Q4 2025

Provider Newsletter

for Highmark Health Options | Highmark Health Options Duals (HMO SNP) | DELAWARE

FEATURED ARTICLES:

New Claims Submission Process for D-SNP Members Begins January 1

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

Important Update Regarding Medicare Telehealth Coverage

Get to Know the Language Profile of Your HHO Patients

...And More.

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Contact Us

Highmark Health Options and Highmark Health Options Duals Provider Services is the first line of communication for providers' questions and inquiries. Provider Services is available Monday–Friday, 8 a.m.–5 p.m., and can be reached by calling the following numbers:

HHO Provider Services: **1-844-325-6251** HHO Duals Provider Services: **1-855-401-8251**

New Claims Submission Process for D-SNP Members Begins January 1

Effective January 1, 2026, Highmark Blue Cross Blue Shield will operate Highmark Health Options Duals (HHO Duals) (HMO SNP) as an aligned Highly Integrated Dual Eligible (HIDE) plan. Members with a HIDE plan receive both Medicare and Medicaid coverage through the same organization. We will make integrated claims decisions for these members across both benefit types, which will streamline the claims submission process for you.

Please review the following instructions thoroughly to prevent any disruption in claim payments.

Single Claim Submission Process

Beginning January 1, 2026, providers will now only need to submit a single claim to the D-SNP Medicare Payer ID (47183), including the D-SNP Medicare ID number for aligned HIDE members. Highmark Health Options will then automatically process claims under both Medicare and Medicaid benefits, eliminating the need for you to submit separate claims for these services.

Date of Service Considerations

Please pay close attention to the date of service for your claims to ensure proper processing.

- **Institutional Inpatient:**
  - Only claims with an admittance date of January 1, 2026, or after will be automatically processed under both HHO Duals (Medicare) and HHO Medicaid eligibility.
  - If the admittance date is prior to January 1, 2026, please follow the standard process: submit the claim to HHO Duals (D-SNP Medicare) and then bill HHO Medicaid with the Explanation of Benefits (EOB).
- **Institutional Outpatient & Professional:**
  - Claims will only be automatically processed under both HHO Duals D-SNP Medicare and HHO Medicaid eligibility if all lines of service on the claim have a date of service of January 1, 2026, or after.
  - If any claim lines have a date of service prior to January 1, 2026, please follow the standard process: bill HHO Duals Medicare first and then bill HHO Medicaid with the EOB.

Click here for a list of frequently asked questions.

Questions?

Call Provider Services at **1-855-401-8251**, Monday–Friday, 8 a.m.–5 p.m.

Post-Acute Care Management: Authorization Process Changing

Effective March 1, 2026, Highmark is moving the management of post-acute care services—including initial and concurrent authorizations, care coordination, and length of stay management—from Home & Community Care Transitions to the Guiding Care platform for Medicare D-SNP members.

This change will impact providers in Delaware who serve Highmark Health Options Duals (HMO-SNP) D-SNP members at the following locations:

- Hospitals
- Skilled nursing facilities
- Inpatient rehabilitation facilities
- Long-term acute care hospitals

Simplified Authorization Submission

Starting March 1, 2026, all initial and concurrent authorization requests for post-acute care for D-SNP members must be submitted through Guiding Care, which you can access through NaviNet using single sign-on (SSO). The determination for your D-SNP member's post-acute authorization will be readily available in Guiding Care.

If you haven't yet registered with NaviNet, we encourage you to do so **here**.

Need More Information?

For additional questions, access the **Provider Resource Center** or reach out to your assigned Helion Network Performance Manager.

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

As a reminder, Highmark is complying with changes from **The Centers for Medicare and Medicaid Services (CMS)** regarding additional benefits your Highmark dual eligible Medicaid and Medicare (D-SNP) patients can receive. The Special Supplemental Benefits for the Chronically Ill (SSBCI) can include flex card values for purchasing healthy foods, paying utility bills, and more.

Both Highmark Health Options Duals (HMO SNP) and Highmark Health Options Duals Select offer 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 Health Options Duals provider, you can help those that aren't yet qualified get these benefits faster by completing a SSBCI Provider Attestation Form upon your patient's request, 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 conditions, and helps Highmark quickly activate their extra benefits.

