

Annual Provider Education

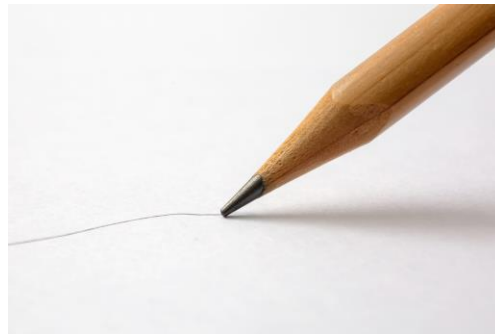
[For Providers \(highmarkhealthoptions.com\)](https://highmarkhealthoptions.com)



Welcome to our Annual Provider Education

The West Virginia Bureau for Medicaid Services (BMS) requires Highmark Health Options West Virginia to provide annual training to participating providers. Providers are to attend at least one education training session.

Your registration and completion of this training will serve as the attestation.



About Highmark Health Options West Virginia

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



Medicaid Plan Overview



Member Enrollment



Listed below are three ways for your patients to enroll in or change coverage to Highmark Health Options West Virginia:



- Online: www.wvpath.wv.gov
- Phone: 1-877-716-1212
- Mail: To local county office which can be found at dhhr.wv.gov/bms/pages/field-offices.aspx

Information can be found at: <https://dhhr.wv.gov/bms/Members/Apply/Pages/default.aspx>



Verifying Patient Eligibility

- NaviNet®
- Highmark Health Options West Virginia IVR (telephonic system)
 - Available 24 hours/7days a week
 - 1-833-957-0020
- BMS Eligibility Verification
 - <https://www.wvmmis.com/default.aspx>
- Provider Services
 - Monday through Friday,
8:00 a.m. – 5:00 p.m.
 - 1-833-957-0020
- Primary Care Provider (PCP) Monthly Roster

Medicaid ID Card Sample

	
Member Name ANNIE KOOLWINK	MEDICAID ID 12345678910
Member ID WVF123456789001	Always carry your ID cards. Show your Highmark Health Options card, your Medicaid card, and any other insurance cards to your doctor.
Primary Care Doctor JOHN DENVER, MD	If your medical condition is very serious or life or death, go to the emergency room or dial 911. For a mental health emergency, dial 988.
Phone 304-555-1212	

CHIP ID Card Sample

	
Member Name PETE KOOLWINK, JR.	WVCHIP ID 12345678910
Member ID WVF123456789001	Always carry your ID cards. Show your Highmark Health Options card, your WVCHIP card, and any other insurance cards to your doctor.
Primary Care Doctor JOHN DENVER, MD	If your medical condition is very serious or life or death, go to the emergency room or dial 911. For a mental health emergency, dial 988.
Phone 304-555-1212	

**Payer ID:
RP118**

Member Benefits



On top of regular Medicaid and CHIP benefits, as a Highmark Health Options West Virginia member, members will get access to our team of master problem solvers who are always there to help our members get access to the benefits and services needed to get healthy and stay healthy, such as:

- ✓ Online Member Portal
- ✓ Disease Management Program
- ✓ Complex Case Management
- ✓ Social Resource Referrals (housing, food, etc.)
- ✓ Extra Benefits
- ✓ Care Coordination
- ✓ Support for Expecting Moms



What's New in 2026



New for Highmark Health Options

- **Dual Eligible Special Needs (DSNP)** – effective January 1, 2026 in 18 WV counties.
 - **Model of Care** – HHO WV is required by CMS to administer a Model of Care (MOC) Plan. In accordance with CMS guidelines, Highmark Health Options WV SNP MOC Plan is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization to provide coordinated care for special needs individuals.
 - **Elective Termination of Pregnancy** – Effective January 1, 2026 elective termination of pregnancies will be managed via HHO WV. This service will require authorization.
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DSNP Service Area



DSNP Benefits Overview

- Physicians Services (Doctor Office Visits) - \$0 copay for a PCP and Specialist
- Facility Services, Substance Abuse, Mental Health and Psychiatric Therapy Services - \$0 copy for individual or group sessions with Telehealth also covered
- Outpatient Hospital Services, Outpatient Diagnostic and Therapeutic Radiology Services - \$0 copay
- Durable Medical Equipment/Prosthetics - \$0 and require prior authorization

Please visit <https://wv.highmarkhealthoptions.com/providers> for additional DSNP benefits.

Model of Care - Medicare

- As a Special Needs Plan, Highmark Health Options WV is required by CMS to administer a Model of Care (MOC) Plan. In accordance with CMS guidelines, HHO WV's SNP MPC Plan is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization to provide coordinated care for special needs individuals.
- Annual review of the MOC is required by all providers. Additional information regarding the MOC as well as the attestation can be found at [Medicare D-SNP Model of Care](#) on our provider portal.
- As part of our members' care team, you can access each member's individualized Care Plan for those who are on your panel via the provider portal. Providers have the right to request a Team meeting with the member and their HHO WV Case Management team.

CAQH

January 1, 2025, Highmark Health Options WV began using the Provider Data Management Portal (CAQH) to manage the provider directory attestation process.

According to Center for Medicaid and Medicare Services (CMS) and Department of Human Services (DoHS) requirements providers must already attest that their provider directory information is correct every 90 days.

If you are already registered with the Provider Data Management Portal (CAQH), ensure that HHOWV is authorized to receive your information on the **Authorize** tab.

If you are new to the Provider Data Management Portal (CAQH), register, gather your credentialing information and login to complete your profile and upload needed documents. Be sure that HHOWV is authorized to access your information on the **Authorize** tab.

You will receive a “**Help Patients Find You**” banner notification on the **Home** tab or an email notice if you have new addresses to accept or reject.

Additional information can be found in our newsletter located on our website at wv.highmarkhealthoptions.com

Resources and Self-Service Tools



NaviNet®

- Easy-to-use, free, internet-based solution for providers to streamline data exchanges between their offices and Highmark Health Options West Virginia.
- From our NaviNet Plan Central page, providers can access announcements, reference materials.
 - Announcements
 - Eligibility information
 - Benefits information
 - Claims Search Inquiry
 - Authorization Portals
 - GuidingCare
 - HealthHelp
 - Reference Materials
 - Enhanced Provider Portal
 - Prior Authorization Requests
 - Provider Appeals
 - Claims Disputes
 - Claims Batch Look-up
 - Remittance Advice Inquiry
 - Secure Messaging

Not a NaviNet user?
Register for a new account



Already a NaviNet user?
Sign In

<https://connect.NaviNet.net>

Highmark Health Website Information

A wide array of resources are available on the Provider Resource Center.

Medicaid Resources:

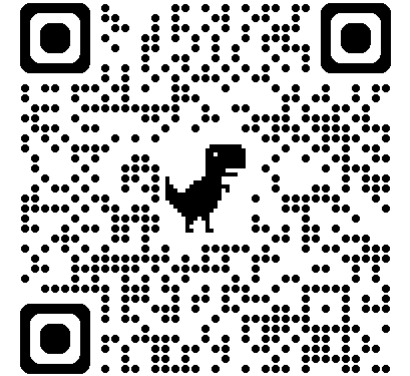
- Provider Manual
- Forms and Reference Materials
- Provider Updates
- Guidelines
- HealthHelp Reference Manual
- Medication Policies
- Policy Search
- Care Plan Access

DSNP Resources:

- Provider Manual
- Forms and Reference Materials
- Provider Updates
- Guidelines
- Provider Orientation
- Care Plan Access
- Model of Care

Additional Resources:

- Pharmacy Tools
- Provider Newsletters
- Online Provider Directory
- Cultural Competency Training and Data Form
- EPSDT Program
- Gold Card Program FAQs
- Fraud and Abuse Laws and Regulations



<https://www.highmarkhealthoptions.com/providers>

Helpful Plan Contacts



- For questions about Contracting with Highmark Health Options, connect with Provider Contracting at 304-424-0365 or HHOWVContracting@highmark.com.
- For questions about working with Highmark Health Options, contact Provider Relations at HHOWVPR@highmarkhealth.org
- Call Provider Services with administrative questions at 1-833-957-0020, Monday – Friday, 8 a.m. to 5 .pm

Website



For Providers Contact Us



[Home](#) / [For Providers](#)



For Providers

<https://www.highmarkhealthoptions.com/providers>

Utilization Management



Referrals and Prior Authorization



When the need for out-of-plan services arises, the ordering physician must obtain an authorization prior to making the referral and prior to services being rendered.

Referrals for Second Opinions:

- Second opinions may be requested by Highmark Health Options West Virginia, the member, or the PCP.
- Referral to an in-network qualified health care professional that is not in practice with the practitioner who rendered the first opinion.
- Out of network referrals may be authorized when no in-network practitioner or provider is accessible or able to meet the member's needs.



Prior Authorization



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- Providers must submit prior authorization requests through GuidingCare, via NaviNet.
 - It is important for prior authorizations to be accompanied by complete clinical information supporting the specific services being requested.
 - Refer to the provider page of our website for a listing of service codes that require prior authorization.
 - Prior authorization is required for potentially experimental, investigational or cosmetic services.
 - Non-covered benefits will not be paid unless special circumstances exist and BMS approves. A medical director's review of a request may determine that the item requested is non-covered. All services not on the BMS fee schedule or any service provided by a non-participating provider requires prior authorization.
 - Refer to the Provider Manual for detailed information on guidelines and procedures for submitting requests and obtaining authorization.

Prior Authorization



Highmark Health Options West Virginia ensures that utilization management criteria are available to practitioners and providers who make a request via telephone, email, or letter. Medical policies are available to practitioners and providers on the Highmark Health Options West Virginia website. Additionally, information about how to request this information is included on all denial notices.

