Highmark Health Options Duals West Virginia

2026 Medicare Provider Manual



HIGHMARK

Please visit **highmark.com/health-options-wv/duals**

For inquiries, please call Provider Services at **1-833-957-0025**.

Table of Contents

Quick Reference **8**

Important Phone Numbers for Highmark Health Options Duals **8**

Helpful Telephone Numbers **11**

Important Addresses **13**

Plan Copayments **17**

Introduction **18**

About This Manual **18**

Overview of Highmark Health Options Duals **18**

About Us 18

Philosophy and Social Determinants of Health 19

History 19

Mission 21

Products 21

Enhanced Benefits for 2026 22

Continuing Quality Care 24

Wellness & Preventive Health 24

Health Care Disparities 25

Community Involvement 26

Benefits of Highmark Health Options Duals 26

How Does Highmark Health Options Duals Work? **27**

Highmark Health Options Duals Medicare Provider Network 27

Provider Self-Service 27

Provider Relations Role 28

Primary Care Practitioner's Role 28

Contracts/No Gag Clause **29**

Quality Improvement **30**

Purpose of the Quality Improvement Program 30

Goals of the Quality Improvement Program 31

Objectives of the Quality Improvement Program 32

Scope of the Quality Improvement Program 32

Clinical Practice Guidelines 35

Patient Safety 36

Reportable Conditions 37

Medical Record Reviews **38**

Potential Preventable Serious Adverse Events/ Hospital Acquired Conditions and Never Events **39**

Living Will Declaration Advance Directives **40**
Member Outreach **40**
Provider Engagement Team (PET) **41**
Highmark Health Options Duals Practitioner Excellence (HHOPE) Program **41**
Highmark Health Options Duals Practitioner Excellence Provider Performance Reporting **41**

Member **42**
Enrollment Eligibility **42**
Health Care Options **42**
Dual Eligible Special Needs Plans 42
Dual Eligible Categories 42
The Enrollment/Disenrollment Process **43**
Member ID Cards **44**
Determining Eligibility **45**
Primary Care Practitioner's Role in Determining Eligibility **46**
Benefits **46**
Medical Benefits 46
Evidence of Coverage 47
Care Management Programs 47
General Medicare Exclusions 48
Prescription Drug Benefits 49
Prescription Drug Coverage Formulary 49
Copayments/Coinsurance 50
Prescription Benefit Design 50
Drugs Covered 50
Drug Exclusions 50
Members' Rights and Responsibilities **52**
Member Satisfaction **54**

Coverage Arrangements **55**
Locum Tenens 55

Primary Care Practitioner **56**
Verifying Eligibility **56**
Primary Care Practitioner (PCP) Selection **56**
Encounters **57**
Accurate Submission of Encounter Data 57
Transfer of Non-Compliant Members **58**
Transfer of Medical Records **58**
Telehealth **59**

Specialty Care Practitioner 60
Verifying Eligibility 60
Coordination of Care 60
Emergency Services 60
Transfer of Medical Records 61
Telehealth 61

OB/GYN Services 62
Verifying Eligibility 62
General Information 62
West Virginia Prenatal Risk Screening Instrument (PRSI) 62
Diagnostic Testing 63
Telehealth 63

Behavioral Health Services 64
Verifying Eligibility 64
Authorizations and Referrals 64
Inpatient Services 64
Outpatient Services 64
Substance Use Disorder (SUD) Services 65
Medical Necessity 65
Crisis Resources 65
Telehealth 66
Substance Use Disorder (SUD) Services 66
Opioid Treatment Programs (OTPs) 66
WV State Opioid Response (SOR) 67
Additional Resources for Substance Use Disorder (SUD) Treatment 67
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Billing Guide 68

Hospital Services 69
Inpatient Admissions 69
Emergency Room 70
Ambulance Services 70
DRG Post-Payment Audits 72
Technical Denials 73
Accessibility to Care (Appointment Standards) 74

Policies and Procedures 75
Policy Changes 75
Practitioner Education and Sanctioning 75
Practitioner Due Process 76

Title VI of the Civil Rights Act of 1964 ..... **77**
Section 1557 of the Affordable Care Act of 2010 ..... **77**
Access and Interpreters for Members with Disabilities **77**
Confidentiality **77**
Fraud, Waste and Abuse (FWA) **78**
Fraud, Waste and Abuse Recovery Requirements 81
Fraud, Waste and Abuse Audits 84
Overpayments **85**
Provider Self-Audit (Self-Identified Overpayment) 85
TRENDSubmit: Provider Self-Reporting Process 86
Medical Record Requests and Standards 86
Environmental Assessment Standards **90**
Provider Changes **94**
FQHC/RHC Provider Changes Process **94**
CMS Guidance on Medicare Marketing Activities **95**
Provider Complaints **97**
Continuity and Coordinations of Care **98**

Referrals and Authorizations 99

Referrals **99**
Out of Plan Referrals 99
Referrals for Second Opinions 99
Self-Referral 99
Authorizations **100**
Process for Requesting Prior Authorizations 102
Outpatient Therapy Services 104
Durable Medical Equipment 104
Services Requiring Authorization 105
Prior Authorization Decision Timeframes and Notification 106
Home Infusion 107
Pharmacy Services 107
Managing Care Transitions **108**
New Technology **109**

Claims and Billing 110

Member Billing Policy **110**
Claims **110**
General Information 110
Timely Filing 112
Electronic Claims Submission 112

Requirements for Submitting Claims to Highmark Health Options Duals Through a Clearinghouse 113
HIPAA 5010 113
Claim Payments (Electronic Remittance Advice/Electronic Funds Transfer) 114
Claims Review Process 114
Cotiviti Claims Pattern Review (CPR) 115
Cotiviti Claims Pattern Review Appeals Process 115
Coordination of Benefits 116
Claim Coding Software 117
Billing 118
Billing Procedures 118
NPI 119
Surgical Procedure Services 120
Anesthesia Services 121
Hospital Services 121
UB-04 Data Elements for Submission of Paper Claim Forms 121
CMS-1500 Data Elements for Submission of Paper Claim Forms 125

Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC) 128
Overview 128
Encounter Definition 128
Prospective Payment System (PPS) Methodology for Medicare 129
Multiple Encounter Submission 129
Timely Filing 130

Appeals and Grievances 132
Introduction 132
What Are Appeals and Grievances? 132
Acting as an Authorized Representative 133
Appeals Regarding Hospital Discharge 134
Skilled Nursing Facility (SNF), Home Health (HHA), or Comprehensive Outpatient Rehbilitation Facility (CORF) Services 135
Quality Improvement Organization (QIO) Review 135
Appeals for Coverage of Other Medical Services 136
IRE Review 138
Administrative Law Judge Review 138
Medicare Appeals Council 139
Federal Court 139
Appeals for Coverage of PArt D Drugs 139
Independent Review Entity (IRE) 141
Administrative Law Judge (ALJ) Review 142

Medicare Appeals Council **142**
Federal Court **143**
Amount in Controversy, Federal Minimum Requirements for Filing **143**
Member Grievances **143**
Grievances 145
Expedited Grievances 145
Quality Improvement Organization Review **145**
How to File a Quality-of-Care Complaint with the QIO 146
Clinical Provider Appeals **146**
Clinical Provider Appeal Process 147

Model of Care 148
Overview **148**
Provider Network 148
Common MOC Terms and Definitions **150**
Other Important Information About Our Model of Care **151**

Preventive Health, Disease, and Care Management 152
Preventive Health Program **152**
Disease Management Programs **152**
Care Management General Information **153**
Core Components of Care Coordinations **153**
Responsibilities of Care Coordination **153**
Referrals to Care Coordination **154**
Transitions from Hospital to Home **154**
Provider Referrals to Disease Management and Care Management Programs **155**

Introduction to Credentialing 156
Who is Credentialed? **156**
Purpose of Credentialing **156**
Credentialing Standards **156**
Ongoing and Performance Monitoring **158**
Practitioner Absences **159**
Denial and Termination **159**
Delegated Credentialing **160**

Quick Reference

Important Phone Numbers for Highmark Health Options Duals

Call Type	Department/ Area	Contact Information	Hours of Operation
Claims Inquiry	Provider Services	**1-833-957-0025**	8 a.m.–5 p.m. Monday–Friday
Authorization Medical/Post Acute and Behavioral Health	Utilization Management	**1-833-957-0025** (use the portal for fastest result)	8:30 a.m.–4:30 p.m. Monday–Friday Calls received during non-business hours are referred to: **1-833-957-0025**
Authorizations for cardiology, physical, occupational and speech therapy, musculoskeletal surgery, interventional pain management procedures, and advanced outpatient imaging, which includes: CT/CTA, MRI/MRA/ MRS, PET scans, myocardial perfusion imaging, and stress echocardiography	HealthHelp	Phone: **1-888-209-2763** (use the portal for fastest result)	8 a.m.–8 p.m. Monday–Friday Website is available 24 hours a day, seven days a week

Continues on the next page

Call Type	Department/ Area	Contact Information	Hours of Operation
Authorizations for sleep studies and radiation oncology services	HealthHelp	Ordering providers can request an authorization using the following methods: Phone: **1-888-209-2763** (use the portal for fastest result)	8 a.m.–6 p.m. Monday–Friday After-hour requests may be submitted via the web portal.
Member Eligibility	Interactive Voice Response System (IVR) Member Eligibility Line	**1-833-957-0025**	24 hours a day seven days a week
Requests for Non-Formulary Drugs and Prior Authorizations	Pharmacy Services	**1-833-957-0025** **Electronic prior authorizations at CoverMyMeds.com** Our searchable drug formulary and prior authorization forms are available at **highmark.com/health-options-wv**	8 a.m.–8 p.m. Monday–Friday Voicemail inbox is monitored 24 hours a day, seven days a week for after-hour requests.
Expedited Redetermination	Part D Prescriber Appeals	**1-800-213-7083**	Voicemail inbox is monitored 24 hours a day, seven days a week for requests and status of redetermination requests.

Continues on the next page

Call Type	Department/ Area	Contact Information	Hours of Operation
Care Coordination	Care Coordination	**1-833-957-0025**	8:30 a.m.–4:30 p.m. Monday–Friday
Member Outreach	Preventive Health	Phone: **1-833-957-0025** Fax: **1-833-559-2849**	8:30 a.m.–4:30 p.m. Monday–Friday
Member Complaints/ Concerns/Inquiries	Member Services	**1-833-957-0025**	8 a.m.–8 p.m. Monday–Friday
Fraud, Waste and Abuse Concerns/ Inquiries	Fraud, Waste and Abuse	**1-844-718-6400**	24 hours a day seven days a week
Integrity and Compliance Concerns	Compliance	**1-844-718-6400** **integrity@highmarkhealth.org**	24 hours a day seven days a week
General Privacy/ Legal Concerns	Privacy	**privacy@highmarkhealth.org**	24 hours a day seven days a week
Report Suspected Privacy Breaches	Integrated Risk and Privacy Operations (IRO)	**integratedriskandprivacyops@ highmarkhealth.org**	24 hours a day seven days a week

Helpful Telephone Numbers

Call Type	Contact Information	Hours of Operation
Highmark Health Options Duals TTY/TDD Provides assistance with hearing impaired	**1-833-957-0025 (TTY: 711)**	8 a.m.–5 p.m. Monday–Friday
Practice Change Information	Fax: **1-855-451-6680** **wv.highmarkhealthoptions.com/providers/**	24 hours a day seven days a week
VSP Provider Servicing	**1-800-615-1883**	9 a.m.–8 p.m. Monday–Saturday
United Concordia Government Business Operations (Provider Services)	**1-844-789-1722**	8 a.m.–5 p.m. Monday–Friday
TruHearing Provider Support	**1-866-581-9462**	8 a.m.–8 p.m. Monday–Friday
Fitness	**1-833-423-4632**	8 a.m.–8 p.m. Monday–Friday
Transportation Services	**1-833-623-2630**	8 a.m.–5 p.m. Monday–Friday 9 a.m.–1 p.m. Saturday
Nurse Line Members can contact the nurse line if they are unable to reach their doctor	**1-833-957-0025 (TTY: 711)**	24 hours a day seven days a week

Continues on the next page

Call Type	Contact Information	Hours of Operation
Service Coordination Members can contact the Service Coordination Team if they need help with scheduling appointments, coordination of care, transportation, or completing their Health Risk Assessment.	**1-855-845-6216**	8:30 a.m.–4 p.m. Monday–Friday
Flex Card If a member qualifies for SSBCI, they will receive dollars to purchase Healthy Food, OTC, Bathroom, Home and Safety Items, Utilities, and Pay at the Pump Gasoline. If a member does not qualify for SSBCI, they will receive dollars to purchase OTC and Bathroom, Home and Safety Items.	**1-833-623-2619**	8 a.m.–8 p.m. Monday–Friday

Important Addresses

Highmark Health Options Duals Medicaid/Medicare Mailing Address List

Important Note:

To ensure your correspondence reaches the intended department, all mailing addresses MUST include the appropriate Delivery Code and Attention Line.

Corporate Office:

Delivery Code
Attention: Highmark Health Options Duals
614 Market St.
Parkersburg, WV 26101

FedEx & UPS Packages:

All FedEx & UPS packages must be sent to the Corporate Office address along with the appropriate Delivery Code and Attention line.

Reason for Mailing:	Mailing Address:
Claims – Highmark Health Options Medical Medicaid Payer ID – RP118	Attention: Claims Administrator PO Box 211349 Eagan, MN 55121 When submitting claims, please note the West Virginia Payer ID Number is RP118. Any claim submitted to the wrong address or with an incorrect Payer ID Number will reject.
Claims – Highmark Health Options Duals WV Medical and Behavioral Health Medicare Payer ID – 88831	Attention: Claims Administrator PO Box 21871 Eagan, MN 55121-0871 When submitting claims, please note the West Virginia Payer ID Number is 88831. Any claim submitted to the wrong address or with an incorrect Payer ID Number will reject.

Continues on the next page

Reason for Mailing:	Mailing Address:
Administrative Claims Reviews	Delivery Code: WC-CLAIMS Attention: Claims Department Highmark Health Options Duals WV PO Box 1749 Parkersburg, WV 26102
Clinical Provider Appeals Fax to **1-833-623-2571** (Preferred submission method)	Attention: Appeals and Grievances Highmark Health Options Duals WV PO Box 890416 Camp Hill, PA 17089-0416
Credentialing	Delivery Code: WC-CRED Attention: Credentialing Highmark Health Options Duals WV PO Box 535191 Pittsburgh, PA 15253-5191
Dental Claims	Attention: Claims United Concordia Dental PO Box 69455 Harrisburg, PA 17106-9455
Member Appeals & Grievances	Attention: Appeals & Grievances Highmark Health Options Duals WV PO Box 890416 Camp Hill, PA 17089-0416
Member Enrollment/Disenrollment	Delivery Code: WC-ENROLL Attention: Enrollment Highmark Health Options Duals WV PO Box 890032 Camp Hill, PA 17089-0032

Continues on the next page

Reason for Mailing:	Mailing Address:
Member Transfers	Delivery Code: WC-ENROLL Attention: Enrollment Highmark Health Options Duals WV PO Box 890032 Camp Hill, PA 17089-0032
Overpayments Self-Audit/Overpayment Form can be submitted through the Provider Portal via Navinet	**For Claim Retraction, mail Overpayment Form to:** Delivery Code: FIPR Attention: FWA/SIU Unit Highmark Health Options Duals WV 120 Fifth Ave. Pittsburgh, PA 15222 **For Checks, mail Checks with Form to:** Highmark Health Options Duals WV Attn: FIPR PO Box 890387 Camp Hill, PA 17089
Pharmacy and Therapeutics (P&T) Committee	Delivery Code: WC-PHARM Attention: Pharmacy Services Highmark Health Options Duals WV PO Box 22158 Pittsburgh, PA 15222
Practice Change Information Fax to **1-855-451-6680** (Preferred submission method) FQHC/RHC providers submit their changes to: **FQHC_RHC_RosterUpdates@highmark.com**	Delivery Code: WC-PDM Attention: Provider Data Management Highmark Health Options Duals WV PO Box 2500 Parkersburg, WV 26102

Continues on the next page

Reason for Mailing:	Mailing Address:
Prescription Drug Claims	Attention: Reimbursements Administrator Highmark Health Options Duals WV P.O. Box 890419 Camp Hill, PA 17089-0419
Quality of Care Correspondence Preferred method of communication: **Quality_of_Care** Fax to **1-855-878-4168**	Delivery Code: WC-QCARE Attention: Quality of Care Highmark Health Options Duals WV 120 Fifth Ave. Pittsburgh, PA 15222
Retrospective Authorization Reviews	Attention: Retrospective Reviews Highmark Health Options Duals WV PO Box 890416 Camp Hill, PA 17089-0417
Subrogation (COB)	Delivery Code: WC-ENROLL Attention: Enrollment Highmark Health Options Duals WV PO Box 890032 Camp Hill, PA, 17089-0032
VSP Vision Claims	**In Network** Vision Service Plan Attention: Claim Services PO Box 495907 Cincinnati, OH 45249-5907 **Out of Network and Retail** Vision Service Plan Attention: Claim Services PO Box 495918 Cincinnati, OH 45249-5918

Plan Copayments

A member's out-of-pocket expense or cost sharing will vary depending upon the level of assistance they may be receiving from the State or Medicaid, as well as which Highmark Health Options Duals plan they have chosen to join. For more benefit information, please refer to the Evidence of Coverage booklet for each health care option located on our website at **highmark.com/health-options-wv/duals**.

For your convenience, copays for frequently used services are listed here:

Dual Eligible Special Needs Plan (D-SNP)	Copayment		
	PCP	Specialist	ER
Highmark Health Options Duals	$0	$0	$0**

**Not covered outside the U.S. except under limited circumstances.

Please note: All members enrolled in Highmark Health Options Duals who also have Medicaid (Medical Assistance) receive some assistance from the State. Some members will be eligible for Medicaid coverage to pay for cost sharing (deductibles, copayments, and coinsurance). They may also have coverage for Medicaid covered services, depending on their level of Medicaid eligibility. Please follow Medicaid coverage and claims processing guidelines. Please contact Highmark Health Options Duals Provider Services for member specific information.

Highmark Health Options Duals dually eligible members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for the cost-sharing.

Providers further agree that upon payment from our company under the Highmark Health Options Duals line of business, providers will accept our plan payment as payment in full; or bill the appropriate state source. Please make sure to follow Medicaid coverage and claims processing guidelines. Balance billing a dual eligible for deductible, coinsurance, and copayments is prohibited by federal law.

Introduction

About This Manual

Our successes, measured by member and provider satisfaction and assessments by the Centers for Medicare and Medicaid Services (CMS), are dependent upon a strong understanding of Highmark Health Options Duals' policies and procedures. The entire Highmark Health Options Duals team is committed to providing accurate, timely, and comprehensive information to our member and provider communities through prompt and dedicated service. This Provider Manual is one way of sharing information with participating practitioner offices, hospitals, and ancillary providers and is considered part of your contractual agreement with us. This manual is a reference and is designed to be updated as needed. Please retain all updates with your manual.

This manual and any updates are available in the Providers section of our website at **wv.highmarkhealthoptions.com/providers/** under Resources.

Overview of Highmark Health Options Duals

About Us

We believe in caring for the whole person in all communities where the need is greatest. We see a future in which everyone has equal opportunity to achieve their best health. Through our leading Medicaid and Medicare programs, we coordinate health care that goes beyond doctors and medicine to help members achieve not just physical health but also deliver whole person care. Our team members are helping to drive this new kind of health care in collaboration with a competitive network of primary care physicians, specialists, hospitals, and other ancillary providers. We are also committed to supporting our neighbors through our many community outreach and engagement programs.

Highmark Health Options Duals offers HMO plans with a Medicare contract. Enrollment in these plans depends on contract renewal. Every year, Medicare evaluates plans based on a five-star rating system. Highmark Health Options Duals complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age. Highmark Health Options Duals does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Philosophy and Social Determinants of Health

We are fully committed to addressing social determinants of health (SDoH), which refers to the conditions in which people are born, grow, live, work, and age.

We offer a wide variety of programs and demonstrations focused on delivering whole person care and addressing SDoH for our members. Many of these initiatives are available by member referral through our care management program.

Highmark Health Options Duals' Community Support Tool, a free support resource tool supported by the "Find Help" platform, is a way to quickly and easily search for community support resources online. Users can find food, housing, and transportation resources. They can also search for employment and mental health support programs.

History

Highmark Health Options West Virginia is the State's newest managed care organization (MCO) and first-ever Blue Cross Blue Shield-branded MCO to serve West Virginians. It officially launched statewide August 1, 2024. With members in every county, HHO WV is the State's fastest growing MCO with nearly 15,000 members.

Highmark Health Options helps each of its members receive the care and services they need to live healthier and more independent lives. We collaborate with providers and regulators to improve health outcomes, simplify the health care experience, and ensure affordability. Highmark Health Options West Virginia members include individuals and families with low income or complex health and social needs, expectant mothers, children, and people with disabilities.

In 2024, Highmark Health Options introduced an innovative social care network in collaboration with frontline nonprofits and community organizations to address critical health care issues such as food, housing insecurity and education.

This year, we are launching a Medicare product geared toward the unique needs of individuals eligible for both Medicare and Medicaid. Highmark Health Options Duals is a Dual Eligible Special Needs Plan (D-SNP) with a Medicare Contract and a contract with the state Medicaid Plan.

As of 2026, Highmark Health Options Duals operates in 18 counties in West Virginia. See map of Medicare covered counties on the next page.

Medicare Covered Counties: (counties that are in dark blue)



For individuals who qualify, there is no, or a low, monthly premium (depending on their level of Medicaid eligibility). Qualifying members receive health care coverage, plus prescription drug coverage, dental, vision, hearing services, fitness center membership, and much more–all from ONE plan!

Mission

Our mission is to care for the whole person in all communities where the need is the greatest.

Products

We offer a Dual Eligible Special Needs Plan (D-SNP), serving those with Medicare Parts A and B, among other qualifying factors.

The plan is:

Highmark Health Options Duals: for those with full Medical Assistance such as FBDE, QMB, QMB+, or SLMB+.

Highmark Health Options Duals offers a variety of benefits to members enrolled in the D-SNP plan:

1. All the benefits of original Medicare.
2. Flex card with a combined allowance for over-the-counter (OTC) products and home and bathroom safety items. SSBCI eligible members will receive an additional allowance for healthy food, utilities, and pay-at-the-pump gasoline.
3. Transportation for health related needs.
4. Prescription drug coverage including Step Therapy.
5. Hearing exams and hearing aids.
6. Preventive and comprehensive dental services, including dentures.
7. Vision exams and eyewear.
8. Case Management programs to help with disease prevention and smoking/tobacco cessation (including additional visits per attempt).
9. A fitness program to help members stay active (including options for home-bound members).
10. Mental health services.
11. Post discharge meals.
12. Personal Emergency Response System.
13. Health and Wellness education.

Enhanced Benefits for 2026

Flex Card

SSBCI Qualified Members receive $235 per month combined allowance for OTC, Home/Bathroom Safety, Healthy Food (SSBCI), and Utility (SSBCI). Members can use the allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Members qualified for SSBCI will also be allowed to purchase gasoline at the pump. Unused allowances expire at the end of the month. Fees and plan restrictions apply.

Non-SSBCI Members receive $50 per month combined allowance for OTC and Home/Bathroom Safety. Members can use the allowance to purchase OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the month. Fees and plan restrictions apply.

Dental Benefits:

- $2,500 in combined allowance for Preventive & Comprehensive services.
- Any combination of routine prophylaxis and periodontal maintenance, including perioprophy, totaling four treatments per year.
- Two endodontic services per year.
- Crowns limited to two per year, one crown in five years per tooth.
- Dentures are covered, one per arch every year including a full or partial denture or an immediate denture and repairs.

Vision Benefit (VSP):

- $200 per year for eyeglass frames or contact lenses.
  - One pair of lenses and frames or contact lenses each year.
  - Lens types covered in full: single vision, lined bifocals, lined trifocals, and lenticular.

Hearing Aid Benefit (TruHearing):

- One TruHearing-branded hearing aid per ear, every three years.
- One year of follow-up visits for fitting and adjustments included.
- Limited to TruHearing's advanced and premium hearing aids, a rechargeable option is available.
- 80 batteries per aid for non-rechargeable models.



To learn more, members can call **1-833-957-0025 (TTY: 711)**, Monday–Friday, 8:30 a.m.–5 p.m.

Highmark Health Options Duals is dedicated to providing benefits to the Medicare and Medicaid populations to meet their medical and social needs. The specific needs of our membership have led to the development of wellness, education, and outreach programs. These programs identify needs and provide effective case management for members with chronic conditions such as asthma, COPD, diabetes, and cardiovascular conditions.

Continuing Quality Care

Health care is an ever-changing field, and we strive to stay on top of the members' needs. We are committed to continually improving and providing high standards of quality in every aspect of service. This commitment is led by the Highmark Quality Improvement/Utilization Management Committee, made up of experts in a wide variety of medical fields. The QI/UM Committee evaluates our ongoing efforts as well as new protocols and quality initiatives in order to improve service and care for members.

