PDN) services, the PCP or a specialist rendering care may submit a letter of medical necessity through the online provider authorization portal, via NaviNet, or contact Utilization Management. Providers should do the following when ordering PDN.

Submit a Letter of Medical Necessity to include:

- Specify the level of care being requested.
- Specify hours per day and schedule being requested.
- Outline care the patient requires assistance with during the hours of service being requested.
- Summarize the patient's past medical history, including review of current conditions driving the need for private-duty services, along with prognosis and treatment plan.
- List all caregivers supporting the patient's care.
- Include the emergency backup plan.

Transitions From Hospital to Home

Initial contact is attempted by Care Coordination while patients are still in the acute care setting.

Interventions are focused on:

- Assessing and arranging home health care needs.
- Assessing and coordinating durable medical equipment needs.
- Coordinating to address gaps in care and preventive screening needs.
- Discussing transportation options and resources for travel to appointments.
- Making and keeping follow-up appointments.
- Medication reconciliation.

Referrals and Prior Authorization

Referrals are not required for services rendered by participating providers. The PCP is responsible for the coordination of a member's health care needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care services. To ensure continuity and coordination of care, when a member obtains care outside of the primary care practice, a report should be forwarded by the rendering provider to the member's designated PCP.

Referrals for Second Opinions

HHO WV ensures member access to second opinions. Second opinions may be requested by HHO WV, the member, or the PCP. HHO WV will provide for a second opinion from a qualified health care provider within the network or arrange for the member to obtain one outside the network, at no more cost to the member. The second opinion specialist must not be in the same practice as the attending physician and must be a participating provider of HHO WV. A referral form is not required for in-network second opinion specialist visits. Out-of-network referrals may be authorized when no participating provider is accessible to the member or when no participating provider can meet the member's needs.

Referrals for Second Surgical Opinions

Second surgical opinions may be requested by HHO WV, the member, or the PCP. When requesting a second surgical opinion consultation, HHO WV recommends that you refer to a consulting practitioner who is in a practice other than that of the attending practitioner, or the practitioner who rendered the first opinion and possesses a different tax identification number than the attending practitioner. HHO WV provides for second opinions from an in-network provider or arranges for the member to obtain a second opinion outside of the network, at no more cost to the member.

Self-Referral

HHO WV has an open-access network, where members may self-refer or directly access services without a referral from their PCP. We encourage all members to discuss specialty care with their PCP, who can coordinate needed services. Services must be obtained from an in-network HHO WV practitioner or provider. There are exceptions to this, however; emergency, family planning, federally qualified and rural health centers and tribal clinic services do not require prior authorization for in-network or out-of-network practitioners or providers. Enrollees may access these services from a qualified practitioner or provider enrolled with the State of West Virginia in the West Virginia Medicaid or CHIP program.

Members may refer themselves for the following types of care:

Dental

When a member joins HHO WV, the member may self-refer to any participating United Concordia Dental dentist directly without a referral from the PCP. Should specialty dental care be needed, the dentist can refer the member to a dental specialist.

Certain oral surgery procedures, such as removal of partial or total bony impacted wisdom teeth, and procedures which involve cutting of the jaw, are covered by HHO WV through HHO WV panel of oral surgery providers. Members requiring these services must be referred by their PCP to an HHO WV participating oral surgeon. The primary care dentist may need to provide x-rays or other information to the PCP to facilitate the referral. The oral surgeon is responsible for authorizing surgical procedures with HHO WV prior to rendering the service (procedures provided in the oral surgeon's office are not subject to the authorization process). When a dental procedure requires the use of a special procedures unit (SPU), the dental provider must contact United Concordia Dental for authorization prior to the services being rendered.

Eye Examinations

HHO WV members may self-refer to any VSP Vision participating provider for a routine eye exam. Corrective lenses and frames may be obtained through any participating optician, optometrist, or ophthalmologist. Should the member require additional medical services, rendered by a participating ophthalmologist or optometrist, the member should coordinate with the PCP.

Mental Health/Substance Abuse

Members are permitted to self-refer for mental health and substance abuse services.

OB/GYN Services

Female HHO WV members may self-refer to any participating OB/GYN for any condition, not just for an annual exam or suspected pregnancy. When a member self-refers to the OB/GYN's office, the OB/GYNs office is required to verify eligibility of the member.

Prior Authorization Process

Admitting or requesting providers are responsible for submitting authorizations to HHO WV Utilization Management and must submit through our authorization portal, GuidingCare, via NaviNet. Should the provider portal be unavailable, use UM phone or fax numbers. If a service requires authorization and is being requested by an in-network specialist, the specialist's office must authorize the service. Hospitals may verify authorization by calling **1-833-957-0020**.

Since a patient's eligibility may change prior to the anticipated date of service, eligibility must be verified on the date of service. For requested authorizations that cannot be approved as proposed by the provider, HHO WV Utilization Management staff will refer the authorization request to a HHO WV Medical Director to review the case.

Authorization Portal

Providers must electronically submit authorizations and will receive responses and real-time updates through the Authorization Portal. Should the provider portal be unavailable, use UM phone or fax numbers. Providers will access the Authorization Portal through NaviNet SSO (Single Sign-On) functionality. From health plan drop-down select HHO WV>GuidingCare>Authorization Portal from the Plan Workflows menu. Upon accessing the Authorization Portal, you will see the home page. From the home page you will be able to start a new authorization, view authorizations in progress, and withdraw a pending authorization. There is a count of Authorizations in progress by the authorization request type.

If Utilization Management is closed and an urgent request for authorization is needed, providers may leave a voice mail on the designated HHO WV Utilization Management voice mail. All voice mail inquiries are responded to within 24 hours. An HHO WV Medical Director is available to review these requests when necessary. For urgent and emergency situations, providers are required to notify HHO WV within 48 hours or two business days of rendering the service.

Information Needed When Calling for Authorization

Providers should have the following information available when calling Utilization Management to authorize a service:

- Member name
- Member HHO WV ID number
- Date of service/admission
- Name of admitting provider
- Name of servicing provider/facility
- Providers NPI
- Diagnosis (ICD-10 code or precise terminology)
- Procedure code (CPT-4, HCPCS, or MA Coding) or billing codes for DME requests
- History of current illness, including treatments tried and failed
- Treatment plan including medications, imaging, laboratory, consults, etc.
- Any other pertinent clinical information

Emergency services do not require a prior authorization.

Claims

HHO WV processes medical expenses upon receipt of a correctly completed CMS-1500 form for professional services and upon receipt of a correctly completed UB-04 form for hospital or facility expenses. Paper claim forms must be submitted on original red claim forms. A claim without valid, legible information in all mandatory categories is subject to rejection or denial. To ensure reimbursement to the correct payee, the group NPI must be included on every claim.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the provider certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the provider or an employee under the provider's direction. The provider certifies that the information contained in the claim is true, accurate, and complete.

Member Billing Policy

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

This provision shall not prohibit collection of copayments on the Plans' behalf made in accordance with the terms of the enrollment agreement between the Plan and the member/subscriber/enrollee. Refer to the "Billing patients for covered services" section of this manual for information on copayments. Members cannot be denied a service if they are unable to pay their copayment. The provider must provide the service and then bill the Member for the copayment. Providers cannot bill enrollees for covered services any amount greater than what would be owed if the entity provided the services directly.

Practitioners may directly bill members for non-covered services; provided, however, that prior to the provision of such non-covered services, the practitioner must inform the member:

- Of the service(s) to be provided.
- That the Plan will not pay for or be liable for said services.
- Of the member's rights to appeal an adverse coverage decision as fully set forth in the Provider Manual.
- Absent a successful appeal, that member will be financially liable for such services.

Claim Submission Requirements

All practitioners and providers are required to report all the services they provide for our members to our company. Practitioners are required to report all services provided to our members by submitting a claim with a copy of the EOB regardless of whether or not additional payment is expected.

Handwritten claims are not accepted. Billing provider address must be a physical location, claims will be rejected if a PO box number is submitted as the billing address.

The assigned 12-digit member identification number is needed for both paper and electronic claims. For practitioners who do not know the member's identification number, it is acceptable to submit with member's Medicaid ID (MAID).

Claims can be submitted with or without the Alpha character prefix appearing on the member's ID card.

Diagnosis Coding

All claims must have complete and accurate ICD-10-CM diagnosis codes for coding claims consideration. If the diagnosis code requires but does not include the fourth- or fifth-digit classification, the claim will be denied.

Hospital Service

Submit hospital claims on a UB-04 claim form. Include the patient's 12-digit HHO WV ID number (UMI) or Medicaid ID number on all claims to ensure that claims are processed for the correct patient.

Providers rendering services in an outpatient hospital clinic should include:

- **CMS-1500**: Provider's group NPI and the provider's individual NPI must be reported.
- **UB-04**: Facility NPI and the provider's individual NPI must be on the claim.

Patient account numbers recorded on the claim form by the provider are indicated in the Patient ID field of the HHO WV remittance advice. Any questions concerning billing procedures or claim payments can be directed to Provider Services.

Information Resources

Rules for format, content, and field values can be found in the Implementation Guides available on the Washington Publishing Company's website. The Provider Remittance provides detailed payment data based on the information provided to Highmark Health Options. If all or part of the claim has been denied, consult the Claim Adjustment Reason Code (CARC) and or the Remittance Advice Remark Code (RARC). CARC and RARC codes are on the Washington Publishing Company website. Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts or errors.