Authorizations are used to:

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

Our Utilization Management assesses the medical appropriateness of services using:

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

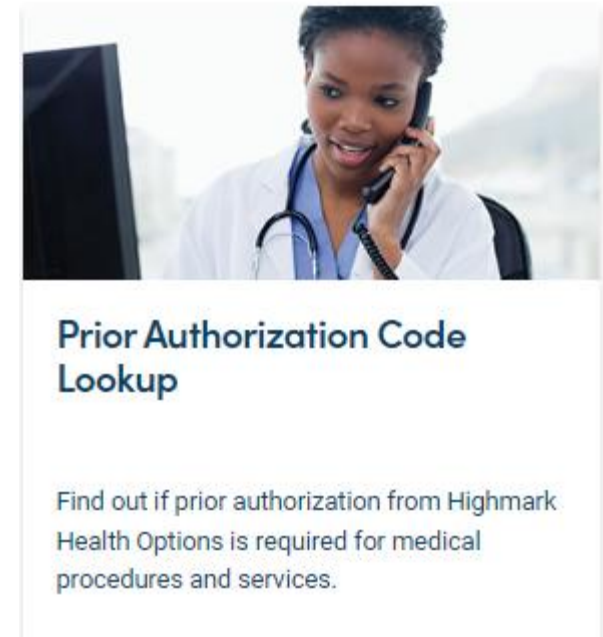
If a request for a covered service does not meet the criteria requirements, a Highmark Health Options West Virginia Medical Director will review for a medical necessity determination. An opportunity to discuss the request with the Medical Director will also be provided to the ordering physician.

GuidingCare - Prior Authorization Portal via NaviNet®

Participating providers must submit authorizations electronically through GuidingCare, via NaviNet®. If the portal is unavailable, please either call or fax our Utilization Management Department.

The GuidingCare user guide can be found under the Forms and Reference Material page of our website: <https://hho.fyi/wv-GuidingCare>.

Providers can utilize the Code Authorization Lookup Tool on the provider page of our website to determine if a code requires prior authorization.



Prior Authorization Contacts and Resources

Who is Authorizing	Services	Phone/Website
Highmark Health Options West Virginia Medical Management (Utilization Management (UM))	<p>Services requiring authorization include but not limited to: Inpatient admissions, certain outpatient procedures, acute inpatient rehabilitation facility, hospice services; residential treatment facility; partial hospitalization</p> <p><u>For ages under 18:</u> Sleep studies and radiation oncology</p>	Submit electronically through GuidingCare, via NaviNet
Pharmacy Prior Authorization	Outpatient physician administered drugs	Submit electronically through GuidingCare, via NaviNet
Care Management	Private duty nursing	Submit electronically through GuidingCare, via NaviNet
HealthHelp	<p>Outpatient imaging services, physical therapy, occupational therapy, speech therapy, trigger point injections, interventional pain management services, and musculoskeletal surgery (MSK) services; Cardiology services</p> <p><u>For ages 18 and older:</u> Sleep studies, radiation oncology</p>	<p>Submit electronically to HealthHelp via NaviNet. Providers are not able to submit any authorization requests through the HealthHelp provider loading page.</p> <p>888-209-2763- phone Expedited Fax Line: 877-637-6935</p>

Direct Access

Our members are permitted to “self-refer” for specialist care.

- Referrals are not required for services rendered by participating providers.
- The PCP is responsible for the coordination of a member’s health care needs including access to services provided by hospitals, specialty care practitioners, ancillary services, and other health care services.
- To ensure continuity and coordination of care, when a member obtains care outside the primary care practice, a medical report should be forwarded by the rendering provider to the member’s designated PCP.
- **If a member self refers**, all applicable Highmark Health Options West Virginia UM prior authorization requirements **need to be followed**.



Occupational Therapy/Physical Therapy

Prior authorization is only required for Medicaid members that have exceeded 20 OT/PT visits during a calendar year, including evaluation and re-evaluation.

Covered occupational and/or physical therapy services include, but are not limited to:

- Initial evaluation – Limited to one per calendar year
- Re-evaluation – Limited to two per calendar year
- Visits – Frequency and duration of visits must be included in the treatment plan of care for prior authorization review
- Continuation of initial approval of therapy services
- Occupational therapy modalities: Types, frequency, and duration of modalities must be included in the treatment plan of care



Speech Therapy

Audiology and speech therapy services must be ordered by an enrolled physician, PA, APRN, and CNS provided by or under the direction of an enrolled licensed audiologist.

Covered speech-language and audiology services are available to Medicaid members up to 21 years of age.

For members 21 years of age and over, limited services such as augmentative communication(AC)/speech generating systems, artificial larynx, tracheostomy speaking valves, speech therapy, and function tests for specific medical conditions are covered.

A prior auth is required for speech therapy.

For the completed OT/PT/ST policy please go to the link below:

[HHO-WV-RP-2013 Therapy Services \(highmark.com\)](https://www.highmark.com/HHO-WV-RP-2013-Therapy-Services)



Private Duty Nursing

Ordering private duty nursing services

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

Submit a Letter of Medical Necessity to include:

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

Medicaid Member Rights



Member Rights



All Highmark Health Options West Virginia members have the following rights to:

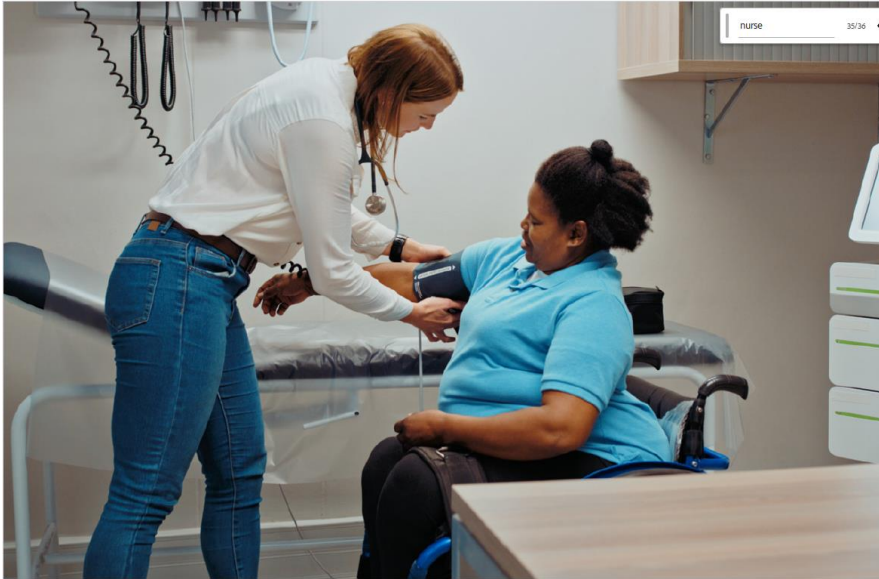
- Be treated with respect, recognizing your dignity and need for privacy, by HHO WV staff and network providers.
- Get information in a way that you can easily understand and find help when you need it.
- Get information that you can easily understand about HHO WV, its services, and the doctors and other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



Member Responsibilities



All Highmark Health Options West Virginia members have a responsibility to:



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

Highmark Health Options West Virginia regularly monitors compliance related to members' rights and responsibilities, including those rights defined by Section 1557 of the Affordable Care Act of 2010. Member rights and responsibilities are also outlined in our provider manual, which is available on the Provider page of our website: <https://hho.fyi/wv-manual>

Dental Services



Highmark Health Options' dental benefit provider is United Concordia Dental. When a member joins our Plan, the member may self-refer to any participating United Concordia Dental dentist directly without a referral from the PCP. Should specialty dental care be needed, the dentist can refer the member to a dental specialist.

United Concordia is available from 8:00 am – 8:00 pm Monday through Friday at 1-866-568-5467.

Certain oral surgery procedures, such as removal of partial or total bony impacted wisdom teeth, and procedures which involve cutting of the jaw, are covered by HHO WV through HHO WV panel of oral surgery providers.

Members requiring these services must be referred by their PCP to an HHO WV participating oral surgeon. The primary care dentist may need to provide x-rays or other information to the PCP to facilitate the referral.

The oral surgeon is responsible for authorizing surgical procedures with HHO WV prior to rendering the service (procedures provided in the oral surgeon's office are not subject to the authorization process).

When a dental procedure requires the use of a special procedures unit (SPU), the dental provider must contact our UM department for authorization prior to the services being rendered.



Vision Services

Highmark Health Options West Virginia's vision benefit provider is VSP Vision. Our members may self-refer to any VSP Vision participating provider for a routine eye exam. Corrective lenses and frames may be obtained through any participating optician, optometrist, or ophthalmologist.

VSP Vision is available from 9:00 am – 8:00 pm Monday – Saturday at 1-800-615-1883.

Should the member require additional medical services, rendered by a participating ophthalmologist or optometrist, the member should coordinate with the PCP.

Provider Responsibilities



Timely Notification of Provider Updates and Practice Changes



To ensure our members have up-to-date and accurate information about Highmark Health Options West Virginia's network providers, it is imperative that providers notify the Plan **30-days** in advance of any demographic, billing or contractual changes.

Ways to submit changes:

- **Practice Change Form** - Address changes, phone & fax number changes, changes of hours of operation, Primary Care Practice (PCP) panel status changes (Open, Closed & Existing Only), practitioner participation status (additions & terminations), and mergers and acquisitions *The Practice Change Form is located under the Forms and Reference Material section of our website: <https://wv.highmarkhealthoptions.com/providers/provider-manual/provider-forms.html>. Please fax to: 1-855-451-6680.
- **Provider Data Form** - Adding a new physician who is not credentialed with Highmark Health Options West Virginia. *Please contact your Provider Account Liaison to obtain this form.
- **Delegated Process** – Only applicable to selected providers, all new physicians, updates and terminations must be submitted through the approved monthly provider enrollment process.



State Provider Revalidation

- The West Virginia Department of Human Resources (DoHS) **requires all Medicaid providers to revalidate their enrollment at least every five (5) years.**
- All providers who provide services to recipients must be enrolled with West Virginia's Bureau of Medical Services.
- Please take the appropriate precautions to ensure revalidation is completed timely to ensure accurate claims payment and participation in the Highmark Health Options West Virginia provider network is not interrupted.
- Please visit <https://www.wvmmis.com/Provider-Enrollment> for application information.

