Q1 2025

Highmark Health Options Newsletter

for Providers | WEST VIRGINIA

HIGHMARK HEALTH OPTIONS

FEATURED ARTICLES:

In this issue.

Contact us.

We're here to help. Provider Relations can answer any questions you may have about working with Highmark Health Options West Virginia and can be reached at **HHOWVPR@highmarkhealth.org**. You can also call Provider Services with administrative questions at **1-833-957-0020 (TTY: 711)**, Monday–Friday, 8 a.m.–5 p.m.

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

Interactive Care Management Programs

Highmark Health Options West Virginia offers comprehensive Interactive Care Management Programs (ICMPs) designed to support your patients' health and well-being.

Our ICMPs feature three distinct programs to address diverse patient needs:

- Maternity Program for pregnant women.
- Complex Case Management for individuals with multifaceted health needs.
- Disease Management for patients with the following chronic conditions:
  - Chronic kidney disease (CKD)
  - Chronic obstructive pulmonary disease (COPD)
  - Congestive heart failure (CHF)
  - Diabetes
  - Inflammatory bowel disease (IBD)

All patients with these diagnoses or conditions qualify for the respective programs. Each program provides personalized support, including evidenced-based health education, self-management tools, and continuous care coordination to improve patient outcomes.

A dedicated clinician will collaborate with you to develop personalized health plans and assist patients with medication management, specialist referrals, and appointment scheduling.

These programs are free, with opt-in and opt-out participation available. Refer eligible patients by calling **1-833-957-0020 (TTY 711)** Monday–Friday, 8:30 a.m.–4:30 p.m.

Highmark Health Options Practitioner Excellence Incentive Program Launch

The 2025 Highmark Health Options Practitioner Excellence (HHOPE) Incentive Program is live as of March 3.

At Highmark Health Options West Virginia, we value the important role providers play in serving our members. That is why we would like to welcome you to the HHOPE Program. This program supports the Highmark Health Options mission to improve the health and wellness of the individuals and the communities we serve by providing access to integrated, superior health care.

Who is eligible for the HHOPE Program?

- Primary Care Providers including:
  - Family practice
  - Internal medicine
  - Pediatrics
- Dentists

Providers must opt-in to the HHOPE Program by contacting their Clinical Transformation Consultant (CTC) or emailing us at **HHOWVPET@highmarkhealth.org**. By opting-in, the provider also acknowledges the intent to participate in the program. Providers will be enrolled based on eligibility criteria outlined in the **HHOPE Provider Guide** and network participation.

Introducing the Highmark Health Options Provider Engagement Team.

The HHO Provider Engagement (PE) team is a dedicated team of CTCs who collaborate with West Virginia providers to achieve quality goals and improve the overall health outcomes of our members. The PE team offers a range of support services, such as providing best practices and performance reviews. These services are designed to improve provider performance and facilitate success within our Program. Your dedicated CTC will serve as your primary point of contact for all quality related inquiries and support. Contact the PE Team at **HHOWVPET@highmarkhealth.org**.

For additional information, please visit the **HHOPE Program page** of our provider website.

Important Reminders About Prior Authorizations

The Highmark Health Options (HHO) **Prior Authorization Code Lookup tool** can help providers determine instantaneously what medical procedures and services require prior authorization.

As a reminder, there are different processes in place for different prior authorization requests, depending on the procedure or service.

GuidingCare Authorization Portal

Any services requiring authorization from the HHO Utilization Management Department must be submitted through GuidingCare, via NaviNet. Please reference the **GuidingCare User Guide** to learn about the portal's authorization request process.

HealthHelp

Prior authorization requests for the following services are managed through HealthHelp:

- Musculoskeletal: spine, knee, hip surgeries
- Interventional Pain Management Services
- Trigger Point Injections
- Outpatient Diagnostic Imaging Services: CT scans, PET scans, MRIs, etc.
- Physical Therapy/Speech Therapy/ Occupational Therapy
- Cardiology
- Sleep Studies (members ages 18 and older)
- Radiation Oncology (members ages 18 and older)

HHO, in collaboration with HealthHelp®, has implemented Single Sign-On (SSO) through NaviNet to help streamline your prior authorization request process.

To submit these requests and check your SSO status, please complete the following steps:

1. Log into NaviNet.
2. Select Highmark Health Options as the Health Plan.
3. Select HealthHelp from Workflows for this Plan.
4. If you're a first time SSO user, you will need to register with an email and password.
5. Click register and you will be immediately connected to HealthHelp to enter your authorization request. Note: If you already have an email on file, you will need to click "Link Account."

