Q2 2025

Provider Newsletter

for Highmark Health Options | WEST VIRGINIA

HIGHMARK HEALTH OPTIONS

FEATURED ARTICLES:

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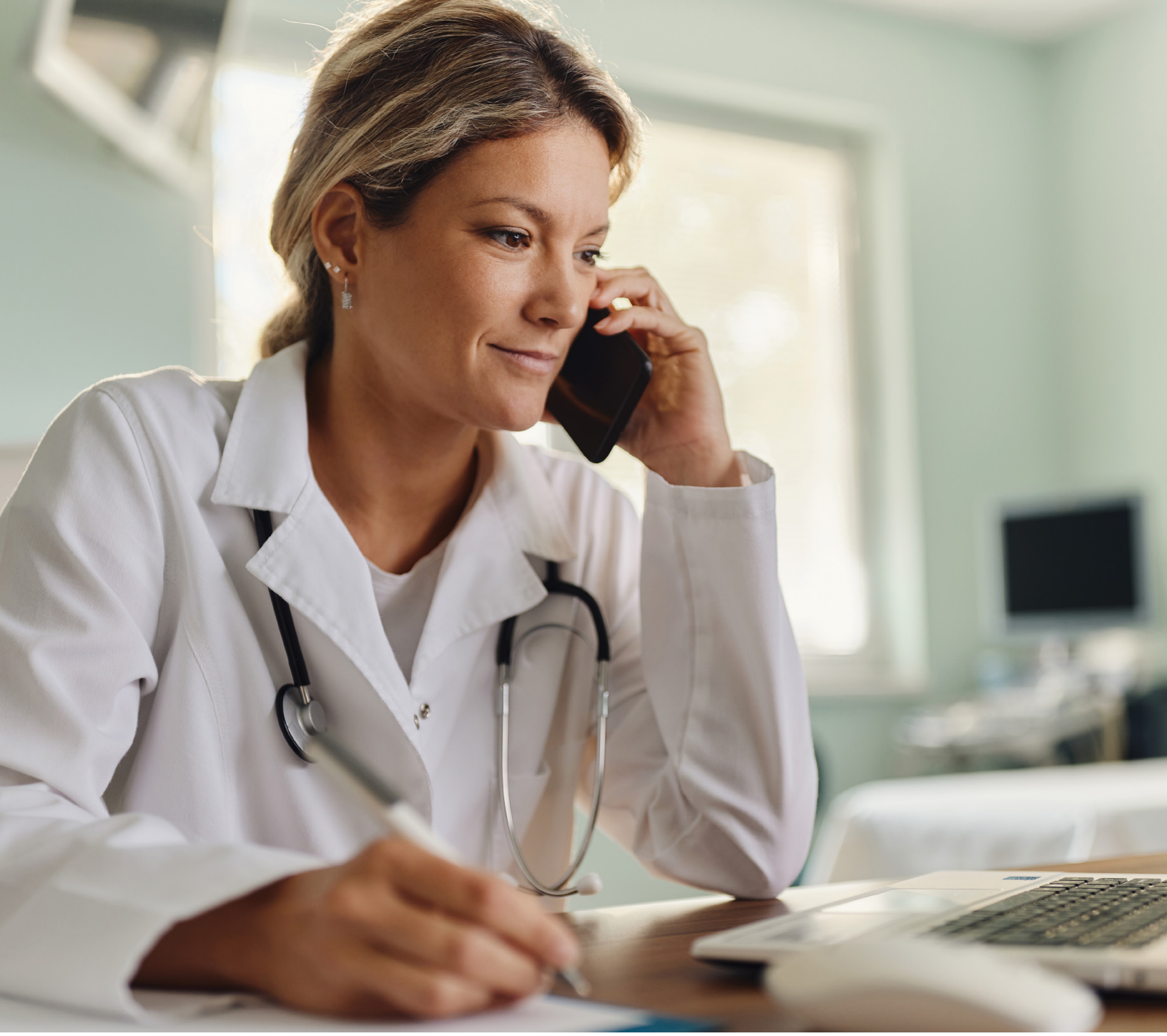

Contact Us

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.

