Q4 2025

Provider Newsletter

for Highmark Health Options | Highmark Health Options Duals (HMO SNP) | WEST VIRGINIA

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 Duals (HMO SNP) Begins January 1, 2026

Highmark Health Options will be offering a Dual Eligible Special Needs Plan (D-SNP) for your patients in select West Virginia counties in 2026. This Plan serves those with Medicare Parts A and B, and who qualify for full Medical Assistance.

Highmark Health Options Duals will cover all Medicare-approved services in addition to extra benefits not traditionally covered by Medicare, such as:

- Comprehensive and preventive dental coverage.
- Free hearing exams and hearing aids.
- Additional money to spend on everyday essentials.

For further information on benefits and programs, visit the **West Virginia Medicare D-SNP member site**.

CMS is taking important steps to address Social Determinants of Health (SDoH) through Special Supplemental Benefits for Chronically Ill (SSBCI). SSBCI benefits can include flex card values, dental services, home-based palliative care, pest control, and home-delivered meals.

To ensure D-SNP patients receive SSBCI benefits, providers must attest to the patient's eligibility. This can be done by submitting an attestation form for new Highmark D-SNP patients, OR, for existing D-SNP patients, by documenting proper diagnosis codes in the patient's chart for qualifying conditions. **Click here to access the SSBCI Attestation Form**.

The Highmark Health Options Duals Plan will be available in the 18 counties highlighted on the map in blue.

We look forward to working with you to serve West Virginia D-SNP patients.

Reminder: New SSBCI Qualification Requirement for Highmark D-SNP Members in 2026

Highmark Health Options Duals (HMO SNP) offers additional benefits to SSBCI-eligible members. We are working to qualify our Dual Eligible members via claims history and risk analysis. Many are already qualified. As a Highmark member provider, you can help those who aren't yet qualified get these benefits faster by completing a SSBCI Provider Attestation Form when your patient requests, and submitting it back to us.

CMS requires that a member's chronic condition and risk of adverse health outcomes be documented in order for members to receive this type of benefit. This form confirms their health needs and medical condition(s) and helps Highmark quickly activate their extra benefits.

SSBCI Benefit Provider Attestation Form and Instructions:

1. **Click here to download the SSBCI Provider Attestation Form.**
2. **Submit the completed form back to us via fax at 844-246-1353.** Your patient will receive a qualified/non-qualified communication once Highmark completes the processing of the completed SSBCI Provider Attestation Form. There is no further action needed by you after the form is submitted.

You can help Highmark qualify our Dual Eligible members for these benefits by documenting proper diagnosis codes in the patient's chart for qualifying conditions and ensuring medical claims contain all applicable diagnoses coded to the highest level of specificity.

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How You Can Support Your Patients

- Remind patients to watch for their qualified or non-qualified notice from Highmark.
- **Discuss Implications:** Encourage patients to consider how these changes impact their care and benefits. Highmark's qualifying conditions are broad and it's likely they will be eligible to receive SSBCI food/utility benefits once you submit their Attestation.
  - **Patient Impact:** To ensure continuity of valuable supplemental benefits, patients are encouraged to stay with their current plan or understand the impact of switching. Switching plans may delay access to these extra benefits due to going through the qualification process again, while staying in the same plan could allow quick qualification for SSBCI food/utility benefits.
- **Highmark Resources:** Direct patients to Highmark Member Services by calling the number on the back of their ID card for more information and support on their qualification status.
- **Patient Attestation Requests:** Please complete an office visit and the Provider Attestation form (available on the **Provider Resource Center Forms** page under SSBCI Attestation Form) and fax them back to Highmark so your patient's qualification determination for these valuable benefits is completed as quickly as possible.

Medicare Parts A and B Cost-Sharing

All members enrolled in Highmark Health Options Duals also have Medicaid (Medical Assistance) or receive some assistance from the State.

Some members will be eligible for Medicaid coverage to pay for cost-sharing deductibles, copayments, and coinsurance. They may also have coverage for Medicaid covered services, depending on their level of Medicaid eligibility.

As a reminder, our dually eligible Medicare Assured members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for the cost-sharing.

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

Our organization and provider network are also 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.

Highmark Health Options Duals plan members have certain rights and responsibilities as members of our plans. To detail those rights and responsibilities in full, we maintain a Member Rights and Responsibilities statement which is reviewed and revised annually.