A list of procedure codes requiring authorization through HealthHelp can be found on the **HealthHelp landing page**. Additionally, HealthHelp offers **training webinars** for your reference.

For questions or information regarding policy and procedures, contact a Highmark Health Options provider representative at **1-833-957-0020**.

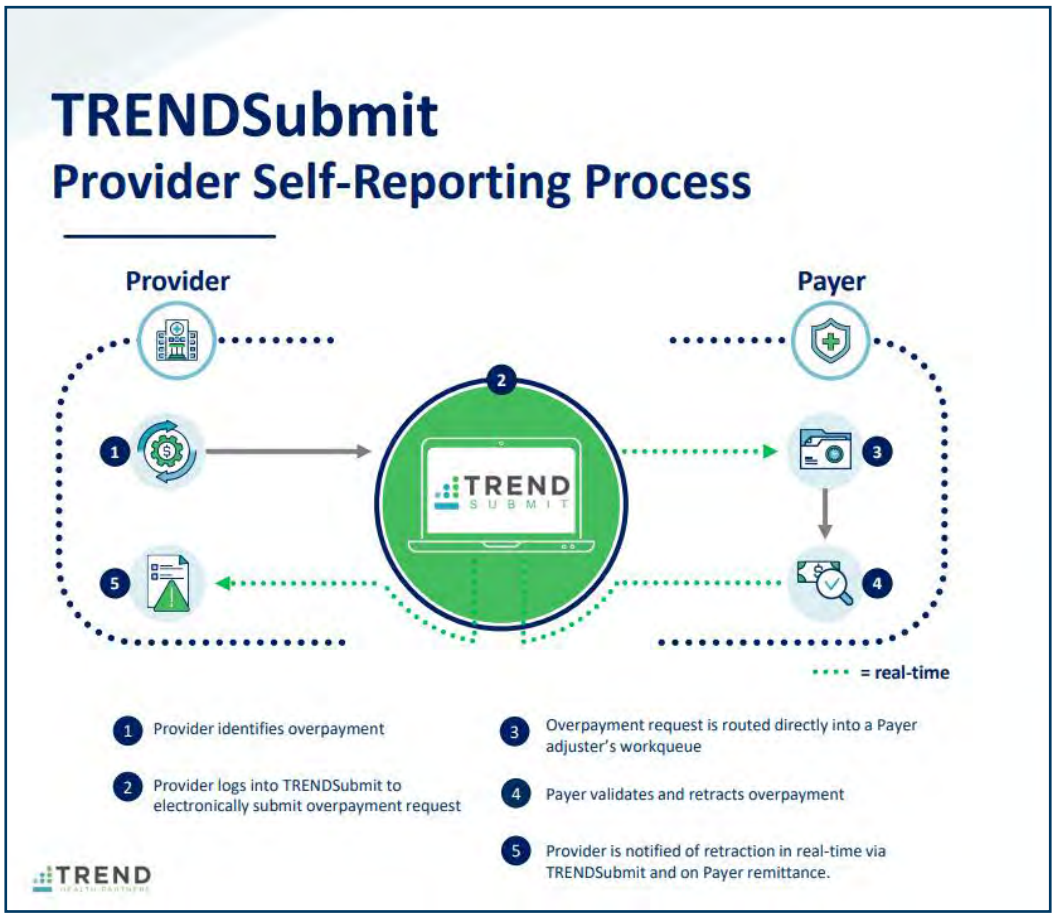
Introducing TRENDSubmit: A New Provider Self-Reporting Process for Overpayments

Federal and state regulations require providers to routinely audit claims for overpayments. To meet this requirement, providers must notify Highmark Health Options in writing of the reason for the overpayment and return the full amount of the overpayment within 60 days of the date they identified the overpayment.

Providers can now electronically submit overpayments via TRENDSubmit.

This secure, online process allows providers to be notified of claim retractions in real-time and eliminates the lengthy manual paper process. Historically, providers have had to complete and submit the **Provider Self-Audit Overpayments Form** that is located on the Highmark Health Options website to complete this process.

Providers can contact Lauren Smith at **lsmith@trendhealthpartners.com** to initiate TRENDSubmit access, receive user training resources, and get ongoing support.



The benefits of TRENDSubmit.