PCP's Role and Responsibilities

The PCP's role is to:

- Maintain continuity of each enrollee's health care by serving as the enrollee's primary care provider.
- Provide primary behavioral health services within their scope of practice.
- Provide 24/7 access.
- Make referrals for specialty care and other Medically Necessary covered services, including behavioral health, both in-network and out-of-network, consistent with HHO WV's utilization management policies.
- Maintain a current medical record for the enrollee, including documentation of all services provided to the enrollee by the PCP, as well as any specialty or referral services.
- Adhere to the EPSDT Periodicity Schedule for enrollees under the age of 21.
- Follow MCO-established procedures for coordination of in-network and out-of-network services for Medicaid enrollees.



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

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

Continuity and Coordination of Care

Specialists and Hospitals must ensure compliance with the Continuity and Coordination of Care requirements, by ensuring that all discharge summaries, consultation and progress reports are reported back to the member's PCP.



Behavioral health provider coordination of care with members PCP

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



Accessibility to Care Standards



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

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

Highmark Health Options West Virginia uses a National Committee for Quality Assurance (NCQA) certified vendor to conduct this annual telephonic accessibility audit.

The appointment standards and other accessibility resources are located under For Providers- Resources section of our website: <https://hho.fyi/wv-carestandards>.



Accessibility Standards

Provider Appointment Access Standards for **PCPs and Medical Specialists** (Timeliness of access to care):

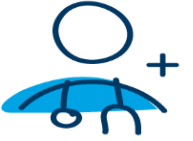
Emergency	Immediately or referred to emergency facility	Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Scheduled in accordance with EPSDT Periodicity Schedule
Urgent Care	Within 48 hours		
Initial Prenatal Care	Within 14 calendar days of pregnancy confirmation		
Supplement Security Income (SSI Members)	Within 45 calendar days of initial enrollment		
After-hours Access (PCP)	Access must be provided 24 hours a day/ 7 days per week. A live person, recording or auto attendant will direct patients in the case of a true emergency to call 911 or go to the nearest Emergency Room. An on-call physician is available after-hours.		

Accessibility Standards

Provider Appointment Access Standards for **Behavioral Health Specialists** (Timeliness of access to care):

Emergency	Immediately or referred to emergency facility	Non-Life-Threatening Emergency	Within 6 hours, or direct to emergency facility or crisis center
Urgent Care	Within 48 hours		
Initial Routine Care	Within 10 business days of		
Follow-up Routine Care	Within 15 business days		

Accessibility Standards- Monitoring Adherence



All offices must comply with Americans with Disabilities Act (ADA) accessibility requirements in patient areas.

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



Provider Satisfaction Survey



Highmark Health Options West Virginia uses a NCQA certified vendor to conduct an annual provider satisfaction survey.

- We use the survey responses to identify initiatives to improve upon the provider experience.
- The Provider Satisfaction Survey is conducted annually. The first wave is a mailing, followed by a second wave mailing to non-respondents, and finally telephonic outreach to the remaining non-respondents.
- Results of the survey will be shared via our provider newsletter, which will be available on our website.



Coverage Arrangements



All participating practitioners must ensure 24-hour, 7 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.



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



Offices should follow CMS regulations with regards to locum tenens – they are recognized for services up to a sixty (60) calendar day time frame. Claims are to be billed under the participating supervising/lead physician.

Reporting Suspected Abuse and Neglect

As a participating provider you are considered a Mandated Reporter. As a Mandated Reporter, you are required by law to report suspected child abuse and/or neglect.

To Report:

- Call WV Child Abuse and Neglect Hotline at 1-800-352-6513. This toll-free intake line is available 24 hours/7 days a week to receive reports of suspected child abuse. As a mandated reporter, you must provide your name and contact information when making the call.

To learn more about Child Protected Services Policy, please visit https://dhhr.wv.gov/bcf/policy/Documents/CPS_Policy.pdf.



Transfer of Medical Records

- Practitioners are required to transfer member medical records within 14 business days of the written request and at no cost to the member.



Reportable Conditions

- By state mandate, providers must report communicable diseases and conditions to local health departments. Highmark Health Options West Virginia's providers are to comply with all state laws in the reporting of communicable diseases and conditions. Timely reporting is vital to minimize outbreaks and prevalence.
 - Reportable diseases include, but are not limited to, the following primary types of diseases: sexually transmitted infections (STIs), TB, and communicable diseases (for example, HIV, AIDS, etc.).
 - Highmark Health Options West Virginia attests annually that we have provided written notification to participating providers about your responsibility to and procedures for reporting these primary types of diseases to the state.
 - Per WV Legislative Rules Title 6-4, Series 7, practitioners and providers must report cases of communicable diseases noted as reportable in West Virginia to the local health departments in the appropriate time frame and method outlined in legislative rules. Per legislative rule, reports of category IV diseases, including HIV and AIDS, are to be submitted directly to the State Health Department, not to local jurisdictions.
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Bureau for Public Health Laboratories

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



Language Services

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



Pharmacy

- HHO WV is responsible for all physician administered drugs.
- Certain drugs require prior authorization or have service limits.
- HHO WV prior authorization criteria can be found at [MEDICATION POLICIES](#).
- BMS required drug criteria can be found at [HEALTHCARE COMMON PROCEDURE CODING SYSTEM \(HCPCS\)/DRUG CODES](#).
- When submitting claims for physician administered drugs purchased through the 340B program, providers must include a “UD” modifier on the claim for proper reporting, in addition to the appropriate billing units, Healthcare Common Procedure Coding System (HCPCS) code and corresponding National Drug Code (NDC).



Pharmacy Phone Numbers

- Providers with questions pertaining to **physician administered drug coverage** under a member's medical benefit should call HHOWV:
 - **1-833-957-0020**
- Pharmacies with questions pertaining to a member's **pharmacy benefit claim processing** can call WV Fee For Service:
 - **WV Medicaid 1-888-483-0801**
 - **WV CHIP 1-855-230-7778**
- Pharmacies and prescribers with questions pertaining to member's **pharmacy benefit claim prior authorization** can call WV Rational Drug Therapy Program (RDTP):
 - **1-800-847-3859**

Compliance



Fraud, Waste, and Abuse (FWA)

Our policies and procedures follow the guidelines set forth by CMS, where applicable:

- [Reporting Fraud | CMS](#)

Providers can find FWA trainings created by the Plan's Fraud, Waste, and Abuse Unit on our website: <https://wv.highmarkhealthoptions.com/providers/provider-manual/provider-training.html>



Complaints, Grievances, and Appeals



Provider Complaint Process

Highmark Health Options West Virginia accepts provider complaints, regardless of their origin or communication method and will provide timely resolution to providers.

Provider Complaints can be forwarded via the Provider Complaint Messaging Center located within the NaviNet Secure Provider Portal

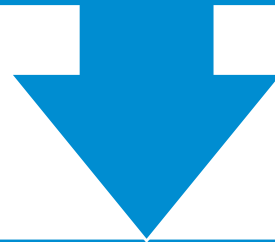


Providers can expect a response within 30 days of receipt.

If additional time is needed to resolve a complaint, status updates will be shared with the provider

Provider Appeals

Any provider may file a provider appeal to request the review of any post-service denial. This process is intended to afford providers with the opportunity to address issues regarding payment only. Appeals for services that have not yet been provided must follow the Member Grievance or Complaint Process. The Provider Appeal Process must be initiated by the provider through a written request. A first level appeal must be submitted in writing within 60 calendar days from the date on the notice of adverse benefit determination (**authorization denial**). In this instance there is a denied authorization however services have already been provided. 180 calendar days from the date of the post-service claim denial, or as governed per contract. **When an authorization has been denied, provider must adhere to the sixty (60) calendar-day time frame, the one hundred and eighty (180) calendar days once the claim has denied does not apply.**



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 and provide justification as to why an authorization was not requested within the timeframe.

Provider Appeals

Provider Appeal Requests can be submitted through our provider portal or fax:

NaviNet

<https://connect.NaviNet.net>

Fax

833-547-2022

- Select Highmark Health Options West Virginia from the NaviNet home page.
- Choose Enhanced Provider Features.
- Select “Submit Appeals and claims Disputes”.
- Please include all **clinical and pertinent** documentation to support your request. Documents can be uploaded through the portal. **You must include medical records, copy of denied claims, reason for the appeal, etc.**
- Additional information regarding the provider appeal process can be found in our provider manual, which is available on our website: <https://hho.fyi/wv-manual>.

Payment Disputes

- Highmark Health Options West Virginia will review any claim that a practitioner feels was denied or paid incorrectly. These are requests that are not regarding medical necessity. Examples of administrative reviews include but not limited to: disputes regarding amount paid, denials regarding lack of modifiers, refunded claim payments due to incorrect payment, or coordination of benefit (COB) issue.
- Please forward all the appropriate documentation, (i.e. the actual claim information, reason for the denial dispute and any supporting information) in order to expedite the review process.
- Payment disputes can be submitted for review via the NaviNet® portal under Enhanced Provider Features then select Submit Appeals and Claims Disputes.
- Providers can also fax payment disputes to 1-833-623-2571.

Member Complaints, Grievances, and Appeals

- **Grievance** – An expression of dissatisfaction about any matter other than an Adverse Benefit Determination (appeal) and either be filed in writing or verbally. A grievance can be about any service that a member received from a provider or by Highmark Health Options West Virginia.
- **Appeal** – A request for a review of an adverse benefit determination.
- An Environmental Assessment will be conducted in response to a complaint which is related to non-compliance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

Detailed information on Member Complaints, Grievances, and State Fair Hearing Process can be found in the Provider Manual, which is located on our website: <https://hho.fyi/wv-manual>.