Highmark Health Options Member Outreach Navigators Empower Patients and Providers

Highmark Health Options offers our members access to our Care Coordination staff that can help them better understand their health care benefits and appropriately access services within a managed health care plan.

Highmark Health Options providers can request support from a Care Coordination team member to help educate members who need more information about their care. This includes topics like appropriate emergency room usage.

Providers are invited to refer Highmark Health Options members for additional guidance adhering to their treatment plan, assistance with keeping scheduled appointments, understanding their benefits, and resources available by completing the appropriate Member Outreach Form:

- For members age 20 and younger: **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Member Outreach Form**
- For members age 21 and older: **Member Outreach Form**

A Highmark Health Options representative will contact the member and follow up with the provider at the provider's request.

Providers must complete their missed appointment outreach prior to sending in the Member Outreach Form for a missed appointment. Missed Appointment Outreach includes three attempts with at least one telephone call per missed appointment.

For more information or to request member outreach, please call Highmark Health Options at **1-833-957-0020**. You can also fax the Member Outreach Form to Care Coordination at **1-833-559-2849**.

Vaccine Reminder: Disease Prevention with Childhood and Adolescent Immunizations

Recent outbreaks of measles, pertussis (whooping cough), and other vaccine-preventable diseases presents an opportunity to remind your Highmark Health Options patients about the importance of childhood and adolescent immunizations.

According to data from the **Centers for Disease Control and Prevention (CDC)**, 95% of measles cases are in individuals with an "unvaccinated or unknown" vaccine status with many of these cases clustered in areas with low vaccination rates.

The **CDC** and the **American Academy of Pediatrics (AAP)** recommend that children stay on track with their well-child appointments and routine vaccinations. On-time vaccination is critical for providing protection against potentially life-threatening disease. The CDC's Immunization Schedules for **birth through age 6** and **children ages 7–18** can assist you and your patients with creating a vaccination plan.

Best Practices

To help your Highmark Health Options patients stay on track with childhood and adolescent vaccines, consider the following:

- Create standing vaccine orders within the Well-Child Visit templates.
- Create Electronic Medical Record (EMR) alerts when members are due for immunizations.
- Incorporating an "immunization catch-up day" into your office workflow to allow patients to get vaccinated and close gaps in immunization records.

Additionally, Highmark Health Option's Care Coordination team will outreach to your office and offer assistance for members who may have immunization care gaps.

Thank you for your dedication to keeping our members and communities healthy by prioritizing childhood and adolescent immunizations.

Coding Corner: Coding for Assisted Living Facilities

On January 1, 2023, CPT codes 99324-99343 for domiciliary, rest home, or custodial care services were eliminated. This change impacts how we bill for Evaluation and Management (E/M) services provided in assisted living facilities.

Clarifying "Home"

To bill for "home visit codes" effectively, the provider must document that the patient was seen in the home (in a private residence) and not in the office. The CPT definition of "home" includes a wide range of locations. The official coding definition of the Home and Residence services states: "Home may be defined as a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship)."

What Codes to Use Now

To accurately bill for E/M services performed in assisted living facilities, you must use the appropriate E/M codes:

- **99341-99345** for new patients
- **99347-99349** for established patients

Select the level based on the complexity of your service and documentation. These codes should always be matched with the appropriate place of service (POS) code.

The appropriate codes to bill for evaluation and management of a member in the assisted living facility are:

- **99341:** Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- **99342:** Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- **99344:** Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

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- **99345:** Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
- **99347:** Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- **99348:** Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- **99349:** Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

Understanding Place of Service (POS) Codes

Correctly identifying the POS code is critical, and the key is specifying that the service occurred in an assisted living setting, not in a home or another health care facility.