- **Reduction in business office administrative costs** – Eliminates the lengthy and costly manual or paper process.
- **User-friendly, simple approach** – Secure, online process with capability to electronically attach supporting documentation. Additionally, the system offers streamlined point and click navigation with minimal keystrokes.
- **100% accountability** – Direct communication between Payer and Provider and real-time overpayment status updates.
- **Comprehensive reporting** – Access to dashboard reporting around submission status, productivity, and root cause analysis. Additionally, the system shares full visibility and tracking of overpayment from submission to retraction.

If you have any questions regarding Provider Self-Audits, you can contact the Highmark Health Options Special Investigation Unit (SIU) at **ProviderSelfAudits@highmark.com.**

Coverage for Coronary Computed Tomography Angiography (CCTA) and Fractional Flow Reserve CTA (FFRCT)

As an active provider to our Medicaid members, Highmark Health Options West Virginia is notifying you of coverage for Coronary Computed Tomography Angiography (CCTA) and Fractional Flow Reserve CTA (FFRCT). The use of CCTA has been effectively shown to diagnose obstructive coronary artery disease (CAD) and is considered a first line test over non-invasive functional tests such as stress echocardiograms, exercise stress tests, or invasive coronary angiography (ICA).

The use of CCTA as an alternative to non-invasive functional tests substantially reduces the number of unnecessary ICAs, resulting in improved outcomes and decreased costs. Contraindications include prior percutaneous coronary intervention (PCI) or coronary artery bypass graft (CABG), acute coronary syndrome, and complex congenital heart disease.

CCTA Heartflow interpretation can be done through a company called Heartflow. FFRCT sites can be found **here** and are still subject to utilization management guidelines.

For our Medicaid members, please consider the use of CCTA and FFRCT when necessary, as a diagnostic alternative when clinically appropriate and available.

Article by: Dr. Laura Swingle, MD

Provider Directory Information is Verified through the CAQH Directory Management Solution

Highmark Health Options requires all network providers to verify their provider directory information every 90 days. This process allows us to comply with CMS requirements to maintain accurate directories and ensure our members can find in-network care as quickly as possible.

Highmark Health Options utilizes the CAQH Directory Management Solution to manage this provider directory attestation process.* This solution helps simplify the process for providers.

To complete this attestation, providers should perform the following tasks:

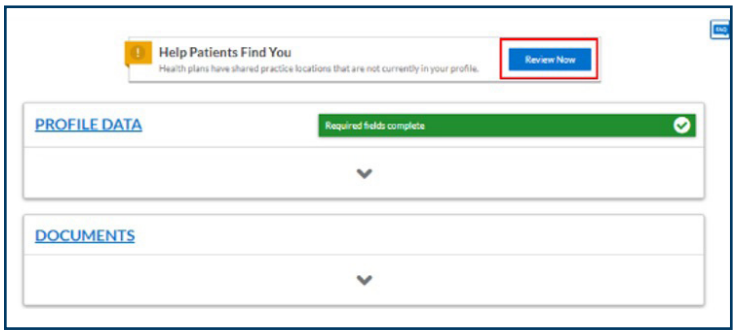
1. If you already are registered with the CAQH Provider Data Portal, **log in here**. Ensure that Highmark Health Options is authorized to receive your information on the Authorize tab, by enabling the "Highmark Government Markets" plan name.

   OR

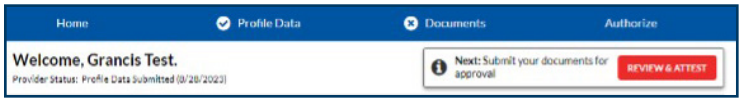
   If you are new to the CAQH Provider Data Portal, **register here**. You will then need to gather credentialing information and **log in** to complete your profile and upload needed documents. Be sure that Highmark Health Options is authorized to access your information on the Authorize tab, by enabling the "Highmark Government Markets" plan name.

   Attestation information, including your current Provider Status, is displayed directly below the top navigation menu for new users. Upon your first login, first complete your Profile Data, then review and attest.

2. 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. These new addresses occur when the provider directory data you have documented in CAQH differs from what Highmark Health Options has on file. Please click the notification to confirm the new address, reject the new address, or add corrections to address, phone number, email address, fax number, and any other directory information.



3. Every 90 days, you will need to re-attest to your provider directory information. The notification directly below the top navigation menu will let you know how many days until your next attestation must be completed. Please promptly review and attest, to ensure we have accurate directory information for you.



If you have any questions, please review the **CAQH Provider Data Portal User Guide** on your login page, visit the **Help page**, or contact CAQH through their live chat or by calling **888-599-1771**, Monday–Friday, 8 a.m.–5 p.m.