Wellness & Preventive Health

Highmark Health Options Duals is committed to improving the life of its membership and is working to find new ways to promote wellness, illness prevention and health education as demonstrated by the following:

- Preventive health care
  - Annual Flu Vaccinations for Adults
  - Annual Wellness Visit
  - Breast Cancer Screening (Women ages 40–74 years)
  - Colorectal Cancer Screening (ages 45–75 years)
  - Diabetes tests as needed, such as HbA1c, dilated retinal eye exam, and microalbumin (members with diabetes)
  - Prenatal and Postpartum care
  - Controlling high blood pressure
  - COVID-19 Vaccination (For eligible population)
- Tobacco cessation education and benefits
- Adult immunization reminders

Health Care Disparities

We understand that in order to help improve our members' quality of life, we must take in to account racial, ethnic, cultural, and linguistic differences as well as sexual orientation and gender identity. For this reason, addressing inequities is high on our leadership's agenda. Highmark has an Excellent Health Outcomes for All Program whose activities are overseen by the Committee for Equitable Health care (HEC). The HEC's primary objective is to address health care disparities for its diverse membership and ensure that services are accessible and provided in a culturally, linguistically, and inclusively competent manner. Highmark's commitment is demonstrated by designing the Excellent Health Outcomes for all Program to follow NCQA's Best Practice framework, which is a voluntary process where organizations commit to providing impartial care to all patients, regardless of their race, ethnicity, socioeconomic status, or other factors by focusing on identifying and addressing health care disparities through data collection, cultural competency, and targeted interventions. 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, linguistic, geographic, and/or personal identity barriers.

In an effort to develop a strong patient-provider relationship, we ask our providers to share their race, ethnicity, and language information via the company's Cultural Competency Data Form. Disclosing this information is strictly voluntary and will not be used for credentialing, contracting or for any discriminatory purposes. The availability of this information allows us to connect members with the appropriate practitioners, to fit their needs and preferences. This allows our providers to foster better provider-patient communication, and improve patients' health, wellness, and safety.

Additionally, we are encouraging all providers to take cultural competency training and to inform us about the various trainings taken by providers and their office staff throughout the year. Providers can access the Cultural Competency Data Form on our website at **wv.highmarkhealthoptions.com/providers/**.

We also have cross-cultural education programs in place to increase awareness of racial and ethnic disparities in health care among our associates, members, and providers. A provider cultural toolkit is available on our website at **wv.highmarkhealthoptions.com/providers/**.

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 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, web-based modules for physicians to practice responding to situations where culturally competent care is needed, and more.

Lastly, we assess our member populations' language profile at least every three years and make the Population Assessment Language Profile report available to practitioners through updates to Provider News.

Community Involvement

Highmark Health Options Duals is an active partner in the community through:

- Participation in community events and sponsorships.
- Assisting community and social services agencies that serve high-risk populations.
- Developing outreach programs at no cost to the community for adults and children to educate them about health, wellness, and safety issues.
- Promoting our health literacy initiative with individuals and organizations in the communities we serve. The goal of this initiative is to help people better understand and navigate the health care system.

Benefits of Highmark Health Options Duals

Highmark Health Options Duals is a "win-win" situation for all involved. Members receive improved access to primary medical care and health and wellness programs. Providers receive timely payments, simplified administrative procedures and dedicated provider servicing. We fulfill our mission and ensure the availability of high-quality medical care for the dual eligible population to positively affect the personal health of individuals.



How Does Highmark Health Options Duals Work?

Highmark Health Options Duals Medicare Provider Network

We contract directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide care for our membership. Our provider network consists of primary care, specialist practitioners, behavioral health providers, hospitals, ancillary locations, a network of pharmacies, 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 our members in their offices the same as they treat patients from any other health plan and agree not to discriminate in the treatment of or in the quality of services delivered to our members on the basis of race, color, national origin, religious creed, sex, sexual orientation, gender identify, disability, English proficiency, age, place of residence, health status, or source payment. Because of the cultural diversity of our membership, participating providers must be culturally sensitive to the needs of our members. Participation in no way precludes participation in any other program with which the provider may be affiliated.

Provider Self-Service

NaviNet is a web-based solution that securely links 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.

We encourage 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 a 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.
- GuidingCare: Prior authorizations for Inpatient, Outpatient, and Family Planning.
- HealthHelp: Prior authorization requests for Musculoskeletal/Pain Management, Diagnostic Imaging, Cardiology, Sleep, Radiation Oncology, and Physical Medicine.
- Submit Provider Post-Service Appeals.
- Submit Claims and Payment Disputes.

Highmark Health Options Duals Providers must initiate authorization requests online by accessing the Authorization Portal through NaviNet Single Sign-On (SSO) functionality. From the Health Plans dropdown on the NaviNet Plan Central page, select Highmark Health Options Duals then GuidingCare or HealthHelp>Authorization Portal from the Plan Workflows menu.

For additional information regarding GuidingCare, please refer to the GuidingCare User Guide on our website at **wv.highmarkhealthoptions.com/providers/**. For additional information regarding HealthHelp, please refer to the HealthHelp User Guide on our website at **wv.highmarkhealthoptions.com/providers/**.

Provider Relations Role

Highmark Health Options Duals uses dedicated, highly trained Provider Account Liaisons (PALs). We are keenly aware that it is essential our providers and their staff have a solid understanding of the members' needs, our contract requirements, protocols, and federal and/or state regulations in order to provide exceptional access and quality health care to our members. The PALs will provide an initial training orientation 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 company policies and procedures.

All Provider In-Service training materials are located on the Highmark Health Options Duals website at **wv.highmarkhealthoptions.com/providers/**.

The annual provider education and orientation training is available on the Highmark Health Options Duals website at **wv.highmarkhealthoptions.com/providers/**.

Each participating primary care practice, specialty care practice and hospital is assigned to a Provider Account Liaison who is responsible for ongoing education.

As a follow-up to the initial orientation, each assigned Provider Account Liaison regularly contacts providers and their staff to ensure full understanding of the responsibilities outlined in the Provider Agreements and Manual.

Primary Care Practitioner's Role

The definition of a primary care practitioner (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 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 our 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.

Contracts/No Gag Clause

Highmark Health Options Duals allows open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care for the patient. All of our 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 our contracts that prohibits open clinical dialogue between practitioner and patient.



Quality Improvement

Purpose of the Quality Improvement Program

The purpose of the Quality Improvement (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 Highmark 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, Highmark Health Options Duals evaluates its performance outcomes to:

- Provide oversight and governance of the SNP Model of Care (MOC).
- 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:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- Equitable health care and Social Determinants of Health (SDoH)

The QI Program strives to improve member adherence to preventive care guidelines, disease management strategies, and therapies that are essential to the successful management of certain chronic conditions.

The QI Program also strives to improve patient safety through:

- Education of members and providers regarding safe practices.
- 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 these efforts impact all members equally, the QI Program aspires to continually identify opportunities to positively impact health outcomes and address any health care disparities as well as language barriers.

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.

Goals of the Quality Improvement Program

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.

The QI Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the Highmark provider network and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality improvement concepts and appropriately recognized quality measurement tools and reports, Highmark focuses on assessing its performance outcomes to identify any potential gaps and opportunities for improvement in the provision and delivery of health care and health plan services, patient safety, satisfaction with care and services, and achieving optimum member health outcomes.

By considering population demographics, health risks, utilization of health care resources, and financial analysis, the organization 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 management 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 develop programs to assist in managing their conditions.

The QI program includes a focus on members who are considered the most vulnerable and receive coordinated care as defined in the MOC.

Highmark developed five focused plan level goals which are:

1. Improve access and affordability of the health care needs of the population.
2. Improvements made in the coordination of care and appropriate delivery of services.
3. Enhance care transitions across settings and providers.
4. Ensure the appropriate utilization of services for preventive health and chronic conditions.
5. Improve member experience.



Objectives of the Quality Improvement Program

The objectives of the QI Program are consistent with the Highmark mission, which is a commitment to both effective uses of health care resources and to continuous quality improvement in order to positively affect the member's whole care and their health-related social needs (HRSN) and social determinants of Health (SDoH).

Quintuple Aim methodology is utilized to make sure programs focus on patient experience, population health, provider well-being and engagement to reduce costs, improve patient outcomes, and enhance care team collaboration. A core component of the Quintuple Aim is equitable health care which improves the overall health of the member population, patient experiences, promotes provider well-being, and focuses on all members having equal opportunities to access high quality health care services.

Highmark utilizes the Plan, Do, Study, Act methodology to implement the QI Program. The QI team creates an annual program strategy and description (Plan) that is reviewed and accepted through the QI Committee structure. The goals, programs, and objectives outlined in the strategy are tracked through a quarterly QI Program Work Plan (Do). The Work Plan includes performance metrics such as HEDIS measures, survey outcomes, meeting minutes, and other departmental reports. Programs at risk are taken through the QI Committee structure for mitigation and/or root cause analysis. Annually, the QI Program, including those items within the MOC are evaluated through the QI Program Evaluation (Study). The evaluation allows the business areas to identify barriers, mitigations, and opportunities for the upcoming year. Program level changes are made based on the evaluation outcomes (Act).

The objectives of the QI Program are outlined below:

1. Development and implementation of an annual QI work plan to assure completion of planned activities. Current whole care needs of the population are evaluated. Programs are implemented to ensure continuous quality improvement. The Work Plan is updated quarterly and annually to determine effectiveness, to identify opportunities for improvement, and to ensure completion of planned QI activities for each year.
2. The provision of appropriate, timely, and quality health care services.
3. Develop guidelines which address the member population.
4. Assess practitioner performance.

Scope of the Quality Improvement Program

The success of the Quality Improvement Program is directly related to the collaboration of all Highmark employees in support of the Highmark mission. The responsibility of implementing the QI Program is a Highmark corporate responsibility, not only that of the Quality Improvement Department. Implementation and evaluation of the QI Program are embedded in to the Highmark daily operations. 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, HEDIS measures, Star measures, Preventive and Clinical Practice Guidelines and a review of Quality-of-Care concerns such as Preventable Serious Adverse Events (PSAE) and Never Events. Identification of the most prevalent chronic disease/conditions to establish goals with positive health outcomes is conducted with the promotion of the Chronic Care Improvement Program (CCIP). The Chronic Care Improvement Program (CCIP) initiative establishes goals with positive health outcomes by identifying the most prevalent chronic diseases/conditions. Initiatives are designed and implemented to prioritize indicators that have not been achieved or are negatively deviating from goals.

Quality of Service

The QI Program focuses on delivering customer service to the members that is professional, equitable, accessible, available, and meaningful. This is ensured through the monitoring of key indicators including, but not limited to, the demographics of the population, including ethnic and racial disparities in health care and language barriers, the annual CAHPS Member Satisfaction Survey, Member Complaints and Grievances, Provider Appeals, 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, assessing and identifying opportunities to improve patient safety throughout the practitioner/provider network, and 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 initiatives based on the results of the annual CAHPS and Health Outcomes Survey (HOS), Care Management satisfaction survey, and the trending of member inquiries, complaints, appeals and grievances to identify areas of opportunity.

Member Experience is also monitored through the quality and availability of provider services. This is ensured through the monitoring of network primary care physician (PCP) and specialist availability and accessibility, medical record reviews, including documentation standards, the assessment of continuity and coordination of care, and the conducting of an annual Member and Provider Satisfaction Survey.

Model of Care

The Model of Care (MOC) is a vital quality improvement tool and an integral component for ensuring that the unique needs of each beneficiary enrolled in a Medicare Special Needs Plan (SNP) are identified and addressed. The Patient Protection and Affordable Care Act (ACA) reinforces the importance of the MOC as a fundamental component of SNP quality improvement. The National Committee for Quality Assurance (NCQA) executes the review and approval of SNP MOCs based on standards and scoring criteria established by the Centers for Medicare & Medicaid Services (CMS).

Model of Care standards are comprised of four clinical and non-clinical elements:

1. Description of the SNP Population (General Population)
2. Care Coordination
3. Provider Network
4. MOC Quality Performance Improvement Plan.
    - Activities falling within the scope of the Highmark Model of Care are overseen and governed by the Quality Improvement Department by way of updates to the QI Work Plan, the MOC Workgroup, and standup meetings as needed.
    - Quality Improvement is responsible to ensure the goals are set within the MOC and the standards are approved and met by CMS.

Additional activities to fulfill the scope:

- Excellent Health Outcomes for All program identifies and assesses factors that potentially impact the members health, including demographics (e.g., age, sex at birth, ethnicity), gender and sexual identity, and other health disparities (e.g., access to and availability of medical facilities and services, variations in disease occurrences, mortality, language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs or barriers that may interfere with conventional provision of health care or services, caregiver considerations, or other concerns).
- Highmark monitors the Network Availability of primary care and specialty practitioners to ensure an adequate network of practitioners is maintained. Also, practitioners are assessed to ensure the cultural and linguistic needs of its members are met.

- Review of activities falling within the scope of the Highmark Health Options Duals Utilization Management department including monitoring criteria and processes to ensure that appropriate utilization decisions are made as outlined in the Model of Care.
- Oversight to ensure proper credentialing of new practitioners as well as the recredentialing of participating providers, non-physician practitioners, and therapy providers.
- Monitoring and evaluation of the Case Coordination program, which includes Preventive Health, Disease, and Case Management programs.
- Monitoring of activities falling within the scope of Highmark's Pharmacy Department and the Pharmacy and Therapeutics (P&T) Committee.
- Evaluation of patient safety
- Monitoring of activities falling within the scope of the behavioral health care program.
- Collaboration with advanced data analytics and other reporting teams to evaluate the population and determine opportunities for improvement.
- Monitoring of activities by Population Health Management (PHM).

To request a copy of the Quality Improvement Program Description, Work Plan or Annual Evaluation, please contact the Provider Services Department at **1-833-957-0025**.

Clinical Practice Guidelines

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

Clinical practice and preventive guidelines are not meant to replace individual practitioner judgment based upon direct patient contact. The Clinical Practice and Preventive Guidelines are listed within the provider portal at **wv.highmarkhealthoptions.com/providers/guidelines-resources**.

- Adult preventive health (screening, counseling, immunizations)
- Asthma management
- Bipolar disorder
- Cardiac (Elevated cholesterol, chronic heart failure, coronary, and other atherosclerotic vascular disease)
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Healthy weight management
- HIV
- Hypertension
- Opioids, prescribing for chronic pain
- Palliative care
- Prenatal care, routine, and high-risk
- Schizophrenia
- Substance use disorder

A paper copy of the individual guidelines is available upon request.

Patient Safety

Patient safety is the responsibility of every health care professional. Health care errors can occur at any point in the health care delivery system; they can be costly in terms of human life, function, and health care dollars. Then there are the indirect costs of health care errors, such as a loss of trust and patient/practitioner dissatisfaction.

There are ways practitioners can develop a culture of patient safety in their practice. Clear communication is key to safe care. Collaboration between members of the interdisciplinary care team, hospitals, other patient care facilities, and the patient is critical. Safe practices include, but are not limited to, providing instructions to patients in terms they can easily understand, writing legibly when documenting orders or prescribing, and avoiding abbreviations that can be misinterpreted.

Read all communications from specialists and send documentation to other providers, as necessary, to assure continuity and coordination of care. When calling in orders over the telephone, have the person on the other end repeat the information back to you.

Collaborate with hospitals and support their safety culture. Bring patient safety issues to the committees you attend. Report errors to your practice or facility's risk management department. Offer to participate in multidisciplinary work groups dedicated to error reduction. Ask our Quality Improvement Department how you can support compliance with our safety initiatives.

We also work to ensure patient safety by monitoring and addressing quality of care issues identified through several internal and external sources such as: pharmacy, care management, and utilization data, continuity and coordination of care standards, sentinel/adverse event data, disease management program follow-up, fraud waste and abuse investigations, practitioners/providers, delegates, state and/or federal agencies, and member complaints.

If you would like to learn more about patient safety, visit these websites:

- Institute of Medicine Report: To Err is Human-Building a Safer Health Care System: **nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system**
- The Joint Commission National Patient Safety Goals: **jointcommission.org/**
- Institute for Healthcare Improvement: **ihi.org/PatientSafety**
- The Leapfrog Group for Patient Safety: **leapfroggroup.org/**
- Agency for Healthcare Research and Quality: **ahrq.gov/**

Reportable Conditions

Highmark Health Options Duals practitioners are contractually required to follow our QI programs, including, but not limited to, reporting certain diseases, infections, or conditions in accordance with 28 Pa. Code § 27.21a. Highmark Health Options Duals Reportable Conditions Policy, QI-050-MC-ALL, has been established to detail this requirement, and the methods by which practitioners will be notified of its necessity.

To request additional information or to obtain a copy of the Reportable Conditions Policy, please contact our Provider Services Department at **1-800-685-5209**. The regulations, which include the complete list of reportable conditions, can be found via the West Virginia Code website at **code.wvlegislature.gov/**.

Medical Record Reviews

From time to time, we will submit an ad hoc request for medical records. It is imperative that providers in our participating network respond to these requests within 14 business days, with the exception of Quality-of-Care cases which require a response within three business days, as dictated per contractual obligations.

If we request medical records, 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 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).

In addition to providing medical records upon request, providers are required to transfer member medical records, or copies of records, to newly designated PCPs, specialists, or treatment facilities within 14 business days from receipt of the request from DHS, its agent, the member, or the member's new treating practitioner without charging the member.

Highmark Health Options Duals also annually conducts a review of our providers' medical records to ensure compliance with criteria as specified in the Medical Record Review Standards. The standards, which incorporate a core set of critical factors, were developed and approved by our Quality Improvement/Utilization Management Committee and adhere to regulatory requirements as prescribed by the National Committee for Quality Assurance (NCQA), state and federal agencies. These standards can be provided upon request or via the Highmark Health Options Duals website at **wv.highmarkhealthoptions.com/providers/**.

A score of 80% is required to pass the medical record review; standards identified as critical are required to be present. Practitioners whose medical records do not comply may undergo remediation in the form of education and additional reviews. Continued non-compliance could result in possible practitioner sanctioning. Consistent and complete medical records documentation is an essential critical component of ensuring members quality to care. Accurate and concise documentation supports provider communication enhancing the continuity and coordination of care.

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, but not limited to case management review, credentialing/recredentialing activities, claims payment retrospective review, utilization management case review, complaint and grievance review, fraud and abuse investigations, practitioner/providers, delegates, and state and/or federal agencies. Once a potential event has been identified an extensive review is conducted by our company's Quality Improvement and Medical Management Departments. The process includes, when necessary, a medical record review and possible telephonic or mail communication with the practitioner/provider. Once it has been determined if an actual event has been discovered, we will, when necessary, verify if payment denial or retraction needs to take place, and notify the practitioner/provider by mail if that is required. Should you have any questions, please contact the company's Provider Services Department at **1-833-957-0025**.



Living Will Declaration Advance Directives

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 **1-833-957-0025**, or by visiting our website at **wv.highmarkhealthoptions.com/providers/**.

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, age 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.

Member Outreach

Providers can request additional assistance from Highmark Health Options Duals WV Care Coordination to offer further health information and education to members. This support includes explaining the importance of keeping scheduled appointments, living with chronic conditions, adhering to treatment plans, and understanding benefits, services, and available resources.

To refer a member for this educational support, complete the Member Outreach Form available on the Highmark Health Options Duals WV website at **wv.highmarkhealthoptions.com/providers/**. A Highmark Health Options Duals WV representative will contact the member and follow-up with the practitioner as requested or needed. For more information or to request member outreach, please call our Care Coordination Department.

Provider Engagement Team (PET)

The Provider Engagement Team is a dedicated team of Clinical Transformation Consultants who partner with our West Virginia Medicare Providers to improve the overall outcomes of our members. The PET team supports providers in achieving their quality performance goals and offers quality improvement best practices. PET is a strategic partner with our providers in achieving their quality goals. Contact the Highmark Health Options Duals Provider Engagement Team at **HHOWVPET@highmarkhealth.org**.

Highmark Health Options Duals Practitioner Excellence (HHOPE) Program

Highmark Health Options Duals values the role practitioners play in serving our members and improving their health. The Highmark Health Options Duals Practitioner Excellence (HHOPE) program recognizes and rewards performance that demonstrates high quality, accessible, and efficient health care. Practice resources, such as the Highmark Health Options Duals Practitioner Excellence Incentive Program Guide, are provided to educate providers on the program. For more information about the HHOPE program, eligibility, and how to participate, visit the Highmark Health Options Duals website at **wv.highmarkhealthoptions.com/providers/**.

Highmark Health Options Duals Practitioner Excellence Provider Performance Reporting

Highmark Health Options Duals Practitioner Excellence (HHOPE) Provider Performance Reporting is available to providers monthly through the Highmark Health Options Duals Care Gap Management Application (CGMA).

Within the CGMA, providers can:

- View member care gaps.
- Submit evidence for care gap closure.
- View their progress towards closing member care gaps.

The CGMA allows providers to view member-specific numerator compliance for each care gap along with the member-specific opportunities for gaps yet to be closed. The provider reporting allows providers to gauge how they are performing. Please contact the Provider Engagement Team with questions, to request a demo, or to set up a new user.

Member

Enrollment Eligibility

Our Medicare plans are designed to provide more than health care for those who qualify. Highmark Health Options Duals offers medical and prescription drug coverage, and all the benefits of Original Medicare, PLUS more benefits.

Health Care Options

Dual Eligible Special Needs Plans

Highmark Health Options Duals is a Dual Eligible Special Needs Plan, (D-SNP); serving those who have BOTH Medicare Parts A and B and Medicaid (Medical Assistance) or assistance from the State and live within the 18 county West Virginia service area.

Refer to the chart below for eligibility criteria.

Enrollment Criteria	
Must be entitled to Medicare Part A	Yes
Must be enrolled in Medicare Part B	Yes
Medicare eligibility may be due to either disability or age	Yes
Must be eligible for either: full Medicaid FBDE/QMB/QMB plus/ SLMB plus	Yes

Dual Eligible Categories

- **Medicaid only ("Full Dual"):** Individual who is eligible for full Medicaid benefits. Medicaid does not pay out-of-pocket costs for Part D cost-share.
- **Full Benefit Dual Eligible (FBDE):** An FBDE individual is eligible for Medicaid either categorically or through optional coverage groups, such as medically needy or special income levels for institutionalized or home and community-based waivers.
- **QMB only (Qualified Medicare Beneficiary):** Individual who is eligible for Medicaid payment of Medicare Cost-Share (i.e., Medicare Part A and/or Part B coinsurance, deductible, premium). Medicaid does not pay out-of-pocket costs for Part D cost-share.

- **QMB plus (Qualified Medicare Beneficiary):** Individual eligible for full Medicaid benefits and Medicaid payment of Medicare cost-share (i.e., Medicare Part A and/or Part B coinsurance, deductible, premium). Medicaid does not pay for Part D cost-share.
- **SLMB plus (Special Low-Income Medicare Beneficiary):** An Individual eligible for full Medicaid benefits and Medicaid payment of Medicare Part B premium only.

The Enrollment/Disenrollment Process

The Centers for Medicare and Medicaid Services (CMS) has periods when beneficiaries can enroll or dis-enroll with/from Medicare. These times are known as election periods. Please contact or direct the member to contact Highmark Health Options Duals for additional information about election periods.

Members can enroll in our plan by using any of these methods:

- Mailing in a paper enrollment form.
- Enrolling online through Medicare's website.
- Enrolling online through Highmark Health Options Duals' website at **highmark.com/health-options-wv/duals**.
- Downloading an enrollment form from the Highmark Health Options Duals website at **highmark.com/health-options-wv/duals**. Under 2026 Enrollment Forms, click on the appropriate state link to open the enrollment form, download and mail completed forms.
- By calling Highmark Health Options Duals at **1-833-957-0025 (TTY: 711 or 1-833-957-0025)**.
- Working with their sales agent, Members of Special Needs Plans must meet specific eligibility requirements. Highmark Health Options Duals confirms the beneficiary's eligibility during the enrollment process.

For the mailing address, please refer to **Member Enrollment/Disenrollment** under the "Important Addresses" section on page 14.

Members can disenroll from our plan by:

- Sending Highmark Health Options Duals, a written request to disenroll.
- Contacting Highmark Health Options Duals and requesting a disenrollment form be sent to them.
- Contacting Medicare at **1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048** or **medicare.com**.
- By enrolling in a new Medicare health plan.

For additional information, Members should call Highmark Health Options Duals or visit **highmark.com/health-options-wv/duals**.

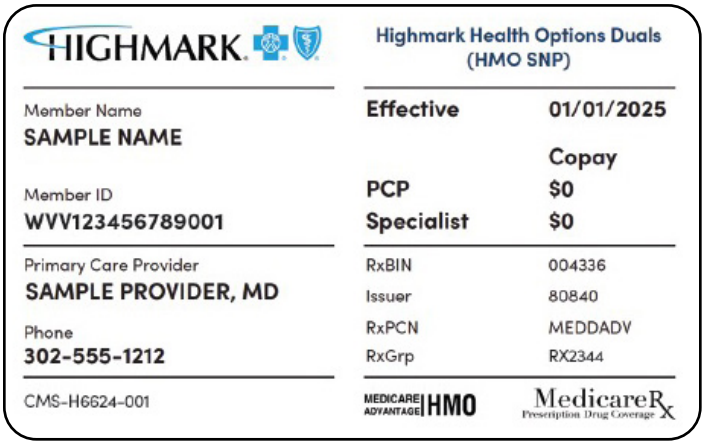
Member enrollments are made effective the first day of the calendar month, and member disenrollments are through the end of the calendar month.

Member ID Cards

Each Highmark Health Options Duals member will receive an ID card. Each card is issued once, unless cards are requested or reissued due to a demographic, PCP, or plan change.

ID Cards are good for as long as the person is a member of Highmark Health Options Duals.

Sample Member ID cards





Determining Eligibility

Because of frequent changes in a member's eligibility, each participating practitioner is responsible for verifying a member's eligibility with Highmark Health Options Duals BEFORE providing services. Verifying a member's eligibility along with requesting the applicable referral or authorization will ensure proper reimbursement for services.