Member Complaints, Grievances and Appeals

- A patient or provider may contact a Member Advocate or Grievance Coordinator at any time for help or any questions about the appeals and grievances process.
- Patients have a right to appoint a representative to act on their behalf.
- If a provider is acting on behalf of a patient, Highmark Health Options West Virginia requires the patient's consent in writing prior to reviewing a request for an appeal or grievance.
- An appeal must be filed within 60 calendar days from the Notice of Adverse Benefit Determination letter. A decision letter will be mailed within 30 calendar days from the date the appeal was filed.
- If the normal timeframe to review an appeal could seriously jeopardize the patient's life, health, or ability to attain, maintain or regain maximum function, providers may ask for an expedited appeal either verbally or in writing. Decisions are sent within 72 hours from the day the request is filed.
- A State Fair Hearing is an appeal process provided by the State of West Virginia either in person or by telephone.
- If a patient does not agree with a denial of an appeal decision, they may request a State Fair Hearing within 120 calendar days of the date of the notice of resolution upholding the adverse benefit determination.



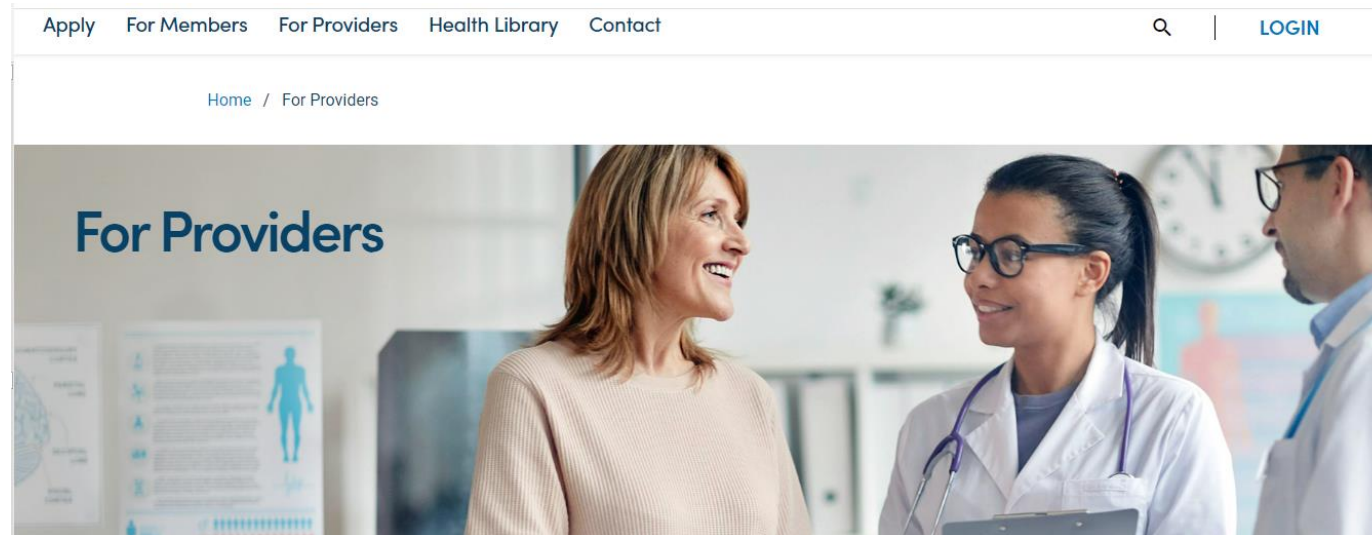
Claims and Billing



Claims Payment Policy

- Highmark Health Options West Virginia is required to cover all services that are covered under West Virginia Medicaid and WVCHIP.
- Highmark Health Options West Virginia follows claims payment policies which are national in scope, simple to understand, and aligned with current industry and medical society standards.

Medical and Reimbursement Policies are made available via the provider page of our website under the **For Providers** tab: <https://wv.highmarkhealthoptions.com/>.



Claims Coding Software



Highmark Health Options West Virginia utilizes a fully automated coding review product that programmatically evaluates claim payments to verify the clinical accuracy of professional claims in accordance with clinical editing criteria.

- This coding program contains complete sets of rules that correspond to CPT, HCPCS, ICD-10, AMA, and CMS guidelines as well as industry standards, medical policy and literature, and academic affiliations.

The program used at Highmark Health Options West Virginia is designed to assure data integrity for ongoing data analysis and reviews procedures across dates of service and across providers at the claim, partitioner, and practitioner-specialty level.



Encounter Data



- All providers are required to report to Highmark Health Options West Virginia all services they provide for Highmark Health Options West Virginia members by submitting complete and accurate claims regardless of expected reimbursement.
- To effectively and efficiently manage members' health services, encounter submissions must be comprehensive and accurately coded.
- All Highmark Health Options West Virginia providers are contractually required to submit encounters for all member visits. Underreporting of encounters can negatively impact all stakeholders.
- For PCPs, encounter data is essential as many of Highmark Health Options West Virginia's quality indicators are based on this information.
- PCPs and specialty care providers must submit claims under the individual national provider identifier (NPI) and tax identification number (TIN) to comply with encounter data reporting. If a provider does not have an NPI, they should submit claims with their MMIS identifier. Claims will be rejected up-front if the individual provider number is not included.



Claims Submission



Electronic claims are accepted through any clearinghouse with payer ID RP118.

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

For submission of professional or institutional electronic claims for Highmark Health Options West Virginia, please refer to the following grid:

CPID	PAYER NAME	PAYER ID
RP118	Highmark Health Options West Virginia (HHO WV)	RP118

Mailing address for paper claims submission:

- Attention: Claims Processing Department
Highmark Health Options WV
PO Box 211349
Eagan, MN 55121



Claims and Billing Reminders

- Highmark Health Options West Virginia will be the payer of last resort for services provided to patients when any commercial or Medicare plan covers them. This excludes EPSDT, early intervention services for children ages 0 to 3 and prenatal visits. If an Explanation of Benefits (EOB) is attached, then coordination of benefits will be applied.
 - Payment for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes are covered to the extent they are recognized by BMS or allowed per medical review determination by Highmark Health Options West Virginia.
 - All encounters, regardless of expected payment must be submitted via CMS1500 or UB format.
 - Correct coding must be submitted for each service rendered using valid CPT & HCPCS codes, appropriate modifiers and place of service locations.
 - Always bill with the highest level of diagnosis code that is valid at the time of service.
 - Handwritten claims are not accepted.
 - Billing provider address must be a physical location, claims will be rejected if a PO box number is submitted as the billing address.
 - Claims status inquiries can be researched via NaviNet for a claim which does not appear on a remittance advice within 60 days following submission.
-

Timely Filing Guidelines for Claims Submission

- Providers must submit a complete, original CMS-1500 or UB-04 claims form within 12 months from the date of service.
- When Medicare is the primary payer, providers must bill with an Explanation of Benefits (EOB) within 12 months from the date of Medicare remittance.
- For all other primary payers, providers must bill with an EOB within 12 months from the date of service.
- Corrected claims or requests for review must be received within 120 calendar days from the date of original claim remittance date. Claims submitted after these deadlines will be denied for untimely filing.



Claims Payment - ERA & EFT

- PNC Healthcare issues the payment on behalf of Highmark Health Options West Virginia via the Claim Payments & Remittances (CPR) service, powered by Echo Health.
- Providers may register to receive payments electronically. The CPR service enables providers to log into a web-based portal to manage their payment preferences and access their detailed explanation of payment (EOP) for each claim payment.

The **PNC Echo UI Users Guide** can be accessed on our website.



- Virtual Card Payments
- Electronic Funds Transfer (EFT) Payments
- Medical Payment Exchange (MPX)
- Paper Checks

If you need assistance,
contact ECHO Health at
allpayer@echohealthinc.com or
888-834-3511, to sign up to receive
EFT payments only or 835 and EFT.

Balance Billing



Payment by Highmark Health Options West Virginia is considered payment in full.

- A participating provider may not balance bill enrollees for covered services. Providers may directly bill patients when noncovered services are provided; however, before providing such services, the provider must notify the patient in writing that:
 - The service(s) to be provided are not covered.
 - They have the right to appeal an adverse coverage decision.
 - They will be financially liable for services if the appeal is not successful.
 - That Highmark Health Options West Virginia will not pay for or be liable for those services.
 - Providers are prohibited by both the Highmark Health Options agreement and BMS contract from collecting copays for missed appointments.



Copayments and Cost-Sharing

WV Medicaid:

WV Medicaid copayment amounts for eligible members are based on the following:

- Cost Sharing applies to current and newly eligible individuals.
- Services cannot be refused for populations with income at or below 133% FPL if the member is unable to pay the copay amount.
- Maximum out of pocket (OOP) cannot exceed 5% of the members' quarterly household income.

The following WV Medicaid populations and services are exempt from copays:

- Pregnant women including pregnancy-related services up to one-year postpartum
- Children under age 21
- Native American and Alaska natives
- Intermediate care facility or IID services
- Preventive services
- Individuals in nursing homes
- Hospice services
- Medicaid Waiver services
- Breast and Cervical Cancer Treatment Program
- Family Planning services
- Behavioral Health services
- Emergency services
- Missed appointments

***The member copayment amount will be reflected on the remittance advice if it is applicable.**

WV CHIP:

The following WVCHIP populations and services are exempt from copays:

- Preventive services
- Medical Home Physician Visits
- Native American and Alaskan natives
- Pregnant women over age 19

Payment Disputes

Our company will review any claim that a practitioner feels was denied or paid incorrectly.

- These are requests that are not regarding medical necessity but rather are administrative in nature such as but not limited to, disputes regarding the amount paid, denials regarding lack of modifiers, or coordination of benefit (COB) issues.
- Please include all the appropriate documentation, (i.e. the actual claim information, reason for the denial dispute and applicable documentation).

Payment disputes can be submitted two ways:

- Via the NaviNet® portal under Enhanced Provider Features then select Submit Appeals and Claims Disputes.
- Via fax to 1-833-623-2571.

OB/GYN Services



OB/GYN Services



Members may self-direct to any participating OB/GYN for any OB/GYN related condition, not just for an annual exam or suspected pregnancy.

OB/GYN's office is required to verify eligibility of the member.

PCPs may perform routine gynecological exams and pap tests and provide care during pregnancy if they are so trained and equipped in their office.

PCPs who provide obstetrical services must bill in accordance with the Plan guidelines and may only provide obstetrical services to those patients assigned to their panel.