Thank you for helping us ensure our members have access to the care they need!

**If you have a delegated credentialing relationship with us, there will be no need to log into CAQH. Please continue with your current roster process.*

Introducing the 2025 Healthy Rewards Program

Help your Highmark Health Options patients improve their health and earn rewards through the 2025 Healthy Rewards Program! By encouraging participation, you can help your patients achieve better health outcomes while benefiting from a supportive program.

Patients earn rewards via a reloadable card for completing various health activities including:

- A1C tests and retinal exams for patients with diabetes (ages 18 and older)
- Prenatal visits, postpartum checkups, well-baby visits, and well-child visits
- Health risk assessments
- HPV vaccinations (ages 9-12)
- Mammograms (women ages 40 and older)
- Flu vaccines (ages 18 and older)

Reward amounts vary, from $10 to $100. Members can even earn a hunting and fishing license digital code for receiving their flu vaccine!

Patients will receive their reward card within eight weeks of completing the activity. They can check their card balance at **mybenefitscenter.com** or by calling **1-888-682-2400**.

A patient can enroll by calling **1-833-957-0027 (TTY: 711)**, Monday–Friday, 7 a.m.–7 p.m. EST. Letting patients know about the program is a simple way to support their well-being and encourage proactive health care.

Chronic Kidney Disease: Medications to Monitor

Many medications can impair kidney function and potentially cause kidney damage. If your patient has chronic kidney disease, you may need to recommend adjusting the dosage of certain medications or switching to alternative medications.

Medicines that may need to be avoided, adjusted, or changed include:

- Pain medicines, including:
  - Nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen and naproxen.
  - Acetaminophen and aspirin may be harmful if overused. They are usually safe in small amounts.
- Herbal supplements, which can contain minerals like potassium that are harmful for people who have kidney disease. Additionally, many herbs can interact with prescription medicines.
- Statin medicines, such as lovastatin and simvastatin.
- Diabetes medicines, including insulin and metformin.
- Heartburn and upset-stomach medicines, such as milk of magnesia and Alka-Seltzer.
- Antimicrobial medicines, including some antibiotics, anti-fungal, and antiviral medicines.

Ensure your patient consults with you or their specialist before starting or stopping any medication.

March is National Kidney Month. Let's raise awareness about kidney health, chronic kidney disease, and potential medication interactions.

Source: Healthwise

Language Data for our Highmark Health Options Medicaid Population

Want to know more about the language profile of your service area? The Highmark Health Options (HHO) Government Quality and Health Equity Department and the Data Analytics team collect and review data from several sources to assist in determining the language characteristics and patterns of our service area and membership to determine the cultural adequacy of services provided.

This information is also used to anticipate and plan for changes in the language services HHO provides to its population. We assess the population's language profile at least annually, using direct reporting from BMS, health risk assessments, and West Virginia state census/community-level data. The language profile of the Highmark Health Options West Virginia service area and membership is very similar when comparing the data on this page.

Language profile of Highmark Health Options West Virginia members as of December 2024.

Enrollment Data

- 99.90% of HHO members report speaking English.
- All other languages were reported as less than 1%.

Language profile for the population of West Virginia.

2023 Census Data – West Virginia

- 96.50% of West Virginia households speak English.
- 1.44% of West Virginia households speak Spanish.
- All other languages reported are below 1% of the service area population.

Heart Failure: Avoiding Medications That Worsen Symptoms

In recognition of American Heart Month this quarter, let's focus on a critical aspect of cardiovascular health: medication interactions.

Certain medications may negatively impact patients with heart failure, potentially worsening their condition or interfering with the effectiveness of prescribed heart failure medications.

Over-the-counter medicines that your patients may need to avoid include:

- Pain relievers called NSAIDs, such as ibuprofen and naproxen.
- Antacids or laxatives that have sodium in them.
- Some cold, cough, flu, or sinus medicines, including medicines that contain aspirin, ibuprofen, pseudoephedrine, ephedrine, phenylephrine, or oxymetazoline.
- Herbal supplements and vitamins, such as black cohosh, St. John's wort, and vitamin E.

Prescription medicines that your patient may need to avoid include:

- Calcium channel blockers
- Heart rhythm drugs that treat a fast or uneven heartbeat
- Prescription NSAID pain relievers
- Certain diabetes medicines

Educating patients about worsening heart failure symptoms (like increased shortness of breath, edema, rapid weight gain, dizziness, or fatigue) and heart attack signs is vital. Empowering them to seek timely care can save lives and improve outcomes. Early intervention is key, and your continued partnership in achieving this is greatly appreciated.