To verify a member's eligibility, the following methods are available to all practitioners:

1. **Highmark Health Options Duals Identification Card:** The card itself does NOT guarantee that a person is currently enrolled in Highmark Health Options Duals. Members are only issued an ID card once upon enrollment, unless the member changes their primary care practitioner, requests a new card or card is reissued due to plan changes such as copayments. Members are NOT required to return their identification cards when they are no longer eligible.
2. **NaviNet:** Providers can verify eligibility/benefits and check claim status via NaviNet. Providers also have the capability to submit certain authorization requests electronically via NaviNet.
3. The Interactive Voice Response System (IVR) is available 24 hours a day, seven days a week at **1-800-642-3515**.
4. To verify member eligibility at each visit, practitioners may contact the plan directly at **1-833-957-0025**. After remaining on the line, press 2 (Provider) to reach:
   - RX Pharmacy Services
   - IVR (Eligibility)
   - Provider Services
   - Utilization Management
   - Credentialing

Note: In an effort to better service our providers, please have your 10-digit NPI or 9-digit tax identification number available.

Providers follow a few simple steps once connected, which are listed below:

Press 1	If you are calling regarding **Retail Pharmacy or Specialty Pharmacy questions**, you will be connected to Pharmacy Services.
Press 2	If you are calling to **Verify Eligibility**, you will be connected to our 24/7 Interactive Voice Response System (IVR).
Press 3	If you are calling regarding Claims, to **Verify Benefits**, on file questions, you will be connected to Provider Service.
Press 4	If you are calling regarding **Authorization Requests**, you will be connected to Utilization Management.
Press 5	If you are calling regarding **Behavioral Utilization Management**, you will be connected to Utilization Management.
Press 6	If you are calling regarding **Credentialing Status**, you will be connected to Credentialing.

Primary Care Practitioner's Role in Determining Eligibility

Primary care practitioners verify eligibility by consulting their panel listing to confirm that the member is a part of the practitioner's panel. The panel list is distributed on or about the first of every month. The primary care practitioner should check the panel list each time a member is seen in the office. If a member's name is on the panel list, the member is eligible with Highmark Health Options Duals for that month. If a member insists that they are effective, but do not appear on the panel list, the provider should call the Provider Services Department for help in determining eligibility at **1-833-957-0025**.

Benefits

Medical Benefits

Highmark Health Options Duals members are eligible for all the benefits covered under the Original (Fee-for-service) Medicare Program. In addition, Highmark Health Options Duals offers additional benefits for dental, vision, hearing, and health and wellness. For a complete list of covered benefits, please refer to the Evidence of Coverage booklet. A complete copy of the Evidence of Coverage booklet for each health care option is located on the Highmark Health Options Duals website at **highmark.com/health-options-wv/duals**.

Members obtain most of their health care services either directly from their primary care practitioner or upon prior authorization (approval in advance) by an in-network specialist/ancillary provider; except for services available on a self-referral basis, such as OB/GYN services and routine vision services. The primary care practitioner is responsible for the coordination of a member's health care needs and access to services provided by hospitals, specialty care practitioners, ancillary providers, and other health care providers as needed.

Evidence of Coverage

The covered services listed in the Evidence of Coverage booklet are covered only when all requirements listed below are met:

- Medicare covered services must be provided according to the coverage guidelines established by CMS.
- Services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of the medical condition and meet accepted standards of medical practice.
- Care is received from a network provider. In most cases, care received from an out-of-network provider will not be covered. Chapter 3 of the Evidence of Coverage booklets provides more information about requirements for using network providers and the situations when Highmark Health Options Duals will cover services from an out-of-network provider.
- A primary care provider (PCP) is providing and overseeing care.

In addition, some services listed in the Benefits Chart (Chapter 4 of Evidence of Coverage booklet) are covered only if the network provider gets approval in advance (sometimes called "prior authorization") from our company. Covered services that need approval in advance are marked in the Benefits Chart by an asterisk.

Care Management Programs

Highmark Health Options Duals WV is committed to supporting our members' health and wellbeing. Highmark Health Options Duals WV strives to help members stay healthy, lead active lives, and improve their quality of life through dedicated programs for complex conditions such as asthma, heart disease, diabetes, chronic obstructive pulmonary disease, congestive heart failure, inflammatory bowel disease, kidney disease, and weight management. Highmark Health Options Duals WV also offers health education and wellness for pregnant members and those seeking smoking cessation support. Our Care Management staff helps with resources, educational information, and self-management planning (specific qualifications apply).

General Medicare Exclusions

In addition to any exclusions or limitations described in the Evidence of Coverage, the following items and services are not covered except as indicated by Highmark Health Options Duals as described under Product offerings:

- Services considered not reasonable and necessary, according to the standards of Original Medicare.
- Experimental medical and surgical procedures, equipment, and medications.
- Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community (may be covered by Original Medicare under a Medicare-approved clinical research study or by Highmark Health Options Duals).
- Private room in a hospital (covered only when medically necessary).
- Personal items in a member's rooms at a hospital or skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in a member's home.
- Custodial care is care provided in a nursing home, hospice, or other facility setting when a member does not require skilled medical care or skilled nursing care.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by a member's immediate relatives or household members.
- Cosmetic surgery or procedures (Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.)
- Routine dental care, such as fillings or dentures. (Routine cleanings may be covered.)
- Non-routine dental care (Dental care required to treat illness or injury may be covered as inpatient or outpatient care.)
- Routine chiropractic care (Manual manipulation of the spine to correct a subluxation is covered.)
- Orthopaedic shoes (unless shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease).
- Supportive devices for the feet (except for orthopaedic or therapeutic shoes for people with diabetic foot disease).
- Routine hearing exams, hearing aids, or exams to fit hearing aids. (Exams to diagnose and treat hearing and balance issues may be covered.)
- Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids. (Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.)

- Reversal of sterilization procedures and/or non-prescription contraceptive supplies.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. (However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under Highmark Health Options Duals, we will reimburse veterans for the difference. Members are still responsible for Highmark Health Options Duals cost-sharing amount.)
- Surgical treatment for morbid obesity (unless it is considered medically necessary and covered under Original Medicare).
- Private duty nurses.
- Meals delivered to members' homes. Some plans offer meals as a supplemental benefit.
- Elective or voluntary enhancement procedures, services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance). (Except when medically necessary.) Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility.

At any time during the year, the Medicare program can change its national coverage. Since the plan covers what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease benefits, depending on the Medicare program change.

Prescription Drug Benefits

Prescription drug benefits are available to all members. Prescriptions must be filled by a participating pharmacy to be covered by the plan. When a member travels outside of the plan service area, a national network of pharmacies is available via our Pharmacy Benefit Manager (PBM) network. If a member must use an out-of-network pharmacy, the member will generally have to pay the full cost of the prescription. The member may then request to be reimbursed for the cost covered by the plan. The plan contracts with CVS Health to develop a network of chain, independent, home infusion and long-term care pharmacies in order to provide pharmaceuticals to plan members. A list of participating pharmacies can be obtained by contacting the plan's Pharmacy Department at **1-833-957-0025** or **TTY: 711**. Prescriptions are available to members who are eligible for pharmacy coverage when written by a plan practitioner. Prescription coverage and cost varies by plan.

Prescription Drug Coverage Formulary

Visit **Highmark.com/health-options-wv/dsnp/dsnp-benefits-programs/dsnp-medication-benefits#formulary** for the most recent version of the formulary.

Copayments/Coinsurance

Member cost sharing for medications varies by plan, drug type, and the amount of extra help, if any, that the member may receive. Members should contact Member Services or refer to their Evidence of Coverage to learn more about their specific coverage.

Days' Supply of Medications: The plan may place limits on the amount of medication a member may receive. Members can typically receive up to a 100-day supply of medication for prescriptions filled at an in-network pharmacy. A 100-day retail or mail order benefit is available for select plans. Some medications such as non-extended day supply drugs may be limited to a 30-day supply.

Prescription Benefit Design

The plan utilizes a closed formulary with limitations on which medications are available for coverage. Practitioners are requested to prescribe medications included in the formulary whenever possible. Some formulary medications may have additional requirements or limits on coverage. These requirements and limits may include prior authorization, quantity limits, or step therapy. If use of a formulary medication is not medically advisable for a member, you must complete a Medicare Request for Drug Coverage Form located on the Highmark Health Options Duals website at **wv.highmarkhealthoptions.com/providers/**. Please refer to the Referrals and Authorizations Section of this manual for information regarding requesting non-formulary drugs.

Drugs Covered

- Legend drugs listed in the closed formulary
- Non-formulary drugs which have been granted a formulary exception for an individual member
- Insulin/disposable syringes/needles
- Compounded medication of which at least one ingredient is a covered Part D prescription drug
- Contraceptives

Drug Exclusions

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.

- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information and the DRUGDEX Information System.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our health plan.
- By law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs."

Non-Part D drugs include:

Non-prescription drugs (or over-the-counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Covered outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of erectile dysfunction

Members' Rights and Responsibilities

Highmark maintains a Members' Rights and Responsibilities statement for all of its Medicare D-SNP products. The Members' Rights and Responsibilities statement is reviewed and revised annually, or as needed, and is distributed to new and existing members and practitioners. We do not and are prohibited from excluding or denying benefits to, or otherwise discriminating against, any eligible and qualified individual regardless of race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age. We monitor compliance related to members' rights and responsibilities, including those rights and responsibilities as defined by Section 1557 of the Affordable Care Act of 2010.

Members can locate their Rights and Responsibilities in the Evidence of Coverage for the company's Medicare D-SNP Members under Chapter 8, "Your rights and responsibilities," or on our website at **highmark.com/health-options-wv/duals**.

The company's Medicare D-SNP members have the right and responsibility to:

Member Rights

- Receive information from Highmark in a way that works for them (in languages other than English, in Braille, in large print, or other alternative formats, etc.)
- Be treated with respect and dignity.
- Receive timely access to covered services and drugs.
- Have their personal health information kept private and confidential.
- Receive information from Highmark about the Plan, its network of providers, their covered services, as well as member rights and responsibilities.
- Have Highmark support their right to participate with practitioners in making decisions about their care.
- Understand their treatment options and participate in decisions for their health care.
- Give instructions about what is to be done if they are not able to make medical decisions for themselves.
- File a complaint and/or to ask Highmark to reconsider decisions the Plan has made by filing an appeal, including complaints about the quality of care.
- Receive more information about their rights.
- Make recommendations regarding the organization's Member Rights and Responsibilities policy.
- Members' choice to exercise these rights will not adversely affect the way Highmark, its providers, or any state or federal agency will treat them.

- Request and/or participate in a scheduled Interdisciplinary Care Team (ICT) meeting which may include your assigned Case Manager, your PCP, caregiver, and any other pertinent personnel directly included in your care.
- Access and have direct input in your individualized care plan (ICP). Your care plan is available on your portal page or can be mailed to you upon request.

Member Responsibilities

- Get familiar with their covered services and the rules they must follow to get these covered services.
- Inform Highmark if they have any other health insurance coverage or prescription drug coverage in addition to our plan's coverage.
- Tell their doctor and other health care providers that they are enrolled in our plan.
- Help their doctors and other providers who care for them by providing needed information, asking questions, and following through on their care.
- Respect the rights of other patients and to act in a way that helps the smooth running of their doctor's office, hospitals, and other offices.
- Pay Medicare premiums, and any applicable copayments or late enrollment penalties.
- Notify Highmark if they move, regardless of whether it is outside or inside of the Highmark service area.
- Call Member Services for help if they have questions or concerns.



Member Satisfaction

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®[1]) measures member satisfaction annually through a national survey. The Centers for Medicare and Medicaid (CMS) requires health plans to use a certified Survey Vendor to conduct the survey, which is utilized by health plans to capture information about consumer-reported experiences with health care, and to identify areas to improve or maintain performance. Results are compared nationally across all Medicare Advantage Plans, are reported to regulatory entities, and count towards a health plan's CMS Medicare Star Rating. Each year, the survey is administered to a sample of members 18 or older following CMS CAHPS survey protocol, and reveals members' experiences with their health plan, health care providers, and services over the six months prior.

Types of questions asked of members include, but are not limited to:

- Getting needed care
- Getting appointments and care quickly
- Health Plan customer service
- Care coordination
- Rating of Health Plan
- Rating of health care
- Getting needed prescription drugs
- Rating of drug plan
- Getting needed screens, tests, and vaccines

[1]"CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)"

Coverage Arrangements

All participating practitioners must ensure 24-hour, seven days a week coverage for members. Coverage arrangements should be made with another Plan participating practitioner or practitioners who have otherwise been approved by the Plan. All encounters must be billed under the name of the rendering practitioner, not the member's assigned primary care practitioner. Reimbursement will be paid directly to the participating covering primary care practitioner.

Covering practitioners, whether participating or not, must adhere to all the Plan's administrative requirements. Additionally, covering practitioners must agree not to bill the members for any covered services. The covering practitioner should report all calls and services provided to the member's primary care practitioner. 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, and all reimbursements will be paid directly to the covering practitioner. Participating practitioners will be held responsible for the actions of their non-participating coverage practitioners.

Primary care practitioners agree that, in their absence, timely scheduling of appointments for members shall be maintained.

Locum Tenens

The plan recognizes that from time to time a provider or practice may need to utilize the services of a locum tenens to aid in practice coverage for its patient population. Offices should follow CMS regulations regarding locum tenens — they are recognized for services up to a 60-calendar-day time frame. During that time, claims are to be billed under the participating supervising/lead physician NPI number and group NPI number along with the appropriate modifier.

Once the 60-calendar-day time frame has elapsed, if the locum provider's services are still needed, the provider should become an employee of the group and would be required to be credentialed.

Primary Care Practitioner

Verifying Eligibility

Please refer to the Determining Eligibility section of this manual to review the various options for validating member eligibility. Both NaviNet and the plan's eligibility verification line are available 24 hours a day, seven days a week. The Eligibility verification phone line can be reached at **1-800-642-3515**.

Primary Care Practitioner (PCP) Selection

Each member in a family has the freedom to choose any participating primary care practitioner, and a member may change to another primary care practitioner should a satisfactory patient-practitioner relationship not develop. A primary care practitioner agrees to accept a minimum number of Highmark Health Options Duals members, as specified by their practitioner agreement, to their patient panel at each authorized office location without regard to the health status or health care needs of such members and without regard to their status as a new or existing patient to that practice or location. After reaching their contracted patient panel minimum the primary care practitioner may, upon 60 days prior written notice to Highmark Health Options Duals, state in writing that they do not wish to accept additional members. The written request excludes members already assigned to the primary care practitioner's practice, including applications in process. The request must be submitted to Highmark Health Options Duals using the Practice/Provider Change Request form located on the provider website at **wv.highmarkhealthoptions.com/providers/**.

For the mailing address, please refer to **Practice Change Information** under the "Important Addresses" section on page 15.

Encounters

Primary care practitioners are required to report all services they provide for Highmark Health Options Duals members by submitting complete and accurate claims. All providers are contractually required to submit encounters for all member visits and all charted diagnoses that the member may suffer from.

Accurate Submission of Encounter Data

Encounter data provides the basis for many key medical management and financial activities at Highmark Health Options Duals:

- Quality of care assessments and studies
- Access and availability of service evaluation
- Program identification and evaluation
- Utilization pattern evaluation
- Operational policy development and evaluation
- Financial analysis and projection

To manage members' health services effectively and efficiently, encounter submissions must be comprehensive and accurately coded. All providers are contractually required to submit encounters for all member visits.

Underreporting of encounters can negatively impact all stakeholders. For primary care practitioners, encounter data is essential as many of our Quality indicators are based on this information.

It is important that all diagnosis codes that are applicable to the member be submitted on every claim, especially chronic conditions. It is also important for the capturing of all quality performance measures that the use of CPTII codes be submitted on every claim when applicable. The expected rate of submission for encounters is 100%. Highmark Health Options Duals provides support and education to practices as indicated by their encounter submission rates.

CMS uses the Hierarchical Condition Categories (HCC) model to assign a risk score to each Medicare beneficiary. Accurate and complete reporting of diagnosis codes on encounters is essential to the HCC model. Physicians must establish the diagnosis in the medical record and coders must use the ICD-10-CM coding rules to record each diagnosis. Chronic illnesses should be coded on each encounter along with the presenting illness. This will help to ensure that CMS has complete data when determining the member's risk score.

Transfer of Non-Compliant Members

Primary care practitioners agree not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Highmark Health Options Duals members on the basis of race, color, national origin, religious creed, sex, sexual orientation, gender identify, disability, English proficiency, age, place of residence, health status or source of payment; and to observe, protect and promote the rights of members as patients. Primary care practitioners shall not seek to transfer a member from his/her practice based on the member's health status. However, a member whose behavior would preclude delivery of optimum medical care may be transferred from the practitioner's panel. The Plan's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given practitioner. Should an incidence of inappropriate behavior occur, and transfer of the member is desired, the practitioner must send a letter requesting that the member be removed from his/her panel including the member's name and Highmark Health Options Duals ID Number to the Medicare Enrollment Department.

For the mailing address, please refer to **Member Enrollment/Disenrollment** under the "Important Addresses" section on page 14.

The Enrollment Department notifies the requesting practitioner in writing when the transfer has been accomplished. If the member requests not to be transferred, the primary care practitioner will have the final determination regarding continuation of primary care services. Primary care practitioners are required to provide emergency care for any Highmark Health Options Duals member dismissed from their practice until the member transfer has been completed.

Transfer of Medical Records

Primary care practitioners are required to transfer member medical records or copies of records to newly designated primary care practitioners within 14 business days from receipt of the request from the member or the member's new primary care practitioner, without charging the member.

Primary care practitioners are required to transfer member medical records or copies of records to newly designated Managed Care Organizations within 14 business days from receipt of the request from the Centers for Medicare and Medicaid Services or its agent.

Telehealth

Members have the option of receiving the services below either through an in-person visit or via telehealth. For telehealth services, a network provider that currently offers the service must be utilized. Telehealth providers must ensure alignment with "CMS Guidance on Medicare Marketing Activities" section.

Telehealth services offered by the plan include:

- Primary care physician (PCP) services
- Physician specialist services
- Individual sessions for mental health specialty services
- Individual sessions for psychiatric services

Prior authorization/plan approval required: No



Specialty Care Practitioner

Verifying Eligibility

Please refer to the Determining Eligibility section of this manual to review the various options for validating member eligibility. Both NaviNet and the plan's eligibility verification line are available 24 hours a day, seven days a week. The Eligibility verification phone line can be reached at **1-800-642-3515**.

Coordination of Care

The primary care practitioner is responsible for the coordination of a member's health care needs and access to services provided by specialists. Therefore, all members are encouraged to coordinate care with their primary care practitioner prior to receiving specialty services except for the services that can be accessed by self-referral. The specialist is responsible for providing written correspondence to the member's primary care practitioner for continuity and coordination of care.

Emergency Services

Federal and state regulations prevent us from requiring members to contact a primary care practitioner, specialist, or the plan prior to seeking emergency care. The decision by a member to seek emergency care is based upon "prudent layperson" standard. Per CMS guidelines: "An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with 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, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services are covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition.

All Highmark Health Options Duals members are informed that they must contact their primary care practitioner for authorization prior to seeking treatment for non-life or limb threatening conditions in an emergency room. However, Highmark Health Options Duals realizes that there are situations when a member is under the care of a specialty care practitioner for a specific condition, such as an OB/GYN during pregnancy, and the member may contact the specialist for instructions. If a specialty care practitioner directs a member to an emergency room for treatment, the specialty care practitioner is required to immediately notify the hospital emergency room of the pending arrival of the patient for emergency services. The specialty care practitioner is required to notify the primary care practitioner of the emergency services within one business day when the emergency room visit occurs over a weekend. Members should be directed to the closest appropriate emergency provider.

Transfer of Medical Records

Specialty care practitioners are required to transfer member medical records or copies of records to newly designated primary care practitioners within 14 business days from receipt of the request from the member or the member's new primary care practitioner, without charging the member.

Specialty care practitioners are required to transfer member medical records or copies of records to newly designated Managed Care Organizations within 14 business days from receipt of the request from the Centers for Medicare and Medicaid Services or its agent.

Telehealth

Members have the option of receiving the services below either through an in-person visit or via telehealth. For telehealth services, a network provider that currently offers the service must be utilized. Telehealth providers must ensure alignment with "CMS Guidance on Medicare Marketing Activities" section.

Telehealth services offered by the plan include:

- Primary care physician (PCP) services
- Physician specialist services
- Individual sessions for mental health specialty services
- Individual sessions for psychiatric services

Prior authorization/plan approval required: No

OB/GYN Services

Verifying Eligibility

Please refer to the Determining Eligibility section of this manual to review the various options for validating member eligibility. Both NaviNet and the plan's eligibility verification line are available 24 hours a day, seven days a week. The Eligibility verification phone line can be reached at **1-800-642-3515**.

General Information

To eliminate any perceived barrier to accessing OB/GYN services, Highmark Health Options Duals allows all female 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 contact Highmark Health Options Duals to verify eligibility of the member.

Highmark Health Options Duals permits its primary care practitioners to perform routine gynecological exams and pap tests and provide care during pregnancy if they are so trained and equipped in their office.

As you care for our members, and you feel additional support or assistance is needed, please refer members to the Care Management Department for ongoing case management and support. To refer to the Care Management Department, please call **1-833-957-0025**.

West Virginia Prenatal Risk Screening Instrument (PRSI)

The first visit with an obstetrical patient is the intake visit, or if a patient becomes a Highmark Health Options Duals member during the course of her pregnancy, her first visit as a Highmark Health Options Duals member is considered to be her intake visit. At the intake visit, a PRSI must be completed. The form can be found on the Highmark Health Options Duals website at **highmark.com/health-options-wv/duals**. The purpose of the PRSI is to help identify risk factors early in the pregnancy and engage the woman in care management.

Providers should fax the PRSI form to **1-833-559-2850**. The form must be faxed to Highmark Health Options Duals within 2–5 business days of the intake visit. The PRSI should be updated and faxed to the Plan at the 28–32-week visits and also at the postpartum visit.

Diagnostic Testing

Fetal Non-stress Tests and Ultrasounds can be performed in the OB/GYN's office or at a hospital without authorization from Highmark Health Options Duals.

Telehealth

Members have the option of receiving the services below either through an in-person visit or via telehealth. For telehealth services, a network provider that currently offers the service must be utilized.

Telehealth services offered by the plan include:

- Primary care physician (PCP) services
- Physician specialist services
- Individual sessions for mental health specialty services
- Individual sessions for psychiatric services

Prior authorization/plan approval required: No



Behavioral Health Services

Verifying Eligibility

Please refer to the Determining Eligibility section of this manual to review the various options for validating member eligibility. Both NaviNet and the plan's eligibility verification line are available 24 hours a day, seven days a week. The Eligibility verification phone line can be reached at **1-800-642-3515**.

Authorizations and Referrals

Inpatient Services

In the case of emergent admission when care cannot be coordinated on a pre-service basis, the Highmark Health Options Duals admitting physician, hospital or member is encouraged to notify the Utilization Management Department as soon as possible of the inpatient admission. Notification facilitates coordination of care management, quality issues, and discharge planning. Highmark Health Options Duals will perform inpatient level of care reviews to establish medical necessity if inpatient request is received within four calendar days of discharge. Admission requests made outside this timeframe must be submitted through retrospective review.

Outpatient Services

Highmark Health Options Duals does not require participating providers to obtain a referral or authorization for most outpatient mental health or substance use disorders covered by Medicare.

Outpatient Behavioral Health services requiring authorization including but not limited to:

- Partial Hospitalization (PHP)
- Intensive Outpatient (IOP)
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Neuropsychological/Psychological Testing
- Services provided by a non-participating provider
- Highmark Health Options Duals will perform outpatient reviews to establish medical necessity.
- Outpatient authorizations must be requested within one business day. Authorization requests made outside of this this timeframe must be submitted through retrospective review.

Substance Use Disorder (SUD) Services

Authorization is required for the below:

- ASAM level of care 4 WM: Medically Managed Intensive Inpatient Withdrawal Management
- ASAM level of care 4: Medically Managed Intensive Inpatient Services
- ASAM level of care 2.5: Partial Hospitalization Services
- ASAM level of care 2.1: Intensive Outpatient Services

The current medical necessity criteria being used for SUD requests is American Society of Addiction Medicine (ASAM).

Failure to obtain a timely authorization may result in a denial of payment. Authorization request must be submitted via the provider portal. For services not covered by Medicare; the services may be covered by the member's county-specific behavioral health plan.

Medical Necessity

If the behavior status does not meet the medical necessity for the proposed level of care, the request is referred to the Behavior Health Medical Director, a board-certified psychiatrist, for review and determination. The current medical necessity criteria being used for behavioral health services are Change Healthcare Optum InterQual., Centers for Medicaid and Medicare Services National Coverage Determinations, Local Coverage Determinations, and the American Society of Addiction Medicine. Members may seek emergent care for behavioral health and/or substance use.

A mental health crisis may or may not be a life-threatening situation in which a person is exhibiting extreme emotional or behavior disturbance and a comprised ability to function, which could result in suicidal or homicidal thoughts or actions.

Emergency services are covered if furnished by qualified providers and are needed to evaluate or stabilize an emergent behavior health crisis.

Crisis Resources

- The National Suicide Prevention Lifeline, where compassionate, accessible care and support is available for anyone experiencing mental health-related distress—whether that is thoughts of suicide, a mental health or substance use crisis, or any other kind of emotional distress. The existing number for the National Suicide Prevention Lifeline (**1-800-273-8255**) is still active.
- The National Mental Health Hotline **888-912-7630** and the Crisis Tex Line (**text HOME to 741741**) can be reached anytime day or night, 24/7, and from anywhere in the country.

- Using either number will get people to the same services. The Lifeline is free, confidential, available 24/7, and can be reached by both phone call (multiple languages) and text (English only). The Lifeline currently serves TTY users either through their preferred relay service or by dialing 711, then **1-800-273-8255**. Additionally, the Lifeline is available through chat by visiting **suicidepreventionlifeline.org/chat**.
- Help4WV offers 24/7 phone, chat, and text line that provides immediate help for any West Virginian struggling with a mental health or addiction issue. People can call or text **844-HELP4WV** (**844-435-7498**) at any time for crisis support. They can also go online to **help4wv.com/contact**.