The Member Rights and Responsibilities statement can be located in either the Member Handbook for Medicaid members or the Evidence of Coverage for Medicare Assured members. The Member Rights and Responsibilities Statement is also available for review online at **highmark.com/health-options-wv**.

Providers are encouraged to contact us if you have questions about this update or need additional member-specific information.

Call Provider Services with administrative questions Monday–Friday, 8 a.m.–5 pm.:

Medicare Assured
1-833-957-0025

Medicaid
1-833-957-0020

Interactive Care Management for Highmark Health Options and Highmark Health Options Duals (HMO SNP) Patients

Highmark Health Options provides comprehensive Interactive Care Management to support the health and well-being of your Highmark Health Options and Highmark Health Options Duals (HMO SNP) patients.

Our Care Management Programs feature three distinct services tailored to meet diverse patient needs:

- **Maternity**
- **Complex Case Management:** For patients with multifaceted comprehensive physical and behavioral health needs.
- **Disease Management:** For patients with, or at risk for:
  - Cardiovascular Disease and/or Conditions (angina, arrhythmias, cardiomyopathy, congestive heart failure, coronary artery disease, hyperlipidemia, hypertension, heart valve disease, myocardial infarction, and stroke)
  - Chronic Kidney Disease (CKD)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Diabetes (and prediabetes)
  - Inflammatory Bowel Disease (IBD)

All patients with these diagnoses, or at risk for these 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.

Refer eligible patients today by calling Highmark Health Options Provider Services at **1-833-957-0020** or Highmark Health Options Duals Provider Services at **1-833-957-0025 (TTY: 711)**, Monday–Friday, 8 a.m.–5 p.m.

Highmark Health Options Duals (HMO SNP) Important Update Regarding Medicare Telehealth Coverage

As of October 1, 2025, changes to Original Medicare telehealth coverage are in effect due to Congress not extending pandemic-era telehealth policies. Now, Original Medicare will only cover most telehealth services for beneficiaries located in a rural office or medical facility.

Note: There are exceptions for the following services and they will continue to be covered by Original Medicare:

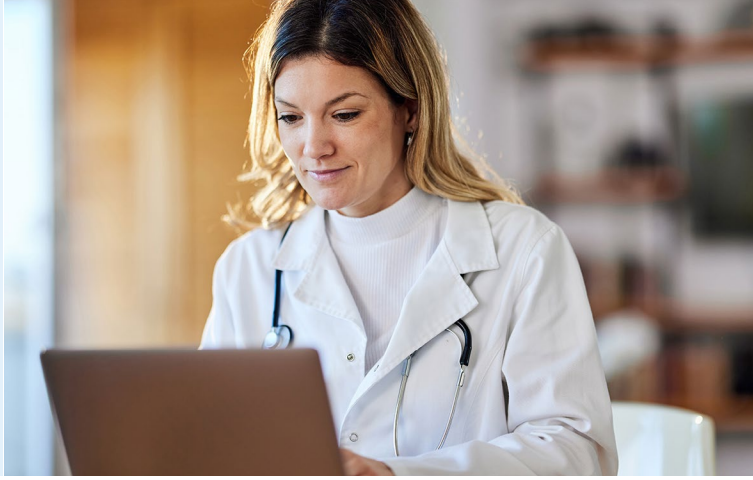
- Monthly End Stage Renal Disease (ESRD) visits.
- Services for the diagnosis, evaluation, or treatment of symptoms of an acute stroke.
- Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder, including a substance use disorder.

How This Affects Highmark D-SNP Plans

While these changes impact Original Medicare, Highmark Medicare D-SNP plans will provide coverage of expanded telehealth benefits for your D-SNP patients in 2026.

For details on a specific plan's telehealth coverage, please refer to the Evidence of Coverage documents for a given benefit year.

Provider Self-Reported Recovery



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 Electronically Submit Overpayments via TRENDSubmit

TRENDSubmit is user-friendly and has real-time status updates with a full audit trail and comprehensive dashboard reporting.

This secure, web-based process was built to streamline the adjudication of provider self-reported overpayments to payers.

Providers can contact Jennifer Baron at **jbaron@trendhealthpartners.com** to initiate TRENDSubmit access, receive user training resources, and get ongoing support.