Reporting Provider Identification Number

PCPs and specialty care providers must submit claims under the individual national provider identifier (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.

Submissions for anesthesiology, pathology, radiology, and emergency department provider groups must include the individual provider identification number.

Any claim billed on a CMS-1500 form must include the individual provider identification number in Box 24J.

It is extremely important to notify Highmark Health Options of any change that involves adding providers to any group practice, as failure to do so may result in a denial of service.

Timely Filing

Practitioners/Providers must submit a complete original, initial CMS-1500 or UB-04 claims form within 12 months from the date of service.

- Claims are accepted through Electronic Data Interchange (EDI). Facilities and providers are encouraged to submit claims via this format. If you bill on paper, we will only accept paper claims on a CMS-1500 or a UB-04 claim forms. No other billing forms will be accepted. Paper claims that are not received on original forms with red ink or with handwriting will be rejected.
- When the primary payer is Medicare, providers must bill with an Explanation of Benefits (EOB) within 12 months from date of Medicare remittance.
- For all other primary payers, provider must bill with an Explanation of Benefits (EOB) within 12 months from date of service. If another third party is billed for a service and the 1-year filing deadline for Medicaid billing is almost exhausted, the provider should bill Medicaid immediately even though the other third party has not furnished the provider with information about payment. Even if Medicaid denies the claim, the submission will give the provider another year (from the 1-year anniversary of the date of service) to file a corrected claim with Medicaid once primary has issued a determination.
- Corrected claims or requests for review are considered if information is submitted within 120 days from the date of original claim remittance advice. Claims submitted after these deadlines will be denied for untimely filing.

Patients with Other Insurance Coverage

HHO WV is the payer of last resort on claims for services provided to patients when any commercial or Medicare plan covers the patient. HHO WV may not delay or deny payment of claims unless the probable existence of third-party liability is established at the time the claim is submitted. Claims must be submitted within the timely filing guidelines.

Submission of Highmark Health Options West Virginia Secondary Payer Claims

To receive payment for services provided to patients with other insurance coverage, the provider must first bill the patient's primary insurance carriers using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's EOB, the provider should submit a claim to HHO WV. Providers must bill within 12 months of date of service. If Medicare is primary provider must bill within 12 months of Medicare remittance. An original bill along with a copy of the EOB is required to process the claim.

The provider must:

- File all claims within timely filing limits as required by the primary insurance carrier.
- Submit a copy of the primary carrier's EOB with the claim to HHO WV within timeframes noted above.
- Secondary and tertiary claims can be sent electronically.
- Be aware that secondary coverage for covered fee-for-service items is provided according to a benefit-less-benefit calculation.
- The amount billed must match the amount billed to the primary carrier. HHO WV will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

Determining Highmark Health Options West Virginia Liability After Primary

Highmark Health Options West Virginia uses the Benefit Less Benefit methodology for COB. If a primary payer paid more than the HHO WV allowed amount or there is no patient liability, HHO WV would not make a payment.

Otherwise, HHO WV pays the lessor of:

- The difference between what the primary paid and our allowed amount.
- The patient responsibility.

Payment Types

Example: In-Network Providers with Primary Plan	
Provider charges	$1,500
Primary carrier allowable	$1,000
Primary payment (80% of allowable)	$800
Highmark Health Options West Virginia allowable if primary	$600
Highmark Health Options West Virginia compares the primary carrier Highmark Health Options West Virginia allowable	$800 vs. $600
Highmark Health Options West Virginia does not issue payment	$0

Example: Patient Responsibility After Primary Plan	
Provider charges	$1,500
Primary care allowable	$1,000
Primary payment (80% of allowable)	$800
Patient responsibility under primary plan	$200
Highmark Health Options West Virginia allowable if primary	$850
Highmark Health Options West Virginia compares the primary carrier Highmark Health Options West Virginia allowable	$800 vs. $850
Highmark Health Options West Virginia issues payment	$50



Auto and Casualty Claims

When a claim is submitted by a provider without an EOB from the auto insurance or a casualty plan, and the original bill does not include any notation of a primary payer payment, HHO WV will take a primary position on the claim and not deny to the extent that plan criteria was followed. HHO WV will perform post payment recovery if determined that auto or casualty insurance was responsible. These claims will be denied for timely filing if they are not received within 12 months of date of service. If the provider submits the claim with the EOB, HHO WV will coordinate benefits.

Subrogation

According to the agreement with the Bureau for Medical Services, if a patient is injured or becomes ill through the act of a third party, medical expenses may be covered by casualty insurance, liability insurance, or litigation. Any correspondence or inquiry forwarded to HHO WV by an attorney, provider of service, insurance carrier, etc. relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement, will be handled by HHO WV's legal team.

Verifying if Primary Coverage No Longer Applies

If a patient indicates they no longer have primary coverage, but the state system contains information indicating other medical coverage is still active, the patient should contact their enrollment broker to have the state system updated. If this is not possible, the provider may contact the primary carrier and request written verification of the coverage. When HHO WV receives a letter from the primary carrier indicating that the patient no longer has coverage, HHO WV will use the letter to investigate the situation and verify if the coverage is canceled and if there is a new plan covering the patient. If the investigation confirms that the patient no longer has primary coverage, HHO WV will submit an electronic request to the state to update the system. HHO WV will update the system immediately and reprocess claims finalized within the 120-day period prior to the date of the onset of the investigation.

Claim Submission Procedures

- Submit claims for all services provided.
- The billing provider's five digit plus four ZIP code is required on all claims in the billing field (and service facility field if used).
- Payment for CPT and HCPCS codes are covered to the extent that they are recognized by BMS or allowed per medical review determination by Highmark Health Options West Virginia. Correct coding must be submitted for each service rendered and nonspecific CPT codes will require a description added to the claim form.
- Highmark Health Options utilizes CMS place of service codes to process claims, and they are the only place of service codes that are accepted.
- Hospitals and facilities should bill on original UB-04 forms; other providers, including ancillary providers, should bill using an original CMS-1500 form.
- Highmark Health Options West Virginia does accept bills through electronic data interchange (EDI) and encourages facilities and providers to submit claims via this format.
- Correct and current provider information must be entered on all claims; The 10-digit NPI is required.
- Correct and current patient information, including the 12-digit patient ID number or Medicaid number, must be entered on all claims.
- Allow four to six weeks for a remittance advice; It is the provider's responsibility to research the status of the claim.
- NDC Requirements Federal regulations require States and Managed Care Organizations (MCOs) to collect NDC numbers from practitioners and providers on claims for the purposes of billing manufacturers for drug rebates. As a result, practitioners and providers will not be reimbursed for drugs unless a valid 11-digit NDC number, Unit of Measure and quantity administered are reported on the UB 04 or CMS 1500 claims. If the NDC data set is missing, incomplete, or invalid, claim will be denied.
- Handwritten claims are not accepted.
- Billing provider address must be a physical location, claims will be rejected if a PO box number is submitted as the billing address.
- The assigned 12-digit member identification number is needed for both paper and electronic claims. For practitioners who do not know the member's identification number, it is acceptable to submit with member's Medicaid ID (MAID).
- Claims can be submitted with or without the Alpha character prefix appearing on the member's ID card.

HealthCheck (EPSDT) Claims

Highmark Health Options will process and pay EPSDT, early intervention services for children ages 0–3, and prenatal visits as primary even when records indicate HHO WV is secondary, and a primary plan exists. If an EOB is attached to the EPSDT, Early Intervention Services, or prenatal claim, then coordination of benefits will be applied. Highmark Health Options will continue to coordinate benefits and require the primary EOBs when submitting the delivery claim.

EPSDT Paper Claim Format Requirements

- All EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381 – 99385 and 99391 – 99395) along with EP modifier.
  - **Note**: Providers must also include the coding for each individual screening they have provided for the member along with the age-appropriate E and M codes.
- The EP modifier must follow the evaluation and management code in the first line of Box 24D on the claim form. Use CPT Modifier (52 or 90) plus CPT codes when applicable.
- The appropriate diagnosis codes Z00, Z00.01, Z00.110, Z00.111, Z00.121, and Z00.129 must be noted in Box 21.
- Report visit code 03 in Box 24(h) of the CMS-1500 form when providing EPSDT screening service.
- Report 2-character EPSDT referral code for referrals made or needed as a result of the screen in Box 10(d) on the CMS-1500 form.

Structured Screening for Development Delays and Autism Spectrum Disorder Screening

WCC Age	Development Screening CPT 96110	Autism Spectrum Disorder Screening CPT 96110 U1
9 months	X	
18 months	X	X
24 months		X
30 months	X	

Codes for referrals made or needed as a result of the screen are:

YO - Other	YV - Vision	YH - Hearing
YM - Medical	YD - Dental	YB - Behavioral

Submit EPSDT Claim Via Paper (1500) or Electronic Format (837P)

All EPSDT screening services, including vaccine administration fees, should be submitted either on a CMS-1500 form or the corresponding 837P electronic format for EDI claims within 12 months of date of service. EPSDT screenings on a UB-04 form or the corresponding 837I electronic format are not accepted.

An EPSDT screening is complete when codes from each service area required for that age, including the appropriate evaluation and management codes, are documented. Consult the current Children's Checkup (EPSDT) Program Periodicity Schedule (Bright Futures Periodicity Schedule and Coding Matrix (PDF) and the Recommended Childhood Immunization Schedule) for screening eligibility information and the services required to bill for a complete EPSDT screen.