SSBCI Benefit Provider Attestation Form and Instructions:

1. **Download the Provider SSBCI Attestation Form on the Provider Resource Center under Forms and Reference Material.**
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 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.

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:

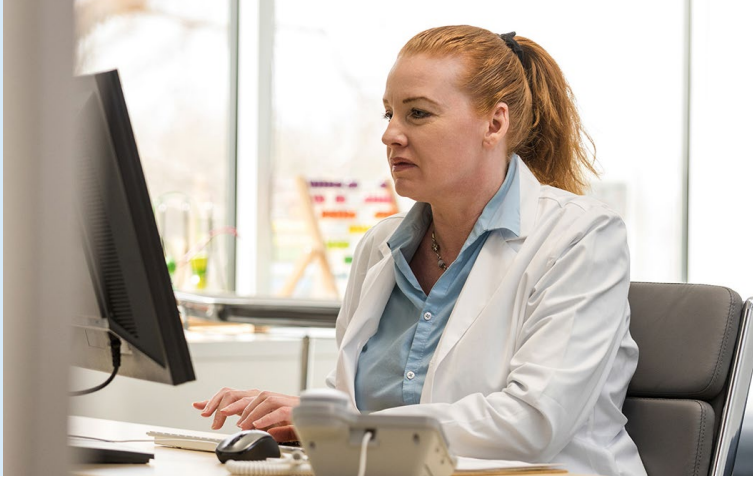
- Monthly End Stage Renal Disease (ESRD) visits, services for the diagnosis, evaluation, or treatment of symptoms of an acute stroke.
- Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder, including a substance use disorder.

How This Affects Highmark D-SNP Plans

While these changes impact Original Medicare, Highmark Medicare D-SNP plans will continue to provide the same telehealth coverage offered throughout 2025. We will continue to 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.

Preparing for Upcoming HEDIS Medical Record Review



Highmark Health Options Delaware is conducting its annual HEDIS medical record review for Measurement Data Year 2025, starting in January, 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**.

2025 Model of Care Training Summary

Provider Training Requirement: If you have not already done so, please complete the Model of Care training before December 31, 2025.

As a Special Needs Plan (SNP), Highmark Medicare Dual Eligible Special Needs Plan (D-SNP) members are required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC). In accordance with CMS guidelines, Highmark's SNP MOC is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization (MAO) to provide coordinated care for special needs individuals. Our network providers are expected to complete and attest to MOC training on an annual basis.

The SNP MOC is divided into four sections:

1. Description of the SNP population
2. Care Coordination
3. SNP Provider Network
4. Quality Measurement & Performance

The annual provider training focuses on the SNP Provider Network section and outlines what Highmark expects from our providers in maintaining an effective MOC.

The MOC ensures that the SNP Provider Network is comprehensive and able to care for the unique and specific needs of the population by implementing the following elements throughout the SNP provider network:

1. Specialized Expertise
2. Use of Clinical Practice Guidelines
3. Care Transition Protocols
4. Annual Model of Care Training

The training also includes common MOC terms and definitions as well as Highmark's contact information.

Review the Model of Care Provider Training found on our **website here**. Once you have completed this training, please submit an attestation indicating that you have completed and comprehend the Model of Care training by **clicking here**.

Osteoporosis Management in Women (OMW): A HEDIS Focus

The Healthcare Effectiveness Data and Information Set (HEDIS) Osteoporosis Management in Women (OMW) measure tracks the percentage of women, ages 67–85 and covered by a Medicare plan, who have experienced a fracture and subsequently received appropriate follow-up care.

What constitutes appropriate follow-up within 180 days (six months) of a fracture?

Patients must have EITHER:

- A bone mineral density (BMD) test (DEXA scan)
- A prescription for an osteoporosis-specific medication

Tips for OMW Improvement

- **Timely DEXA Scans:** Ensure your patients receive a follow-up DEXA scan within 180 days of a fracture. Either the primary care provider or an endocrinologist can order the DEXA scan.
- **Proactive Prescribing:** Provide a BMD prescription promptly after a fracture diagnosis and strongly encourage patients to complete the screening.
- **Patient Follow-up:** Track completion of BMD screenings and discuss results with patients at their subsequent visits.
- **Medication Adherence:** Ensure the prescribed medication is dispensed and received by the patient from the pharmacy. Common treatment options can include:
  - Denosumab
  - Ibandronate
  - Zoledronic acid
  - Teriparatide
  - Romosozumab
- **Screen for Falls and Fractures:** Routinely inquire about falls or new fractures during patient appointments.
- **Assess Risk Factors:** Systematically evaluate women for osteoporosis risk factors, including:
  - Low body weight
  - Excessive alcohol intake
  - Current tobacco use
  - History of previous fractures
  - Use of medications that can impact bone health (e.g., corticosteroids)