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

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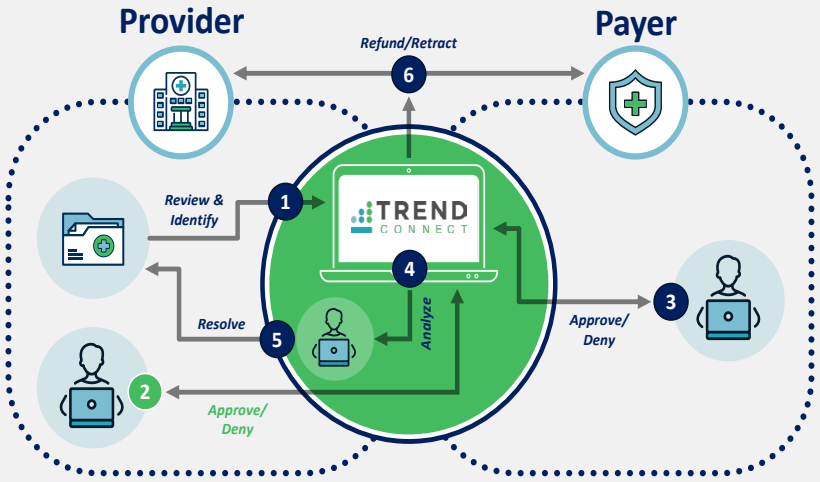
TRENDSubmit Workflow

TREND HEALTH PARTNERS

Provider Self-reported Recovery

TRENDSubmit is a secure, web-based built to streamline the adjudication of provider self-reported overpayments to payers.

- **User-friendly**, simple approach **driving 100% accountability**
- Drives **real-time status updates** with a **full audit trail** and comprehensive **dashboard reporting**



Seamless Workflow

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1. Provider reviews **credit balance data** from provider's patient accounting system and identifies payer overpayments
2. **Provider reviews and approves / denies overpayments** in TRENDConnect
3. If approved by provider, **payer reviews and approves / denies overpayments** in TRENDConnect
4. Provider **analyzes feedback from payer** to determine which are true overpayments vs. adjustment errors or mis-postings
5. Provider **resolves false credits based on payer root cause feedback** in provider's system
6. If approved by provider and payer, **TRENDConnect processes refunds / retractions** of overpayments

Ensuring Clear Communication with Members: Language Access Resources

Highmark Health Options (HHO) is committed to helping you provide the best possible care for our members. This includes ensuring effective communication, regardless of language.

Language Identification Card

To assist members in communicating their language needs, HHO offers a FREE, easy-to-use language card. Members can:

- Print the card
- Save a digital version on their phone
- Request a printed copy from Member Services

This card allows members to easily identify their preferred language during office visits and when receiving services.

Your Role in Providing Interpreter Services

As an HHO provider, your contract requires you to arrange and coordinate interpreter services for patients. This ensures meaningful access to care for those with limited English proficiency. HHO can assist you in locating interpreter resources upon request.

Additional Resources Available

- **Alternative Formats:** The Member Handbook and other important information are available in large print, Braille, and multiple language translations at no cost to the member. Please instruct patients to call Member Services at **1-844-325-6251** to request these formats.
- **Cultural Competency Training:** Enhance your understanding of diverse cultural needs with our **Cultural Competency Toolkit**.
- **Multilingual Signage:** Download multilingual signs that allow patients to indicate their language needs quickly and easily by pointing.

Click here to access the HHO-Provider Language Access Guide for Interpretation Services or scan the QR Code.

By utilizing these resources, you can help us ensure all members receive the clear and effective communication they deserve.

Reminder: Appropriate Use of JW and JZ Modifiers

Highmark follows industry standards, consistent with the **Centers for Medicare and Medicaid Services (CMS)** approach, requiring the appropriate use of the drug wastage modifiers, JW and JZ. Drug wastage modifiers should be present on all applicable claims. For example, claims for drugs supplied in single-dose containers must include either the JW modifier to indicate waste or JZ modifier to attest that the full quantity was used.

Protect West Virginia's Children from Lead Poisoning

Regularly prioritizing lead screening in young children is crucial in West Virginia. Lead exposure causes harm even at low levels, and screening is an important step to protect healthy development.

- **Extremely low screening rate for children:** Screening among children under 72 months in West Virginia was low in 2021, with only 14.2% of children receiving blood lead screenings **according to the West Virginia Department of Health and Human Resources**.
- **Constant exposure risks:** The **CDC reports** that lead continues to be identified in everyday items like food, clothing, and toys.

As you know, lead exposure can have devastating, long-lasting effects on children, including slowed development, learning and behavior problems, and speech and hearing difficulties. More information about these issues can be found on the **CDC website**.