EPSDT Payment

Claims will be paid at the provider's EPSDT rate only if the appropriate evaluation and management code and EP modifier are submitted.

Electronic data interchange (EDI) requirements for EPSDT claims:

- All EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381 – 99385, and 99391 – 99395) along with the EP modifier. Each EPSDT screening as a child well visit should be listed as outlined above.
- Providers should call out each individual screening that is done with a well visit should be listed.
- The EP modifier must follow the evaluation and management code in the first position on the claim form. Use CPT Modifier (52 or 90) plus CPT code when applicable.
- The appropriate diagnosis codes Z00, Z00.01, Z00.110, Z00.111, Z00.121, and Z00.129 must be noted in Box 21 on paper claims. Electronic claims should be a loop or segment.
- Appropriate evaluation and management codes must be included.
- Appropriate referral codes for first time referrals to dental and first-time referrals to specialists.
- Populate the SV111 of the 2400 loop with a "yes" for an EPSDT claim (this is a mandatory federal requirement).
- Populate the Data Element CLM12 in the 2300 Claim Information Loop with "01" (meaning EPSDT).
- Populate NTE01 of the NTE segment with "ADD". This means that the additional information is available in 'field' NTE02.

Populate NTE02 with the NTE segment of the 2300 Claim Information Loop with the appropriate referral codes:

YO - Other	YV - Vision	YH - Hearing
YM - Medical	YD - Dental	YB - Behavioral

All EPSDT Submissions Must Use ICD 10 Codes

HHO WV requires PCPs who are treating children to enroll them in the Vaccine for Children (VFC) Program. This program provides vaccines at no cost to providers. The VFC website provides an overview of the program and includes information regarding eligibility requirements. Highmark Health Options will reimburse an administrative fee when a vaccine administration code is billed for each vaccine code along with the appropriate NDC number.

Electronic Claims Submission

Claims are accepted through Electronic Data Interchange (EDI). Facilities and providers are encouraged to submit claims via this format. The EDI 837 Health Care Claim transaction is the electronic transaction for claims submissions.

HHO WV accepts claims electronically through any clearinghouse. Practitioners are encouraged to take advantage of our electronic claims processing capabilities.

Submitting claims electronically offers the following benefits:

- Faster claims submission and processing.
- Reduced paperwork.
- Increased claims accuracy.
- Time and cost savings.

For submission of professional or institutional electronic claims for HHO WV, please refer to the following grid for clearinghouse Payer IDs:

CPID	Payer Name	Payer	Claim Type
RP118	HHO WV	RP118	Professional
RP118	HHO WV	RP118	Institutional

Requirements for Submitting Claims to HHO WV through a Clearinghouse

- When submitting claims please note the West Virginia Payer ID Number is RP118. Any claim submitted with an incorrect Payer ID Number will be denied.
- The billing provider address submitted on claims must be a physical street address (paper and electronic). Claims will be rejected if a PO Box number is submitted as the billing address.
- The assigned 12-digit member identification number is needed for both paper and electronic claims. For practitioners who do not know the member's identification number, it is acceptable to submit with member's Medicaid ID (MAID).
- Claims can be submitted with or without the Alpha character prefix appearing on the member's ID card.
- To assure that claims have been accepted via EDI, practitioners should receive and review acceptance/rejection reports from their clearinghouse.
- If you are not submitting claims electronically, please contact your EDI vendor for information on how you can submit claims electronically.
- Our company will accept electronic claims for services that would be submitted on a standard CMS-1500 or a UB-04 claim forms. We will accept electronic COB transactions via 837 processing in accordance with the implementation guides for both 837 Professional and Institutional processing.
- Submitting COB claims electronically will save providers time and eliminate the need for paper claims with copies of the other payer's EOB attached. This will increase quality, consistency, and speed of payment.

Claim Payments Electronic Remittance Advice

Our company has engaged PNC Healthcare to migrate to a new claims payment platform, Claim Payments & Remittances (CPR) service, powered by Echo Health. This platform allows our company to make payments based on provider's preferences, maximizing electronic payment options and simplifying adoption.

Providers may register to receive payments electronically. The new CPR service enables providers to log into a web-based portal to manage their payment preferences and access their detailed explanation of payment (EOP) for each claim payment.

Outlined below are new payment options:

1. **Virtual Card Payments**: If you are not currently registered to accept payments electronically, you will receive virtual credit card payments with your EOP.
2. **Electronic Funds Transfer (EFT) Payments**: If you are interested in a more automated method of receiving payments, EFT is a fast and reliable payment method. You can also choose to automate the associated remittance information via an 835 Electronic Remittance Advice (ERA) sent directly to your organization or your clearinghouse.
   - To sign up to receive EFT payments only or 835 and EFT from our company, visit **www.enrollments.echohealthinc.com/EFTERAInvitation.aspx?ReturnUrl=%2f**.
   - To sign up to receive EFT payments only or 835 and EFT from our company and from all Echo payers, visit **www.view.echohealthinc.com/EFTERA/efterainvitation.aspx**.
3. **Medical Payment Exchange (MPX)**: Provides the option to direct print an in-office check at no cost, receive virtual card payment or enroll for EFT.
4. **Paper Checks**: To receive paper checks and paper EOPs, you must contact CPR Customer Service to elect to opt out of virtual card payments or remove your EFT enrollment.

The Companion Documents provide information about the 835 Claim Remittance Advice Transaction that is specific to the plan and the plan's trading partners. Companion Documents are intended to supplement the HIPAA Implementation Guides. Rules for format, content, and field values can be found in the Implementation Guides available on the Washington Publishing Company's website at **www.wpc-edi.com**.

Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts or errors.

Claims Review Process

Our company will review any claim that a practitioner feels was denied or paid incorrectly. These are requests that are not regarding medical necessity rather are administrative in nature such as, but not limited to, disputes regarding the amount paid, denials regarding lack of modifiers, refunded claim payments due to incorrect payment, or coordination of benefit (COB) issues. The request may be conveyed via fax to **1-833-623-2571** if the inquiry relates to an administrative issue. The provider can also submit a request through the Provider Portal via NaviNet. Please forward all the appropriate documentation, i.e., the actual claim to expedite the review process.

We cannot accept verbal requests to retract claim overpayments. Providers may complete and submit a Refund Form or a letter that contains all the information requested on this form. The refund form is located on the HHO WV website.

This form, together with all supporting materials relevant to the claim reversal request being made including but not limited to an EOB from other insurance carriers and the refund check.

Claims inquiries for administrative reviews may also be submitted. For the mailing address, please refer to the Important Addresses section on **pg 10**.

Cotiviti Claims Pattern Review (CPR)

Highmark Health Options utilizes Cotiviti Claims Pattern Review (CPR) to enhance the accuracy, integrity and timeliness of our claims processing. CPR has enabled efficient Payment Policy Management and allows for the review of claims using "real time" analytics, including the ability to pause claims processing and enabling Cotiviti CPR experts to review claims for proper validation prior to payment.

Cotiviti Claims Pattern Review Appeals Process

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

Claim Coding Software

HHO WV uses a fully automated coding review product that programmatically evaluates claim payments to verify the clinical accuracy of professional claims in accordance with clinical editing criteria. The program used is designed to assure data integrity for ongoing data analysis and reviews procedures across dates of service and across providers at the claim, provider, and provider-specialty level. This coding program contains complete sets of rules that correspond to:

- AMA CPT-4
- HCPCS
- ICD-10
- CMS guidelines and industry standards
- Medical policy
- Literature and academic affiliations

Claim Types

Clean Claims

Refers to a claim for payment for a health care service that has no defect or impropriety. Claims will be considered clean if the appropriate authorization has been obtained in compliance with HHO WV policy and procedure manual and the following elements of information are furnished on a standard UB-04 or

CMS-1500 form (or their replacement with CMS designations) or an acceptable electronic format through a HHO WV-contracted clearinghouse:

- Patient name
- Patient medical plan identifier
- Date of service for each covered service
- Description of covered services rendered using valid coding and abbreviated description
- Name of provider and plan identifier
- NIAC code
- Provider tax identification number
- Provider's NPI
- Provider's taxonomy code
- Valid CMS place of service code
- Billed charge amount for each covered service
- Primary carrier EOB when patient has other insurance
- All applicable ICD-10-CM diagnosis codes - inpatient claims include diagnoses at the time of discharge or, in the case of emergency room claims, the presenting ICD-10-CM diagnosis code
- DRG code for inpatient hospital claims

Nonclean Claims

A defect or impropriety will include but is not limited to:

- A particular circumstance requiring special treatment that prevents timely payment from being made on the claim.
- Lack of required substantiating documentation.
- A claim from a health care provider who is under investigation for fraud or abuse regarding that claim will not be considered a clean claim.

Claims are paid in accordance with the terms outlined in the MCO contract with BMS. Clean claims are paid within 30 days of receipt. The date of receipt is specified as the date HHO WV receives the claim, as indicated by its date stamp (including electronic) on the claim, and date of payment as the date of the check release or other form of payment release to the provider. For in network providers, clean claims not paid within 30 days are subject to payment of 18% per annum, calculated daily for the full period in which the clean claim remains unpaid beyond the 30-day clean claims payment deadline.