Telehealth

Members have the option of receiving the services below either through an in-person visit or via telehealth. For telehealth services, a network provider that currently offers the service must be utilized. Telehealth providers must ensure alignment with "CMS Guidance on Medicare Marketing Activities" section.

Telehealth services offered by the plan include:

- Primary care physician (PCP) services
- Physician specialist services
- Individual sessions for mental health specialty services
- Individual sessions for psychiatric services

Prior authorization/plan approval required: No

Substance Use Disorder (SUD) Services

Opioid Treatment Programs (OTPs)

Members may receive treatment for opioid use disorder at Opioid Treatment Programs (OTPs). Treatment services include drugs approved by the Food and Drug Administration (FDA) for the treatment of opioid use disorder, dispensing and administration of opioid agonist and antagonists including naloxone, toxicology testing, individual and group therapy, counseling, intake activities, and periodic assessments. These services are covered through bundled Part B codes where, for dually eligible individuals, Medicare is the primary payer and Medicaid is the payer of last resort. As such, providers are to bill Medicare for OTP services provided to dually eligible individuals before billing the Medicaid program.

For more information, please see the following resources:

- Our Payment Policy for Opioid Treatment Providers (OTPs) **wv.highmarkhealthoptions.com/providers/**
- Centers for Medicare & Medicaid Services OTP Webpage **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program**

WV State Opioid Response (SOR)

State Opioid Response (SOR) | Bureau for Behavioral Health Expanding Treatment, Accessing Support, and Preventing Death & Substance Use Disorder (SUD). The State Opioid Response (SOR) Grant supports West Virginia's response to the opioid epidemic. The grant award, from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), is administered by the West Virginia Department of Human Services (DoHS) Bureau for Behavioral Health (BBH) SOR Team.

SOR grantees across West Virginia are funded to expand the availability of treatment with medication and additional evidence-based services for individuals with substance use disorder (SUD), including individuals with opioid use disorder and stimulant use disorder. SOR grant funding help to identify and engage individuals with SUD with treatment and provides supports to help individuals stay in long-term recovery. BBH recognizes barriers to treatment, successful recovery, and evidence-based prevention to the general population, including individuals in SUD recovery. BBH encourages the involvement of families in treatment and recovery and assists the family of an individual with an SUD or co-occurring mental health disorder.

SOR initiatives addressing barriers include:

- **Naloxone Education**
- Transportation: **Learn more** and Request a Trip **1-866-696-6195**
- Child Care: **Subsidized Child Care Resource and Referral Services**
- Stigma Reduction Campaign: **Back to Life WV**
- Learning the Latest on Evidence-Based Practice: **SOR Workshop Series**
- Acronyms: **DoHS Acronym List**

Additional Resources for Substance Use Disorder (SUD) Treatment

- SAMHSA National Helpline: The Substance Abuse and Mental Health Services Administration offers around-the-clock help for substance abuse and mental health concerns. Text 435748, call **1-800-662-4357**
- National Drug Helpline: This alcohol and drug abuse hotline offers 24/7 support at **1-844-289-0879**.

- Crisis Text Line: Chat and Tex Support: Access free 24/7 support from trained volunteers through online chat at crisistextline.org or by texting 741741.
- Addiction Treatment Locator, Assessment and Standards (ATLAS) Platform **TreatmentATLAS.org**
- National Treatment Locator for Substance Use Disorders (SUDs) **FindTreatment.gov**
- Local County Assistance **County, Region, or Statewide Councils | Bureau for Behavioral Health**

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Billing Guide

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive and integrated public health approach to the delivery of early intervention and treatment services through universal screening for persons with substance use disorders (SUD) and those at risk of developing these disorders. These services are not intended to treat members already diagnosed with substance use disorder or those members already receiving substance use disorder treatment services. Highmark Health Options Duals compensates providers for completing SBIRT screenings in physical health care settings. By universally screening their patient population at annual visits, health care professionals can assist patients who may not be seeking care for substance use, but whose substance use behaviors may be inhibiting their social, professional, emotional, or physical well-being. Patients receiving regular SBIRT screenings demonstrated significant reductions in substance use. The purpose of this guide is to provide education and billing guidance to providers to obtain reimbursement for SBIRT services. This guide will be updated periodically to reflect changes based upon industry standards and practice. Highmark Health Options Duals reserves the right to conduct post-payment medical record audits for validation purposes and in accordance with state and federal accreditation, your provider agreement, and regulatory requirements.

For more information on substance use disorders and access to the SBIRT Billing Guide please visit **wv.highmarkhealthoptions.com/providers/**.

Hospital Services

Inpatient Admissions

For Highmark Health Options Duals to monitor the quality of care and utilization of services by our members, all practitioners are required to obtain an authorization number for all hospital admissions by contacting the Utilization Management Department via our GuidingCare authorization portal, accessed via NaviNet. If for some reason GuidingCare is unavailable, providers can contact our Utilization Management Department at **1-800-685-5209**. In the event services are needed urgently or emergently, authorizations must be requested within four calendar days of discharge. Admission requests made outside of this timeframe must be submitted through retrospective review.

Failure to obtain a timely authorization for scheduled care may result in the administrative denial of your claim without regard to medical necessity. Claims submitted for non-emergent care without prior authorization will be denied.

Highmark Health Options Duals will accept an inpatient authorization request from the primary care practitioner, ordering practitioner, the attending practitioner, or the hospital's Utilization Review Department for both emergent and non-emergent hospital care; however, no party should assume the other has obtained authorization.

The Utilization Management Representative refers to a Highmark Health Options Duals Medical Director if criteria or established guidelines and/or policies are not met for a determination.

In the case of an emergent admission when care cannot be coordinated on a pre-service basis, the Highmark Health Options Duals admitting physician, hospital or member is encouraged to notify the Highmark Health Options Duals Utilization Management Department as soon as possible of the inpatient admission. Notification facilitates coordination of care management, quality issues, and discharge planning. Highmark Health Options Duals will perform inpatient level of care reviews to establish medical necessity. Authorization requests made after the care has been completed (post service/post discharge) must be submitted as an appeal once a claim denial has been received. Utilization Management will not accept post-service authorization requests.

During the discharge planning process, if Highmark Health Options Duals is notified by the Quality Improvement Organization (QIO) that the member disagrees with the attending physician's discharge, a written detailed notice of discharge will be provided to the member through a process agreed upon by the hospital and Highmark Health Options Duals and will be provided to the member within the timeframes established by CMS.

Emergency Room

Members are informed through the Evidence of Coverage how and when to utilize emergency services. Emergency services do not require prior authorization. If a member is unsure whether to go to the emergency room, the member is instructed to call his/her primary care practitioner for advice.

Ambulance Services

Emergent ambulance transport does not require prior authorization. Non-emergent ground ambulance transport by a participating provider does require prior authorization; as well as for non-emergent ground ambulance transport by a non-participating provider except as noted below.

Highmark Health Options Duals 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.

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 (SNF)
  - SNF to Hospital (non-emergent)
  - Hospital to Rehabilitation Facility
  - Rehabilitation Facility to Hospital (non-emergent)
- Ambulance transport to home upon discharge (if medically necessary).

Highmark Health Options Duals 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 911 transportation or transport to a psychiatric facility for a member under a psychiatric commitment order without an authorization from Highmark Health Options Duals.

Highmark Health Options Duals also considers the following situations emergent, and thus does not require authorization when rendered by a Highmark Health Options Duals participating ambulance provider:

- ER to ER
- ER to Acute Care or Behavioral Health Facility
- Acute Care to Acute Care or Behavioral Health Facility
- Hospital to Hospital (when a patient is being discharged from one hospital and being admitted to another)
- End Stage Renal Dialysis Center*

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

*Ambulance transportation by non-participating providers to End Stage Renal Dialysis Centers does not require authorization. Although there is no pre-authorization required for participating or non-participating ambulance transport for a member with ESRD for dialysis services, the ambulance transport must meet Medicare's medical necessity program coverage criteria in order for payment to be made.

Authorization for non-emergent air ambulance transportation is required by Highmark Health Options Duals' Utilization Management Department. These authorization requests should be submitted via our GuidingCare authorization portal, accessed via NaviNet. If for some reason GuidingCare is unavailable, providers can contact our Utilization Management Department at **1-833-957-0025**. A Highmark Health Options Duals participating Ambulance provider should be contacted to render non-emergent 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 member returning to the original facility upon completion of service, is the responsibility of the originating facility and does not require an authorization from Highmark Health Options Duals.

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.



DRG Post-Payment Audits

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

For reviews conducted by a designated delegate, 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 the delegate describing the outcome of the medical records and claim review.
- You will have 30 calendar days to either accept the delegate's findings or request a reevaluation by providing supporting information for the paid claims to the delegate.
- If you disagree with the delegate's 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 our Fraud, Waste and Abuse Hotline by calling **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)); and
- 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 us 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 Highmark Health Options Duals' Financial Investigations and Provider Review Division by calling our Fraud, Waste and Abuse Hotline at **1-844-718-6400**.

We would like to take this opportunity to provide some additional reminders to facilities when submitting claims that include implant invoices.

- All claims, including implant invoices, are subject to timely filing and follow up guidelines as well as the Highmark Health Options Duals coding edits.
- Providers will either submit a corrected claim with the invoice attached, or mail or fax required documentation via the Claims Review process with a copy of the original or corrected UB claim form, or the denied remit from the original claim.
- Providers MUST follow the Appeals Process if it is felt that the denial of the claim is incorrect.
- If the surgery is denied, the implant charges will also be denied.
- Date of Service, Billed Charges, etc. must match that of the invoice.
- Providers should expect to receive payment within approximately 40 days after submission of a clean claim and invoice. Provider Services can help with inquires on those claims and invoices that have been submitted but have received no response.

If there are any questions regarding this process, please do not hesitate to contact your Provider Account Liaison.

Accessibility to Care (Appointment Standards)

Highmark Health Options Duals West Virginia maintains accessibility to care standards and processes for ongoing monitoring of access to health care. Providers are contractually required to conform to these standards to ensure that health care services are provided to our members in a timely manner.

Provider Type	Appointment Type	Access Standard
Primary Care (PCP) Behavioral Health (BH)	**Emergent Care**	**Immediately seen or referred to an emergency facility** Practice sites will be able to schedule an appointment immediately or refer the member to an emergency facility.
Primary Care (PCP) Behavioral Health (BH)	**Urgent Care**	**Immediately seen or scheduled within 24 hours** Practice sites will be able to schedule an appointment either immediately or within 24 hours of being contacted by member.
Primary Care (PCP) Behavioral Health (BH)	**Non-Urgent, but in need of medical attention**	**Within seven business days** Practice sites will be able to schedule an appointment within seven business days of being contacted by member.
Primary Care (PCP) Behavioral Health (BH)	**Routine or Preventative Care**	**Within 30 business days** Practice sites will be able to schedule an appointment within 30 business days of being contacted by member.

Policies and Procedures

Highmark Health Options Duals has developed policies and procedures to provide guidelines for identifying and resolving issues with practitioners who fail to comply with the terms and conditions of the applicable Practitioner Agreement, policies and procedures, or accepted Utilization Management Standards and Quality Improvement Guidelines.

Policy Changes

In order for Highmark Health Options Duals to be in compliance with federal and state laws, regulations and regulatory bulletins governing the Medicare and Medicaid Programs in the course of providing services, providers and their staff will be bound by all applicable federal and state Medicare and Medicaid laws and regulations. Providers will comply with all applicable instructions, bulletins and fee schedules promulgated under such laws and all applicable program requirements of regulatory agencies regarding the Medicare and Medicaid programs. Additionally, providers need to be aware that no regulatory order or requirement of the Centers for Medicaid and Medicare, Departments of Insurance, Health or Human Services shall be subject to arbitration with the Plan.

Practitioner Education and Sanctioning

Highmark Health Options Duals practitioners will be monitored for compliance with administrative procedures, guidelines, trends of inappropriate resource utilization, potential quality of care concerns and compliance with medical record review standards. Practitioner education is provided through Provider Engagement staff, Provider Account Liaisons, and our Medical Directors.
The company follows a tiered approach of education and sanctioning prior to implementing termination procedures. Network practitioners who do not improve through the provider education process will be referred to the Quality Improvement/Utilization Management Committee for evaluation and recommendations. Recommendations may include remediation or practitioner sanctioning.

Examples of repeated practitioner conduct that may be further reviewed for education and remediation include, but are not limited to:

- Member complaints.
- Reported occurrences of excluding or denying health care services to a member based on his or her race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age.
- Failure to obtain prior authorization for a referral to a non-participating practitioner.
- Failure to obtain prior authorization for those services requiring such.

- Utilization management trends exceeding the peer group.
- Quality indicator outcomes below the peer group.
- Identification of Severe Quality of Care concerns.
- Failure to cooperate with administrative aspects of the QI/UM Program.
- Failure to provide adequate practitioner coverage.
- Failure to be accessible to members via telephone or answering services.
- Repeated failure to be compliant with the established accessibility standards.
- Repeated failure to comply with Environmental Assessment standards.

Highmark Health Options Duals conducts ongoing monitoring of Medicaid and Medicare sanction information by utilizing the OIG report, CMS Preclusion Listing, and the West Virginia Medicaid Provider Sanctioned/Exclusion list. If a participating provider is found on the reports, the provider's file is pulled for further investigation and presented to the QI/UM Committee for a decision. Upon notification from CMS that a provider has been terminated due to loss of licensure and/or criminal convictions, Highmark Health Options Duals will immediately move forward with terminating the provider from its network. The effective date of termination will be the same date utilized by CMS.

Practitioner Due Process

We have established a policy and procedure to define the situations when due process procedures are afforded to practitioners, and to specify the due process procedures available in accordance with federal and state regulations, in particular the Health Care Quality Improvement Act of 1986. The Practitioner Due Process Policy will be updated in accordance with federal and state regulations, and will indicate the appropriate procedures to notify new applicants and participating practitioners whenever:

- Credentialing or recredentialing applications are denied.
- Adverse determinations are made regarding participation.
- Action to suspend or terminate an agreement occur.
- A participating physician or health care practitioner is being terminated due to quality-of-care concerns or other conduct.

A physician or health care practitioner has the right to request a hearing in the event he or she receives a proposed Professional Review Action as recommended by the Plan's Quality Improvement/Utilization Management Committee.

Title VI of the Civil Rights Act Of 1964

Providers are expected to comply with the Civil Rights Act of 1964. Title VI of the Act pertains to discrimination on the basis of national origin or limited English proficiency. Providers are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of translator services as necessary for these members.

Section 1557 of the Affordable Care Act Of 2010

Providers are expected to comply with the Affordable Care Act of 2010. Section 1557 prohibits discrimination on the basis of race, color, national origin, religious creed, sex, sexual orientation, gender identity, English proficiency, age of a disability in certain health programs and activities.

Access and Interpreters for Members with Disabilities

Providers are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each practitioner is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. Highmark Health Options Duals will assist practitioners in locating resources upon request. The Plan offers the Member Handbook and other information in large print, Braille, on cassette tape, or computer diskette at no cost to the member. Please instruct members to call Member Services at **1-833-957-0025** to ask for these other formats. Practitioner offices are required to adhere to the Americans with Disabilities Act guidelines, Section 504, the Rehabilitation Act of 1973, and related federal and state requirements that are enacted from time-to-time.

For interpreter services, please contact a qualified medical interpretation service or Language Line Services. Practitioner offices can contact the AT&T Language Line at **1-800-874-9426** for assistance with Limited English Proficient (LEP) patients at 711 or **1-800-654-5988** for patients with hearing impairments.

Confidentiality

Through contractual agreements, all practitioners and providers have agreed to abide by all policies and procedures regarding member confidentiality. The goal for performance for confidentiality is for practitioners to secure patient records from unauthorized access.

Under these policies, the practitioner or provider must meet the following:

- Provide the highest level of protection and confidentiality of members' medical and personal information used for any purpose in accordance with federal and state laws or regulations.

This includes implementing policies and procedures for managing access to and use of race, ethnicity, preferred language, sexual orientation, and gender identity/preference data.

- Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.
- Assure that a member's individually identifiable health information as defined by HIPAA, also known as Protected Health Information (PHI), necessary for treatment, payment, or health care operations (TPO), is released to Highmark Health Options Duals without seeking the consent of a member, unless federal or state laws require express written consent. This information includes PHI used for claims payment, continuity and coordination of care, accreditation surveys, medical record audits, treatment, quality assessment and measurement, quality of care issues, and disease management. We follow the requirements of HIPAA and limit our requests to the amount of PHI that is minimally necessary to meet the payment, treatment, or operational function. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations.
- Environmental security of confidential information is conducted by all providers and practitioners treating our members. This includes both internal and external monitoring of practice and provider sites. Provider and practitioner sites must comply with the Environmental Assessment standards that require that patient records be protected from public access.

Fraud, Waste and Abuse (FWA)

We have a comprehensive policy for handling the prevention, detection and reporting of fraud, waste, and abuse (FWA). It is our policy to investigate any actions by members, employees or practitioners that affect the integrity of the Plan and/or the Medicare Program. We enforce all industry standard claim coding requirements including those from NCCI, AMA CPT, ICD-10-CM, NCDs LCDs, and HCPCS.

Providers are responsible for knowing the following FWA definitions as applicable to Medicaid and Medicare:

- **Fraud:**
  An intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. Fraud can be committed by many entities, including a health plan, a subcontractor, a provider, a state employee, or a member, among others.
- **Waste:**
  Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs.
  - Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

- **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 or federal regulations) for health care in a managed care setting.
  - Abuse can be committed by the 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, the health plan, a subcontractor, or provider.
- **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 $5,000–$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.
- **Compliance Program:**
  To ensure compliance with FWA requirements of Medicaid contracts and Medicare Manuals, the Plan and providers will have:
  - Written policies, procedures, and standards of conduct readily available for all employees which outline our commitment to an 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, and
  - Provisions to promptly take action to detected offenses and develop corrective action initiatives.
- **Financial Investigations and Provider Review (FIPR):**
  A multi-faceted unit within the Plan that is involved in detecting and investigating FWA. In addition, the team works to ensure that claims are paid correctly by both pre-pay and post-pay auditing methods and in accordance with recipient benefits and provider contracts.

As a participating practitioner with us, the contract that is signed requires compliance with our policies and procedures for the detection and prevention of FWA. Such compliance may include, but is not limited to:

- Referral of information regarding suspected or confirmed FWA to us;
- 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; and
- Completion of provider compliance assessment.

Providers can find FWA trainings created by the Plan's FIPR Team on our website at **wv.highmarkhealthoptions.com/providers/**. All providers are required to have a representative review the Provider FWA Training upon contracting with us and annually thereafter. The provider representative will be responsible for communicating the information obtained from the Provider FWA Training to the entire staff of the provider. 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 requested by the Plan. Further information and updates concerning the Provider FWA Training can be found on the Highmark Health Option Duals website.

Our policies and procedures follow the guidelines set forth by CMS, where applicable.
For further information on Fraud, Waste and Abuse, Providers should refer to the CMS website **Reporting Fraud | CMS**.

It is our policy to discharge any employee, terminate any practitioner or recommend any member be withdrawn from the Medicare Program who, upon investigation, has been identified as being involved in FWA activities.

If FWA is suspected, whether it is by a member, employee, or practitioner, it is your responsibility to immediately notify us by calling the Fraud, Waste and Abuse Hotline at **1-844-718-6400**.

Some common examples of provider fraud, waste and abuse are:

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

- Billing more than once for the same service.
- Billing or charging recipients for covered services.
- Balance billing.
- Up-coding.
- Dispensing generic drugs and billing for brand name drugs.
- Falsifying records.
- Performing inappropriate or unnecessary services.
- Altering claims.

Some common examples of member fraud, waste and abuse are:

- Loaning or using another person's ID.
- Changing or forging an order or prescription.
- Selling prescriptions/medications.
- Stealing providers' prescription pads.
- "Doctor shopping" for prescriptions.

Fraud, Waste and Abuse Recovery Requirements

Our Company has FWA functions that are responsible for ensuring claims payment accuracy and to detect and prevent FWA which include:

- Pre-payment claims edits and medical record reviews.
- Retrospective claims edits and medical record reviews.
- Provider education.
- FWA investigations and audits.
- 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: Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), National Correct Coding Initiative (NCCI), National Committee for Quality Assurance (NCQA), and state Medicaid regulations & bulletins. Additionally, all claims should be coded and documented in accordance with the HIPAA Transactions and Code Sets which include ICD-10-CM, National Drug Codes (NDC), Code on Dental Procedures and Nomenclature, HCPCS Codes, CPT Code, and Other HIPAA code sets.

Our Company will conduct pre-payment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. We will recover claims payments that are contrary to national and industry standards. We will conduct progressive reviews, such that, providers may be requested to submit additional samples or documentation during the reviews.

If any of the FWA recovery efforts identify overpayments, the following activities will occur:

- We will comply with all federal and state guidelines to identify overpayments,
- We may determine provider recoveries based on audit results and extrapolation methodologies,
- We will pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within 60 days,
- We will refer suspected FWA to appropriate agencies, such as Medicaid oversight and CMS Medics, and
- We may recommend corrective actions that may include pre-payment review, payment suspension, and potential termination from the Plan's provider network.

We may deny payment or pursue overpayments for the following reasons (including but not limited to):

NCCI Procedure to Procedure (PTP) edits
NCCI Medically Unlikely (MUE) edits
NCCI Add-On Code edits
Retrospective coordination of benefits
Retrospective termed member eligibility
Retrospective rate adjustments
Incorrect fee schedule applied to claim
Provider excluded
Provider license terminated or expired
Provider does not meet the requirements to render services
Different rendering provider
No authorization or invalid authorization
Inaccurate claim information
Duplicate claims

Non-covered service
Outpatient services while member was inpatient
Overlapping services
Patient different than member
Per diem services billed as separate or duplicate charges
Services provided outside of practice standards
Group size exceeds limitations
No services provided including no-shows and cancellations
Missing records
Missing physician orders
Missing medication records
Missing laboratory results
Invalid code or modifier
Invalid code combinations
Diagnosis codes that do not support the diagnosis or procedure
Add-on codes reported without a primary procedure code
Clinical documentation issues
Claims documentation issues
Insufficient documentation
Potentially fraudulent activities
Excessive services
Altered/forged records
Inpatient readmissions (up to 30 days)

Fraud, Waste and Abuse Audits

At times, FIPR will 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 by the Plan, 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.

Additionally, we partner with multiple vendors to conduct various pre-payment and post-payment audits or reviews. Such audits or reviews could include:

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

Vendor specific questions should be directed to the Plan's Provider Services by calling **1-833-957-0025**.



Overpayments

The Plan, 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. We have a process in place for our network providers to report the receipt of a self-identified overpayment. Providers must notify us in writing of the reason for the self-identified overpayment and should provide payment within 60 calendar days in accordance with 42 U.S.C. §1320a7k(d).

If the claim is:

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

Providers can submit the Provider Self-Audit form that is located on the provider portal. It is imperative that Providers include the explanation of the Self-Audit and the claims they represent. Please provide a listing of claims as requested on the Provider Self-Audit/Overpayment Form which is located on our website at **wv.highmarkhealthoptions.com/providers/**.

Conversely, if providers use an extrapolation calculation to determine payment, a description of that methodology and the calculation should be included with your submission.

The overpayment letter and check (if applicable) should be sent directly to Highmark Health Options Duals.

If a listing of claims is not provided, we cannot guarantee that the claims will not be included in separate audits, 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.

For the mailing address, please refer to **Overpayments** under the “Important Addresses” section on page 15.

Additionally, for more information on self-audits, see the "Self-Audit" e-bulletin posted by CMS at **cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-self-audit.pdf**

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.

Medical Record Requests and Standards

We may request copies of medical records from the provider in connection with claims overpayment or for cases involving alleged FWA. If we request medical records, the provider must provide copies of those records at no cost to the Plan.

This includes notifying any third party who may maintain medical records of this stipulation. In addition, the provider must provide access to any medical, financial, or administrative records related to the services provided to our members within 30 calendar days of our request or sooner. All required documentation must be submitted at the time of the original medical record request. Additional documentation will not be accepted after the review is complete.

We require providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations, and Medicare manuals as well as other applicable professional associations and advisory agencies.