These POS codes all apply to the 9341-99349 code sets:

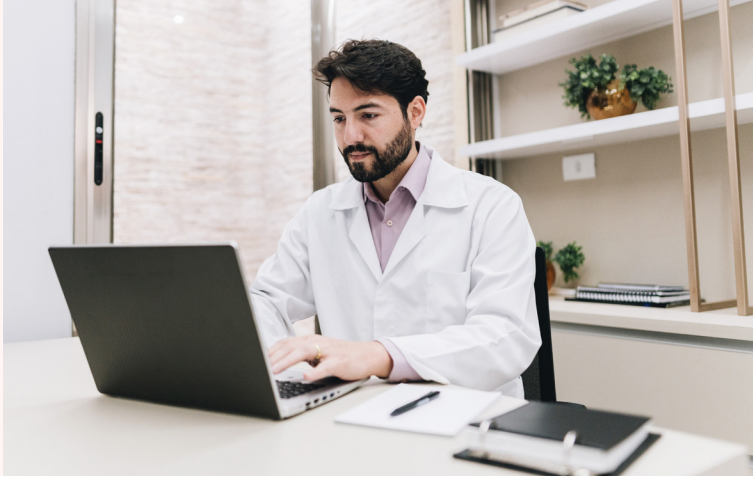
- 12 Home
- 13 Assisted living facility
- 14 Group home
- 16 Temporary lodging
- 33 Custodial care facility
- 55 Residential substance abuse treatment facility

Accurate coding helps ensure your claims are processed timely and successfully.

Source:

The CPT® 2023 Professional Edition codebook. Evaluation and Management (E/M) Services. Home and Residence services.

Mark Your Calendar for the 2025 Provider Fraud, Waste, and Abuse (FWA) Training



When

July 9, 2025 from 12:00 p.m. to 1:00 p.m.

Speakers

Mara Elliot, RHIA Special Investigations Unit Lead Investigator, Highmark Health Options

Kylie Wilson, MS Fraud, Waste, and Abuse Compliance Consultant, Highmark Health Options

Meeting Information

The Highmark Health Options (HHO) Financial Investigations and Provider Review (FIPR) Division will be hosting a live provider FWA training webinar on Wednesday, July 9, 2025. Providers or provider representatives are strongly encouraged to take advantage of this live opportunity. Please use the registration link below to reserve your spot today!

Objectives Include

1. Provide an overview of FWA.
2. Review FWA laws and regulations.
3. Identify provider responsibilities as they relate to FWA.
4. Discuss provider documentation requirements.
5. Identify the various types of FWA Investigations.
6. Discuss outcomes for non-compliance with state, federal, and contractual obligations.

Registration Link

Click **here** to register. After registering, you will receive a confirmation email containing information about joining the webinar. If you have questions, please contact your designated Provider Account Liaison.

To help increase accessibility to training, HHO has placed previous FWA trainings on our website **here**. As a reminder, all providers must have a representative review the Provider FWA Training upon contracting with HHO and annually each year after. The provider representative will be responsible for communicating the information obtained from the Provider FWA Training to the entire staff of the provider. Providers must either attend the annual Provider FWA Training or independently review the required materials and may need to submit proof of training completion when requested by HHO.

HHOPE Incentive Program: New Webinar Date Added and CGMA Launch

As we shared in the **Quarter 1 Newsletter**, the **2025 Highmark Health Options Practitioner Excellence (HHOPE) Incentive Program** launched March 3.

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, comprehensive health care.

Providers must acknowledge that they are opting-in to the HHOPE Program by Sept. 30, 2025.

2025 HHOPE Overview Webinar Series

The HHO Provider Engagement Team is offering the final 30-minute webinar on Sept. 18 at 1 p.m. to provide an overview of the 2025 HHOPE Program.

You can register today by following the steps below:

1. **Use this link** and click "Register."
2. On the registration form, enter your information and then click "Register." Once the host approves your request, you will receive a confirmation email message with instructions on how to join the event.

Highmark Health Options 2025 CGMA Launch

We are pleased to announce the Highmark Health Options 2025 Care Gap Management Application (CGMA) launched on April 1. The CGMA has been designed to help you by simplifying the flow of important care gap information between you and us.