Fraud, Waste, and Abuse

HHO WV has a comprehensive policy for handling the prevention, detection, and reporting of fraud, waste, and abuse (FWA). It is HHO WV's policy to investigate any action by members, employees, or providers that affects the integrity of HHO WV or the Medical Assistance Program. HHO WV enforces all industry standard claim coding requirements, including those from NCCI, AMA CPT, and ICD-10-CM.

Providers are responsible to know the following FWA definitions as applicable to Medicaid:

- **Fraud:** Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting, committed by an entity, including health plan, a subcontractor, a provider, or a member, among others.
- **Waste and Abuse:** Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid/Medicare Programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Medicaid contracts, Medicare manuals, and the requirements of state and federal regulations for health care in a managed care setting.)
  - **Abuse** can be committed by health plan, subcontractor, provider, state employee, or a member, among others. Abuse also includes member practices that result in unnecessary cost to the Medicaid/Medicare Programs, health plan, a subcontractor, or provider.
  - **Waste** is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs.
- **Compliance Program:** To ensure compliance with FWA requirements of Medicaid contracts, our Company and providers will have:
  - Written policies, procedures, and standards of conduct readily available for all employees which outlines our commitment to a FWA program.
  - Effective training and education related to FWA for all employees, first tier and downstream entities, or subcontractors.
  - Mechanisms to report compliance issues or FWA.
  - Enforcement standards through publicized disciplinary guidelines.
  - Provisions for internal monitoring and auditing.
  - Provisions to promptly take action to detected offenses and develop corrective action initiatives.
- **False Claims Act:** The False Claims Act (FCA) provides that any person who knowingly presents or causes to be presented a false or fraudulent claim for payment or approvals (among other activities) is liable to the United States Government for a civil penalty of five thousand dollars ($5,000) to ten thousand dollars ($10,000) plus three times the amount of damages the Government sustains because of the act of that person (as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990). The FCA includes a qui tam provision, where individuals can bring claims on behalf of the government in exchange for a percentage of any recovery.

- **Financial Investigations and Provider Review (FIPR) Team:** A multi-faceted unit within our Company that is involved in detecting and investigating FWA. In addition, the unit works to ensure that claims are paid correctly by both pre-pay and post-pay auditing methods and in accordance to recipient benefits and provider contracts.

Compliance Requirement

Providers sign an agreement that requires compliance with HHO WV policies and procedures for the detection and prevention of fraud, waste, and abuse. Such compliance may include, but is not limited to:

- Referral of information regarding suspected or confirmed FWA to HHO WV.
- Submission of statistical and narrative reports regarding FWA activities.
- Submission of medical record requests for pre-payment and post-payment review.
- Participation in interviews and audits.
- Completion of provider compliance assessment.

Provider Fraud, Waste, and Abuse (FWA) Training

All providers are required to have a representative review the provider FWA training upon contracting with HHO WV and annually thereafter. The provider representative will be responsible for communicating the information obtained from the training to the entire staff. It is the provider's responsibility to either attend the annual provider FWA training or independently review the required materials. Providers will be expected to submit proof of their completion of the training when asked.

FWA Policies and Procedures

HHO WV policies and procedures follow the guidelines set forth by CMS. For further information on FWA, providers should refer to the CMS website: **www.cms.gov/training-education/partner-outreach-resources/fraud-abuse**.

It is HHO WV's policy to discharge any employee, terminate any provider, or recommend any member be withdrawn from the Medicaid program who, upon investigation, has been identified as being involved in fraudulent or abusive activities. If fraud or abuse is suspected, it is the provider's responsibility to immediately notify HHO WV by calling the Fraud, Waste, and Abuse Hotline at **1-844-718-6400**.

Common examples of provider FWA:

- Billing for services not rendered.
- Billing for supplies not being purchased or used.
- Billing for more time or units of service than provided.
- Billing incorrect provider service or location.
- Billing for services that the clinician or facility is not appropriately licensed.
- Billing for used items as new.
- Billing more than once for the same service.
- Billing or charging Medical Assistance recipients for covered services.
- Billing separately for services in lieu of an available combination code.
- Balance billing.

- Dispensing generic drugs and billing for brand-name drugs.
- Falsifying records.
- Performing inappropriate or unnecessary services.
- Upcoding.
- Altering claims.

Common examples of member FWA:

- Misreporting or failing to report information such as income, ownership of resources and property, or who lives in the household.
- Sharing Medicaid ID card.
- Trafficking SNAP benefits.
- Changing or forging an order or prescription.
- Selling prescriptions/medications.
- Stealing provider's prescription pads.
- "Doctor shopping" for prescriptions.

Fraud, Waste, and Abuse Recovery Requirements

HHO WV has fraud, waste, and abuse recovery functions that help ensure claims payment accuracy and to detect and prevent FWA, which include:

- FWA investigations and audits.
- Pre-payment claims edits and medical record reviews.
- Retrospective claims edits and medical record reviews.
- Provider education.
- Provider compliance assessments.
- Provider overpayment determinations and extrapolations.

Our FWA recovery functions rely on reimbursement policies, medical record standards, and coding requirements that are outlined in the following: CMS, American Medical Association (AMA), National Correct Coding Initiative (NCCI), NCQA, and state Medicaid regulations. All claims should be coded and documented in accordance with the HIPAA Transactions and Code Set Standards, which includes ICD-10-CM, National Drug Code (NDC), Code on Dental Procedures and Nomenclature code, HCPCS codes, CPT code, and other HIPAA code sets.

FWA Reviews

HHO WV conducts prepayment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. HHO WV will recover claims payments that are contrary to national and industry standards. HHO WV conducts progressive reviews, and providers may be asked to submit additional samples or documentation during the reviews.

If any of the recovery efforts identify overpayments, HHO WV will:

- Comply with all federal and state guidelines to identify overpayments.
- Possibly recommend corrective actions that may include pre-payment review, payment suspension, and potential termination from the network.
- Pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within 60 days.
- Refer suspected FWA to appropriate agencies.
- Determine provider recoveries based on audit results and extrapolation methodologies.

HHO WV may deny payment or pursue overpayments for the following reasons, but is not limited to:

- Add-on codes reported without a primary procedure code
- Altered or forged records
- Claims documentation issues
- Clinical documentation issues
- Diagnosis codes that do not support the diagnosis or procedure
- Different rendering provider
- Duplicate claims
- Excessive services
- Group size exceeds limitations
- Inaccurate claim information
- Incorrect fee schedule applied to claim
- Inpatient readmissions (up to 30 days)
- Invalid code combinations
- Invalid code or modifier
- Insufficient documentation
- Missing laboratory results
- Missing medication records
- Missing physician orders
- Missing records
- NCCI add-on code edits
- NCCI Medically Unlikely (MUE) edits
- NCCI Procedure to Procedure (PTP) edits
- No authorization or invalid authorization
- No services provided including no-shows and cancellations
- Noncovered service
- Outpatient services while member was inpatient
- Overlapping services
- Patient different than member
- Per diem services billed as separate or duplicate charges
- Potentially fraudulent activities
- Provider does not meet the requirements to render services
- Provider excluded
- Provider license terminated or expired
- Retrospective coordination of benefits
- Retrospective rate adjustments
- Retrospective termed member eligibility
- Services provided outside of practice standards

Overpayments

HHO WV, its providers, and its members are responsible for the identification and return, regardless of fault, of overpayments. In the event that we make an overpayment to a provider, we must recover the full amount of that overpayment. Additionally, if a provider identifies an overpayment from us, the provider is responsible for returning the overpayment in full at the time of discovery.

Provider Self-Audit (Self-Identified Overpayment)

Federal and state regulations require providers to routinely audit claims for overpayments. A process is in place for providers to report the receipt of an overpayment. Providers must notify HHO WV in writing of the reason for the overpayment as well as returning the full amount of overpayment within 60 days after the date on which they identified the overpayment.

If the claim is:

- Less than two years old, retraction is preferred.
- Over two years old, a check is preferred.

If a listing of claims is not provided, HHO WV cannot guarantee that the claims will not be audited again, for the same reason. Deposit of a provider check or retraction of the requested claims does not constitute complete agreement to the submitted self-audit results or overpayment amount. FIPR may contact the provider to discuss self-audit results as necessary.

Providers can submit the Provider Self-Audit form that is located on HHO WV's website. For more information on self-audits, use the Self-Audit Toolkit on the CMS website.

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, etc.)
- 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
- Other information (as required)

TRENDSubmit

Provider Self-Reporting Process:

Providers can electronically submit overpayments via TRENDSubmit. This secure, online process allows providers to be notified of claim retractions in real-time and eliminates the manual paper process. The TRENDSubmit team provides user training resources and ongoing support. Providers can contact Jennifer Baron via email at **jbaron@trendhealthpartners.com** in order to initiate TRENDSubmit access.

HHO WV FWA Audits

FIPR will periodically conduct audits regarding FWA. If selected for an audit, the provider will receive a letter from the primary investigator, or delegates that have been contracted, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond.

Overpayment letters issued through administrative reviews will be sent at the discretion of FIPR management.

HHO WV partners with multiple vendors to conduct various pre-payment and post-payment audits or reviews, such as:

- Inpatient and outpatient chart reviews.
- Retrospective data mining reviews.
- Subrogation.
- Pre-payment clinical validation and claims pattern reviews.