Providers should follow the below guidelines for basic medical records:

- Providers are responsible for following all requirements under federal and state regulations, publications, and bulletins that are pertinent to the treatment and services provided.
- Providers should follow the medical record standards as defined in Medicaid contracts, Medicare manuals, provider contracts, Provider Manuals, and all regulations.
- Providers are responsible for having compliance programs that prevent and detect FWA and report and return overpayments within 60 days of identification.
- Providers must have member records that include all Medicaid and/or Medicare requirements, are individual and kept secure.
- Providers are responsible for obtaining the appropriate order, referral, or recommendation for service.
- 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 clinician 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)

Consent to Treatment	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by clinician
	Lists the types of services and/or treatments
	Includes the benefits and any potential risks
	Includes alternative services and/or treatments
	Must be easy to read and legible

Release of Information for Payment	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by author/clinician
	Lists the types of services and/or treatments
	Must be easy to read and legible

Privacy Practices	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by author/clinician
	Must be easy to read and legible

Medical Information	Must contain the minimum personal biographical data: DOB, gender, address, home telephone number, employer, occupation, work telephone, marital status, name of next of kin, and next of kin telephone number
	Allergies and adverse reactions
	Significant illnesses and medical conditions
	Medical history, such as family history, psychosocial history, medical surgical history, baseline physicals, and periodic updates
	High risk behaviors (Tobacco/cigarette, alcohol, substance misuse, HIV/STD, nutrition, social and emotional risks, etc.)
	Laboratory and other studies ordered
	Continuity of care is documented
	Immunizations and dates
	Must be easy to read and legible

Treatment Plan	Valid for dates of service
	Identifies the patient
	Signed and dated by clinician (witness or author's identification)
	Documents that member or guardian reviewed or participated with the development of the treatment plan
	Addresses the chief complaint and clinical finding with a plan of care consistent with standards of care and clinical practice
	Identifies the diagnosis
	Identifies interventions and goals of treatment
	Documents necessity for treatment
	Reviews are completed timely as applicable
	Must be easy to read and legible

Progress/ Clinical Entry Note	Dates of service
	Identifies the patient
	Signed, dated, and credentialed by author/clinician
	Start and stop times for time-based services
	Units of service
	Place of service
	Note is missing narrative/description of services
	Note does not identify the treatment goals and objectives
	Note does not list symptoms and behaviors
	Note does not identify follow-up or next steps in treatment
	Corresponding encounter or timesheets as applicable
	Must be easy to read and legible

Medication List	Medication prescribed
	Signed and dated by clinician
	Lists dosages, dates, and refills
	References the side effects and symptoms
	Must be easy to read and legible

Environmental Assessment Standards

We have established specific guidelines for conducting Environmental Assessment Site Visits, including medical record-keeping standards for all practitioner types, including primary care practitioners, specialty care practitioners, and dental providers. An Environmental Assessment will be conducted on an ongoing basis through monitoring of complaints. Our subcontracted vendor conducts all site visits for contracted dental providers. The purpose of the site visit is to ensure that practitioners are in compliance with our Environmental Assessment Standards.

When an environmental assessment is required, a Provider Account Liaison will schedule an on-site or virtual site visit with the office site to conduct an Environmental Assessment. The Environmental Assessment must be conducted with the Office Manager or with a practitioner of the practice. The Provider Account Liaison will complete the Environmental Assessment Form and physically or virtually tour the office as well as interview staff and examine the appointment schedule. The Provider Account Liaison will assess the office for evidence of compliance with the Environmental Assessment Standards.

Upon completion of the review, the Provider Account Liaison will conduct an exit interview with the Office Manager and/or practitioner. The results of the Environmental Assessment will be reviewed. Non-compliance issues must be addressed with a corrective action plan within 30 days of receipt for non-compliant standards.

The Provider Account Liaison will conduct a follow-up visit within 90 days or until the office site is compliant. If any of the standards are not met, the Medical Director will assess the potential impact of the discrepancy to patient care and evaluate the corrective action plan. If the plan is not acceptable, the Medical Director may suggest a different corrective action plan. If the office is not agreeable to correcting the identified problem, the information will be presented to the Quality Improvement/Utilization Management Committee for review. Special circumstances may be granted based upon size, geographic location of the practice, and potential harm to members. The Provider Account Liaison will communicate the final results to the practitioners.

Provider Account Liaisons conduct site visits that include compliance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 for those practices as determined by the Department of Public Welfare.

The Environmental Assessment Standards are listed on pages 91-93.

Environmental Assessment Standards

Physical Accessibility and Appearance	
Parking	• Parking lot should have adequate parking available near the physician office. • Parking lot should have one handicap accessible space per every 25 parking spaces. • Accessible parking spaces are clearly marked for people with disabilities.
Exterior Path of Travel	Persons using a mobility aid (e.g., walker, scooter, or wheelchair) can get from the accessible parking space to the office door.
Curb Ramps	The curb ramps are at least 36" wide leading to the office.
Ramps	There are railings present if the ramp is longer than 6 ft.
Building Entrance	The patient entrance and exit are clearly marked and unobstructed.
Elevators	There is an elevator present when the office is not located on the first or ground floor.
Hallway Doors	The hallway entrances/exits are handicapped accessible.
Provider Interior Path	• Pathways through the provider's office are wide enough for a person to maneuver a wheelchair. • The office, waiting room, restroom, and at least one exam room is wheelchair accessible.
Bathroom Facilities	Support rail(s) are present in bathroom facilities.
Waiting Area	• The office hours are displayed. • Patient areas are clearly marked as non-smoking.

Medical Record Keeping

- All providers must maintain current and comprehensive medical records which conform to standard medical practices.
- Patient records must be secure from public access at all times.
- The office must have a written confidentiality policy that applies to all staff.
- Records are documented legibly.
- Office must have an organized filing system to ensure prompt retrieval of patient records (alphabetically, with social security numbers).
- There must be a single chart for each patient. If family records are kept, individual records must be clearly delineated.
- Records must identify the member on each page.
- All medically related patient phone calls documented in the medical record.
- Office recalls missed appointments and makes documentation in the medical record.
- Chart Documentation:
  - Allergy or NKA visible in the same place on every record.
  - Patient medical history in each record. Is there a medical history in each patient record?
  - Treatment/progress notes in each patient record.
  - Problem List in the medical record (PCPs and PCP Specialists Only).
  - Standard place in the medical record for preventive care/immunizations (PCPs and Specialists only).

**IF PROVIDER RELATIONS HAS QUESTIONS OR THE CHART DOES NOT MEET THE STANDARD THEN A COPY OF ONE RECORD NEEDS TO BE GIVEN TO QI FOR REVIEW.

Scheduling/Availability/Office Protocols

Scheduling: PCPs and PCP/ Specialists Only

1. Wait time for emergent care appointment; immediately seen or referred to an emergency facility (PCP and Behavioral Health Specialists only).
2. Wait time for Urgent Care; immediately seen or scheduled within 24 hours (PCP and Behavioral Health Specialists only).
3. Wait time to schedule a routine appointment must be within 30 business days (PCP and Behavioral Health Specialists only).
4. Wait time for non-urgent, but in need of medical attention (sick visit) within seven business days (PCP and Behavioral Health Specialists only).

Scheduling/Availability/Office Protocols (continued)	
Scheduling: PCPs and PCP/ Specialists Only (continued)	5. Wait time in the waiting room and exam room should be no more than 30 minutes or at any time no more than up to one hour when the practitioner encounters an unanticipated urgent medical condition visit or is treating a patient with a difficult need. 6. Practice must have at least 20 hours of patient scheduling time per week per office. 7. Practice must have physician coverage arrangements for vacations, etc.
Office Protocols	1. The office must have a recall system for patients who miss appointments and document in Medical Record, whether a postcard, or a telephone call was made/sent. At least one attempt to contact the member must be made by telephone. At least three attempts must be made. 2. **PCP and PCP/Specialist Only:** The Office is able to perform EPSDT screens (offices whose panel limit is 21 and under). Should the PCP be unable to conduct the necessary EPSDT Screens, 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 in to the Member's PCP medical record.
Emergency Care	**PCP and PCP/Specialist:** A physician must be available 24 hours a day, seven days per week, directly or through on-call arrangements for urgent or emergency care and provide triage and appropriate treatment or referrals for treatment. This can be accomplished by answering machine or answering service.

Exit Interview with Office
Review the Environmental Assessment Standards and your findings at this time. Provide the standards for the medical record review process and give approximate date for completion of the credentialing process.

Provider Changes

To ensure our members have up-to-date and accurate information about Highmark Health Options Duals' network providers while accessing our provider directory, it is imperative that providers notify us of any of the following:

- Address changes
- Phone and 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

The physician agreement indicates that participating providers must submit written notice 90 calendar days prior to the date the provider intends to terminate. There is also 60 days' notice required if you plan to close your practice to new patients and 30 days' notice required for a practice location change. Please refer to the Practice/Provider Change Request Form which is located on our provider website at **wv.highmarkhealthoptions.com/providers/**.

FQHC/RHC Provider Changes Process

The Highmark Health Options Duals physician agreement indicates that participating providers must submit written notice 90 calendar days prior to the date the provider intends to terminate. There is also 60 days' notice required if you plan to close your practice to new patients and 30 days' notice required for a practice location change.

Whenever an FQHC/RHC has new adds (physician or group), demographic changes and/or terminations that occur within an FQHC/RHC practice location(s), the FQHC/ RHC Provider Change Form must be completed and sent to the plan within the timeframes indicated above.

Please refer to the FQHC/RHC Provider Change Form which is located on our website at **wv.highmarkhealthoptions.com/providers/**.

CMS Guidance on Medicare Marketing Activities

Below is the CMS guidance on provider marketing activities as detailed at 42 CFR § 422.2266.

Activities with health care providers or in the health care setting.

(a) **Where marketing is prohibited.** The requirements in **paragraphs (c)** through **(e)** of this section apply to activities in the health care setting. Marketing activities and materials are not permitted in areas where care is being administered, including but not limited to the following:

(1) Exam rooms.

(2) Hospital patient rooms.

(3) Treatment areas where patients interact with a provider and clinical team (including such areas in dialysis treatment facilities).

(4) Pharmacy counter areas.

(b) **Where marketing is permitted.** Marketing activities and materials are permitted in common areas within the health care setting, including the following:

(1) Common entryways.

(2) Vestibules.

(3) Waiting rooms.

(4) Hospital or nursing home cafeterias.

(5) Community, recreational, or conference rooms.

(c) **Provider-initiated activities.** Provider-initiated activities are activities conducted by a provider at the request of the patient, or as a matter of a course of treatment, and occur when meeting with the patient as part of the professional relationship between the provider and patient. Provider-initiated activities do not include activities conducted at the request of the MA organization or pursuant to the network participation agreement between the MA organization and the provider. Provider-initiated activities that meet the definition in this **paragraph (c)** fall outside of the definition of marketing in **§ 422.2260**. Permissible provider-initiated activities include:

(1) Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from the **Medicare website**), including in areas where care is delivered.

(2) Providing the names of MA organizations with which they contract or participate or both.

(3) Answering questions or discussing the merits of a MA plan or plans, including cost sharing and benefit information, including in areas where care is delivered.

(4) Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Offices, the **Medicare website**, or **1-800-MEDICARE**.

(5) Referring patients to MA plan marketing materials available in common areas.

(6) Providing information and assistance in applying for the LIS.

(7) Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.

(d) **Plan-initiated provider activities.** Plan-initiated provider activities are those activities conducted by a provider at the request of an MA organization. During a plan-initiated provider activity, the provider is acting on behalf of the MA organization. For the purpose of plan-initiated activities, the MA organization is responsible for compliance with all applicable regulatory requirements.

(1) During plan-initiated provider activities, MA organizations must ensure that the provider does not:

(i) Accept or collect Scope of Appointment forms.

(ii) Accept Medicare enrollment applications.

(iii) Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.

(iv) Mail marketing materials on behalf of the MA organization.

(v) Offer inducements to persuade patients to enroll in a particular MA plan or organization.

(vi) Conduct health screenings as a marketing activity.

(vii) Distribute marketing materials or enrollment forms in areas where care is being delivered.

(viii) Offer anything of value to induce enrollees to select the provider.

(ix) Accept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization.

(2) During plan-initiated provider activities, the provider may do any of the following:

(i) Make available, distribute, and display communications materials, including in areas where care is being delivered.

(ii) Provide or make available marketing materials and enrollment forms in common areas.

(e) **MA organization activities in the health care setting.** MA organization activities in the health care setting are those activities, including marketing activities that are conducted by MA organization staff or on behalf of the MA organization, or by any downstream entity, but not by a provider. All marketing must comply with the requirements in **paragraphs (a)** and **(b)** of this section. However, during MA organization activities, the following is permitted:

(1) Accepting and collecting Scope of Appointment forms.

(2) Accepting enrollment forms.

(3) Making available, distributing, and displaying communications materials, including in areas where care is being delivered.

Provider Complaints

We have created a Provider Complaint system for participating and non-participating providers to raise issues with Highmark Health Options Duals policies, procedures, and administrative functions. Complaints will be investigated, and the details of the findings and disposition will be communicated back in writing to the provider within 30 days of receipt. If additional time is needed to resolve issues, Highmark Health Options Duals will provide status updates to the provider as applicable.

Any misdirected submissions, including but not limited to administrative reviews or clinical appeals, in to the provider complaint system will be routed to the appropriate department. The provider will be advised of the redirection and educated on proper handling and contact details of the appropriate department for future reference.

All network providers are required to be NaviNet enabled. Providers are expected to use this tool to access the Provider Complaint Messaging Center. All non-participating providers will be directed to complete the Highmark Health Options Duals Non-Participating Provider Complaint Form which is located on the Highmark Health Options Duals website at **highmark.com/health-options-wv**.

The form may be submitted to **HHOProviderComplaint@highmark.com** or faxed to **1-833-841-8069**.

Continuity and Coordination of Care

Specialists, Hospitals & Skilled Nursing facilities must ensure compliance with the Continuity and Coordination of Care requirements, by ensuring that all discharge summaries and progress reports are reported back to the member's PCP. Continuity and Coordination of Care across settings is a regulatory requirement.

Care across settings, such as between Primary Care Physicians (PCPs) and specialists, presents many challenges to the continuity of information, relationships, and treatment.

Much of the Plan's membership is made up of the most vulnerable individuals. Some of whom suffer from severe or chronic illnesses. Enhanced communication is imperative across all the touchpoints within these patients' care to make the informed decisions which will ensure their well-being. Failure to share information about the care of a patient can result in suboptimal outcomes, increased costs, and medical errors.

It is to the benefit of both the patient and health care professional to communicate any reports, therapies, medications, and concerns identified by providers across treatment settings. For additional continuity of care concerns or assistance, please contact your Provider Account Liaison.



Referrals and Authorizations

Referrals

Out of Plan Referrals

Occasionally, a member may need to see a health care professional outside of Highmark Health Options Duals' provider network. When the need for out-of-plan services arises, the primary care practitioner must contact our Utilization Management Department to obtain an authorization via our GuidingCare authorization portal, accessed via NaviNet. If for some reason GuidingCare is unavailable, providers can contact our Utilization Management Department at **1-833-957-0025**. The Utilization Management Department will review the request and make arrangements for the member to receive the necessary medical services with a specialty care practitioner in collaboration with the recommendations of the primary care practitioner. Every effort will be made to locate a health care professional within an accessible distance to the member.

Referrals for Second Opinions

Second opinions from a qualified health care professional may be requested by a member. When requesting a second opinion consultation, Highmark Health Options Duals recommends that you issue a referral to an in-network qualified health care professional that is not in practice with the practitioner who rendered the first opinion. If an in-network, qualified health care professional is not available, contact our Utilization Management Department to assist in arranging and obtaining an authorization for the second opinion of an out-of-network provider at no additional cost to the member than an in-network referral.

Self-Referral

All Highmark Health Options Duals members are encouraged to coordinate care with their primary care practitioner prior to receiving specialty services except for the services that can be accessed by self-referral.

Members may refer themselves for the following types of care:

- Routine women's health care
- Pap smears
- Pelvic exams
- Mammograms
- Flu shots

- Pneumonia vaccinations
- Specialist visits
- Prostate screening
- Colorectal screening
- Bone mass measurements
- Diabetes monitoring training
- Dialysis
- Behavioral health services
- Substance use services
- Vision exams*
- Hearing exams*

*Benefit coverage varies by product.

Authorizations

The function of an authorization is to confirm the eligibility of the member, verify coverage of services, assess the medical necessity and appropriateness of care, establish the appropriate site for care, and identify those members who may benefit from case management or disease management. Authorization is the responsibility of the admitting practitioner or ordering provider and can be obtained by contacting the Highmark Health Options Duals' Utilization Management Department prior to services being rendered via our GuidingCare authorization portal, accessed via NaviNet.

If for some reason GuidingCare is unavailable, providers can contact our Utilization Management Department at **1-833-957-0025**. (Refer to the section listed as the Process for Requesting Prior Authorization.) The Utilization Management Department assesses the medical appropriateness of services using nationally recognized criteria, such as McKesson's InterQual® Criteria, the American Society of Addiction Medicine (ASAM) Guidelines, the Centers for Medicare and Medicaid Services (CMS)-definition of medical necessity, CMS National and Local Coverage Determinations, and our company's medical policies when authorizing the delivery of health care services to plan members.

The CMS definition of medically necessary specifically states that a service must be medically necessary to be covered, which means that it must be reasonable and necessary for the purpose of diagnosing or treating illness or injury to improve the functioning of a malformed body member. It refers to services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition; are used for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of the member or the doctor.

Prior authorization must continue to be obtained for members through Highmark Health Options Duals for admissions and concurrent stays to a Skilled Nursing Facility, a Long-Term Acute Care Hospital, and an Inpatient Rehabilitation Facility.

The following services require prior authorization from Highmark Health Options Duals or have a payment policy applied:

- Acute inpatient admission and continued stays
- Notification of discharge (acute IP discharge)
- Behavior health admission/continued stay review psych
- Behavior health substance use/misuse admission/continued stay review
- Behavior health discharge
- Behavior health outpatient requests
- Chiropractic visits
- Durable medical equipment (DME) requests

Note: A comprehensive list of items requiring authorization can be found on our website under the provider section. Remember to check for medical or payment policies that may apply.

- Medical Policies: **wv.highmarkhealthoptions.com/providers/**
- Payment Policies: **wv.highmarkhealthoptions.com/providers/**

Note: Failure to follow the prior authorization process may result in the administrative denial of your claim regardless of medical necessity. It is the responsibility of the provider to submit a request for a retrospective authorization when outside of their control, an authorization was not obtained. In the event services are needed urgently or emergently, authorizations must be requested within four calendar days of discharge for inpatient services and within one business day for outpatient services. Authorization requests made outside of this this timeframe must be submitted through retrospective review.

Along with the authorization, the provider must submit justification as to why an authorization was not requested such as the member was incapacitated, the member provided the wrong insurance information at the time of service, or the procedure meets the definition of requiring emergency stabilization along with all relevant medical records to Highmark Health Options Duals.

For the mailing address, please refer to **Retrospective Authorization Reviews** under the "Important Addresses" section on page 16.

Note: Highmark Health Options Duals Providers must initiate authorization requests online by accessing the Authorization Portal through NaviNet Single Sign-On (SSO) functionality. From the

Health Plans dropdown on the NaviNet Plan Central page, select Highmark Health Options Duals then GuidingCare>Authorization Portal from the Plan Workflows menu. For additional information regarding GuidingCare, please refer to the GuidingCare user Guide on our website.

Process for Requesting Prior Authorizations

The Utilization Management Department is committed to assuring prompt, efficient delivery of health care services and to monitor quality of care provided to Highmark Health Options Duals members. The Utilization Management Department can be contacted via our GuidingCare authorization portal, accessed via NaviNet. If for some reason GuidingCare is unavailable, providers can contact our Utilization Management Department between the hours of 8:30 a.m.–4:30 p.m., Monday–Friday, at **1-833-957-0025**.

When calling before or after operating hours or on holidays, practitioners are asked to leave a voicemail message and a Utilization Management Representative will return the call the next business day. Urgent requests or questions are directed to call **1-833-957-0025**.

Highmark Health Options Duals WV providers must submit authorization requests online by accessing the GuidingCare Authorization Portal through NaviNet Single Sign-On (SSO) functionality for all UM related requests, including but not limited to, the following services:

- Inpatient maternity
- Inpatient services
- Durable medical equipment
- Select surgical procedures
- Diagnostic testing
- Genetic testing

In the case of an emergent admission when care cannot be coordinated on a pre-service basis, the Highmark Health Options Duals admitting physician, hospital, or member is encouraged to notify the Utilization Management Department as soon as possible of the inpatient admission. Notification facilitates coordination of care management, quality issues, and discharge planning. Highmark Health Options Duals will perform concurrent inpatient level of care reviews to establish medical necessity. In the event services are needed urgently or emergently, authorizations must be requested within four calendar days of discharge. Admission requests made outside of this timeframe must be submitted through retrospective review.

Authorization requests made after the care has been completed (post service/post discharge) must be submitted as an appeal once a claim denial has been received. Utilization Management will not accept post service authorization requests.

When requesting authorization of planned procedures, we recommend contacting the Utilization Management Department as soon as possible, but within a minimum of two working days in advance when possible. Authorization requests should be submitted through our GuidingCare authorization portal, accessed via NaviNet. If for some reason GuidingCare is unavailable, providers can contact our Utilization Management Department.

Once a request is received, the information given will be reviewed, and the member's eligibility verified. However, since a member's eligibility may change prior to the anticipated date of service, eligibility must be verified on the date of service.

The following information may be needed to authorize a service:

- Member name and birthdate
- Member ID number
- Procedure code, if applicable (CPT4, HCPCS)
- Durable Medical Equipment (DME) codes and cost of ttem(s), when applicable
- Date of service
- Name of admitting/treating practitioner
- Name of the practitioner requesting the service
- NPI number
- Any other pertinent clinical information such as:
  - Diagnoses/comorbidities
  - Age
  - Complications
  - Progress of treatment
  - Medical history
  - Previous test results
  - Current medications
  - Psychosocial situation
  - Home environment/social situation, when applicable

When Highmark Health Options Duals has authorized services provided by a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) and it has been determined that coverage for the services will end, the Highmark Health Options Duals staff will coordinate with the SNF, HHA, or CORF through a process agreed upon by the facility/agency and Highmark Health Options Duals to deliver the appropriate notification (Notice of Medicare Non-Coverage) to the member. The notification will inform the member of the discontinuation of the service and will be provided to the member within the timeframes established by CMS.

Note: Failure to follow the prior authorization process may result in the administrative denial of your claim regardless of medical necessity. It is the responsibility of the provider to submit a request for a retrospective authorization when outside of their control, an authorization was not obtained.

Along with the authorization the provider must submit justification as to why an authorization was not requested such as the member was incapacitated, the member provided the wrong insurance information at the time of service, or the procedure meets the definition of requiring emergency stabilization along with all relevant medical records. The information must be sent directly to Highmark Health Options Duals.

For the mailing address, please refer to **Retrospective Authorization Reviews** under the "Important Addresses" section on page 16.

Outpatient Therapy Services

All outpatient therapy treatment services including physical therapy, occupational therapy, and speech therapy require a prior authorization. Outpatient therapy services require prior authorization through the HealthHelp website at healthhelp.com/Highmark Health Options Duals or by calling the dedicated toll-free phone number, Monday–Friday, 8 a.m.–6 p.m. at **1-800-546-7092**. A separate authorization number is required for each procedure ordered. The therapy provider will be asked to fax the current progress notes, plan of treatment, and goals, which support the medical necessity of the therapy services.

In keeping with our commitment of promoting continuous quality improvement for services provided to our members, we entered in to an agreement with HealthHelp to implement a Musculoskeletal (MSK) Management Program. This program includes prior authorization for non-emergent MSK procedures including outpatient, interventional spine pain management services (IPM), inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries; you would call the HealthHelp dedicated toll-free phone number, Monday–Friday, 8 a.m.–6 p.m. at **1-800-546-7092**.

Durable Medical Equipment

For DME, medical supplies and orthotics and prosthetics the following information is needed when requesting authorization:

- Name of requested equipment or medical supply, appropriate code (HCPCS), and cost
- Rental vs. purchase request
- Amount of items requested
- Clinical information to support the medically necessary service request

Services Requiring Authorization

Utilization Management prior authorization is required on the following services:

- Elective Inpatient Admissions, including behavioral health and substance misuse (inpatient rehabilitation, skilled nursing facility, and long-term acute care hospital admissions are managed via Highmark Health Options Duals)
- Genetic testing
- Hyperbaric oxygen therapy
- Non-invasive positive pressure ventilation
- Readmissions within 30 days
- Durable Medical Equipment (DME), orthotics, prosthetics, medical supplies, or monthly rentals
- Cardiology Procedures including Peripheral Revascularization, Cardiac Devices, Ablation/ EPS (HealthHelp)
- Complex outpatient imaging services (HealthHelp)
- Chiropractic services (chiropractic services are covered to correct a subluxation by means of manual manipulation of the spine)
- Outpatient psychiatric partial hospitalization
- Outpatient rehab (physical therapy, occupational therapy, speech therapy, including therapy performed in the home (HealthHelp))
- Experimental/investigational services
- Plastic surgery/cosmetic procedures
- Non-participating provider services (exception: emergency room, dialysis, emergency ambulance transport)
- Outpatient surgical procedures as follows:
  - Bariatric surgery/stapling
  - Blepharoplasty
  - Breast reduction
  - Carpal tunnel surgery
  - Genital reconstruction
  - Hyperbaric oxygen therapy
  - Hysterectomy
  - Implants
  - Musculoskeletal surgeries (HealthHelp)
  - Pain management interventions, including spinal procedures (HealthHelp)
  - Panniculectomy
  - Radiation oncology (via Health Help)

- Removal of breast implant
- Rhinoplasty
- Sleep studies, PAP therapy, oral appliances (Health Help)
- Spinal neuro stimulator services
- TMJ surgery
- Transplants
- Tubal ligations
- Varicose vein surgeries performed at a Short Procedure Unit or Ambulatory Care Center

Note: A comprehensive list of items requiring authorization is located on our website at **wv.highmarkhealthoptions.com/providers/**.

In addition, participating providers can access our provider portal, via NaviNet to determine if a code requires prior authorization.

In the case of urgent/emergent admissions, the Highmark Health Options Duals admitting physician, hospital, or member is encouraged to notify the Utilization Management Department as soon as possible of the inpatient admission. Organ transplants require prior authorization and must be performed at a Medicare-approved transplant center, per CMS requirements. The following types of transplants are covered: corneal, kidney, pancreas, liver, heart, lung, heart-lung, bone marrow, intestinal/multi-visceral, and stem cell.

Prior Authorization Decision Timeframes and Notification

Standard Decisions:
For standard precertification requests, the Utilization Management Department will make a decision to approve, deny, or limit authorization of the service request as expeditiously as the enrollee's health condition requires, but no later than seven calendar days from the receipt of the request. Verbal notification of either decision will be made to the provider on behalf of the enrollee. Notification will be sent to the requesting provider and enrollee in writing on all initial authorization determinations no later than seven calendar days from the receipt of the request.