Highmark Health Options West Virginia members may also self-refer for family planning services.

West Virginia Prenatal Risk Screening Instrument (PRSI)

- The first visit with an obstetrical patient is the intake visit, or if a patient becomes an HHO member during the course of her pregnancy, her first visit as an HHO member is considered to be her intake visit. The PRSI form must be completed at the intake visit.
- Providers can fax the completed PRSI form to Highmark Health Options Care Coordination Team at 1-833-559-2850 immediately and filed in the member's medical record.
- The PRSI must be submitted to the Care Coordination Team within two to five business days of the intake visit.
- The PRSI should be updated at the 28 to 32 week visits and at the post-partum visits. These two updates should also be submitted to the Care Coordination Team immediately following completion.
- The PRSI is not a claim; however, the PRSI must be received by the Plan to process the claim for the intake visit.

OB Coding



Under the per visit reimbursement structure, the following procedure codes should be used when billing:

- All prenatal visits and dates of service must be included on the CMS-1500 form and identified with the appropriate E&M codes (99202 – 99205 and 99211 – 99215) only.
- The U9 pricing modifier must follow the code in the first position on the claim form.
- Delivery charges must be identified with CPT codes.
- HHO WV will reimburse providers a payment of \$200 plus the contracted percentage increase for initial prenatal visits rendered within the first trimester.
- To receive the bonus payment, providers must report the following: 99429-HD (First Trimester Outreach), T1001-U9 (Initial Risk Assessment), and E&M code (99202-992052 and 99211-99215); -25 modifier needs to be billed on the E&M (99202-99205 and 99211-99215) in addition to the U9 pregnancy modifier. All three codes must be reported together on the same claim form, along with diagnosis of pregnancy, to allow the bonus payment. Additionally, FQHCs must use the T1015 code with the above mentioned guidelines.
- If the members first prenatal visit doesn't occur within the first trimester, then code 99429-HD should not be billed.

Family Planning Services

Our members have direct access for family planning services without a referral or authorization and may also seek family planning services at the practitioner or provider of their choice (in or out of network).

The following services are included:

- Annual gynecological exam and pap smear
- A comprehensive family planning exam
- Contraceptive supplies, devices, and medications for specific treatment and contraceptive counseling
- Pregnancy diagnosis and counseling
- Treatment of a sexually transmitted disease
- Lab services

Sterilization/Hysterectomy

- In accordance with WV Medicaid and WVCHIP we will cover a sterilization or hysterectomy determined to be medically necessary by the attending physician in consultation with the patient.
- All federal and state laws regarding this benefit must be adhered to, ensuring the completion of the required forms, and shall comply with the requirements of 42 CFR 441. Subpart F. 45.
- The required forms are located on the Bureau for Medical Services website. The consent form must be submitted with the claim.

Participating providers should educate members about the release of necessary medical data to HHO WV.

NOTE: Elective termination of pregnancy will be managed via HHO WV effective Jan. 1, 2026. This service will require authorization.

HealthCheck (EPSDT) Program



HealthCheck (EPSDT)

- Program is based upon the federally mandated EPSDT Program for Medicaid eligible children under the age of 21.
- Required screens, tests, and immunizations are outlined by the West Virginia EPSDT Program Periodicity Schedule.
- New Members must be seen within forty-five (45) days from the effective date of enrollment.

Highmark Health Options West Virginia Care Coordination:

- Outreach via telephone and mail, to members to provide education and assistance with scheduling appointments, transportation, and other issues that prevent access to health care.
- Outreaches to members identified by the PCP offices who are delayed with screens and/or immunizations or who are non-adherent with appointments. Providers can complete the Member Outreach Form to identify members who need outreach. The form can be accessed on our website at: <https://hho.fyi/wv-EPSDToutreach>.

West Virginia HealthCheck



West Virginia HealthCheck

When should you take your child to the doctor?

"If my child is not sick, should I still make an appointment?"

YES!

- You will talk about normal growth and development for your child.
- Your child will receive tests for hearing and vision.
- Your child will receive an oral health screen and referral to a dentist.
- Your child will receive a head-to-toe physical exam.
- It is an easy way to keep up-to-date on your child's shots.

For More Information or Assistance:

1-800-642-9704

www.dhhr.wv.gov/healthcheck

Well Child Checkups

Well child checkups are important because they allow your doctor to make sure your child is healthy and growing well. They also give you a chance to ask questions and discuss any concerns you may have. Checkups can detect health problems early and in some cases, prevent health problems from occurring.

Your child's healthcare provider may be a doctor (MD or DO), physician assistant (PA) or an advanced practice registered nurse (APRN).

Schedule of Well Child Checkups

Infancy	Early childhood	Late childhood	Adolescence
• 3-5 days	• 12 months	• 5 years	• 12 years
• By one month	• 15 months	• 6 years	• 13 years
• 2 months	• 18 months	• 7 years	• 14 years
• 4 months	• 24 months	• 8 years	• 15 years
• 6 months	• 30 months	• 9 years	• 16 years
• 9 months	• 3 years	• 10 years	• 17 years
	• 4 years	• 11 years	• 18 years
			• 19 years
			• 20 years

Be Prepared for Your Child's Checkup

- Write down any questions you may have about your child's health.
- Bring a list of all the medications that your child is taking including prescriptions, over-the-counter meds and vitamins.
- Bring a copy of your child's shot record.
- Ask about a follow-up appointment.

WVDHHR/RRH/CMCH/HealthCheck 11-2011

- Providers should refer to West Virginia HealthCheck for assessment questions and for the periodicity schedule found at: <https://dhhr.wv.gov/healthcheck/Pages/default.aspx>.
- Providers are required to submit HealthCheck forms to BMS. Additional information can be found at: [Provider Information \(wv.gov\)](#).

Vaccines for Children

- Both state and federal regulations require that immunizations be brought up to date during health screens and any other visits the child makes to the office.
- Highmark Health Options West Virginia follows the recommended childhood immunization schedule approved by the CDC Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics, and the American Academy of Family Physicians here: <https://www.cdc.gov/vaccines/schedules/hcp/index.html>.
- Children under 19 years of age receiving Medicaid are eligible for Vaccines for Children (VFC) Program.
- An administrative fee will be reimbursed when a vaccine administration code is billed for each VFC vaccine code along with the appropriate NDC number.



EPSDT Billing

- An EPSDT visit is considered complete when ALL the age-appropriate screens are completed (including immunizations) and then properly billed.
- Incomplete EPSDT screens are office visits where the provider did not complete all the components listed on the Periodicity Schedule for the child's screening period.
- All EPSDT screening services, including vaccine administration fees, must be submitted to Highmark Health Options West Virginia either on a CMS-1500 or the corresponding 837P format for EDI claims within 12 months from the date of service. EPSDT screenings on a UB-04 form or the corresponding 837-I are not accepted.
- All EPSDT screening services must be reported with the age-appropriate evaluation and management code along with the EP modifier.
- If an EPSDT service cannot be performed, please utilize modifier 52. The service is expected to be provided at the next visit.
- If a child is referred to an outside laboratory, please use the appropriate procedure code with modifier 90.
- Highmark Health Options will process and pay EPSDT services as primary. If an EOB is attached, coordination of benefits will be applied.

Oral Health Fluoride Varnish Program



- Primary Care providers may receive a reimbursement for fluoride varnish application.
- Providers are encouraged to complete the Smiles for Life Curriculum course prior to administering this service but are not required.
- A referral to a dentist at or after age 1 is recommended. A referral to a dentist shall be mandatory at age 3 and annually thereafter through age 18 for WV CHIP members and age 20 for Medicaid members.
- The application of the fluoride varnish should be covered for children ages six months to three years. Providers should include education and counseling with the child's caregiver.
- WV CHIP allows coverage for two fluoride varnish applications per year (once every six months).
- Application must be provided and billed in conjunction with a comprehensive well-child exam and an oral health risk assessment should be conducted prior to application.

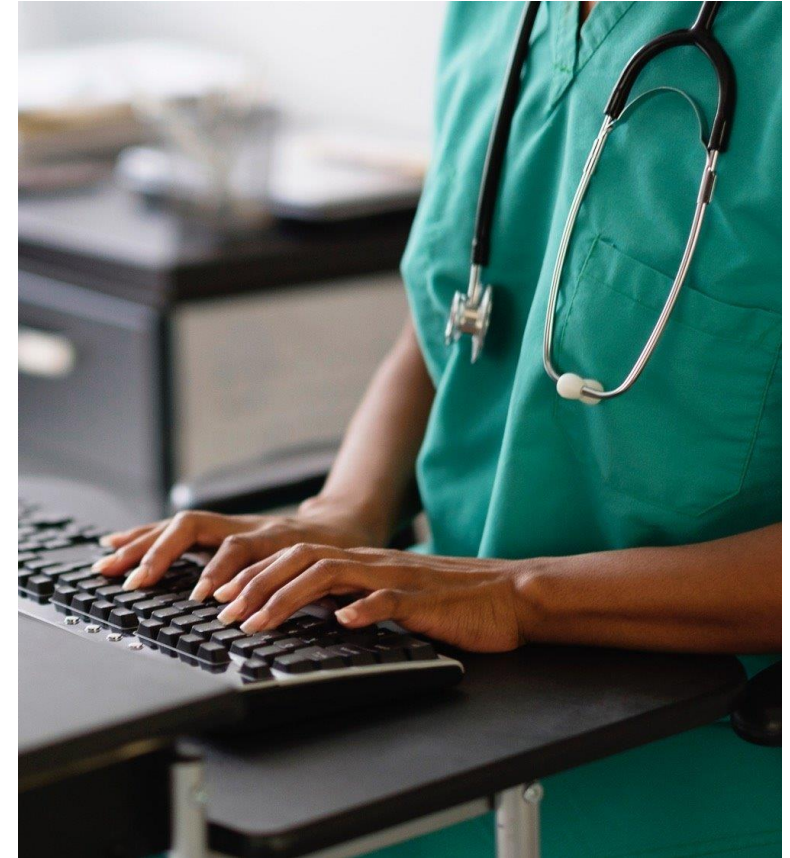


Behavioral Health and Substance Use Disorder



Behavioral Health and Substance Use

- Members are permitted to self-refer for behavioral health and substance abuse services.
- Primary care physicians and all non-behavioral health providers are encouraged to recommend behavioral health services when appropriate.