Source: Healthwise

Cotiviti Claims Pattern Review (CPR)

In 2025, Highmark Health Options (HHO) will enhance its existing claim editing program to broaden the overall accuracy, integrity, and timeliness of our claims processing. To make these enhancements, HHO will implement Cotiviti Claims Pattern Review (CPR). CPR will enable efficient Payment Policy Management and review of claims while utilizing real-time analytics, including the ability to pause claims processing to let Cotiviti CPR experts review claims for proper validation prior to payment. As part of this process, registered nurses with coding certifications will review claim data in conjunction with patient claim history to validate appropriate claims processing.

Where to send appeals for Cotiviti Claims Pattern Review.

Providers have the right to submit for review any claim they feel was denied or paid incorrectly. Providers will have three options to send in Cotiviti CPR Appeals:

1. Direct upload to the **Secure Portal**. Click on the "Submit Records" button and enter your password high90CCVC.
2. Secure faxing to **800-409-0499**.
3. Mailing the records directly to Cotiviti. Please mark the envelope "Confidential" and send to:

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

Information regarding Cotiviti CPR will be reflected in the HHO Medicaid Provider Manual in the near future. Please be on the lookout for these updates using the Provider Page on the **HHO website**.

Coding Corner

ICD-10 codes are fundamental in substantiating the medical necessity of a service. Each code corresponds to a specific diagnosis or condition that a health care provider is treating. When submitting claims to insurance companies or Medicare, providers must correctly include these codes to justify the need for certain treatments or procedures.

An authorization is not a guarantee of payment, and providers are required to adhere to the coding and billing reporting guidelines.

Please see example below for a scenario in which ICD-10 codes are reported as the ONLY diagnosis on a claim (the primary diagnosis on a professional claim or principal diagnosis on a facility claim).

- **Example:** First code the underlying disease, such as, Pachydermoperiostosis (M89.4). L62 (this ICD-10 code describes Nail disorders in diseases classified elsewhere) is not accepted as a primary diagnosis because instructions require the underlying condition to be coded first.

The residual or late effect of an injury generally requires two codes. The primary diagnosis must describe the nature of the sequela. The secondary diagnosis describes the original injury and usually has an "S" in the 7th position to indicate sequela. (Sequela of cerebrovascular disease is an exception.)

See the example below:

- **Primary Diagnosis:** Treatment of ankle instability following a sprain: M24.271 (this is the ICD-10 code for Disorder of ligament, right ankle).
- **Secondary Diagnosis:** S93.411S - Sprain of calcaneofibular ligament, right ankle, sequela S93.411S is not accepted as a primary diagnosis because instructions require the residual condition be coded first.

Below are some additional diagnoses and their definitions:

- **External Causes Diagnosis:** These codes are supplements to the principal or primary diagnosis code indicating the nature of the condition.
- **Manifestation Diagnosis:** ICD-10-CM convention requires the underlying condition sequenced first followed by the manifestation.
- **Secondary Diagnosis:** A "secondary only" ICD-10-CM code refers to a diagnostic code that can only be used as a secondary diagnosis and cannot be listed as the primary diagnosis on a claim; meaning it should always be accompanied by another primary diagnosis code when billing medical services.
- **Sequela Diagnosis**: According to the ICD-10-CM Manual guidelines, a sequela (seventh character "S") code is not appropriate as a primary, first listed, or principal diagnosis on a claim.
- **Laterality Policy**: Laterality is a unique attribute to the ICD-10-CM code set built into certain ICD-10-CM code descriptions.

Sources:

1. **West Virginia Bureau for Medical Services. (2016, November 1). Chapter 200 Definitions and Acronyms. Retrieved from DHHR.wv.gov**
2. **Centers for Medicare and Medicaid Services. (2024, October 1). ICD-10-CM Guidelines FY25. Retrieved from CMS.gov**
3. **Novitas. (2021, December 10). Medically Necessary Services and Prior Authorization. Retrieved from Novitas Solutions**

Pregnancy and Dilated Cardiomyopathy

If your patient is pregnant and presents with dilated cardiomyopathy, this serious condition requires close monitoring and management given the pregnancy.