For standard concurrent requests, the Utilization Management Department will make a decision to approve, deny, or limit authorization of the service request as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the receipt of the request. Verbal notification of the decision will be made to the provider on behalf of the enrollee. Notification will be sent to the requesting provider and enrollee in writing on all authorization determinations. Written notification will occur within 72 hours of receiving the request.

Expedited Decisions:
For expedited requests, the Utilization Management Department will make a decision to approve, deny, or limit authorization of the service request as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the receipt of the request. The Utilization Management Department will notify the requesting provider telephonically on all denied expedited determinations. Written notification to the enrollee and provider will occur with all denied and approved determinations within 72 hours from receipt of the request. Approval determinations may be messaged through the portal to the provider.

Home Infusion

Nursing visits and supplies related to home infusion services do not require an authorization. Refer to pharmacy regarding authorization requirements for infusion drugs.

Pharmacy Services

Highmark Health Options Duals utilizes a closed formulary. Practitioners are encouraged to prescribe formulary medications when medically appropriate. Some formulary medications may have additional coverage restrictions, such as a quantity limit or step therapy. If changing to a formulary medication is not medically advisable for a member, or if an exception is needed for a formulary medication that has coverage restrictions, a practitioner must initiate a request for drug coverage by one of the following methods: submitting an electronic prior authorization via **CoverMyMeds.com**, faxing the Request for Drug Coverage Form to **1-833-623-2629** or calling Pharmacy Services at **1-833-957-0025**. Practitioners should ensure that all relevant information is available when calling or submitting as failure to provide this may result in an adverse coverage determination.

We encourage practitioners to utilize the Request for Drug Coverage Form located on the Highmark Health Options Duals website at **wv.highmarkhealthoptions.com/providers/**. These forms may be photocopied or you can also request a copy by calling Pharmacy Services.

All standard requests for Part B or Part D drugs submitted with the necessary clinical information will be reviewed and a decision made as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request by Pharmacy Services; all expedited requests within 24 hours after receipt of the request. In certain cases, the plan will automatically authorize a temporary supply of a non-formulary drug to allow sufficient time to transition the enrollee to a formulary alternative or request an exception.

Enrollees and practitioners are notified in writing and/or telephonically of decisions in accordance with CMS guidance.

Managing Care Transitions

Highmark Health Options Duals WV teams (i.e., Utilization Management and Care Coordination) prioritize seamless coordination of care during member transitions, especially when moving from an acute care setting to another setting. Inadequate transitions can result in poor quality of care, gaps in necessary services, and increased patient safety risks. These issues can contribute to costly and unnecessary hospital readmission(s), preventable adverse events, and medication (i.e., drug-related) errors.

Highmark Health Options Duals WV facilitates effective transition of care coordination throughout the authorization process by collaborating closely with practitioners and providers. For both planned and unplanned transitions, the health care provider (or organization) transitioning the member must provide a patient care plan to the receiving health care provider (or organization) within one business day of the transition notice. This timely sharing of a comprehensive care plan enhances continuity and coordination of care, reducing patient risks.

A patient care plan includes essential, patient-specific information relevant to the patient's clinical condition and health status. It should encompass both medical and non-medical details, such as a current problem list, allergies/sensitivities, medication regimen, contact information for the patient and health care providers, baseline physical and cognitive functioning, and advance directives.

The transitioning health care provider (or organization) often includes this care plan in patient documents such as discharge summaries, transfer summaries, or patient instructions. Additionally, changes to the member's health care status or care plan should be communicated to the member and/or their caregiver within one business day.

To facilitate and ensure safe transitions, Highmark Health Options Duals WV identifies scheduled and unscheduled care transitions, establishes a single point of contact for member support throughout the process, and maintains communication with the member, their responsible party, primary care provider, and other treating health care professionals and providers.

New Technology

Any new technology or new use of existing technology identified during the Utilization Management review process, and requiring authorization for implementation of the new technology will be forwarded to the Medical Director for authorization. If there is a question about the appropriate governmental agency approval of the technology, the Medical Director will investigate the status of the technology with the agency, consult appropriate specialists related to the new technology, professionals (who have expertise in the technology), and other major payers/state agencies and opinions of professional societies and/or utilize the contracted services of Elsevier for information related to the new technology. The technology will also be investigated through CMS National and Local Coverage Determinations.

Highmark Health Options will review new health care services, procedures, devices, and pharmacological treatments to evaluate their appropriateness for members. The necessary information will be presented for evaluation to the Quality Improvement/Utilization Management (QI/UM) Committee or Pharmacy and Therapeutics (P&T) Committee in accordance with current presentation process requirements (with the exclusion of Medical Policies) for recommendations as to whether a new technology should be included as a covered benefit for members and/or covered on a case-based decision for a specific member.

If it is determined that no other approved technology is available and/or the Medical Director and consultants feel that the possibility for a positive outcome would be achieved with the use of the new technology, approval may be given. Highmark Health Options Duals will consider those specific medical items, services, treatment procedures, or technologies not specifically identified as non-covered or non-reimbursable by Medicare as defined within National Coverage Determinations.

Claims and Billing

Member Billing Policy

Highmark Health Options Duals offers a Dual Eligible Special Needs Plan (D-SNP) which is designed for those eligible for BOTH Medicare (PART A and B) and Medicaid (Medical Assistance) or assistance from the State. Individuals who qualify for both are commonly referred to as Duals.

Because our members are enrolled in a Medicare Advantage Plan, there is a limit to how much a member will have to pay out of pocket each year for medical services that are covered under Medicare Part A and Part B.

A member's out-of-pocket expense or cost sharing will vary depending upon the level of assistance they may be receiving from the State or Medicare, as well as which Highmark Health Options Duals plan they have chosen to join.

Maximum Out of Pocket (MOOP) is a cost sharing limit that once reached, triggers a Medicare Advantage plan to pay 100% of the allowed costs for covered Part A and Part B services. MOOP is accumulated as claims for Part A and Part B services are received, and finalized by, a health plan.

Medicare Advantage Plans must calculate MOOP based on the accrual of all cost-sharing in the plan benefit, regardless of whether that cost-sharing is paid by the beneficiary, Medicaid, other secondary insurance, or remains unpaid.

As a reminder, our Dual-Eligible Highmark Health Options Duals members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for cost-sharing.

Providers further agree that upon payment from Highmark Health Options Duals, providers will accept the plan payment as payment in full or bill the appropriate state source. Please make sure to follow Medicaid coverage and claims processing guidelines. Balance billing a dual eligible for deductible, coinsurance, and copayments is prohibited by federal law.

Claims

General Information

Procedures for Highmark Health Options Duals are as follows:

- All claims should be coded and documented in accordance with the HIPAA Transactions and Code Sets which includes International Classification of Diseases (ICD-10-CM), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) with modifiers where appropriate, and National Drug Codes (NDC).

- The Center for Medicare and Medicaid Services (CMS) place of service codes are the only place of service codes accepted for processing claims.
- New codes will be added to the Highmark Health Options Duals respective fee schedules effective the first of the month upon receipt of notification from CMS. The new fees/rates will be loaded in to the claims system for payment within 30 days from the notification. If a provider would like the new rate considered, it is the provider's responsibility to resubmit a corrected claim with the appropriate coding within the timely allowance. Retroactive payments are not made to the provider.
- Claims are accepted through Electronic Data Interchange (EDI). Facilities and providers are encouraged to submit claims via this format.
- Paper and EDI claims without the required National Provider Identifier (NPI) numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form. Paper claims will be handled just like rejected EDI claims and will not be loaded in to the claims system. Providers will be held to timely filing policies in regard to submission of the initial and corrected claims.
- Handwritten claims are not accepted.
- Correct/current member information, including the 8-digit member ID number, must be entered on all claims. The member ID number or MBI (Medicare Beneficiary Identifier) in alpha and numeric format will be accepted on electronic claims. The member ID number is preferred to assure that the claim is processed under the correct individual.
- Claims can be submitted with or without the Alpha character prefix appearing on the member's ID card.
- The billing provider address submitted on claims (paper and electronic) must be a physical address. Claims submitted will be rejected if a P.O. Box number is submitted as the billing address.
- Please allow four to six weeks for a remittance advice. It is the practitioner's responsibility to research the status of a claim.
- All claims, including corrected claims, must be filed within 365 days from the date of service.
- When Highmark Health Options Duals is secondary to any commercial plan. Claims must be submitted within timely filing guidelines.
- Inpatient hospital claims must be submitted with an MS-DRG Code.
- Providers of obstetric services are reimbursed on a global basis for deliveries. Individual visits are not reimbursed and should not be billed.
- In the case of a claims overpayment, we will produce a negative remittance advice. The negative remittance advice will capture the overpayment and the impacted claims. Overpayments will be deducted from future claim payments until the provider's account returns to a positive status. Providers also have the capacity to submit a reimbursement to balance the account.

Timely Filing

All claims, including corrected claims, must be filed within three hundred sixty-five (365) days from the date of service. We prefer to receive claims electronically, but we do accept claims submitted on paper. If you bill on paper, we will only accept paper claims on a CMS-1500 or a UB-04 Form. No other billing forms will be accepted.

For more information, visit the Medicare website at **cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500**.

UB-04 and a CMS-1500 Claim Forms can be found on the provider website at **wv.highmarkhealthoptionsdualshealthoptions.com/**, under General Provider Forms & References.

Any claim that has been submitted to Highmark Health Options Duals but does not appear on a remittance advice within 60 days following submission should be researched by calling our Provider Services Department at 1-833-957-0025 to inquire whether the claim was received and/or processed.

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.

Highmark Health Options Duals accepts claims electronically in data file transmissions through any clearinghouse. Providers 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, please refer to the following grid for Clearinghouse Payer IDs:

CPID	Payer Name	Payer ID	Claim Type
2298	Highmark Health Options Duals WV	88831	Professional
2912	Highmark Health Options Duals WV	88831	Institutional

Requirements for Submitting Claims to Highmark Health Options Duals through a Clearinghouse

When submitting claims, please note the West Virginia Payer ID Number is 88831. Any claim submitted with the incorrect Payer ID Number will reject.

The billing provider address submitted on claims must be a physical address. Claims will be rejected if a P.O. Box number is submitted as the billing address. In order to prevent claims from being rejected, please be sure to submit a physical address as the billing address.

- The assigned 8-digit member identification number is needed for both paper and electronic claims. For providers who do not know the member's identification number, it is acceptable to submit the member's Medicare Beneficiary Identifier (MBI).

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

The NPI (National Provider Identifier) number is required, and the Member's 8-digit identification number is necessary. When care is coordinated, the referring provider's name and NPI are also required. A claim will be rejected if it does not include required NPI(s) and current procedure and diagnosis codes.

To ensure that claims have been accepted via EDI, providers 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. Highmark Health Options Duals will accept electronic claims for services that would be submitted on a standard CMS-1500 or a UB-04 claims form. However, services billed by report cannot be submitted as attachments along with electronic claims.

HIPAA 5010

The 5010 version of the HIPAA electronic transactions is required in order to support the transfer of ICD-10 diagnosis code and ICD-10 procedure code data on claims and remittances.

Claim Payments (Electronic Remittance Advice/Electronic Funds Transfer)

Our company uses PNC Healthcare Claim Payments & Remittances (CPR) service, powered by Echo Health. This platform allows our company to make payments based on providers' preferences, maximizing electronic payment options and simplifying adoption.

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

Outlined below are 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 **enrollments.echohealthinc.com/EFTERAInvitation.aspx?tp=MDAyNzA=** .
   - To sign up to receive EFT payments only or 835 and EFT from our company and from all Echo payers, visit **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.

Claims Review Process

We will review for reconsideration any claim that a provider 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 issues. Administrative claim reviews can be initiated by the provider through a written request, or by contacting our Provider Services Department or via fax to **1-833-623-2571**. A plan participating provider can also submit a request through the Provider Portal via NaviNet. To help us resolve the dispute, please forward documents that support your position including Claim ID Number, Member ID Number, date of service and clear rationale. Initial claims that are not received within the timely filing limit will not qualify for review. All follow-up review requests must be received within 365 calendar days of the date of service on the claim. Claims inquiries for administrative reviews should be sent directly to Highmark Health Options Duals WV.

For the mailing address, please refer to **Administrative Claims Reviews** under the "Important Addresses" section on page 14 or fax to **1-833-623-2571**.

We cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit a Refund Form or a letter that contains all of the information requested on this form.

The Refund Form is located on the provider website at **wv.highmarkhealthoptions.com/providers/**.

The form, together with all supporting materials relevant to the claim(s) reversal request being made including but not limited to an Explanation of Benefits (EOB) from other insurance carriers and your refund check should be mailed to the Finance Operations Overpayment P.O. Box.

For the mailing address, please refer to **Overpayments** under the "Important Addresses" section on page 15.

Cotiviti Claims Pattern Review (CPR)

Highmark Health Options Duals 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 enable 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 **1-833-623-2571**.
3. Mailing the records directly to Cotiviti. Please mark the envelope "Confidential" and send to:

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

Coordination of Benefits

Coordination of Benefits (COB) is the process of establishing financial responsibility for a claim and coordinating benefit payments between two or more insurance plans. It allows another insurance plan to pay the provider first as a primary payment. Once it has been determined what the first insurer (primary carrier) has paid, it is necessary to determine if there are any benefits remaining to be paid.

Some of our members have other insurance coverage. Highmark Health Options Duals follows Medicare coordination of benefits rules. We will not deny or delay approval of otherwise covered treatment or services unless the probable existence of third-party liability is identified in our records for the member at the time the claims are submitted.

Please note the following criteria applies and designates when Highmark Health Options Duals is not the primary plan for Medicare covered members:

- Enrollee is age 65 or older and covered by an Employer Group Health Plan (EGHP) because of either current employment or current employment of a spouse of any age and the employer employs 20 or more employees.
- Enrollee is disabled and covered by an Employer Group Health Plan because of either current employment or a family member's current employment, and the employer that sponsors or contributes to the Large EGHP plan employs 100 or more employees.
- For an enrollee entitled to Medicare solely on the basis of end-stage renal disease and Employer Group Health Plan coverage (including a retirement plan), the first 30 months of eligibility or entitlement to Medicare.
- Workers' compensation settlement proceeds are available.
- No-fault or liability settlement proceeds are available.

In order to receive payment for services provided to members with other insurance coverage, the practitioner must first bill the member's primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's Explanation of Benefits (EOB), the practitioner should submit a claim to Highmark Health Options Duals.

The practitioner must:

- Follow all authorization and billing procedures.
- 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 our company within 365 days of the date of the service.
- The amount billed must match the amount billed to the primary carrier. We will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

Members seeking care, regardless of primary insurer, are required to contact their primary care practitioner and use participating providers or obtain appropriate authorization for health care professionals outside of the network.

Highmark Health Options Duals accepts 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 eliminates the need for paper claims with copies of the other payer's explanation of benefits (EOB) attached. This will increase quality, consistency, and speed of payment.

Please consult with your software vendor to insure they have electronic COB submission capability and work with your EDI vendor to review the HIPAA implementation guide and submission requirements.

Claim Coding Software

Highmark Health Options Duals uses HIPAA compliant automated coding software to improve accuracy and efficiency in claims processing, payment, and reporting and to verify the clinical accuracy of professional and outpatient claims in accordance with clinical editing criteria.

This coding software will review claims against sets of rules that correspond to Current Procedural Terminology (CPT-4), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases - version 10 (ICD-10), Revenue Codes, American Medical Association (AMA), and the Centers for Medicare and Medicaid Services (CMS) guidelines as well as industry standards, medical policy and literature and academic affiliations.

The software used is designed to assure data integrity for ongoing data analysis and reviews procedures across dates of service and across providers at the claim, practitioner, and practitioner-specialty level.

Our company payment policies focus on areas such as, but not limited to:

- National billing edits including the Correct Coding Initiative (CCI)
- Modifier usage
- Global surgery period
- Add on code usage
- Age appropriateness
- State guidelines
- CMS' National Coverage Determinations (NCD's)
- CMS' Local Coverage Determinations (LCD's)

Billing

Billing Procedures

A "clean claim" as used in this section means a claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirement for equivalent claims under Medicare.

In addition, a claim shall be considered "clean" if the appropriate authorization has been obtained in compliance with our company's Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS-1500 claim forms (or their replacement with CMS designations, as applicable) or an acceptable electronic format through our contracted clearinghouse.

We may pend or deny a claim if you do not list:

- Patient name, address, date of birth and ID number.
- Patient medical plan identifier.
- Date of service for each covered service.
- Complete service information, including date of service(s), place of service(s), number of services (day/units) rendered, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes, with modifiers where appropriate, current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity—inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD-10-CM diagnosis code.
- Current National Drug Code (NDC) 11-digit number, NDC unit of measure and NDC units dispensed.
- Name of practitioners/providers and applicable/required National Provider Identifier (NPI) numbers.
- The billing provider address submitted on claims must be a physical address.
- Provider Tax Identification Number (TIN).
- Valid CMS place of service code(s). **Place of Service Code Set | CMS**
- Billed charge amount for each covered service.
- Primary carrier Explanation of Benefits (EOB) when patient has other insurance.
- MS-DRG code for inpatient hospital claims.

The billing provider address submitted on claims must be a physical address. Claims will be rejected if a P.O. Box number is submitted as the billing address. In order to prevent claims from being rejected, please be sure to submit a physical address as the billing address.

Highmark Health Options Duals processes medical expenses upon receipt of a correctly completed CMS-1500 form and hospital expenses upon receipt of a correctly completed UB-04 form.

Sample copies of a UB-04 and a CMS-1500 claim forms can be found on the Highmark Health Options Duals website at **Place of Service Code Set** | **CMS**, under General Provider Forms & References.

A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink.

NPI

As mandated in the Affordable Care Act (ACA), all providers of medical or other items or services and suppliers that qualify for a National Provider Identifier (NPI) are required to include their NPI on all claims for payment submitted under the Medicare and Medicaid programs.

Please find a few highlights of the ACA requirements and company policies and procedures to support these requirements below:

- NPIs for billing, rendering, ordering, and attending providers are required to be reported on paper claims in addition to electronic claims.
- For imaging and clinical laboratory services and items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as well as home health services, the NPI of the ordering/referring provider is required in addition to the NPI of the billing provider on paper claims and EDI claims.

Paper and EDI Claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal Service to the billing address on the claim form and just like rejected EDI claims, will not be loaded in our claims system. Providers will be held to timely filing policies in regard to submission of the initial and corrected claims.

NOTE: Applicable Paper Claim Fields:

CMS-1500 The following fields are to be reported as indicated:	
Field 17b	NPI of Referring Provider (for imaging, clinical laboratory, DMEPOS, and home health) **(required)**
Field 24J	NPI of Rendering Provider **(required)**
Field 32a	NPI of Service Facility (if applicable)
Field 33a	NPI of Billing Provider **(required)**

UB-04 The following fields are to be reported as indicated	
Field 56	NPI of Billing Provider **(required)**
Field 76	NPI of Attending Physician **(required)**
Field 77	NPI of Operating Physician (if applicable)
Field 78	NPI of Other Physician (if applicable)
Field 79	NPI of Other Physician (if applicable)

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

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 practitioner 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 practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained in the claim is true, accurate and complete.

For the mailing address, please refer to **Claims** under the "Important Addresses" section on page 13.

Any questions concerning billing procedures or claim payments can be directed to our Provider Services Department at 1-833-957-0025.

Surgical Procedure Services

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient in the same operative session or on the same day for which separate payment may be allowed. Our company determines reimbursement of surgical procedures upon the clinical intensity of each procedure and reimburses at 100% for the most clinically intensive surgery, and 50% for the subsequent procedures. Reimbursement for more than five procedures requires medical record documentation. Pre- and post-operative visits will only be reimbursed to the extent that they qualify for payment according to the follow-up criteria.

Anesthesia Services

Highmark Health Options Duals processes anesthesia services based on anesthesia procedure codes only. Anesthesia services should be billed with the correct American Society of Anesthesiologists (ASA) code in the range of 00100-01999, which are included in the CPT manual and reimbursed as time-based anesthesia. All services must be billed in minutes. Fractions of a minute should be rounded to whole minutes (30 seconds or more: round up; less than 30 seconds: round down). For billing purposes, the number of minutes of anesthesia time will be placed in field 24G on the CMS-1500 claim form for all providers who bill in paper format. All anesthesia services should be billed with the appropriate anesthesia modifier.

Hospital Services

Hospital claims are submitted on UB-04 claim forms. To assure that claims are processed for the correct member, the member's 8-digit identification number must be used on all claims. To aid in the recording of payment, patient account numbers recorded on the claim form by the practitioner are indicated in the Patient ID field on the remittance advice.

UB-04 Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for electronic claims submissions.

Field #	Description	Requirements
1	Provider name, address, city, state, zip telephone, fax, country code	Required – Facility name and physical address where services were rendered (P.O. Box # is not acceptable here)
2	Pay to name, address, city, state, zip	Required – If different from billing provider in Field 1
3a	Patient control number	Required
3b	Medical record number	Not required
4	Type of bill	Required – If four digits are submitted, the lead 0 will be ignored
5	Federal tax number	Required
6	Statement covers period	Required
7	Unlabeled field	Not used
8a	Patient name	Required

Field #	Description	Requirements
9	Patient address	Required
10	Birthdate	Required
11	Patient sex	Required
12	Admission date	Required for inpatient and home health
13	Admission hour	Not required
14	Type of admission/visit	Required, if inpatient
15	Source of admission	Required
16	Discharge hour	Not required
17	Patient status	Required
18-28	Condition codes	Maybe required in specific circumstances (Consult CMS criteria)
29	Accident state	Not used
30	Unlabeled field	Not used
31-34	Occurrence codes and dates	Maybe required in specific circumstances (Consult CMS criteria)
35-36	Occurrence span codes and dates	Required, if inpatient
37	Unlabeled field	Not used
38	Responsible party name and address	Not required
39-41	Value codes and amounts	Required, if inpatient
42	Revenue codes	Required
43	Revenue descriptions	Required
44	HCPCS/Rates/HIPPS codes	Required, if outpatient
45	Service dates	Required, if outpatient
46	Service units	Required
47	Total charges	Required
48	Non-covered charges	Required, if applicable
49	Unlabeled field	Not used

Field #	Description	Requirements
50	Payer identification	Required
51	Health plan ID	Not required
52	Release of Information Certification Indicator	Required
53	Assignment of benefits	Not used
54	Prior payments	Required, if applicable
55	Estimated amount due from patient	Not required
56	National Provider ID	Required – NPI Number
57	Other Provider ID	Health Plan Practitioner Identification Number should be entered on paper claims only – legacy number reported as secondary identifier to NPI on electronic claims
58	Insured's name	Required, if applicable
59	Patient relationship to insured	Required, if applicable
60	Certificate-Social Security Number-Health Insurance Claim-Identification Number	Health Plan Member Identification Number Required
61	Insurance group name	Required, if applicable
62	Insurance group number	Required, if applicable
63	Treatment authorization code	Required, if applicable
64	Document control number	Not required
65	Employer name	Required, if applicable
66	Diagnosis and procedure code qualifier	Required
67	Principal diagnosis code	Required (Coding for present on admission data required)
67A-67Q	Other diagnosis codes	Required (Coding for present on admission data required)
68	Unlabeled field	Not used

Field #	Description	Requirements
69	Admitting diagnosis code	Required
70A-70C	Patient reason for visit	Not required
71	Prospective Payment System (PPS) code	Required for DRG Code – If four digits submitted, the Lead 0 will be ignored
72	External cause of injury codes	Not used
73	Unlabeled field	Not used
74	Principal Procedure Code and date	Required, if applicable
74A-74E	Other procedure codes and date	Required, if applicable
75	Unlabeled field	Not used
76	Attending Provider Name and identifiers (Including NPI)	Maybe required in specific circumstances (Consult CMS criteria) If not required, do not send
77	Operating Provider Name and identifiers (Including NPI)	Maybe required in specific circumstances (Consult CMS criteria) If not required, do not send
78-79	Other Provider Name and identifiers (Including NPI)	Maybe required in specific circumstances (Consult CMS criteria) If not required, do not send
80	Remarks	Maybe required in specific circumstances (Consult CMS criteria)
81	Code – Code field	Optional (Consult CMS criteria)

CMS-1500 Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for electronic claims submissions.