Behavioral Health and Substance Use Disorder

Behavioral Health Services

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

BH Crisis Intervention Services (CIS)

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

Substance Use Disorder (SUD) Services

SUD services are behavioral health treatment services provided to members with a known or suspected substance use disorder when medically necessary. **Benefits include** targeted case management, behavioral health assessment, drug screening, inpatient and outpatient services, residential adult services, Naloxone administration services, methadone and non-methadone medication assisted treatment, and peer recovery support services, e.g., Group Recovery Support.

Tobacco Cessation Resources



Tobacco Cessation

Highmark Health Options West Virginia realizes that our providers can have the biggest impact in helping our members quit using tobacco.

- Tobacco cessation benefits are available to Highmark Health Options West Virginia members.



Health Related Social Needs (HRSN)





Health Equity (HE)

The state in which everyone has a **fair and just opportunity** to attain their highest level of health.

Social Determinants of Health (SDOH)

The **conditions into which people are born, live, learn, work, play, worship, and age** that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Health Related Social Needs (HRSN)

The **social and economic needs that each individual experiences** that affect their ability to maintain their health and well-being.

SDOH, HRSN, and Health Equity

SDOH	Health Related Social Needs (HRSN)	HEALTH EQUITY
<p>The conditions into which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions are shaped by the distribution of money, power, and resources and are impacted by institutional bias, discrimination, and racism.</p>	<p>The social and economic needs that individuals experience that affect their ability to maintain their health and well-being.</p>	<p>The state in which everyone has a fair and just opportunity to attain their highest level of health.</p>
<p>Can be grouped into 5 domains:</p> <ol style="list-style-type: none"> 1. Economic Stability 2. Education access and quality 3. Health care access and quality 4. Neighborhood and built environment 5. Social and Community Context 	<p>Include factors such as (but not limited to):</p> <ul style="list-style-type: none"> • Housing quality, instability and homelessness • Lack of affordable utilities • Food/Nutrition insecurity • Personal safety and violence • Education, Employment, and Income • Lack of transportation • Family and Social Support 	<p>Achieving this requires focused and ongoing societal efforts to address:</p> <ul style="list-style-type: none"> • Historical and contemporary injustices overcome economic, social, and other obstacles to health and health care • Eliminate preventable health disparities.
<p>Broad and Systemic.</p>	<p>Perpetuation of health inequalities and contribute to poor health outcomes, drives lapses in coverage and access to care, and higher downstream medical costs.</p>	<p>Broad and Systemic.</p>
<p>Requires policy change and long-term strategies.</p>	<p>Focus on the immediate social needs affecting individual health derived from a person specific assessment of Social Determinants of Health.</p>	<p>Requires policy change and long-term strategies.</p>
<p>Contribute to wide health disparities and inequalities.</p>	<p>Individual and immediate. Can be addressed through direct referrals, services, and intervention.</p>	<p>Contribute to wide health disparities and inequalities.</p>

Provider Resources

We value our providers and appreciate their important role to identify and address Health-Related Social Needs (HRSN) of our members. In partnership, we offer resources that are easily accessible to providers.

Highmark Health Options Resource Center

The Highmark Health Options Resource Center is an all-encompassing database of free or reduced cost social care programs throughout the community for staff, providers, and members. The platform allows “seekers” (those looking for programs) the ability to easily view program specific requirements, contact information, and even make direct online referrals. The Highmark Health Options Resource Center can be accessed via:

- [Highmark Health Options WV website](#)
- [Provider Portal](#)

Using SDOH Z CODES Can Enhance Quality Improvement Initiatives:

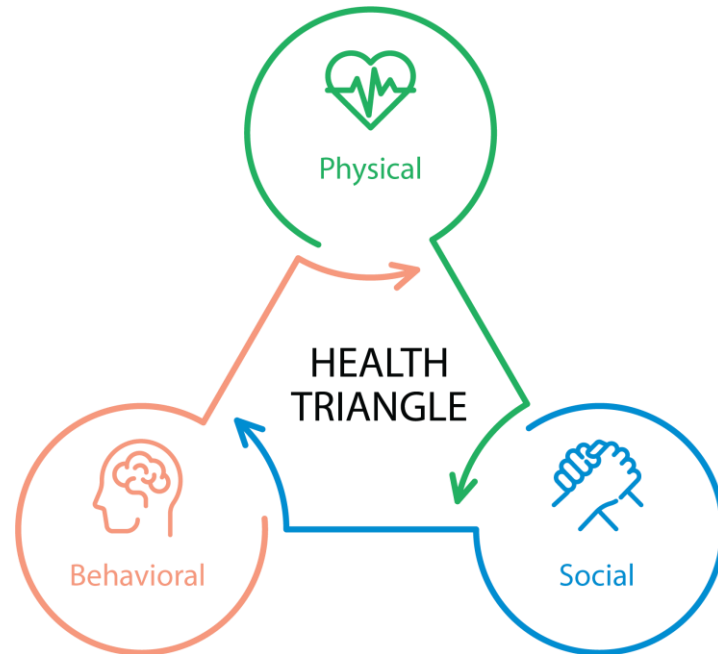
Follow the ICD-10-CM coding guidelines and assign all relevant SDOH Z codes to support quality improvement initiatives.

Social Determinants of Health (SDoH)



Whole Person Care

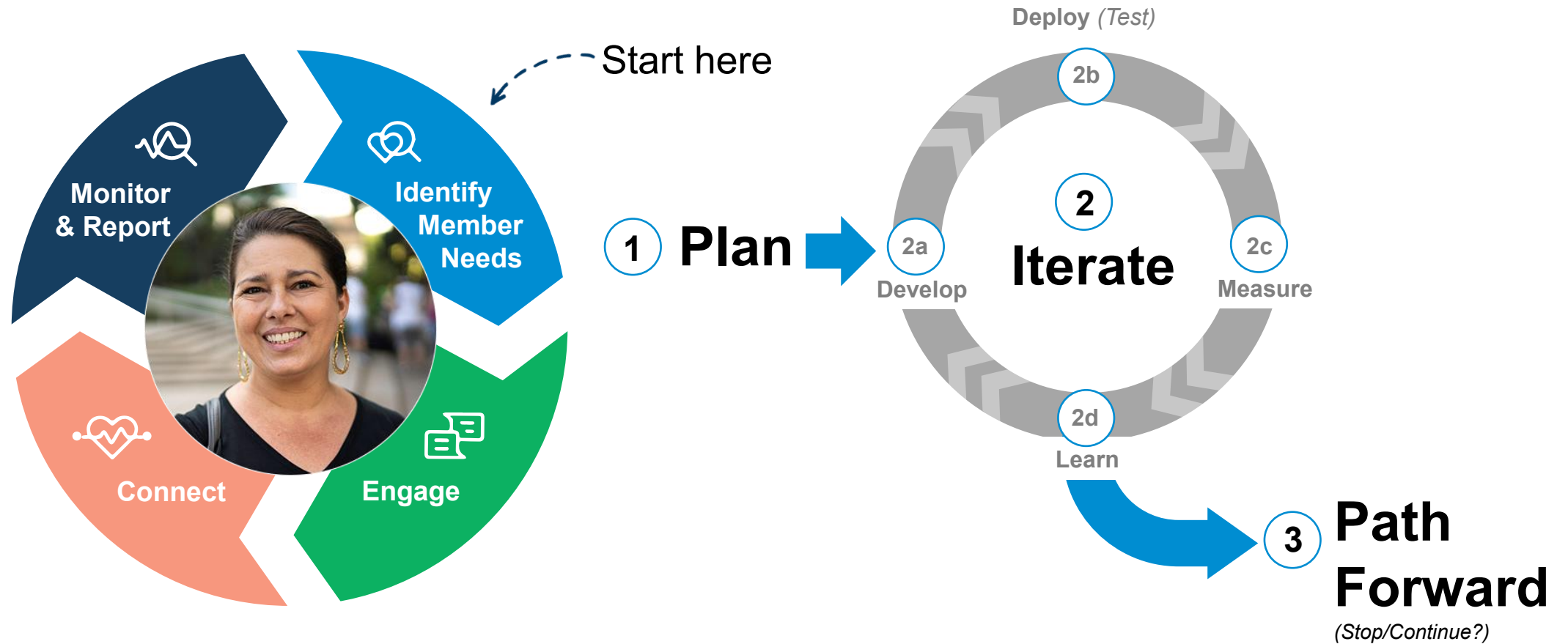
A person's holistic health is more than just their physical health – behavioral and social are key tenets in their journey.



Social Determinants of Health: The conditions in which people are born, grow, work, live, worship and age.

40% Socioeconomic Factors	Education Job Status Family Social Support Income Community Safety
10% Physical Environment	Physical Environment
30% Health Behaviors	Tobacco Use Diet & Exercise Alcohol Usage Sexual Activity
20% Health Care	Access to Care / Quality of Care

Connecting Members to the Right Social Care Solutions



Universal Assessment: Getting to Root Causes



We ask “non-health” questions to help identify root causes of poor health and work together to find solutions.

- Employment
- Financial Resource Strain
- Food Insecurity
- Health Care, Clothing, and Childcare Access and Affordability
- Health Literacy
- Housing Stability
- Safety
- Social Connections
- Transportation needs



“Sometimes people find that their income does not quite cover their living costs. In the last 12 months, has this happened to you?”