Vendor specific questions should be directed to Provider Services.

DRG Post-Payment Audits

Our Company or a subcontractor, conducts monthly post-payment reviews of inpatient claims to verify the accuracy of DRG payments.

For reviews conducted by our subcontractors, you should expect the following:

- You will receive a letter requesting records for specific paid claims.
- You will have 30 calendar days to provide the requested medical records for review.
- Failure to submit the requested records may result in an administrative denial by our Company and recoupment of the original payment.
- You will receive a determination letter from our subcontractor describing the outcome of the medical records and claim review.
- You will have 30 calendar days to either accept the subcontractor's findings or request a reevaluation by providing supporting information for the paid claims to the subcontractor.
- If you disagree with the delegate reevaluation, our Medical Director can review your supporting information to make a final determination.
- If you do not respond to these notifications, we will proceed with a payment adjustment. Questions should be directed to FIPR by calling the FWA Hotline at **1-844-718-6400**.

Technical Denials

Technical Denial determinations are not subject to reconsideration and further appeals but may be subject to re-review/reopening. These types of denials include:

- Medical record not being submitted timely (42 CFR 476.90(b)).
- Billing errors (including cost outlier denials due to duplicative billing for services or for services not actually furnished or not ordered by the physician).

You will receive correspondence from our Company indicating the specific claims and required documents required for review. If you do not respond to these notifications, we will proceed with a payment adjustment.

Questions regarding Technical Denials should be directed to FIPR by calling the FWA Hotline at **1-844-718-6400**.

FWA Medical Records Request

HHO WV may request copies of medical records from the provider in connection with claims overpayment or for cases involving alleged FWA. If medical records are requested, the provider must provide copies of those records at no cost. This includes notifying any third party who may maintain medical records of this stipulation. The provider must provide access to any medical, financial, or administrative records related to the services provided to patients within 30 days of the request or sooner. All required documentation must be submitted at the time of the original medical record request. Documentation will not be accepted after the review is complete.

Providers are required to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Set Standards, and Medicaid regulations as well as other applicable professional associations and advisory agencies.

Providers should follow the guidelines for basic medical records:

Consent to treatment	• Identifies the patient. • Includes the benefits and any potential risks. • Lists the types of services and treatments. • Must be easy to read and legible. • Signed and dated by patient. • Signed, dated, and credentialed by provider. • Valid for dates of service.
Release of information for payment	• Identifies the patient. • Lists the types of services and treatments. • Must be easy to read and legible. • Signed and dated by patient. • Signed, dated, and credentialed by author or provider. • Valid for dates of service.
Privacy practices	• Identifies the patient. • Must be easy to read and legible. • Signed and dated by patient. • Signed, dated, and credentialed by author or provider. • Valid for dates of service.

Medical information	• Allergies and adverse reactions. • Continuity of care is documented. • High risk behaviors (tobacco or cigarette, alcohol, substance use, HIV STD, nutrition, social and emotional risks, etc.). • Immunizations and dates. • Laboratory and other studies ordered. • Medical history, such as family history, psychosocial history, medical-surgical history, baseline physicals, and periodic updates. • Must be easy to read and legible. • Must contain the minimum personal biographical data: – Address – DOB – Employer – Gender – Home telephone number – Marital status – Name of next of kin – Next of Kin telephone number – Occupation – Work telephone number
Treatment plan	• Addresses the chief complaint and clinical finding with a plan of care consistent with standards of care and clinical practice. • Documents necessity for treatment. • Documents that patient or guardian reviewed or participated with the development of the treatment plan. • Identifies the diagnosis. • Identifies interventions and goals of treatments. • Identifies the patient. • Must be easy to read and legible. • Reviews are completed timely as applicable. • Signed and dated by provider (witness or author's identification). • Valid for dates of service.
Progress or clinical entry note	• Corresponding encounter or timesheets, as applicable. • Dates of service. • Identifies the patient. • Must be easy to read and legible. • Note does not identify follow-up or next steps in treatment. • Note does not identify the treatment goals and objectives. • Note does not list symptoms and behaviors. • Note is missing narrative or description of services. • Place of service. • Signed, dated, and credentialed by author or provider. • Start and stop times for time-based services. • Units of service.
Medication list	• Lists dosages, dates, and refills. • Medication prescribed. • Must be easy to read and legible. • References the side effect and symptoms. • Signed and dated by provider.

Providers are responsible for:

- Following all requirements under federal and state regulations, publications, and bulletins that are pertinent to the treatment and services provided.
- Having compliance programs that prevent and detect FWA and report and return overpayments within 60 days of identification.
- Obtaining the appropriate order, referral, or recommendation for service.

Providers must:

- Follow the medical record standards as defined in Medicaid contracts, provider agreements, provider manuals, and all regulations.
- Have patient records that include all Medicaid requirements, are individual and kept secure.
- All documentation must meet the requirements of the service codes that are submitted on the claims form.
- All progress notes and billing forms must be completed after the session.
- All documentation and medical record requirements must be legible.
- All amendments or changes to the documentation must be signed and dated by the provider amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.
- Each medical record should be individualized and unique and should include a patient identifier on every page. No clone or copying and pasting of medical records.

Complaints, Grievances, and Appeals

Provider Complaint Procedures

HHO WV accepts provider complaints, regardless of their origin or communication method and will provide timely resolution to providers. Complaints are investigated, and the details of the findings and disposition will be communicated back to the provider within 30 days of receipt. If additional time is needed to resolve the complaint, HHO WV will provide status updates to the provider.

Complaints About Claim Payments

Complaints about administrative claims payment are handled as a provider dispute. Providers may file a written complaint about claims payment by fax, through an online provider portal, or mail within 12 months of the date of service, or 60 calendar days of the date of payment, whichever is later.

When a service has been denied due to lack of prior authorization or denied based on medical necessity and still provided to the patient, providers can appeal that decision after the service through the clinical provider appeals process. See "Requesting a first level appeal" below.

Requesting a First Level Appeal

Any provider may file an appeal to request the review of any post-service denial. This process is intended to afford providers with the opportunity to address issues regarding payment only. The provider appeal process must be initiated by the provider through a written request. A first level appeal must be submitted in writing within 60 calendar days from the date on the notice of adverse benefit determination and within 180 calendars days from the date of the claim denial, or as governed per contract.

When submitting a written request for an appeal, providers are required to submit all supporting documentation including, but not limited to:

- A copy of the denied claim.
- Patient's medical records containing all pertinent information regarding the services rendered by the provider.
- Reason for the appeal.

Providers will be informed of:

- The decision in writing within 60 calendar days from receipt.
- Approval or denial; payment for approvals will be issued within 60 calendar days of notification.
- Additional appeal rights as applicable.

Requesting a Second Level Appeal

If a provider is not in agreement with the first level provider appeal committee's decision, the provider may seek a second level provider appeal. A request for a second level provider appeal must:

- Be submitted in writing within 60 calendar days of the date on the first level provider appeal decision letter, or as governed by contract.
- Include specific reasons as to why the provider does not agree with the first level provider appeal committee's decision.

All second level provider appeal reviews will:

- Be completed within 60 calendar days from the date the second level provider appeal request was received.
- Inform the provider of its decision in a written decision notice within 60 calendar days.

This is the final level of appeal, and the decision is binding, unless otherwise governed per contract.

Appeals and Grievances

Appeals

An appeal is a request for a review of an adverse benefit determination:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- HHO WV's failure to provide services in a timely manner.
- HHO WV's failure to act within 30 calendar days from the date the plan receives a grievance or appeal.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, and other member financial liabilities.

Grievances

A grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination (appeal) and can either be filed in writing or verbally. A grievance can be about any service that a member received from a provider or by HHO WV.

Examples of a nonmedical grievance:

- If a provider or HHO WV employee was rude.
- If a member is upset HHO WV extended the time to make an authorization decision.
- If the member feels a provider or HHO WV did not respect their rights as a member.

Examples of medical grievances are:

- If a member has a concern with the quality of care or services, they have received.
- If a member has trouble finding or getting services from a provider, resulting in a delay in treatment.

Filing Grievances and Appeals on Behalf of a Patient

Patients and providers will not be punished for filing an appeal, complaint, or grievance. A patient or provider may contact a Member Advocate or grievance coordinator at any time for help or any questions about the appeals and grievances process. Patients have a right to appoint a representative to act on their behalf. If a provider is acting on behalf of a patient, HHO WV requires the patient's consent in writing prior to reviewing a request for an appeal or grievance.

Filing an Appeal

Providers can file appeals by phone or in writing. When filing an appeal include:

- Patient's name and ID number
- Provider phone number(s)
- Provider address
- State what the appeal is about
- State why the appeal is being filed
- State the desired outcome of the appeal
- Any additional information to support the appeal

An appeal must be filed within 60 calendar days from the date of the Notice of Adverse Benefit Determination letter.

Rendering Services During Appeal Process

It is important to know that the patient may have to pay for the services received during the appeal or State Fair Hearing process if the final decision is not in the patient's favor. If the decision is in the patient's favor, HHO WV will authorize services within 72 hours from the date when the notice reversing the determination is received.

If the patient was previously authorized and getting services, the patient may ask to continue getting these services if:

- The patient files the request for an appeal timely (within 10 calendar days of HHO WV sending the Notice of Adverse Benefit Determination).
- The appeal involves the termination, suspension, or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The patient requests an extension of services.