Field #	Description	Requirements
1	Insurance type	Required
1a	Insured identification number	Health plan member identification number
2	Patient's name	Required
3	Patient's birth date	Required
4	Insured's name	Required
5	Patient's address	Required
6	Patient relationship to insured	Required
7	Insured's address	Required
8	Reserved for NUCC use	Not required
9	Other insured's name	Required, if applicable
9a	Other insured's policy or group number	Required, if applicable
9b	Reserved for NUCC use	Not required
9c	Reserved for NUCC	Not required
9d	Insurance plan name or program name	Required, if applicable
10a,b,c	Is patient condition related to: a) Employment b) Auto accident c) Other accident	Required, if applicable
10d	Claim Codes (Designated by NUCC)	Not required
11	Insured's Policy Group or FECA Number	Required
11a	Insured's date of birth, sex	Required, if applicable
11b	Other Claim ID	Required, if applicable
11c	Insurance plan name or program name	Required, if applicable

Field #	Description	Requirements
11d	Is there another Health Benefit Plan?	Required, if applicable
12	Patient or Authorized Person's signature	Required
13	Insured or Authorized Person's signature	Required
14	Date of current: Illness OR injury OR pregnancy	Required, if applicable
15	Other date	Not required
16	Dates patient unable to work in current occupation	Required, if applicable
17	Name of referring practitioner or other source	Required, if applicable
17a	Other identification number of referring practitioner	Required, if applicable
17b	National Provider Identifier (NPI)	Required
18	Hospitalization dates related to current services	Required, if applicable
19	Additional claim information (Designated by NUCC)	May be required in specific circumstances (Consult CMS criteria)
20	Outside lab	Required, if applicable
21	Diagnosis or nature of illness or injury (Relate to 24E)	Required
22	Resubmission code and/or original ref. no	Required, if applicable
23	Prior authorization number	Required, if applicable
24A	Date(s) of service	Required
24B	Place of service	Required
24C	EMG	Required, if applicable
24D	Procedures, services, or supplies CPT/HCPCS/Modifier	Required
24E	Diagnosis code pointer	Required

Field #	Description	Requirements
24F	Charges	Required
24G	Days or units	Required
24H	EPSDT Family Plan	Required, if applicable
24I	ID qualifier	Required, if applicable
24J	Rendering Provider ID	Required
25	Federal Tax Identification Number, SSN/EIN	Required
26	Patient account number	Required
27	Accept assignment	Required
28	Total charge	Required
29	Amount paid (Required when another carrier is primary payer)	Required, if applicable
30	Reserved for NUCC use	Not required
31	Signature of Physician or Supplier including degrees or credentials/date	Required Health Plan individual practitioner name and date required
32	Service facility location information	Required Facility name and physical address where services were rendered required (P.O. Box #s are not acceptable here)
32a	Name and address of facility where services were rendered (If other than home or office)	Required
32b	Other ID #	Required, if applicable
33	Billing provider info and phone number	Required Facility name and physical address where services were rendered (P.O. Box #s are not acceptable here)
33a	NPI number	Required
33b	Other ID #	Required, if applicable

Federally Qualified Health Centers (FQHC)/ Rural Health Clinics (RHC)

Overview

In accordance with the Centers for Medicare and Medicaid Services (CMS) Highmark Health Options Duals requires FQHCs and RHCs to submit qualified visits using established specific payment codes. The FQHC/RHC Billing Guide is ONLY applicable to those practices who are contracted under a Participating Provider Agreement. FQHCs contracted under an Ancillary Services Agreement are reimbursed at the CMS Prospective Payment System (PPS) rate. RHCs contracted under an Ancillary Services Agreement are reimbursed at the CMS All-inclusive Rate (AIR).

Encounter Definition

Rates are charged for each Encounter. An eligible Encounter is defined as:

Medical Service Encounter: An encounter between a medical provider and a patient during which medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Family planning encounters and obstetrical encounters are a subset of medical encounters.

Eligible Providers include:

1. Physician (including podiatrists)
2. Psychiatrist
3. Mid-level practitioners:
    - CRNP (midwife or a licensed nurse practitioner)
    - Licensed Physician Assistant
    - Speech, Physical, and Occupational Therapist
    - Audiologist
    - Chiropractor
    - Case Manager
    - Nutritionists
    - Licensed Social Workers
    - Licensed Professional Counselors (LPC)
    - Marriage and Family Therapist and Mental Health Counselors
    - Licensed Clinical Psychologist
    - CRNP with a mental health certification

Prospective Payment System (PPS) Methodology for Medicare

Refer to the MLN Matters® Articles for the FQHC and RHC to determine the appropriate encounter code that drives the PPS rate payment:

- Article titled MLN Matters Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)
  - MLN Matters® Number: MM8743
- Article titled MLN Matters Required Billing Updates for Rural Health Clinics
  - MLN Matters® Number: MM9269 Revised

For more information visit the FQHC-RHC resources webpage and review the FQHC/RHC Annual Training Provider Orientation PowerPoint at **wv.highmarkhealthoptions.com/providers/**.

Multiple Encounter Submission

Encounters with more than one eligible practitioner and multiple encounters with the same eligible practitioner that take place on the same date, at a single location, and that have the same diagnosis constitute a single encounter.

The following two conditions are recognized for payment of more than one encounter rate on the same day:

1. After the first encounter, the member suffers a different illness or injury requiring additional diagnosis or treatment; and
2. The patient has a medical visit, a behavioral health visit, or a dental visit on the same day.
   - The medical necessity of multiple encounters must be clearly documented in the medical record. Providers must exercise caution when billing for multiple encounters on the same day, and such instances are subject to post-payment review to determine the validity and appropriateness of multiple encounters.
   - Providers may not inappropriately generate multiple encounters by unbundling services that are routinely provided together during a single visit or scheduling multiple patient visits for services that could be performed at a single visit.
   - Include only one encounter per claim. Claims with more than one encounter listed will be denied. When billing for more than one encounter per day, submit one claim for each encounter. On each claim, to indicate it is a separate encounter, enter “unrelated diagnosis” and the time of both visits in field 19 on the CMS-1500 Claim Form or in the Comments field when billing electronically.
   - Documentation for all encounters must be kept in the member’s file.

All participating FQHCs/RHCs providers are required to bill with the following Place of Service Code.

50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

For services rendered at an FQHC or RHC facility, please do not bill with POS 11.

All claims must be billed with the appropriate FQHC or RHC qualified encounter code for Medicare. Total charges for the encounter should be billed with appropriate approved E&M code(s) from the current Medicare Fee Schedule. Claims submitted with just the encounter code will not be paid.

All practitioners must come over on the FQHC/RHC Provider Change Form or Roster Template and be set up with the plan's credentialing/claims system prior to rendering services. All FQHCs/RHCs must have a collaborative agreement on file between the physicians, and extender(s) on staff. For more information on the FQHC/RHC Provider Process refer to the Policies and Procedures section of the manual.

Timely Filing

All claims, including corrected claims, must be filed within 365 days from the date of service. We prefer to receive claims electronically, but we do accept claims submitted on paper. If you bill on paper, we will only accept paper claims on a CMS-1500, or a UB-04 claim form. No other billing forms will be accepted.

For more information visit the Medicare website at **cms.gov/medicare/coding-billing/electronic-billing/professional-paper-claim-form**.

UB-04 and CMS-1500 Claim Forms can be found on the provider website at **wv.highmarkhealthoptions.com/providers/**, under General Provider Forms & References.

For more Claims and Billing information, refer to the Claims and Billing sections:

- Member Billing Policy
- General Information
- Electronic Claims Submission

- Requirements for Submitting Claims to Highmark Health Options Duals through SDS-Smart Data Solutions
- HIPAA 5010
- Claim Payments (Electronic Remittance Advice/Electronic Funds Transfer)
- Claims Review Process
- Coordination of Benefits
- Claim Coding Software
- Billing Procedures
- UB-04 Data Elements for Submission of Paper Claim Forms
- CMS-1500 Data Elements for Submission of Paper Claim Forms

Any claim that has been submitted to our company but does not appear on a remittance advice within 60 days following submission should be researched by calling the Provider Services Department to inquire whether the claim was received and/or processed.



Appeals and Grievances

Introduction

Highmark Health Options Duals encourages its members to let us know right away if they have questions, concerns, or problems related to covered services or the care that they receive. Members are encouraged to contact Member Services for assistance.

This section provides an outline of rules for making complaints in different types of situations. Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complaint, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to dis-enroll or penalize a member in any way for making a complaint.

What Are Appeals and Grievances?

A member has the right to make a complaint if he or she has concerns or problems related to coverage or care. "Appeals" and "grievances" are the two different types of complaints that can be made.

An "appeal" can be filed if a member asks Highmark Health Options Duals to reconsider and change a decision we have made about what services or benefits are covered or what we will pay for a service or benefit.

A member may file an appeal under these circumstances:

- If we refuse to cover or pay for services a member thinks we should cover
- If we or one of our plan providers reduces or cuts back on services or benefits that a member has been receiving, or
- If a member believes that we are stopping coverage of a service or benefit too soon

A "grievance" is the type of complaint that can be made if a member has any other type of problem with Highmark Health Options Duals or one of our plan providers.

For example, grievances may be filed if a member is experiencing a problem regarding the following situations:

- The quality of care by a plan provider
- Waiting times for appointments or in the waiting room
- Provider behavior or the behavior of the provider's office staff
- Not being able to reach someone by phone or get the information needed, or
- The cleanliness or condition of a provider's facilities

Generally, grievances should be filed directly with Highmark Health Options Duals, but for matters related to quality of care, members also have the opportunity to file such complaints with a Quality Improvement Organization (QIO). The QIO in West Virginia is Commence Health. QIO quality of care reviews are discussed on page 135.

Acting as an Authorized Representative

Highmark Health Options Duals will accept appeals or grievances made by the member and/or his/her authorized representative or the prescribing physician or other prescriber or a non-participating provider involved in the member's care. A member may have any individual (relative, friend, advocate, attorney, congressional staff member, member of advocacy group, or suppliers, etc.) act as his/her representative, as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law.

In order to act as a representative, the member and representative must complete the Appointment of Representative Form (AOR) (or an equivalent document) which is located on the Highmark Health Options Duals website at **wv.highmarkhealthoptions.com/providers/**.

The appointment remains valid for a period of one year from either the date signed by the party making the appointment or the date the appointment is accepted by the representative, whichever is later. The appointment is also valid for any subsequent levels of appeal on the claim or service in question unless the member specifically withdraws the representative's authority.

If the requestor is the member's legal guardian or otherwise authorized under state law, no appointment is necessary. We will require submission of appropriate documentation, such as a durable power of attorney.

A physician who is providing treatment to a member (upon providing notice to the member) may request an appeal on the member's behalf without having been appointed as the member's representative.

A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation. Providers who do not have a contract with our company must sign a "Waiver of Liability" statement that the provider will not require the member to pay for the medical service under review, regardless of the outcome of the appeal. The "Waiver of Liability" can be found on the Highmark Health Options Duals website at **wv.highmarkhealthoptions.com/providers/**.

It is important to note that the appeals process will not commence until Highmark Health Options Duals receives a properly executed AOR or for payment appeals from non-participating providers, a properly executed Waiver of Liability statement.

Appeals Regarding Hospital Discharge

There is a special type of appeal that applies only to hospital discharges. If a member feels that the Highmark Health Options Duals coverage of a hospital stay is ending too soon, the member or his or her authorized representative can appeal directly and immediately to the Quality Improvement Organization (QIO). Quality Improvement Organizations are assigned regionally by the Centers for Medicare and Medicaid Services (CMS). The QIO for the state of West Virginia is Commence Health. The QIOs are groups of health professionals that are paid to handle this type of appeal from Medicare patients. When such an appeal is filed on time, the stay may be covered during the appeal review. One must act very quickly to make this type of appeal, and it will be decided quickly.

If a member believes that the planned discharge is too soon, the member or his/her authorized representative may ask for a QIO review to determine whether the planned discharge is medically appropriate. "The Important Message from Medicare" document given to the member within two days of admission and copied to the member within two days of discharge provides the appeal information as well as the QIO name and telephone number.

In order to request a QIO review regarding a hospital discharge, the member or his or her authorized representative must contact the QIO no later than midnight of discharge date and before leaving the hospital. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If the QIO reviews the case, it will review medical records and provide a decision within one calendar day after it has received the request and all of the medical information necessary to make a decision. If the QIO decides that the discharge date was medically appropriate, the member will have no financial liability until noon of the day after the QIO provides its decision. If the QIO decides that the discharge date was too soon and that continued confinement is medically appropriate, we will continue to cover the hospital stay for as long as it is medically necessary.

If the member or his/her authorized representative does not ask the QIO for a review by the deadline, the member or authorized representative may ask our company for an expedited appeal. If the member or authorized representative asks us for an expedited appeal of the planned

discharge and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited appeal decision. If the expedited appeal decision is in the member's favor, we will continue to cover the hospital care for as long as it is medically necessary. If the expedited appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date, unless an Independent Review Entity (IRE) review overturns our decision.

Skilled Nursing Facility (SNF), Home Health (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) Services

There is another special type of appeal that applies only when coverage will end for SNF, HHA or CORF services. If a member feels that coverage for these services is ending too soon, he or she can appeal directly and immediately to the QIO. As with hospital services, these services may be covered during the appeal review if filed on time.

If Highmark Health Options Duals and/or the care provider decide to end coverage for SNF, HHA or CORF, a written Notice of Medicare Non-Coverage (NOMNC) must be delivered to the member at least two calendar days before coverage ends or the second to the last day of service if care is not being provided daily (such as HHA). The member or authorized representative will be asked to sign and date this document. Signing the document does not mean that the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in the provider's records.

Quality Improvement Organization (QIO) Review

For these types of services, members have the right by law to ask for an appeal of a termination of coverage. As will be explained in the notice referenced above, the member or his or her authorized representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency. If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day following the day the notice is received. If the notice is received more than two days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, the QIO will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will also look at medical

information, talk to the doctor, and review other information that our company provides to the QIO. It is important that the provider immediately faxes all of the member's medical records to the QIO for their review. Our company will provide both the member and the QIO a copy of the explanation for termination of coverage of these services.

After reviewing all the information, the QIO will decide whether it is medically appropriate for coverage to be terminated on the date that has been set for the member. The QIO will make this decision within one full day after it receives the information necessary to make a decision. If the QIO decides in favor of the member, our company will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the termination date that appears on the advance notice. Neither Original Medicare nor our company will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

If the member or his/her authorized representative does not ask the QIO for a review in a timely manner, the member or authorized representative may request an expedited appeal. It is important to note that if the member or authorized representative requests an expedited appeal regarding termination and services continue to be provided, the member may have financial liability if services are provided beyond the termination date.

If our company staff decides upon expedited appeal review that services are medically necessary to continue, we will continue to cover the care for as long as medically necessary. If the decision is not in the member's favor, we will not cover any of the care that was provided beyond the termination date, and the member may be financially responsible.

Appeals for Coverage of Other Medical Services

After our company has issued an organization determination, a member or authorized representative may file an appeal. If we deny all or part of a request for coverage of services or payment for services, a member may ask for us to reconsider our decision. This is called a request for reconsideration. A member or authorized representative may call Member Services or file a reconsideration or get assistance in filing. We can also accept written requests for appeal which can be forwarded to the address below or fax to the appeals department at **1-833-560-1828**. All appeals must be filed within 65 calendar days of any initial denial notice. Additional time may be granted for good cause. Any requests for good cause extensions must be completed in writing.

The first step of the appeal process is referred to as a request for reconsideration. If the member's medical condition warrants it, an expedited appeal may be requested. Our company's staff will make every effort to gather all the information needed in order to make a decision about the

appeal. Qualified individuals who were not involved in making the initial coverage determination will review the appeal. Members also have the right to obtain and provide additional information as part of the appeal. Additional information in support of the member's appeal may be provided in writing.

For the mailing address, please refer to **Member Appeals & Grievances** under the "Important Addresses" section on page 14.

Information may also be provided by fax at **1-833-560-1828** or calling Member Services at **1-833-957-0025** to submit a verbal appeal or schedule to submit in person.

Members or authorized representatives also have the right to ask us for a copy of the information that pertains to their appeal. Members may call Member Services at the number listed above in order to make such a request.

For a decision about payment for care already received, the appeal must be finalized by our company within 60 days, which includes payment for the services or forward the appeal to the Independent Review Entity (IRE) for review. For a standard review, about medical care not yet provided, we must finalize the appeal within 30 days or sooner if the member's health condition warrants. If the request is for a Medicare Part B prescription drug not yet received, we must finalize the appeal within seven calendar days of receipt of an appeal. For expedited appeals regarding medical care or Part B drugs, our company has up to 72 hours to make a decision but will make it expeditiously as the enrollee's health condition requires. All adverse reconsideration decisions are automatically forwarded to the IRE for review. Also, if we do not issue a decision within the standard or expedited timeframes as outlined above, the appeal will be automatically forwarded to the IRE for review. The IRE has a contract with CMS and is not part of our company.

When the appeal is for services that have not been received, if the member requests an extension, or:

- The extension is justified and in the enrollee's interest due to the need for additional medical evidence from a non-contract provider that may change an MA plan's decision to uphold a denial; or
- The extension is justified due to extraordinary, exigent, or other non-routine circumstances.

We cannot take extra time when the appeal is for a Part B prescription drug.

Upon completion of the reconsideration, all parties to the appeal will be notified of the outcome. If the decision is a denial, the member or authorized representative will be verbally notified that their appeal has been forwarded to the IRE.

IRE Review

Our company will automatically forward all adverse reconsideration decisions to the IRE. The member may request a copy of the file that is provided to the IRE for review. The IRE will notify the member of the receipt of the appeal, review the request, and make a decision about whether we must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to 60 calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to 30 calendar days to issue a decision, if the appeal is for a Part B prescription drug the IRE must decide within seven calendar days. For expedited appeals regarding medical care, the IRE has up to 72 hours to make a decision. These timeframes can be extended by up to 14 calendar days if more information is needed and the extension is in the member's best interest. The IRE cannot take an extension if the appeal is for a Part B prescription drug.

The IRE will issue its decision in writing to the member or authorized representative and the plan. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge (ALJ).

Administrative Law Judge Review

If the IRE decision is not in the member's favor, and if the dollar value of the contested benefit meets minimum requirements the member or his or her authorized representative may ask for an Administrative Law Judge (ALJ) to review the case. The ALJ also works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

During an ALJ review, the member may present evidence, review the record, and be represented by an attorney. The ALJ will not review the appeal if the dollar value of the medical care is less than the minimum requirement, and there are no further avenues for appeal. The ALJ will hear the case, weigh all of the evidence and make a decision as soon as possible.

The ALJ will notify all parties of the decision. The party against which the decision is made has the opportunity to request a review by the Medicare Appeals Council. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council

The party against whom the ALJ decision is made has the right to request the review by the Medicare Appeals Council (MAC). This Council is part of the federal department that runs the Medicare program. The MAC does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review. If they decide not to review the case, either party may request a review by a federal court judge; however, the federal court judge will only review cases when the amount in controversy meets the minimum requirement.

Federal Court

The party against whom the Medicare Appeals Council decision is made has the right to file the case with federal court if the dollar value of the services meets the minimum requirements. If the dollar value of the service in question is less, the federal court judge will not review it and there is no further right of appeal.

Appeals for Coverage of Part D Drugs

Our company encourages its members to contact us through Member Services with any questions, concerns or problems related to prescription drug coverage. As with medical services, we also have processes in place to address various types of complaints that members may have regarding their prescription drug benefits.

Prescribing physicians or other prescribers who feels that an enrollee's life or health is in serious jeopardy may have immediate access to the Part D appeal process by calling **1-800-213-7083**. Prescribers may also use this number to address process or status questions regarding the Part D appeal process.

An "appeal" is any part of the procedure that deals with the review of an unfavorable coverage determination. A member or his/her authorized representative may file an appeal if he/she wants us to reconsider and change the decision we have made about what Part D prescription drug benefits are covered or what we will pay for a prescription drug. This is called a redetermination.

It is important to note that if our company approves a member's exception request for a non-formulary drug, the member may not request an exception to the copayment that applies to that drug.

Problems getting a Part D prescription drug that may be addressed by an appeal are as follows:

- If the member is not able to get a prescription drug that may be covered.
- If a member has received a Part D prescription drug that may be covered but we have refused to pay for the drug.
- If we will not pay for a Part D prescription drug that has been prescribed because it is not on the formulary.
- If a member disagrees with the copayment amount.
- If coverage of a drug is being reduced or stopped.
- If there is a requirement to try other drugs before the prescribed drug is covered
- If there is a limit on the quantity or dose of the drug.

There are several steps that members may use to request care or payment from our company. At each step, qualified personnel evaluate the request, and a decision is made. If the decision is not in the member's favor, there are subsequent appeal options available.

After our company has issued a coverage determination, a member or authorized representative or prescribing physician or other prescribers may file an appeal, also commonly referred to as a request for redetermination. All appeals must be filed within 60 calendar days from the date of the coverage determination. If the member's life, health, or ability to regain maximum function is in jeopardy, an expedited appeal may be requested. Our associates will make every effort to gather all the information needed in order to make a decision about the appeal. Qualified individuals who were not involved in making the coverage determination will review each request. Members have the right to obtain and provide additional information as part of the appeal. Additional information in support of the member's appeal may be provided in writing.

For the mailing address, please refer to **Member Appeals & Grievances** under the "Important Addresses" section on page 14.

Information may also be provided by calling Member Services at **1-833-957-0025** to submit a verbal appeal or schedule to submit in person.

Members also have the right to ask us for a copy of the information that pertains to their appeal. Members or Providers may reach the Member Services as indicated above in order to make such a request.

Upon completion of the redetermination, the member and parties to the appeal will be notified of the decision. For a standard pre-service decision about a Part D drug, we have up to seven calendar days to issue a decision and authorize the drug in question.



If the member's health condition requires it, the decision will be issued sooner. If we don't issue a decision within seven calendar days, the request will automatically be forwarded to the Independent Review Entity (IRE) for review.

If the request is for reimbursement for a Part D Drug that has already been decided, then we must authorize payment for the benefit within 14 calendar days from the date it receives the request and make payment (i.e., mail the payment) no later than 30 calendar days after the date we received the request.

For an expedited appeal regarding Part D drugs that have not been provided, we have up to 72 hours to issue a decision and authorize the requested medication. However, will make it expeditiously as the enrollee's health condition requires. If an expedited appeal was requested and our company does not comply with the 72 hour timeframe, the case will automatically be forwarded to the IRE for review.

If the redetermination does not result in the approval of the drug under review, the member may ask for review by an IRE. It is important to note that IRE review of Part D drug denials is not automatic as it is for medical services. The IRE has a contract with the federal government and is not part of our company.

Independent Review Entity (IRE)

The member or his or her authorized representative must submit a request to the IRE in writing within 60 calendar days of the appeal decision notice. An expedited IRE is also available if the member's condition requires it. The IRE's name and address will be included in this notice. If a member requests review by IRE, the IRE will review the request and make a decision about whether our company must cover or pay for the medication. For an expedited IRE review, the IRE must issue a decision within 72 hours. For a standard IRE review, the IRE has up to seven calendar days to issue the decision and 14 calendar days to issue a decision on payment.

The IRE will issue its decision in writing, explaining the reasons for the decision. If the decision is in the member's favor and the member has already paid for the medication, we will reimburse the member within 30 calendar days of the IRE's decision. We will also send the IRE confirmation that we have honored their decision. If the decision is in the member's favor and the member has not yet received the drug, we will authorize the medication within 72 hours of receiving the decision notice. Confirmation will be sent to the IRE in this situation as well.

If an expedited IRE review was conducted, we will authorize the medication within 24 hours of receiving the IRE's decision notice. If the member is not satisfied with the result of the IRE review, he or she may request the review by an Administrative Law Judge.

Administrative Law Judge (ALJ) Review

If the decision is not in the member's favor, the member or his/her authorized representative may request the review by an ALJ. In order to request a review by an ALJ, the value of the drug in question must meet minimum requirements. To calculate the amount in controversy, the dollar value of the drug will be projected based on the number of refills prescribed for the requested drug during the plan year. This projected value includes copayments, all expenses incurred after the member's expenses exceed the initial coverage limit and any expenses paid by other entities. Claims may also be combined to meet the dollar value requirement if the claims involve the delivery of Part D drugs to the member, if all claims have been reviewed by the IRE, each of the combined requests are filed in writing within the 60 day filing limit, and the hearing request identifies all of the claims to be heard by the ALJ.

The request must be made in writing within 60 calendar days of the date of the IRE decision. The member may request an extension of the deadline for good cause. During the ALJ review, the member or appointed representative may present evidence, review the record, and be represented by counsel.

The ALJ will hear the member's case, weigh all of the evidence submitted, and issue a decision as soon as possible. The ALJ will issue a decision in writing to all parties.

If the decision is in the member's favor and the member has already received and paid for the drug in question, our company will reimburse the member within 30 calendar days from the date we receive the ALJ decision. If the decision is in the member's favor and the member has not yet received the drug in question, we will authorize the medication within 72 hours of the date we receive the ALJ decision. In cases where an expedited ALJ review was requested, we will authorize the medication within 24 hours of receiving the ALJ notice.

If the ALJ rules against the member, the ALJ notice will provide instructions on how to request a review by the Medicare Appeals Council.

Medicare Appeals Council

If the decision of the ALJ is not in the member's favor, Medicare Appeals Council (MAC) review may be requested. The MAC is part of the department that runs the Medicare program. There is no minimum dollar value for the MAC to conduct a review. The MAC does not review every case it receives. When it gets a case, it decides whether to review the case. If the MAC decides not to review the case, a written notice will be issued, and this notice will advise the member if any further action can be taken with respect to the request for review. The notice will instruct the member how to request a review by a federal court judge.

If the MAC reviews the case, it will inform all parties of its decision in writing. If the decision is in the member's favor and the member has already received and paid for the drug in question, our company will reimburse the member within 30 calendar days of receiving the MAC notice.

If the decision is in the member's favor, but the member has not yet received the drug in question, we will authorize the drug within 72 hours of receiving the MAC notice. If an expedited MAC review was requested and the decision is in the member's favor, we will authorize the drug within 24 hours of receiving the MAC notice.

If the MAC reviews the case and the decision is not in the member's favor, the member may request a judicial review, but only if the dollar value of the medication meets minimum requirements.

Federal Court

If the member is not satisfied with the decision made by the MAC, in order to request judicial review of the case, the member must file civil action in a United States District Court. The MAC letter will explain how to do this. The dollar value of the drug in question must meet the minimum requirement to go to a federal court. The federal judiciary is in control of the timing of any decision. If the judge decides in the member's favor, our company is obligated to authorize or pay for services under the same time constraints as outlined above. If the judge issues a decision that is not in the member's favor, the decision is final and there is no further right of appeal.

Amount in Controversy, Federal Minimum Requirements for Filing

Appeal Level	Calendar Year 2023	Calendar Year 2024	Calendar Year 2025	Calendar Year 2026
ALJ Hearing	$180	$180	$190	Not yet available
Judicial Review	$1,850	$1,840	$1,900	Not yet available

Member Grievances

A grievance is different from an appeal in that it usually does not involve coverage or payment for benefits. Concerns about failure to pay for a certain drug or service should be addressed through the appeals processes.