With this powerful, yet easy-to-use web application, you will be able to:

- View member care gaps and your progress towards closing member care gaps.
- Submit evidence for care gap closure.
- View your Highmark Health Options member roster.
- View your HHOPE Program reporting to identify progress and opportunities.

Please contact your Clinical Transformation Consultant (CTC) or email us at **HHOWVPET@highmarkhealth.org** with questions, to request a demo, or to set up a new user.

Thank you for your partnership and participation in the HHOPE Program.

Federal Reporting Requirements

Highmark Health Options West Virginia must comply with the following federal reporting and compliance requirements and must submit applicable reports to the Bureau for Medical Services (BMS) for the services listed below:

1. Abortions must comply with the requirements of 42 CFR §441. Subpart E – Abortions. This includes completion of the information form—Certification Regarding Abortion.
2. Hysterectomies and sterilizations must comply with 42 CFR §441. Subpart F – Sterilizations. This includes completion of the consent form.
3. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and reporting must comply with 42 CFR §441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

Additional information regarding the state requirements and procedures for these services can be found in the **Medicaid Physician Provider Manual**.

Required Reportable Diseases

As health care providers, you play a vital role in protecting the health of our community. Accurate and timely reporting of communicable disease allows for critical disease surveillance, investigation, and public health follow-up.

Disease reporting assists with:

- **Disease Surveillance:** Tracking disease trends to identify outbreaks and potential public health threats.
- **Case Investigation:** Understanding the source and spread of infections to prevent further transmission.
- **Public Health Follow-up:** Providing education, treatment, and preventive measures to individuals and their contacts.

West Virginia law requires the reporting of three primary categories of diseases. The managed care organization (MCO) may be responsible for further screening, diagnosis, and treatment of identified cases enrolled in the MCO, or the screening, diagnosis, and treatment of case contacts enrolled in the MCO, as necessary to protect the public's health.

Categories include:

- **Sexually Transmitted Diseases (STDs):** Division of Surveillance and Disease Control has an established program for notifying partners, including follow-up of contacts to individuals with HIV and AIDS. MCOs may be contacted to provide appropriate screening and treatment for contacts who are enrollees.
- **Tuberculosis (TB):** Report individuals with diseases caused by M. tuberculosis to the West Virginia Office of Prevention and Epidemiology Services (OEPS), TB Program.
- **Communicable Diseases:** Division of Surveillance and Disease Control, Communicable Disease Program.

Disease surveillance allows appropriate public health action to be taken–patient education and instruction to prevent further spread, contact identification and treatment, environmental investigation, outbreak identification and investigation, etc.

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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. Detailed infectious disease reporting requirements can be obtained from the **Bureau for Public Health**. Please familiarize yourself with these requirements to ensure compliance.

Adhering to these reporting requirements is essential for maintaining public health and ensuring the well-being of our community. Your cooperation in reporting these diseases promptly and accurately is greatly appreciated.

For further information, please contact Provider Services at **1-833-957-0020 (TTY 711)**.

Upcoming Medical Record Review

As part of our contract with the West Virginia Bureau for Medical Services (BMS) to provide coverage for the Medical Assistance population, we are required to perform medical record audits. These reviews are conducted on a periodic basis to ensure that our providers are keeping accurate and sufficient record documentation on our members.

This review assesses compliance with multiple standards and critical elements developed and approved by the Highmark Health Options Quality Improvement & Utilization Management Committee to meet state, federal, and regulatory requirements. Some examples of these standards include documentation of continuity and coordination of care, execution of an advanced directive, legibility of written documentation, follow-up visits, and signing and dating of notes.

If your practice is selected for this review, you will be contacted by the Quality Improvement Team for support and guidance. We kindly ask for your assistance with providing copies of the supporting documentation relating to the medical record review standards. For your reference, the Medical Record Review Standards are available upon request, or can be found in our **Provider Manual**.

Our intention is to provide feedback and work collaboratively to address areas needing improvement. Our goal is to ensure that our members' medical records meet the required regulatory standards as outlined by contractual agreement with BMS.

Thank you for your time and cooperation.