If HHO WV continues the patient's services during the appeal process, HHO WV will cover these services until:

- The patient or patient's representative withdraws the appeal or request for a state fair hearing.
- The patient or patient's representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after HHO WV sends the notice of an adverse resolution.
- The time period or service limits of a previously authorized service have been met.
- A decision from the State Fair Hearing Officer was not in the patient's favor.

After Filing an Appeal

A letter confirming receipt of the appeal will arrive within five business days after the appeal is received. It will also include information about the appeal review process.

Providers, if acting on behalf of the patient, may:

- Ask to look over all documents for the appeal.
- Present additional information in person or in writing as a representative on behalf of the patient.
- Request a copy of the information used to review free of charge.
- Submit additional information to support the appeal.

A health care professional who has the appropriate clinical expertise, as determined by the state, in treating the member's condition or disease will review the case. Providers may extend the time frame for making the appeal decision for up to 14 calendar days. HHO WV may also extend the time frame for decision up to 14 calendar days if additional information is necessary and the delay is in the member's best interest. Providers will receive a written notice with the reason for the delay.

After review, a decision letter will be mailed within 30 calendar days from the date the appeal was filed. This letter will state the reason for the decision and further appeal rights including the right to ask for a State Fair Hearing.

Expedited ("Fast") Appeals

If the normal time frame to review an appeal could seriously jeopardize the patient's life, health, or ability to attain, maintain, or regain maximum function, providers may ask for an expedited either verbally or in writing. Decisions are sent within 72 hours from the day the request is filed.

The following information is required for expedited appeals:

- Patient's name and ID number
- Provider phone number(s)
- Provider address
- State the service or item being appealing
- State why the member's life or health or ability to attain, maintain, or regain maximum function is in jeopardy
- State the desired result from the appeal
- Any additional information to support the appeal

After Filing Expedited Appeals

The time frame for an expedited appeal is very short. Immediate action is required. Providers may:

- Submit additional information to support the appeal.
- Ask to look over all documents for the appeal.
- Present additional information as a representative on behalf of the patient.
- Request a copy of the information used to review the appeal free of charge.

A health care professional who has the appropriate clinical expertise, as determined by the state, in treating the patient's condition or disease will review the case. Providers may extend the time frame for making the appeal decision for up to 14 calendar days. HHO WV may also extend the time frame for decision up to 14 calendar days if additional information is necessary and the delay is in the patient's best interest. Providers will receive a written notice with the reason for the delay.

Providers will be contacted about the outcome of the expedited appeal after a decision is made. A decision letter will also be mailed within 72 hours from the date the appeal was filed. This letter will provide the reason for the decision and further appeal rights including the right to ask for a State Fair Hearing.

State Fair Hearings

A State Fair Hearing is an appeal process provided by the State of West Virginia either in person or by telephone. If a patient does not agree with a denial of an appeal decision, they may request a State Fair Hearing within 120 calendar days of the date on the notice of resolution upholding the adverse benefit determination. A State Fair Hearing can be requested by calling or writing to the State's the Bureau for Medical Services office.

If providers are acting on behalf of a patient, they may request a State Fair Hearing instead of, or in addition to, filing an appeal. Providers may ask for a State Fair Hearing if HHO WV has:

- Delayed service.
- Denied, suspended, terminated, or reduced a service.
- Failed to give a timely service.

After Filing a State Fair Hearing

Patients will receive a letter from the State Fair Hearing Officer that will provide the date, time, and location of the hearing. The letter will also tell providers how to prepare for the hearing. Providers may ask to review and copy all documentation regarding the State Fair Hearing.

Continuing Services During the State Fair Hearing Process

It is important to know that the patient might have to pay for the services they received while the State Fair Hearing was pending if the final decision is not in the patient's favor. If the decision is in the patient's favor, HHO WV will authorize services immediately.

If the patient was previously authorized and getting services, the patient may ask to continue getting these services if:

- The patient files the State Fair Hearing request timely (within 10 calendar days of HHO WV sending the denial of appeal).
- The State Fair Hearing involves the termination, suspension, or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The patient requests an extension of services.

If HHO WV continues the patient's services during the State Fair Hearing process, HHO WV will cover these services until:

- The patient or patient's representative withdraws the request for a State Fair Hearing.
- The patient or patient's representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after HHO WV sends the notice of an adverse resolution.
- The time period or service limits of a previously authorized service have been met.
- A decision from the State Fair Hearing Officer was not in the patient's favor.

Grievance Process

To file a grievance or a grievance on behalf of a patient, call Member Services or submit in writing or by filling out a Member Grievance Form. If a provider files a grievance on behalf of a patient, the patient cannot file a separate grievance.

When filing a grievance, include:

- Patient name and ID number
- Provider phone number
- Provider address
- Those involved in the grievance
- Details of the occurrence
- Date of the occurrence
- Where the occurrence happened
- The desired outcome from the filed grievance
- Any supporting documentation

There is no time limit to file a grievance.

After a Grievance is Filed

A letter will arrive within five business days after the grievance is filed to confirm receipt by HHO WV.

It will include:

- Information about the grievance review process
- Provider rights as a patient representative, including the right to:
  - Review or request a copy of all documentation regarding the grievance free of charge.
  - Submit additional information.

A grievance coordinator will then send the case to a subject matter expert or a health care professional.

- If the grievance does not involve a medical issue, a HHO WV staff members, who has not been involved with the grievance but is a subject matter expert, will review the request.
- If the grievance is medical in nature, a health care professional that has the appropriate clinical expertise, as determined by the state, in treating the patient's condition or disease will review.

A decision will be made within 30 calendar days after the grievance is received and will tell providers the reason(s) for the decision. Patients may extend the time frame for the grievance decision up to 14 calendar days. HHO WV may also extend the time frame for decision of the grievance up to 14 calendar days if additional information is necessary and the delay is in the patient's best interest. Patients will receive a written notice with the reason for the delay.

Appendix A: Description of MCO Covered and Excluded Services

MCO Covered Services for Mountain Health Trust

Highmark Health Options West Virginia Inc. (HHO WV) is responsible for providing to enrollees, either directly or through arrangements, all Medically Necessary covered services as outlined in this Appendix A and will assume financial responsibility for the provision of these services. The MCO is responsible for determining whether services are Medically Necessary and whether prior approval is required for services.

While this manual outlines covered and excluded services, please note that the West Virginia Medicaid and WVCHIP policy, including the State Medicaid Plan, WVCHIP State Plan, program instructions, attendant provider manuals, program bulletins, and all published policy decisions issued by BMS, is the final authority for defining these services. Providers should refer to the FFS Medicaid provider manuals available on the WV DoHS website for an explanation of service limitations under the MHT program.

MHT Medical Service	Definition	Scope of Benefits	Limitation on Services
Abortion	Pregnancy termination determined to be Medically Necessary by the attending physician in consultation with the patient in light of physical, emotional, psychological, familial, or age factors (or a combination there of) relevant to the well-being of the patient.	Drugs or devices to prevent implantation of the fertilized ovum and for medical procedures necessary for the termination of an ectopic pregnancy. The MCO must provide coverage in compliance with the BMS Policy Manual, Chapter 519.19 Women's Health Services.	Written physician certification of medical necessity. All Federal and State laws regarding this benefit must be adhered to.
Ambulatory Surgical Center Services	Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, as well as private practitioners.	Nursing, technicians, and related services. Use of the facilities where surgical procedures are performed; drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure; diagnostic or therapeutic services or items directly related to the provision of a surgical procedure. Materials for anesthesia.	Physician services; lab & x-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs and DME are excluded.

MHT Medical Service	Definition	Scope of Benefits	Limitation on Services
Cardiac Rehabilitation	A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore enrollees with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department.	Supervised exercise sessions with continuous electrocardiograph monitoring. The Medically Necessary frequency and duration of cardiac rehabilitation is determined by the enrollee's level of cardiac risk stratification.	N/A
Chiropractor Services	Services provided by a chiropractor consisting of manual manipulation of the spine.	Manipulation to correct subluxation. Radiological examinations related to the service.	Certain procedures may have service limits.
Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a clinic (that is not part of a hospital) on an outpatient basis.	General clinics, birthing centers, and health department clinics, including vaccinations for children.	N/A

MHT Medical Service	Definition	Scope of Benefits	Limitation on Services
Early and Periodic Screening, Diagnoses and Treatment (EPSDT)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services encompass all mandatory and optional Medically Necessary services (including treatment and items as per 42 USC 1396d(a)) to correct or ameliorate defects, and physical and mental illness and conditions discovered during HealthCheck screenings in enrollees under age twenty-one (21). These services are provided based on a periodicity schedule and are offered to both Medicaid and WVCHIP enrollees in the same comprehensive manner.	Includes comprehensive periodic and interperiodic screenings (health and developmental history, unclothed physical exams, lab tests including blood lead, vision, hearing, dental, behavioral health screenings, immunizations, and health education), and all Medically Necessary diagnostic and treatment services (e.g., vision/hearing defects, dental care, immunizations, specialized medical/ behavioral health services) identified during screenings, as per 42 USC 1396d(a). Services include those that correct, ameliorate, maintain, improve, or prevent worsening of conditions.	Limited to individuals under age twenty-one (21). Medical necessity decisions for EPSDT are individualized; services are not subject to flat limits, hard limits, monetary caps, or budgetary constraints.
Family Planning Services and Supplies	Services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy.	All family planning providers, services, and supplies.	Sterilization is not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Hysterectomies and pregnancy terminations are not considered family planning services. Treatment for infertility is not covered.