Take Action Today

- **Educate families:** Discuss the importance of lead screening and the dangers of lead poisoning with all parents or guardians.
- **Offer in-office screening:** Provide convenient in-office blood lead screening to improve completion rates and ensure continuity of care.
- **Test at every opportunity:** Each office visit, including sick visits, can be used to perform blood lead testing.
- **Use CPT Code 83655:** This code indicates that a blood lead test was performed.

Additional Resource

The National Lead Information Center (**800-424-LEAD**) can provide education and guidance for parents or guardians on preventing exposure, resources for lead removal, and consumer alerts.

Medicaid Prior Authorization List (PAL) Update Reminder

As a reminder from the fax notification sent in October 2025, please visit the Highmark Health Options West Virginia Provider Resource Center (PRC) for a **list of procedure codes** added to the Highmark Health Options West Virginia Medicaid PAL. These require prior authorization that began on December 1, 2025.

To find these codes, please visit the **PRC** and click on Provider Resources in the tool bar at the top of the page. Then click on Prior Authorization Code Lookup. Scroll down to the bottom of the page to view the latest updates under Prior Authorization Code Lists. Advanced Notification of these updates will be provided via fax or newsletter, and posted on our website 60 days prior to the effective date. You can also enter any CPT code in the Main Search Bar to check prior authorization requirements.

Annual HEDIS Medical Record Review

Highmark Health Options West Virginia is conducting its annual HEDIS medical record review for Measurement Data Year 2025, starting in January 2026, and continuing through April 2026. The National Committee for Quality Assurance (NCQA) requires this review to assess provider compliance with standardized performance measurements.

We appreciate your assistance with medical record collection and review and are happy to assist you in fulfilling this request in any way we can. To best meet your needs, there are multiple options for submitting medical records including secure fax, UPS, or an on-site review. Highmark Health Options' retrieval staff will contact providers to discuss their preferred submission method.

It is important to remember that, as per the Participating Provider Agreement, providers are obligated to respond to these medical record requests within the requested timeframe and at no cost to Highmark Health Options or its members.

The HEDIS measurements are being collected to cover various areas that include:

- Weight Assessment and Counseling for Children/Adolescents
- Care for Older Adults
- Controlling High Blood Pressure
- Diabetes-related Assessments (Glycemic Status and Blood Pressure Control)
- Transitions of Care
- Prenatal and Postpartum Care

For any questions or concerns about this process, providers can contact Leslie Riding at **leslie.riding@highmark.com** or by calling **412-918-8981**.

Policy Updates

Highmark regularly reviews and updates our policies and procedures. Advanced notification will be provided via our newsletter or by fax, and posted on our website 60 days prior to the effective date.

You can find these medical policy updates at the following links.

Policy Updates

- **Notification date:** December 22, 2025
- **Effective date:** March 1, 2026

Medicaid Policies effective March 1, 2026:

1. **HHO-WV-MP-2002 Pharmacogenomic Testing**
2. **HHO-WV-MP-2019-001 Photodynamic Therapy with Porformer Sodium**
3. **HHO-WV-MP-2250-001 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling**
4. **HHO-WV-MP-2001-001 Observation to Inpatient**
5. **HHO-WV-MP-2004-001 Bariatric Surgery**

Archive:

1. **HHO-WV-MP-2027-001-Breast Reconstructive Surgery**

Medicare Policies effective March 1, 2026:

1. **HHO-DSNP-WV-MP-3001-001 Observation to Inpatient**
2. **HWC-WV-DSNP-2044 -001 Post Acute Care**

Medicaid Policy Annual Review:

1. **HHO-WV-RP-2007-002-Behavioral Health Outpatient Services** – Changes include adding service limitations to appropriate procedure codes and added information regarding autism.
2. **HHO-WV-RP-2115-002 EPSDT** – No changes to policy
3. **HHO-WV-RP-2140-002 Telehealth** – No changes to policy
4. **HHO-WV-RP-1259-002 Multiple Surgical Reduction** – No changes to policy

Accessibility Standards (Timeliness of Access to Care)

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**.

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 practitioners, 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 in the **Cultural Competency Toolkit**.

Notice of Practice/ Practitioner Changes

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.

Encounter 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.

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 Highmark Health Options West Virginia, 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.

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

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 Wholecare.

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.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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MXCRM-0694-1025 (12/19/25)