Interactive Care Management Enhancements

As we discussed **last quarter**, Highmark Health Options West Virginia provides comprehensive Interactive Care Management to support the health and well-being of your patients.

We are excited to announce that we have recently implemented Prediabetes, Hypertension, and Hyperlipidemia care as a part of our Interactive Care Management. Starting April 25, 2025, members diagnosed with these three chronic conditions can receive personalized support and care coordination through our Disease Management programs.

In addition to these newly added conditions, our programs also feature the following services tailored to meet diverse patient needs:

- **Maternity:** For pregnant women.
- **Complex Case Management:** For individuals with multifaceted comprehensive physical and/or behavioral health needs.
- **Disease Management:** For patients with:
  - Chronic Kidney Disease (CKD)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Congestive Heart Failure (CHF)
  - Diabetes
  - Inflammatory Bowel Disease (IBD)
  - Prediabetes
  - Hyperlipidemia
  - Hypertension

All patients with these diagnoses or conditions qualify for personalized support. Each program offers evidence-based health education, self-management tools, and ongoing care coordination to improve 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 offered at no cost, with flexible opt-in and opt-out participation.

To refer eligible patients, call
1-833-957-0020 (TTY 711)
Monday–Friday, 8:30 a.m.–4:30 p.m.

Clinical Practice and Preventive Health Guidelines

Highmark Health Options believes in providing the best possible health care to our members. To help promote excellent care, we follow clinical practice and preventive health guidelines. These guidelines are developed using the latest evidence-based clinical practice guidelines from professionally and industry-recognized sources or through the experience of board-certified providers from appropriate specialties when guidelines are not available. They help guide our providers in administering consistent, high-quality health care for specific conditions relevant to our members. Providers are encouraged to review these applicable guidelines. They are not meant to replace the clinical judgement of our providers, but instead to support you in making informed decisions about the best care for our members.

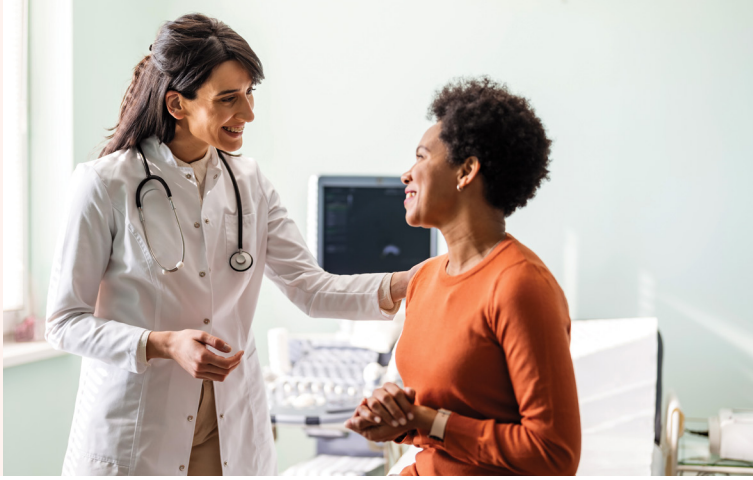
Before we put these guidelines into practice, they are reviewed and approved by the Highmark Health Options Quality Improvement and Utilization Management Committee.

Examples of some of the guidelines include:

- Pediatric Preventive/EPSDT/Lead Screening (birth to age 21)
- Adult Preventive Care
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar
- Cardiac Medical Management
- COPD
- Cystic Fibrosis
- Depression
- Diabetes
- HIV
- Hypertension
- Major Depression in Adults in Primary Care
- Opioid Prescribing for Chronic Pain
- Healthy Weight Management
- Healthy Weight Management in Children and Adolescents
- Palliative Care
- Routine and High-Risk Prenatal Care
- Preventive Dental Care
- Schizophrenia
- Sickle Cell Disease
- Substance Use Disorder

A complete listing of the guidelines are available on our **provider website**. To obtain a paper copy, call Provider Services at **1-833-957-0020**, Monday–Friday, 8 a.m.–5 p.m.