MHT Medical Service	Definition	Scope of Benefits	Limitation on Services
Gender Affirmation for Gender Dysphoria	Gender Dysphoria is a condition defined in the DSM in which a person experiences clinically significant distress or impairment because there is an incongruence between their biological sex and gender identity. Gender affirmation surgeries are covered for individuals diagnosed with gender dysphoria and meeting certain criteria to align their biological sex with their gender identity. Gender affirmation surgeries is a service court ordered for BMS to cover and subject to change with legislative action.	All treating, rendering, ordering, or referring providers. Male to Female (MTF) and Female to Male (FTM) gender affirmation surgeries when conditions of coverage are met and prior authorization is obtained.	Enrollees must be twenty-one (21) years or older prior to being considered for this procedure. No surgery should be performed while a patient is actively psychotic. Contraindications to surgery include an accompanying psychiatric disorder, severe environmental challenges, failure to remain in a crosssex role during the trial period, illicit drug use, or a lack of Gender Dysphoria diagnosis.
Handicapped Children's Services/ Children with Special Health Care Needs Services	Specialty services provided to handicapped children and those who may be at risk of handicapping conditions.	Provides linkage and coordination of services to all WV children with special needs and limited direct medical services, equipment, and supplies to those families that meet financial and other program eligibility requirements.	Services are provided to children under twenty-one (21), with the following diagnoses, but not limited to: cystic fibrosis; myelocys-tomeningocele /myelodysplasia; congenital heart defects; craniofacial deformities; seizure disorders; and metabolic disorders.
Home Health Care Services	Nursing services, home health aide services, medical supplies suitable for use in the home.	Provided at enrollees' place of residence on orders of a physician.	Residence does not include hospital nursing facility, ICF/MR, or state institution. Certain suppliers have service limits.

MHT Medical Service	Definition	Scope of Benefits	Limitation on Services
Hospice	In-home care provided to a terminally ill individual as an alternative to hospitalization.	Nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment, drugs, biologicals, home health aide, and homemaker.	Must have physician certification that enrollee has a life expectancy of six (6) months or less. Enrollees aged twenty-one (21) and over waive right to other Medicaid services related to the treatment of terminal illness.
Hospital Services, Inpatient	Hospital services provided for all enrollees on an inpatient basis under the direction of a physician.	All inpatient services, including bariatric surgery, corneal transplants, stem cell transplants, and long-term acute care (LTAC).	Excludes those adults in institutions for mental diseases (IMDs). Excludes behavioral health inpatient stays with a DRG of 425-433 or 521-523 or MS-DRG 880-887 or 894-897. Unlimited Medically Necessary days based on diagnosis related groups. Transplant services must be in a facility approved as a transplant center by Medicare and prior authorized by Medicaid.
Hospital Services, Outpatient	Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service.	Preventive, diagnostic, therapeutic, all emergency services, or rehabilitative medical services.	Services not generally furnished on an inpatient basis by most hospitals in the state. Only technical component of certain services.

MHT Medical Service	Definition	Scope of Benefits	Limitation on Services
Inpatient Rehabilitation	Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals.	Services that are medical inpatient rehabilitation services for Medicaid eligible individuals, and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification.	N/A
Laboratory and X-Ray Services, Non-Hospital	Laboratory and x-ray services provided in a facility other than a hospital outpatient department.	All laboratory and x-ray services ordered and provided by or under the direction of a physician. Includes laboratory services related to the treatment of SUD.	Must be ordered by physician. Certain procedures may have service limits.
Nurse Practitioners' Services	Services provided by a nurse midwife, nurse anesthetist, family, or pediatric nurse practitioner.	Specific services within specialty.	Certain procedures may have service limits.
Other Services Speech Therapy Physical Therapy Occupational Therapy	N/A	Treatment or other measures provided by speech, physical or occupational therapists to correct or ameliorate any condition within the scope of their practice.	Hearing aid evaluations, hearing aids, hearing aid supplies, batteries and repairs are limited to enrollees under age twenty-one (21). Certain procedures may have service limits or require prior authorization. Augmentation communication devices limited to children under twenty-one (21) years of age and require prior approval.

MHT Medical Service	Definition	Scope of Benefits	Limitation on Services
Physician Services	Services of a physician to an enrollee on an inpatient or outpatient basis.	Services are provided within the scope of medical practice of an MD or D.O. Includes medical or surgical services of a dentist, medical services related to the treatment of SUD, and fluoride varnish services. Physician services may be delivered using telehealth.	Certain procedures may have service limits or require prior authorization. Fluoride varnish services may only be provided to children ages six (6) months to three (3) years.
Podiatry Services	Foot care services.	Treatment for acute conditions, i.e., infections, inflammations, ulcers, bursitis, etc. Surgeries for bunions, ingrown toenails. Reduction of fractures, dislocation, and treatment of sprains. Orthotics.	Treatment of children limited to acute conditions. Routine foot care treatment for flat foot, and subluxations of the foot are not covered.
Private Duty Nursing (PDN)	Nursing services for enrollees who require more individual and continuous care than is available from a visiting nurse or routinely provided by hospitals or skilled nursing facilities.	Twenty-four (24)-hour nursing care if Medically Necessary.	Prior approval may be required. Limited to children under twenty-one (21) years of age.
Prosthetic Devices and Durable Medical Equipment (DME)	Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury.	Medically Necessary supplies, orthotics, prosthetics, and DME.	Certain orthotics, prosthetics, and DME require prior approval. Certain procedures have service limits. Medical supplies and DME in nursing facilities and ICF/MRs are covered in the per diem paid to these providers. Customized special equipment considered.
Pulmonary Rehabilitation	Individually tailored multidisciplinary approach to the rehabilitation of enrollees who have pulmonary disease.	One-on-one therapeutic procedures to increase strength or endurance of respiratory muscles and functions.	N/A

MHT Medical Service	Definition	Scope of Benefits	Limitation on Services
Right from the Start Services (RFTS)	Services aimed at early access to prenatal care, lower infant mortality, and improved pregnancy outcomes.	Care coordination and enhanced prenatal care services.	Pregnant women (including adolescent females) through twelve (12) months postpartum period and infants less than one (1) year of age. No prior authorizations can be required for RFTS services.
Rural Health Clinic Services: Including Federally Qualified Health Centers	Physician, physician assistant, and nurse practitioner providing primary care in a clinic setting.	Physician, physician assistant, nurse practitioner, nurse midwife services, supplies, and intermittent visiting nurse care in designated shortage areas.	N/A
Tobacco Cessation	Treatment for tobacco use and dependence.	Diagnostic, therapy, counseling services, and quit line services. The children's benefit also includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits.	N/A

MHT Medical Service	Definition	Scope of Benefits	Limitation on Services
Transportation, Emergency	Transportation to secure medical care and treatment on a scheduled or emergency basis.	Emergency ambulance and air ambulance.	Emergency transportation provided to the nearest resource. By most economical means determined by patient needs in accordance with BMS Policy Manual Chapter 524 Transportation.
Tubal Ligation	Family planning service provided to individuals of childbearing age to permanently prevent pregnancy.	In accordance with West Virginia Code § 9-5-12(d), the Department of Human Services shall make payment for tubal ligation.	Any licensed doctor providing these services must be compliant with the Federal Social Security Act 42 CFR §441, Subpart F – Sterilizations, §441.255 and §441.256 requirements, which requires informed consent and medical necessity.
Vision Services	Services provided by optometrists, ophthalmologists, surgeons providing medical eye care and opticians. Professional services, lenses including frames, and other aids to vision. Vision therapy.	Children under twenty-one (21)-exam, treatment services, lenses, frames, and needed repairs.	Adults limited to medical treatment only. Prescription sunglasses and designer frames are excluded. For adults, eyeglasses are limited to the first pair after cataract surgery. Contact lenses for adults and children covered for certain diagnosis.

MCO Covered Dental Services for Mountain Health Trust

MHT Dental Service	Definition	Scope of Benefits	Limitation on Services
Dental Services (Adult)	Services provided by a dentist, orthodontist, or oral surgeon.	1. Emergency procedures to treat fractures, reduce pain, or eliminate infection and; 2. Diagnostic, preventive, and restorative services.	Adult coverage has a $2,000 per two (2) fiscal year (July 1–June 30) maximum benefit. Services classified as cosmetic are not covered. WVCHIP enrollees will not be subject to any annual, lifetime, or other aggregate dollar limitations on any dental services covered under the State Plan per 42 CFR § 457.480.
Dental Services (Children)	Services provided by a dentist, orthodontist or oral surgeon or dental group to children under the age of twenty-one (21).	Emergency and non-emergency: surgical, diagnostic, preventive, and restorative treatment, periodontics, endodontics, orthodontics, prosthodontics, extractions, and complete or partial dentures.	Limited to individuals under the age of twenty-one (21).