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- **Develop a Fracture Care Pathway:** Implement a standardized process within your practice to identify patients with new fractures and ensure they receive timely BMD screening and, if indicated, osteoporosis medication.
- **Educate and Empower Patients:** Discuss the importance of bone health, fracture prevention, and adherence to screening and treatment plans with your patients.

Adhering to the HEDIS OMW measure not only contributes to quality care metrics but, more importantly, ensures that our female Medicare beneficiaries receive the necessary interventions to prevent future fractures and improve their quality of life. By staying informed about these updated guidelines and emphasizing the importance of timely vaccination, you can play a vital role in improving the health and well-being of your patients and our members.

Clinical Practice Guidelines 2025

Highmark Health Options compiles clinical practice and preventive health guidelines to assist providers in delivering appropriate care relevant to our members.

These guidelines are developed using clinical practice guidelines (CPGs) from recognized sources. The guidelines also serve as a guide for Highmark Health Options' various wellness programs.

General CPG Limitations: Guidelines may not apply to every patient or clinical situation; some variation from guidelines is expected. Provider judgment and knowledge of an individual patient replaces clinical practice guidelines. In addition, guidelines do not determine insurance coverage of health care services or products. Coverage decisions are based on member eligibility, contractual benefits, and determination of medical necessity.

A complete listing of Highmark Health Options guidelines is viewable **online**. Physical copies are available upon request. For a physical copy, please contact the Quality Improvement Department at **1-844-325-6251**.

Delaware Flu Vaccination Update

Seasonal Update

For the 2025–26 season, all influenza vaccines are trivalent. Bill the appropriate CPT product code and the administration code together.

- **VFC:** Highmark Health Options requires PCPs who are treating children to enroll them in the Vaccine for Children (VFC) Program. This program provides vaccines at no cost to providers. The VFC website provides an overview of the program and includes information regarding eligibility requirements.
- **Diagnosis:** Always report Z23 — Encounter for immunization.
- Highmark Health Options will reimburse an administrative fee when a vaccine administration code is billed for each vaccine code along with the appropriate NDC number.

CPT Product Codes

Code	Vaccine Type	Age
90656	IIV3	≥6 months
90657	IIV3 (peds)	6–35 months
90658	IIV3 MDV	0.5 mL
90673	RIV3	≥9 years
90660	LAIV3 intranasal	2–49 years
90653	aIIV3 adjuvanted	≥65 years
90662	HD-IIV3	≥65 years
90661	ccIIV3	All ages

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Administration Codes

Situation	Code(s)
<19 yrs with counseling	90460 + 90461
≥19 yrs or no counseling	90471 + 90472
Intranasal/oral (LAIV3)	90473 + 90474

Clean-Claim Checklist

Requirement	Note
Correct CPT	Must match age/brand/route
Diagnosis	ICD-10-CM Z23
VFC doses	Bill $0 line with SL if payer requires
Modifier -25	Append only for separate same-day E/M

Delaware Essentials

- **Provider Requirement:** PCPs must enroll children in the VFC Program.
- **Reimbursement:** Highmark Health Options reimburses an administrative fee when billing with vaccine admin codes plus NDC number.
- **Reporting:** Delaware mandates DelVAX reporting for all immunizations.
- **MCOs:** Some (e.g., AmeriHealth Caritas DE) reimburse admin but not VFC vaccine product.

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.

Get to Know the Language Profile of Your HHO Patients

Highmark Health Options (HHO) implements quality improvement efforts to continually review aspects that affect patient care and satisfaction, and looks for ways to improve them. To help providers meet patients' language needs, HHO shares details with providers about the languages patients in their area may speak and provides information on available interpreting services. Providers can request this information by contacting Provider Services at **1-844-325-6251**.

HHO annually assesses languages spoken by the patient population in the service area and compares them to the data that providers report on their network applications.