The member grievance process may be used to address other problems related to coverage, such as:

- Problems with waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- The cleanliness or condition of a network pharmacy.
- If a member disagrees with our decision not to expedite a request for coverage determination.
- If our company does not provide a decision within the required timeframe.
- If our company does not forward a case to an IRE if we do not comply with required timeframes for reconsideration.
- If our company does not provide the member with required notices.

Members also have the opportunity to file expedited grievances under certain conditions. See page 145.

Members are encouraged to contact our Member Services first in order to be provided with immediate assistance. Our associates will try to resolve any complaint over the telephone. If a written response is requested, one will be provided. If our Member Services staff is not able to resolve the telephone complaint, we will provide a written response to the member. Our company employs a formal, multi-disciplinary process to review member grievances. Members may file a grievance by calling our Member Services Department or by writing to Highmark Health Options Duals.

For the mailing address, please refer **Member Appeals & Grievances** under the “Important Addresses” section on page 14.

Information may also be provided by fax at **1-833-560-1828** or by telephone at **1-833-957-0025**.

If the member would like to have someone else file a grievance on their behalf, an Appointment of Representative Form (AOR) must be completed. The form is located on the Highmark Health Options Duals website at **wv.highmarkhealthoptions.com/providers/**.

Grievances must be filed within 60 days of the date of the incident.

Upon receipt of any standard grievance, we will send the member an acknowledgement letter. The acknowledgement letter will include details of the member’s grievance, explain the grievance process, and inform the member of their rights during the grievance process.

Grievances

The member or the authorized representative will have the opportunity to submit any information, documentation, or evidence regarding the grievance. Our company will conduct a full and thorough investigation of the substance of the complaint including any aspect of clinical care involved. The member or the member's representative will be notified orally or sent a written response as quickly as the case requires based on the member's health status, but no later than 30 calendar days after receiving the grievance. We may extend the timeframe by up to 14 calendar days if the member requests the extension or if we justify a need for additional information and the delay is in the member's best interest.

Expedited Grievances

Our company also has a process in place where it may be necessary to expedite the review of a grievance because the member's life, health, or ability to regain maximum function is in jeopardy.

Members may file expedited grievances in the following circumstances:

- When we have extended the timeframe to make an Organization Determination.
- When we have extended the timeframe to resolve a Reconsideration.
- When we have refused to grant a member's request for an expedited Organization Determination.
- When we have refused to grant a member's request for an expedited Reconsideration (Appeal).

The circumstances outlined above are the only times that an expedited grievance review is available. When an expedited grievance is filed, we will take prompt, appropriate action, including a full investigation within 24 hours of receiving the request. The member or representative will be notified of the decision by telephone within 24 hours of filing the Expedited Grievance, and a letter explaining the decision will follow within three days.

Quality Improvement Organization Review

Complaints concerning the quality of care received under Medicare may be investigated and acted upon by our company under the internal grievance process or by an independent organization called the Quality Improvement Organization (QIO) or by both. For example, if a member believes that his or her pharmacist provided the incorrect dosage of a prescription or was prescribed a medication in error, the enrollee may file a complaint with the QIO in addition to or instead of a complaint filed under the plan sponsor's grievance process. For any complaint filed with the QIO, our company must cooperate with the QIO in resolving the complaint. This includes directing providers to respond to QIO requests for information within 14 days.



How to File a Quality-of-Care Complaint with the QIO

QIOs are assigned regionally by CMS. For members who reside in West Virginia, quality of care complaints filed with the QIO must be made in writing to the following address:

Commence Health
BFCC-QIO Program
PO Box 2687
Virginia Beach, VA 23450
Phone: 1-888-396-4646 (TTY: 888-985-2660)
Fax: 1-855-236-2423

Clinical Provider Appeals

All providers participating with our health plan may file a formal provider appeal to request the review of any post-service denial for payment denied due to medical necessity or for lack of prior authorization. This process is intended to afford providers with the opportunity to address issues regarding payment only. Appeals for services that have not yet been provided must follow the Member Reconsideration or Redetermination processes above. The formal Provider Appeal Process must be initiated by the provider through a written request for an appeal.

For the mailing address, please refer to **Clinical Provider Appeals** under the "Important Addresses" section on page 14 or fax to **1-855-501-3904**.

Providers who are non-contracted with our company may also file an appeal; however non-contracted providers must follow the member appeals process for reconsiderations as outlined above.



Clinical Provider Appeal Process

First Level Provider Appeal

1. To request a provider appeal, providers must make a written request for appeal which must be received by the plan within:
   a. 60 calendar days of the date of their denial notice denying an authorization unless otherwise negotiated by contract. In this instance, there is a denied authorization, however, services have already been provided.
   b. 180 calendar days of the date of their denial notice denying a post-service claim unless otherwise negotiated by contract. When an authorization has been denied, provider must adhere to the 60 calendar-day timeframe, the 180 calendar days once the claim has denied does not apply.
2. When submitting a written request for an appeal, the provider is required to submit any and all supporting documentation including, but not limited to, a copy of the denied claim, the reason for the appeal, and the member's medical records containing all pertinent information regarding the services rendered by the provider.
3. All first level provider appeal reviews will be completed within 60 calendar days of the date the written request was received.
4. The provider will be informed of the decision in writing by mailing/faxing notification within 60 calendar days from receipt. This notification will include additional appeal rights as applicable (i.e., Second Level Provider Appeal—see below). If the appeal is approved, payment will be issued within 60 calendar days of notification.

Second Level Provider Appeal

1. If the 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 to the plan in writing within 60 calendar days of the date on the first level provider appeal decision letter, or as otherwise indicated via contract. All second level provider appeal requests must include specific reasons as to why the provider does not agree with the plan's first level provider appeal committee's decision along with any additional supporting documentation.
2. All second level provider appeal reviews will be completed within 60 calendar days from the date the second level provider appeal request was received.
3. The second level appeal committee will inform the provider of its decision in a written/fax decision notice within 60 calendar days. This is the final level of appeal, and the decision is binding, unless otherwise governed per contract.

Model of Care

Website location: **highmark.com/health-options-wv/duals**

Overview

As a Special Needs Plan (SNP), Highmark is required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC) Plan. In accordance with CMS guidelines, Highmark SNP MOC Plan is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization (MAO) to provide coordinated care for special needs individuals.

Highmark D-SNP has a MOC that has goals and objectives for the targeted populations, a specialized provider network, uses nationally recognized clinical practice guidelines, conducts health risk assessments to identify the special needs of beneficiaries, and adds services for the most vulnerable beneficiaries including, but not limited to, those beneficiaries who are frail, disabled, or near the end of life.

The SNP MOC includes four main sections: Description of the SNP population (general population), Care Coordination, Provider Network, and MOC Quality Measurement and Performance Improvement. This SNP Provider Network section explains what Highmark Health Options Duals expects from their providers.

Provider Network

The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP beneficiaries. SNPs must ensure that their MOC identifies, fully describes, and implements the following elements for their SNP provider networks.

This MOC section contains three elements:

- Specialized expertise
- Use of clinical practice guidelines and care transition protocols
- MOC training for the provider network

Within the above elements, Highmark D-SNP's expectations of providers are explained in detail.

The below is a summary of Highmark D-SNP provider network composition and responsibilities:

1. Highmark D-SNP expects all network practicing providers to utilize the most current, up-to-date clinical practice guidelines when providing care to members to ensure the right care is being provided at the right time, as well as to reduce inter-practitioner variation in diagnosis and treatment.

2. Highmark D-SNP encourages practitioners to follow the adopted clinical practice guidelines but allows the practitioners to execute treatment plans based on a member's medical needs and wishes. When appropriate, behavioral health guidelines are followed utilizing national clinical criteria.
3. During a care transition, it is expected that the transferring facility will provide a discharge summary and care plan information to the receiving facility within one business day. Members who are transitioning home should receive a copy of their discharge summary and care plan at the time of discharge. A copy should be sent to the primary care physician (PCP) within one business day.
4. Highmark D-SNP expects all network practicing providers to receive and attest to MOC training annually. If there is a trend of continued non-attestation, those providers found to be non-compliant with the Model of Care may be targeted for potential clinical review. For those non-compliant providers, individual results such as, but not limited to, utilization patterns, hospital admissions, readmissions, and HEDIS performance outcomes may be reviewed. If there are issues identified, a Corrective Action Plan may be requested.
5. Highmark D-SNP conducts medical record reviews at least annually and expects all network providers to respond to record requests on time. Reviews are conducted for PCPs, Specialty Care Practitioners, Behavioral Health Practitioners, and ancillary providers. Results from the reviews are communicated to providers and include opportunities for improvement and education as needed.
6. Highmark D-SNP encourages providers to participate in Interdisciplinary Care Team (ICT) meetings. As a provider, you are an important part of the member's ICT. The ICT members conduct a clinical analysis of the member's identified level of risk, needs, and barriers to care to develop an Individualized Care Plan (ICP), which will be reviewed with the member. The ICT analyzes, modifies, updates, and discusses new ICP information with the member and providers as a team, when appropriate. Providers can request an ICT meeting for their members by calling **1-833-957-0025**.
7. Highmark D-SNP expects providers to stay up to date by visiting our website and communicating by utilizing the Provider Portal, as these are the easiest ways for providers to receive information and updates. The following are important communications that can be found on our website:
   - Provider e-newsletters are updated and highlight information regarding any new clinical programs or updates.
   - Provider Manuals are updated annually and reviewed during annual trainings. Current manuals are also available on the provider section of our website.
8. The following are functionalities available via the Provider Portal:
   - Automated ICT communications.
     - Care plans generated or updated by the ICT.
     - Discharge reports of quarterly performance dashboards that show gaps in care and chronic conditions.

- Secure messaging is also available to have open dialog between providers and internal staff who are part of the member's ICT.

9. Highmark Health Options Duals expects provider directories to be continuously updated, such as changes to the office address, phone numbers, office hours, hospital affiliations, and acceptance of new patients.

Common MOC Terms and Definitions

Members may ask you about the following information that is routinely discussed with their case manager.

Health Risk Assessment (HRA) Survey: Highmark uses the HRA to provide each Medicare member a means to assess their health status and needs as well as priorities to improve their health by promoting positive behaviors. The HRA is also used by the case managers to provide an assessment of risk that can generate referrals for clinical programs. Newly enrolled members identified by the Centers for Medicare and Medicaid Services (CMS) on a monthly enrollment file are requested to complete an initial HRA within 90 days of their effective date as required by CMS Model of Care standards. Existing members are required to complete an HRA within 12 months of the last completed HRA or the member's enrollment date if there is no completed HRA on record.

Individualized Care Plan (ICP): Highmark D-SNP utilizes the information collected from the HRA as well as other available clinical data, such as claims and encounters, to create a care plan that is individualized to each member's needs and priorities. The ICP will be created in conjunction with the member and/or caregiver to ensure it includes consideration of the member's personal care preferences, self-management goals, and objectives.

At a minimum, a completed ICP will contain:

- Services and interventions specifically tailored to the member's Health-related Social Needs (HRSN) and Social Determinants of Health (SDoH) needs.
- Documentation of the member's personal health care preferences (as appropriate).
- Member self-management goals and objectives (as appropriate).
- Clearly defined goals with measurable outcomes.
- Progress and action toward the goals.
- Whether the goals have been "met" or "not met."
- Appropriate alternative actions if "not met."

Interdisciplinary Care Team (ICT): Member care routinely demands a combination of efforts from physicians of various disciplines, registered nurses, and licensed social workers, as well as other pertinent skilled health care professionals and paraprofessionals. Comprehensive patient care planning involves coordination, collaboration and communication between this ICT and the member. Highmark D-SNP Provider Portal should be utilized frequently for any communications regarding members, their ICP, or ICT.

Other Important Information about Our Model of Care

All members have an assigned Care Manager. If you need to reach them about care plans, request additional support for your member, or schedule a formal ICT meeting, Case Management can be reached at the following number: **1-833-957-0025 (TTY: 711)**. Specific questions regarding the Model of Care Plan should be addressed with your Highmark Health Options Duals Provider Representative.

* **Action Required:** Please go to **highmark.com/health-options-wv/duals**
  Fill out the provider information at the bottom of the page after reviewing the MOC training. Click agree to acknowledge you have reviewed and understand Highmark Health Options Duals' Model of Care Information and submit your attestation.



Preventive Health, Disease, and Care Managment

Preventive Health Program

The Highmark Health Options Duals Preventive Health Program focuses on the importance of health screening and early detection of diseases.

Key interventions of the program include:

- Reminders for preventive health screenings.
- Telephonic outreach to assist members in scheduling mammograms when indicated.
- Physician notification of members overdue for mammograms and/or cervical cancer screening.
- In-home colorectal screening kits available to members.
- Member newsletters with articles focusing on the importance of preventive health.
- Health screening information on the Highmark Health Options Duals website.

Disease Management Programs

Highmark Health Options Duals WV Management Program focuses on member education, self-management, and medication adherence to enhance quality of life and reduce emergency room visits and hospitalizations. The program promotes an active lifestyle while aiming to minimize or prevent exacerbations.

Highmark Health Options Duals WV identifies members diagnosed with the following conditions for the Disease Management Program:

- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Diabetes
- Hyperlipidemia
- Hypertension
- Inflammatory Bowel Disease
- Prediabetes

Care Management General Information

The goal of Care management, i.e., care coordination, is to address medically or socially complex conditions by enhancing the integration of services to improve health outcomes and prevent disease.

The care coordination team consists of licensed nurses and social workers with expertise in various areas such as maternity, special needs patients (pediatric and adults), human immunodeficiency virus/acquired immunodeficiency syndrome, substance use, chronic physical/behavioral conditions, health, and wellness. Their diverse backgrounds enable them to provide comprehensive support tailored to the specific needs of individuals.

Care Coordination is a multifaceted process that plays a crucial role in ensuring patients receive comprehensive and effective care. By integrating assessment, planning, coordination, and advocacy, Highmark Health Options Duals WV health care professionals tailor interventions to meet individual needs, improve outcomes, and prevent complications. Early intervention is key to expanding treatment options and managing conditions proactively, which can significantly enhance a patient's quality of life and overall health.

Core Components of Care Coordination

- **Assessment:** Evaluating patient needs and resources.
- **Planning:** Developing a care plan tailored to the patient's needs.
- **Intervention:** Implementing the care plan and facilitating linkage to necessary services that promote comprehensive coordination of benefits for optimal member experiences and outcomes.
- **Quality monitoring:** Tracking the effectiveness of interventions and services.
- **Evaluation/Reassessment:** Reviewing and adjusting the care plan as needed based on patient progress and changing needs.

Responsibilities of Care Coordination

- **Liaison activities:** Coordinating with health care practitioners, social service agencies, advocacy groups, and other relevant organizations.
- **Complex case management:** Managing the care of individuals with complex conditions/diseases or serious needs.
- **Service coordination:** Ensuring seamless integration of services across various care providers, including primary, specialty, ancillary, and behavioral health services.

- **Social service access:** Helping members navigate city, county, and state agencies for ongoing social services affecting medical access.
- **Transitions:** Managing the transition of care from hospital to home, ensuring continuity and support.

Referrals to Care Coordination

Referrals to Care Coordination are appropriate for individuals facing:

- **Serious and complex medical needs:** Adults or children with multiple or severe medical conditions requiring comprehensive management.
- **Behavioral health or substance use issues:** Individuals struggling with behavioral health disorders or substance use that necessitates integrated care and support.
- **Health-related Social Needs/Social Determinants of Health concerns:** Problems such as social isolation, food insecurity, inadequate housing, transportation issues, or exposure to domestic violence that impact their overall well-being and access to care.

These criteria help identify patients who would benefit from coordinated efforts to address their complex needs and improve their health outcomes.

Transitions from Hospital to Home

The transition from hospital to home can be challenging. Highmark Health Options Duals WV's goal is to minimize confusion and support patients effectively during this critical period.

To facilitate a smooth transition, Highmark Health Options Duals WV Care Coordination initiates contact with the patient while they are still in the acute care setting and focuses on these key areas:

- **Follow-up appointments:** Ensuring patients make and keep follow-up appointments with their health care providers.
- **Home health care needs:** Assessing and arranging medically necessary home health services to support recovery.
- **Durable medical equipment:** Coordinating the acquisition of any needed medical equipment for home use.
- **Transportation:** Discussing and arranging transportation options for follow-up appointments.
- **Gaps in care and preventive screenings:** Identifying and addressing any gaps in care, including coordinating preventive screenings.

Highmark Health Options Duals WV Care Coordination team is dedicated to comprehensive patient support, focusing on essential aspects such as medication adherence, appointment management, and ensuring transportation needs are met.

Provider Referrals to Disease Management and Care Management Programs

Care Coordination staff are available Monday–Friday, from 8 a.m.–5 p.m., at **1-833-957-0025** to help manage members' health care needs.

Participation in all Care Coordination Programs is voluntary, and members can opt out at any time by contacting us.

Providers can also refer patients directly by calling Highmark Health Options Duals WV. For assistance outside of these hours or on holidays, please call Provider Services at **1-833-957-0025** or refer to the Quick Reference section in this manual as needed.



Introduction to Credentialing

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), master's level and Doctorate of Psychology (Ph.D.), Doctorate of Philosophy (Ph.D.), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapists (LMFT), and Clinical Social Workers and other medical practitioners and behavioral health care specialists as deemed appropriate. (This listing is subject to change.)

Extenders: Physician Assistant (PA), a Certified Nurse Midwife (CNM), a Certified Registered Nurse Practitioner (CRNP), Master level 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, clinical laboratories, outpatient physical therapy and speech therapy providers, FQHCs, Rural Health Clinics (RHC) and facilities providing mental health and substance misuse services. (This listing is subject to change.)

Purpose of Credentialing

Credentialing is the process of performing a background investigation, as well as validation of a practitioner and provider's credentials and qualifications. The credentialing and recredentialing processes also encompass a complete review of, but not limited to, malpractice histories, quality of care concerns and licensure status. Our company prides itself on the integrity and quality of the composition of the practitioner and provider networks.

Credentialing Standards

Highmark Health Options Duals has established credentialing and recredentialing policies and procedures that meet CMS, DOH, DHS, and NCQA standards. Highmark Health Options Duals adheres to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach.

All information must be current and up to date to begin the credentialing process. Therefore, it is important to provide us with your CAQH ID on a completed Provider Data Form and submit all attachments in a timely manner with the most current information available. We will obtain your most current application through the CAQH database.

In addition, extenders are required to submit a copy of their collaborative/written agreement with a Highmark Health Options Duals participating supervising practitioner. This agreement must adhere by state specific regulations for collaborative/written agreements for extenders. Any time there is a change in the extender's supervising physician, the extender will be required to submit a current copy of his/her new collaborative/written agreement as indicated in his/her approval letter.

Where applicable, the submittal of the collaborative/written agreement must include a copy of the letter of approval from the State and if applicable per the collaborative/written agreement, a DEA is required.

Highmark Health Options Duals standards include, but are not limited to the following:

- A current, unrestricted license
- Fully completed and attested CAQH application
- National Provider Identifier (NPI) number
- Curriculum Vitae and/or Work History to include month and year
- Copy of current, unencumbered DEA certificate, if applicable
- Acceptable malpractice history as subject to decision by our company's medical directors and legal counsel
- Unexpired professional liability coverage as mandated by state law, of no less than $500,000 per occurrence, $1,500,000 per aggregate and coverage provided by the Medical Care Availability and Reduction of Error Fund (Mcare) or Federal Tort Coverage
- Active participation in the Medicare and/or Medical Assistance Programs; free of sanctions
- Foreign graduates must submit an ECFMG certificate
- Other items as deemed appropriate

The credentialing/recredentialing process involves primary sourced verification of practitioner credentials.

The Credentialing Department will notify practitioners, in writing, within 45 calendar days of receiving any information obtained during the credentialing or recredentialing process that varies substantially from the information provided by the practitioner. Practitioners have the right to correct erroneous information submitted by another party or to correct his or her own information submitted incorrectly. Applicants have 10 calendar days from the date of our company's notification to submit written corrections and supporting documentation to the 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, or a copy of the credentialing criteria. 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.

All practitioners must be recredentialed at least every three years in order to continue participation within our company. This helps to ensure continued compliance with National Committee for Quality Assurance (NCQA), Center for Medicare and Medicaid Services (CMS) and the Department of Health (DOH), as well as to uphold the integrity and quality of the networks. Extensions cannot be granted.

We are committed to protecting the confidentiality of all practitioner information obtained by the Credentialing Department as outlined in our Confidentiality of Practitioner/Provider Credentialing Information Policy and Procedure.

Ongoing and Performance Monitoring

Our company's Credentialing Department conducts ongoing monitoring of sanctions, licensure disciplinary actions, and member complaints.

Sanction information is reviewed by utilizing the Office of Inspector General's (OIG) report, the Medicare Opt-out Listing (CMS), CMS Preclusion Listing, and applicable state disciplinary reports. Information can also be obtained from the American Medical Association (AMA) and the National Provider Data Bank (NPDB)/Healthcare Integrity Practitioner Data Bank (HIPDB) as needed.

Monitoring of limitations on licensure is conducted on a monthly basis. If a participating practitioner is found on the OIG, Medicare Opt-Out List, Medicare/Medicaid sanction/exclusion listing or applicable state disciplinary action report, the practitioner's file is immediately pulled for further investigation. Depending on severity level of the sanction, the practitioner may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or immediately terminated. In all instances, the information is reported to the QI/UM Committee.

The credentialing department monitors member complaints as part of the recredentialing process on a monthly basis. The credentialing department receives complaint reports, which reveals member complaints filed against practitioners as well as trends in those complaints. If the complaint is deemed viable by the reporting area, it is documented in the reports. Depending upon the severity level of the complaint(s), the practitioner may be sent to the Medical Director for

review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or terminated and outcome presented to Quality Improvement/Utilization Management Committee.

Our recredentialing process includes a comprehensive review of a practitioner's credentials, as well as a review of any issues that may have been identified through a member complaint report and/or quality of care database.

Practitioner Absences

Highmark Health Options Duals continues to follow NCQA guidelines for practitioners called to active military service, on maternity leave or an approved sabbatical. However, it is the practitioner's or his/her office's responsibility to notify us in writing that the practitioner is called to active duty or beginning the leave, as well as an expected return date. The letter should also include the practitioner who will be covering during his or her leave. The Credentialing Department will not terminate the practitioner called to active duty, on maternity leave or on an approved sabbatical if appropriate coverage is in place. Practitioner/practitioner's office should notify us of the practitioner's return, as soon as possible, but not exceeding 10 business days from the practitioner's return to the office. The Credentialing Department will determine, based upon the length of time, if the practitioner will have to complete a recredentialing application. If the practitioner requires recredentialing, it must be completed within 60 calendar days of the practitioner resuming practice.

Denial and Termination

In accordance with Highmark Health Options Duals' business practices, the inclusion of a practitioner in our Provider Network is within the sole discretion of our company.

We conduct credentialing in a non-discriminating manner and do not make credentialing decisions based on an applicant's type of procedures performed, type of patients, or a practitioner's specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation, or disability. We understand and abide by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall on the sole basis of the disability be excluded from participation.

If a practitioner does not meet our baseline credentialing criteria, the QI/UM Committee will make a final determination on participation or continued participation. If a practitioner fails to submit information and/or documentation within requested time frames, processing of the practitioner application may be discontinued or terminated. All requests for recredentialing updates must be completed and returned in a timely manner. Failure to do so could result in denial or termination of participation.

Denial and termination decisions that are made based on quality concerns can be appealed and are handled according to Highmark Health Options Duals' Due Process Policy and Procedure. If necessary, the information is reported to the National Practitioner Data Bank and Bureau of Quality Management and Provider Integrity in compliance with the current 45 CFR Part 60 and the Health Care Quality Improvement Act, as well as state licensing boards.

Practitioners who want to request a review of a termination, other than for quality-of-care concerns, must submit a written request for the review along with any supporting documentation to us within 30 calendar days of the date of the certified notification.

Delegated Credentialing

Delegation is the formal process by which Highmark Health Options Duals has given other entities the authority to perform credentialing functions on our behalf. We may delegate certain activities to a credentialing verification organization (CVO), Independent Practitioner Association (IPA), hospital, medical group, or other organizations that employ and/or contract with practitioners. Organizations must demonstrate that there is a credentialing program in place and the ability to maintain a program that continuously meets our program requirements. The delegated entity has authority to conduct specific activities on behalf of our company. We have the ultimate accountability for the quality of work performed and retain the right to approve, suspend, or terminate the practitioner's and site. Any further sub-delegation shall occur only with our approval and shall be monitored and reported back to us.



NaviNet® is a separate company that provides an internet-based application for providers to streamline data exchanges between their offices and Highmark Health Options Duals such as routine eligibility, benefits, and claims status inquiries.

HealthHelp is a separate company that administers prior authorizations for certain services for Highmark Health Options Duals.

VSP is a separate company that administers the vision benefit(s) for Highmark Health Options Duals.

United Concordia Dental is a separate company that administers the dental benefit(s) for Highmark Health Options Duals.

TruHearing is a registered trademark of TruHearing, Inc. TruHearing is a separate company that administers the hearing aid benefit(s) for Highmark Health Options Duals.

Findhelp is a separate company that gathers community-based organization resources for Highmark Health Options Duals.

Optum is a separate company that administers E&M audits, education, and probe audit expansion for Highmark Health Options Duals.

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



614 Market St.
Parkersburg, WV 26101

How to Contact Highmark Health Options Duals West Virginia
1-833-957-0025 (TTY: 711)

Provider Services Hours of Operation
Monday–Friday, 8 a.m.–5 p.m.

How to Find Participating Providers or Pharmacies
highmark.com/health-options-wv

LAST UPDATED: 03/2026