Ensuring Quality Care and Service through our QI/UM Program



The Highmark Health Options Quality Improvement/Utilization Management (QI/UM) Program strives to ensure our members receive excellent health care and services.

To help achieve this, Highmark Health Options continuously monitors how well we're helping our members:

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

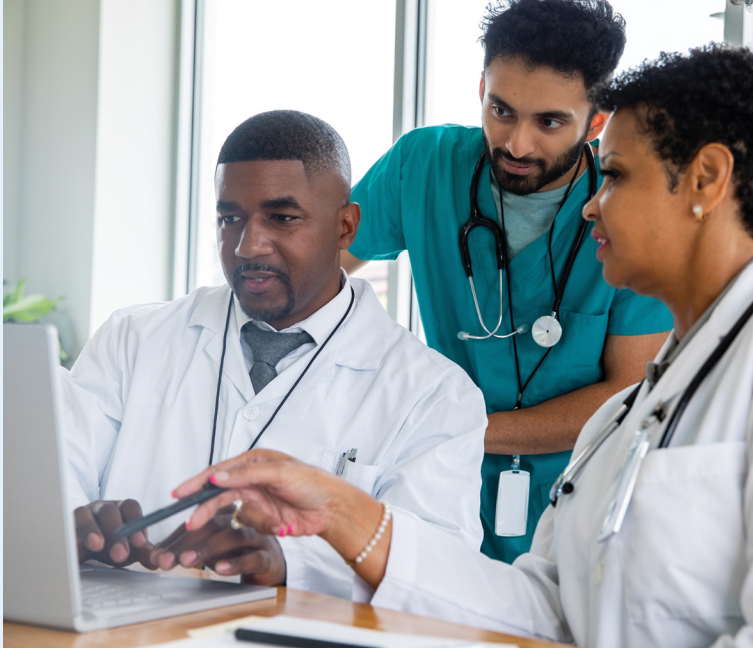
The Program uses results from member surveys, medical record reviews, the Healthcare Effectiveness Data Information Set (HEDIS®), and other tools to measure how we are doing and to help set goals for future quality activities. We also work closely with you, our network providers, to monitor the care and services our members receive and determine what we can do to better serve them.

Highmark Health Options maintains a QI/UM Work Plan to analyze activities conducted as part of its QI/UM Program. This Work Plan is evaluated every three months to identify issues and ensure that actions have been taken to address them.

We also conduct an annual review of our QI/UM Program to see how well we've met the health care and service needs of our members. The annual evaluation of the 2024 QI/UM Program is complete, and we accomplished the majority of the Program goals, implemented new and innovative programs, identified areas for improvement, and are developing plans to address improvement opportunities in 2025.

Please call Provider Services at **1-833-957-0020 (TTY 711)** if you would like to request more information about our 2025 Quality Program, QI Work Plan, or summary evaluation of the 2024 QI/UM Program.

Policy Updates



Highmark Health Options regularly reviews and updates our policies and procedures. To help you know what policies have been amended, we have included an overview of upcoming reviews and updates.

The policy updates listed below will go into effect at the end of July 2025.

Medicaid Policies

Effective Date: July 26, 2025

Annual Review:

1. **HHO-WV-RP-2122-001-Ambulatory Surgical Center:** Changes include adding additional eligible modifiers.
2. **HHO-WV-RP-2128 Multiple Imaging Reduction:** No changes.
3. **HHO-WV-RP-2200 Provider Preventable Conditions, Hospital Acquired Conditions, or Other Preventable/Adverse Events:** No changes.
4. **HHO-WV-RP-2205 Claims Reprocessing after Rate Changes:** No changes.
5. **HHO-WV-RP-2236-001-Prior Authorization:** No changes.
6. **HHO-WV-RP-2203-001-Noncovered or Non-Reimbursable Services:** Changes include adding additional non-covered services.
7. **HHO-WV-MP-2003-001-Abdominoplasty & Panniculectomy:** Changes include adding additional covered procedure and diagnosis codes and updating section "Panniculectomy is not covered when performed in conjunction with:".
8. **HHO-WV-MP-2228-001-Vision Therapy:** Changes include adding and deleting covered diagnosis codes.