MCO Covered Behavioral Services for Mountain Health Trust*

MHT Behavioral Service	Definition	Scope of Benefits	Limitation on Services
Behavioral Health Rehabilitation for Individuals Under Age Twenty-One (21) Psychiatric Residential Treatment Facility (PRTF)	Behavioral health rehabilitation performed in a children's residential treatment facility.	Diagnosis, evaluation, therapies, and other program services for individuals with mental illness, mental retardation, and SUD.	Procedure specific limits on frequency and units.
Behavioral Health Outpatient Services	Behavioral health clinics, behavioral health rehabilitation, targeted case management, psychologists, and psychiatrists. (Emergency room services are included in the MCO benefits package.)	Diagnosis, evaluation, therapies, including Medication Assisted Treatment (MAT), and other program services for individuals with mental illness, IDD and SUD.	Procedure specific limits on frequency and units. Only assertive community treatment (ACT) providers certified by BMS or the Bureau of Behavioral Health and Health Facilities may provide ACT services. Excludes children's residential treatment.
Psychological Services	Services provided by a licensed psychologist in the treatment of psychological conditions.	Evaluation and treatment, including individual, family, and group therapies. Psychological services may be delivered using telehealth.	Evaluation and testing procedures may have frequency restrictions.

MHT Behavioral Service	Definition	Scope of Benefits	Limitation on Services
Hospital Services, Inpatient – Behavioral Health and Substance Use Stays	Inpatient hospital services related to the treatment of mental disorders or SUD.	Inpatient hospital services related to the diagnosis, evaluation, and treatment of behavioral health or SUD.	N/A
Inpatient Psychiatric Services for Individuals Under Age Twenty-One (21)	Inpatient psychiatric facility services furnished at a psychiatric hospital or a distinct part psychiatric unit of an acute care or general hospital under the direction of a physician for individuals under age twenty-one (21).	Active treatment of psychiatric condition through an individual plan of care including post discharge plans for aftercare. Service is expected to improve the enrollee's condition or prevent regression so the service will no longer be needed.	Certification must be made prior to admission that outpatient behavioral health resources available in the community did not meet the treatment needs of the enrollee. Pre-admission and continued stay prior authorization.
Inpatient Psychiatric Services for Individuals Age Twenty-One (21) to Sixty-Four (64)	Inpatient psychiatric facility services furnished at an Institution for mental diseases (IMD).	Active treatment of psychiatric condition through an individual plan of care including post discharge plans for aftercare. Service is expected to improve the enrollee's condition or prevent regression so the service will no longer be needed.	May cover institutions for mental diseases (IMD) stays for enrollees aged twenty-one (21) to sixty-four (64) as "in lieu of services" for up to fifteen (15) days during a calendar month.

MHT Behavioral Service	Definition	Scope of Benefits	Limitation on Services
Drug Screening	Laboratory service to screen for presence of one (1) or more drugs of use.	Screening ordered by the treating practitioner that is deemed Medically Necessary and reasonable within commonly accepted standards of practice. Results are intended to alter patient management decisions. Full scope of benefits detailed in WV Provider Manual, Chapter 529.	Standing orders must be individualized for each enrollee and updated every thirty (30) days; drug screenings in excess of twenty-four (24) per calendar year are subject to prior authorization. All limitations are detailed in WV Medicaid Provider Manual, Chapter 529.2.
Substance Use Disorder (SUD) Services	Targeted case management and physician-supervised medication and counseling services provided to treat to those with a SUD.	Comprehensive SUD state plan and waiver services listed in Article III, Section 10.11	Opioid Treatment Program services included in the SUD waiver will be provided through Medicaid FFS.

* An outpatient follow-up session immediately following the discharge from the facility is a covered MCO benefit.

The MCO is not required to provide weight management services for MHT; the MCO may provide these services as a Value-Added Service except for bariatric surgery which is a covered benefit under the State Plan.

MCO Benefits Covered Under Fee-For-Service (FFS) Medicaid

The following services are excluded from the MCO's capitation rates, but will remain covered Medicaid services for persons who are enrolled with the MCO. The State will continue to reimburse the billing provider directly for these services on a FFS basis. The State may consider the use of specialized carve-outs in the future.

Medical Service	Definition	Scope of Benefits	Limitation on Services
Early Intervention Services for Children Ages Three (3) Years and Under	Early intervention services provided to children ages three (3) and under through the Birth to Three (3) program.	Services provided by enrolled Birth to age three (3) providers.	N/A
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Community based services for the mentally retarded and those with related conditions.	Services provided both in and out of a group living facility which include but are not limited to: physician services, nursing services, dental, vision, hearing, laboratory, dietary, recreational, social services, psychological services, habilitation, and active treatment.	Services are provided based on a plan of care developed by an interdisciplinary team headed by a physician. Enrollee must be certified as needing ICF/MR level of care by physician and psychologist. Limited to the first thirty (30) days.
Nursing Facility Services	Facility based nursing services to those who require twenty-four (24)-hour nursing level of care.	Full range of nursing, social services, and therapies.	Not covered.

Medical Service	Definition	Scope of Benefits	Limitation on Services
Personal Care Services	Medically Necessary activities or tasks ordered by a physician, which are implemented according to a Nursing Plan of Care developed and supervised by a registered nurse. These services enable people to meet their physical needs and be treated by their physicians as outpatients, rather than on an inpatient or institutional basis.	Services include those activities related to personal hygiene, dressing, feeding, nutrition, environmental support functions, and health-related tasks.	Room and board services, services which have not been certified by a physician on a Personal Care Medical Eligibility Assessment (PCMEA) or are not in the approved plan of Medically Necessary care developed by the registered nurse, hours that exceed the sixty (60) hours PMPM limitation that have not been prior authorized, services provided by an enrollee's spouse or parents of a minor child, and supervision that is considered normal childcare.
Personal Care for Individuals Enrolled in the Aged/Disabled Waiver	Community care program for elderly.	Assistance with activities of daily living in a community living arrangement. Grooming, hygiene, nutrition, non-technical physical assistance, and environmental.	Limited on a per unit per month basis. Physicians order and nursing plan of care is required.

Medical Service	Definition	Scope of Benefits	Limitation on Services
Prescription Drugs	Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance.	Prescription drugs dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children to age twenty-one (21), and prenatal vitamins.	Not Covered: Drugs for weight gain, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Hemophilia blood factors are covered by FFS. Drugs and supplies dispensed by a physician acquired by the physician at no cost are not covered. Hemophilia-related clotting factor drugs and Hepatitis-C virus-related drugs are covered by FFS.
School-based Services	Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting.	Services provided in a school-based setting.	Limited to individuals under age twenty-one (21). Refer to the FFS Medicaid provider manuals for an explanation of service limitations.
Organ Transplant Services	Transplantation of organs and tissues	Organ transplant services are covered when considered generally safe, effective, and when no alternative medical treatment as recognized by the medical community is available. The transplant must be utilized for the management of disease as a recognized standard treatment in the medical community and must not be of an investigational or research nature and must be used for end-stage diseases, not as prophylactic treatment.	Corneal and stem cell transplant services are covered under managed care, not FFS.

Medical Service	Definition	Scope of Benefits	Limitation on Services
Transportation, Non-emergency	Routine medical transportation to and from Medicaid/WVCHIP covered scheduled medical appointments.	Includes transportation via multi-passenger van services and common carriers such as public railways, buses, cabs, airlines, and private vehicle transportation by individuals. Ambulance services as appropriate.	Prior authorization by BMS is required for multi-passenger van services. Prior authorization by county DoHS staff is required for transportation by common carriers. Prior authorization by BMS may be required for non-emergency ambulance transportation.
Tubal Ligation	Family planning service provided to individuals of childbearing age to permanently prevent pregnancy.	In accordance with West Virginia Code § 9-5-12(d), the Department of Human Services shall make payment for tubal ligation without requiring at least thirty (30) days between the date of informed consent and the date of the tubal ligation procedure.	Any licensed doctor providing these services must be compliant with the Federal Social Security Act 42 CFR §441, Subpart F – Sterilizations, §441.255 and §441.256 requirements, which requires informed consent and medical necessity.
Opioid Treatment Program services under the Substance Use Disorder (SUD) Services 1115 waiver	Physician-supervised daily or several times weekly opioid agonist medication and counseling services provided to maintain multidimensional stability to those with severe opioid use disorder.	Comprehensive opioid MAT program including medication, treatment services and laboratory services.	Must be provided in a BMS-licensed methadone clinic and in accordance with ASAM® criteria.

Abortion Services

Effective January 1, 2026, termination of pregnancies will be managed via HHO WV. These services will require prior authorization.

West Virginia 1915(c) Waiver Programs

The following services are excluded from the MCO's capitation rates and will be provided under separate waivers:

Medical Service	Definition	Scope of Benefits	Limitation on Services
Aged/Disabled Waiver	Community based services for aged/disabled as an alternative to nursing facility care.	Nursing care, transportation, and homemaker services.	May not be provided in a hospital, nursing facility, or ICF/MR. Cost of service must be less than nursing facility care.
Intellectual and Developmental Disability Waiver	Community based services for mentally retarded/ developmentally disabled individuals as an alternative to ICF/IDD level of care.	Day and residential habilitation (aggressive active treatment), respite, transportation, and case management.	May not be provided in a hospital, nursing facility, or ICF/MR. Cost of service must be less than nursing facility care.

HealthEdge Software, Inc. is a separate company that provides the GuidingCare® authorization software and portal.

HealthHelp is a separate company that offers education and guidance from specialists in sleep, cardiology, radiation oncology, physical medicine, diagnostic imaging, and musculoskeletal and interventional pain management for Highmark Health Options.

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