Symptoms may range from subtle fatigue to overt heart failure (shortness of breath, edema, etc.). The diagnosis should be confirmed with an electrocardiogram (ECG), and other appropriate testing as clinically indicated and medically necessary. Treatment is essential and focuses on optimizing cardiac function and managing symptoms to ensure both maternal and fetal well-being.

Close collaboration with a maternal-fetal medicine specialist is essential. Medications for pregnant patients with dilated cardiomyopathy may include:

- Angiotensin-converting enzyme (ACE) inhibitors (if tolerated in pregnancy - careful consideration required).
- Diuretics with careful monitoring for electrolyte imbalances.
- Potentially other agents deemed appropriate by a cardiologist experienced in managing pregnancy-related cardiomyopathy.

Monitoring for worsening heart failure, arrhythmias, and other complications is crucial during this time. Delivery management with input from both cardiology and obstetrics is also important to ensure a healthy delivery.

Postpartum management is also necessary, as the condition may improve, persist, or even worsen. Prognosis is highly variable and depends on the severity of the cardiomyopathy and how well it responds to treatment. Additionally, the risk of future pregnancies should be carefully discussed with the patient after delivery.

Source: Healthwise

Member Rights and Responsibilities

Highmark Health Options West Virginia Medicaid members have certain rights and responsibilities as members of our plan. To detail those rights and responsibilities in full, Highmark Health Options (HHO) maintains a Members' Rights and Responsibilities statement, which is reviewed and revised annually.

HHO and its provider network do not and are prohibited from excluding or denying benefits to, or otherwise discriminating against, any eligible and qualified individual regardless of race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age. Some additional rights and responsibilities include:

Members have the right to:

- Receive information from HHO in a way that works for them (in languages other than English, in Braille, in large print, or other alternate formats, etc.).
- Be treated with fairness and respect at all times.
- Receive timely access to covered services and drugs.
- Have personal health information kept private and confidential.
- Receive information from HHO about the plan, its network of providers, covered services, and rights.
- Have HHO support their right to make decisions about their care.
- Issue a complaint and to ask HHO to reconsider decisions made by filing an appeal.
- Know their treatment options and risks in a way they can understand.
- Participate in decisions about their health care, including the right to refuse any recommended treatment.
- Be given instructions about what is to be done if they are not able to make decisions for themselves. This includes maintaining an advance directive, such as a living will or a power of attorney for health care.
- Contact the Bureau for Medical Services if they believe their rights have not been respected due to their race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age.

Members are responsible for:

- Getting familiar with their covered services and the rules they must follow to get these covered services.
- Informing HHO if they have any other health insurance coverage or prescription drug coverage in addition to our plan.
- Telling their doctor and other health care providers that they are enrolled in our plan.
- Helping their doctors and other providers care for them by providing needed information, asking questions, and following through on their care.
- Respecting 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.
- Notifying HHO if they move, regardless of whether it is outside or inside of the service area.

The Member Rights and Responsibilities Statement can be found in the Medicaid Member Handbook or on our website under **Members Rights and Responsibilities**. For more information, please call Provider Services at **1-833-957-0020**.

Accessibility Standards

Highmark Health Options (HHO) West Virginia maintains standards and processes for ongoing monitoring of access to health care.

To help ensure our members receive services in a timely manner, practice sites are contractually required to follow these standards. Please take a few minutes to review the accessibility standards and share with your office staff that schedule member appointments, including off-site central scheduling and call center staff.

These standards and additional resource information related to accessibility are available on our HHO provider website. You can access the standards **here**.

Cultural Competency Data Form

Please help us improve the Highmark Health Options member experience by completing the Cultural Competency Data Form.

By providing your race, ethnicity, language, and cultural competency training data, you allow Highmark Health Options to better connect members to the appropriate providers, deliver more effective provider-patient communication, and improve patient health, wellness, and safety. The information requested is strictly voluntary, and the information you provide will not be used for any adverse contracting, credentialing actions, or discriminatory purposes.

The Cultural Competency Data Form is located on the **Highmark Health Options website**.

You can also download a copy of the **Cultural Competency Data Form here**.

Plan Contact Information

For questions related to contracting, connect with Provider Contracting at **304-424-0365** or **HHOWVContracting@highmark.com**.

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

As a reminder, our **Prior Authorization Code Lookup Tool** can help you identity if prior authorization from HHO is required for medical procedures and services.

Call Provider Services with administrative questions at **1-833-957-0020**, Monday–Friday, 8 a.m.–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, radiation oncology, physical medicine, diagnostic imaging, and musculoskeletal and interventional pain management for Highmark Health Options.

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

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