Outreach and Referral Platform

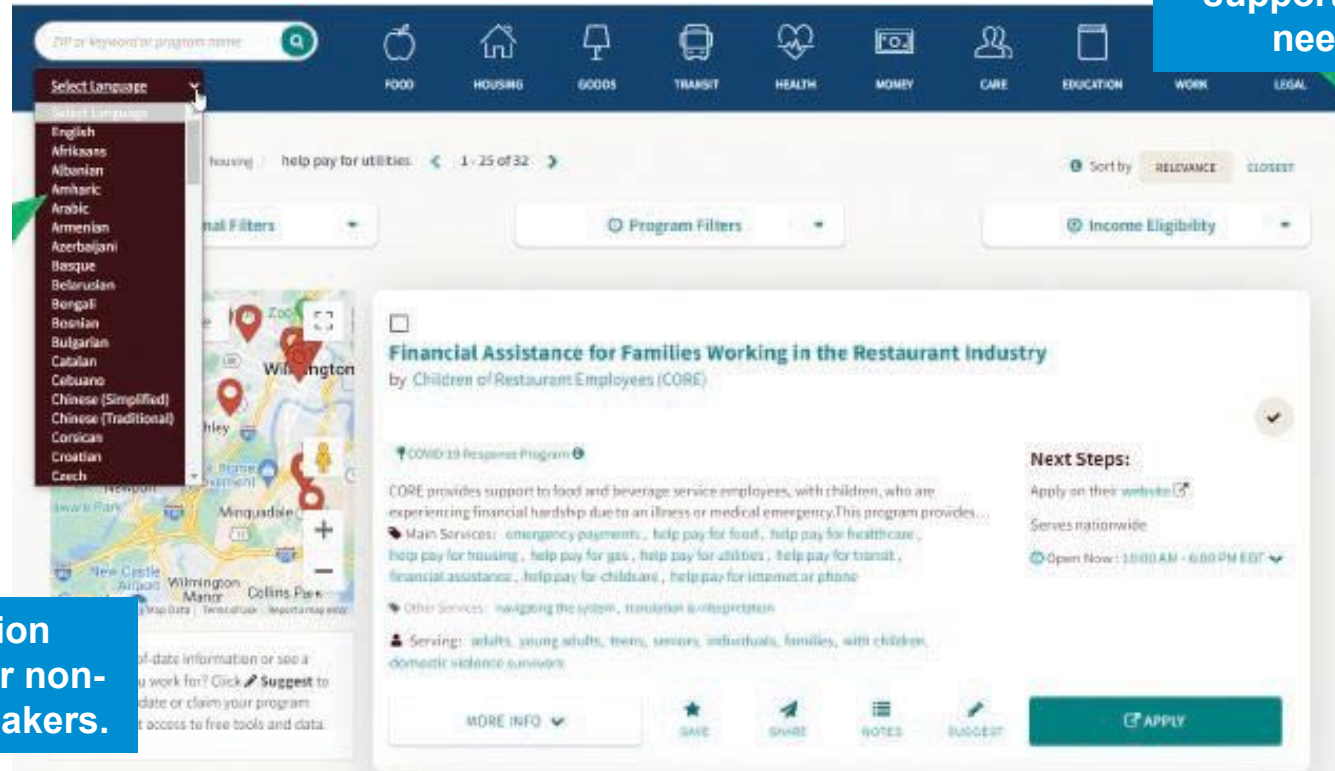
Connecting members to help via

<https://highmark.findhelp.com/>

Thousands of programs across the country to support social needs.



Translation available for non-English speakers.



IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) data with ICD-10-CM Z Codes

Exhibit 1. Recent SDOH Z Code Categories and New Codes

Z55 – Problems related to education and literacy

- Z55.5 – Less than a high school diploma (Added, Oct. 1, 2021)

- NEW** • Z55.6 – Problems related to health literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment (Added, Oct. 1, 2021)

- Z58.6 – Inadequate drinking-water supply (Added, Oct. 1, 2021)

- NEW** • Z58.8 – Other problems related to physical environment

- NEW** • Z58.81 – Basic services unavailable in physical environment

- NEW** • Z58.89 – Other problems related to physical environment

Z59 – Problems related to housing and economic circumstances

- Z59.0 – Homelessness (Updated)

- Z59.00 – Homelessness unspecified (Added, Oct. 1, 2021)

- Z59.01 – Sheltered homelessness (Added, Oct. 1, 2021)

- Z59.02 – Unsheltered homelessness (Added, Oct. 1, 2021)

- Z59.1 – Inadequate Housing (Updated)

- NEW** • Z59.10 – Inadequate housing, unspecified

- NEW** • Z59.11 – Inadequate housing environmental temperature

- NEW** • Z59.12 – Inadequate housing utilities

- NEW** • Z59.19 – Other inadequate housing

- Z59.4 – Lack of adequate food (Updated)

- Z59.41 – Food insecurity (Added, Oct. 1, 2021)

- Z59.48 – Other specified lack of adequate food (Added, Oct. 1, 2021)

- Z59.8 – Other problems related to housing and economic circumstances (Updated)

- Z59.81 – Housing instability, housed (Added, Oct. 1, 2021)

- Z59.811 – Housing instability, housed, with risk of homelessness (Added, Oct. 1, 2021)

- Z59.812 – Housing instability, housed, homelessness in past 12 months (Added, Oct. 1, 2021)

- Z59.819 – Housing instability, housed unspecified (Added, Oct. 1, 2021)

- Z59.82 – Transportation insecurity (Added, Oct. 1, 2022)

- Z59.86 – Financial insecurity (Added, Oct. 1, 2022)

- Z59.87 – Material hardship due to limited financial resources, not elsewhere classified (Added, Oct. 1, 2022; Revised, April 1, 2023)

- Z59.89 – Other problems related to housing and economic circumstances (Added, Oct. 1, 2021)

Z60 – Problems related to social environment

Z62 – Problems related to upbringing

- Z62.2 – Upbringing away from parents

- NEW** • Z62.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)

- NEW** • Z62.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)

- Z62.8 – Other specified problems related to upbringing (Updated)

- Z62.81 – Personal history of abuse in childhood

- NEW** • Z62.814 – Personal history of child financial abuse

- NEW** • Z62.815 – Personal history of intimate partner abuse in childhood

- Z62.82 – Parent-child conflict

- NEW** • Z62.823 – Parent-step child conflict (Added, Oct. 1, 2023)

- Z62.83 – Non-parental relative or guardian-child conflict (Added Oct. 1, 2023)

- NEW** • Z62.831 – Non-parental relative-child conflict (Added Oct. 1, 2023)

- NEW** • Z62.832 – Non-relative guardian-child conflict (Added Oct. 1, 2023)

- NEW** • Z62.833 – Group home staff-child conflict (Added Oct. 1, 2023)

- Z62.89 – Other specified problems related to upbringing

- NEW** • Z62.892 – Runaway [from current living environment] (Added Oct. 1, 2023)

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstance

Z65 – Problems related to other psychosocial circumstances

Cultural Competence



Healthcare Disparities and Cultural Competency

Highmark Health Options West Virginia believes a strong patient-provider relationship is the key to reducing the gap in unequal healthcare access and healthcare outcomes due to cultural and language barriers. Highmark Health Options West Virginia is continuously working to close the gap in health outcomes by focusing on education and prevention.

Highmark Health Options West Virginia has cross-cultural education programs in place to increase awareness of racial and ethnic disparities in healthcare among our employees, members, and providers. Highmark Health Options West Virginia is an active partner in the community through many outreach and community-based activities.



Cultural Competency Provider Resources

Highmark Health Options West Virginia has assembled a list of resources and web-based tools to assist you and your office staff in providing care that is sensitive to the cultural and linguistic differences of your patients.

Participating providers are required to view our Cultural Competency training annually, which is available on the provider page of our website:

<https://www.brainshark.com/highmarkmedicaid/vu?pi=zJdzuDdoZzibduz0>



Limited English Proficiency (LEP)



Participating providers are required, by law, to provide translation and interpreter services (including American Sign Language services) at their practice location.

- For interpreter services, please contact a qualified medical interpretation service, such as Language Line Services.
- Practitioner offices can contact the Language Line at 1-800-874-9426 for assistance with Limited English Proficient (LEP) patients and the WV State Relay Line at 866-430-1274 for patients with hearing impairments.

Providers are responsible for the coordination and cost of interpreter services for members who are hearing impaired.



Care Management



Care Management



Care Management provides a population health model that focuses on active condition monitoring, lifestyle management, preventive health, care coordination, and community resource referrals. Individualized care plans are established for members. Providers are invited to provide input into care plans, as needed.

To refer patients to the Care Management Program, providers can call 1-833-957-0020. Patients have the choice to opt-out of all Care Coordination Programs at any time.

For patients with more complex physical or behavioral health or substance use disorder needs, Care Coordinators are available to optimize health and help prevent disease progression. Care Coordinators are licensed clinicians (registered nurses) or licensed behavioral health professionals (social workers) with medical or social service backgrounds.

Care Management



Highmark Health Options West Virginia Care Management delivers a multidisciplinary, continuous, and holistic population health model focused on active condition monitoring, preventive care, lifestyle management, and coordinated support to improve health outcomes and overall well-being.

Core Focus Areas

- Active condition monitoring and lifestyle management
- Preventive health care and early intervention
- Care coordination and referrals across the continuum

Care Management Programs and Clinical Support

Key Program Areas

- Complex Case Management
- Disease Management
- Maternity Care Management
- Preventive Health & Health Promotion

Clinical and Care Coordination Support

- Members with complex physical, behavioral health, or substance use disorder needs receive enhanced care coordination
- Care Coordinators include licensed clinicians such as registered nurses, licensed behavioral health professionals, and medical social service professionals



Member Identification, Outreach and Engagement

Member Identification & Outreach

- Eligible members are identified through multiple channels
- Care Management staff conduct proactive outreach to explain eligibility and available programs and supports

Member Choice

- Participation in care management is voluntary
- Members are informed of their option to opt in or opt out at any time



Care Planning, Additional Supports, and Referrals

Individualized Care Planning: Individualized care plans are developed in collaboration with the member

- Providers are invited to contribute input into care plans, as appropriate via our website: <https://www.brainshark.com/highmarkmedicaid/vu?pi=zJiztXiaUzibduz0>

Care Coordination: Coordination for conditions such as:

- Chronic medical and behavioral health conditions
- End-stage renal disease, human immunodeficiency virus, oncology
- Behavioral health and substance use disorders
- Intellectual or developmental disabilities and special health care needs

Additional Member Supports: Service Coordinators assist with appointment scheduling, access to community resources and wellness programs, including diabetes prevention and weight management

Provider Referrals: Providers may refer members directly into Care Management at any time by calling 1-833-957-0020.