The most recent analysis concluded that Delaware had greater than 1,000 residents speaking the following primary languages:

- Arabic
- Bengali
- Chinese (including Mandarin and Cantonese)
- French
- German or Other West Germanic
- Gujrati
- Haitian Creole
- Hindi
- Italian
- Korean
- Russian, Polish, or Other Slavic
- Spanish
- Swahili
- Tamil
- Telugu
- Vietnamese

Highmark additionally performs a comprehensive language profile analysis using the most recent U.S. Census community-level data. This analysis reveals that 154,374 individuals, representing 15.8% of the population in Delaware, reside in households where a language other than English is spoken.

Further detailed findings from the Delaware Census data indicate the following:

- **Spanish:** Over 61,967 individuals, or 7.6% of the population, reported having Spanish speakers in their homes.
- **Indo-European Languages:** Approximately 32,727 individuals, or 4%, reported the presence of Indo-European language speakers in their homes.
- **Asian Languages:** More than 15,986 individuals, or 2%, reported having Asian language speakers in their homes.
- **Other:** 1.6% of the population.

These community-level statistics closely align with Highmark's internal membership language reporting.

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

Highmark 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 **1-844-325-6251 (TTY: 711)** or Highmark Health Options Duals Provider Services at **1-855-401-8251 (TTY: 711)**, Monday–Friday, 8 a.m.–5 p.m.

Accessibility Standards

Highmark Health Options (HHO) Delaware 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**.

Member Rights and Responsibilities

Highmark Health Options Medicaid and Medicare Duals members have certain rights and responsibilities as members of Highmark. To detail those rights and responsibilities in full, Highmark maintains a Member Rights and Responsibilities statement, which is reviewed and revised annually.

Highmark 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.

Members have the right to:

- Receive information from Highmark 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 Highmark about the Plan, its network of providers, covered services, and rights.
- Have Highmark support their right to make decisions about their care.
- Issue a complaint or ask Highmark to reconsider decisions the Plan has made by filing an appeal.
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Receive a written explanation in the event a medical service or Part D drug is not covered, or if their coverage is restricted in some way.
- Receive a copy of their medical records free of charge upon request. 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 Department of Health and Human Services' Office for Civil Rights 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.

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

Members are responsible for:

- Getting familiar with their covered services and the rules they must follow to get these covered services.
- Informing Highmark 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 acting in a way that helps the smooth running of their doctor's office, hospitals, and other offices.
- Paying Medicare premiums and any applicable copayments or late enrollment penalties.
- Notifying Highmark if they move, regardless of whether it is outside or inside of Highmark's service area.
- Follow plans and instructions for care that they have agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

*If a minor becomes emancipated, or legally freed from control by his or her parents (over the age of 16), or marries, he or she shall be responsible for following all Highmark Health Options member guidelines set forth above.

The Member Rights and Responsibilities Statement can be found in the Medicaid Member Handbook, the Evidence of Coverage, or on our website at **Medicaid Member Resources** and **Medicare Member Resources**.

For more information, please call Provider Services at:

- Medicaid: **1-844-325-6251**
- Medicare Duals: **1-855-401-8251**

Medicare Parts A and B Cost-Sharing

All members enrolled in Highmark Health Options Duals (HMO SNP) D-SNP plan 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 dual eligible Medicare 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 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 members 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 Medicaid and Medicare Assured 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 dual eligible members. The Member Rights and Responsibilities Statement is also available for review online at **HighmarkHealthOptions.com**.

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.:

HHO Duals
1-855-401-8251 (TTY: 711)

HHO Medicaid
1-844-325-6251 (TTY: 711)

Participating Providers Should Not Balance Bill Patients

Highmark Health Options (HHO) continues to receive numerous complaints about participating providers who have inappropriately balance billed HHO patients for services.

As a reminder, reference the below language from page 19 of the Highmark Health Options Provider Manual Billing Responsibilities section.

Billing patients for covered services

Under no circumstance may a provider bill; charge, collect a deposit from, seek compensation, remuneration, or reimbursement from; or have any recourse against a patient for nonpayment by Highmark Health Options for covered services.

Contact Provider Services at **1-844-325-6251** to learn more about balance billing.

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.

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

Highmark BCBSD Health Options Inc. d/b/a Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association.

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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