Archive:

1. **HHO-WV-MP-2009-001-Deep Brain Stimulation:** Policy archived 05/15/2025.
2. **HHO-WV-MP-2221 Corneal Transplantation:** Policy archived 05/15/2025.

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**.

Culturally Competent Care

Culturally competent care is a life-long learning journey, that includes skills, values, and principles that acknowledge, respect, and contribute to effective interactions between providers and the cultural groups you encounter. Culture is the customary beliefs, social forms, and material traits of a racial, religious, or social group, and it influences a person's decision-making and behavior. Providing care without considering a person's cultural background can negatively impact health outcomes.

There are four attributes that assist in developing culturally competent care:

- **Awareness** of your own view of the cultural world.
- **Attitude** toward differences between cultures.
- **Knowledge** of diverse cultural beliefs, views, and practices.
- **Skills** to navigate the differences between cultures.

By considering an individual's background and integrating cultural knowledge into care plans, you can provide effective, respectful care for patients. Additionally, culturally competent care helps improve patient education, reduces racial health disparities, and promotes better health outcomes.

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.

Implicit bias refers to unconscious attitudes and stereotypes people may have about certain groups of people that can affect judgements and decisions.

A few important skills that can help improve patient interactions include:

- **Listen actively:** Avoid mental distractions, learn about a person's culture and experiences, and ask questions.
- **Demonstrate empathy:** Seeing and feeling the situation of another; engaging through inquiry and dialogue.
- **Engage effectively:** Have a mutually beneficial and reciprocal learning experience in which individuals learn from one another. Keep an open-minded approach for respect of new ideas from different perspectives and acceptance of other views, even when you may not agree with them.

Notice of Practice/ Practitioner Changes

Medicaid

One of the many benefits available to Highmark Health Options members is improved access to medical care through the Highmark Health Options contracted provider network. We strive to provide the most accurate and up-to-date information in our provider directory to allow our members unhindered access to network providers.

To ensure our members have correct information about our network providers, it is imperative that providers notify Highmark Health Options of any of the following:

- Address changes
- Phone and fax number changes
- Changes in hours of operation
- Primary Care Practice (PCP) panel status changes (Open, Closed, and Existing Only)
- Practitioner participation status (additions and terminations)
- Mergers and acquisitions

Providers who experience such changes must provide Highmark Health Options a written notice at least 60 days in advance of the change by completing the **Highmark Health Options Practice/ Provider Change Request Form**, or providers may submit notice on your practice letterhead.

Please submit change requests via fax or mail.

Fax: 1-855-451-6680

Note: FQHC/RHC providers should submit their changes to **FQHC_RHC_RosterUpdates@highmark.com**.

Mail:
Attention: Credentialing Department
Highmark Health Options WV
PO Box 2500
Parkersburg, WV 26102

PCPs and specialty care providers must submit claims under the individual national provider identification number (NPI) and tax identification number (TIN) to comply with encounter data reporting. Claims will be rejected up front if the individual provider number is not included. The only exception to this requirement applies to UB-04 charges for providers services when a remittance advice is issued to a hospital facility.

BMS billing guidelines state all providers must submit a taxonomy code on every claim. The submitted taxonomy must be associated with the specialty with which the provider has been credentialed. In instances where the provider's NPI is associated with more than one Highmark contracted specialty, the provider taxonomy code correlating to the services rendered should be submitted on the claim.

Encounters Submissions

In order to effectively and efficiently manage a member's health care services, encounter submissions must be comprehensive and accurately coded.

As a reminder, all Highmark Health Options providers are contractually required to submit encounters for all member visits regardless of expected payment.

Additional 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 is required for medical procedures and services.

Gold Card Program

Keep an eye out for an overview of our Gold Card Program in the next Provider Newsletter. The Gold Card Program exempts selected providers from some prior authorization requirements, allowing increased self-management.

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

MXCRM-0304-0425 (06/24/2025)