Maternity Program

This population-based program is directed toward improving outcomes for all pregnant patients. Specific interventions are designed to identify and prospectively intervene with patients at high-risk for adverse pregnancy outcomes. All pregnant patients are eligible and can opt out at anytime.

The program offers maternity care coordination to:

- Provide patient education, support, and guidance before, during, and after pregnancy
- Decrease the need for Neonatal Intensive Care Unit admissions
- Improve the frequency of prenatal and postpartum care
- Reduce the incidence of low birth weight and preterm deliveries



Complex Case Management Program



Complex Case Management Program

Our Complex Case Management Program supports eligible patients in taking control of their health care needs.

HHO WV collaborates with our providers to coordinate health care services enabling patients to regain optimal health or improve functional ability.

Eligible patients are identified as needing comprehensive and disease-specific assessments and reassessments.



Complex Case Management Program

This eligible population may include the following patients:

- Patients at risk for a hospital admission.
- Patients who need assistance to become more self-reliant in managing their health care.
- Patients with a complex medical history.

The program includes the following:

- Comprehensive assessment of the patient's condition.
- Determination of available benefits and resources.
- Development and implementation of a case management plan of care with patient-centered prioritized goals, monitoring, and follow-up.



Quality Improvement Program



Quality Improvement Program

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

HHO WV will continuously monitor how well we're helping our members:

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

Quality Improvement Program

- The Quality Program will leverage results from member surveys, medical record reviews, the Healthcare Effectiveness Data Information Set (HEDIS®), and other tools to measure how we are doing and to help set goals for future quality activities. We also plan to work closely with you, our network providers, to monitor the care and services our members receive and determine what we can do to better serve them. HHO maintains a QI Work Plan to monitor activities conducted as part of the QI Program.
- This Work Plan will be evaluated every three months to identify issues and ensure that actions have been taken to address them.
- We will also conduct an annual review of our QI Program to see how well we've met the health care and service needs of our members. The review will tell us if we accomplished our QI Program goals, evaluate the effectiveness of new and innovative programs implemented, identify areas for improvement, and define plans to address or mitigate improvement opportunities in the future.

Federally Qualified Health Centers and Rural Health Clinics



Who is Credentialed?

- Highmark Health Options West Virginia credentials all Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Highmark Health Options DOES NOT credential the individual provider for these facility types.
- New Site Location with a different TIN, NPI, Medicaid or Medicare ID is required to go through the credentialing process.
- You can contact your Provider Account Liaison for a Highmark Health Options Organizational Provider Application and the required documentation needed with the completed application.

Requirements for New FQHC/RHC Locations

1. A completed and accurate Highmark Health Options West Virginia Organizational Application including NPI, TIN numbers, attached W-9, accurate disclosure questions, and signed attestation).
2. Facility must be enrolled with WV Medicaid.
3. Page 6 of the application must be completed with the provider's initials and provider licenses must be attached.
4. A copy of the professional and general liability policies.
5. FQHC are recredentialed at the Facility level every three years.



Requirements for FQHC/RHC Changes

- All practice changes must be submitted using the Practice Change Form, which can be found under the Forms and Reference Material section of our website: <https://hho.fyi/wv-PCF>
- When updating multiple providers at two or more service locations, use the Roster Template for multiple updates. The roster can be found under the Forms and Reference Material section of our website: <https://hho.fyi/wv-ProviderRoster>
- All appropriate fields on the form must be completed.
- For any Tax ID or Payment Remittance Name or Address Change, a W-9 must be attached.
- Any time a new location is added, an HHO WV Organizational Provider Participation Application must be completed and submitted with an updated change form.
- Completed change forms and required attachments are sent to:
FQHC_RHC_RosterUpdates@highmark.com

Please note: It can take up to 30 days to complete roster updates. Also, incomplete change forms will be returned to the original sender.



Reporting FWA: Special Investigations Unit (SIU)

If you suspect FWA, it is your responsibility to report the issue to us. You can report FWA in the following ways:

Phone:

1-844-718-6400

Mail:

Highmark Health Options
Delivery Code: FIPR
Attn: FWA/SIU Unit
120 Fifth Ave.
Pittsburgh, PA 15222

Email:

SIU_HHO@highmark.com

Or you can use the [Online Form](#) to report suspected Fraud, Waste, or Abuse.

Provider Self-Audit: Required by BMS, CMS & OIG

- Providers can submit overpayments to Highmark Health Options West Virginia by using the Provider Self-Audit Overpayment form found in the Provider Resource Center of our website: <https://wv.highmarkhealthoptions.com/content/dam/digital-marketing/en/highmark/highmarkhealthoptionswv/documents/HHO-WV-Self-Audits-Overpayments-Form-112025.pdf>
- BMS, CMS & OIG require providers to conduct self-audits to identify documentation errors & potential overpayments.
- Federal & State laws and regulations require overpayments to be returned within **60** days of identification



Resources for Self-Audits:

DoHS Guidance

OIG Guidance

CMS Guidance



HIGHMARK
HEALTH OPTIONS 

HHO WV Census and Language Information



Language Profile Commonwealth of WV

Total Population – 1.77 million

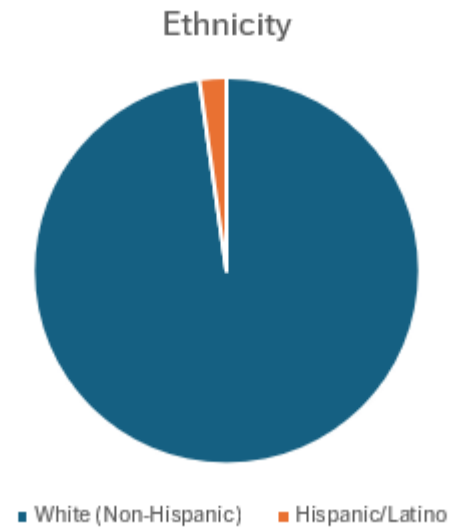
- 2.1% identify as Hispanic or Latino
- 91.2 % identify as White (Non-Hispanic)
- 96.5% people speak only English
- 1.44% of people speak Spanish
- No other language, represents 5% of the population

2022 Census Data West Virginia



Ethnic Composition

2022 data shows Hispanic/Latino had the largest increase as 2.1% of the population, and 91.2% are White (Non-Hispanic)



Healthy Rewards Program



Healthy Rewards Program

- At Highmark Health Options (HHO), nothing is more important than the health and wellbeing of our members. That is why we are rewarding our West Virginia Medicaid members for taking action to get well and stay well. You can help. By educating your patients with our rewards program!
- With the Healthy Rewards Program, members can earn a reward each time they complete an eligible health activity.
- Rewards are sent through a reloadable rewards card.
- Members should receive their rewards card within eight weeks of completing their eligible health activity.
- Members can call 1-888-682-2400 or go to mybenefitcenter.com to see the value of their rewards card and find a complete list of participating retailers in their area.

Eligible Health Activities

Healthy Activities	Reward Details	Award Amount
A1c Test for Members With Diabetes	Members who have diabetes and are ages 18 and older can earn \$25 once per year by completing an A1c test in 2024 while enrolled with Highmark Health Options.	\$25
Retinal Eye Exam for Members with Diabetes	Members who have diabetes and are ages 18 and older can earn \$50 once per year by completing a Retinal Eye Exam in 2024 while enrolled with Highmark Health Options.	\$50
Prenatal Visit in First Trimester	Members who are pregnant in 2024 can earn \$50 by completing a visit during their first trimester. The visit must occur in 2024 while enrolled with Highmark Health Options.	\$50
Completion of Six Prenatal Visits	Members who are pregnant in 2024 can earn \$100 by completing six total prenatal visits. The visits must occur in 2024 while enrolled with Highmark Health Options.	\$100
Postpartum Visit	If members have given birth, members can earn \$25 by having a postpartum visit within 7-84 days after birth. The visit must occur in 2024 while enrolled with Highmark Health Options.	\$25
Well-Child Visits	Members between ages 3-21 can earn \$25 by completing a wellness exam in 2024 while enrolled with Highmark Health Options.	\$25

Eligible Health Activities

Healthy Activities	Reward Details	Award Amount
Well-Baby Visits in First 15 Months	Infant members can earn a \$50 reward once they complete all six well-baby visits with their PCP before their 15th month of life in 2024. The sixth visit must occur in 2024 and their 15th month of life must occur in 2024 while enrolled with Highmark Health Options.	\$50
Health Risk Assessment	Members ages 18 and older can earn \$10 once per year by completing a Health Risk Assessment in 2024, while enrolled with Highmark Health Options.	\$10
Two HPV Vaccines by 13 Birthday	Members between ages 9-12 can earn \$25 if they complete their second HPV vaccine prior to their 13th birthday, with their second vaccine occurring in 2024 while enrolled with Highmark Health Options.	\$25
Mammogram	Female members ages 40 and older can earn \$50 once per year for completing a mammogram. The visit must occur in 2024 while enrolled with Highmark Health Options.	\$50
Flu Vaccine	Members ages 18 and older can receive one Hunting and Fishing License activation code for receiving their flu vaccine in 2024 while enrolled with Highmark Health Options.	Hunting and Fishing License digital code

THANK YOU!

For questions about Contracting with Highmark Health Options, connect with Provider Contracting at 304-424-0365 or HHOWVContracting@highmark.com

For questions about working with Highmark Health Options, contact Provider Relations at HHOWVPR@highmarkhealth.org

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



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

HealthHelp is a separate company that offers education and guidance from specialists in sleep, cardiology, and radiation oncology for Highmark Health Options.

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

VSP Vision is a separate company that administers the vision benefit(s) for Highmark Wholecare.

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.
